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States of Jersey
Public Health Committee

REPORT ON UNPLANNED PREGNANCY

October 1993

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States of Jersey
Public Health Committee

REPORT ON UNPLANNED PREGNANCY

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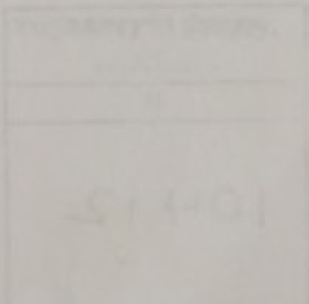

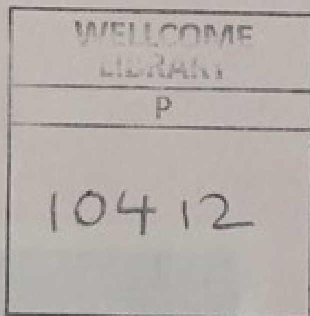
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States of Jersey
Public Health Committee

REPORT ON UNPLANNED PREGNANCY

1. BACKGROUND

1.1 Annual statistics received from the United Kingdom Office of Population Censuses and Surveys include data required under the Abortion Law of the United Kingdom. Since 1986 this information has classified separately the number of abortions performed in England and Wales for women giving Jersey as their place of residence (See Appendix).

1.2 The Public Health Committee has been concerned about the numbers of abortions performed in the United Kingdom for Jersey residents, and agreed, in its Act No.16, of 4th December 1991, that urgent action was necessary to alleviate the continuing social and medical problems of unplanned pregnancies resulting in abortions.

1.3 On 5th February 1993, the Public Health Committee agreed that a Working Party be established *'to review the recommendations of the Report of the Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy, September 1991, and to advise the Public Health Committee of recommendations for family planning services in Jersey'*. The Working Party first met on 19th March 1992, and the Report of the Working party was received by the Committee on 7th July 1993. Membership of the Working party is listed in Appendix 1, and its Terms of Reference are given in Appendix 2.

1.4 The Public Health Committee, having received the views of the Education and Social Security Committees on the Working Party Report, decided on 3 November 1993 to publish a revised Report to inform the public and interested bodies of the Committee's opinion on the development of services relating to unplanned pregnancy in Jersey.

2. SCOPE OF THE REVIEW

2.1 The objectives of this Report are to review the existing services in relation to unplanned pregnancy in Jersey and to outline the views of the Public Health Committee on the future development of these services.

2.2 The clinical services reviewed include those provided by the Department of Health, Family Planning Clinic and general medical practitioners. In addition, the roles of the Education Department, Social Security Department, Health Promotion Unit, Children's Department, Youth Service and the Housing Department are considered.

2.3 **The information available is necessarily limited in some areas. It has not, for example, been possible to examine individual school curricula in detail or to interview women who have obtained an abortion, and the conclusions are therefore partly derived from the considered opinions of Departmental Officers and other advisers to the Working party.**

2.4 The Report takes into account recommendations of the Royal College of Obstetricians and Gynaecologists, the Institute for Health Policy Studies and the Family Planning Association, and also information on family planning and contraception services from public sector and voluntary organisations in the United Kingdom and the Netherlands.

2.5 **The above reports contain evidence based on detailed studies on unplanned pregnancy in the United Kingdom and the Netherlands, and whilst they do not directly refer to Jersey there seems to be no reason to believe that the situation in Jersey is significantly different.**

3. THE NATURE OF THE PROBLEM

3.1 Definition of 'unplanned pregnancy'

3.1.1 It is assumed, in the absence of any more specific information, that abortion statistics are an indication of the incidence of unplanned pregnancy. However, it should be remembered that not all unplanned pregnancies are aborted, and in this respect the scale of the problem may be greater than the available statistics indicate. Conversely, not all unplanned pregnancies are unwanted, and many unexpected pregnancies eventually become loved babies.

3.1.2 Neither should it be taken for granted that all pregnancies that are aborted are unwanted. There may be a number of social and economic pressures (for example parental pressure on an unmarried mother, or housing difficulties for a young couple) which lead to the reluctant decision to abort a pregnancy. In these circumstances the pregnancy might be wanted, but the timing inappropriate, and there may be need for suitable family planning.

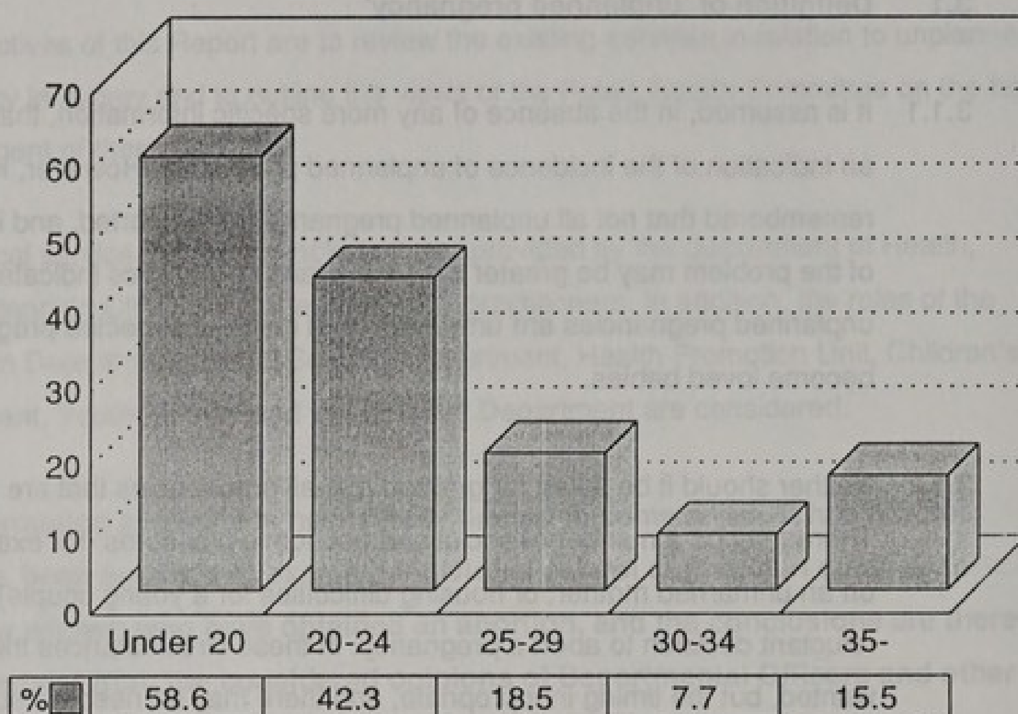
3.1.3 The situation is clearly complex, and it is therefore difficult to define the term 'unplanned pregnancy' exactly. However, it is generally agreed that it is desirable to reduce the number of unplanned pregnancies, and this should be associated with a reduction in the number of abortions performed.

