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Unplanned Pregnancy
and
Teenage Pregnancy

A Review
by
Stephen Peckham

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UNPLANNED PREGNANCY

AND

TEENAGE PREGNANCY

A REVIEW

**Stephen Peckham
Research Fellow**

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UNPLANNED PREGNANCY AND TEENAGE PREGNANCY: A REVIEW

SUMMARY

This paper reviews and discusses recent literature on unplanned and teenage pregnancy. The main points are that:

- * There is a lack of information on the numbers of unplanned and unwanted pregnancies.
- * There is substantial ignorance about the availability and use of contraceptives, particularly emergency contraceptives.
- * The number of unplanned and teenage pregnancies have risen over the past five years.
- * Unplanned and teenage pregnancy is associated with lower socio-economic class.

The main issues raised are:

- * The need to develop better information systems which provide comparable data for both GP and clinic based contraception services.
- * The development of improved involvement by DHAs in sex education initiatives.
- * The need for good co-ordination between different contraception, abortion and sterilisation services.
- * The development of specialist for young people linked to broader advice and information on health and other issues as well as pregnancy and after birth/abortion services.
- * To ensure close links between information and action on sexually transmitted diseases and contraception.
- * The need for close cooperation with other agencies, particularly those providing services for, and working with, young people.
- * The need to improve publicity about the use of contraception and the availability of services.

Many of these issues have been raised by the recent reports of the Royal College of Gynaecologists and Obstetricians Report of the RCOG Working Party on Unplanned Pregnancy and the House of Commons Health Committee report Maternity Services: Preconception. The recommendations of these two reports are reproduced as Appendices A and B.

UNPLANNED PREGNANCY AND TEENAGE PREGNANCY: A REVIEW

General introduction.

There has been a general concern regarding the issue of unplanned pregnancies and it has been specifically highlighted in the Public Health Reports of Wessex Research Consortium members during the last two years. Because of this concern it was suggested that this issue could be used as a case study for examining the progression of Public Health Report recommendations into policy and practice.

The highlighting of this issue has sparked off a number of pieces of work on teenage pregnancies - a review of sex education in schools (Helen Trippe, Southampton and SW Hants HA), family planning services undertaken by GP's (Hants FHSA with Basingstoke and Winchester DHAs), and the management and quality of family planning services within the Region (Wessex RHA). The Consortium will not duplicate this work. However the existence of this other research will be useful and contact has been made with these other projects.

In January 1992 the NHS Management Executive published 'Guidelines for reviewing family planning services: Guidance for regions'. Whilst this document does not specifically address the issues of unplanned and teenage pregnancy the guidance is of general relevance in respect of reviewing access to, and the targeting of, services. The guidance specifically mentions services for young people and draws on the recent PSI report on services for young people (Allen 1991). In addition, other groups such as people with disabilities and ethnic groups are identified as having special needs. Issues relating to these groups are not addressed in this paper as the literature examined does not identify any sub groups of the population except young people.

The objective of this paper is to provide guidance on the approximate level of unplanned pregnancies and give background information on which women are more likely to have an unplanned pregnancy. This analysis is based on a review of recent literature and research. In particular there have been two recent reports dealing with the issue of unplanned pregnancy, and their contents and recommendations have influenced the content of this report. These reports are of the 'Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy' and House of Commons Health Committee on 'Maternity Services: Preconception'.

The paper then goes on to examine the implications for local health authorities and, based on a review of practice elsewhere, suggests strategies for reducing the number of unplanned pregnancies. However due to the problems of definition this information can only be of a very general nature. This paper will, though, highlight recommendations made by other commentators, note issues of concern and define areas for possible action.

The paper will then develop many of these issues in relation to teenagers. Teenage pregnancies have been highlighted for concern due to the rising teenage pregnancy rate and the medical and social problems which are perceived to be associated with it.

Linked to this paper there are two briefing papers on unplanned and teenage pregnancy which summarise the main issues and list points for further action.

SECTION ONE

UNPLANNED PREGNANCY

Defining the problem.

One of the main issues associated with measuring the level of unplanned/unintended pregnancies is that of definition.

"This is a complicated and muddled world where unplanned pregnancies may be wanted, where wanted children may emerge from unwanted pregnancies, where the offspring of wanted pregnancies may be rejected, where infatuation with infants grows cold and where children may be wanted solely to meet their parents' pathological needs." (Cheetham 1977 p3)

Whilst it is difficult to define what is meant by an unplanned or unwanted pregnancy it is generally accepted to be beneficial to try and reduce the number of such pregnancies.

"Unplanned pregnancy can cause much stress and unhappiness for the woman and her partner, and possibly for the child if the pregnancy continues, but it is also a problem for society as a whole. The problem has two components: firstly, concern because of the ethical issues raised by sexual behaviour that has harmful results and by legal abortion; secondly, because unplanned pregnancies, however they are managed, consume medical and social service resources." (RCOG 1991 p7)

Unwanted pregnancies are more likely to result in

- spontaneous miscarriage
- premature labour
- perinatal death

and that children resulting from an unwanted pregnancy face

- increased risk of dying in their first year
- higher prevalence of mental and/or physical disability
- greater incidence of infections and accidents
- higher risk of non-accidental injury
- greater chance of being a member of a broken family.

(Basingstoke Public Health Report 1991 p38)

In addition whilst a substantial proportion of women and their partners adapt to and accept an unplanned pregnancy there remain some problems associated with these pregnancies.

"Women who are unintentionally pregnant are more likely to get depressed during pregnancy and to smoke. They also have a less satisfactory relationship with the nurses and doctors they come into contact with during pregnancy and delivery, they report getting less information and support over feeding their babies

than other mothers and were less likely to feel they were treated with kindness and understanding. Babies resulting from unintended pregnancies are somewhat disadvantaged physically as well as socially. Maternity services do little to help overcome the disadvantages and may even augment them by operating an inverse care law¹."

(Institute for Social Studies in Medical Care 1991)

Because of the problem of definition it is difficult to ascertain what the level of unplanned pregnancy is. However two studies in the 1980's suggest national rates of 31.3% (Fleissig 1991) and 36% (Metson 1988) of all pregnancies. Fleissig's research, which updated a similar survey carried out in 1984, showed that particular groups of women were more likely to have an unplanned pregnancy.

The RCOG have argued that more statistics should be regularly collected in order to better understand the levels of unplanned and unwanted pregnancies (RCOG 1991 p12 & p60).

Any discussion about unplanned pregnancy needs to be linked to the issues of family planning and abortion. Contraception use clearly has an impact on the level of unintended pregnancy. Similarly, given that 1 in 5 pregnancies are terminated, of which only 2% are terminated for fetal abnormalities (Smith 1990), abortion levels may indicate the levels of unplanned and/or unwanted pregnancies.

The next three sections will therefore examine which women are most likely to have an unplanned pregnancy, abortion and the use of contraception.

...those who already had four or five children who had continued their pregnancies late into their 40s were more likely than the other women to have a late abortion.

(Institute for Social Studies in Medical Care 1991)

¹This is Julian Tudor Hart's thesis that "the availability of good medical care tends to vary inversely with the need for it in the population served" (Lancet 1971[1] 405-412).

Women most likely to have an unplanned pregnancy.

"Unplanned pregnancy is a consequence of either a failure to plan sexual activity and the use of contraception, a failure to use a contraceptive method correctly or the failure of a contraceptive method.....The factors resulting in unwanted pregnancies in the United Kingdom are: unplanned sexual activity; failure to use contraception; failure of the contraceptive method used; poor social circumstances that may render the woman or couple unable to cope with a child; the detection of potentially handicapping conditions in the fetus."

(RCOG 1991 p54)

There is little research which is directly related to studying those women at risk, as defined above. The Institute for Social Studies in Medical Care have done five studies since 1967. The latest of these was by Fleissig in 1989. Fleissig's data showed that young and single women were most likely to have unplanned pregnancies;

70.1% of all pregnancies for single women
56.9% of all pregnancies for under 20 year olds
44.4% of all pregnancies for 21 - 25 year olds
(Fleissig 1991)

The studies carried out in 1967/8, 1973, 1975 and 1984 showed a sustained decrease in the proportion of unintended pregnancies. However the 1989 study found this trend reversed, with a large increase in unintended pregnancies amongst mothers in their early twenties.

Women least likely to have an unplanned pregnancy are

".....among those who already had just one baby, among those who had continued their education until they were 19 or more and among those who owned, or whose partner owned, their own home."

(Institute for Social Studies in Medical Care 1991)

These findings are supported by Wilson who in a study in Nottingham in the 1980's on contraception services found that there was a direct correlation between social disadvantage and unplanned pregnancy (Wilson 1989).

Another survey carried out in 1988 found that about one third of those women with an unplanned pregnancy had not used contraception and that 40% of those using contraception were erratic users or using less reliable methods - rhythm or withdrawal (Metson 1988 pp905-906). Griffiths found that 52% of all women, in a sample presenting for termination, were pregnant following contraceptive failure (Griffiths 1990 p18).

Abortion.

Abortion was legalised in Great Britain in 1967 and the numbers performed have been steadily increasing over the years. Criteria for a legal abortion are drawn fairly tightly. Smith has shown very few abortions are carried out for fetal abnormalities (Smith 1988). This would suggest that the majority are undertaken in cases of unwanted pregnancies, including adverse family circumstances and contraceptive failure and emotional distress or physical danger to the mother.

In 1988 19.7% of all conceptions ended in abortions. There is a marked difference within this overall figure for abortions to single and married women - the respective rates being 36.8% and 7.7%. There is also a marked difference by age as shown by the following table:

% of all conceptions terminated by abortion by age group 1988.

