Emergency contraception - a pilot study by school nurses

The Health of the Nation (Department Of Health, 1992) stated that by the year 2000 unintended teenage pregnancy should be reduced by half. Having failed in this undertaking the government set a similar target in our Healthier Nation (DoH, 1998) but extended the deadline to the year 2010, the high rate of teenage pregnancy in this country is shameful according to prime minister Tony Blair, as recorded in the report by the Social Exclusion Unit (1999).

School nursing has frequently been referred to as an invisible service (DeBell and Jackson, 2000). Despite a determined effort to raise their profile and dispel the myth that their main remit is of tackling head lice, many health professionals as well as the general public remain unaware of the extensive expertise of school nurses.

In recent years, however, the government has discovered the hidden talents of this group of nurses who have been catapulted from obscurity to apparent notoriety through recommendations made in many government documents, not only in the field of health but also in the field of education.

While school nurses continue to respond to the many recommendations for their service, an area that many feel they can improve upon is that of addressing problems of sexual health. Tackling unintended teenage pregnancy and reducing sexually transmitted infection (STI) is a priority for school nurses in Selby and York NHS Trust. We believe our recent project to administer emergency contraception has already made an impact on the health and well-being of young people in the two schools involved in the pilot project.

The beginning
The project was initiated in response to research published by the NHS Centre for Reviews and Dissemination (1997), which highlighted the fact that school-based sex education could be effective in reducing teenage pregnancy when it was linked to contraceptive services.

Areas of the country that have a particularly high rate of pregnancy can secure extra funding through Health Action Zones (HAZ). Selby and York have pockets of high rates of unintended teenage pregnancy, but not significantly high enough to qualify for such funding. However, we did feel compelled to address the problem in areas of our city and town, which we identified as having specific difficulties.

In November 1999 all school nurses in the region were offered and received training in the issuing of emergency post-coital contraception in the form of levonorgestrel (Levonelle-2). This training was provided by the family planning department with no pressure to provide services in schools, but with the understanding that it would increase the knowledge level of school nurses at the very least and possibly initiate the introduction of emergency contraception at the most.

Part of my remit as school health nurse manager is to participate in the local teenage pregnancy steering group, which is a sub-group of the wider cross-government teenage pregnancy strategy set up by the Teenage Pregnancy Unit (TPU). This multiagency forum works towards a common goal and there are many examples of excellent ‘joined-up’ working between agencies within this arena. Joined-up working and thinking has been given high priority in government. Documents and is a continuing feature in policy development (Kiddy and Thurtle, 2002).

An example of this commitment to ‘work together’ towards a common goal was the decision made by school nurses and the teenage nurse adviser in York to pilot the provision of emergency contraception in two secondary schools. The remit of the teenage nurse adviser is specifically geared towards the sexual health needs of young people. We share a common vision that together we can ‘make a difference’ for this group.

Identification of pilot sites
The geographical spread of schools within our service includes many rural locations as well as inner city sites. The country schools suffer from a lack of adequate provision for young people and there is an unavoidable inequality of service.

One rural area was identified as having specific difficulties as far as sexual health needs were concerned and the head teacher of the school had already made it known that she would welcome increased input.

In addition to this we were aware that local family planning services had been withdrawn from this particular region, leaving a deficit of appropriate provision and meaning that young people would need to travel in to York city centre (approximately 15 miles away) to access young people’s services.

We also identified an inner city area of York that had a higher than average incidence of unintended teenage pregnancy. This area is served by two large secondary schools and the head teacher in one of these schools had already shown an interest in the provision of emergency contraception in her school.

We were aware of the limitations of our service as far as resources and staffing were concerned: we have had no increase in staffing in 11 years and have had to absorb an array of new initiatives into our existing
workload. We knew that if we commenced emergency contraception, we would not be given dedicated time, but would have to fit it in somehow.

Furthermore about 30 per cent of our workforce retired at this time and we had many new staff to induct who were untrained in emergency contraception. Only five of the school nurses that remained were trained in emergency contraception and there are 16 secondary schools. Therefore, although we received expressions of interest from three other schools, we decided to restrict our pilot study to two schools: one rural and one inner city.

Setting up the pilot study
A steering group was set up consisting of four school nurses along with the teenage nurse adviser. At the initial meeting we decided which other professionals should form part of our group and we subsequently invited members from family planning, community paediatrics and education.

Although these professionals attended meetings that were relevant, the frequency and duration of the meetings meant that it was impractical for everyone to attend them all. The original group of five, however, attended all the two-hour meetings that were held every two weeks for a six-month period.

One of the first aims of the project was to set a realistic start date and this was done with the aid of a Gantt chart – a display chart used for scheduling. We decided to commence the pilot study at the beginning of the new academic year and that it would run for a complete school year from September 2001 to July 2002.

As the meetings progressed we invited other parties to attend additional meetings if there were specific issues involving them. These extra meetings involved representatives from social services and the police. Parties invited to the regular meetings were: the consultant community paediatrician for school health services; the assistant director of education; the physician from family planning who took part in our training; the nurse manager of family planning; the directorate manager for the trust; the family planning manager for the primary care trust; and the local teenage pregnancy coordinator.

Invitations to our regular meetings were extended to participating schools, the directorate manager for children’s services and the planning manager for the local PCT. We obtained written commitment from the two participating schools at an early stage.