3.2 Abortion statistics

3.2.1 The statistics received from the Office of Population Censuses and Surveys on numbers of abortions performed on Jersey resident women are given in appendix (iii). An analysis of these statistics for 1991 according to the age groups of the women concerned shows that 51 out of the total 87 pregnancies in women under 20 years were terminated (figure 1.). The scale of the problem is indicated by the overall proportion of pregnancies aborted (22.5%), that is 307 out of a total of 1,364 conceptions during 1991.

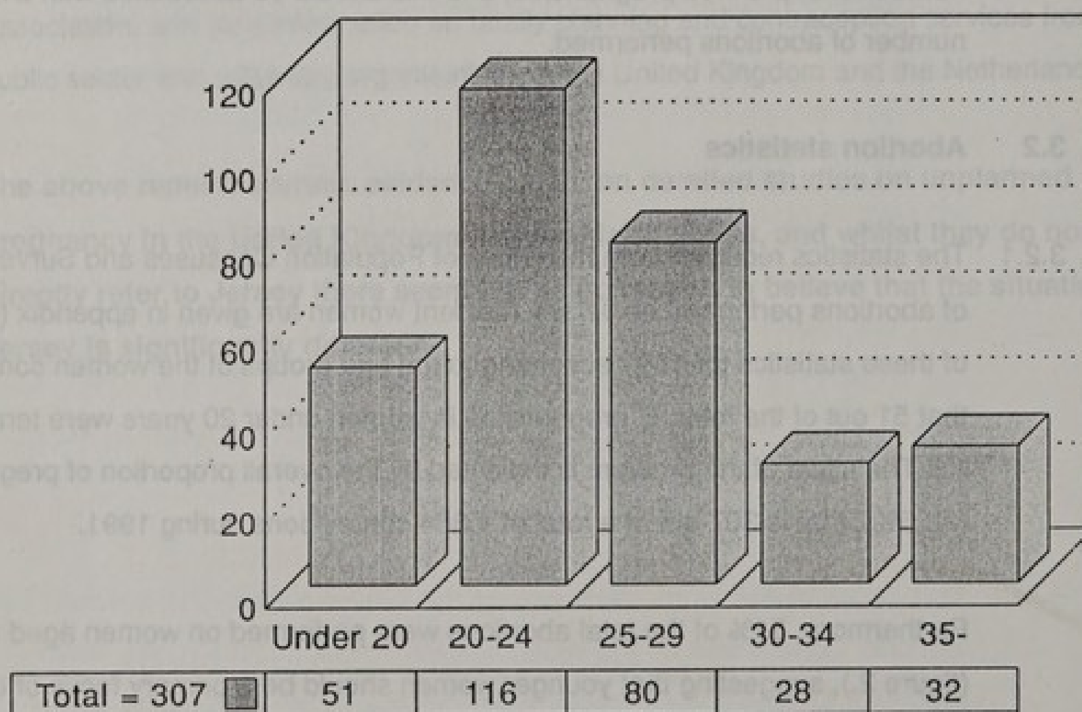
Furthermore, 51% of the total abortions were performed on women aged up to 25 years (figure 2.), suggesting that younger women should be a primary focus of concern.

Figure 1. Percentage of pregnancies (in age groups) which were aborted in 1991.



%	58.6	42.3	18.5	7.7	15.5

Figure 2. Number of abortions in age groups (1991).



Total = 307	51	116	80	28	32

3.3 Incidence of unplanned pregnancy

3.3.1 Notwithstanding the difficulty in defining 'unplanned pregnancy', various authorities estimate that the incidence of unplanned pregnancy is about one in five conceptions.

3.3.2 The evidence of the preceding paragraphs suggests that, while unplanned pregnancy occurs at any child-bearing age, the problem in Jersey is largely associated with women in the the first decade of their reproductive life - up to the age of 25 years.

3.3.3 Sexual behaviour and the desire to have children is influenced by many factors including religious and ethical beliefs, the role of a woman as a worker and in the home, and the attitudes of the community towards sexual relationships [1] . It is possible that a younger woman or her partner may be unprepared to accept a parental role, unable to afford to give up working or to meet the costs of bringing up a child, or unwilling to give up their career.

3.3.4 However, it is often in the under 20 years age-range that sexual motivation is greatest, sometimes without the formal structure of marriage or a stable relationship to support a woman if she becomes pregnant [2] . No evidence is available concerning the proportion of abortions performed on unmarried Jersey-resident women, but it is considered that the value of marriage should not be under-estimated in relation to sexual relationships. On the basis of the UK data, it appears that sexual activity is often not linked with the formation of a stable relationship, the desire to have children, or ability to support the upbringing of children.

3.3.5 There is no reliable evidence concerning the nationality, period of residence in Jersey, or the socio-economic status of women who have had an abortion in the United Kingdom, although studies in the United Kingdom suggest that women from a socially disadvantaged background are less able to cope with a child and more likely to be adversely affected by an unplanned pregnancy [3] .

1. *Report of the RCOG on Unplanned Pregnancy, September 1991, Ch. 5.*
2. *Ibid. Paragraph 6.5.*
3. *Institute for Health Policy Studies 'Unplanned Pregnancy and Teenage Pregnancy', April 1992, p. 9.*

3.4 Consequences of unplanned pregnancy

3.4.1 The potential adverse consequences of an unplanned pregnancy for the mother include financial hardship, loss of housing, social stigma and loss of self-esteem, feelings of guilt and depression, psychological stress or breakdown, loss of employment or career prospects, break-up of a relationship, and of course the personal and moral dilemma of a possible abortion.

3.4.2 Evidence from the United Kingdom [4] suggests that children resulting from an unplanned pregnancy are more likely to be disadvantaged or adversely affected by increased risk of dying in their first year, and have a higher incidence of illness or injury.

3.4.3 Although women directly bear the consequences of unplanned pregnancy, the responsibility and sometimes some of the hardship falls equally on men, and solutions to the problem must address the needs of men as well as women.

3.5 Preventing unplanned pregnancy

3.5.1 Abortion is not considered to be an appropriate means to effect family planning and, whenever possible, abortion should be avoided as a solution to unplanned pregnancy. A policy of preventing unplanned pregnancy, rather than offering abortion, is advocated, on the grounds of minimising the personal, social and ethical difficulties of an abortion and possibly reducing the incidence of sexually-transmitted disease.