Under 16	53.2%
Under 20	35.8%
20 - 24	20.8%
25 - 29	12.7%
30 - 34	13.8%
35 - 39	24.0%
40 and over	45.1%

(OPCS 1991b)

Since 1988 many DHA's reduced the resources for family planning services and this is true for consortium members. However it is not yet possible to determine if there has been a significant rise in the number of abortions. Obviously only a tentative causal link could be made, particularly against the general rising trend in the number of abortions being carried out (15.5% of all conceptions in 1978 to 19.7% in 1988 - OPCS 1991b table 12.1).

Again there is a marked difference between age groups with abortion rates for young women increasing whilst for those over 30 years of age the rate shows a slight decrease. Of particular interest are the rates for 15-19 and 20-24 year olds where the rates have increased from 17.2 and 16.3 per 1000 in 1978 to 23.9 and 26.1 per 1000 in 1988 (OPCS 1991b).

The majority of abortions are undertaken in private and charitable clinics - 100,383 compared to 73,517 in NHS facilities in 1990 (OPCS 1991a). 50% of all women pay for their abortion (Munday et al 1989). Most abortions are carried out within 12 weeks. Teenagers are more likely to have an abortion later - 17.9% of under 20 year olds have abortions after 12 weeks compared to an average of 12.2% for all women. Abortions in NHS facilities are carried out later than in non-NHS ones, only 21.4% of all abortions in the NHS carried out under 9 weeks compared to 46.3% in non-NHS facilities (OPCS 1991a table 14).

The numbers of abortions carried out would appear to be linked to the availability of free contraception. For example, in the UK the numbers of abortions fell by 9000 between 1973 and 1976 following the introduction of free contraception (Munday et al 1989) and Jones suggests that, in relation to the USA, lack of access to and free availability of contraception is a cause of the high USA abortion rate (Jones et al 1989 pp217-224).

In the UK these figures relate to a system where it could be argued that abortion is not available on request:

"This is far from abortion on request and it is the youngest and most vulnerable women who are most likely to end up having late abortions." (Munday et al 1989)

This situation is further exacerbated by the fact that there are class differences as those women with a high socio-economic status are more likely to have an abortion than those with a low socio-economic status. Given that women under 20 years of age with a high socio-economic status are less likely to get pregnant, the majority of abortions are for young working class women (Phoenix 1991 p46). Hudson and Ineichen argue that abortion is not a desirable outcome of pregnancy for very young girls.

"When the woman's physical and emotional well-being are involved, it is those at the younger end of the age range who are most at risk and most vulnerable.....Abortion may be seen as a quick, easy solution, but the consequences of an abortion may be unsettling and disturbing in the long term unless support and counselling have been offered both before and after the event.....The younger the woman the less likely she is to recognise her feelings or to impart them to others in seeking help."

(Hudson and Ineichen 1991 p47)

The timing of an abortion for teenage girls tends to be later than for older women as they often make public their pregnancies later than women intending to be pregnant. For example a survey in the mid 1980's of 220 abortions for young girls found that only 2 were offered vacuum aspiration (performed up to 12 weeks) and that many were refused hospital abortions because of their advanced stage of pregnancy (Skinner 1986). Data for 1990 shows that 3.7% of under 16s had abortions over 20 weeks and 18.6% between 13 and 19 weeks compared to an average for all ages of 1.3% and 10.9% respectively (OPCS 1991a table 14).

Medical staff can use the conscientious-objection clause in the Abortion Act to refuse to recommend or perform a termination. These attitudes may deter some women, especially the very young.

"Inefficient pregnancy testing services, general practitioners' unsympathetic attitudes or reluctance to approve abortions, the narrow range of reasons for

which consultant gynaecologists will perform abortions, and inadequate district resources have all been identified as key factors in causing delay into the second trimester of pregnancy and in forcing women to obtain abortions from private sector providers."

(Jones et al 1989 p189)

The RCOG argue that access to an abortion is an essential part of the pattern of services available to pregnant women. They found no evidence that abortion is being used instead of contraception. However they conclude

"...that it is used as a means of achieving control over reproduction when there has been poor planning of sexual activity or when contraceptive inefficiency has resulted in an unwanted pregnancy." (RCOG 1991 p52)

Metson found that just over a third of the women in his sample with unplanned pregnancies terminated the pregnancy a proportion of whom had experienced contraceptive failure (Metson 1988 p904). Contraceptive failure may be a significant cause of unwanted pregnancy (Griffiths 1990 p18). Thus reinforcing the need for abortion to remain an option for women with unplanned pregnancies.

There is a clear need for an accessible abortion service which is not restricted through lack of finances, discouraging attitudes or knowledge women of all ages as part of any overall strategy to reduce the number of unwanted births. This is also the view of the RCOG who concluded

"We consider that legal abortion should be an option for women stressed by unwanted pregnancy. Current attitudes to sexuality and the current availability and effectiveness of contraception make the occurrence of some unwanted pregnancies inevitable. Restriction of legal abortion would cause hardship to women and children and could result in the appearance of illegal abortion." (RCOG 1991 p53)

The RCOG also point out that some women may have abortions for social and economic reasons as women lose many opportunities, compared to men, during pregnancy and child care (RCOG 1991 p51).

Thus even where there may be a preference for a child external economic and social factors may force women to opt for an abortion.

Contraception.

Failure to use, or the incorrect use of contraception can lead to an unplanned pregnancy. Use of contraception relates to knowledge of and the availability of contraceptive methods (Jones et al 1989, RCOG 1991). In their study across developed countries Jones et al suggest that the availability of contraception free, or at very low cost is a significant factor in determining contraceptive use (Jones et al 1989 pp218-219).

In the U.K. contraception is available from GPs, NHS Family Planning Clinics, private and voluntary clinics and through private sales (eg. chemists). There are a variety of contraceptive methods and the last three General Household Surveys (GHS) in 1983, 1986, and 1989, have included questions on contraceptive use. The most popular methods are the pill, condom and sterilisation. The methods and usage are discussed in more detail below. The availability of free contraceptives is firmly established and has been incorporated in the NHS since 1974, although health authorities have been able to supply free contraceptives since 1967 on social or medical grounds.

Another important determinant of the level of contraceptive use is the level of and attitudes towards sexual activity. This shapes peoples views towards contraception.

Sexual activity:

There are no comprehensive surveys relating to sexual activity for the general population. Interest has tended to be concentrated on young people and these studies are discussed below. Attitudes towards sexual activity are though very important and dictate attitudes towards things such as sex education and contraception. The RCOG address this issue

"Attitudes to sexual behaviour in Britain are confused, complex and contradictory. Sexual images and situations are used frequently for commercial reasons but there are negative public attitudes towards education about sexuality and contraception.....This ambivalent public attitude is partly due to a lack of knowledge and partly a desire not to offend a vocal but small minority who oppose effective sex education." (RCOG 1991 p50)

They also point out that

"Double standards for male and female sexual behaviour abound. Many young women hesitate to use contraception or to insist on its use, as to do so might imply a degree of sexual sophistication that could meet disapproval. Attitudes to sex and contraception in

Britain need to become more open.....Before people are willing and able to use contraception more often tend more effectively to prevent unplanned pregnancies."
(RCOG 1991 p51)

Contraceptive use:

The determinants of contraceptive use are very complex and relate to a number of interrelated factors such as confidence in the ability to plan, ability to cope with children, beliefs about the value of having children, lifestyle and moral and ethical values. Data on contraceptive use is available from the 1983, 1986 and 1989 General Household Surveys (GHS).

In 1989 72% of 18-44 year old women used some form of contraception, this compares to 75% in 1983 and 1986 and 68% in 1976². There is no certainty that this data reflects actual or consistent usage rather than preferences, however, it does provide a guide to contraceptive use and method preferred. In 1989, for 18-44 year old women the most preferred methods were:

pill	25%
condom	16%
sterilisation - female	11%
- male	12%

(quoted in RCOG 1991 p36)

Pill usage has declined slightly over the last 10 years, this may be due to fears over possible side effects (eg. cancer of the cervix) or if taken alongside the increase in condom usage, especially among younger women, it could relate to concerns over HIV/AIDS (OPCS 1990 p160). Method of contraceptive use is related to age. For example younger women are more likely to be pill users whereas older women have partners who are more likely to use the condom. Older women/men who are married and have children are more likely to be sterilised (OPCS 1990 pp159-163). Analysis by educational attainment shows that for

"....women aged 30-49 were more likely to be sterilised the lower their level of educational qualification, ranging from 11% of those with GCE 'A' level or above to 24% of those with no qualifications. The differences in percentages of men sterilised were statistically insignificant."
(OPCS 1990 p160)

Some 6% of women use ineffective methods - withdrawal or the safe period, although this does not suggest that these women are at risk from unplanned pregnancy. The RCOG conclude that in general women were using contraception to minimise the risk of unplanned pregnancy with less than 3% (based on the 1986 GHS) placing themselves at risk by not using contraception (RCOG 1991 p35).

²Family Formation Study by Dunnell, K., HMSO 1989.

Analysis by age does show though that contraceptive usage increases by age. Teenagers are less likely to be using contraception and cite no sexual relationship as the reason (OPCS 1990 table 7.47). The GHS gives no information as to whether contraception would be used at the initialisation of sexual intercourse. There is a fuller discussion regarding teenagers later in this paper.

Sterilisation is clearly an important method of contraception. The RCOG point to evidence showing long waiting times for sterilisation and a withdrawal of funding for this service when performed for contraceptive purposes only. The RCOG argue that sterilisation, for men in particular is a cheap and effective method of contraception and should be offered by the NHS (RCOG 1991 pp39-40).

