

**RESEARCH REVIEW**  
**TEENAGE PREGNANCY**

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## Introduction

Since the 1980s teenage pregnancy has been an issue of often intense public and media interest. Negative characterisations of young mothers have been dominant in the media (Griffin, 1993) and this has helped shape public perceptions (Kelly, 2000; Holgate and Evans, 2006). Kelly (2000) has argued that teenage mothers have served as scapegoats for negative social trends (such as poverty), and are often stereotyped as irresponsible or neglectful mothers. There is a tendency to place the blame for pregnancy and childbirth on the teenage mother, rather than the father, suggesting that there is greater cultural acceptability for young men to assert their masculinity in casual intercourse (Thornberry, Smith and Howard, 1997; Carpenter, 1998; Shields and Pierce, 2006).

For Shields and Pierce (2006), the intense interest in teenage pregnancy stems from its connection to a number of controversial issues in UK society, including the control of fertility, cultural and social attitudes towards sex, whether sex education should take place in private within families or in public within schools, socio-economic inequalities, religious objections to pre-marital sex, the cost to the state of teenage pregnancy and parenthood, the abortion debate, discussions around the quality of parenting, and the different parenting roles of mothers and fathers.

This research review considers these issues, alongside the trends and rates in teenage pregnancy in England and government interventions to reduce the rate of teenage pregnancy in this country.

## Definitions

Conceptions are defined as pregnancies which result in one or more live or still births or a legal abortion under the Abortion Act 1967. What constitutes a teenager is very variable: the following explanation is taken from a joint publication from the Department for Children, Schools and Families (DCSF) and the Department of Health (DH).

*'Teenager' is used variously to mean young people under 18, under 19, and under 20 in different contexts. For the Teenage Pregnancy Strategy, the key group is the under 18s, whose conception rates and outcomes the strategy primarily addresses. The Every Child Matters programme covers young people from 'birth to age 19'. For the measurement of national breastfeeding and smoking rates, the Infant Feeding Survey uses the under 20s as its youngest age group. Studies of outcomes for teenagers and their children sometimes use under 18s and sometimes under 20s. Maternity services for teenagers use various age cut offs depending on local needs and resources. Some specialist maternity services are available to all young women under a particular age (such as 18 or 19), while others are targeted at the youngest age group but are available to older teenagers if there are other indications of special need. (DCSF and DH, 2008a)*

## The Policy Context

In June 1999 the government produced a national teenage pregnancy strategy which had two goals:

- To halve the rate of conceptions among those under 18 years old in England by 2010 and set a firmly established downward trend in the conception rates for under-16s by 2010
- To achieve a reduction in the risk of long-term social exclusion for teenage parents and their children.

The drive to reduce the number of teenage conceptions in this country stemmed from several factors: concerns about the health, relationships, education and employment (and, therefore, income levels) of those who do become young parents and about the poor outcomes for their children (Social Exclusion Unit, 1999; DH, 2007); the costs to the state of supporting single young mothers (Teenage Pregnancy Strategy Evaluation Team, 2005); and the fact that the UK rate has consistently been far higher than that in similar developed countries in Europe – more than twice the equivalent rate in Germany or France in 2004, and about four times the rate in the Netherlands and Switzerland (Healthcare Commission, 2007).

*Every Child Matters* (ECM), a Green Paper on Children published by the then Department for Education and Skills (DfES) set out the government's vision for children and young people against five outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution and enjoying economic well being (DfES, 2003). The teenage pregnancy strategy is cited as a key policy area to contribute to these outcomes. *Every Child Matters: Next Steps* (DfES, 2004a) set out how the Change for Children agenda will take forward these reforms and this was enshrined in legislation by the Children Act 2004. The teenage pregnancy strategy contributes to all of the ECM five outcomes: the 'being healthy' outcome includes a reduction in the under-18 conception rate as a specific target. Other relevant outcome measures include reducing the infant mortality rate and the proportion of 16 to 19 year-olds not in education, employment or training.