3.5.2 There is a strong case, therefore, for enabling people to be able to choose the time when they will become pregnant, and to support the provision of health education, family planning and contraceptive services which make that decision effective.

4. *Institute for Health Policy Studies 'Unplanned Pregnancy and Teenage Pregnancy', April 1992, p. 7.*

3.5.3 It is recognised that, ideally, the development of policies on sex education, family planning and information for children or young people about contraception should be based on achieving a balance between providing appropriate and timely information and promoting premature awareness.

3.5.4 Studies in the United Kingdom, [5] the Netherlands [6] and other countries suggest that whilst a high proportion of adults use appropriate methods of contraception, others still fail to use any contraception or use less effective methods, and some experience practical difficulties in the use of contraception.

3.5.5 Evidence concerning use of contraception by teenagers [7] indicates that:
'intercourse tends to be unplanned and infrequent, and it is not surprising to find that most teenagers do not use contraceptives at first intercourse and delay their use for many months.

Much research points to the fact that teenagers often take risks in their lifestyles. Levels of contraceptive use are therefore difficult to measure in any definitive way. Of greatest concern must be the increased risk during the first few months of sexual activity.'

3.5.6 However, erratic or incorrect use of contraception is not the sole reason for failure to prevent pregnancy, and other issues include lifestyle, self concept, relationships with family and peers and perceptions of society in general. The need in education programmes is not for better communication of facts, but in developing decision making skills and moral guidance.

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5. Report of the RCOG on Unplanned Pregnancy, September 1991, Para. 4.1-4.4.
6. E Jones et al.: Pregnancy, Contraception and Family Planning Services in Industrialised Countries, Yale University Press 1989, p.177.
7. Institute for Health Policy Studies 'Unplanned Pregnancy and Teenage Pregnancy', April 1992, p. 23-24.

4. THE EXISTING SERVICES

4.1 Personal and social education programmes

4.1.1 The provision of 'sex education' for young people in most schools in Jersey is integrated within a programme of personal, social and health education. The TACADE [8] approach to teaching provides teachers with an effective tool to assist young people to develop skills necessary for growing up. It is suitable for working in a number of areas such as drugs and sex education. The approach helps young people to recognise their sexuality at the appropriate stages, the development of responsible personal relationships and providing information on healthy sexual behaviour, as well as providing practical information at the time a young person needs to know.

4.1.2 The programme implemented by the Education Department in both primary and secondary schools is sensitively constructed to meet individuals needs, encourages each person to respect others' values, and helps them to develop their own moral values and opinions on the social and personal aspects of sexuality in a way which is appropriate for their age. In conjunction with the TACADE programme, the facts about contraception and the issue of planned/unplanned pregnancy are dealt with.

4.1.3 The Education Committee commissioned a report from HM Inspectors, in October 1989, on the effectiveness of school programmes in preparing young people for adult life, including health and sex education. HMI reported:-

'The States recently produced guidelines for sex education to form the basis of a scheme of work in schools. Health education occurs both within Personal and Social Education and specialist subjects. Current issues such as alcoholism, drugs, smoking and the spread of AIDS are considered... When health issues do arise, pupils display a good understanding and are thoroughly appreciative of the provision made.'

In general, it is felt that the personal and social education is sound, interesting and appropriate. There have been further improvements in the schools inspected and other schools since the HMI report was written.

4.1.4 The sex education objectives of the National Curriculum at secondary school level are specified in table (1).

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8. The Advisory Council for Alcohol and Drug Education.

Table (1). **National Curriculum objectives**

Key stage 3 (Age 11-13 years)

A child should:

- recognise the importance of personal choice in managing relationships so that they do not present risks, e.g. to health or personal safety;
- understand that organisms can be transmitted in many ways, in some cases sexually (e.g. HIV);
- discuss moral values and explore those held by different cultures and groups;
- understand the concept of stereotyping and identify its various forms;
- be aware of the range of sexual attitudes and behaviours in present day society;
- understand that people have the right not to be sexually active, recognise that parenthood is a matter of choice, know in broad outline the biological and social factors which influence sexual behaviour and and their consequences.

Key stage 4 (age 14-16 years)

A child should:

- understand aspects of Britain's (sic) legislation relating to sexual behaviour;
- understand the biological aspects of reproduction;
- consider the advantages and disadvantages of various methods of family planning in terms of personal preference and social implications;
- recognise and be able to discuss controversial issues such as conception, birth, HIV/AIDS, child-rearing, abortion and technological developments which involve consideration of attitudes, values, beliefs and morality;
- be aware of the need for preventative health care and know what this involves;
- be aware of the availability of statutory and voluntary organisations which offer support in human relationships, e.g. Relate;
- be aware that feeling positive about sexuality and sexual activity is important in relationships, understanding the changing nature of sexuality over time and its impact on lifestyles, e.g. the menopause;
- be aware of partnerships, marriage and divorce and the impact of loss, separation and bereavement;
- be able to discuss such issues as sexual harassment in terms of their effects on individuals.

4.1.5 The Education Department's strategy for quality assurance is implemented through the Advisory Service, supplemented by HMI Reports where necessary and periodic reviews to address specific issues. The advisory service monitors time-tables, teaching input and communication with parents. The present teaching materials and methods have been in use in secondary schools for six to seven years, and primary TACADE materials were introduced two to three years ago. The approach will continue to be reviewed regularly and improved where necessary. The Education Department is about to appoint a seconded teacher to develop strategies, promote effective programmes and monitor and evaluate the provision of personal and social education.

4.2 General Practitioner family planning services

4.2.1 All General Medical Practitioners (GPs) in Jersey offer advice on a range of family planning services, and all are able to provide or prescribe the most commonly used appliances and contraceptives. More specialised services, such as fitting a cap or IUCD, are offered by nearly half the practitioners (See table 2 below).

Table (2). **General practitioner family planning services**

	Number	Per-cent of:- practitioners	practices
Medical practices	27		
Medical practitioners	92		
Offer contraception	92	100	100
Fit cap	41	45	78
Fit IUCD	43	47	89
Family Planning Certificate	24	26	48

4.2.2 Whilst about a quarter of GPs possess a Family Planning Certificate, about half of all practices have at least one practitioner who is Family Planning qualified. Patients can usually ask to see the practitioner of their choice, and most practices can offer a female doctor.