Contraceptive failure is, obviously, a component in placing women at risk of unplanned pregnancy. The most effective methods are sterilisation, the pill, IUDs, the diaphragm and the condom. Research on unplanned pregnancy suggests though that women with unplanned pregnancies may be erratic users of contraception. Metson, for example, found that 67.3% of his sample of women with unplanned pregnancy were using a contraceptive method. Of these 30% were erratic users or not using at the time of conception and a further 40% were using unreliable methods (rhythm and withdrawal). Five of the 41 pill users reported problems related to the efficacy of the lower dosage pills (Metson 1988). Problems of efficacy, associated with the lower dosage pills, have also been recorded by other researchers (Griffiths 1990, Brook 1991, Owen-Smith 1991, Fleissig 1991). Fleissig suggests that newer oral pills

".....are only just sufficient for efficacy and errors of compliance are common. Other research suggests that some women are not aware of the lowered efficiency of the combined contraceptive pill after a gastrointestinal upset or while taking antibiotics. Counselling and detailed explanation of particular methods of birth controls time consuming but essential."
(Fleissig 1991 p147)

Given that some women do not use contraception, greater emphasis should be placed on emergency (post-coital) contraception. There are two methods available - the oral pill effective if taken within 3 days of intercourse and the IUCD which is effective if inserted within 5 days. One of the major obstacles to the use of emergency contraception is lack of knowledge both among the public and health professionals (Burton et al 1990, Duncan et al 1990, Johnstone & Howie 1990). The RCOG have recommended that a major publicity campaign should be launched to inform people about emergency contraception and information should be given to all relevant health professionals (RCOG 1991 p59).

Obtaining contraception:

Government policy is that

"...consumers should be free to choose their source of contraceptive advice and that health authority family planning services complement rather than duplicate those which general practitioners provide. Choice is important to ensure that all those who wish to use this service can do so." (Quoted in RCOG 1991 p43)

Between 1975 and 1988/89, whilst the numbers of patients seen for family planning services, in clinics and by Gps, has increased in England and Wales by nearly 50% the numbers attending family planning clinics dropped by nearly 20%. Today 70% of those receiving contraceptive care go to Gps (RCOG 1991 p64). There may be many reasons for this trend, but nationally, DHAs are closing down or reducing family planning services for financial reasons. DHA clinics operate on cash limited budgets in contrast to Gps who receive payments from unrestricted funds. Clearly an anomaly exists in the way family planning services are managed and co-ordinated.

General practitioners and family planning clinics are further differentiated by the types of people who seek contraceptive advice and the different services offered. Gps tend to:

- be consulted by women who have had a child
- are biased towards oral contraception
- only may fit diaphragms and IUCDs
- unlikely to supply free condoms

Whereas family planning clinics:

- tend to see younger women
- offer a wide variety of choice
- provide free condoms
- are likely to provide advice and counselling on sexual matters
- provide a wide range of materials and advice on contraception and related issues

(Wilson & Heslop 1991, Fleissig 1992)

The RCOG also point to the need for somewhere for women reluctant to approach their Gps on confidentiality grounds and the vital role family planning clinics have in providing postgraduate training in contraception for medical and nursing staff (RCOG 1991 p44).

Surveys of GP and clinic users suggest that more time, choice and expertise is felt to be available at clinics and opening times were often more appropriate (Wilson & Heslop 1991, Fleissig 1992). Fleissig's survey found that Asian women were seven times less likely to attend either Gps or clinics (Fleissig 1992 p112). Attenders at 3 local clinics in Nottingham were asked about where they would go for contraception if their local clinic closed and

only 40% said they would transfer to their GP often citing the clinic strengths as stated above (Wilson & Heslop 1991 pp50-51).

It would seem more appropriate for contraception services to be co-ordinated to ensure adequate choice and avoid any duplication of services. Data collected on family planning services differs between DHAs and Gps and it is essential that this is rectified to enable adequate planning and monitoring of services (RCOG 1990 p56). Possible models for co-ordinating services include a senior DHA appointed specialist overseeing provision by Gps and the DHA or by using structured agreements or contractual links.

International comparisons.

The levels of unplanned pregnancies in this country compares favourably with other countries as the following table shows.

Country	Year	Planned pregnancy rate*	Unplanned pregnancy rate*	Total pregnancy rate*	% of which unplanned
Belgium	1977	1.17	0.83	2.00	41.5
Canada	1985	1.24	0.79	2.03	38.9
Denmark	1976	1.32	1.18	2.50	47.2
Finland	1978	1.03	1.06	2.09	50.7
France	1979	1.18	1.35	2.53	53.4
Netherlands	1983	1.37	0.28	1.65	17.0
Sweden	1982	1.39	0.80	2.19	36.5
G.B.	1977	1.35	0.63	1.98	31.8
U.S.	1983	1.25	1.31	2.56	51.2

* Represents the number of births a woman would have if she reproduced through her fertile years at the rates currently observed for women at successive ages.

(Jones et al 1989 table 2.2 p12)

The Netherlands has the lowest percentage of unplanned pregnancies yet the planned pregnancy rate is similar to Great Britain. There is high usage of reliable methods of contraception and easy access to sterilisation. There is substantial open debate about sexual matters and contraception is actively promoted by the government. There is also a network of clinics providing services to particular 'at risk' groups as well as a network of counselling centres (Jones et al 1989).

Reducing unplanned pregnancy.

There are no definitive causes of unplanned pregnancy. Rather there is a complex interplay of social, psychological and economic factors as well as contraceptive method failure. Whilst it is not possible to eradicate unplanned pregnancy there are a number of ways DHAs could influence peoples decisions and ensure

that people have access to contraception, abortion and adequate health care.

Sex education: DHAs should develop closer links with the delivery of sex education within the community (RCOG 1991, House of Commons 1991, Hudson and Ineichen 1991). Central government should introduce a central curriculum on sex education (RCOG 1991, House of Commons 1991). This issue is discussed further below.

Provision of contraception: Services need to be better advertised. The RCOG have recommended that advertising of contraceptives should be widespread and without restriction on times or places (RCOG 1991 p59). Services should ensure that women have better information about using contraception, particularly the newer oral pills (Fleissig 1991, Owen-Smith 1991, Brook 1991, Metson 1989).

People should be made more aware of the availability of emergency contraception and there should be concerted efforts made to disseminate information (Griffiths 1990, RCOG 1991 p59). Sterilisation services, for men in particular, present a cheap and effective way of providing contraception and therefore this service should be made available, on the NHS, for contraceptive purposes (RCOG 1991 p59).

There is a strong argument for rationalising the organisation for the provision of contraception services and ensuring that they are linked to abortion, counselling, sterilisation, pre-conception and ante-natal services (RCOG 1991, House of Commons 1991). More co-ordination between GP and community family planning services is required (RCOG 1991).

The contracting process may provide the opportunity to ensure a more comprehensive service. DHAs and FHSAs could co-operate to draw up service specifications and decide priorities for action. This would be easier and more efficient if only one agency, probably the DHA because of the associated services, purchased all of the services.

Targeting of services: Women from socially deprived areas and those under the age of 20 years are more at risk from unplanned pregnancy. Services should be targeted towards these women (see below for teenagers). Research on the use of three trial young persons clinics (Allen 1991) suggests that older women appreciate the non medical approach adopted by these services (Allen 1991) and thought should be given to investigating alternative methods of delivering contraceptive services.

SECTION TWO

TEENAGE PREGNANCY

Defining the problem.

The issue of teenage pregnancy has been of growing concern over the past 20 years (Bury 1984, Jones et al 1985, Trussell 1988, Phoenix 1991) despite teenage conception rates being lower than in the early 1970s. However, between 1978 and 1988 the conception rate³ for women under 20 years old in England and Wales rose from 60.2 per 1000 to 66.6 per 1000. This reflected an increase in conception rates for 15 to 18 year olds in particular. The birth rate for this age group remained fairly constant (43 per 1000 in 1978 compared with 42.8 per 1000 in 1988). The abortion rate however, rose similarly to the conception rate (from 17.2 per 1000 to 23.9 per 1000). Whilst this rate is lower than in the early 1970's there has been an increase over the last 6 years (OPCS 1991b tables 12.1-12.7).

Teenage pregnancy is perceived as a problem leading to adverse social and medical consequences. Research in Britain and the U.S.A. has shown that teenage mothers are more likely to have low weight babies, be dependent on state benefits, have poor knowledge of child development, a higher prevalence of fetal distress and premature/postmature babies, that in their first 5 years their children are twice as likely to be admitted to hospital as a result of an accident or gastroenteritis and score less well on verbal and non verbal ability tests (Bury 1984 pp21-25, Hudson & Ineichen 1991, Corbett & Meyer 1987, Hayes 1987).

It is questionable though, whether 'teenage pregnancy' is a problem by definition. In reality it is merely a descriptive term as there are substantial differences in pregnancy, abortion and birth rates between younger and older teenage women. Phoenix argues that combining a term for youthfulness - such as teenage/young/adolescent - with the term 'mother' implies that teenage mothers are immature.

"Since motherhood requires maturity, the implication is that 'young mothers' are really too young to be mothers. The terms 'teenage/young/adolescent' in conjunction with the word 'mother' thus have negative connotations about the ability of those who become mothers in their teenage years."
(Phoenix 1991 p6)

Corbett and Meyer have also argued that not all adolescent pregnancies are unwanted and that further research is needed to

³Conception rates are calculated as the number of women who become pregnant per thousand women in the age group being considered. They are usually calculated as rates of abortion plus rates of birth. This, in fact, is not totally accurate because 'many pregnancies end in miscarriage and these are not recorded' (Bury, 1984).....Further inaccuracies arise when numbers and rates of conceptions are related to specific ages....OPCS says, 'The exact number of conceptions shown are subject to errors arising from the estimation of women's ages at conceptions' (Phoenix p37).

determine whether negative consequences are related to teenage pregnancies when a conscious choice has been made to give birth (Corbett and Meyer 1987 p4).