All local authorities have a teenage pregnancy coordinators to consult on effective interventions and as a contact point for the Teenage Pregnancy Unit based in DCSF. Each authority has a 10-year strategy in place, with local under-18 conception rate reduction targets of between 40% and 60%. The *Every Child Matters: Change for Children Agenda* (DfES, 2004b) required local authorities to draw up a Children and Young People's Plan by 2006 to meet the five ECM outcomes, with the local teenage pregnancy strategy being an integral part of that plan by 2008. Funding for the implementation of local strategies continued, but was no longer ring-fenced within a specific Local Implementation Grant. Under the Youth Public Service Agreement, reducing teenage conception rate is now part of Local Area Agreement (LAA) targets for councils, and 106 out of 150 councils have chosen this as a priority. In addition, the Department of Health has made reducing teenage conceptions a Tier 2 Vital Signs indicator (NHS national priority for local action).

Two national, government-funded media campaigns support the teenage pregnancy strategy. The first, 'RU Thinking', is aimed at younger teenagers and promotes

delaying sex and avoiding peer pressure. The second, 'Want Respect? Use a Condom' promotes the use of condoms and is aimed at sexually active young people. Additionally, the Parentline Plus initiative 'Time to Talk' provides support for parents to talk to their children about sex and relationships.

## **Teenage Conception, Abortion and Birth Rates in England**

The latest (provisional) figures show that in 2007 the conception rate for young women under 18 in England was 41.7 per 1,000 young women in that age group (40,298 conceptions). This represents a reduction since 1998, the baseline year for the teenage pregnancy strategy, when there were 41,089 under-18 conceptions, a rate of 46.6 per 1,000. However, the change in the rate between 1998 and 2007 currently stands at 10.7%, reinforcing doubts as to whether the 2010 target of a 50% reduction will be met (TPIAG 2008). Moreover, the 2007 rate shows an increase from that of 2006 when it was 40.6 per thousand under-18s. (Office for National Statistics and Teenage Pregnancy Unit, 2009).

Despite the high media focus on very young mothers, statistically only a small minority of teenagers become pregnant before they reach 16: in 2005 only 6% of all teenage conceptions were to girls aged 16 or under (DCSF and DH, 2007).

In 2007, the under-16 conception rate for England was 8.3 per 1,000 girls aged 13-15 (7,715 conceptions). This is 6.4% lower than the teenage pregnancy strategy's 1998 baseline rate of 8.8 conceptions per 1,000 girls in this age group. However, it, too, marks an increase on the 2006 figures when 7,330 young women in that age group became pregnant, a rate of 7.7 per 1,000 (Office for National Statistics and Teenage Pregnancy Unit, 2009).

Overall there has been a 23.3% decline in teenage births since 1998. The discrepancy between this rate of reduction and that of teenage conceptions is linked to the increasing number of abortions. In 2007, 50.6% of conceptions to under-18s were terminated by abortion, compared with 42.4% in 1998. The comparable figures for under-16s show an increase from 52.9% in 1998 to 61.9% in 2007 (ibid).

Teenage fathers remain a somewhat 'invisible' group (Thornberry, Smith and Howard 1997), in part because their details are not always included on the birth registration. In 2006, 13,443 births in England and Wales were registered to men under 20 years of age. Of these, 602 were married, of whom 283 (47%) had wives also aged under 20. The remaining 12,841 births to fathers under 20 were jointly registered by unmarried parents: in 9,810 of these cases (76%) the mother was also under 20 (Office for National Statistics, 2008). According to data from the Teenage Pregnancy Unit, only a quarter of fathers of babies born to teenage mothers in 2005 were aged under 20 (DCSF and DH, 2007).

### **Regional differences in rates**

In some areas of England the rate of under-18 conceptions is considerably higher than the national average. These are predominantly seaside and rural areas (Bell et al., 2004) and deprived local authorities (Uren, Sheers and Dattani, 2007). In 2007,

13 of the 32 inner and outer London boroughs had rates above the national average (Office for National Statistics and Teenage Pregnancy Unit, 2009).

Moreover, the inner London boroughs with the highest rates showed the lowest percentage reduction from 1998. In Haringey, for example, there has been a 12.3% *increase* in conception rates among under 18s since 1998, with the 2007 rate standing at 70, itself a rise from 62.3 in 1998 (Office for National Statistics and Teenage Pregnancy Unit, 2009). Conversely, Kensington and Chelsea which shows a high percentage decrease since 1998 (29.3%) has had a consistently much lower rate of conceptions than other boroughs (currently 29.5 per 1,000 under-18s).