4.2.3 Estimates based on prescribing patterns for England and Wales [9] suggest that approximately 16,000-20,000 GP family planning consultations take place each year in Jersey, or about 4%-5% of the total GP workload, and approximately 14,000 prescriptions for oral contraceptives are issued each year.

9. Prescription Pricing Authority 'PACT' prescribing data.

4.2.4 The average cost of a general practitioner consultation is approximately £19.00 - £20.00, and typically a woman may attend every four to six months for oral contraceptives. The States has agreed a Medical Benefits Refund for members of the Health Insurance Scheme, currently set at £8.80. The cost of oral contraceptives is about £1.20 monthly.

4.3 Department of Health Family Planning Clinic services

4.3.1 The Family Planning Clinic provides consultations with a family planning trained female doctor and family planning trained nurse in six clinic sessions, operated Monday - Friday each week, including some evening clinics. The Clinic can provide a comprehensive range of family planning advice, prescribe contraceptives and fit appliances. Emergency contraception is available in appropriate circumstances.

4.3.2 Due to a campaign to increase public awareness, attendances have increased significantly in recent years (Appendix iv) and in 1992, a total of 2,721 clients attended, 557 of whom were under 19 years old (See figure 3 below).

Figure (3) - Family Planning Clinic attendances 1992

4.3.3 The cost of Family Planning Clinic consultations and contraceptives are kept at a relatively nominal level, and criteria for exemption of appropriate clients from all charges are based on medical/ socio-economic grounds.

4.4 Emergency contraception

4.4.1 Post-coital contraception, or 'emergency contraception', is administered after intercourse but is effective before implantation occurs, and is therefore considered by medical authorities to be a form of contraception rather than abortion. The method may consist in either insertion of an intra-uterine device not more than five days after ovulation, or administration of hormone treatment within 72 hours of unprotected intercourse to prevent implantation.

4.4.2 The failure rates of the two methods differ (intra-uterine device - negligible; hormone treatment 1% to 4%) and, depending on the method, the associated medical risks include ectopic pregnancy, nausea, disruption of the next menstrual cycle, some pain and possible exacerbation of pelvic inflammatory disease. Emergency contraception is not considered suitable as a routine method for preventing pregnancy, and repeat provision of this treatment to an individual is discouraged in favour of a more considered approach to family planning.

4.4.3 The advantages of emergency contraception are that it is a 'last resort' method to escape unplanned pregnancy, which is safe and effective as much as three to five days after intercourse. The administration of this form of contraception provides an opportunity to discuss future family planning and to counsel the woman on alternative contraception. An appropriate follow-up appointment is normally provided around three to four weeks later.

4.4.4 Emergency contraception is widely available, in appropriate circumstances, from general medical practitioners, the Family Planning Clinic and the Visitor's Clinic (without appointment for visitors and seasonal workers). Exceptionally, when these services are not normally available and time is critical, it may be available from the General Hospital Accident and Emergency Department.

4.5 Health Promotion Unit

4.5.1 The Health Promotion Unit provides and co-ordinates resources and programmes designed to encourage healthy behaviour in all age groups. Programmes aimed towards young people have the greatest benefit, since healthy lifestyles established in childhood are more likely to become permanent. The Health Promotion team optimise the use of resources by supporting other individuals who have a continuing role to play in health education, e.g. teachers, youth leaders or health visitors, based on the TACADE approach.

4.5.2 The role of the Health Promotion Unit in reducing the incidence of unplanned pregnancy is achieved through teachers' support groups to provide advice on approaches to sex education and family planning; training for primary school teachers in the use of TACADE skills at primary level; workshops for youth leaders on sexuality, HIV and AIDS; and promotion of a Health Education Certificate course.

4.5.3 The resources available on loan to individuals or groups are aimed to facilitate education around issues concerning sexuality, relationships and contraception. The materials include teaching packs and videos for use in schools and youth clubs; leaflets, booklets and posters on contraception and sexual health; teaching models, contraception kits and condoms for educational purposes.

4.5.4 The Unit supports the work of Family Planning nurses and community organisations involved in promoting sexual health, is regularly involved in local and national awareness campaigns and provides visits to schools and other organisations to supplement on-going health education.

4.6 Youth Service

4.6.1 The Youth Service is committed to the development of strategies within which health issues are seen as integral to youth work. The Service aims to foster the environment necessary for young people to develop skills which enable them to make their own informed decisions about their health, behaviour and relationships.

4.6.2 These objectives are achieved in an informal setting through the voluntary participation of young people in youth clubs, other organisations and activities. Issues such as sexuality and sexual health which would normally be sensitive can be addressed in a way which is acceptable to young people, at a time when they are relevant to the individual concerned.

4.6.3 Through youth workers' involvement in the Secondary Health Education group, it is intended to build on the school curriculum. A wide range of training opportunities are offered to youth leaders, including some on health issues, promoted in conjunction with the Department of Health, Education Department and other organisations.

4.7 Children's Service

4.7.1 The role of the Children's Service in relation to unplanned pregnancy is to provide counselling and support to young girls where family or other support is absent. The aim is to enable the very young, often inexperienced girl to make responsible decisions with regard to her situation, and to encourage her to develop the skills needed to cope with the formidable task of caring for herself or bringing up a child alone.

4.7.2 La Chasse House provides accommodation for up to six young single mothers and their babies, and there is additional family accommodation which can be used for an older mother and her child. Expectant mothers may attend on a daily basis a programme of help and training in domestic and child care skills. Where possible, however, young mothers are offered on-going support on a non-residential basis, and home visits may be provided after re-settling in a hostel or flatlet. Day-care may also be provided for children under five, in order to monitor a vulnerable child.

4.7.3 In conjunction with the Department of Health, Education Department and Parish authorities, the Children's Service aims to ensure that children are born who are wanted, and that they enjoy a happy, secure and healthy childhood. The Service links closely with the Maternity Unit to ensure that any mother and baby who are felt to need help receive a visit and are put in contact with the appropriate resources.

4.7.4 Strategies have been developed which recognise the social trends; increased numbers of single-parent families and changing attitudes of young people towards having children outside marriage and to adoption. Consequently, the Children's Service has expanded its resources to help young families bringing up children in sometimes difficult circumstances.

4.7.5 Family Care Services include workers who provide guidance and practical help with the management of a home and the care of children. Working closely with the families, they visit homes and work in Family Centres to provide specialist assistance with unsatisfactory parental care, 'at risk' babies, very young mothers and expectant mothers, and single parents who need sensitive, supportive help.