Some commentators (Phoenix 1991, Hudson & Ineichen 1991) have attributed this view as a reaction to the fact that births outside marriage have dramatically increased from about 30% in the mid 1970's to over 70% in 1988 (OPCS 1991b table 12.1).

Also it is not clear if age is the determining factor which causes these negative consequences of pregnancy. Research has clearly shown that certain social factors are associated with increasing the likelihood of teenage pregnancy. These include incomplete education, lower educational attainment and fewer qualifications, lower socio-economic class background, coming from larger families and coming from broken homes (Estaigh & Wheatley 1990, Hudson & Ineichen 1991, Bury 1984).

"Many of the negative consequences seem more likely to be the result of the poor socio-economic circumstances in which women who give birth before they are 20 years of age live, and of the fact that they are more likely than older mothers to be having their first child. If parity and various factors known to be correlated with social class are controlled for, the differences between younger and older mothers are greatly reduced."
(Phoenix 1991 p24)

For very young mothers there are, however, real health risks to both mother and child.

Mothers under 15 are twice as likely to have premature or low birth weight babies.

Their babies are more likely to die in the perinatal period.

Pregnant adolescents under 15 have a maternal death rate that is 2.5 times that for mothers age 20 - 24.

(Bury 1984 pp24-27, Corbett and Meyer 1987 pp3-5)

Clearly the health issue is only one of a number of considerations which need to be taken into account. Others for example include education, training, family circumstances, source of income and housing. In a review of the literature, Bury found evidence that children of teenage mothers were more likely to be admitted to hospital with gastroenteritis, or following an accident and do worse at school. But if the teenager was well supported by their partner, family and services the outcomes for their children are improved (Bury 1984 p22).

The combination of the socio-economic circumstances of teenage mothers and the health and social consequences of teenage pregnancy has led some commentators to describe a 'cycle of deprivation' (Phoenix 1991, Hudson & Ineichen 1991, Bury 1984).

It would not seem appropriate to make assumptions about teenage pregnancies as a whole. However, determining a cut off age is

very difficult and would be an arbitrary exercise. This is because non-medical factors play a significant role. For example does a single 18 year old mother who is living on income support owe her situation to a failure of pre-conceptual care or a failure of social and economic policy which might have affected her even if she wasn't a parent?

Age may not then be the most crucial factor and it would be wrong to define teenage pregnancy as a 'problem'. As Hudson and Ineichen argue

"Teenage motherhood is not,....inevitably a disaster. Its success, in terms of the healthy development of both mother and child, depends above all on the right kind of help being available at the right time..... Our other task is to seek prevention, in preference to cure. Calling for sexual restraint by teenagers might be useful, and receives added impetus with the threat of AIDS; but to assume that it will be entirely successful is simply naive. Teenagers need - and indeed deserve - access to appropriate contraception, just as older people do. And the creation of sexually healthy attitudes, needless to say, needs to be tackled from a child's earliest years."
(Hudson and Ineichen 1991 p226)

International comparisons.

There are significant variations in pregnancy rates between countries as shown by the following table

Pregnancy rate*	15-19	15-17	18-19
U.S. total	96	62	144
U.S. white	83	51	129
England & Wales	45	27	75
France	43	19	79
Canada	44	28	68
Sweden	35	20	59
Netherlands	14	7	25

* rate per 1000 women at age.
(Jones et al 1985 p55)

These figures clearly indicate why there is more concern in the U.S. about teenage pregnancy and suggest that it is worth investigating the reasons for the variations between countries. Of particular interest are the low pregnancy rates for the Netherlands and Sweden. Not included in this study, but of interest is the experience in Denmark which in 1977 had a pregnancy rate of 47.6 per 1000 15-19 year olds but by 1985 had reduced this to 25.4 per 1000 (David et al 1990 p11).

Sexual activity and contraceptive use.

The age of first menstruation for girls has decreased from around the age of 14 in 1900 to about 12. It is suggested that this accounts for about half of the increased sexual activity among teenage girls (Bury 1984, Hudson and Ineichen 1991). However, it is thought that the largest rise in sexual activity occurred during the 1950s and 60s. For example, in the UK, in 1964 14% of 16 year old males and 5% of females had experience of sexual intercourse compared with 32% and 21% in 1974/5 (Bury 1984 p33).

This pattern is similar to other developed countries with little variance in the median age at first intercourse in Denmark, Sweden, USA, Great Britain, France, Canada and the Netherlands - Sweden has the lowest age of around 17 years and Canada the highest at around 19 years (David et al 1990 pp11-12, Jones et al 1985 p56).

Sexual intercourse tends on the whole to occur in stable relationships of at least six months duration. Intercourse is likely to be sporadic, infrequent and unplanned (Bury 1984 p34). The reasons for intercourse are varied and relate to issues such as self perception and wider personal relationships and failures (Bury 1984, Hudson and Ineichen 1991, Sharpe 1987, Phoenix 1991).

Studies also indicate that girls are less likely to enjoy sexual intercourse than boys (Bury 1984 p34). Hudson and Ineichen argue that these issues relate to the learning of gender roles in society which also exacerbate a division of intercourse from the notion of sexual fulfilment within relationships (Hudson & Ineichen 1991 pp13-27).

Research in the 1980s suggests that sexually active teenagers are more likely to use contraception than those 20 years ago (Bury 1991, Hudson & Ineichen 1991). However, very young people, under the age of 16, are less likely to use contraceptives (Hudson & Ineichen 1991, Trussell 1988, Winter & Breckenmaker 1991).

Contraception is associated with promiscuity not just by the young people but also adults (Birch 1987, Hudson & Ineichen 1991, Phoenix 1991). For many young people planned or premeditated sex combined with an expectation of contraceptive use is equated with low sexual morals (Hudson & Ineichen 1991 p108). However, research from abroad shows no relationship between higher levels of sexual activity and higher conception rates. For example, Denmark and Sweden have much higher levels of sexual activity amongst young people but lower pregnancy rates than this country (Boethius 1985, David et al 1990, Jones et al 1989).

Given that intercourse tends to be unplanned and infrequent it is not surprising to find that most teenagers do not use contraceptives at first intercourse and delay their use for many months. Research has also shown that there is still substantial "...ignorance among teenagers about bodily parts and functions." (RCOG 1991 p25).

This ignorance was confirmed in the survey undertaken by the Family Planning Association in conjunction with the Sunday Mirror in October 1991. The survey showed that 25% of 15/16 year olds and 66% of 13/14 year olds had not received sex education on contraceptives (Sunday Mirror 24/11/91).

Whilst this may go some way to explaining why some teenagers do not use contraception the reasons for non usage are varied and do not solely relate to questions of knowledge about contraception or risk of pregnancy (Bury 1984 pp39-47). Much research points to the fact that teenagers often take risks in their life styles (Hayes 1987, Corbett & meyer 1987). 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. Research in the 1970s involving 4000 American teenagers

"...found that 22% of all premarital pregnancies occur during the first month of sexual activity and 50% occur during the first six months."

(Bury 1984 pp38-39)

Contraceptive misuse or failure is a significant cause of pregnancy. In Simms and Smith's survey of mothers under 20 years old, 20% said that they had been using contraception when they conceived (Simms and Smith 1986). Phoenix, in her sample of young mothers found that nearly 20% of those mothers who considered it important not to become pregnant had been using contraception (Phoenix 1991 p81). Reasons for these findings may relate to erratic or incorrect use (Fleissig 1991, Metson 1988) and that younger women make greater use of, but are the least effective users of condoms (Griffiths 1990).

Attitudes towards sexual activity and contraceptive use would appear to be tied up with issues broader than sex education and the provision of contraceptives. Other issues include lifestyle, self concept, relationships with family and peers and perceptions of society in general. Any attempt to improve contraceptive use and reduce the teenage pregnancy rate would need to tackle this wide range of issues (Jones et al 1985, Hayes 1987, Bury 1984).

Sexually transmitted diseases: As teenagers are poor users of contraception they are more at risk from sexually transmitted diseases (STD) of which there are some 30 known types.

Of particular concern must be AIDS. In the U.S.A. 45% of 13-21 year olds with Aids were infected with HIV through heterosexual contact (Hudson & Ineichen 1991 p152). Teenage pregnancy is associated with risk taking lifestyles, including substance abuse. Whilst there are no comparative figures for the U.K. if we follow the American experience then AIDS is a very serious threat to young people, especially young females (Hudson & Ineichen 1991 p152).

Studies at GUM clinics show that condom usage is low - 5.8% of regular partners and 13.2% of casual partners (Thin et al 1989 p160). Young people attending GUM clinics are also more likely to have a STD than older attenders - 100% of under 20 year olds compared to 82% of over 20s (Thin et al 1989 pp158-159).

In addition to STDs young women are at risk from pelvic inflammatory disease (research in America suggests up to 1 in 8 sexually active adolescent women are infected), which can lead to infertility and ectopic pregnancy and cervical cancer (Hudson & Ineichen 1991 p149).

Contraceptive advice for young people.

The survey by the Family Planning Association in conjunction with the Sunday Mirror asked a sample of 13-16 year olds who they would turn to for advice on sex, contraception and relationships. The results show marked differences between boys and girls:

	BOYS %	GIRLS %
Mother	39	76
Father	41	7
Female friends	6	59
Male friends	39	9
Teacher	16	20
Doctor	24	28
Family planning clinic	8	18
Problem page	5	24

(Sunday Mirror 24/11/91)

A recent survey by the Brook Advisory Centres (Brook Advisory Centres 1991) showed that health authority family planning services do not meet the needs of young people. 44% of the requests for help (under 16 year old girl requesting to start the pill and for emergency contraception/ teenage boy requesting condoms for contraception and for protection) failed to be given an appointment within one week.