Deprived local authorities also have larger proportions of conceptions leading to births than do more affluent areas (Uren, Sheers and Dattani, 2007). The rate of births to under-18s in the 10% most deprived wards is nine times higher than that in the 10% least deprived (DCSF and DH, 2007). Higher abortion rates are typically found in the more affluent areas (which usually have lower conception rates). Richmond, Greater London, for instance, had a teenage pregnancy rate of 15.7 per 1,000 under-18s in 2007, yet 67% of conceptions were terminated by abortion. This contrasts with Blackpool where the conception rate was 60.9 per 1,000 and 32% of conceptions ended in abortion (Office for National Statistics and Teenage Pregnancy Unit, 2009).

The government guidance for local authorities (LAs) and primary care trusts (PCTs) (DfES, 2006a) highlighted the wide variation between areas in making progress towards the government targets. Based on reviews of action on teenage pregnancy in local areas, the guidance pointed to the ingredients of success: engagement of delivery partners; selection of a senior champion responsible for and leading on the local strategy; effective sexual health advice service; prioritisation of sex and relationships education (SRE); a focus on interventions targeted at the young people at greatest risk of pregnancy, especially those who are looked after; training on SRE for partner organisations working with the most vulnerable young people; and a well-resourced youth service providing places to go and things to do for young people.

Further guidance produced in September 2006 (DfES, 2006b) on accelerating delivery of the teenage pregnancy strategy set out how the government will focus support on areas with high and increasing rates. Provision of contraceptive and sexual health services which are focused on and trusted by young people and are well known by professionals working with them was highlighted as having the greatest impact on conception rate reductions in areas with high rates.

All areas were expected to implement the measures designated as successful in reducing teenage pregnancy rates. Nevertheless in 2008, the Department of Health pointed out that some LAs and PCTs needed to improve performance as they were not on a trajectory to meet their planned contributions to reducing under-18 conceptions by 50% by 2010 (Department of Health, 2008).

## **Factors Influencing Teenage Pregnancy**

Ulvedal and Feeg (1983) pointed to the fact that young women who become pregnant are products of their own natural family configuration and that dysfunctional

or broken homes were a recurring theme in the research. Landy and Walsh (1988), in a study of teenage pregnancy and parenthood in Canada, suggested that there were three major types of explanation for young motherhood: 1) lack of information about contraception and knowledge of its availability to teenagers; 2) socio-cultural factors such as poverty and cultural acceptance; and 3) psychological and psychodynamic perspectives. Coleman and Dennison (1998) pointed out that young women who become pregnant are often the less able and less motivated students.

The government identified education-related factors (such as low education attainment, no qualifications and disengagement from school), background and family circumstances, including being looked after (in the care of a local authority), belonging to a particular ethnic group, being the daughter of a teenage mother or of a mother who has low educational aspirations for her children (DfES, 2006b; NICE, 2007). The validity of the government's stated risk factors was recently supported in an independent longitudinal study (Allen et al., 2007).

A recent systematic review of research across Europe found the following factors were most consistently associated with teenage pregnancy: socio-economic disadvantage; disrupted family structure; low educational level; and low aspirations (Imamura et al., 2007). Further associations included poor access to services, diverse risk-taking behaviours (such as experimenting with alcohol, smoking and drugs) and low sexual health knowledge, though the independent effects of these factors was less conclusive.

Socio-economic deprivation, intergenerational poverty transfer and social exclusion have been most consistently and widely associated with teenage pregnancy and parenthood (Hobcraft and Kiernan, 1999; Social Exclusion Unit, 1999; McLeod, 2001; Kemp et al., 2004; Austerbery et al., 2005; Mayhew and Bradshaw, 2005; Cabinet Office, 2006; DCSF and DH, 2007; Uren, Sheers and Dattani, 2007; Chen et al., 2007). Poverty has to be seen within the overall dynamic of lack of opportunity, inappropriate role models and a lack of a sense of a future among disadvantaged young people, where young women feel (whether consciously or unconsciously) that they lack options and choices in shaping their lives (Holgate and Evans, 2006). Sure Start Plus was initiated in 2001 with the aim of reducing the long-term social exclusion associated with teenage pregnancy (Wiggins et al., 2005).