4.7.6 The Children's Service also supports childminding services to assist families in emergencies, for children who need special day-care in a family environment, and to support very young mothers in returning to work and becoming independent. Involvement of the community and voluntary helpers is seen as a positive contribution to the caring services in Family Centres, residential homes and day-care settings.

4.8 Housing Department

4.8.1 The Housing Department aims to assist, as far as possible, those who are in need of accommodation as a result of a pregnancy, whether planned or not. Whenever accommodation may be made available, the Housing Department will provide direct assistance. If accommodation cannot be provided, help and advice can be given on housing qualifications, Private Rent Rebates, Housing Associations and possibly referral to other agencies.

4.8.2 For a prospective parent facing an unplanned addition to their family, the problems of having to find a home or a larger home may be an additional worry. They must qualify under the Housing Law to be eligible to occupy the majority of dwellings, property prices and rents are high, and many landlords operate a policy of 'no children' in their accommodation.

4.8.3 The Housing Law severely restricts the availability of any suitable accommodation for an expectant parent who does not qualify to rent or lease property. Application may be made under Housing Regulation 1 (1)(g), which allows the Housing Committee to grant consent to someone on grounds of hardship who would not otherwise qualify. Not all applicants are successful, and even those that are may not necessarily find it easy to obtain accommodation.

4.8.4 Applicants to the Housing Committee for direct assistance with rental accommodation must qualify under the Housing Law, must also be aged over 18 years and, in the case of a single parent, have custody of the child(ren). A means test is applied to establish whether the applicant can afford to self-house in the private sector. Those who are registered on the waiting list may initially be offered hostel accommodation or, alternatively, may wait in the private sector for up to two years for an offer of permanent accommodation to be made (although it is hoped to reduce this waiting time to 12 months over the next three years). Existing States tenants will be placed on the waiting list if their family out-grows the accommodation they occupy.

4.8.5 For those who are able to find accommodation in the private sector, the Housing Committee has recently introduced a Private Rent Rebate scheme which offers an equivalent rebate to that available to States tenants. It is also anticipated that over the next few years housing associations will play an increasing part in providing secure housing for families on low incomes including, initially, applicants nominated by the Housing Committee from its waiting list.

4.8.6 The Housing Department maintains close links with La Chasse House, administered by the Children's Service, and provides alternative accommodation to many ex-residents.

5. ISSUES ARISING

5.1 The focus of this Report is on the approaches to reduce the incidence of unplanned pregnancy, and the support that is available to a woman, her partner and their child resulting from an unplanned pregnancy.

This publication does not explore the issue of abortion, which is the subject of a separate Report, or wider aspects of family planning and infertility.

It is recognised that the issue of unplanned pregnancy relates primarily to patterns of sexual activity in younger people which are unlikely to be easily changed. The RCOG Report concludes: *' that the sexual drive is strong and that well-managed sexuality is fundamental to individual happiness and a major factor in the stability of relationships between couples. Much of the difficulty that couples have in managing their sexuality is due to their feeling that sex is embarrassing, disapproved of and potentially dangerous, with the result that sexual pleasure is mixed with guilt and anxiety. Young people may know about the biology of sex but rarely have been given the vocabulary and the skills they need to communicate with each other about this aspect of life... Consequently intercourse tends to occur as a result of their sexual drive, without planning, and often without adequate contraception.'* [10]

5.2 Personal and social education programmes

5.2.1 The development of responsible sexual relationships and people's attitudes to sexual behaviour are determined to a large extent by the personal and social education they have received in school, within their home and elsewhere. Yet there is a certain amount of ambivalence in this area; it is expected that young people should be informed enough to make the right decisions, while some people continue to oppose effective sex education on the grounds that they will become too aware.

5.2.2 **The Committee strongly endorses the existing approach to personal and social education of young people, to foster responsible sexual relationships and planned pregnancy.**

10. *Report of the RCOG on Unplanned Pregnancy, September 1991, Para. 6.6.*

5.2.3 Parental involvement:

It is recognised that the role of the school must be supported by young people's parents and others (for example youth workers), and that appropriate information or guidelines should be received by parents to enable effective participation. Parents are invited to attend meetings on personal and social education, and materials are often displayed at 'new parents' evenings.

5.2.4 **A recent evaluation (April 1993) demonstrated that most parents receive some information from schools, but improvements may be possible and further investigation might be helpful to determine parent's needs.** It is intended that a seconded teacher, to be appointed as an adviser in personal and social education, should have this important aspect included in his/her job description.

5.2.5 It is accepted that parents should retain the option to withdraw their child from sex education at school, although parents should be supported to enable them to deal with these issues themselves and ensure that the child would still receive some appropriate sex education from other sources.

5.2.6 **In addition to support for parental involvement, development of a peer-led approach amongst young people to promoting sexual health is a priority. The Committee endorses the current strategy of helping young people to develop relationship skills to enable them to say 'no' to unwanted sexual pressures.**

5.2.7 Specialised teaching skills

It is apparent that those teachers who are particularly experienced in sex education provide a high standard of education. To date fifty-seven secondary school staff have undergone TACADE training, which provides the vehicle for sex education in schools, and there is a trained team of teachers in each of the secondary schools. Whilst it is not necessary for teachers to have counselling skills to teach sex education, a counselling course has been arranged for the future. In addition, schools have effective pastoral systems which provide for the individual needs of pupils.

5.2.8 **Continuing support for teachers is needed, particularly since some might feel uncomfortable with sex education, to enable the subject to be provided in a co-ordinated manner.**

5.2.9 **The Health Promotion Unit has a vital role in promoting sexual health and responsible sexual behaviour amongst all adults, particularly sexually active younger people, and also in supporting teachers, youth workers and parents in the personal and social education of children.**

5.2.10 **Schools and youth organisations should seek to build on the existing initiatives developed by the Education Advisory Service in conjunction with the Health Promotion Unit, to provide all teachers, youth workers and others with the support, skills and competencies necessary to enable personal and social education to be continued through the school curriculum and beyond.**

5.2.11 Access to educational materials

There is a wide range of high quality health education literature and other materials to support the personal and social education programme, available from the Education Department, the Health Promotion Unit, Family Planning Clinic and other sources. However, the distribution of this material through schools, general medical practices or youth clubs is not as widespread as it might be, and they should be regularly supplied with educational material.

