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Preventing Teenage Pregnancy

Conference Proceedings

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**INSTITUTE FOR HEALTH POLICY STUDIES
FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF SOUTHAMPTON**

PREVENTING TEENAGE PREGNANCY

**Conference Proceedings for a conference held
at Chilworth Manor, Southampton
on Monday 5th July 1993**

**ISBN 085432 5042
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March 1994**

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INTRODUCTION

A year and a half ago the Government published *The Health of the Nation* White Paper which set a target for reducing pregnancies in young women under the age of 16 from 9.5 per 1000 to 4.8 by the year 2000 (DoH 1992). Health Authorities are now trying to develop effective strategies which will meet this target. This conference held on the first anniversary of the publication of *The Health of the Nation* explored a number of key issues relating to the prevention of teenage pregnancy which will need to be addressed if the target is to be reached.

The morning plenary sessions opened with Dr. Roger Ingham who discussed recent research on the sexual lifestyles of young people. Dr. Ingham contrasted the findings of a survey of sexual behaviour of young adults with the 'rational' model of health behaviour and drew out the policy implications of this. He also addressed the current debate on sex education and the wording of the draft guidance on sex education which had been issued by the Department for Education.

While, there is little context within the White Paper for choosing to target under 16's, the White Paper comments that 'a package of measures which substantially reduces pregnancies in the under 16s may also be expected to exert a similar effect on unwanted pregnancies in those over 16'. So any discussion of teenage pregnancy cannot be limited to the under 16 year old age group. However, Jonathan Montgomery discussed the legal situation regarding this age group as there is often confusion regarding whether advice and services can be provided for them. His paper emphasised his view that there is strong legal support for the provision of confidential advice and services.

Young people's views of family planning services was the subject of the paper presented at the conference by Professor Ian Diamond. His presentation drew on the work he and his colleagues undertook for the Wessex Regional Health Authority on consumer views of family planning services. A published version of the results of this work are included in this conference report¹. Professor Diamond particularly focused attention on the wishes and needs of young people and the options for service delivery assessing the contributions of family planning services in special clinics and general practice and the roles of doctors and nurses.

In the afternoon the conference divided into a number of workshops to examine a number of practical aspects of reducing teenage pregnancies. These explored issues relating to sex education, family planning, the contribution of voluntary youth services, planning and monitoring services and the needs of teenage mothers.

The importance of sex education was explored at the conference by Mindo Vark and Dr. Helen Trippe. They examined the policies developed by local schools and the objectives

¹ Cooper et al (1994) 'Choosing and using contraceptives: Integrating qualitative and quantitative methods in family planning.' *Journal of the Market Research Society* 35(4), 325-339.

and content of schools sex education programmes. In particular they emphasised the key role of the Teacher/Adviser.

The developments within the voluntary sector were represented by the work of youth agencies such as Off The Record in Havant and the Youth Trust on the Isle of Wight. Kevin Feaviour and Dr Jane Botell discussed the work of youth agencies and the experience of the Isle of Wight Youth Trust is presented in these conference proceedings.

But the delivery of effective services requires substantial planning and good monitoring and evaluation. These issues were explored in the workshop presented by Nicola Woodward and Stephen Peckham. They presented an approach based on the development of local targets and drew out the information needs for developing local strategies as well as the need for interagency collaboration. They also presented material on monitoring services and this is reproduced here.

In the last workshop we are reminded by Trish Skuse and Frances Hudson that even with the best planning and effective service deliveries there will still be teenage mothers and it is important to ensure that services are developed for them. The workshop was based on Frances Hudson's experience of running the Avon County Unit for school girl mothers in Bristol and Tricia's research for her Phd and the Trust for the Study of Adolescence on teenage mothers.

*Stephen Peckham
Research Fellow
IHPS, March 1994*

SEXUAL LIFESTYLES OF YOUNG PEOPLE

Dr Roger Ingham, Senior Lecturer
Department of Psychology, University of Southampton

Introduction

Sexual health is a crucially important issue; I am assuming throughout my talk that this is not disputed by people here. Whether or not we feel obliged to direct our professional lives in accordance with the wishes of the Government regarding target reductions in rates of teenage pregnancy and STDs (HMSO, 1992), and whether or not we are convinced by the regular reports in the press (refuelled recently by the Day Report) on there being little risk of HIV infection for heterosexuals, there is no doubt that sexual activity and aspects of sexuality are closely related to both physical and psychological health. Even if the risk for HIV is lower amongst heterosexuals than was thought to be the case a few years ago (and this is not at all surprising given the poorer knowledge base there was then about levels of sexual activity and the nature of the virus) this is no reason to divert attention from the increasing recognition that sexual health needs to be taken very seriously.

What I want to attempt to do today is to provide an overview of recent research on sexual lifestyles of young people, and then to make some tentative suggestions of what we need to be thinking about in terms of policy and provision. I would also like to say a little about the recent debates in the House of Lords which have led to the proposed amendments to the sex education aspects of the Education Act.

A brief overview

Before starting on this, however, I want to say a little about the situation regarding conception rates amongst young teenagers in the areas of the country closest to the Wessex region. The national picture (**OVERHEAD ONE**) shows that the South East and South West come towards the bottom of the league table in the country overall. Also shown on this overhead are some data (HEA/MORI, 1990) on what is known about sexual activity and condom use in these different areas of the country - these data are potentially interesting in that differential rates of conception might reflect different levels of activity and/or different levels of contraceptive behaviour. The data here relate to different age ranges simply because we don't have data on sexual activity amongst younger age groups, and, of course, the data on contraceptive behaviour only relate to condom use rather than other forms which affect probability of conception. Although we don't have time now to consider these data in detail, I can assure you that, as they stand, there are not really any clear clues as to what is going on. Apart from the North having the highest conception rates together with the highest rates of reported sexual intercourse and lowest rate of condom use at last intercourse, the rest of the data are rather 'fuzzy'.

Turning to more local data, the rates across the Wessex region (**OVERHEAD TWO**) show quite wide variation. Some of these figures are really quite hard to understand at face value. Thus, for example, why should Basingstoke have such a markedly lower rate than, for example, Swindon? A number of recent studies (for example, Smith, 1993) have demonstrated a reasonable statistical link between conception rates and various simple

SOME COMPARATIVE DATA RELATING TO TEENAGE PREGNANCY

<i>REGION</i>	<i>RATES (1990)</i>	<i>INT'SE</i>	<i>COND</i>
NORTH	13.1	57	45
YORKS & HUMB	12.3	53	55
NORTH WEST	11.8	52	52
E MIDLANDS	10.8	52	48
EAST ANGLIA	8.4	52	48
W MIDLANDS	11.6	51	53
SOUTH EAST	8.1	49	54
SOUTH WEST	8.9	51	46

NOTES:

RATES - number of conceptions per 1000 women aged 13 to 15 years

INT'SE - proportion of women aged 16 to 19 years who report having had 'full sexual intercourse' (from HEA/MORI survey)

COND - proportions (16 to 19 years) reporting condom use at last intercourse (from HEA/MORI survey)

COMPARATIVE DATA RELATING TO TEENAGE PREGNANCY IN THE WESSEX REGION (1990 RATE PER THOUSAND WOMEN AGED BETWEEN 13 AND 15 YEARS)

<i>DISTRICT</i>	<i>RATES</i>
EAST DORSET	6.9
WEST DORSET	6.3
PORTSMOUTH / SE HANTS	10.7
SOUTHAMPTON / SW HANTS	11.3
WINCHESTER	7.1
BASINGSTOKE	5.0
SALISBURY	7.5
SWINDON	10.4
BATH	7.9
ISLE OF WIGHT	9.2
<i>REGION</i>	8.5
<i>ENGLAND AND WALES</i>	9.6

measures of deprivation, although it must be acknowledged that some of these measures really are quite crude indicators. There is also the problem of what to do with such findings. They can, of course, be used as a basis for the geographical targeting of services, but we have to concede that in many other areas of health research the effects of structural features are very powerful and difficult to overcome. A group of us here are in fact planning a study to explore the nature of these variations within Wessex in some considerable detail, looking at not only a considerably wider range of statistical and community indices, but also at the nature of the current provision and accessibility of services in the different areas.

However, in addition to such statistical attempts to account for variation, we also need to be informed by a high level of understanding of the actual contexts in which early sexual activity occurs, by the understandings and interpretations which young people have of the various aspects involved, their perceptions of risk, and other related issues.

Summary of sexual lifestyles

I want to very briefly summarise some of the work that we have been doing here on young people's sexual activity. Various different projects have involved detailed discussions with over 200 young people covering sexual attitudes, knowledge and activities, surveys of the attitudes of teachers, governors and parents on aspects of school sex education, a detailed study in Salisbury on young peoples' views on sex education programmes in nine different schools, and other related issues. Most of what I refer to came from the detailed individual interviews with young people, a study which was funded by the Economic and Social Research Council. Although the research was originally set up in the context of HIV/AIDS related concerns, much of the material gathered is, of course, relevant to the topic of early pregnancy.

The interviews lasted between one and three and a half hours, were tape-recorded and transcribed, and painstakingly analysed to identify not only detailed information regarding activity levels, contraceptive use, and other 'objective' data, but also recurrent themes, justifications, explanations, and perceptions. The interviews and much of the analyses were conducted by the research staff on the project - Alison Woodcock and Karen Stenner.

Clearly, time does not allow a full treatment of many of the details of the data collected. Amongst the total sample of 225 people aged between 16 and 25 years, there were about 35 who claimed not to have had sexual intercourse. Most of these were either guided by strong religious beliefs associating sex with marriage, or reported no moral objection to premarital sexual activity but had not yet had the opportunity to engage in it. (In terms of self-esteem, by the way, this latter group would be particularly interesting to explore further). Of the remainder, the patterns in terms of the ages at which they became sexually active appear to be very similar to those obtained on much larger samples used in survey work. Obviously, with this type of study and the relatively small number of subjects (although not small compared with other qualitative research) we cannot claim any representativeness for our sample, but we do not believe the material that we analysed and report are atypical of the range of understandings that would be found amongst young people more generally.

By way of summary I want to contrast our key findings with what might be called a 'rational' model of health behaviour. The Health Belief Model (being used as an archetypal 'rational' model) is based on the premise that if people are presented with factual information, are aware of the risks involved in particular activities, feel a sense of personal vulnerability, and perceive the benefits of a particular action to outweigh the costs, then they will adopt the 'rational' course of action. In the current context, this would involve either abstinence from sexual intercourse, or adopting safe and reliable methods of contraception. You will not be surprised to hear that not all of our sample behaved in this way! To provide the contrast, I want to summarise what we have called the 'impediments'. By these, we mean concepts and/or processes which have helped us to understand what is going on during these early sexual encounters, and why it is that young people, despite having fairly high (but variable) knowledge levels and awareness of risk (at least objectively), do not appear to behave 'rationally' (Ingham *et al.*, 1992)

The seven impediments are shown on the overhead (**OVERHEAD THREE**). I shall say a word or two about each, but let me also add a further aspect of this analysis. Later on, I shall be saying a few words about the policy implications of our research, and the rest of today's agenda is very much geared towards practical steps. This list of impediments, then, also serves as a guide to the sorts of issues which would need to be covered in a successful programme of sexual health and sexuality education. In other words, to the extent that these issues appear to affect the likelihood of people engaging in safe or unsafe sexual activity, then they will need to be addressed at some stage and in some form if we really are going to affect patterns of activity and, thereby, the rates of early unwanted pregnancy and the levels of STDs amongst young people.

In due course, but not today, I want to develop this idea into a grid, such that these impediments (and others which might emerge from further analysis and research) appear down the left hand column, and possible means and contents of alternative forms of provision appear alongside. The resulting document would constitute a type of 'Sexual Health Charter', highlighting (in a similar way to the Patient's Charter) what can be regarded as setting out the basic entitlements of young people so that they might enjoy healthy and rewarding sexuality (or to use a phrase which may be more acceptable, which would assist in attaining the Health of the Nation targets). And please let me stress that the use of the word 'Charter' here does not in any way suggest an encouragement or enticement to engage in sexual activity; the NHS Patient's Charter, for example, does not encourage us all to be ill!

The first three impediments may have more direct relevance to avoidance of HIV infection, but are not irrelevant to conception.

Perceived personal invulnerability: This refers to the finding that even in those cases in which people know about objective levels of risk and what constitute risk behaviours, they perceive their own personal risk to be low. This may be due to lack of knowledge or understanding of the information they are given, and it was clear from our material that many myths still exist in relation to when someone can and cannot conceive. In relation to HIV infection, we identified eighteen separate justifications as to why people felt themselves to be invulnerable; since some of these related to an apparent general acceptance that life is a gamble, then similar views may well apply to risks of pregnancy. Some interesting

**SUMMARY OF IMPEDIMENTS TO RATIONAL
HEALTH-RELATED DECISION MAKING
IN THE FIELD OF SEXUAL BEHAVIOUR**

1. Perceived invulnerability
2. Lay perceptions of concepts
3. Positive reasons for non-rationality
4. External and internal pressures
5. Ideologies and power
6. Mystique of sexual behaviour
7. Negotiation and the notion of joint decision-making

**REPORTED TIME TO FIRST INTERCOURSE SINCE
BECOMING A 'COUPLE'
(IN PERCENTAGES)**

TIME	M	F	TOT
Less than 24 hours	31	25	27
Between 24 hrs and 2 wks	33	21	26
Between 2+ wks and 1 mo	18	9	13
Between 1+ mo and 6 mo	15	29	23
More than 6 months	3	16	11

interpretations of risk assessment were identified, involving comparisons of the chances of 'getting HIV' or becoming pregnant with those of being run over by a bus. What emerges from these analyses is not just varying levels of knowledge, but also varied perceptions as to the extent to which some young people believe themselves actually capable of exerting control over the levels of risk to which they are exposed (Woodcock *et al.*, 1992a)

Feelings of invulnerability are enabled and maintained through a wide range of conceptions and misconceptions, in many cases indicating an understanding of particular parts of the 'received wisdom', and filling out the gaps with 'knowledge' gained from the media, from friends or from 'common sense'. In our current Salisbury study, a common complaint by the students is that the topics covered in their PSE (or Biology, RE, or others) lessons are determined by the teachers, rather than being related to the particular issues that the young people themselves wish to raise.

Understandings of terminology: As part of our analysis of the government HIV campaign based on the theme 'if you don't know your partner, use a condom' we looked closely at the relationship between the extent to which people did 'know' their partners and their contraceptive behaviour. We did find, by the way, that, in relation to HIV avoidance, this advice was consistently misinterpreted, and the campaign was, in some ways, counter-productive; since this conference is about pregnancy, however, I won't dwell on this issue. Some of our data were, however, relevant in relation to conception avoidance. The intention behind the advice to 'get to know your partner' was, we believe, twofold. One aim was to enable a risk-assessment to be made; in other words, if it was discovered that a potential partner had many previous partners without using adequate protection, then the 'rational' young person would insist on avoidance of penetrative sex or condom use. The second assumption was that 'knowing' someone in the sense intended would make it easier to discuss with them the sorts of activities which one would like to engage in, what type of contraception should be used, and so on. If we can assume that the longer one has known someone then the easier it is to discuss such issues, then the length of time prior to intercourse is a relevant measure. We defined this as the time between becoming a couple (rather than first meeting) and progressing to sexual intercourse, and we focused specifically on first ever intercourse (Ingham *et al.*, 1991)

Around a quarter of our participants reported their first ever intercourse within 24 hours of becoming a couple (**OVERHEAD FOUR**), with a further quarter between 24 hours and two weeks. These very short intervals were more common amongst the quarter or so of our females whose first sexual intercourse occurred when they were aged fourteen years or below and, not surprisingly, they reported knowing nothing at all about their partners (many of whom were considerably older). These very early encounters, with little or no knowledge of partners, were also associated with low rates of condom use (**OVERHEAD FIVE**).

Positive reasons for not following advice: In many cases, we found evidence that our respondents knew what was the 'appropriate' course of action but had developed positive reasons why such advice could, or should, not be followed. Again, we will use examples relating to revelation of prior sexual experience. To successfully negotiate delay in intercourse, or non-penetrative activities, or condom use, involves a risk that ones previous sexual activities will be revealed. Thus, to appear to be highly skilled in condom use, or to know too much about different kinds of contraception, or to even be carrying condoms

**REPORTED CONDOM USE ACCORDING TO
CATEGORY OF KNOWING PARTNER AT FIRST
EVER INTERCOURSE**

**(PERCENTAGES WITHIN KNOWLEDGE
CATEGORIES)**

CATEGORY OF KNOWING	CONDOM USE	
	YES	NO
VIRGIN	50	50
NON-VIRGIN	59	41
NO KNOWLEDGE	31	69
(TOTALS)	48	52

**REPORTED REASONS FOR FIRST EVER
INTERCOURSE
(IN % - MULTIPLE CATEGORISATION POSSIBLE)**

	Females	Males
Relationship variables	58	18
Physical variables	14	57
Peer pressure	13	43
Situational pressure	28	8
'Carried away'	25	23
Other	8	0



(especially for females) gives off impressions to others.