"The extremely high proportion of health authorities where no help was available appeared to be due to inaccurate entries in the telephone directory, the closure of clinics and the failure of the health authority, even during office hours, to provide a person or ansaphone to give callers useful information." (Brook Advisory Centres 1991)

The most negative reactions from staff were for the request by the under 16 year old girl for the pill. She was often referred to her GP or was interrogated about her personal details (Brook Advisory Centres 1991). Generally though, there is a reluctance by teenagers to use their GP for advice because of concerns over confidentiality (Plummer 1989 p11) which is further compounded

in relation to contraception by the ambiguous position of Gps following the Gillick Case in 1981. Thus the referring of under 16s to Gps is particularly worrying. This whole area may be further complicated as action is now being taken by Mrs. Gillick against her health authority regarding contraception advice to under 16 year olds without parental consent (Jan. 1992).

In America teenagers are also unlikely to approach their physician (GP) because of fears over confidentiality, although the situation is complicated by the fact of differential charging strategies between physicians and clinics (Hayes 1987 pp154-164).

However in contrast services in Denmark and Holland are also provided primarily by physicians but with much lower pregnancy rates (David et al 1990, Jones et al 1989). This suggests that other factors rather than simply who delivers the service may be important- for example wider acceptance of contraception and more open discussion about sexual matters.

The RCOG highlight the inconsistencies in the guidelines to Gps given by the British Medical Association and the General Medical Council. The GMC's advice means that young people under the age of 16 cannot be sure that what they say will be treated confidentially and the BMA guidelines are ambiguous in relation to assessing a girls maturity (RCOG 1991 p46).

"We consider that young people under 16 who are sexually active require confidential professional counselling in relation to contraception.....A trained responsible outsider, such as a general practitioner or a family planning doctor or a family planning nurse, may be a more effective source of counselling." (RCOG 1991 p46)

Even if the confidentiality issue is resolved work with young people suggests that they would still be reluctant to use Gps in case someone they knew saw them at the surgery (Plummer 1989 p11, Allen 1991 pp113-119)). This strengthens the argument for specialist advice services. The RCOG, in common with other commentators, argue that health authorities should provide specialist, separate clinics or sessions for young people (RCOG 1991 p45). The concept of sperate sessions for young people is recognised by central government who have suggested this approach to DHAs since the 1970s (DHSS 1974 & 1986).

It is questionable whether young people would use traditional family planning clinics even if separate sessions were run (Allen 1991, Bury 1984, Simms & Smith 1985). Research among young people shows that they prefer advisory services in premises designed to meet young peoples needs and separate from other services (Allen 1991, NAYPCAS guidance and Plummer 1989).

Evaluative research in America, during the mid 1980s, on the work of the 'Self Center' would seem to support this view. The centre provided free sex education, family planning and counselling services. In addition the centre workers were involved with sex education classes and individual counselling in two local schools. The three year evaluation showed significant increases

in contraceptive use and that if education started early enough the age of first intercourse can be delayed. Interestingly, unlike many programmes the 'Self Center' had a high level of involvement by boys (Hayes 1987 pp171-173). More recent American evaluative research confirms the superiority of specialist clinics, with continued, improved contraceptive usage (Winter & Breckenmaker 1991, Kirby et al 1991).

A recent report has evaluated three young peoples projects in the U.K. (Allen 1991). The three projects were established following research commissioned by the Department of Health and Social Security in the early 1980s which suggested that the needs of younger people were not being adequately met by existing provision for family planning and abortion (see Allen 1991 p1). These projects were aimed at providing services for 15-24 year olds. The evaluation found that whilst most users were within this age band the majority were aged over 20 years old (Allen 1991 pp19-43). The report questions whether this is the right target group arguing that services should be directed towards the under 20s. From the work with young people the report concludes that they wanted

"... a lot of local centres, which were discreet and inconspicuous, but easy to find and well-publicised. to be open at convenient times, to be informal and non-clinical, staffed by friendly, non-judgemental, well-qualified staff...offering general counselling on problems which might affect all teenagers.... services to be confidential at all levels." (Allen 1991 pp301-302)

Allen reports that the stress on confidentiality permeated the interviews with young people.

"It is the single most important factor in designing services for young people, and it is sad that some young people have such little faith in the extent to which they can rely on confidentiality in their dealings with professionals and other agencies."

(Allen 1991 p302)

Allen found a strong measure of support by professionals for specialist services for young people and echoed the views of young people about the types of services needed.

There was no evaluation of the long term efficacy of the projects in terms of contraceptive use or numbers of pregnancies and outcomes. Overall about 50% were making their first visit to a family planning service, this rose to 60% of under 16s. Some of the young people using these services had bad experiences of regular family planning clinics (particularly those under 16 or seeking an abortion) and many perceived the clinics as too public, not anonymous or not confidential (Allen 1991 pp107-109).

International comparisons with Sweden and the Netherlands suggest that services directed specifically at young people can result

in lower conception rates (Jones et al 1985 pp56-58). For example whilst the Dutch clinic system is less extensive than the British one, it is directed mainly at meeting the needs of young people and in Sweden there are parallel clinic systems for the general population and for the school age population. Both of these countries also ensure that the clinic systems are integrated with other medical and advisory services and sex education (Jones et al 1985 p56, Trussell 1988 pp264-265).

Sex education.

There is little long term evaluative research on the links between sex education and teenage pregnancy, but studies in America (Jones et al 1985, Hayes 1987, Trussell 1988) and the experience in Sweden (Boethius 1985) and Denmark (David et al 1990) suggest that comprehensive, good quality, sex education is an important contributor to the range of services advising about contraceptive use. This paper does not specifically review literature on sex education but all commentators place improved sex education as a main policy objective (Bury 1984, RCOG 1991, House of Commons Health Committee 1991, Phoenix 1991 and Hudson & Ineichen 1991).

The effectiveness of sex education as a preventive tool is shown by the Swedish experience of reducing the level of gonorrhoea by 40% in 5 years during the early 1970s. Sweden also has one of the lowest teenage pregnancy rates in the world and studies show that 5-15 year olds in Sweden have a better sexual knowledge than their U.K. and U.S.A. counterparts (Boethius 1985 pp278-279).

The Netherlands which has the lowest teenage pregnancy rate, of all developed countries, does not have an extensive school based sex education curriculum. However, the government funds sex education by private family planning associations which have close links with schools and clinics and there is a heavy emphasis on sex education in the media (Jones et al 1985, Trussell 1988).

Critics of sex education have argued that it can initiate sexual activity. Research in America has found no association between sex education and initiation of sexual intercourse (Hayes 1987, Trussell 1988). Sex education in schools alone is unlikely though, to delay sexual intercourse (Wilson & Breckenmaker 1991, Kirby et al 1991). Most commentators also agree that it will be more effective as part of a wider discussion on sexuality in the community, as is the case in Sweden or the Netherlands (Hayes 1986 pp143-148, Jones et al 1985, Boethius 1985). Hayes notes however, that sex education is a low cost option compared with other strategies (Hayes 1987 pp147-148). Jones et al, in their comparative international study, argued that sex education together with more openness about sex is an important factor in lowering teenage pregnancy (Jones et al 1985 p59).

In this country, although there are central guidelines on sex education, the ultimate responsibility lies upon individual schools. Thus the provision of sex education varies considerably. The RCOG argue that this is not sufficient and that there should

be a nationally developed curriculum providing a comprehensive and co-ordinated sex education programme involving the support of the health education and other appropriate medical staff in schools (RCOG 1991 p58). This view is supported by the House of Commons Health Committee who recommended

".....that the Department of Education and Science and the Department of Health work together to produce a more comprehensive health education/health promotion syllabus for pupils aged 5-16 years, and that the implementation of this curriculum be monitored regularly at a national level."

(House of Commons 1991 para.75)

Given that currently the responsibility for sex education lies with schools DHAs should seek to work with local schools to develop improved sex education including advice and information on contraception, sexuality, lifestyles and relationships, pregnancy, abortion and general health and social care. Training should be made available for teaching staff which would be the responsibility of DHA staff involved with contraception and pregnancy services for young people (Allen 1991, Hudson & Ineichen 1991, Hayes 1986).

Pregnancy and abortion: advice, care and support.

There will always be some teenage pregnancies and therefore services for pregnant teenagers need to be considered alongside contraceptive services. Clearly for those teenagers who request termination, abortion services must be available (see discussion above). Many teenage pregnancies whether planned or unplanned may be wanted and contraceptive failure or misuse is not uncommon (Phoenix 1991 pp80-83, Metson 1988, Fleissig 1991). In addition, if teenagers are not able to get an abortion then they have little choice but to continue the pregnancy to term.

There are a range of services for pregnant teenagers from the normal ante-natal clinics to specialist services. In America there has been some evaluative research on specialist ante-natal services for young women but no similar studies have been undertaken in the U.K. although some health authorities run special clinic sessions (eg. at St. George's Hospital, Tooting, City and Hackney Young People's Project).

The first point of contact for many teenagers will be for a pregnancy test, this view is supported by the evaluation of the special young peoples projects discussed above (Allen 1991 pp70-83). The evidence from this report suggests that if services were more welcoming teenagers may attend earlier allowing them more choices and where required or needed improved ante-natal care. The American experience does indicate that where services are easily accessible young people are more likely to use the service (Hayes 1987 pp196-200). A study of a community based centre showed that similar pregnancy outcomes to hospital clinics are achievable with a less formal approach. However considerable

benefits in terms of lifestyle improvement and contraceptive use were noticed in the centre's patients.