5.2.12 **Schools, medical practices and youth organisations should make the existing educational materials more freely available, display posters and provide leaflets, with appropriate follow-up to provide counselling and advice if requested.**

5.2.13 In the Netherlands the impact of the media in communicating basic information and lowering the barriers to open discussion on sexuality has been profound. **Local media might have a greater contribution to play in disseminating information and dealing with issues of sexuality, pregnancy and contraception.**

5.3 Family planning services

5.3.1 Many people who wish to use or obtain advice on contraception consult a general medical practitioner. This means that GPs are of vital importance in the effective provision of family planning services in the community.

5.3.2 The aims of the Family Planning Clinic should not be to duplicate GP services but to develop a complementary role, bearing in mind:

- the availability of a female doctor trained in family planning at every clinic session;
- the need to give clients choice to encourage full take-up;
- the need to develop separate, less formal arrangements for young people;
- the wider health role - for instance, provision of health promotion information, advice and counselling on sexual matters.
- the recognised training role of Family Planning Clinic staff.

5.3.3 **There is a clear need to promote the services of the Family Planning Clinic, in consultation with the Jersey Medical Society, to ensure a balance between the services provided by specialist clinics and those provided by GPs.**

5.3.4 Accessibility of services

The availability of family planning services through the island's twenty-seven GP practices appears to offer a highly accessible provision for most people. However, access/ acceptability may be limited for some, especially young people, because of ill-founded concerns about confidentiality and the need for appointments.

5.3.5 The schedule of Family Planning Clinic sessions has been planned and increased to meet client needs, including day-time and evening sessions. However, it may be considered helpful to include a weekend session - particularly geared to 'the morning after'/ emergency contraception clients, possibly with open access without appointments.

5.3.6 **The accessibility of Family Planning Clinic sessions, GP family planning services and counselling should be reviewed to ensure the following principles are fulfilled:**

- **assurance of confidentiality,**
- **possibility of attendance by self-referral, without an appointment,**
- **convenient opening times, e.g. weekends and after school hours,**
- **accessible locations.**

5.3.7 It is important that family planning services are developed to meet the differing needs of men and women. In particular, the shared responsibility for contraception should be recognised, and greater openness about discussing contraception should be encouraged.

5.3.8 **The Committee supports policies for the sale of condoms through machines in appropriate locations, including youth clubs, subject to agreement of the club managements. The wider availability of vending machines in pubs and night clubs is also encouraged.** However, while it is recognised that this form of contraception has the benefit of minimising the risks of sexually-transmitted diseases, it is not the most reliable in regard to preventing pregnancy.

5.3.9 Cost of family planning services

In a study across developed countries it has been suggested that the availability of contraception free or at very low cost is a significant factor in determining contraceptive use [11]. It is possible that cost factors may influence access to GP and Family Planning Clinic services, particularly for young people with low incomes who may be most 'at risk'. The Social Security Health Benefits Scheme reduces the cost of a GP consultation to between £9.00 to £10.00 for those who are members of the Health Insurance Scheme, but this residual fee and prescription costs may still be a consideration to young girls or those to whom the Health Benefits do not apply. A further procedure to claim Health Insurance Exception may also act as a deterrent.

11. *Jones et al.: Pregnancy, Contraception and Family Planning Services in Industrial Countries, Yale University Press, 1989.*

5.3.10 Although the present cost of Family Planning Clinic consultations (£4.00) and prescriptions is generally regarded as nominal, it has been proposed that the service should be free of charge. There is no evidence whether or not these costs are a disincentive to clients; they are kept low to prevent any financial constraint and, in appropriate circumstances, clients are exempt from charges. It has been suggested that the criteria to determine exemption from charges could be reviewed.

5.3.11 In the United Kingdom the number of abortions fell by 9,000 between 1973 and 1976 following the introduction of free contraception, and in some countries where contraception is not free the abortion rates remain high. However, differing cultures and access to abortion services in these countries may also be important factors, and there is no conclusive evidence that cost alone is a significant disincentive to clients.

5.3.12 Options for family planning service provision might include:

- free GP or Family Planning Clinic consultations;
- inclusion of contraceptives on the 'prescribed list' subject to the standard prescription charge (or free on the basis of Health Insurance Exemption);
- completely free contraceptive provision, without a prescription charge.

5.3.13 Providing that free contraceptive services would be available to all beneficiaries under the Health Insurance Scheme, such arrangements would be acceptable within the conditions of the Health Insurance (Jersey) Law. However, amendment of legislation would be required to introduce the concept of free general practitioner consultation. In addition, the resource implications of such provision from the Health Insurance Fund would require either additional funding or affect the level of subsidy for other general practitioner services or prescribed medicines.

In view of current financial constraints, additional funding for such a proposal would need to be considered in the context of other priorities for revenue expenditure.

5.3.14 <u>Family planning expertise</u>

It is observed that 26% of general practitioners hold a Family Planning Certificate, or equivalent, and that a greater proportion of general practitioners could undertake post-graduate training to qualify in family planning. In principle, it has been accepted that further education would be welcomed by many general practitioners.

5.3.15 One of the important functions of the Family Planning Clinic is to provide specialised professional training in family planning for junior medical staff, nurses and health visitors.

The Family Planning Clinic should build on this role to provide post-graduate education programmes for general medical practitioners leading to qualification in the Family Planning Certificate.

5.3.16 <u>Information on family planning services</u>

Much of the available information on family planning services refers to United Kingdom services and organisations, and details of the local arrangements are less widely publicised.

5.3.17 **Appropriate local information leaflets and other materials should be made available, and advice sought on the possible involvement of local media, to increase public awareness of services available - including counselling, family planning, emergency contraception, pregnancy advice and other assistance.**

5.3.18 Although many GP practices provide information leaflets detailing the services available, more specific information could be provided on the particular doctors who are qualified in family planning, possibly advising on the availability or otherwise of a female doctor, and informing patients of their opportunity for choice of practitioner.

5.3.19 **GP practice information leaflets and Family Planning Clinic information, detailing the availability and range of family planning services, should be made available at public locations and information points, for example public libraries and the Social Security Department.**

5.3.20 There is evidence from the UK [12] and the Netherlands [13] that the effectiveness of services to reduce the incidence of unplanned pregnancy can be improved by targeting information to specific population groups. Groups who could receive special attention might include:

- young men and young women - (separate advisory clinics);
- immigrants and seasonal workers;
- people with special needs, for example those with learning difficulty who may be especially vulnerable.

5.3.21 **An important aspect of a targeted approach might be the development of information and publicity materials in a style and languages (possibly Portuguese as well as English) which would reach target groups more effectively, for example young people and those with special needs.**

Such information would need to be widely available, and include specific information on, for example, the confidentiality of services, or the availability and limitations of emergency contraception.