Such reputational issues feature prominently. Some respondents felt that to report on previous activities could be seen as bragging (which, although acceptable in many all-male peer contexts was not generally thought to be acceptable in the context of a new intimate relationship). At the other extreme, those with little or no experience reported embarrassment at the prospect of revealing this to actual or potential partners. Clearly, since self-disclosure generally operates in a reciprocal fashion, an unwillingness on the part of one partner to begin, or respond to, such discussions makes them rather short-lived.

What is important to understand from these brief examples, is that the explanations given are perfectly rational from within the framework of the respondents' own positions and/or understandings. Our intention is to point out the ways in which these various rationalities are at odds with, and counteract, the 'received rationality' of official biomedical wisdom.

External and internal pressures: Rational models assume a level of independent and free choice after weighing up the various pieces of information. The models do not generally account adequately for the powerful effects of pressures of various kinds. In keeping with other researchers (for example, Lees, 1986), we have found clear evidence of the effects of peer or media pressure to engage in intercourse, especially amongst males, but not uncommon in females (**OVERHEAD SIX**). Again, reputational features are crucial in understanding the processes involved here - for roughly half of the males, to be sexually active was felt to be 'demanded' by peer groups. For females, although there were some for whom losing a reputation as a 'fridge' was very important, sexual experience outside of a caring relationship was considered unacceptable in many contexts.

In some cases, these external pressures become internalised, such that beliefs in what constitutes a 'real' man or woman provided strong pressures to become sexually active, even though there was no immediate intention of telling others about it. The notion of reputation can be applied equally with regard to 'self as audience' as to 'other as audience'

Other forms of external pressures included force, either physical or emotional and, not surprisingly, women were considerably more likely to be the victims. When reporting how they felt about their first ever intercourse after the event, many women reported strong feelings of regret and self-recrimination. For example:

... (there was no pleasure) ... because all I could think about was how much pain I was going through at the time and I couldn't really settle down and enjoy it because it was just hurting me too much ... but even though he said he was trying to do it as gently as possible - to prevent me from being hurt - I was still hurt ... and afterwards I just felt used and cheated by it all and I still went ahead and done it again

(AW: why did you feel used and cheated?)

because I didn't love him and I knew he didn't love me, and I didn't really feel anything for him and didn't expect anything to happen ... whether he did or not I don't know, but because I didn't love him ... and I always believed that it would be someone I loved first and it

wasn't so I felt a bit out of order for that, so I cheated myself more than anything, nobody else (female, 16).

"I regretted it, I really did. I thought 'oh God, this is not the way to lose it' ... you are supposed to lose it in a meaningful relationship, you know. You're supposed to do it after you've known a guy for five months, six months, you know. There's me on my one night stand, pissed as hell, and lose it in someone else's bedroom, you know. I thought, 'great, well done'" (female, 17).

We know from other research (Currie, 1992) that lowered self-esteem - whether due to having experienced abuse or through other negative early sexual experiences - leads to less careful sexual activity. The frequency with which our female respondents expressed such regret points strongly to the need for the provision of opportunity to have continuous support available, rather than a single input of information at a particular age.

Ideologies and power: The Women's Risk and AIDS Project publications (for example, Holland *et al.*, 1991, 1992) have presented the case for the importance of gender ideologies and power in this area, and, of course, many of the issues referred to above can be better understood in these frameworks. Similarly, the various different discourses highlighted by authors such as Hollway (1984) have been valuable in understanding our data, and the ways in which gendered subjectivities are maintained and re-produced by some of the male and the female respondents is well demonstrated. Hollway (*op. cit.*) highlights three such discourses, being the *have-hold* (where the aim of the woman is to get hold of and keep hold of a man for protection and procreation), the *male sexual drive* (where men have an insatiable desire for sexual outlet and it is women's job to assist) and the *permissive* (where sexual activity is seen as pleasurable in itself and without commitment on either side). The key point about discourses (which are rather more complex than we have time to deal with here) is that they identify the taken-for-granted assumptions within particular social worlds. This does suggest that analysis of the ways in which gender expectations are portrayed in magazines and other media could form an important part of a comprehensive sex education programme.

The limited extent to which such discourses are available for subjective analysis poses a serious challenge to the concepts of rationality and individual decision-making contained in the models of health behaviour mentioned earlier.

The mystique of sexual behaviour: Different social constructions of sexual activity emerge from our transcripts; some are based on moral conceptions, some on the notion of natural and spontaneous behaviour, and so on. The majority contain a central essence involving mystique. Many respondents referred to the avoidance of the topic by parents, the embarrassment of many teachers to go beyond the biological, and the ways in which coy language and *double entendres* are used in the media, by adults and within relationships. This construction of sexual activity as something mystical is hardly an adequate preparation for rational and considered thinking.

What this social construction does, of course, is make it very difficult for prospective sexual partners to talk to each other in specific terms about activities, more generally relying

on vague and evasive phrases (such as 'doing it', 'being careful', 'using something', and so on). But it goes further than this.

It also 'gives permission' to people to behave in an irrational fashion. "I don't know what came over me" or "I'm not usually like that" are common and acceptable justifications for what might appear to themselves and others to be aberrant behaviour. In other words, many of our examples in which people were clearly aware of the discrepancy between what they should do and what they did do can be internally justified and accepted, since the construction of sexual activity involves assumptions of mystical and uncontrollable forces.

It is in the consideration of this topic that we can begin to map out a possible role for the concept of 'rationality'. Rather than regarding it as an inherent 'property' of individuals, or as an overwhelming force, we should regard it as an option. In other words, people can choose to be rational or not (always subject to the effects of - often powerful - constraints). It is an option to be considered alongside other options, subject to the proviso that we may be (and often are) called to account for our behaviour (cf Harre, 1979). The social contexts in which such accounting, or warranting, takes place, as well as the nature of what is being accounted for, determine the extent to which 'rationality' is an acceptable justification for actions both for others-as-audience and for selves-as-audience. Gold *et al.* (1991) have produced a revealing account of some of the justifications produced for self and others in the context of safe and unsafe sex amongst gay men.

Regarding rationality as an option has implications for the way we regard the concepts of 'costs' and 'benefits', as used, for example, in the Health Belief Model. Rather than basing these in terms of specific biomedical and health preserving actions or behaviours (common in many applications of the HBM), we should afford greater priority to the importance of reputations and identities within particular social worlds. This will need much more opportunity for discussion, and awareness raising, of these social aspects of real contexts in which sexual encounters occur.

Negotiation and joint decision making: The final impediment to the acceptance of a notion of rational and individual decision-making models as applied to sexual activity is the obvious point that it is a joint effort. In our material, 'negotiation' regarding safer sexual practices, such as it is, tends to be based on assertion and insistence. For example, one young man told us:

"She produced condoms from the glove compartment of her car ... She just said 'Do you know what these are for?'... I said 'yes' ... and she said 'good - use it'... so I thought, 'right, fair enough' " (male)

An interesting aspect of this particular example is that the young man in question had not, in fact, ever had intercourse before, nor had he handled a condom. The fact that he was not able to admit this to the woman concerned (for fear of loss of face) clearly increased the risk of failure. But examples of women taking this kind of initiative (or being 'assertive') were not common.

We need more research in this area, and, amongst the potentially important factors, are the clash of different lay beliefs, the use of threats, power differentials in terms of

gender, age or experience, and the use and effectiveness of warranting statements, justifications, and so on. Research by a colleague, Gertjan van Zessen at NISSO (the Netherlands Institute for Social Sexological Research) in Utrecht demonstrates that the 'safeness' of outcomes of a high proportion of sexual encounters can be better predicted by awareness of the interactional dynamics than by individuals' scores on knowledge, attitudes or intention scales.

Intermediate summary

Let me try to summarise the story so far. In the light of what we know from research on young people's early sexual experiences, we can draw out the following implications for programmes.

1. We need to move away from an emphasis on facts and the idea of simple messages towards allowing the opportunity for more active discussion of the more dynamic issues involved. In this connection, it is rather depressing to read in the proposed revisions to Circular 11/87 from the Department for Education 'The Secretary of State considers that within this clear [... moral ...] framework the aims of a programmes of sex education [in schools] should be to present facts in an objective and balanced manner' (para. 3, DfE, 1993)
2. This will involve more opportunity and preparedness to deal with sensitive issues and to relate these to the concerns and reality of young people themselves (rather than relying on didactic teaching methods).
3. Attempts should be made to tackle some of the wider social contexts in which early sexual activity takes place; key amongst these is the issue of gendered power relations through appropriate encouragement of assertiveness and empowerment (including 'empowering men to be de-powered'). This should involve an element of media analysis, and role-plays are likely to be an effective device for drawing out some of the issues.
4. In sum, we need a more 'open' climate regarding sex and sexuality. Cross-national comparisons, by the way, suggest that such an environment is indeed associated with fewer early pregnancies. **OVERHEAD SEVEN** shows some mid-1980s data on teenage pregnancy from three countries, with the figures from the Netherlands (regarded as being 'open') strongly suggesting the direction in which we should be moving (Jones *et al.*, 1985, 1986).

Policy implications

There are a number of agencies which have a role to play in the delivery of effective sex education and in providing the opportunities for suitable and relevant support and advice. Time does not permit a detailed consideration of each of these, so I will say a few brief words about each before spending a little longer on the school setting.

Parents are cited frequently by the government as being the 'lead players' in this area; the proposed Revised Circular 11/87 states 'In approaching their responsibilities in this area,

**SOME COMPARATIVE DATA ON SELECTED
MEASURES (MID 1980s)**

(RATES PER 1000 WOMEN AGED 15-19)

COUNTRY	PREG'Y	LEGAL ABOR'N
U.S. (TOTAL)	96.0	45.7
U.S. (WHITE)	83.0	-
E. AND W.	45.0	20.9
NETHERLANDS	14.0	4.2

(FROM JONES, 1985, 1986)

schools should recognise that parents are the key figures in helping their children to cope with the physical and emotional aspects of growing up and preparing them for the challenges and responsibilities which sexual maturity brings. The teaching offered by schools should be complementary and supportive to the role of parents' (para. 5, DfE, 1993). Our own research (both the ESRC study and the Salisbury study) suggests that many young people find it extremely difficult to talk to their parents about these matters, and other work we have done on parental attitudes suggests that this embarrassment is mutual!

The health services clearly have a major role; for the purpose of today's conference I shall not say more about this. My colleague, Professor Ian Diamond, will later be talking about his own recent research (Cooper et al., 1992) on young people's perceptions of the support and help they receive from general practitioners, family planning clinics, and so on. I should just mention that the recent changes in funding arrangements threaten to reduce the flexibility with which additional clinics can be provided at times and places which are appropriate for young people with limited transport and resources.

The youth service sector is introducing some exciting and innovative facilities; these include the Off the Record 'Choices' project in Portsmouth which uses a peer education model of delivery and appears to be being extremely well-received. (Further details of this scheme and other possibilities are included in the reports from the Workshops later in this collection).

I shall devote the rest of my time to schools, since many commentators believe that good early sex education in schools is the key to this area, and should reach a very high proportion of young people. We need to start with a reminder of one of the major aims of the education system in this country, as contained in the Education Reform Act 1988 (Section 1(2)), which requires all maintained schools to offer a curriculum which:

- b) 'prepares such pupils for the opportunities, responsibilities and experiences of adult life'

Given the importance of sexual activity in relation to the physical and psychological health of people, a case could be made that appropriate coverage of the area is rather more relevant and important than some of the issues currently covered in the National Curriculum.

School-based sex education

There is a general problem associated with school based sex education which concerns the issue of differentiation. In any one class of, say, fourteen/fifteen year olds there will be some who have already experienced intercourse (with varying degrees of volition and impact on self-esteem), some who are close to it and others who are some years away. There may also be a few who have experienced sexual abuse in one form or another. It is difficult to see how a really effective input can be considered with such an heterogeneous population and it is not surprising that research on consumers' views consistently reveal that school based education is either too late, too early or not relevant (Woodcock *et al.*, 1992b). This stresses the need for flexible and alternative forms of provision (not necessarily school-based) being available for young people at different stages of their sexual development, as and when required. Some self-selection of young people into smaller groups may help to overcome this

problem - although the introduction of 'sex clubs' (divided into 'beginners', 'intermediate' and 'experienced') would probably not find favour, self selection on the basis of friendship groups may be worth pursuing. The argument would be that self-selected groups would be more homogeneous in attitudes, knowledge and behaviour than would randomly assigned groups, an hypothesis which is being studied at present by one of my students, Sarah Edmonds, as part of her M Sc (Educational Psychology) coursework.

As an aside, let me mention that the results from our Salisbury study indicate strongly that young people want more opportunity for discussion in smaller groups, and that they would like greater coverage of some of the more sensitive issues related to sexuality, such as rape and abuse, at earlier ages than they are currently introduced (if they are at all). They would also appreciate teachers (or outside speakers) who are youngish, use humour, and do not evade embarrassing issues.

The analysis of 'discourse', introduced briefly earlier, is also useful in considering the recent and current policy debates in this country. The discussions in the Houses of Lords and Commons almost certainly reflect the kinds of issues that are raised at more local levels by some parents, school governors, and others. If we believe that the climate in which sex education is 'delivered' needs to be altered, then we must be prepared to argue the general case at these levels in addition to planning our specific forms of intervention. For the remainder of my paper I want to briefly outline what I see to be the main arguments in the current debate as well as some of the associated issues and problems with the likely outcomes.

Lord Stallard's amendment to the Education Act was debated on 21 June 1993; although it was subsequently withdrawn, Baroness Blatch (on behalf of the Government) accepted the principles behind it and promised to return with a technically more correct version for the 3rd Reading (subsequently passed on 6 July, the day after this paper was delivered). Two key issues can be identified (in at least my reading) of the Hansard transcript of the debate of 21 June.

- Very few of the speeches really tackled the health issues directly, the majority being concerned with discourses about morality, fear, innocence, and so on.
- The whole debate appeared to be driven by a strong belief in, and commitment to, the rights of parents to be able to avoid their children from being confronted with sex education.

Lord Stallard started by pointing to the irony of the current situation, in which some parts of sex education are included in the National Curriculum (HIV/AIDS in Science) but the rest is voluntary (schools need to have a policy, but this could simply be that such issues are not covered). This creates a situation in which pupils cannot be withdrawn from some parts of sex education since there is no right of withdrawal from national Curriculum subjects. The solution is to take HIV/AIDS out of the National Curriculum, make sex education (with unspecified content) compulsory in secondary schools (but not part of the National Curriculum) and to increase the opportunity for parents to opt out their children.

Amongst the arguments put forward for increasing this right was that he had received

'a great deal of correspondence' from people complaining about the coverage in their local schools and that he had 'been flooded' with examples of what these people (and he) considered to be inappropriate material at different ages - if we had the time we could go through some of the examples that he cited and discuss whether we agree with his own perception of their inappropriateness (a couple of examples will suffice - he complains that at age nine, children should be able to talk about and discuss 'What makes a penis go hard? What is a period? If you are HIV positive does it mean you have to get AIDS?' At age ten, 'Sexuality - what is it and what words describe it? Does sex always lead to having a baby? Discuss that question. When is it OK for people to touch me? When is it OK for me to touch other people?'). Clearly, taking such comments out of context makes it difficult to reach firm conclusions, although I believe that we could come up with some pretty strong justifications for covering such topics in the wider context of bodily changes, children's curiosity about reproduction, sexual abuse, and other similar issues. Indeed, one of the most consistent findings (as mentioned earlier) from our Salisbury study is that young people (even aged 11/12) do read and hear a great deal about abuse, rape and abortion in the media, and would very much like the chance to talk the issues through and to learn more about them.

In the light of our increasing understanding of the contexts of the development of early sexual activity, as can make a few points regarding this amendment.

1. We know from other contexts that the 'withdrawal method' is not very effective!
2. The status of subjects which are compulsory but not part of the National Curriculum is very uncertain. Since there are, as yet, no guidelines (and any that do emerge from the School Curriculum and Assessment Authority will only be advisory) there is a risk that some schools will adopt only tokenistic coverage. This is particularly likely in the light of point 3 below.
3. Due to schools having a legal requirement to cover the subjects covered by the National Curriculum, there is great pressure on time and space for other subjects. Similarly, the cost implications for schools to buy in visiting experts to cover some aspects of sex education might be an inhibiting factor, especially where such coverage is not compulsory. Given the rights of parents to know how the school is performing in core subjects (through the publication of league tables), and given the governments' commitment to parental involvement in the content and delivery of sex education, it might be a good idea to encourage schools to publish league tables of the rates of pregnancy and abortion amongst their students so that parents can judge for themselves on the effectiveness of programmes!
4. The practical implications of withdrawal will cause problems for schools. Many schools now adopt a cross-curricula approach, and it is clear from our Salisbury study that topics can come up in a range of subject lessons, often unanticipated. (For example, some students commented positively on a discussion which arose during an English lesson in response to their having read a particular novel which raised questions about homosexuality. They were impressed with the teacher's ability to hold a sensible discussion with the class when this issue arose spontaneously). Presumably, the option of complete withdrawal would involve the teacher needing to consult a list of students and asking some to leave prior to responding to such genuine

interest amongst their students. The alternative, and possibly more likely, response to this bureaucratic complication would be for schools to adopt a rather more 'safe' policy, deal with the subject only in one class (PSE, PDS or similar) and possibly adopt a rather cautious syllabus to minimise the probability of parents withdrawing their children. This may be made more likely by the comments contained in the draft revised Circular 11/87, where it states quite clearly that the school's function is to support the parents (para 5 states that 'The teaching offered by schools should be complementary and supportive to the role of parents').