"Of those patients who were smoking at the time of their first prenatal visit, the percentage who stopped or reduced smoking throughout the remainder of their pregnancy was significantly higher for the Corner clients...Comparative percentages [with a local hospital prenatal clinic] for contraceptive use at 6 months, 12 months and 24 months were 78.4% versus 45.0%, 48.5% versus 28.8%, and 27.4% versus 12.8% for the Corner and the OB clinic, respectively. Comparative pregnancy rates at the same intervals were 4.7% versus 26.6%, 16.0 versus 23.3%, and 15.4% versus 30.4%, respectively." (Kay et al 1991 p536)

Adequate health care for pregnant teenagers is an important factor in protecting the health of the mother and child and reduces the adverse consequences associated with early pregnancy and childbirth (Trussell 1988, Phoenix 1991, Hayes 1987). Evidence would seem to suggest that services organised specifically for young people have superior outcomes in terms of general use than other forms of health care. Young people are more likely to attend early for a pregnancy test if they have already been using the same service for contraceptive or other advice and support, this is the rationale of many school based clinics in the U.S.A. (Hayes 1987 pp196-199). This concept was a key element in the City and Hackney project where it was accepted that

"While the provision of family planning is the focus, it is important that this is linked to pregnancy testing, antenatal care and abortion services."
(Jessop 1988 p646)

It is clear that for young pregnant women advice and support is as essential as it is pre-conception. The same issues about the style of approach, friendliness, confidentiality and accessibility apply as much at this stage as for any other advisory or support service for young people. There is evidence to suggest, for example that some young people are coerced in to having abortions when they don't want to, by clinic staff who make judgements on the young women's behalf (Allen 1991 pp139-145, Phoenix 1991 pp88-93) and conversely some young women wanting abortions have been deterred or prevented from having one (Hudson & Ineichen 1991 pp46-51).

Apart from abortion, childbirth can involve further choices for a young mother as to whether to keep the child or have her or him adopted. Adoption use to be more common but has decreased with the availability of abortion (Phoenix 1991 pp89-90, Sharpe 1987 pp204-212). However, young pregnant teenagers should be aware of this option if they are to have a choice in pregnancy.

Integrated services for young people would appear to be the best option to pursue (Allen 1991, Hayes 1987, Bury 1984 p74). This would provide continuity for young people and might encourage the involvement of young men in these issues rather than leaving it all to young females. The current situation is only likely to maintain the predominant view that teenage pregnancy is only an issue for young women, including its prevention (Hayes 1987, Phoenix 1991, Hudson & Ineichen 1991).

Reducing unintended teenage pregnancy.

Teenage pregnancy is linked to a range of issues concerning the lifestyle, social and economic circumstances, and self image of young people. It is clear that many young people make positive choices to become pregnant and given appropriate care the outcomes of these pregnancies tend not be any different than for older women. Concern, however, should be focused on very young teenagers who become unintentionally pregnant.

The level of teenage pregnancy varies from area to area and to point to any one cause is impossible. Clearly there is a link with social deprivation, in particular the way socio-economic disadvantage tends to compound the problems for pregnant teenagers. Experience from other countries does suggest though that it is possible to reduce the number of unintended teenage pregnancies (David et al 1990, Jones et al 1985, Hayes 1987).

Services need to be structured around three areas

1. Those that impart knowledge or influence attitudes.
2. Those that provide access to contraception.
3. Those that enhance life options.

Sex education is one of the most important areas of work and is cited by American researchers as one of the main reasons for the difference between a countries like Denmark and Sweden, which have low teenage pregnancy rates, and the U.S.A., which has a very high one (David et al 1990, Jones et al 1985, Hayes 1987, Trussell 1988). The RCOG's strong recommendation for improved sex education is one that should be pursued by all those concerned with teenage pregnancy and unplanned pregnancy generally (RCOG 1991 pp58-59).

Other main reasons for differences between countries with high and low teenage pregnancy rates are the availability of free contraception and more open discussion about sexuality. Countries with these, such as Denmark, the Netherlands and Sweden, tend to have lower teenage pregnancy rates (David et al 1990, Jones et al 1985).

Whilst America does have a very high teenage pregnancy rate a substantial amount of research on projects aimed at reducing teenage pregnancies would seem relevant to this country. The success of community and school based advisory centres and clinics could provide a good model upon which to base services in this country. Whilst the outcome of the evaluative study on the three British projects has yielded some evidence to support

this approach, further work is needed which crosses the divide between those agencies responsible for health and those with an educational and social care remit (Plummer 1989, Allen 1991).

Services for young people need to be integrated with general support and advice services covering a range of topics, not just health, and provide a range of direct services, including preconception advice, contraception, pregnancy testing and counselling, abortion counselling, counselling on sexuality, ante-natal and post-natal care (Bury 1984, Allen 1991).

Research also stresses the importance of ensuring that teenagers are equipped with appropriate life skills. Evaluative work in America on life skills and decision making programmes suggests that these are effective ways of reducing unintended teenage pregnancies (Lindsay & Rodine 1989, Hayes 1987). British researchers and workers with pregnant teenagers and young mothers have also pointed out the need to ensure that young people maintain access to education, work skills and to develop better decision making skills (Phoenix 1991, Hudson & Ineichen 1991). Many American services for young people have these broader aims such as the Teen Outreach Program⁴ a life management skills curriculum which on evaluation has been proved to reduce teenage pregnancy and increase the participants life chances (Lindsay & Rodine 1989 pp56-57, Philliber et al 1991).

Some commentators (Hudson & Ineichen 1991, Lindsay & Rodine 1989) argue that attitudes at the preschool stage are as important as work with school aged children and teenagers. In America there are a number of projects aimed at improving the educational attainment of children by working with their parent at an early age (Lindsay & Rodine 1989). In this country the Bristol child healthcare model being developed for use by Health Visitors and other workers with parents with young children is being seen as a possible contributor to the improvement of life chances (Hudson & Ineichen 1991).

These projects are clearly linked to the view that teenage pregnancy needs a broader approach involving different attitudes about sex and an attempt to reduce teenage pregnancy by improving self image and decision making abilities. Evidence from the USA, Sweden and the Netherlands suggests that better awareness and improving knowledge about sex can reduce the numbers of teenage pregnancies (Jones et al 1985, Hayes 1987, Trussell 1988). Of particular interest are the approaches in Sweden and the Netherlands, where there is a stronger commitment to more information on sex and the provision of contraceptive services.

It has been suggested that a broad community based approach could work in this country but although a pilot project was developed funding could be obtained (Ashton & Seymour 1988 pp120-127). From the work done in Liverpool in the mid 1980s it is clear that such an approach does have the support of a diverse range of

⁴This programme is based on discussion group work led by a trained teacher out of school hours together with voluntary service work in the community. In 1990/91 there were 108 projects across the USA.

organisations and individuals in the community (Ashton & Seymour
1988 pp120-127).

SECTION THREE

CONCLUSION

Conclusion.

Whilst the discussion above reviews unplanned and teenage pregnancy separately the two issues are clearly linked. Unplanned teenage pregnancy is, for example, like unplanned pregnancy in that both are associated with low socio-economic status. Commentators on both subjects also point to the need for improved sex education and openness about sex as a way of reducing the incidence of unwanted pregnancies. However, it would seem beneficial to treat young people separately from older people. This is because young people themselves tend to prefer services designed purely for their use, and the evidence seems to suggest that such services may be more effective.

The need for separate services for young people has been recognised for some time by the government and specific guidance has been issued since 1974 (DHSS 1974, DHSS 1986). This has been reinforced in the latest guidance to regions for reviewing family planning services (NHSME 1992 para 3.2).

Little attention has been paid in this paper to gender issues in relation to the provision of contraception services. Most research concentrates on women. There is some work relating to teenage fathers and some of the studies quoted above allude to the female/male dimension. There would seem to be a need for further discussion about this issue and this may, most appropriately, be done in relation to services for young people.

As mentioned in the introduction, the needs of specific sub groups of the population have not specifically been addressed although some of Fleissig's findings relate to Asian women's use of family planning services (Fleissig 1992). This is not to say that these groups are not important but rather that there is little available information. The guidance to regions suggests that these issues are followed up. It could be useful for services to build links with organisations representing and working with people with disabilities and learning difficulties, homeless people and people from ethnic communities for example.

The paucity of evaluative research in this area makes it difficult to recommend courses of action or specific policies. This conclusion, therefore, sets out the main recommendations of three recent influential reports, referred to in the above text, produced by the RCOG, House of Commons Health Committee and the Policy Studies Institute. Following these there is a section bringing together the main common points for action which commentators on this topic have put forward. Lastly, there are a number of suggestions for further action by DHAs.

Many of these recommendations and suggestions for further action mirror aspects of the guidance for regions on reviewing family planning services.

Recommendations made by RCOG:

A summary of the recommendations made by the RCOG in their report can be found in Appendix A, however the main points are detailed below.

The RCOG made the development and delivery of a nationally monitored and supported curriculum for sex education the essence of its main recommendations (recommendations 7.1 - 7.8). This included an improved health education component in teacher training, the appointment of a specialist teacher to co-ordinate health education work, and that health authorities should consider having

"Selected health care personnel trained in family planning and sexuality [who] could be involved in sex education of teenagers. Such personnel could be invited to assist the specialist teachers by acting as leaders in group discussions. Such staff could create links between the pupils and local services for young people." (recommendation 7.8)

They argued that the prevention of unplanned pregnancy is an important goal of teaching and training in human sexuality and contraception (recommendation 7.9), that GPs should have appropriate training (recommendation 7.10) and that adequate training combined with opportunities for practical experience is available (recommendation 7.11).

The RCOG felt that more information about contraception and contraceptive services should be made available, that there should be a range of freely provided contraceptive services - including youth advisory services - to ensure people have choice and that sterilisation is an important method of permanent contraception and should be provided free by the NHS (recommendations 7.12 - 7.20).