5.3.22 Emergency contraception

Guidelines on the use of emergency contraception have been formulated and agreed between the Public Health Committee and the Jersey Medical Society.

5.3.23 **However, many people are not aware of the availability of emergency contraception, from General Practitioners or other sources, and better information about this and other forms of contraception would be beneficial. Women should be fully aware that they can discuss with a General Practitioner the use and limitations of emergency contraception in order to prevent unplanned pregnancy.**

5.3.24 **The availability of emergency contraception should be balanced against a need for counselling and education beforehand and an appreciation of safer sex practices.**

12. *Brook Advisory Centres, London.*
13. *Rutgers Stichting, The Hague, Netherlands.*

5.4 Co-ordination of services

A complex range of services and agencies are involved in health education, family planning services and the provision of support to people who are affected by an unplanned pregnancy.

5.4.1 **A co-ordinated approach needs to be taken to ensure that those who aim to provided assistance are effectively linked, working together without overlapping their limited resources, to ensure that no-one fails to gain access to appropriate services when needed.**

5.4.2 In addition to prevention of unplanned pregnancy, there is merit in co-ordinating other related aspects of the work undertaken by agencies involved, for example, in health promotion and HIV/AIDS, ante-natal care, child welfare and social services.

5.4.3 The Report of the Social Services Review Group (May 1992) highlighted the benefits of closer co-ordination of health and social services, and in this context it would also be appropriate to develop closer permanent links with General Practitioners in the provision of family planning services, and with the Education Department in the provision of personal/ health education programmes.

5.5 Independent sector provision

5.5.1 In other countries, part-voluntary or non-profit making organisations make a considerable contribution to the effective provision of family planning services. Examples include the Brook Advisory Centres in the UK and *Rutgers Stichting* in the Netherlands, which are seen by many as more approachable because they are not 'official' government bodies.

5.5.2 In the present context of resource constraints, it might be possible to evaluate the potential contribution of a charitable or part-grant funded organisation in Jersey, which might work in co-ordination with the public sector (Health, Education and Social Security Departments) and General Practitioners to extend the existing range of services without significant additional resource implications.

5.5.3 Brook Advisory Centres are operated in the United Kingdom under the administration of a national non-profit organisation, providing independent and confidential counselling and practical support in relation to contraception, pregnancy testing and abortion advice. The services offered by Brook are aimed particularly at younger people, and based in an accessible and informal environment, such as a youth club or community centre. Clients can attend in complete confidence and without appointments, yet receive specialist professional advice.

5.5.4 The Youth Service has been working with the Parent's Action Group on Education (PAGE) to examine other services outside the statutory bodies that may be relevant to young people. It is believed that a counselling service would enable young people to discuss the issues which they feel unable to deal with in school, the family or elsewhere, and should have a positive impact on reducing unplanned pregnancies in young people.

5.5.5 **The principles of an independent counselling service should include:**

- **confidentiality of client's information;**
- **availability at times convenient to young people;**
- **an accessible location;**
- **independence of any statutory bodies and separate from any existing departments;**
- **well publicised service;**
- **supported by professionally qualified family planning counsellors.**

5.5.6 Independent advisory centre

The Committee proposes the establishment of an independent pregnancy advisory service, offering professionally-qualified family planning advice. It is envisaged that independent-sector and charitable support would be available to promote the development of such a service.

6. SUMMARY OF RECOMMENDATIONS

Personal and social education

6.1 The Committee strongly endorses the existing approach to personal and social education of young people, to foster responsible sexual relationships and planned pregnancy. (Paragraph 5.2.2).

6.2 Improvements may be possible in the information provided to parents by schools, and further investigation might be helpful to determine parent's needs. (Paragraph 5.2.4).

6.3 In addition to support for parental involvement, development of a peer-led approach amongst young people to promoting sexual health was a priority. The Committee endorses the current strategy of helping young people to develop relationship skills to enable them to say 'no' to unwanted sexual pressures. (Paragraph 5.2.6).

6.4 Continuing support for teachers is needed, particularly since some might feel uncomfortable with sex education, to enable the subject to be provided in a co-ordinated manner. (Paragraph 5.2.8)

6.5 The Health Promotion Unit has a vital role in promoting sexual health and responsible sexual behaviour amongst all adults, particularly sexually active younger people, and also in supporting teachers, youth workers and parents in the personal and social education of children. (Paragraph 5.2.9).

6.6 Schools and youth organisations should seek to build on the existing initiatives developed by the Education Advisory Service in conjunction with the Health Promotion Unit, to provide all teachers, youth workers and others with the support, skills and competencies necessary to enable personal and social education to be continued through the school curriculum and beyond. (Paragraph 5.2.10).

Information

6.7 Schools, medical practices and youth clubs should make the existing educational materials more freely available, display posters and provide leaflets, with appropriate follow-up to provide counselling and advice if requested. (Paragraph 5.2.12).

6.8 Local media might have a greater contribution to play in disseminating information and dealing with issues of sexuality, pregnancy and contraception. (Paragraph 5.2.13).

6.9 Appropriate local information leaflets and other materials should be made available, and advice sought on the possible involvement of local media, to increase public awareness of services available - including counselling, family planning, emergency contraception, pregnancy advice and other assistance. (Paragraph 5.3.16).

6.10 GP practice information leaflets and Family Planning Clinic information, detailing the availability and range of family planning services, should be made available at public locations and information points, for example public libraries and the Social Security Department. (Paragraph 5.3.18).

6.11 An important aspect of a targeted approach might be the development of information and publicity materials in a style and languages (possibly Portuguese as well as English) which would reach target groups more effectively, for example young people and those with special needs. (Paragraph 5.3.20).

6.12 Many people are not aware of the availability of emergency contraception, from General Practitioners and other sources, and better information about this and other forms of contraception would be beneficial. Women should be fully aware that they can discuss with a General Practitioner the use and limitations of emergency contraception in order to prevent unplanned pregnancy. (Paragraph 5.2.22).

Family planning and contraception

6.13 There is a clear need to promote the services of the Family Planning Clinic, in consultation with the Jersey Medical Society, to ensure a balance between the services provided by specialist clinics and those provided by GPs. (Paragraph 5.3.2).

6.14 The accessibility of Family Planning Clinic sessions, GP family planning services and counselling should be reviewed to ensure the following principles are fulfilled:

- assurance of confidentiality,
- possibility of attendance by self-referral, without an appointment,
- convenient opening times, e.g. weekends and after school hours,
- accessible locations.

(Paragraph 5.3.5).