Disaffection and low expectations/ambition among young women from deprived backgrounds are now widely accepted as key determinants of teenage pregnancy (Fletcher et al., 2008). According to research carried out jointly by the universities of Bristol and Newcastle, less than half the pregnant young women and mothers interviewed said they were attending school regularly at the time they conceived (Hosie et al., 2005). Negative experiences of education, a dislike of school, poor attendance and low attainment are increasingly being highlighted as significant risk factors in teenage pregnancy (Austerbery et al., 2005; Bonnel et al., 2005; Dawson, 2006). These factors, combined with low self-confidence and self-esteem (Emler, 2001), mean that many teenage mothers are ambivalent and unsure about their future direction in life and find it hard to compete in the labour market. Becoming a mother, therefore, might be an option to fill the void (Hallam and Creech, 2007).

There is a particularly high risk of teenage pregnancy among looked after children, where the main risk factors linked to young child-bearing, such as socio-economic deprivation, limited involvement in education, limited access to positive consistent adult support, being a child of a teenage mother, low self-esteem and experience of sexual abuse are found at significantly higher levels (Corlyon and McGuire, 1997; Jackson and Sachdev, 2001; Hayden, 2003; Mackie and Patel-Kanwal, 2003; SCIE, 2005). According to one study, a quarter of children who had been in care were parents by the age of 20 (Barn, Andrew, and Mantovani 2005).

Additionally, a number of surveys have identified teenagers' low levels of knowledge about using contraception and accessing sexual health services as risk factors (Graham, Green, Glasier, 1998; Brook, 2005; Reeves et al., 2006).

Little attention has been paid to identifying the risk factors that increase the likelihood of becoming a teenage father, but they encompass socio-economic deprivation, low educational performance, early sexual activity and drug use (Thornberry, Smith and Howard, 1997).

## **Teenage Parenthood: Causes for Concern**

Research points to the social exclusion and poor health outcomes for both the mother and child associated with early parenthood.

- Teenage mothers are likely to experience tension and conflict in their relationships with partners and with families (Vary, 2001; The Prince's Trust, 2001) and are very unlikely to be living with a partner by the time they reach their 30s and 40s (Ermisch, 2003).
- They have negative attitudes towards school and low educational aspirations (Russell, 1994) and a very low rate (30%) of participation in education, employment or training beyond compulsory school-leaving age (DWP, 2006). They are reportedly deterred by the reluctance of many mainstream schools to reintegrate them, the impact of peer pressure (Dawson, 2006) and a lack of child-care options (Dawson, 1997). Though many report an intention to resume their education when the child is older (Corlyon and McGuire, 1999), they often do not achieve the necessary qualifications for further education and frequently struggle in the increasingly high-skill labour market (DCSF and DH, 2007).
- Teenage childbearing reduces employment experience by up to three years and generates an adult pay differential ranging from 5% to 22% (Chevalier and Viitanen, 2001) though a contrary view is that although they are less likely than older mothers to be employed later in life, their pay is not affected if they are (Ermisch, 2003).
- Low income means that teenage mothers are unlikely to become homeowners in later life and likely to remain dissatisfied with their neighbourhood (Ermisch, 2003; Wellings et al., 2001; Berrington et al., 2007).
- Overall, they are more likely than older mothers to perceive themselves as being in poor health (Wellings et al., 1996).
- Irreconcilable tensions between being a parent and being a teenager cause pressure on the mental health and well-being of young mothers, with the result that they are much more likely than older mothers to develop post-natal

depression which can continue throughout the first three years of the child's life (Ermisch, 2003; Liao, 2003; Berthoud et al. 2004). This can have an adverse effect on attachment to the baby and on parenting ability (Martins and Gaffen, 2002).

- There is an increased likelihood of their children growing up in lone-parent families, living in poverty, poor housing and suffering from poor nutrition (Social Exclusion Unit, 1999; Mayhew and Bradshaw, 2005).
- Babies of teenage mothers are more likely to be born pre-term, with a 25% higher risk of low birth weight (Botting et al., 1998), which may be linked to smoking and poor nutrition throughout pregnancy (Bolling, 2005).
- They are less likely than the children of older mothers to be breastfed (Hamlyn et al, 2002; Stanner, 2001).
- In the first year of life they are at increased risk of mortality from sudden infant deaths, accidents and injuries (Corcoran, 1998; Department of Health 2007a) and by the time they are five years of age, children born to teenage mothers are more likely to have reduced educational attainment, more emotional and behavioural problems, be at increased risk of maltreatment or harm and to have experienced higher rates of illness, accidents and injuries than those born to older mothers (Moffitt et al, 2002).
- Coping problems are more common among teenage mothers than older parents (Meadows and Dawson, 1999) and anxiety and depression might lead to high A&E admissions for their children (Berrington et al., 2007). They also have less knowledge of child development than their adult counterparts and display more punitive parental attitudes, which can contribute to their children's reported reduced verbal interaction (Koniak-Griffen et al., 2000)