5. Some schools currently offer the chance for individual counselling by teachers for students if they want it (and, indeed, this is a potentially effective way of tackling the problems of differentiation mentioned earlier). However, the possibility of schools adopting a more 'safe' approach to this activity is again made more likely by the rather enigmatic warning contained in the draft revised Circular; in para 30, it warns 'On the specific question of the provision of contraceptive advice to girls under 16, the general rule must be that giving an individual pupil advice on such matters without parental knowledge or consent would be an inappropriate exercise of a teacher's professional responsibilities and could, depending on the circumstances, amount to a criminal offence'. The draft circular explains that a teacher should, if faced with such an approach, (a) encourage the pupil to seek advice from his/her parents, and (b) warn the pupil of the risks involved. It goes on to describe how the teacher should consider whether the matter should be taken further by involving the headteacher, parents and/or other support services. In para 32, the revised circular states: 'In considering whether to deal with the provision of individual advice and counselling in their policy on sex education, governing bodies should bear these considerations in mind'. Although one could imagine circumstances in which there would be wide agreement that others did indeed need to be involved (cases of suspected abuse, for example), such a 'warning' might again have the impact of inhibiting the development of such services in the local implementation of school policies. Further, many young people in our Salisbury study (and in Ian Diamond's work on Family Planning Services and other projects) have stressed the very high importance which they attach to the need for a confidential service being available. A school which cannot guarantee such a service is unlikely to be used by students for the individual advice and support which so many of them tell us that they would like.
6. Finally, there is the issue concerning cases where young people and their parents do not agree. Our own research findings, as well as those from many other projects, have consistently pointed to the difficulty that many young people have in discussing issues with their parents; not only is embarrassment an issue (on both sides) but also there are some clear disagreements on what should and shouldn't be talked about. Many of our young people described their parents as wanting to inhibit discussion because it appeared that they did not feel that it was appropriate for young people to talk and/or think about such matters. If such parents were to take up the option of withdrawal against the wishes of their children, then some real dilemmas are raised for the schools concerned. We have received many comments from teachers describing how pupils (perhaps from certain ethnic and/or religious backgrounds) approach them for advice and support, but specifically state that they don't want their parents to know (and similar findings are reported from Family Planning Services).

The challenge

I would like to end with a piece of polemic. It is clear that there will be much discretion with regards to how sex education develops in the light of the apparent changes in the legislative position as well as the moral climate which has led to such changes. This discretion will be exercised by parents, teachers, and, perhaps above all, school governors. It is likely that the sorts of arguments being debated in the House of Lords will be mirrored in many local arenas as the new policies are discussed and implemented. I would hope that all of the people at this conference will feel empowered to argue the case that policies in schools and other agencies should be based on research and data, rather than on narrow dogmas or incorrect assumptions about what will be effective in reaching the targets for improvement in sexual health amongst young people.

Finally, let me end with a further quotation from Lord Stallard's speech introducing his withdrawal amendment. He remarked that '... we copy so much from the United States ... so would it not be a good idea to copy some of [this]: 'The only bright thing on the horizon comes from correspondence I have received from America ... A new movement has sprung up and is gaining in momentum ... It is described as an abstinence movement ... It is said that [quote] .. *American children are learning the A to V of a new kind of sex education - A for abstinence and V for virginity ... students are told to 'just say no' in an estimated 5000 of the country's 16000 districts ... In California, teenagers following a course called Sex Respect chant a 'chastity pledge' - 'Do the Right Thing! Wait For The Ring', while in New York the city school board ... has just demanded that health educators going into schools to teach about AIDS must sign a commitment to emphasise abstinence over safe sex in their classroom presentation*'.

Would that life were so simple

References

Cooper, P., Diamond, I. and High, S. (1992) *Quality Measures in Family Planning Services, Summary Report and Recommendations by the Regional Steering Group*, Wessex Regional Health Authority, December, 1992

Currie, C. (1992) *personal communication*, Research Unit in Health and Behaviour Change, University of Edinburgh

Department for Education (1993) *Sex Education in Schools: Proposed revision of circular 11/87*, April 1993

Gold, R. S., Skinner, M. J., Grant, P. J. and Plummer, D. C. (1991) Situational factors and thoughts associated with unprotected intercourse in gay men, *Psychology and Health*, 5, 259-278

Harre, R. (1979) *Social Being*, Oxford, Basil Blackwell

HEA/MORI (1990) *Young Adults' Health and Lifestyle: Sexual Behaviour*, London, Health Education Authority

HMSO (1992) *The Health of the Nation; a Strategy for Health in England*, presented to Parliament by the Secretary of State for Health by Command of Her Majesty July 1992 (Cmnd 1986), London, HMSO

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. and Thomson, R. (1991) Between embarrassment and trust; young women and the diversity of condom use, in Aggleton, P., Hart, G. and Davies, P. (eds) *AIDS: Responses, Interventions and Care*, London, The Falmer Press

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. and Thomson, R. (1992) Pressure, resistance, empowerment: young women and the negotiation of safer sex, in Aggleton, P., Davies, P. and Hart, G. (eds) *AIDS: Rights Risk and Reason*, London, The Falmer Press

Hollway, W. (1984) Gender difference and the production of subjectivity, in Henriques, J., Hollway, W., Urwin, C., Venn, C and Walkerdine, *Changing the Subject: Psychology, Social Regulation and Subjectivity*, London, Methuen

Ingham, R., Woodcock, A. and Stenner, K. (1991) Getting to know you young people's knowledge of partners at first intercourse, *J. of Community and Applied Social Psychol.*, 2 (1), 117-132

Ingham, R., Woodcock, A. and Stenner, K. (1992) The limitations of rational decision making models as applied to young people's sexual behaviour, in Aggleton, P., Davies, P. and Hart, G. (eds) *AIDS: Rights Risk and Reason*, London, The Falmer Press

Jones, E.F., Forrest, J.D., Goldman, N., Henshaw, S., Lincoln, R., Rosoff, J.L., Westoff, C.F. and Wulf, D. (1985) Teenage Pregnancy in Developed Countries: Determinants and Policy Implications, *Family Planning Perspectives*, 17, 2, 53-63

Jones, E.F., Forrest, J.D., Goldman, N., Henshaw, S., Lincoln, R., Rosoff, J.L., Westoff, C.F. and Wulf, D. (1986) Teenage Pregnancy in Industrialised Countries, New Haven, CT, Yale University Press

Lees, S. (1986) *Losing Out: Sexuality and adolescent girls*, London, Hutchinson.

Smith, T. (1993) Influence of socioeconomic factors in attaining targets for reducing teenage pregnancies, *British Medical Journal*, 306, 1232-1235

Woodcock, A., Stenner, K. and Ingham, R. (1992a) Young people talking about HIV and AIDS: interpretations of personal risk of infection, *Health Education Research: Theory and Practice*, 7, 2, 229-247

Woodcock, A., Stenner, K. and Ingham, R. (1992b) "All those videos, contraceptives, and that ... ": Young People Talking about School Sex Education, *Health Education Research: Theory and Practice*, 7, 4, 517-531

THE LAW AND UNDER 16s

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Introduction

Those seeking to prevent unwanted teenage pregnancies need to be aware of the legal framework in which they work. The law performs at least three functions in this area. First, it enshrines a set of moral values, which include setting itself against sexual activity under the age of sixteen. This does not mean that professionals must accept the moral stance reflected by the law. There is a strong philosophical tradition that holds that it may be morally justified in some circumstances to disregard the law.

The second function played by the law is a more practical one. Professionals who overstep the legal boundaries may find themselves penalised for doing so. In theory, professionals could expose themselves to the risk of prosecution if they encourage under age sex, which is an illegal activity. They might also be sued for acting improperly, they and their employers would wish to know and take steps to avoid the risk of such litigation. Professionals need to know what the ground rules are, in order to offer the best service possible without overstepping the boundaries provided by the law.

The third function the law sometimes plays is a mythological one. People are often frightened by their perception of the legal regime into acting defensively, often to the detriment of their clients. There is, in fact, little reason to suppose that the law prevents professionals giving young people the support they need. Misconceptions of the legal position may often create unnecessary caution. This paper aims to clarify the law, so that the myths can be replaced by a sound understanding of the reality.

1. Sex, under 16s and the law

Teenage pregnancy will necessarily be the product of criminal activity. The main offence is unlawful sexual intercourse (Sexual Offences Act 1956, s 6). This is committed by a boy or man who has sex with a girl under sixteen. The girl herself is not guilty of the offence. A young man under the age of twenty-four has a defence provided (a) he has not been charged with a similar offence before, and (b) he reasonably believed that the girl was over sixteen. A more serious offence is committed if a man or boy has sex with a girl under thirteen, and there is no special defence for young males (Sexual Offences Act 1956, s 5). Intercourse without consent is rape, but for the purposes of that crime, a young woman may give consent under the age of sixteen.

Sexual activity will also constitute an indecent assault. Here, the sex of the child is immaterial. This is the only way that sex between a boy under sixteen and a woman over the age of sixteen would be unlawful. The absence of consent is an essential part of this offence, but by statute the consent of people under sixteen does not count (Sexual Offences Act 1956, s 14(2), 15(2)).

It follows from this that even consensual sexual activity between fifteen year olds will be criminal in the eyes of the law. However, it would be very rare indeed for a prosecution to be brought. The more difficult question is the implications of the fact that there is unlawful activity for those advising and supporting young people.

2. Family planning advice

Usually, the law does not restrict health professionals giving advice to their clients, and the difficulties arise only in relation to care that involves physical contact. However, where a client is involved in criminal activity, it has sometimes been argued that assisting them to cope with the consequences of their actions may encourage them to commit the crime. Thus it might constitute inciting, aiding or abetting a crime. In our context, there is a specific offence of 'encouraging unlawful sexual intercourse' (Sexual Offences Act 1956 s 28).

This was one of the arguments put forward in the **Gillick** decision (**Gillick v W. Norfolk & Wisbech HA** [1985] 3 All ER 402). It was firmly rejected by the House of Lords, who held that there would be no encouraging of sexual intercourse within the legal prohibition provided that the family planning advice was offered because the health professional believed it would be in the best interests of the girl's health (rather than intended to facilitate the sexual activity).

Although the **Gillick** decision involved medical practitioners, the principles established are general ones. Others supporting young people would be similarly protected from prosecution for encouraging unlawful sexual intercourse.

Those counselling young people should not therefore feel constrained by the criminal law. However, they would be wise to ensure that their advice and literature cannot be interpreted as suggesting that young people ought to be sexually active. It is unlikely that the acceptance that young people are, in practice, sexually active would cause any difficulties.

3. Family planning care and treatment

The legal issues in relation to the provision of treatment for family planning to those under sixteen are primarily concerned with the validity of their consent. Anything that involves touching the young person would be unlawful if they had not consented. A failure to obtain a valid consent would leave the health professional open to being sued for damages. Any action would be brought in the name of the child, but parents can sue on their children's behalf. The crucial question is therefore how to ascertain whether a child is capable of consenting (for a full review of the law, see J. Montgomery, 'Consent to health care for children' (1993) 5(3) *Journal of Child Law* 1-8).

With those over sixteen there is little difficulty, as the Family Law Reform Act 1969 expressly states that their consent would be valid as if they were adult (s 8). Where the young person is under sixteen, their consent will be valid provided they are of 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed' (**Gillick** at 423). The test of understanding must be applied in relation to the specific care

in question, and thus children will be mature enough to consent to some types of care before they can understand others.

Unfortunately, some aspects of this test, known as 'Gillick competence,' remain obscure. The judges in the **Gillick** case disagreed about what had to be understood. On one view, it is only necessary to consider the extent to which the physical aspects of care are appreciated (how to take the pill, use a cap etc; what effects it will have; when to seek further advice). On the other, the wider social moral and family implications have to be understood. The circular governing family planning for young people, reissued by the DHSS after the **Gillick** case, took the cautious view (HC(86)1). It recommends that doctors look for 'sufficient maturity to understand what [is] involved in terms of the moral, social and emotional implications.' This view of the meaning of the **Gillick** case is arguable, but the better view is that the same type of understanding should be expected of young people as is expected of adults. This points to the first approach, where moral and social judgements are irrelevant.

While there remains a conflict between these two interpretations of the **Gillick** decision it is obviously impossible to give categorical advice about the state of the law. However, it is unlikely that a judge would overturn a health professionals assessment of a child's ability to consent, providing that the professional was acting in good faith in the interests of their patient/client. In Scotland, where the **Gillick** principle has been given statutory force, it has been explicitly stated that legal competence turns on 'the opinion of a qualified medical practitioner attending' the child (Age of Legal Capacity (Scotland) Act 1991, s 2(4)). It is probable that English judges would approach the matter in the same way. In the light of this, health professionals should feel free to adopt the narrower, medical, test of understanding. Those who wish to be cautious would be safer adopting the broader test, but this would be at the expense of turning away some young people who could probably be helped.

In addition to getting consent from the young people, it is also legally possible to obtain consent from one of the adults with parental responsibility (**Re R** [1991] 4 All ER 177, **Re W** [1992] 4 All ER 627). This could be (a) the young person's mother, (b) the father if married to the mother, if a formal parental responsibility agreement between the parents has been registered with the court, or if a court order has been made giving him parental responsibility (c) the local authority where a child is the subject of a care order, (d) a person with whom the child is living under a 'residence order' under s 8 of the Children Act 1989. In addition, any person caring for the child without formal parental responsibility may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare' (Children Act 1989, s 3(5)). This can include consenting to health care (**B v B** [1992] 2 FLR 327).

The fact that consent may often be obtained from both a parent and young person has been extremely controversial. It effectively denies young people to right to refuse care. However, it must be emphasised that the mere fact that care **can** be given on the basis of parental consent even in the face of the young person's objection does not mean that it **must**. Health professionals are fully entitled to accept a young person's refusal as final provided that to do so would not be negligent. Lord Donaldson, who is largely responsible for the legal possibility of such forced care, has expressly said that he would not expect doctors to

force an abortion on a young person. He relied on doctors to protect young people from the excesses of the law.

The legal action for negligence, often known as the malpractice action, is also relevant to the process of selecting appropriate contraceptive techniques, choosing how to advise a patient/client about their options, and administering care. The test for negligence is set out in **Bolam v Friern HMC** [1957] 2 All ER 118:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men [sic] skilled in that particular art.

Thus, a health professional's decisions and actions would only be negligent if no responsible body of professional opinion would support them. The courts will not choose one school of thought over another, so it would be very difficult to argue that declining to force family planning on a young person was negligent. The **Bolam** test is now applied to all professionals, although doctors are perhaps more favourably treated than others.

In the light of the legal principles outlined above, the guidance offered by the Department of Health and Social Security (as it then was) on the provision of family planning for young people under sixteen can be considered. It is important to note that this guidance cannot alter the law, nor is it definitive of the legal rules. Indeed, it can be seen to be unhelpfully cautious in the context of reducing teenage pregnancy rates. The guidance advises that services should only be offered when the following five conditions exist.

- (1) the young person can understand advice and has "sufficient maturity to understand what is involved in terms of the moral, social and emotional implications."
- (2) the young person cannot be persuaded to inform or permit the informing of the parents.
- (3) the young person is "very likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment."
- (4) the young person's physical or mental health would be likely to suffer if no contraceptive advice or treatment is given.
- (5) the young person's best interests require that contraceptive advice or treatment be given without parental consent.

(DHSS, Contraceptive advice and treatment for young people under 16 HC(86)1)

The first condition refers to consent, and it has already been pointed out that it takes a rather cautious interpretation of the actual legal requirements. The requirement that the young person understand the moral social and emotional implications of what they are doing is probably too onerous (see above). The third principle captures the need to avoid the criminal offence of encouraging unlawful sexual intercourse. If intercourse is happening or very likely to happen anyway, it is improbable that providing contraceptives could be construed as encouragement. The other three conditions (2, 4 and 5) can only have legal

force in so far as it would be negligent to ignore them. The actual legal test reinforces the opinions of the health professions, not the DHSS view. In general the three principles capture the way in which professionals are likely to approach their clients needs. However, the guidance is too strict if responsible health professionals could provide contraceptive advice and care in other circumstances. In particular, it would not necessarily be unacceptable to offer care without placing clients under pressure to inform their parents (in contrast to the second principle from the guidance).