6.15 The Committee supports policies for the sale of condoms through machines in appropriate locations, including youth clubs, subject to agreement of the club managements. The wider availability of vending machines in pubs and night clubs is also encouraged. (Paragraph 5.3.7).

6.16 The Family Planning Clinic should build on its training role to provide post-graduate education programmes for general medical practitioners leading to qualification in the Family Planning Certificate. (Paragraph 5.3.14).

6.17 The availability of emergency contraception should be balanced against a need for counselling and education beforehand and an appreciation of safer sex practices. (Paragraph 5.3.23).

Co-ordination of services

6.18 A co-ordinated approach needs to be taken to ensure that those who aim to provide assistance are effectively linked, working together without overlapping their limited resources, to ensure that no-one fails to gain access to appropriate services when needed. (Paragraph 5.4.1).

Counselling service

6.19 The principles of an independent counselling service should include:

- confidentiality of client's information;
- availability at times convenient to young people;
- an accessible location;
- independence of any statutory bodies and separate from any existing departments;
- well publicised services;
- supported by professionally qualified family planning counsellors .
  (Paragraph 5.5.5).

6.20 The Committee proposes the establishment of an independent pregnancy advisory service, offering professionally-qualified family planning advice. (paragraph 5.5.6).

APPENDIX (I).

Members of the Working Party

Constable J Roche	Public Health Committee (**Chairman**)
Deputy Mrs P A Bailhache	Education Committee
Deputy Mrs S Baudains	Social Security Committee
Rev Dr A Williams	Jersey Council of Churches
Dr C R Grainger	Medical Officer of Health
Mr N MacLachlan	Consultant Obstetrician and Gynaecologist
Dr R Porcherot	Jersey Medical Society
Mr B Grady	Education Department
Mrs E Arthur	Social Security Department
Mr M Entwistle	Department of Health (Working Party Manager).

APPENDIX (ii) - TERMS OF REFERENCE

The Terms of Reference, agreed by the Working Party in its meeting on 21st May 1992, were as follows:

To review the existing services in relation to unplanned pregnancy in Jersey, and to advise the Public Health Committee, relevant States Committees and other organisations on the future development of these services.

The Working Party will take account of the following in its deliberations:

i) the Report of the Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy, September 1991;

ii) the Report of the Institute for Health Policy Studies on Unplanned Pregnancy and Teenage Pregnancy, April 1992;

iii) the current range of contraception services available in the United Kingdom and elsewhere;

iv) the Public Health Committee's discussion document on the law relating to abortion; [14]

v) the present policies of the States in regard to manpower and resource issues.

14. *Note: The discussion document on abortion was not available to the Working Party prior to formulating its conclusions, and therefore could not be taken into consideration.*

Appendix (iii). - Statistics

JERSEY RESIDENTS - ABORTIONS IN ENGLAND AND WALES - 1987 - 1991

AGE	1987	1988	1989	1990	1991	TOTAL
- 19	43	65	63	55	51	277
20 - 24	118	118	125	116	116	593
25 - 29	67	80	79	84	80	390
30 - 34	25	27	33	29	28	142
35 +	34	23	22	39	32	150
TOTAL	287	313	322	323	307	1552

JERSEY RESIDENTS - BIRTHS AND ABORTIONS - 1991

AGE	ABORTIONS	LIVE BIRTHS	TOTAL CONCEPTIONS	% CONCEPTIONS ABORTED
15 - 19	51	36	87	58·6
20 - 24	116	158	274	42·3
25 - 29	80	353	433	18·5
30 - 34	28	336	364	7·7
35 +	32	174	206	15·5
TOTAL	307	1057	1364	22·5

Appendix (iv). - Family Planning Clinic

Clinic Attendances 1988 - 1992

Year	New Patients	Repeat Attendances	Total
1988	334	1,280	1,614
1989	288	1,156	1,444
1990	363	1,250	1,613
1991	651	1,988	2,639
1992	620	2,101	2,721

FAMILY PLANNING CLINICS

The following table shows attendances in 1992, broken down into age groups, local residents or seasonal workers, and treatment given.

Age	Total	Resident	Seasonal	Pill Total	Combined Pill	Mini Pill	Coil	Cap	Injec-tion	Post-Coital Pill	Pregnancy Test	Discussion
-16	61	60	1	30 (49%)	30	-	-	-	2	12 (20%)	10 (16%)	8
16 - 19	496	435	61	374 (75%)	365	9	1	3	1	52 (10%)	27 (5%)	39
20 - 24	769	580	189	569 (73%)	551	18	11	22	38 (5%)	27 (4%)	32 (4%)	54
25 - 29	661	576	85	513 (77%)	469	44	13	23 (3%)	16	17	27 (4%)	54
30 - 39	600	576	44	410 (68%)	330	80	54 (9%)	34 (6%)	5	5	11	78
40+	134	130	4	88 (65%)	34	54	19 (14%	16 (12%)	4	0	2	17

Appendix (v).

Papers and reports considered by the Working Party

1. Report of the Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy, September 1991.

2. Report of the Institute for Health Policy Studies on Unplanned Pregnancy and Teenage Pregnancy; Wessex Research Consortium, April 1993.

3. Guidelines for reviewing family planning services - Guidance for regions; NHS Management Executive, January 1993.

4. Family Planning Services - A model for District Health Authorities; Family Planning Association, November 1990.

5. Sex education - Guidelines for schools; Education Committee, 1988.

6. Guidelines for developing a sex education policy - a resource document for teachers and school governors.

Appendix (vi).

Organisations and individuals consulted by members of the Working Party

Education Department -	Mrs A Esterson
	Mrs E Southern
	Mrs M Snowden
	Mr D Gibaut
Health Promotion Unit -	Dr K Le Cornu
Family Planning Clinic -	Dr G Llewellin
	Dr S Foster
Youth Service -	Mr P Gambles
Children's Department -	Mrs B Chappell
	Mrs N Hopkins
Housing Department -	Mr E Le Ruez
H.M. Attorney-General -	P M Bailhache Q.C.

Appendix (vii).

Acknowledgements are also due to the following organisations for providing information and literature:

- Family Planning Association
- Brook Advisory Services
- Rutgers Stichting (Netherlands family planning organisation)
- United Kingdom Department of Health (Health Promotion)

Appendix (vi).

Departments and individuals who contributed as members of the Working Party

[illegible]	[illegible]
	[illegible]
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[illegible]	[illegible]
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	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Appendix (vii).

Acknowledgements are given to the following organisations for providing information and literature:

- [illegible]
- [illegible]
- [illegible]
- [illegible]