In the relationship between poverty and early parenthood, causality appears to run in both directions. A central question in recent research has been whether the poor outcomes are specifically caused by the mother's age or whether they are due to other factors such as deprivation and low post-16 participation in education, employment or training. Researchers at the Institute of Education have argued that it is social exclusion, not teenage pregnancy, that is the main reason for poor outcomes (Austerbery et al., 2005), while others have stated that the age of the mother is a major contributing factor (Chen et al., 2007; Berrington et al., 2007). A further explanatory factor for poor maternal health outcomes is that pregnant teenagers and their partners are less likely than older people to access maternity care early in pregnancy and are less likely to keep appointments for antenatal care (DCSF and DH, 2008a).

## **Gender Relations and Cultural Attitudes**

### **Gender relations**

The issue of teenage pregnancy is strongly connected to gender relations and the different behaviours of young women and men. In a recent review of the academic evidence by Brook (2007), young men were found to be more blasé about the importance of sexual health services than women and less aware of these services, frequently relying on their female partners to find out about them (Pearson, 2003). These attitudes link with cultural behaviours among young men with regard to sexual activity: within a male peer group there is more focus on being seen as sexually

competent and active, which can lead to attitudes of disregard and indifference towards sexual health (Frosh, Pattman and Phoenix, 2002). However, in many cases teenage boys can exaggerate attitudes of sexual risk-taking which can be used to cover up anxieties during adolescence about 'appropriate' masculine behaviour and may not necessarily transmit in practice during relationships with young women (Wight, 1996; O'Donnell and Sharp, 2000).

Research points to different societal expectations of young women and men with regard to the acceptability of early sexual activity. Parents who called a UK help-line with anxieties about their children's sexual behaviour were almost twice as likely to be concerned about their daughters than their sons (Parentline Plus, 2008). In a qualitative study of teenage sexual behaviour in rural and seaside locations, it was found that young men were expected to become sexually active early while young women were commonly denigrated if they did so (Bell, et al., 2004). The young women were reluctant to appear willing to participate in sexual activity because of the opprobrium of doing so, and there was, therefore, a lack of contraceptive planning. In studies among BME adolescents, it has been found that greater religious and familial expectations are placed on young women not to have sex than on young men from similar backgrounds (Curtis et al., 2005; French et al., 2006).

## **Cultural attitudes**

There has been a change in social attitudes since the 1970s in relation to the acceptability of 'early motherhood' and, notwithstanding current anxieties, the rates of teenage pregnancy were higher 30 years ago (Corlyon and McGuire, 1997). In 1961 the average age of marriage was 23 (Office for National Statistics, 2000) and early motherhood, provided it was within marriage, was more culturally acceptable than now (though totally unacceptable outside marriage). In current times young childbearing, even within marriage, is perceived in a more disadvantageous light (Shields and Pierce, 2006). As young people are staying in education longer and deferring their progression to economic independence, the duration of adolescence is extending (Morrow and Richards, 1996; UNICEF, 2001; Holgate and Evans, 2006).

Scandinavian countries (where teenage pregnancy rates are low) have a more open and realistic attitude towards teenage sex than the UK and the US (where rates are high) and comprehensive strategies on contraception for teenagers have been in place since the 1970s (Lewis and Knijn, 2003). Additionally, higher levels of state funding in areas such as higher education mean that there are greater incentives and options for young females to delay child-bearing (Dagurre and Nativel, 2006).

## **Ethnicity**

Cultural factors such as the role of religion, parental attitudes and beliefs, and peer-group adherence and norms are strong influences on young people (French et al., 2006). 'Connectedness' to their parents' traditional culture and frequent religious observance reduce the likelihood of early sexual activity among all ethnic groups (Curtis et al., 2005).