5. Confidentiality

In practice, one of the most important legal issues is the rights of young people to confidentiality. If confidentiality is not guaranteed, then it is probable that young people would choose to go without advice than risk professionals informing their parents of their sexual activity. Unfortunately, adolescents' right to privacy is one of the most obscure areas of the law governing family planning.

The **Gillick** decision says very little about confidentiality, and commentators have disagreed about its significance in this area. Some argued that young people were only entitled to confidentiality if they were competent to consent to care (I. Kennedy, **Treat Me Right** (1988) 111-117). This meant that no one could know whether young people were entitled to confidentiality when they entered a clinic. You could only know whether confidentiality should be guaranteed once an assessment of maturity to consent to treatment had been made. On this view of the law young people seeking help would always run the risk that they might be found to be legally 'incompetent' and therefore that their parents might discover that they were sexually active. This might well deter them from seeking help.

The contrary view of the legal position is that whether or not young people are entitled to confidentiality turns on whether they can understand the nature of confidentiality (not the nature of treatment). Thus, if they appreciate what it means to demand secrecy, and do so, then the health professional would be bound to keep their affairs private (J. Montgomery, 'Confidentiality and the immature minor' [1987] *Family Law* 101-104, see also Scarman, 'Law and medical practice' in P. Byrne (ed) **Medicine in Contemporary Society** (1987) 137-138).

The latter view is clearly more attractive to those who wish to promote the autonomy of young people. However, it would perhaps be wrong to make much of the difference between these when assessing the practical implications. The key issue is, in fact, the scope of exceptions to the duty of confidence. This can be illustrated by a relatively uncontroversial example. What is the position where a young person who is being sexually abused seeks contraceptive advice? In such circumstances, it is widely agreed that it is legitimate to breach confidence to protect them. It is also generally accepted that confidentiality owed to an adult abuser may be broken to protect a victim. Breaching the confidence of a child patient in this situation can be justified on both understandings of the legal position. On the first view, parents, and others, may be told of the problem because the child victim has no right to privacy. On the second view, although there is a right of confidentiality, it yields to a stronger public interest in protecting the victims of abuse.

The position becomes more controversial when it comes to deciding whether a health professional may inform a parent that their child has sought advice about family planning. It has been argued that the obligations of parents to care for their children justify informing them of their children's request for advice because there is a public interest in enabling them to carry out their responsibilities (see Kennedy, above, and also A. Grubb & D. Pearl 'Medicine, health, the family and the law' [1986] Family Law 227). If this is accepted, then it would become routinely possible to break the confidences of young people. This would be true even when the young person was competent to consent. This is because, under the current law, parents retain the power to consent even after their children become competent, and they therefore retain responsibility for taking health care decisions.

The main point to emphasise, however, is that the mere fact that there may be a legally recognised basis for breaching the confidentiality of young people seeking family planning advice does not mean that health professionals are bound to inform parents. There is a considerable difference between the position where health professionals **may** breach confidence and where they **must** breach confidence. If only the former is the case, then health professionals are free, by choice, to offer a more confidential service than the law is able to guarantee.

There are no general legal obligations to give parents information about their children. Parents can normally demand information that the professionals do not wish to reveal through an application under the Access to Health Records Act 1990. However, under this Act, competent children may prevent their records being disclosed. The Act explicitly provides that where children are able to appreciate the nature of the application for access and refuse to consent to their parents seeing the records, then the parents may not be given access (s 4(2)(a)). Even when a child cannot appreciate the nature of the application, the health professional is not bound to allow the parents access if it would be against the child's interest (s 4(2)(b) for exclusion from all the records and s 5(1)(a) for exclusion from part of the records). Further, access cannot be given to any part of the record that would disclose information provided by a child in the expectation that it would not be disclosed to the applicant (s 5(3)). Thus if children confide in health professionals on the basis that their parents will not find out, then parents must be refused access to the records of that consultation.

It is possible to use these provisions of the Access to Health Records Act 1990 to interpret the common law (ie judge made law) justifications for informing parents if their children seek confidential advice. The policy of the Act seems clearly to be one of confidentiality for children who seek it. Where a doctor acquires information on the basis that it would not be revealed to the parents, then their rights of access under the 1990 Act are limited. It would be incompatible with that provision to say that there is a legal principle entitling parents to know everything about their children's care. Against this, there is a comment by Lord Templeman in the **Gillick** decision that, in his opinion 'confidentiality owed to an infant is not breached by disclosure to a parent responsible for that infant if the doctor considers that such disclosure is necessary in the interests of an infant.' However, this comment is not binding on a subsequent court, and in any event can be said to be superseded by the more explicit position that the statute adopts.

In summary, it must be accepted that the law is unclear. Parents are not entitled to know if their children seek confidential advice on family planning. However, it is quite possible that a health professional who wished to breach confidence and tell a parent would act lawfully. It all turns on what is meant by 'the public interest' and that is a notoriously woolly concept. In effect, the law leaves it up to the professionals to follow their own consciences.

Finally, it is necessary to consider the position of non-health professionals such as teachers and social workers. Although there is precious little authority, it is widely accepted that the law supports confidentiality in the health professions. In this context the legal basis for confidentiality is said to be that the public interest in effective health care requires it (see **W v Egdell** [1990] 1 All ER 835). Without promising confidentiality, health professionals would not be given the information they need to assess properly the needs of their patients/clients. It is possible that a similar public interest justification would provide a foundation for confidentiality in relation other caring professions. However, there is no certainty that this is the case. Nevertheless, even without such a general foundation in the public interest, the law may guarantee confidentiality if sensitive information is shared on the mutual understanding that it will remain secret (**Stephens v Avery** [1988] 2 All ER 477). Thus, there may not automatically be an obligation of confidentiality on teachers and social workers, but where there is an explicit understanding that information would be kept secret, then the position would almost certainly be same as for health professionals.

Conclusion

This brief review of the law governing family planning advice for those under sixteen, aiming to help them avoid teenage pregnancy, has shown that professionals should not be frightened of the law.

It is true that the young people in question will be committing criminal offences. However, the **Gillick** case recognised that it would make their position worse rather than better if this fact prevented them being given advice on how to protect themselves from the risks of disease and pregnancy. Thus, those giving such advice will not be guilty of encouraging criminal behaviour.

Although the law remains slightly uncertain, young people who understand the choices they are making are legally competent to give a valid consent. This makes the provision of family planning drugs or devices lawful. In fact, the law goes even further in facilitating the avoidance of pregnancy in that where the child rejects contraception it can in theory be imposed upon them if someone with parental responsibility authorises it.

Most importantly, the law ensures that parents may not require health professionals to reveal that their children have sought advice. It is quite proper for professionals to guarantee confidentiality to young people who come to them. It must be acknowledged that the confidentiality on offer is not absolute, but that is just as true of adult patients' rights to privacy. Professionals who wish to breach confidence, would probably be entitled to inform parents if the interests of a young person require it. However, when they feel that it is appropriate to do so is a matter for their consciences, it is not laid down by law.

Statutes

Age of Legal Capacity (Scotland) Act 1991
Access to Health Records Act 1990
Children Act 1989
Family Law Reform Act 1969
Sexual Offences Act 1956

Cases

B v B [1992] 2 Family Law Reports 327.
Bolam v Friern HMC [1957] 2 All England Law Reports 118.
Gillick v W. Norfolk & Wisbech HA [1985] 3 All England Law Reports 402.
Re R [1991] 4 All England Law Reports 177.
Re W [1992] 4 All England Law Reports 627.
Stephens v Avery [1988] 2 All England Law Reports 477.
W v Egdell [1990] 1 England Law Reports 835.

References

DHSS, **Contraceptive advice and treatment for young people under 16** HC(86)1.
A. Grubb & D. Pearl 'Medicine, health, the family and the law' [1986] Family Law 227-240.
I. Kennedy, **Treat Me Right** (1988) 111-117.
J. Montgomery, 'Confidentiality and the immature minor' [1987] Family Law 101-104.
J. Montgomery, 'Consent to health care for children' (1993) 5(3) Journal of Child Law 1-8.
Scarman, 'Law and medical practice' in P. Byrne (ed) **Medicine in Contemporary Society** (1987) 137-138.

CHOOSING AND USING CONTRACEPTIVES: INTEGRATING QUALITATIVE AND QUANTITATIVE METHODS IN FAMILY PLANNING

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1. Introduction

In Britain, family planning has for the past two decades been supplied by both specialised family planning clinics and by family doctors and people have had a free choice of source. Under new proposals health commissions will now ask all providers to tender to provide family planning and will award tenders on the basis of quality and cost of provision. This paper describes research aims to help commissions to improve the provision of family planning in Britain by identifying the services which are most desired by the users of family planning and by assessing the potential for the provision of these services.

The work first involves a qualitative component comprising a series of focus groups of users and potential users of contraception. These included single sex focus groups of teenage men and women, those in their twenties and those aged over 30. The results of these focus groups were then used to develop a series of questionnaires which were sent to random samples of family doctors, and specialised family planning doctors and nurses. A feature of these questionnaires was the development of a battery of attitudinal questions based on statements made by members of the focus groups. This paper describes the methodology used in the project and gives a brief overview of the results.

2. Background to Study

In July 1991 the then Minister of Health, Mrs Virginia Bottomley asked Britain's ten Regional Health Authorities to review family planning service provision with their constituent District and Family Health Service Authorities. In January 1992 the Department of Health issued comprehensive guidelines to inform and help the reviews. The aim was to provide better and more effective family planning services for those who need them. This would be achieved through comprehensive assessments of local need; more effective integration of family planning in general practice and family planning clinics; and the development of strategies for better take-up and monitoring of services.

Since then, the Government has shown a continuing commitment to improving family planning by including it, under the heading of HIV/AIDS and Sexual Health, as a key area for action in the Health of the Nation White Paper. The objectives for family planning set out in the White Paper are to reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000, and to ensure that by 1994/95 the full range of National Health Service (NHS) family planning services, however provided, should be appropriate, accessible and comprehensive. Guidance on how to incorporate Health of the Nation targets in corporate contracts, business plans and purchasing contracts was published in October 1992. More recently the Department of Health and the NHS have prepared and published handbooks for implementing each of the Health of the Nation key areas.

In addition, family planning provision in Britain is currently under review as a result of changes in the NHS purchasing strategies. In particular NHS managers now have to contract provision from different sources. This means that a set of quality measures of family planning is required which identify the best ways of providing family planning so as to enhance consumer satisfaction. Informing such policy requires scientific information on the attitudes and experiences of users and potential users, on current provision and on the potential for providing an improved service. There have been few recent studies in Britain to inform such policy.

This study was therefore carried out by the Department of Social Statistics at the University of Southampton, on behalf of the Wessex Regional Health Authority and the Department of Health. The aims of the study were to find out where the family planning service was failing the public by an integrated study of the perceptions of the public, of General Practitioners (GPs) and of specialised Family Planning Clinics. Wessex is a region in the central South of England. It has relatively high levels of health and has a mix of large cities (Southampton, Portsmouth), developing urban centres and many rural areas.

3. Methodology

There has been very little research which has studied both the consumers and potential consumers of contraception and the full range of providers including GPs. To inform policy on provision effectively it is essential that health planners know both what the consumers of family planning (FP) want and whether such preferences are currently being met or could be met. The lack of previous research meant it was imperative that the research centred on consumers' views and experiences of FP provision, rather than being structured around those ideas perceived as important by health professionals. The study was therefore designed to enable consumers to develop the themes most important to them, and to obtain the reactions of providers to the issues identified in this way.

3.1 Asking the Consumers

3.1.1 Method of Data Collection

The first stage was to ask a sample of contraceptive users and potential users throughout Wessex about their experiences of and preferences for contraceptive provision. The study aimed to provide information in three areas.

- i) what FP services should be provided
- ii) how such FP services should be delivered
- iii) how information on FP services should be disseminated effectively.

The depth of information required, the need for personal experiences to be described, and the desire to generate ideas for improvements to FP services suggested the use of focus groups in this part of the study. Focused discussion groups led by a trained researcher are particularly appropriate as they allow consumers to provide detailed information in their own terms, and in a forum of a group discussion to express fears, ignorances and prejudices which do not seem strange when they discover other people

experience the same feelings. In addition the discussion setting is ideal for a reasoned evaluation of new ideas by consumers. A total of 19 focus groups were held throughout Wessex.

3.1.2 Criteria for participation

Contraceptive requirements vary for people of different ages and childbearing experiences. In addition people from different social backgrounds and those living in rural as opposed to urban areas are likely to have different exposure to the various sources of contraceptive provision. Because of the sensitive nature of the topic, it was important that the members of each group are of the same sex and similar ages to allow for uninhibited discussion. Therefore focus groups were held among three groups of women: aged under 20; 20-29; and over 30, together with two age groups of men; aged under 20; and over 25. In addition the focus groups were held throughout Wessex in both rural and urban locations as accessibility to source varies greatly. Rural dwellers will often be largely restricted to family doctors. Within the broad specification of sex and age, people were selected according to relevant background variables to ensure a mix of characteristics and experience within the groups, which it was believed would stimulate discussion and the interchange of ideas.

It was important that the groups represented, as far as possible, normal users and potential users of contraception. Members of focus groups were recruited by trained interviewers in a number of locations - large health centres, technical colleges and schools. Potential recruits were first asked a number of questions to determine whether they were the right age and social background for the particular group, and were then asked about their use of contraception and where they usually went to obtain it. The purpose of this "sift" questionnaire was to eliminate those who would be unsuitable for the study - either because of their demographic characteristics or because they knew nothing about contraception or its provision. For both male and female teenagers it was not necessary for participants to be users of contraception, but those who did not know of any possible outlet for contraception were eliminated from the study. In addition, men and women who were sterilised or currently with a sterilised partner were also omitted from the study, as they were not potential FP consumers. Those who were suitable were then invited to take part in a discussion group on an evening in the near future. If they agreed they were given details of the location and received a reminder phone call the day before. An analysis of the sift questionnaire revealed no differences, as a group, between those who were unable to attend the discussion and those who attended.

3.1.3 The topics

While the aim of using focus groups is to permit respondents to discuss topics in a natural and lively way it is crucial that the researcher has a specific list of topics which have to be introduced. In this study these topics were formed into a "Question Route" which the group leaders (moderators) aimed broadly to follow. Moderators had a degree of flexibility in allowing topics to be introduced at different times to improve the flow of the discussion and in allowing exploration of issues introduced by participants and important to the group.

The question route included an introduction and four sections which address the main topics which lead to contraceptive use: sources of knowledge of contraception; expectations and demands for the provision of contraceptives; the choice of different methods of contraception; and opinions of and recommendations for improved advertisement of contraceptive provision. After the first part, in which the participants were asked whether they felt they had a wide knowledge of contraception, the participants were shown a display of a wide range of contraceptives. They were then asked the question again to see if they had changed their minds after seeing the range. An example of a question route for this study is provided in Appendix 1.

This question route was piloted and discussed in depth before being used. A number of adaptations were made for different types of respondents, particularly for the male groups to maintain the appropriateness of the questions.

3.1.4 Fieldwork and Analysis

The focus groups were led by trained researchers who were of the same sex and similar age to the members of the group. Participants' first names only were used throughout. Each of the discussions was recorded, a transcript made and this put into machine readable form. Subsequent analysis was undertaken using specialist software (the Ethnograph (Qualis Research Associates, 1988)). The analysis comprised a comprehensive content-analysis of each discussion group to combine responses from different groups under themes identified from the data.

3.2 Asking the Providers

3.2.1 Questionnaire Design

The results of the focus group discussions were used to design three questionnaires, one for each of the major groups of providers: General Practitioners, family planning clinic (FPC) doctors, and FPC nurses. In order to allow comparison between the surveys, the three questionnaires were designed with a similar structure.

The questionnaires covered four main themes:

- information about the range of services currently offered, and the type of advice and provision given by doctors and FP nurses both in FPCs and general practices. Respondents were also asked about the extent of contact with client groups with different contraceptive needs, eg. single teenage women, women with completed families wishing to avoid further pregnancies, etc.
- an evaluation by providers of possible changes in provision developed from focus group discussions. Respondents were asked whether they already offer the service, or if not offered, whether provision was feasible. For those services it was thought could not be provided, respondents were asked what they saw as the major obstacles to provision.

- an assessment of providers' perceptions of family planning provision. A battery of attitudinal statements examined providers' views of themselves and of their patients, and addressed issues surrounding the style and effectiveness of services provided. Again those statements were developed from the focus group discussions, and reflected the views and experiences of current and potential FP clients.
- basic information about experience and training.

3.2.2 The Samples

GPs were selected for the survey by systematic random sampling of all GPs in Wessex. The sample was designed to be representative on practice variables, including District Health Authority area, location on a rural/urban continuum, and size of practice; and on the GP characteristics of sex, age and level of involvement in FP services. This was achieved through implicit stratification by ordering the sampling frame on the relevant variables, and drawing a one in four systematic sample. A sample of size 541 was selected.

The total number of doctors and nurses working in FPCs in the region was small, and a 100% sampling rate was both possible and optimum. The population of FPC staff in Wessex comprised 98 doctors and 137 nurses.