They stress the importance of the provision of legal abortion (recommendation 7.21) and

"Each health authority should consider the advantages of appointing a senior specialist to oversee the provision of contraception and sterilisation, both by community clinics and in general practice. The same specialist should oversee the organisation of the provision of legal abortion. Community gynaecology is a term that includes all these functions and might be recognised as a subspeciality within gynaecology." (recommendation 7.22)

The RCOG also note the need for improved information on unplanned and unwanted pregnancies and the need for comparative data from GP and clinic contraceptive services (recommendations 7.24 & 7.25).

Recommendations made by the House of Commons Health Committee:

The list of recommendations and conclusions made by the Health Committee are included in Appendix B. Whilst these cover a range of issues relating to pre-conception issues some are of direct relevance to the issue of unplanned pregnancy.

Areas of particular concern were the adequacy of sex education in schools, lack of information on pre-conception care, the need for better co-ordination of family planning services, the provision of a range of services to provide choice and the need to review what data should be collected on family planning services.

Recommendations of Policy Studies Institute:

From the evaluation of the three projects for young people Allen makes a number of recommendations regarding the delivery of services to young people (Allen 1991 pp304-311). 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

Concerns expressed/possible action suggested by researchers:

All commentators have stressed the need for improved sex education and a number have pointed to the need for much closer co-operation between agencies working with young people (Hudson & Ineichen 1991, Bury 1984, Hayes 1987, Ashton & Seymour 1988). Experience in Sweden, the Netherlands and in some places in the USA would seem to support this view (Jones et al 1985, Trussell 1988, Hayes 1987).

Lack of knowledge about different forms of contraception is highlighted by a number of authors who suggest better information and wider choice (Fleissig 1991, Burton et al 1990, Duncan et al 1990, Griffiths 1990, Brook Advisory Centres 1991). Emphasis is placed on the need to provide a choice of providers (Fleissig 1992, Wilson & Heslop 1991) and ensure specific services for young people (Bury 1984, Hayes 1987, Trussell 1988, Phoenix 1991, Hudson & Ineichen 1991).

Specialist, integrated pre-conceptual, ante-natal and post-natal services should be developed for young people providing advice, information and services on all aspects of contraception and pregnancy (Hudson & Ineichen 1991, Hayes 1987).

Suggested areas for further work by local DHAs:

1. Further information is needed about what sort of services are required by the public and what services are currently offered by GPs. The Regions quality study and the review by Hampshire FHSA with two DHAs should help our understanding of service patterns and needs. It is suggested that when the results of these projects is known further discussion about unplanned pregnancies is undertaken. In addition sufficient information should then be available to discuss issues relating to the co-ordination and management of contraceptive and associated services.
2. Information seems to be a key concern and DHAs should consider what action they could take to improve the public's knowledge of emergency contraception and the availability of contraception services. Targeted publicity campaigns might be a useful method which could be evaluated by examining contraceptive service uptake, abortion statistics and conception rates.
3. Clinic user surveys could be undertaken to find out who uses the service and see whether this matches the target groups of those women at highest risk of an unplanned pregnancy. Links could be developed with agencies and groups working with women from the high-risk groups.
4. DHAs should consider establishing a working group consisting of representatives of the DHA, the Education Authority, Youth Services, FHSA, Social Services and possibly the Probation Service to co-ordinate work on, and to discuss strategies aimed at, preventing unintended teenage pregnancies. Such a strategy is being adopted by Dorset DHA and it is suggested that this work is monitored to help other DHAs develop appropriate services.
5. For young people in particular, free pregnancy testing may encourage early contact with health care services and DHAs should consider ways of making such a service available which would be accessible to young women.

6. DHAs should consider developing links with local schools and other agencies working with young people. Staff involved with contraception services could participate in a school's sex education curriculum or in discussion groups etc.
7. Because of the close relationship between contraceptive usage and sexually transmitted diseases it would be beneficial for DHAs to develop close service links between contraception services and other professionals and agencies involved in working with people at risk from STDs (eg drug services in relation to HIV/AIDS).
8. Abortion services should be reviewed to ensure that women are receiving adequate and appropriate services. In particular to ascertain whether some women are being forced into the private sector thus denying abortions for those women without the financial resources.

APPENDIX A

**SUMMARY OF THE RECOMMENDATIONS
MADE BY THE
ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS**

7 Summary of recommendations

Sex education in schools

- 7.1 A flexible curriculum for sex education in schools is necessary. This would be developed and monitored on a national level and would be similar to those which exist in many other countries in Europe and in some parts of the US and Australia. Such curricula should stress the importance of responsible and caring relationships.
- 7.2 Policies and programmes on sex education at local education authority and school level need to be monitored, and mechanisms for sharing good practice developed, both locally and nationally.
- 7.3 Continuity between home and school would be improved if seminars on sex education were organised at a local level for parents and school governors.
- 7.4 Attitudes in schools to sex education would be improved if initial teacher training courses had health education as a compulsory component. This would include relationships, sexuality and contraception.
- 7.5 All schools need one or more teachers with special training in sex education.
- 7.6 Sex education would improve if a specialist teacher in each school co-ordinated the teaching of health education, including education about relationships, sexuality and contraception. The co-ordinator would develop the curriculum in accordance with the National Curriculum, National Curriculum Council guidance and governor's policy in the context of a particular school. The co-ordinator would facilitate liaison between governors and parents.
- 7.7 All secondary schools should use teaching methods that are appropriate to the needs of the teenage group. These should create a climate where both girls and boys, able-bodied and those with a physical or mental disability, can participate fully. Such teaching should be designed to help young people to discuss sexual topics and should encourage the formation of standards for sexual behaviour.
- 7.8 Selected health care personnel trained in family planning and sexuality could be involved in the sex education of teenagers. Such personnel could be invited to assist the specialist teachers by acting as leaders in group discussions. Such staff could create links between the pupils and local services for young people.

The training of health professionals

- 7.9 Teaching and training in human sexuality and contraception is essential for health professionals. Theoretical knowledge must be complemented by the acquisition of the ability to communicate with patients about sexual matters. The prevention of unplanned pregnancy is an important goal of such training but there are important implications for the psychological benefit of patients and for the control of the spread of sexually transmitted infection, including HIV.
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LIST OF RECOMMENDATIONS AND CONCLUSIONS

Reducing the incidence of smoking among women, and especially young women, is perhaps the biggest single challenge to health promotion agencies and could contribute significantly to improved mortality and morbidity rates. (Para 8)

All women need to be made aware of the effects of alcohol on their health and the impact it can have on conception and on the developing baby. Sensible drinking advice should include the potentially harmful impact that heavy drinking can have on people's physical and mental health and on their ability to conceive. (Para 9)

Initiatives aimed at dealing with drug abuse and misuse are an important part of preconception care. (Para 10)

Common sense dictates that the health status of the mother must influence the health status of her baby, since all nutrition to the fetus comes from its mother. (Para 12)

The MRC vitamin study suggests that improved diet or vitamin supplementation might help all women at risk of having a low birthweight or disabled child to produce a healthy baby. We recommend that the Department commission a study to determine whether folic acid supplementation will reduce the overall incidence of neural tube defects rather than just recurrences. (Para 23)

We are persuaded that, at the very least, it would do more good than harm if measures were taken to improve the diet and nutritional status of women at risk of having a low birthweight or disabled child. At best, such measures could reduce the incidence of disability and childhood illness; at the least, they may improve the health of the women concerned. However, we recommend that a scientifically valid randomised controlled trial involving women who have previously given birth to a low birthweight baby be carried out to investigate the influence of nutrition on birth outcome. (Para 25)

Immunisation of all young women against rubella is vital. (Para 26)

We recommend that the Government take the following steps:

- (i) commission the appropriate epidemiological research to establish the incidence of toxoplasma infection in pregnancy in the United Kingdom and the incidence of symptomatic and asymptomatic infection in new born babies;**
- (ii) fund research into improved tests for the diagnosis of recent infection in pregnancy;**
- (iii) allocate resources to enhance the knowledge of the appropriate health professionals into the diagnosis, prognosis and treatment of toxoplasma infection. (Para 29)**

To avoid both listeriosis and salmonella, women contemplating pregnancy should be advised about the potential dangers of soft cheeses, pate, eggs, cooked chilled meats, ready to eat poultry and the need thoroughly to cook certain foods. The Chief Medical Officer has issued information to all doctors about listeriosis and salmonella. This advice should be brought to the attention of all women who may become pregnant. (Para 32)

All men, women and schoolchildren need to be made aware of how HIV and AIDS can be contracted and how it can be avoided as part of preconception care. (Para 33)

The adoption of safer sex methods can help reduce the spread of HIV and other sexually transmitted diseases. (Para 34)

All women need to be aware, before becoming pregnant, of ways of avoiding or preventing infection which would damage a baby during pregnancy. (Para 35)

Health professionals to whom disabled people go for advice about pregnancy should give advice and information to enable them to make an informed choice about parenthood. (Para 40)

It is important that steps are taken to reduce or eliminate exposure of women and men planning pregnancy to radiation and certain chemical hazards. We recommend that the Health and Safety Executive in collaboration with employers' organisations and Trade Unions should aim to identify those factors which may have an influence on pregnancy outcome and to explore ways and means by which those people planning to have children could be better protected. (Para 44)

Encouraging and enabling people in low socio-economic groups to improve their standard and quality of life are one of the most difficult, but important challenges facing Government. Steps taken to alleviate social deprivation will make a significant contribution to improving the outcomes of pregnancy. (Para 47)

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- 7.10 General practitioners should aim towards ensuring that they are appropriately trained in contraceptive practice before they offer this service to patients. A suitable qualification remains the Certificate of the Joint Committee on Contraception.
 - 7.11 The provision of practical training in contraceptive practice needs to be reviewed urgently by the appropriate authorities to ensure that there are sufficient training centres that are able to provide appropriate practical experience.