According to a study by the University of Sheffield, a high value was placed on motherhood and child-bearing among many BME communities, particularly those from Muslim backgrounds where early parenthood within marriage is not stigmatised

or viewed negatively (Higginbottom et al., 2006). Teenage conception rates were found to be higher amongst Bangladeshi young women than in the general population, as it was not uncommon for women to marry early. However, pregnancy outside marriage is strongly opposed and this compels many young people to marry (French et al., 2006). In contrast, unmarried parenthood was more acceptable in Jamaican communities where there were more liberal attitudes towards sex. However, there was concern that a lack of male role models negatively affected young Jamaican men's attitude to sex and relationships (ibid). Nevertheless, while black Caribbean young men were found in one study to be more likely to be sexually active than white British young men, condom use among black Caribbean and black British young men was higher than among young white males (Curtis et al., 2005).

Across these studies there was marked variation about early sexual activity not only *between* but also *within* ethnic and religious groups. Generalisations about minority populations are frequently problematic: for example, some Muslim women were sexually active before marriage and some young Caribbean men were not (Higginbottom et al., 2006; Curtis et al., 2005). The shifting dynamics of cultural attitudes within ethnic groups and differences in sexual behaviour between generations also play a part. Younger generations across ethnicities were frequently more relaxed about sexual relations than their parents. Correspondingly, many parents from BME communities felt ill-equipped to adapt to this changing context and to engage directly with their children on sexual health topics. They employed strategies such as maintaining strong religious beliefs and focusing on education and social advancement as a means of discouraging their children from early sexual activity (French et al., 2006).

## Contraception

A study by the University of Southampton and Brook found that only a third of sexually active young people used condoms consistently and there were significant gaps in knowledge about sexual health and alternative contraceptive methods (Ingham et al., 2005). In a study which surveyed 2,000 young people in East London, 48% of young women and 43% of young men reported having unprotected sex on at least one occasion (Curtis et al., 2005). In the evaluation of the teenage pregnancy strategy, the proportion of young people having unprotected sex increased between 2001 and 2004 (Teenage Pregnancy Strategy Evaluation Team, 2005). In a study of contraceptive use among young teenagers (13 to 16 years old), 26% were sexually experienced but 45% did not use contraception (Wallace et al., 2007).

According to the British Pregnancy Advisory Service, 45% of young women under 17 requesting abortion said they had not used any contraception at the time they conceived (BPAS, 1999). Conceptions to 16 and 17 year-olds account for around 80% of all conceptions to under-18s. This age-group, therefore, is defined by the government as being most in need of effective contraception to avoid unintended pregnancy (Department of Health, 2008). Moreover, around 20% of under-18 conceptions are to young women who already have a child and many of these pregnancies are unplanned (Department for Children, Schools and Families and Department of Health, 2007; DCSF and DH, 2008a). Part of the remit of specialist midwifery posts, clinics and classes which have been established for young parents

is to provide effective support to prevent second unplanned pregnancies (DCSF and DH, 2008b).

Studies have suggested that Long Acting Reversible Contraception (LARC) methods of contraception should be made more widely available to young women (FFPRHC, 2004; Curtis et al., 2005). A guideline from the National Institute for Clinical Excellence (NICE) suggested that LARC was particularly suitable for women with learning or physical disabilities, and under-16s. The guidance also pointed to the potential £100million a year saving to the NHS by reducing unplanned pregnancies by 73,000 a year if only 7% of women switched from the contraceptive pill to LARC (NICE, 2005).

In February 2008, £26.8million new government funding for 2008/09 was awarded from the Comprehensive Spending Review to improve young people's access to contraception and help reduce the number of teenage pregnancies. Local health teams were awarded extra money to work with women of all ages to promote the full range of methods of contraception including LARCs. £14million was allocated by the Department of Health to Strategic Health Authorities for innovative new ways of helping young people get access to sexual health advice and contraception. Funding priority was for areas showing high and increasing rates of conceptions and/or high abortion and repeat abortion rates. In addition, £500,000 was invested nationally to develop a campaign between the Department of Health and the Teenage Pregnancy Unit to highlight contraceptive choices available to young women.

## **Decisions about Teenage Pregnancy**

Research on whether or not young women become pregnant intentionally or by accident highlights the ambiguity and uncertainty of decision-making processes. A study by Cater and Coleman (2006) found that most 'planned' or 'intentional' pregnancies were not directly related to the desire for a child, but rather to young people's background. Those with an unsettled background, living in poor neighbourhoods with limited employment or training opportunities, saw parenthood as a means of changing direction and giving meaning to their lives (ibid). The majority of young women saw motherhood as providing them with a purpose, a sense of satisfaction and an opportunity to create a loving family, frequently in compensation for their own negative childhood experiences. Parenthood was also seen as a means of avoiding continued family disruption and unhappiness and giving their life value (Ibid; Austerbery et al., 2005).