3.2.3 Fieldwork

Postal questionnaires were sent to the selected samples with a covering letter and return envelope. A duplicate questionnaire was sent to non-respondents after 3 weeks. The development of the questionnaire is described in Section 4. Questionnaires not returned six weeks after the first mailing were treated as non-response.

The questionnaires were returned before the cut-off date by 78% of the sample of GPs; by 80% of the FP doctors and by 87% of the FP nurses. These are very high response rates and reflect the importance attached to this topic by all three groups of providers. This importance was stressed in a covering letter and also mentioned to some GPs at training days.

4. Results

The focus groups gathered extensive information on the decision making processes, expectations and experiences of contraceptive users and potential users. From these discussions many suggestions for improvements to FP services emerged. These results formed the basis for the questionnaires sent to FP providers. Some results were simply presented as suggested improvements, and providers asked to evaluate them. For other results the potential for change was best assessed by measuring the extent to which providers recognised and were sympathetic to patients' needs. This was achieved by obtaining reactions to a series of attitudinal statements. It was also necessary to obtain information about current practices in order to examine the need and potential for some suggested improvements. The main results and the way in which they were fed into the

questionnaires are discussed below under the broad aims of the focus groups described in Section 3.1.1.

4.1 What FP Services Should be Provided

4.1.1 Effectiveness of FP Providers

The focus groups show that FP users want improved choice when deciding about contraception methods. To achieve this they need better information on the range of contraceptives available, more advice about the effectiveness and potential side effects of particular methods, and clear instructions about method use. In general, respondents of all ages had very poor contraceptive knowledge, but became aware of their limitations only after seeing the range displayed during the focus groups. They were critical of the amount and quality of information they received from providers, and felt that GPs in particular tend to assume patients seeking contraceptive advice already had adequate basic knowledge.

Providers' views of patients' contraceptive knowledge were obtained by measuring the extent of agreement with attitudinal statements. For example:

Most adults have obtained the majority of their knowledge from friends and magazines rather than through formal sex education.

Most young people are well informed about contraception through sex education in schools.

Giving good FP advice is difficult because patients usually know 'the treatment' they want.

Respondents overwhelmingly agreed there is a need to raise levels of awareness about contraceptive methods amongst users and potential users. Suggestions as to how this may be achieved were included in the questionnaires and providers asked to evaluate them. The main suggestions were for clinics for young people in technical colleges and youth centres, adult health education sessions in the evenings to promote knowledge of FP methods, and Health Centre Open Days featuring FP among other health care issues.

Respondents were also critical about the limited range of methods available to them, and the quality of services they received particularly from GPs. A common view was that GPs are 'pill-pushers' and have little knowledge of or interest in alternative methods of contraception. Typical quotes from our respondents were:

"I didn't feel there was any choice. I walked into the doctor's surgery and said 'I want to talk about contraception' and he said 'So you want to go on the pill then do you?'. And that was it, you know, just about five minutes consultation, you know. He took my blood pressure and that was it."

"Went in there, said I wanted contraception. He wrote a prescription, gave it to me and walked out. Said I was too young to slag it about. That was it. Didn't explain how to take it or nothing."

Some respondents did not feel confident in their GPs' expertise in FP and felt that they need more training in FP provision to enable them to provide good FP services. Other respondents had found they were unable to obtain their chosen method from their usual provider. This was seen as unsatisfactory, as the initial consultation was seen as a waste of both the doctor's and the patient's time if the patient was then referred to another source. The conclusion from the focus group was that FP services would be improved if all FP providers were able to advise on and supply all methods of contraception.

The questionnaire to providers included questions about the range of services they provide and patterns of referral. This provided a description of the services available to consumers, and an indication of the extent and nature of limitations in provision by particular subgroups of providers. Providers' reactions to criticisms of current FP provision were obtained by including a number of statements about doctors' roles and effectiveness in the attitudinal section. For example:

Most GPs know little of FP apart from the latest advertising on contraceptive pills

Frequent GP updating is needed to provide effective GP services.

FP requires so much practical experience that GPs should either specialise or opt out entirely.

IUDs should only be fitted by doctors who fit several each month.

Another criticism of GPs as FP providers was that many of them lack the personal skills necessary for giving effective advice and counselling. Statements about the importance of counselling skills and the GP's role in FP counselling were also included in the attitudinal section.

FP requires special counselling skills.

In giving FP advice GPs should stick to medical issues and leave counselling to others.

The young and single need advice but their attitude makes it difficult for doctors to provide this.

Effective contraception is wholly dependent on the ability of the patient to follow instructions.

4.1.2 Range of Services

It was suggested that FP provision should be expanded to include a range of ancillary services covering general reproductive health. A number of these suggestions were included in the questionnaires for FPC staff. In addition, some FP clients had experienced 'follow-up care' from FPCs, in that they were prompted to make subsequent appointments at the first visit, they were sent reminder letters for their next appointment, and follow-up letters for missed appointments. Many respondents thought this kind of service would greatly improve provision, and these suggestions were included for evaluation by all providers.

4.2 How FP Services Should be Delivered

4.2.1 The Setting

For young women in particular taking the first step in seeking contraceptive advice takes a lot of courage, and even some older women said they found the experience intimidating. Many felt unable to ask questions and felt guilty about taking up the doctor's time on trivial and non-health issues. It was clear from our discussion groups that FP provision needs a 'user-friendly' image, and a setting that allows clients to feel at ease and offers opportunities to raise issues important to them.

A number of statements were included in the attitudinal sections to gauge the extent to which doctors recognise these needs. Examples are:

Many patients are nervous and embarrassed about seeking FP advice, particularly at the first consultation.

Effective counselling to the young and single needs an atmosphere which cannot be provided in a GP's surgery.

FP is a social rather than a medical issue.

Giving FP advice is more time consuming than treating many other conditions.

If patients were better informed about FP then the doctor's task would be easier.

4.2.2 Family Planning Nurses

FP nurses in both GP surgeries and FPCs were generally seen favourably by FP clients of all ages. Respondents felt that nurses were helpful, accommodating and helped a patient to feel at ease. Many felt able to discuss problems with nurses and ask questions they thought too trivial to raise with a doctor. Because of this they often preferred to obtain general FP advice from a specialist nurse, and liked to have a nurse present during examinations. One respondent described how FP services are improved by making good use of FP nurses.

"What I liked about the first time I came to the FPC was that I actually spoke to the nurses and went in and had my twenty minutes with the nurses first of all. They actually gave me a number of leaflets and told me about breast examination and everything like that. They just asked me if I had any questions. I didn't feel embarrassed about asking my questions, talked about my medical history and smears and everything like that, and I just thought they were very thorough - whereas with my doctor, I have a female doctor, but I think she didn't want to look into anything else other than what you were going to her for. She wasn't interested in the background or anything like that, whereas at the FPC I just find there's more interest, more willingness to help."

The questionnaire to GPs included a section about the use made of nursing staff in FP provision. This provided a description of current practice and allows evaluation of the potential for developing this valuable resource. Nurses working in FPCs were the subject of one of the surveys developed out of the focus group study.

4.2.3 Access

Many FP clients experienced problems obtaining access to advice because of the times at which FP sessions were held and the difficulties of obtaining and waiting for appointments. There were particular problems for working women and teenage clients restricted by school or college hours. A popular suggestion for improvement was for FP sessions on Saturday mornings. This would not only ease access problems for the women themselves, but many thought it would also encourage men to accompany their partners and take a more active role in obtaining advice and making decisions about contraceptive methods.

Views were mixed as to whether FP sessions are better organised through appointments or on a drop-in basis, and the conclusion from the focus groups is that good FP services should include both. Suggestions for Saturday morning sessions, appointment based FP and drop-in sessions were included in the questionnaires for all providers.

An important issue, particularly for young women, was that access to emergency contraception should be easy and not subject to delay. Although many women knew it could be taken up to 72 hours following the unprotected sex, they felt very unhappy about spending that time not knowing whether they would become pregnant. This was a particular problem if the unprotected sex occurred on a Friday night. It was suggested that information on emergency contraception should be more readily available, and provision should be made for access on a daily basis.

The extent to which providers sympathised with these concerns was measured by an attitudinal statement:

FP services are not complete unless they provide access to post-coital contraception outside office hours.

FPC staff were also asked to evaluate suggestions for a 24-hour phone service giving information about access to emergency contraception, and for links with hospital casualty departments to provide out of hours emergency contraception.

4.2.4 Confidentiality / Anonymity

Preferences for services from GPs and FPCs tended to differ according to age and contraceptive need. Many of the youngest women in the focus groups were concerned about the confidentiality of FP services, particular when their parents were unaware that they were sexually active. These women preferred to avoid the family doctor, as they were worried that the GP or receptionist would (perhaps accidentally) let the parents or other relative know. Typical quotes are:

"I wouldn't trust them. My Mum's going in all the time because she gets bad asthma, she picks up inhalers each week. I wouldn't trust them in case they said something."

"I don't think I would like to go to my doctor because although I have not been there for years, he knows my parents, and my parents would not exactly be very pleased if they ever thought of the reason why."

FPCs were generally seen as more confidential and anonymous, although in rural communities there remains the problem of being recognised entering the clinic or in the waiting room. In recent years clinic closures have restricted client choice of source for FP services, but it was clear from the discussions that there is a continuing need for both sources to be available.

Both groups of providers were asked about the extent of their contact with specific client groups. Obtaining a profile of the clients seen by GPs and FPCs may indicate how future provision would best be organised to meet the needs of all potential clients. Providers' awareness of clients' concerns about confidentiality were also measured by obtaining reactions to attitudinal statements. For example:

Patients worry more about confidentiality of information given to clerical staff than they do about that given to medical staff.

It is difficult for clinics to ensure patient anonymity in small communities.

Some respondents thought that whether FP services were provided by GPs or FPCs, they would be improved if special FP sessions were provided for specific subgroups. Special provision for teenage women and for couples in particular may reduce the embarrassment commonly experienced by single teenage women and by males in settings seen as predominantly for married women. In addition, many older women felt intimidated walking into a waiting room full of teenagers, especially if they were likely to know them. A teacher in one of the groups was particularly worried about this. Older respondents also recognised that young people would prefer separate sessions to avoid meeting a parent's peer.

On the other hand, many respondents felt that special sessions in general practice would increase embarrassment as the purpose of the visit was obvious to any observer. Many felt that obtaining FP advice during normal surgery visits gave greater confidentiality.

The focus groups suggest there is a need for FP provision in both special sessions and general visits. A number of suggestions were included in the questionnaires to examine the extent to which the different groups of providers see such provision as feasible.

4.2.5 Age and Sex of Doctor

While it was generally agreed that it was the quality of the doctor which was of utmost importance, the respondents felt that women should be given the option of seeing a female doctor for FP services, and most felt that if given the choice they would prefer to see another woman. This was particularly important for young women, and for women of all ages if the consultation involved an examination. For older women the age of the doctor was of more importance than the sex. Several older respondents had been examined by a young male doctor and found it embarrassing.

The suggestion that FP clients should always be given the option to see a female doctor was included in the questionnaire for evaluation by providers. In addition an attitudinal statement measured opinions as to the importance of sex and age relative to the quality of the doctor.

Patients don't need a young doctor, an old doctor, a male doctor, or a female doctor, just a good doctor.

4.3 How Should Information on FP Services be Disseminated

The majority of focus group respondents knew that FP services could be obtained from GPs, but levels of awareness of FPCs as alternative sources were very poor. Even amongst respondents who were aware of FPCs, many did not know where they are located or how to contact them. The focus groups agreed that improving FP services entails giving clear information about contraceptive methods and exactly where and when they can be obtained. Many suggestions were made as to how FP services could be effectively advertised. These suggestions were not presented to providers for evaluation as these aspects of provision are more the concern of Health Authorities. However, the extent to which providers recognise the need for greater and more effective publicity was measured by attitudinal statements.

One important way to improve clinic provision is to find reliable ways of informing consumers about what is available, when and where.

It is easy enough for people who need FP services to find them without the need for extensive advertising.

It would encourage more young people to seek contraceptive advice if FP clinics had a more 'user-friendly' name.

4.4 Summary

In this section we have demonstrated that the questionnaires for providers were based on issues important to the focus group participants, and we have shown how the majority of questionnaire items were developed directly from focus group results. The sections of the questionnaires which included questions directly obtained from the focus groups are included in Appendix 2. The full analysis can be found in Cooper et al (1992b).

5. Response to Questionnaires

There was a high level of response to all three questionnaires, and the results show that the majority of providers of FP recognise the importance of their roles and are well motivated to deliver quality services. However, some of the less satisfactory aspects of current FP provision identified by consumers in the focus groups are reflected in the reported behaviour and attitudes of some subgroups of providers.

5.1 Range of Services

Consumers were of the opinion that good FP provision entails all providers being able to advise on and provide all methods of contraception. Response to the questionnaires showed that the large majority of FPC doctors offer the full range of contraceptive methods, and in addition a substantial proportion offer a range of services not directly connected with FP but which are a response to closely related needs.

Although most GPs offer the majority of services, availability of more specialised services such as IUD, cap and diaphragm fitting is more limited. There are marked differences in services available from GPs who have the Joint Committee on Contraception (JCC) certificate, which is the formal FP qualification for GPs currently obtainable in Britain. These GPs offer a wider range of methods than those without the JCC certificate.

5.2 Quality of Services

The focus groups suggested that some GPs need more training in FP provision, and lack the skills necessary to deliver quality services. GPs are not required to obtain formal training in FP in order to provide services to clients, but the JCC Family Planning Certificate is specifically intended to train GPs in effective provision. The GP survey showed that 33% of GPs in Wessex who provide FP services do not hold the JCC certificate, and 36% of long term providers have not attended a refresher course within the last five years. These findings support the view that there is a need for further training amongst a substantial proportion of GP providers of FP services.

Responses to the attitudinal questions showed that GPs generally recognise that FP requires specialist skills, but this is felt more strongly by JCC holders, female GPs and

younger age groups. The focus groups had reported unsympathetic attitudes from some GPs, and this was reflected in the GP survey in the general view that effective FP depends on the patient rather than on the doctor. This view was strongest amongst GPs aged over 50. JCC holders and female GPs tended to see responsibility as more doctor-based. These groups also showed greater sensitivity to clients' problems in general.

The inference from these findings is that increasing the number of GPs who hold the full JCC Family Planning Certificate will improve FP provision, at least by extending the range of services available to clients through their usual provider. Higher levels of awareness of the need for specialist skills and appreciation of patients' needs are associated with attendance on the JCC course, but these data cannot show whether this is cause or effect.

It is a condition of employment for FPC staff that they have a formal qualification in FP. Both FPC doctors and nurses agree that effective FP provision requires special skills, and both are generally aware of patients' problems and concerns. The majority are confident that they are able to provide effective counselling to their clients. However, this contrasts with suggestions from the focus groups that some young people perceive the clinic environment as intimidating.

5.3 Characteristics of Clients

The client group most often seen at FPCs is young single women. This trend supports the findings of focus groups that young women preferred an FPC because of fears about confidentiality and anonymity. Responses to the surveys of FPC staff show that both doctors and nurses are aware of these concerns.

Among GP providers the largest client groups are women (other than teenagers) without children, and women who have children and wish to delay or space further pregnancies. This supports the focus groups finding that these women are the least concerned about confidentiality, and find obtaining FP from their family doctor convenient. Teenage women are less likely to be seen in rural practices than in urban practices. This may reflect compositional differences between rural and urban populations. However it is also likely to reflect the focus group result that young women are particularly concerned about confidentiality in small close-knit communities.

The GP survey also showed that teenage women are more likely to be seen by female GPs and those under 40. This reflects the focus groups finding that the sex and age of the doctor is of greatest importance to young women. Responses to the attitude statements show that these groups of GPs are generally more aware of the problems young people experience in seeking FP advice. This greater awareness may arise from the greater involvement of these GPs in provision to young people. However it is likely that the more sympathetic attitudes of females and younger GPs encourage teenagers to choose to obtain FP services from them.

The characteristics of clients seen by different groups of providers support the view that there is a continuing need for choices of source of FP advice to be available, in order to meet the needs of all potential consumers.

5.4 The Role of Nurses

The nurses' role in FP provision was seen very positively by consumers in the focus groups. Practice nurses are used to complement GP provision in many practices. The use of nurses was higher in urban areas (58%) than rural areas (34%) and in practices where at least one nurse held a formal qualification in FP. However there is some under-utilisation of trained nurses in the provision of FP services. Under two thirds of practices with trained nurses regularly use them for providing routine FP services. This under-utilisation may arise because much FP provision is obtained during normal surgery visits to the GP.

In FPCs nurses have a major role in the provision of general FP services, and a substantial proportion also undertake more specialised counselling roles. The extent of nurse involvement differs between FPCs and reflects differences in local custom and practice.

The surveys show some potential for greater utilisation of trained nurses in FP provision, which may result both in more effective use of GPs' and FPC doctors' time and in greater client satisfaction.