Provision of contraceptive services

- 7.12 Men and women need information about and education in the use of contraception. They need to know where to obtain services. This function of health education needs special funding
- 7.13 Contraceptive methods and services would be used more effectively if they were advertised in the media without restriction on the time of day.
- 7.14 Contraceptive advice and supplies (including condoms) should be provided free of charge within the National Health Service by family planning clinics, general practitioners and hospitals.
- 7.15 Professional bodies should consider advising that all sexually active young people are entitled to complete confidentiality from the doctor they consult about sexual matters and about contraception.
- 7.16 Sterilisation is an important method of permanent contraception for both men and women. Male and female sterilisation operations, accompanied by appropriate counselling, should be freely available in the National Health Service. Waiting times for this service should be kept as short as possible.
- 7.17 General practitioners who supply contraceptive services should be encouraged to provide clear information in their practice leaflet on the methods they have available for their patients.
- 7.18 Information about emergency contraception should be part of routine counselling for all methods of contraception. Emergency contraception should be advertised locally and should be freely available through general practitioners, community family planning clinics and accident and emergency departments.
- 7.19 Each health authority should ensure that there is a choice of contraceptive services from general practitioners, community family planning clinics and youth advisory clinics as each service meets the needs of particular groups of men and women at different times during their fertile years.
- 7.20 More effective and more acceptable contraceptive methods are needed. Special funding is required for research and development.

Legal abortion

- 7.21 Legal abortion is a necessary option for women stressed by unwanted pregnancy. Health authorities should accept responsibility for the abortions needed by women resident in their districts.
 - 7.22 Each health authority should consider the advantages of appointing a senior specialist to oversee the provision of contraception and sterilisation, both by community clinics and in general practice. The same specialist should oversee the organisation of the provision of legal abortion. Community gynaecology is a term that includes all these functions and might be recognised as a subspecialty within gynaecology.
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- 7.23 Some unplanned pregnancies would not be unwanted if maternity and paternity leave was recognised by all employers. For the same reason, working parents should be entitled to tax allowances to assist with the cost of child care and with the care of old people. The care of young children would be facilitated if all educational opportunities for adults were available both part-time and full-time.

Data collection

- 7.24 Surveys of samples of the women in the population aged 15-49 should be performed at regular intervals. These would broadly cover similar ground to the Family Formation Survey of 1976. Such surveys would assess the occurrence of pregnancy by age, number of existing children, education, income, the relationship between the woman and her partner, the use of contraception and her history of legal abortion. The pregnancies would be classified as planned and unplanned and the last child as wanted and unwanted. These data would monitor the social structure of society and would assist the planning of health education and the provision of services for women and children. These surveys could either focus specifically on topics or form part of wider surveys of women's health.
- 7.25 In order to plan and monitor the provision of contraceptive advice and supplies, detailed statistical collection is required at a local and at national level. Such a system should ensure comparative analyses between family planning clinics and general practitioners.
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APPENDIX B

LIST OF RECOMMENDATIONS AND CONCLUSIONS MADE BY THE HOUSE OF COMMONS HEALTH COMMITTEE

We recommend that the Department and the Health Education Authority mount regular campaigns about sensible drinking targetted at young people, and especially young women as potential mothers. (Para 54)

We look forward to the start of the Health Education Authority's nutrition programme and recommend that relevant nutritional advice for women and men planning a pregnancy be provided in this programme. (Para 56)

We recommend that the information in the report by the Committee on the Medical Aspects of Food Policy on dietary reference values be used to improve the explicit dietary and nutrition advice to women planning a pregnancy. (Para 57)

We recommend that the Health Education Authority draw together the best dietary advice and produce a short, readily comprehensible booklet describing food which is best for health, and detailing sources of necessary minerals and vitamins. The booklet could also contain advice on how to avoid problematic infections which could be contracted from food, such as toxoplasmosis and listeria and advice about tobacco and alcohol consumption. The booklet should be specifically targeted at young people and women of child bearing age. We also recommend that this booklet should be attractively presented and made available, free of charge, at all outlets where 'preconception care' in its widest sense, is available. These include General Practitioners' surgeries and waiting areas, family planning clinics, schools, ante-natal clinics. (It could also be made available at book shops or newsagents). (Para 59)

We recommend that advice on preconception care be identified as a key area of work for the Health Education Authority. We also recommend that the Health Education Authority produce material which is made widely available on the issues relevant for people planning pregnancy and information on where people can go to get advice when there are specific problems. This information should be made available in languages other than English and the information should be made available in a range of formats. (Para 67)

We recommend that evaluation should form part of all health promotion and health education programmes and strategies. This evaluation work should be carried out preferably by an external independent body or organisation with the appropriate expertise. (Para 68)

We are concerned that health and sex education in schools may not be accorded the priority they require. We recommend that the Department of Education and Science and the Department of Health work together to produce a more comprehensive health education/health promotion syllabus for pupils aged 5 - 16 years, and that the implementation of this curriculum be monitored regularly at a national level. (Para 75)

We recommend that all schools designate a teacher to coordinate health education and that this teacher should have specialist training in sex education. (Para 80)

We believe that no one profession is better placed or necessarily better informed or qualified to provide preconception care. All health care professional groups have a role to play. (Para 87)

We recommend that the Department of Health issue guidance on how primary health care teams can make the maximum use of the opportunities that exist in a primary care setting to provide preconception care. (Para 89)

Whilst the primary health care team is obviously likely to be one of the main providers of preconception care there is a need for Government to ensure that all sections of the community have access to primary care services regardless of their social or medical circumstances and for ensuring that preconception care is made available in other service settings, such as local community based family planning clinics. (Para 91)

We agree with the need to make the role of Family Planning Clinics in preconception care more widely publicised. We recommend that the Department of Health conduct a modest national publicity campaign advertising the availability of preconception care in family planning clinics (this may require the Department to produce guidance to health authorities on what preconception care could be usefully provided in such settings). We also recommend that the Department of Health publish or commission an information booklet on preconception care and family planning services, with translations into a number of other languages. We also recommend that staff providing family planning services be adequately trained to ensure that they are up to date with current developments and information on preconception care (including dietary advice) and that they possess the right interpersonal skills to provide preconception care in an appropriate and sensitive way. (Para 96)

We believe that the Department of Health should take urgent steps to ensure that the Government's policy of providing a choice of family planning services is being acted upon in each District. (Para 107)

We recommend that the Government use their planned Regional reviews of family planning services to:

- (i) list the family planning clinics in each Region that have been closed in the last five years and the alternative family planning services available in those areas;**
- (ii) make recommendations as to what statistics should be collected locally, regionally and nationally to enable accurate comparisons to be made between community clinic family planning services and general practitioner family planning services;**
- (iii) ask each Region to consider whether each district health authority in partnership with their local Family Health Service Authority(ies) should nominate a specialist worker to have responsibility for overseeing the provision of family planning services in community clinics and by GPs;**
- (iv) consider the setting up of special family planning services for young women in each district health authority area and how these services can best be provided; and**
- (v) ensure that each District Health Authority purchases local family planning clinic services in order to provide choice for women. (Para 107)**

We recommend that the Government commission research in a number of different areas of the country into the effects of offering a detailed preconception care service on birthweight, perinatal and infant mortality and morbidity and on the possible reduction of referrals for infertility treatment and the reduction of post natal morbidity in the mother. Such research should also examine and evaluate the impact of the provision of preconception care in schools, in the primary health care setting, in local community based family planning clinics and in maternity services. (Para 117)

The views and experiences expressed in the evidence underline our recommendations that preconception care and preparation for parenthood should form an important part of education in schools, general health promotion and family planning work and rely on the use of existing services and staff to provide general preconception care with the caveat that more strenuous efforts should be made to ensure that preconception care and advice is made appropriate for and accessible to those groups in society who most need it. (Para 121)

We recommend that the Chief Medical Officer draw to the attention of all General Practitioners the need to advise people with existing medical problems of the implications of their illness for future pregnancies. (Para 123)

We recommend that every woman should be provided with a copy of her obstetric notes to keep after the birth of her baby for future reference. (Para 124)

We believe that the weight of evidence is sufficient to indicate the need for improved genetic services in the UK at the primary and community health care level backed up by a sufficient Regional Clinical Genetic Service incorporating the required laboratory services, pathology services, counselling services, clinical, laboratory and counselling expertise and the setting up and running of genetic registers. We recommend that the Department of Health, as a matter of urgency, instruct each Regional Health Authority to review their genetic services. This review should determine the extent to which each Region's Genetic Service is able to provide for the needs of their population. (Para 133)

We recommend that the Health Education Authority include information on genetic disorders and where people can go for further information and advice in its programme of work on preconception care that we recommended they undertake in paragraph 67. We also recommend that the Department of Health provide guidance for relevant health personnel on genetic disorders, their prevention and the specialist services that are available. (Para 134)

We recommend that the Director of Research and Development in the NHS Management Executive and the Medical Research Council jointly commission the necessary research to investigate the primary causes of neuro-developmental disorders. (Para 135)

We recommend that the Department encourage the integration of the prevention and treatment of haemoglobin disorders within Regional Genetic Services and include a review of the current arrangements for providing preventive services for inherited blood disorders as part of the Regional review of genetic services we recommended in paragraph 133. (Para 138)

We recommend that information should be readily available to couples about where to go for further help if they believe they may have difficulty in conceiving. Such advice should be offered at all Family Planning Clinics and at GP surgeries. (Para 139)

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