In a study by Bender (2008), the decision-making process among young women about whether to terminate the pregnancy or carry the baby to term was characterised by uncertainty. It was a highly emotive issue and often the individuals did not clearly explore the costs and benefits of all options, with final decisions being most closely tied to family influences and background. Brady et al. (2006), albeit in a study with only a small sample, found that the most pertinent influence on a pregnant young woman's decision-making was her relationship with her parents, who commonly became actively involved in the decision but whose attempts to impress upon the young woman the responsibilities involved in parenthood might be viewed as coercive.

A study carried out in a deprived area in the north of England found that anti-abortion views were quite prevalent and that many teenage girls continued with unplanned pregnancies because their families and local community were opposed to abortion (Tabberer et al., 2000). Lack of impartial information and advice and the fact that many local girls chose to have their babies were found to be important factors when teenagers decided to carry the baby to term. A study carried out in the south-west of England, compared the attitudes towards abortion and teenage pregnancy of advantaged and disadvantaged young women aged 16 to 20 (Jewell, Tacchi and Donovan, 2000). Although they recognized that it would not be an easy choice, all of the advantaged group said they would be likely to opt for an abortion if they became pregnant in their teens. They put much greater emphasis on the importance of career, university, money and personal development than the disadvantaged women did. Consequently they felt that the best age for starting a family was in their late twenties or early thirties, whereas the disadvantaged women thought it was between 17 and 25 years.

A recent exploration of young women under 20 who presented for abortion in England and Wales found that those with recorded previous pregnancies have steadily risen from 1991 to 2007. The increase in the proportion of abortions which followed a previous birth was by 42%, and the increase in the proportion following a previous abortion was by 68% (Collier, 2009).

## **Preventing Teenage Pregnancy**

The evaluation of the teenage pregnancy strategy recommended that future efforts should be directed at tackling the underlying socio-economic determinants of teenage pregnancy, with even greater focus on interventions that selectively target young people from poorer backgrounds (Teenage Pregnancy Strategy Evaluation Team, 2005).

In the review of the teenage pregnancy strategy in 2006 (DfES 2006a), attention was turned to focusing on interventions aimed at young people at greatest risk, increasing resources in youth services, making sexual health services more 'young people friendly', and promoting multi-agency working across children's trusts and services (DfES 2006b; DCSF and DH, 2007; DH, 2007b).

## **Sex education**

Studies have concluded that school-based sex and relationships education (SRE) can delay sexual activity and reduce pregnancy rates, particularly when it is linked to contraceptive services (Dickson et al., 1997; Swann et al., 2003). However, the variable quality of school SRE in the UK has been highlighted, and the UK Youth Parliament, Ofsted and the Teenage Pregnancy Independent Advisory Group (TPIAG) have all called for SRE to be made a statutory subject in all schools (TPIAG & IAGSH, 2006; UK Youth Parliament, 2007; Ofsted, 2007; TPIAG, 2008).

A report by Ofsted (2007), detailed that teaching of Personal, Social and Health Education (PSHE which includes SRE) is inconsistent across schools: it does not sufficiently address young people's needs, is not allocated sufficient lesson time and is frequently taught by non-specialists, resulting in low-quality teaching. The

importance of improving SRE education as a source of learning about sex for young people was also confirmed in the evaluation of the teenage pregnancy strategy which recommended making high quality PSHE mandatory in the national curriculum (Teenage Pregnancy Strategy Evaluation Team, 2005). Furthermore, the UK Youth Parliament's survey of nearly 22,000 young people on SRE provision found that just under half the sample had not received any teaching on teenage pregnancy and 55% of girls had not been taught how to use a condom effectively (UK Youth Parliament, 2007). The Teenage Pregnancy Independent Advisory Group (TPIAG), an advisory non-departmental public body set up in 2000 to advise the government on the Teenage Pregnancy Strategy and to monitor its implementation has played a strong role in repeatedly calling for SRE to be made statutory in schools (TPIAG, 2008).