5.5 Suggested Improvements

The improvements to FP services suggested by the focus groups and included in the questionnaire for evaluation by providers were generally well received, especially by FPC staff. Both FPC doctors and nurses responded favourably to suggestions for change, and if a service was not already offered, most thought it was feasible and were prepared to offer the service. The most common obstacle to provision was cost effectiveness, in that the cost of providing the service was too great given the expected demand.

Amongst GPs most suggestions were also received positively, with substantial proportions prepared to offer those services not already provided. The exceptions to this were the suggestions for Saturday morning FP sessions and drop-in sessions. The most common obstacles to provision were that GPs are too busy, or that it was 'not practice policy'.

There was a mixed reaction from GPs to the suggestions for separate FP sessions for particular subgroups of clients. About a third of all GPs were prepared to offer such sessions. Amongst those not prepared to offer separate sessions, explanations of obstacles fell into two main groups. About a half of these GPs said that their current provision was adequate and therefore it was unnecessary to extend services in this way. The remainder said that their current practice of giving FP services during normal surgery visits preserves patient privacy better than a more 'visible' attendance at separate FP sessions. This mix of opinion matches that found among focus group respondents.

The focus groups suggested ways in which information about and access to emergency contraception could be improved, and FPC staff were asked to evaluate these suggestions. The great majority of both doctors and nurses were prepared to offer a 24-hour phone service giving information about access to services. About a quarter of

respondents said their FPC already has links with local hospital casualty departments to provide out of hours emergency contraception, and a further 44% thought such a service feasible. There was a difference between GPs and FPC staff in attitudes towards the need for access to post-coital contraception outside office hours. Overall GPs tended to disagree that such provision is a necessary part of FP services, while there was some agreement from FPC doctors, and stronger agreement from FPC nurses.

5.6 Summary

The focus groups identified a number of areas where current FP services fail to meet consumer needs, and overall these were confirmed by the findings from the questionnaire to providers. However, these surveys also confirm the potential for change and a willingness on the part of many providers to improve the services they offer. The full analysis of FP provision by GPs and by FPC doctors and nurses can be found in Cooper et al (1992c, 1992d).

6. Recommendations

As a result of this research a series of eleven recommendations were made to Wessex Regional Health Authority and to the Department of Health. These included effective marketing of FP services; increased formal training of GPs; extension of the role of nurses in FP provision; continuation of flexible provision through existing alternative outlets; easy and well-publicised access at all times to emergency contraception; and contracts to cover issues of confidentiality, improved information, convenient times for FP to be available, and the option to see a female doctor.

The full set of recommendations is reported in Cooper et al (1992e).

References

Cooper P, Diamond D, Gould C, High S and Schlamm E - The Use, Users and Sources of Contraception in the United Kingdom: A Literature Review (1992a).

Cooper P, Diamond I, Gould C, High S and Partridge J - Choosing and Using Contraceptives: Consumers' Experiences in Wessex. Department of Social Statistics, University of Southampton (1992b).

Cooper P, Diamond I and High S - The Provision of Family planning Services by General Practitioners: A Social Survey in Wessex. Department of Social Statistics, University of Southampton (1992c).

Cooper P, Diamond I, High S and Pearson S - The Provision of Family Planning Services by Family Planning Clinics: A Social Survey in Wessex. Department of Social Statistics, University of Southampton (1992d).

Cooper P, Diamond I and High S - Opportunities and Choices. Winchester: Wessex Regional Health Authority (1992e).

Table 1: Examples of Attitudinal Statements on Questionnaires to Health Professionals

FP is a social issue rather than a medical issue.

Giving effective FP advice is more time consuming than treating many other conditions

FP requires special counselling skills.

Frequent GP updating is needed to provide effective FP services.

Giving good FP advice is difficult because patients usually know ‘the treatment’ they want.

In giving FP advice GPs should stick to medical issues and leave counselling to others.

Most GPs know little of FP apart from the latest advertising on contraceptive pills.

The young and single need advice but their attitude makes it difficult for GPs to provide this.

Effective contraception is wholly dependent on the ability of the patient to follow instructions.

If patients were better informed about FP then the GPs task would be easier.

User friendly written instructions are an essential ingredient for successful FP.

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References

TEENAGE PREGNANCY AND SEX EDUCATION PROGRAMMES IN LOCAL SCHOOLS

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Recent Annual Reports of the Director of Public Health have highlighted high rates of teenage abortion in the District. (Table 1). The White Paper 'Health of the Nation' ⁽¹⁾ includes a target to reduce teenage conception rates in the under-16s. Against this background and in the light of evidence suggesting a relationship between effective sex education and lower rates of teenage pregnancy, ⁽²⁾ a survey of aspects of sex education in schools in the District was carried out. A major objective was to establish the extent to which local schools' sex education programmes reflected official guidelines and practices suggested by a literature review to be effective. Information about schools' use of District services for sex education was also sought. These included outreach work by Family Planning Nurses and Health Promotion Officers and input into teacher education and training by the Teacher/Adviser in Personal and Social Health Education.

94% of secondary and middle schools in the District responded to the survey and in most cases questionnaires were completed by teachers or senior staff. There was a high compliance with official recommendations for schools to have a policy for sex education and to designate a particular teacher to be in charge of sex education. However, it was clear that while teachers regarded sex education as an important part of the curriculum, because of constraints such as those imposed by the National Curriculum, they were unable to allocate an appropriate amount of the time to the subject. Secondary schools in particular found it hard to give children exposure to the subject in all years of schooling. Even in the time that was available, schools recognised that certain aspects of sex education did not receive sufficient attention. Teaching about emergency contraception was a particular example.

The content of school programmes of sex education, other than those areas designated as compulsory under the National Curriculum, varies from school to school according to what is felt by teachers and governors to be important. While many schools are clearly trying to address the more sensitive issues, it was evident that teachers welcomed and valued help offered by Community Unit and Health Education Service staff with these and other areas. Two thirds of schools wanted further involvement of the Teacher-Adviser in the planning of their programmes and three quarters of all secondary schools wanted more help from Family Planning nurses in the future. It was also clear that District outreach services should receive greater publicity since a few schools appeared unaware of their existence.

Programme objectives and priorities

Approximately two-thirds of schools felt that increasing pupils' knowledge about sexuality, building self-esteem and increasing understanding about feeling and relationships were high priority objectives in their sex education programmes. However, under half of schools placed prevention of unwanted pregnancy as a high priority objective and only a quarter felt that postponement of first intercourse was an important aim of school programmes.

Contact with other schools and with parents about sex education programmes

Less than a fifth of schools consult with feeder schools in their area about the planning and content of programmes. Almost a third of schools did not involve parents in their programmes.

Attendance by teachers at training course

Only a quarter of respondents to the questionnaire had attended a training course in health education in the previous two years.

Conclusions

While there is much good work going on in individual schools, several official recommendations, important in effective delivery of school sex education programmes, appear difficult to fulfil. These include the amount of time assigned to the subject, the depth of coverage given to certain topics, consultation on programmes with neighbouring schools and active involvement of parents in programmes. There may also be problems associated with the release of teachers from schools to attend training. Greater attention to these areas might mean that the sex education that is being delivered could be made more effective.

Survey results and recommendations are being sent to individual schools, the Local Education Authority and to the Health Commission and Community Unit. Recommendations include the development of joint strategy for sex education between the LEA, schools and the Health Commission; strengthening of formal and informal alliances with the LEA to assist in the development of more effective sex education; improve publicity for outreach services and the setting up of joint training schemes by the Community Unit and the LEA for staff involved in sex education. The role of the Teacher/Adviser is seen as central in implementation of these plans.

References

1. The Health of the Nation: A Strategy for Health in England. HMSO 1992.
2. Jones EF, Forrest JD, Goldman N, Henshaw SK et al. Teenage pregnancy in developed countries: determinants and policy implications. *Family Planning Perspectives* 1985; 17(2):53-56.

YOUNG PEOPLES PROJECTS

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Off the Record
&
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The Isle of Wight Youth Trust is an independent agency with Charity status established in 1985 to provide professional support for young people up to 25 years. It is financed by voluntary contributions and grants from the IWhA, JCC and LCC.

Its aim is to meet the young person at his/her point of need, wherever that might be, in a non-judgemental and non-directive way. It is a free and confidential service combining the work of professional counsellors and a medical team financed separately by the IW Hospital Trust. The counsellors are present on site throughout the week, the doctor and nurse on just one afternoon.

The doctor, that is me. The Youth Trust, that is where I work. What has this to do with reducing Teenage Pregnancy rates?

The Isle of Wight has the highest rate of teenage pregnancy in the country. This posed the question -

Why?

Did they choose to become pregnant.

Were they ignorant of contraception.

Were they ignorant of the available Family Planning Services.

Was there a barrier to receiving those services.

Answers

There was a significant number of teenage girls who wanted to be pregnant.

Contraception knowledge was difficult to test but I tried to be involved with the production of the Isle of Wight Sex Education Document as well as the Sex Education Programme in the Island schools.

By visiting Youth Clubs, schools and my work in the local community there seemed to be a variation in a knowledge of existing contraception services in General Practice and Family Planning Clinics.

The major barrier to accessing contraception was confidentiality. The Island is a small place and everybody knows everybody else - at least they think they do. It was obvious that young people seeking help on sexual problems, contraception, pregnancy, TOP were reluctant to attend their "family" GP or indeed their local FP clinic where they might have to sit in the waiting room alongside their neighbour or even their mother.

We needed to open a service which would be just for young people, which would be free and would remove their fears about a conventional service. It would welcome anybody up to 25 years, including under 16 years. It would be run in a professional manner along the lines of a Family Planning Clinic. Above all it would be confidential.

The service aimed to meet the needs of young people.

Where?

At a site in Newport (centre of Island) with easy access to the schools and bus station and yet safely tucked away. In fact situated in a converted end of terrace house.

When?

Between the end of school day and home. Actually 3.00pm - 6.00pm.

What staff?

Majority request for female staff. Actually female Family Planning certified doctor and nurse.

How could they access the service?

Walk-in self referral, family or agency referral.

What needs would they have?

Advice and information.

On the spot Pregnancy Testing.
Contraception.

Pregnancy and TOP Counselling.

Access to medical examination.

Confidentiality

Although we keep private files it has been known for young patients to give false identification, often resulting in correction by telephone on leaving the clinic i.e. post TRUST.

Only with the permission do I inform the GP of prescribed contraception i.e. OCP. However I encourage it because of possible side effects and drug interaction, and then only by a private letter.

If I believe a young person under 16 years is at risk of pregnancy and understands the risks associated with a chosen contraception I am able to prescribe without parental permission although I always encourage it.

With cervical cytology reporting it is Island practice to inform the patient of the result by letter. To overcome problems of confidentiality with patients at the Trust Clinic I write "NO Correspondence to Home" on the Smear request and the patient has to contact me directly for the result. A copy of the result is sent to the GP with the patients permission and with the same message.

Numbers at Clinic

Variable but between 6 and 8 each clinic, attending alone, with boyfriend or in groups of friends.

Trends in Clinic

- (1) To improve patient compliance with OCP I have secured the most appropriate health information - written and verbal.
- (2) Increase in proportion of <16 year old girls.
- (3) Increase in wart virus changes in cervical cytology.
- (4) Change in contraceptive practice from OCP to OCP + condom - now patient led.
- (5) Increase in pregnancy testing.
- (6) Increase in request for PCC.
- (7) Increase in infertility counselling.
- (8) Increase in planned teenage pregnancy.
- (9) Very slow increase in male patient numbers.

New Initiatives at the Youth Trust

- (1) Improvement in premises.
- (2) Advertising and promotion in the form of school timetables and sweatshirts.
- (3) Opening of our own Charity Shop.
- (4) Telephone Helpline.
- (5) Satellite Clinics.

Of course we have had to cut our coat according to our cloth, resulting in putting the Helpline temporarily on hold and concentrating our resources in one satellite clinic in an area of need - Ryde.

Our aim is to reduce unwanted teenage pregnancy. I do believe we are helping young people to be free to talk about their sexual lives, to receive contraceptive education at their personal point of need and to receive appropriate contraception. However, we are also there when things go wrong, to be alongside them to pick up the pieces of a life sometimes shattered by an unwanted pregnancy.

IDENTIFYING NEED AND MEASURING OUTCOMES.

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&

Nicola Woodward, HIV/AIDS & Sexual Health Programme Manager,
Wessex Regional Health Authority

We started the workshop by taking a closer look at the target on teenage pregnancy in *The Health of the Nation*. The key target in the White Paper is:

To reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13-15 in 1989 to no more than 4.8).

However, while most attention has been focused on this key aim it is important not overlook the general objectives of this target which are:

To reduce the number of unwanted pregnancies.

and

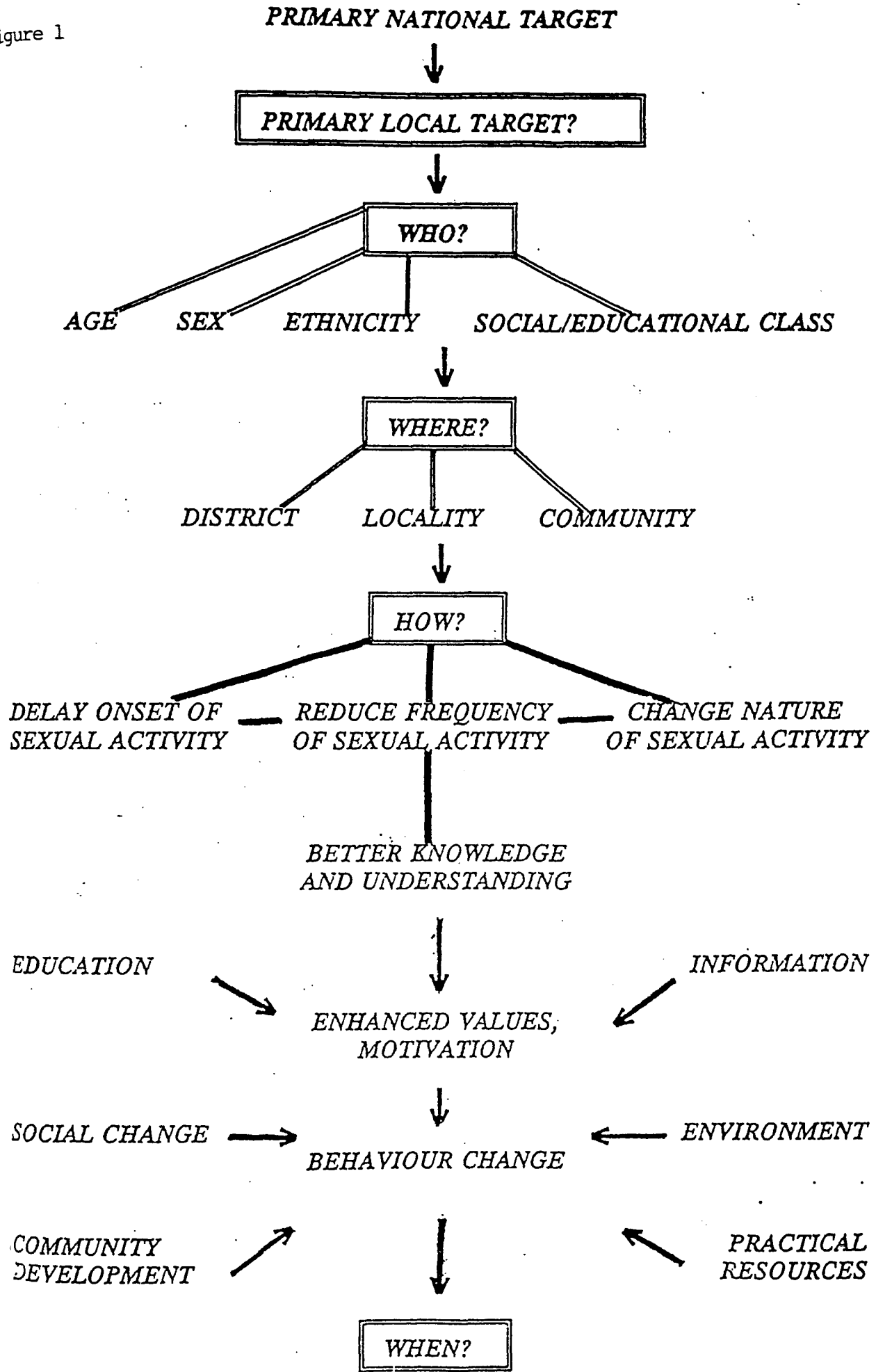
To ensure the provision of effective family planning services for those people who want them.

These broader objectives are extremely important, particularly as achieving the key target of a 50% reduction in the under 16 conception rate will be very difficult, if at all possible in some areas. This is partly due to the complexities surrounding teenage conception but also relates to problems in reducing conceptions where the numbers of young women under 16 becoming pregnant is already very small.

It is also useful to examine the philosophy behind the target and the objectives. In the *Key Area Handbook: HIV/AIDS and Sexual Health* the government sets out its philosophy and how they see this as being achieved.