Before starting the pilot study, a considerable amount of time was taken up in steering group meetings discussing whether we would also issue condoms in the schools; this had not been our initial intention. The previous education secretary David Blunkett, as cited in Day (2000), expressed a concern that condoms should not be handed out in schools. However, we felt unable to justify issuing levonorgestrel after the ‘event’ without providing the method that would help to prevent conception and would also protect against STIs. With the participating schools’ consent and the approval of the school governors we provided this additional service.

Probably the largest oversight was our lack of awareness that other services may not wish to share with us their experiences of setting up a similar project. We had assumed that we would be able to gain access to information and help from other areas. With the exception of the Department of Community Health in Sheffield, we received disappointing responses from the four other services we approached who we knew to be carrying out similar projects. This was extremely disappointing and made us determined to offer advice and share our own experience at the end of our pilot.

When work got under way we were encouraged to find that we had been realistic in our timescale and the study began, as predicted, at the beginning of the autumn term after considerable consultation with head teachers, school governors, parents and partner organisations. The audit ran for the full year without any problems and provided us with useful information and encouraging results.

Audit findings
Initially, the huge difference in results at the two schools were staggering (see Fig 1). But the reasons behind the difference were easily identified.

![Figure 1: Rural and inner city teenage pupils’ uptake of contraceptives/advice](image-url)

**Fig. 1.** Rural and inner city teenage pupils’ uptake of contraceptives/advice.
The coeducational rural school, with 1300 pupils, had no specific family planning service and certainly no ‘young person specific’ service. Unless a trip in to York was made, contraception could only be obtained via the GP. The coeducational city school, comprising 853 pupils, was already well provided for in terms of young people’s services within the family planning structure. These services included:

- A health centre approximately a quarter of a mile away from the school itself, which provides a specific service for youngsters two days a week after school;
- An after-school service in the city centre (daily and on Saturday afternoons), which provides advice on sexual health in addition to contraceptive services.

It was immediately obvious that there was an inequality of health service provision within these two communities. However, although the provision of services appeared to be excellent for city children they were not ideal. The questionnaires completed by the youngsters using our service illustrated a reluctance to use the ‘local’ health centre because of the lack of anonymity – family and friends might also be visiting the health centre at the same time and realise why the young person was there.

Why is there a staggering difference in teenagers seeking advice and requesting condoms in the two schools? There is no doubt in our minds that the reason for this is the provision of communication, through sex education lessons, provided in part by the school nurse and teenage nurse adviser in the rural school, which already had an excellent programme in progress. The rural school had the following provision:

- Sex education lessons provided by a teacher in conjunction with the school nurse and the teenage nurse adviser;
- Weekly drop-in sessions with the school nurse;
- Weekly emergency contraception sessions with the school nurse and the teenage nurse adviser.

This kind of service run by school nurses where sex education is linked with contraceptive services has already been identified through research as being effective in reducing teenage pregnancy (Office for Standards in Education, 2002; Social Exclusion Unit, 1999; NHS Centre for Reviews and Dissemination, 1997).

The city school, which would normally have had similar in-school services to the rural school, had suffered during the time span of our project as they had a vacancy for the position of head of personal and social health education (PSHE). This meant that no sex education lessons had taken place during the year. The school nurse would normally make a considerable contribution towards these lessons but a term after the commencement of the audit she retired. Her subsequent replacement had an induction period of six months, which meant that apart from the actual provision of emergency contraception in school, which I provided, no other support service was available.

This demonstrates the role the school nurse has to play in addressing the sexual health needs of youngsters through the PSHE programme. Although the official pilot study is complete, the new academic year has shown a massive change. For example, we can see that now the full quota of staff are in post, with the new school nurse presenting weekly drop-in sessions and presenting regular sex education lessons, the two schools are providing a similar service.

If we were to present another audit, where both schools have their full compliment of staff with equal provision, we would see that the inner city school has an increase in the amount of young people attending for condoms. This tells us that sex education does work because during the period that the inner city school did not have a school nurse, very few youngsters attended for advice and condom provision.

This reinforces and endorses what the NHS Centre for Reviews and Dissemination is saying – that the provision of sex education in conjunction with one-to-one drop in services by a school nurse really works. The new school nurse is participating in sex education lessons, a drop-in service has been re-established and the demand for condoms in the city school is fast approaching the level of demand in the rural school, already reported on.

**Conclusion**

School nurses in Selby and York along with the teenage nurse adviser feel that the project has had considerable benefits for young people and has been a highly successful process. This has led to the implementation of an emergency contraception service in a further two sites in our area. The original pilot sites have expressed a wish that we should continue to deliver the service on a permanent basis and we are now able to operate across four permanent sites. Other schools have expressed interest but we are not able to respond until there is an assurance of more funding for school nurses.

Evaluation in terms of reducing unintended teen pregnancy is extremely difficult to measure as local statistics are shown by ward category rather than by school. However, we have confirmation from the teenage pregnancy coordinator for York and North Yorkshire that there has been a slight but significant decrease in teenage pregnancy in both areas. Furthermore, one school has confirmed that they have been unaware of any pregnancy during the last academic year, which could not be said about the previous year.

Success invariably brings with it extra work and an increased demand for service provision. This is a definite limitation and must be carefully considered. Until the government recognises the expertise and potential provided by the school nursing service and rewards the service accordingly with increased funding, our talents will remain restricted and not fully realised.

Though the main discussion has addressed unintended teenage pregnancy, the story for us is far from over. York has been successful in acquiring considerable funding for a chlamydia pilot and, again not far from the front-line, school nurses in York are working with the teenage nurse adviser in preparing to set up chlamydia testing in a local secondary school. We are in the very early stages of