Planned parenthood provides benefits for the health of individuals, families and communities. Family planning services aim to promote this by providing access to contraception, sterilisation and advice on unplanned pregnancy. Additionally, education, counselling and health promotion can enable prospective parents to choose healthy lifestyles and increase the chances that their children will be wanted and healthy. Delaying and spacing pregnancies and limiting family size contributes to the physical and mental health of mothers and children and general family well-being. The effective use of condoms or other barrier methods of contraception also promotes sexual health by giving protection against sexually transmitted diseases. (Para. 5.1.3)

Figure 1



Developing local targets

The first key task for purchasers is to develop local targets. The process for developing local targets is shown in Figure 1. The setting of targets will require a detailed analysis of local characteristics of the population (sex and age structure, ethnicity, class structure etc), an appreciation of the geography of the area, and a discussion about the goals of the policy based on information about young people's sexual behaviour, contraception usage etc. From this basis it is possible to develop a better knowledge and understanding of the changes required and how these might be achieved.

Breaking down of the target in this way is extremely important as from the literature on teenage conception we know that while the antecedents of conception are multi-factorial there are particular groups who are more at risk of unintended pregnancy and that certain groups less likely to use, or benefit from existing service provision. Information will, for example be required on the number of young men attending, social class breakdown, the area young people come from. Some of these issues are highlighted later with regard to outcome measures.

Obtaining information

Using the target setting approach outlined in Figure 1 specific information needs are highlighted. Clearly there is an need for both qualitative and quantitative data. More importantly, there is a need to draw on information from, and the expertise of a wide variety of agencies.

Epidemiological information can be drawn from a number of sources and these are shown in Figure 2. As important though are the range of agencies and sources shown in Figure 3 which demonstrates the need for collaborative approaches to this issue. Health authority purchasers are not the only agencies with an interest in teenage pregnancy and therefore many organisations and individuals will have information on the issue.

The figure also serves to demonstrate that teenage pregnancy is not specifically a health issue alone. But, as the Royal College of Obstetricians and Gynaecologists observed in their 1991 report on unplanned pregnancy, teenage conceptions lead to both additional health and social care costs.

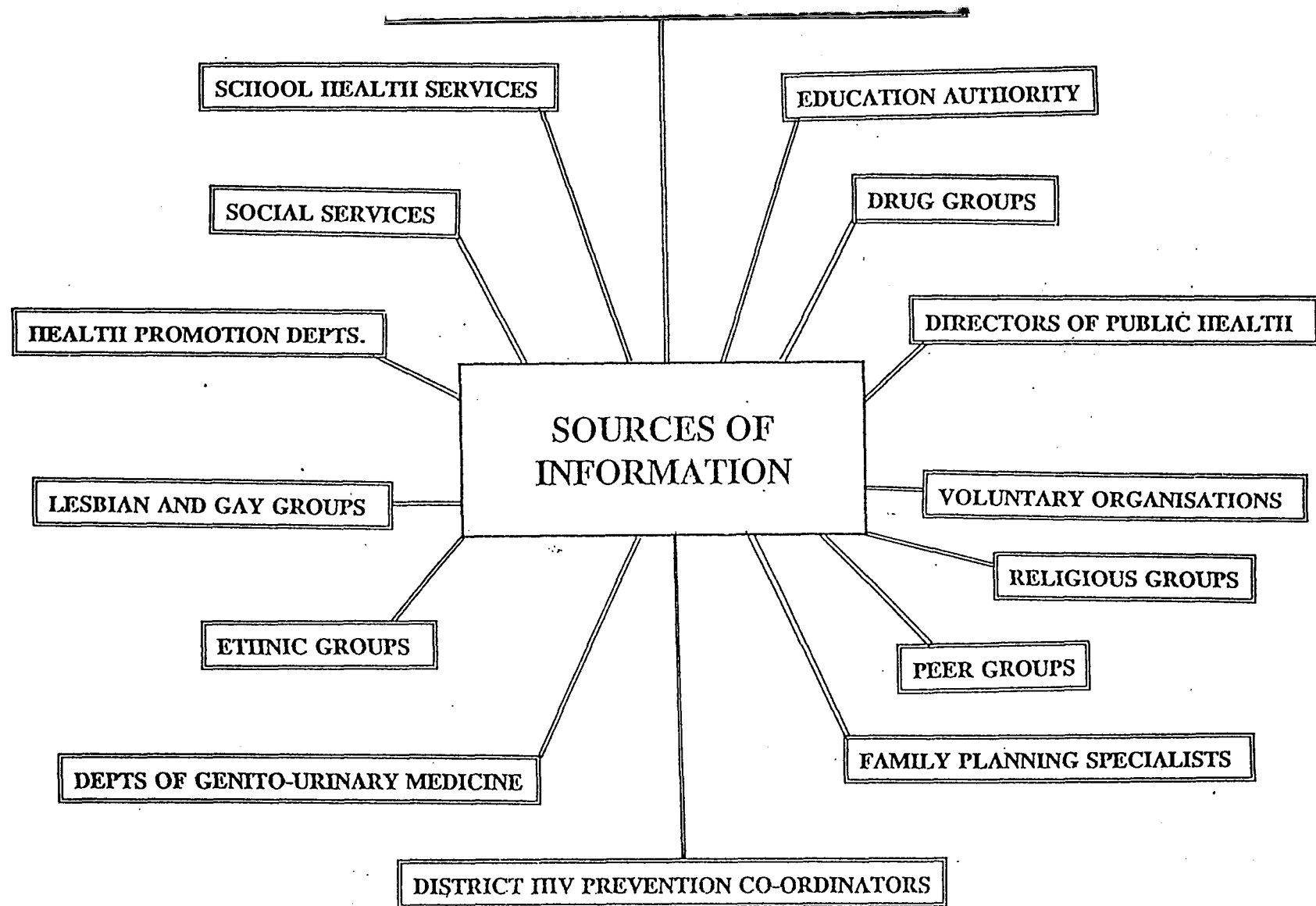
Informal sources of information will be extremely important and could come from a variety of sources not normally used. For example youth projects and surveys in schools may provide useful data.

One key point to bear in mind that there is a lot of literature on the teenage pregnancy and a number of projects are running in this country. DO make use of existing data on what young people think about services and use the experience of others.

Figure 2

SOURCES OF EPIDEMIOLOGICAL INFORMATION

- * HEALTH SERVICE INDICATORS PACKAGE**
- * O.P.C.S. STATISTICS**
- * PUBLIC HEALTH COMMON DATA SET**
- * FORM KT31: SUMMARY OF FAMILY PLANNING
ACTIVITIES**
- * FORM FP1001: PROVISION OF CONTRACEPTIVE
SERVICES BY GPs**
- * FORM KC60: DIAGNOSIS OF SEXUALLY
TRANSMITTED DISEASES**
- * PACT DATA: PRESCRIPTIONS DISPENSED
BY PHARMACIES AND GPs. IN FHSA**
- * LITERATURE**

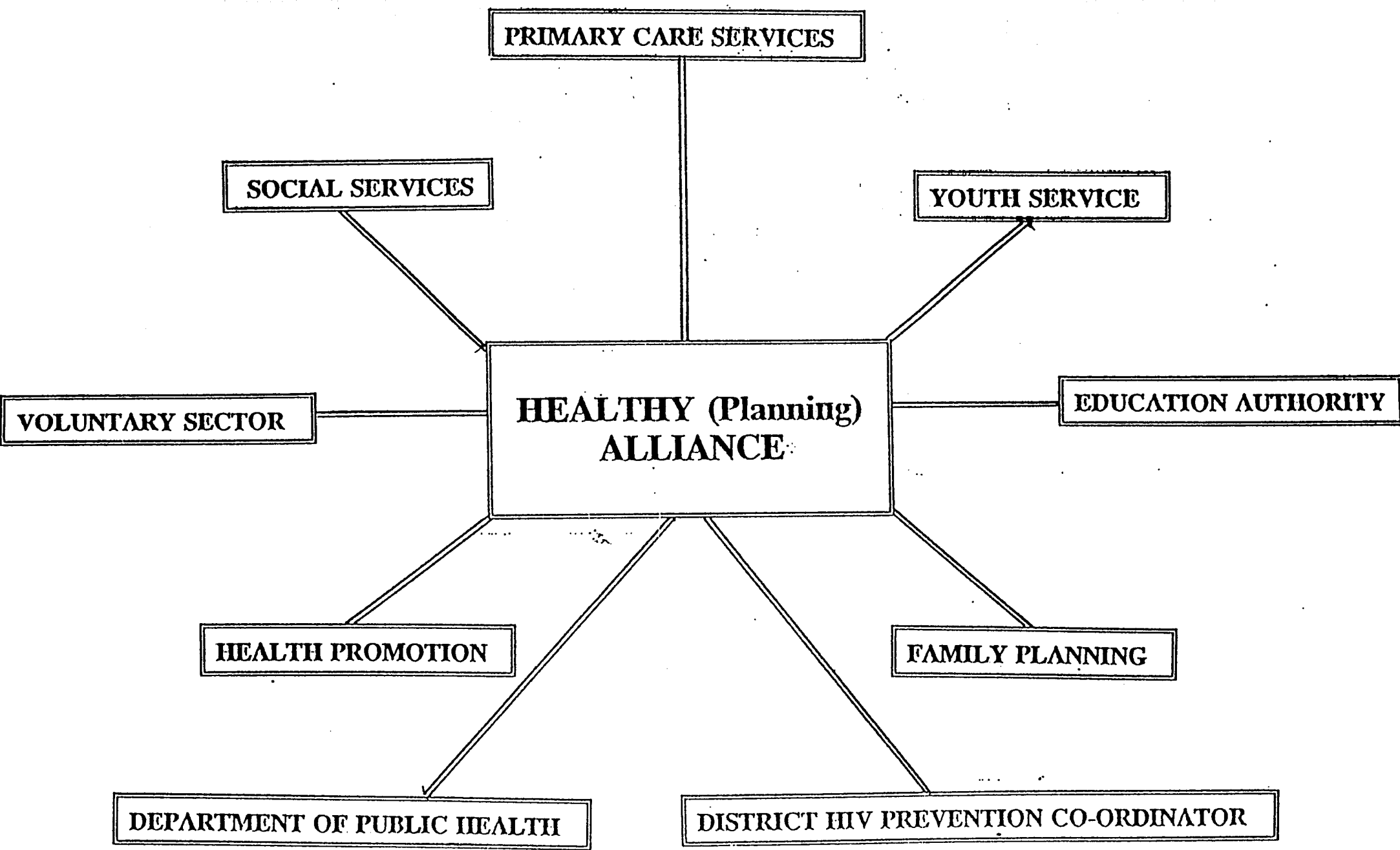


Planning services/identifying service options

By building on this base of needs assessment, target development and joint approaches it is possible to develop the range of services that will be required. Ideally this should be based on a joint approach (Peckham 1993) and this 'Healthy Alliance' approach is advocated by the *Health of the Nation*. Figure 4 outlines the sorts of partnerships that need to be formed.

Because there is little literature in the UK on what approaches are effective in preventing unplanned teenage pregnancy it is important to develop general strategies which purport to be effective strategies and to draw on local knowledge and experience in other countries. There is substantial literature on what are perceived to be best approaches and the information given below on protocols will also be useful.

It is also important to examine local circumstances and identify any local work by schools, academic institutions, the youth service, voluntary organisations etc which may provide useful information on what services would be more effective. For example where local youth clubs have discussed health issues young people may have expressed their opinions about local contraception and advice services and the issues they face, as well as explored what they feel a good service might be.



Developing protocols and outcome measures

The information included here summarises some key points from the literature and provides a guide for developing good practice guidelines, protocols for services and suggests outcome measures that can be monitored.

Protocols for service.

Reference - Winter, L. & Breckenmaker, LC. (1991) Family Planning Perspectives 23(1) pp24-30.

Based on a review of 6 specialist clinic services for adolescents. Features that services should incorporate:

- Education provided in a one-to-one session rather than a group session.
- Information should be concrete not abstract, visual aids (such as pictures, a pelvic model or posters) were used with adolescents.
- To ease the teenagers' anxiety, the initial visit was scheduled as two appointments, with counselling and education at the first and the medical examination at the second (a pelvic examination is standard in the USA). The two appointments were generally scheduled two weeks apart. The patient began using her medical method after the second visit. - In the study there was only a 4.3% drop rate between first and second visits.
- Need for frequent contact with the clinic. The initial follow up visit was made six weeks after the start of contraceptive method. This is to reduce the numbers of usage problems.
- Allow adequate contact time, longer than normal clinic times.
- Staff members trained in adolescent psychosocial development.
- Encourage male participation. Provide opportunity for partners/parents/friends after individual consultations.
- Help adolescents to recognise and resist peer pressure.
- Staff members should strongly encourage parental involvement with teenage patients, while clearly communicating the teenager's right to confidential services.

Clinics where these protocols were implemented showed that teenagers using the services had similar levels of contraceptive use and levels of satisfaction to teenagers using the control clinics.

However, where teenagers experienced problems with a contraceptive method, the experimental clinic users were more likely to continue using contraception than those using the control clinics (70% compared with 40%). Teenagers were more knowledgeable at clinics using the protocols. Teenagers at the experiment clinics had significantly less pregnancies (including those who only attended the first visits 3.1% compared with 5.5%, for those completing treatment phase 4.0% compared with 7.8%).

Key issues to note in developing services

Reference: Hayes, CD (ed), (1987) Risking the Future Vol I

Review of evaluative research on provision of contraceptives for adolescents (chapter 6):

- Clinics that offer a community education programme for teenagers in combination with provision of contraceptive services (physical examination and prescription) have a lower mean delay between first intercourse and first visit.
- Those that obtain the support of local community groups (primarily the churches in USA), develop active relationships with youth organisations, are open on weekends and in the evenings, accept walk-in clients, are conveniently located, require less counsellor time per patient, and provide fewer services have a lower mean delay.
- Adolescents who return to the clinic at regularly scheduled intervals (3 - 6 months) were found to be more reliable contraception users.
- An evaluation of 10 school based clinics in St Paul, Minnesota found that between 1973 and 1983/4 the birth rate declined from 79 per 1000 to 26 per 1000. However, abortion and pregnancy rate statistics were not available. Contraception continuation rates were favourable - 93% at 12 months and 82% at 24 months after initial visit. The main problem with school based clinics is that they are only accessible during school times and cater for those children attending school.
- A community based clinic (Self Center, Baltimore) served two schools operating from shop front premises providing free advisory, counselling and contraception services. The programme had little effect on teenagers attitudes to teenage pregnancy, ideal age for child bearing or the acceptability of sex between two people. However both boys and girls showed increased knowledge about contraceptive measures, there was some delay in first intercourse, increased use of contraceptives, conceptions reduced by 26% compared to an increase in control schools.

Recommendations of Policy Studies Institute

Allen, I. (1991) Family Planning And Pregnancy Counselling Projects for Young People.

From the evaluation of the three projects for young people Allen makes a number of recommendations regarding the delivery of services to young people. Briefly these are:

- That all DHAs should give priority to developing special services for under 20 year olds.
- That services should be 'user friendly', be informal, have open access, provide a range of services and counselling and not be limited to just contraception and pregnancy.
- They should be widely publicised.
- That 'outreach' work should be undertaken by the service in collaboration with other health education services for young people (eg. HIV/AIDS).
- To ensure collaboration with other professionals and agencies providing services for young people.
- The need for improved education in sex and personal relationships, delivered by a variety of agencies and including information on HIV/AIDS.
- That each DHA should aim to develop a health strategy for young people

These recommendations are contained in the Regional Guidance produced by the NHSME.

Evaluation criteria

Clearly it is very difficult to set goals in terms of contact rates and target conception rates. Only very general rates could be set based on best known rates as there is nothing in the literature to suggest targets. For example the conception rates per 1000 teenage women by age in England and Wales in 1990 were

AGE	RATE
13 & under	1.3
14	6.6
15	21.6
16	46.4
17	69.5
18	89.2
19	99.5

In terms of contact rates it would not be sensible to have general rates if the clinic is not attracting young people from the 'higher risk' age groups.

American research suggests that those with higher education/ higher social class are more likely to be better clinic attenders. We also know from the literature that young women from higher social classes are more likely to use contraception and, if pregnant, are more likely to have the pregnancy terminated. Therefore, it is not just a case of how many young people come but perhaps examining who is coming.

Below are given some suggested criteria for measuring outcomes which are not purely focused on pregnancy, abortion and birth rates.

Some suggested criteria

1. Process measurements related to the protocols outlined above.
2. The extent to which the clinic is integrated with other youth services and general education.
3. Routine surveys of clinic users. For example on delay of use of contraceptives, knowledge about contraception, consistency of contraception use (on return visits).
4. Time delay in attending clinic - ie. are young people attending before, at the time of, or after commencing sexual activity.
5. Numbers, age and class of young men using the service, particularly as individuals (survey or proxy information on booking in form eg. address, housing, schooling, employment etc.).
6. Numbers, age and social class of young women attending (survey or proxy information on booking in form eg. address, housing, schooling, employment etc.).
7. Frequency of attendance and numbers of missed appointments.
8. Measure percentage of target population attending - ensure that population is stratified by age, sex, social class etc.
9. Young people's satisfaction of services.

Items 3-5 are based on the knowledge that it is non-use in first 6 months or so and poor use of a contraceptive method which places most young women at risk of pregnancy.

Further indicators of effective family planning services, have been developed in relation to the Health of the Nation by the Key Area Implementation Group on HIV/AIDS and Sexual Health.

Indicators of effective family planning services

INDICATOR			
Pattern of provision of family planning and contraception services <ul style="list-style-type: none"> • General practice • Community Health Services • Hospital services 	Data submitted by FP clinics - KT31 FP1001s and FP1002s Hospital activity data	DHA/FHSA	Services for young people Sterilisation and vasectomy
Facilities provided by CHS clinics <ul style="list-style-type: none"> • sexual health advice • contraceptive advice • range of contraceptive methods • pregnancy testing and counselling 	Service agreements	DHAs	
Level of staff training provided in family planning within district	DHA data	DHAs	
Funding arrangements within region for family planning services provided by <ul style="list-style-type: none"> • CHS • Other providers 	RHA data	RHAs	
No. women provided with emergency contraception in each district per month by source	PACT data - prescriptions issued by GPs for emergency contraception (NB may give underestimate) KT31 data submitted by FP clinics	DHA, FHSA	
No. sterilisations and vasectomies undertaken each month	Hospital activity data	RHA, DHA	

Quality of FP Services provided by CHS	Clinical audit by clinic staff	Family planning clinics	
Availability of FP Services provided by General medical practitioners <ul style="list-style-type: none"> No. general practices with written policy on sexual health Level of publicity of services provided No. of GPs with Family Planning certificate No. women registered for family planning services per year per practice No. claims for IUCD insertion per year No. prescriptions per GP per yr <ul style="list-style-type: none"> oral contraception coils diaphragms emergency contraception spermicides No. practices providing free condoms No. practices providing pregnancy testing and counselling 	FHSA survey FHSA survey FHSA survey FP1001 FP1002 PACT data ? VAMP Research data FHSA survey FHSA survey	FHSA's	
Quality of family planning services provided in general practice	Clinical audit	Practice	

No. women referred for abortion per month by <ul style="list-style-type: none"> • GP • Community Health Services • Other 	Hospital activity data	DHA/FHSA	
No. abortions performed per month within each district <ul style="list-style-type: none"> • % done on NHS • % < 12/40 • % medical 	Hospital activity data	DHA	
Accessibility of family planning services provided by Community Health Services <ul style="list-style-type: none"> • no. clinic sessions by location <ul style="list-style-type: none"> no. doctor sessions - % female no. nurse sessions • no. clinic sessions specifically for young people • no. patients seen in each clinic each month • advertisement/signposting of services • provision of 24 hour information service - including advice on emergency contraception • opening times of clinics • ease of obtaining an appointment • availability of drop-in services • Waiting time to be seen in clinic 	Service agreements	DHAs	

References

- Allen, I. (1991) Family Planning And Pregnancy Counselling Projects for Young People. London: Policy Studies Institute.
- Cooper, P, Diamond, I. & High, S. (1992) Quality Measures in Family Planning Services: Summary Report and Recommendations. Wessex Regional Health Authority.
- DOH (1992) Health of the Nation. London: HMSO.
- DOH (1993) Health of the Nation Key Area Handbook: HIV/AIDS and Sexual Health.
- Estaigh, V. and Wheatley, J. (1990) Teenage Pregnancy, in Family Planning and Family Well-Being. Occasional Paper Number 12. London: Family Policy Studies Centre
- Garlick, R., Ineichen, B. and Hudson, F. (1993) 'The UPA score and teenage pregnancy.' Public Health 107, 135-139.
- Hayes, C. D.(ed.) (1987) Risking the Future. Vol 1, Adolescent Sexuality, Pregnancy, and Childbearing. Washington, D.C.: National Academy Press.
- Hudson, F. and Ineichen, B. (1991) Taking it Lying Down - Sexuality and Teenage Motherhood. Basingstoke: MacMillan.
- Ingham, R., Woodcock, A. & Stenner, K. (1991) 'Getting to know you....young people's knowledge of their partners at first intercourse' Journal of Community and Applied Social Psychology 1(2), 117-132.
- Ingham, I. (1993) Can We Have a Policy on Sex? Institute for Health Policy Studies, University of Southampton.
- Kay, B J. Share, D A. and Jones, K. (1991) 'Process, costs and outcomes of community based prenatal care for adolescents.' Medical Care 29(6), 531-542.
- Kirby, D., Waszak, C. and Ziegler, J. (1990) 'Six school-based clinics: their reproductive health services and impact on sexual behaviour.' Family Planning Perspectives 23(1),
- NHS Management Executive (1992) Guidelines for reviewing family planning services: Guidance for regions. NHSME: London.
- Peckham, S. (1992) Unplanned and Teenage pregnancy: A Review. Institute for Health Policy Studies, University of Southampton.
- Peckham, S. (1993) 'Preventing unintended teenage pregnancies' Public Health 107, 125-133.
- Phoenix, A. (1991) Young Mothers? Cambridge: Polity Press.

Royal College of Obstetricians and Gynaecologists (1991) Report of the RCOG Working Party on Unplanned Pregnancy.

London: RCOG.

Simms, M. and Smith, C. (1986) Teenage Mothers and Their Partners. London: HMSO.

Smith, T. (1993) 'Influence of socioeconomic factors on attaining targets for reducing teenage pregnancies' British Medical Journal 306, 1232-5.

Wilson, S. (1989) 'A model for planning local contraceptive services.' Public Health 103, 369-376.

Wilson, S. H., Brown, T. P. & Richards, R. G. (1992) 'Teenage conception and contraception in the Regions.' Journal of Public Health Medicine 14(1), 17-25.

Winter, L. and Breckenmaker L C. (1991) 'Tailoring family planning services to the needs of adolescents.' Family Planning Perspectives 23(1), 24-30.

SUPPORT FOR PREGNANT TEENAGERS

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Introduction

The Health of the Nation directive has prompted many research and intervention efforts to focus on the prevention of teenage pregnancy. However, even if the desired 50% reduction amongst the under 16's is attained, which is by no means certain, this still leaves a requirement for service provision for this age group. Such provision must enable the young mothers to attain the best possible outcomes for themselves and their children.

Defining pregnant teenagers

Before any discussion as to service provision and support for pregnant teenagers can commence the scope and influence of the Health of the Nation guidelines must be considered. The requirement is that conceptions to the under 16's be reduced by 50% and considerable resources have been devoted towards achieving this end. However, expectations that this will "solve the problem" of teenage pregnancy are unrealistic. The majority of teenage pregnancies occur to the over 16 age group and not to young women under the age of 16. In 1990 (the latest figures available) 10.1 women out of every 1000 under the age of 16 became pregnant. This compares with 69.0 per 1000 women under the age of 20 (OPCS, 1993). Clearly, even if the number of pregnancies to the under 16's is halved, it still leaves a substantial number of teenage women in need of some kind of service provision. These points have a considerable bearing on the nature of support required by the women involved.

Whilst the under 16 group is important it should not be focused on to the exclusion of all others nor should the needs of one group be generalised to all. The point is this, just as the term single mum has tended to become synonymous with teenage mum [when in reality divorce is the greatest source of single parent families (Hobcraft & Joshi, 1989)], considerations for the under 16's have been merged with teenagers in general. Furthermore, Smith (1993) has pointed out significant differences between groups of teenage mothers when stratified by social and geographical contexts. In sum, teenagers do not constitute a homogenous group and service provision must be tailored to meet the specific requirements of the client group. In addition, an implicit assumption of guidelines such as Health of the Nation is that all teenage pregnancies are unplanned and unwanted. Whilst I acknowledge that under 16's are much less likely to choose to be pregnant, for the older group this is clearly not always the case. In terms of services for pregnant teenagers, the nature of support needed by a 13 year old who did not choose to become pregnant and a 18 year old who elected to become a mother are likely to be very different. The pregnancy and motherhood experiences will vary physically, emotionally, socially and psychologically and unless we are aware of these developmental changes throughout the adolescent years we are in danger of providing services which do not match the needs of the user. Before we can

provide support for pregnant teenagers we must have a clear understanding of exactly who our client group is and what it means to them to be pregnant.

Parentcraft groups for pregnant teenagers

Despite the widespread assumption that teenage pregnancies automatically have problematic pregnancies and deliveries it is gradually becoming accepted that outcomes for adolescent mothers, particularly older adolescents are not as severe as was once thought. One mediator towards a positive outcome is social support. The psychological literature has long held social support to be the key to positive outcomes in a variety of stressful circumstances (Cobb, 1976, Callaghan & Morrissey, 1993). Social support theory is increasingly being applied to the domain of pregnancy and motherhood, and more specifically to teenage motherhood. It has been suggested that high levels of family and community support are instrumental in reducing levels of low birth weight babies to adolescent women (Gale, Seidman, Dollberg, Armon & Stevenson, 1989). Support need not be familial to be of value: Grace & Smoke, (1988) reported that specialised antenatal care for pregnant adolescents can have a positive impact on outcome of pregnancies and Cartoof, Klerman & Zazueta (1991) suggested that women who received more adequate antenatal care delivered infants of higher birth weight and gestational age.

Pregnant teenagers are reported to be poor attenders of antenatal clinics and parentcraft groups. Late confirmation and reluctance to accept the pregnancy exacerbate the problem. A lack of adolescent only clinics present a major barrier to comprehensive antenatal care (Kinsman & Slap, 1992). In my study of teenage mothers I ask those who attended parentcraft classes designed specifically for young mothers, whether they would attend regular groups if the young mums group did not exist. Although the sample size was small the following replies are indicative of the problems encountered by these women and the values of such groups to them:

*"I doubt it very much because they do a parentcraft class in my town...I walked in and everyone was so much older than me and they just stared at me. I felt so out of place. I wouldn't have been able to concentrate on what I was doing. I just went home again. I didn't feel as if I belonged there...there was nobody even remotely my age...
...It (the young mums group) is good because you think you're the only person in the world that's in that situation and you go there and you see how all those who've had their babies are coping and that it's really helpful. It helped me such a lot. They cope. They're just like normal. They cope really well...it's good to know that you're not the only one and there's other people in the same situation and that there are people to help you." (16 year old woman)*

"I went to one (class for adult women) but it was so embarrassing that I wouldn't go.. they were all so much older than me - there's nothing organised for my age group in my town... you ask questions and they either think you're stupid... They assume that because you're a woman you know what you're at and it's a stupid thing to say. How am I supposed to know? I haven't been out of school that long. I've only just left school and gone to college and then they say you're going to have a baby. They don't tell you anything really. They assume you know." (17 year old woman. Her GP failed to inform her that the antibiotics she was prescribing would interfere with the

effectiveness of the Pill)

"I went to one locally but they wouldn't allow me in because they were 19 years and up, so I started to go to the young mums group." (18 year old woman who planned her pregnancy)

There are far too few antenatal classes designed specifically to meet the needs of teenage mums (Bury, 1984) but despite the problems of setting them up, recruiting appropriate and sympathetic staff and of irregular attendance figures, special antenatal groups should be developed wherever possible (Mills, 1990). Such service provision need not be confined to the antenatal period or necessarily come under the medical umbrella, the essential ingredients are an appreciation of the needs of the client group and clear understanding of exactly kind of what support they need. As one of the quotes highlighted, young pregnant women can gain much just from contact with others in similar circumstances.

Conclusion

The Health of the Nation directive has prompted much emphasis to be placed upon reducing teenage pregnancies, particularly amongst the under 16 age group. Whilst it is important that unwanted pregnancies to this age group should be cut, budgets should not be directed solely to achieving this end. The majority of teenage pregnancies occur amongst the older adolescent population and their needs also need addressing, whether it be in helping to preventing unintended pregnancies or supporting them through their pregnancies. In planning supportive services to young mothers the lack of homogeneity amongst teenage mothers must certainly be acknowledged. Parentcraft, antenatal and mother and baby groups offer opportunities for young women to develop their own supportive network and thereby help them maximise the use of their own resources. Such provision optimises positive outcomes for both mother and baby and limit cost to the state.

References

Bury J.(1984) Teenage Pregnancy in Britain. Birth Control Trust. London

Callaghan P. & Morrissey J. (1993) "Social Support and Health: A Review." Journal of Advanced Nursing 18:203-210

Cartoof et al (1991)

Cobb S. (1976) "Social Support as a Moderator of Life Stress" Psychosomatic Medicine 38,5:300-314.

Gale R., Seidman D., Dollberg S., Armon Y. & Stevenson D. (1989) "Is Teenage Pregnancy a Neonatal Risk Factor?" Journal of Adolescent Health Care 2,1: 53-102

Grace J. & Smoke M. (1988) "Effectiveness of Prenatal Care and Education for Pregnant Adolescents: Nurse-midwifery Interventions and Team Approach." Journal of Nurse Midwifery 33,4: 178-184.

Hobcraft J. & Joshi H. (1989) Population Matters. In H. Joshi (ed) The Changing Population of Britain Basil Blackwell. Oxford.

Kinsman S. & Slap G. (1992) "Barriers to Adolescent Prenatal Care." Journal of Adolescent Health Care 13: 146-154.

Mills M. (1990) "Teenage Mothers". In Alexander J., Levy V. & Roach S. (eds) Postnatal Care: A Research Based Approach. pp 125-142. Macmillan. London.

OPCS (1993) Birth Statistics: Review of the Registrar General on Births and Patterns of Family Building in England and Wales, 1991. Series FM1, No. 20. HMSO. London.

Smith T. (1993) "Influence of Socioeconomic Factors on Attaining Targets for Reducing Teenage Pregnancies." British Medical Journal 306:1232-1235.

CONCLUSION

The discussion during the day ranged across an enormous spectrum of issues relating to teenage pregnancy. Yet, there were some common themes.

The first of these was the need for multi-agency and multi-disciplinary approaches. This was raised by all the workshops as a prerequisite of good planning and service delivery.

The second common theme was the need to involve young people and to find out what sorts of services and information they require. This was stressed particularly in the paper given by Professor Diamond, but echoed by many of the workshops.

A third theme was the need for dedicated services for young people which set out to meet the needs of this age group. Many speakers and conference participants felt that more resources were needed for this area of work. It is hoped that with the emphasis on sexual health within the *Health of the Nation* and a relaxation of the boundaries for HIV prevention allocations so that broader sexual health work can be funded, more resources will be available in future years.

The most significant factors in relation to the prevention of unintended teenage pregnancy are the degree of openness about sexuality, the content, context and scope of sex education on offer to young people, and the accessibility of counselling services and contraceptive advice. Findings such as these have implications for policies which seek to reduce unwanted teenage pregnancy rates, both in the fields of health and sex education and in the provision of family planning and related services.

For District Health Authorities there would seem to be a range of action which they could take:

- Develop special services for under 20 year olds.
- Ensure that services are 'user friendly', informal, have open access, provide range of services and counselling, for young men and women, and not be limited to just contraception and pregnancy.
- Services should be widely publicised.
- Outreach work should be undertaken by the service in collaboration with other health education services for young people (eg. HIV/AIDS).
- Collaborate with other professionals and agencies providing services for young people.

- Recognise the need for improved education in sex and personal relationships, delivered by a variety of agencies and including information on HIV/AIDS, and develop joint strategies.
- Develop a health strategy for young people which emphasises a broad approach to tackling teenage pregnancy.

However, it is important to recognise though that this issue is not one to be addressed by someone else. It is the responsibility of everyone who works with young people.

We all have a responsibility to ensure that attitudes to sexual issues and contraception change. Good quality and comprehensive sex education must be provided in schools. With responsibility for this being in the hands of school governors, and now likely to be up to individual parents, it is up to parents as well as professionals to ensure that young people receive appropriate advice and support. Above all we must work collectively, across service and agency boundaries to provide a network of services giving advice, care and support that is acceptable to young people. This will involve developing alliances across services as was highlighted at the conference.

Providing accessible family planning services together with effective health and sex education is one thing, changing the climate of opinion about how to handle early manifestations of sexuality by young people is another. The first can be tackled by health authorities and general practitioners in conjunction with education, social services, youth agencies and voluntary organisations. The second, as suggested, requires a radical change in the way issues related to sexuality are viewed within our society and is in many ways our joint responsibility.

Progress towards these goals will also require strong support from government departments which have an input into the related social and economic factors. Whether such measures will allow us to achieve the *Health of the Nation* target by the year 2000 seems doubtful for many reasons, but we should not ignore the challenge and work in this area can only help to increase choices for young people and it is our responsibility that young people are at the centre of our thoughts and strategies. It is their lives and we should be helping them become responsible people by providing them with the skills that they need to make decisions and ensure that services are in place to ensure that they have access to advice, information and contraception as well as support during pregnancy, abortion and after birth.