In Wales, sex and relationship education is already part of the curriculum and it is a legal requirement in Northern Ireland. In England (and Scotland) there has been no legal requirement to teach SRE in schools. The Healthy Schools Programme ([www.healthyschools.gov.uk](http://www.healthyschools.gov.uk)) is the main vehicle for establishing SRE and health advice services in schools. However, in October 2008 the government announced that, subsequent to a review on the nature of provision, a new PSHE curriculum, expected by 2010, will include compulsory sex and relationships education for pupils aged five to 16.

There are significant religious objections from a number of sources around pre-marital sex and contraception use, with claims that any teaching of SRE increases sexual activity in young people (National Children's Bureau, 2004). Discussions with teenagers about contraception become very difficult if sex is seen as unmentionable and forbidden, and this is a major drawback of the abstinence-based SRE programmes which have been encouraged in the US since the mid-1990s (Daguerre and Nativel, 2006). In these models, abstinence is presented as the sole choice for young people, and information on other options is limited or absent (Santelli et al., 2006). However, there is no evidence that abstinence-only education either reduces teenage pregnancy or improves sexual health, or that teaching about contraception leads to increased sexual activity (Swann et al., 2003). Rather, research suggests that by withholding information about contraception in abstinence-only models, young people are placed at higher risk of pregnancy and (Jemmot, Jemmot and Fong, 1999; Bearman, 2001; Dailard, 2002).

According to some researchers, the government's reluctance to make SRE compulsory connects to wider social debates around the role of the school compared to the family. Shields and Pierce (2006) put forward the view that many families strongly believe sex education to be a private matter for parents which should take place at home rather than in the public sphere. A report from Ofsted (2007), points out that parents can play a significant role in advising and supporting their children, but some young people cannot get the support they would like from their parents and schools have a key responsibility with regard to sex education. A number of research studies have indicated that, in practice, young people find it difficult to talk to their parents about sex and that many parents themselves feel reluctant or ill-equipped to discuss sexual health with their children (Curtis et al., 2005; French et al., 2006; Parentline Plus, 2008; Turnbull, Wersch and Schaik., 2008).

In a study by a UK telephone support service for parents, very few parents were able to discuss sex and relationships frankly with their children (Parentline Plus, 2008). The evaluation of the fpa's Speakeasy programme – a community-based educational programme to support and encourage parents to communicate with their children about sex, sexual health, and relationships – showed that parents particularly valued the increased confidence and lack of embarrassment in talking about sex which they had gained from the course (Ramm et al., 2007).

## **Access to services**

Providing young people with access to appropriate sexual health and contraceptive services is one of the current priorities in the government's drive to reduce teenage conceptions: since the launch of the teenage pregnancy strategy in 1999, the government has released a range of guidance on access to sexual health advice for school staff (DfES , 2004c) and social workers and social care practitioners (DfES, 2006c). Following the publication of the 2007 conception figures in 2009 (Office for National Statistics and Teenage Pregnancy Unit, 2009) the government undertook to provide an additional £20.5million in funding for schemes to help teenagers get better access to contraception and information on the risks of unprotected sex. Of this, £7million is for new media campaign to raise awareness of different contraceptive options; £10million for local health services to ensure contraception is available in the right places and at the right time; £1million to support further education colleges to develop and expand on-site contraception and sexual health services; and £2.5million to develop a healthy college programme.

Studies have highlighted that opening times of sexual health services often do not match young people's availability and school commitments (Bell et al., 2004; French et al., 2006 ). There is also local and regional variation in the distribution of in-school sexual health services – in London only 11.4% of schools have on-site services whereas in the South West this rises to 40.2% (Dawson, 2006; Emerson, 2008). Young people in rural locations have found it more difficult to access advice on contraception and sex, due to the limited range of professionals in the local area and the fact that they are often known to their families (Bell et al., 2004). Young men appear to have considerably less contact with services, including sexual health services than young women (Office for National Statistics 2006), and are not well-informed about where to go for sexual health advice (Duncan, 2002; Sahili et al., 2002).

Confidentiality appears to be particularly important for young people accessing sexual health services (Brook, 2005), and some respondents to this survey were not clear whether health professionals could tell others (including family members) about their visits. This is also reflected in the evaluation of the teenage pregnancy strategy (Teenage Pregnancy Strategy Evaluation Team, 2005) which found that a third of under-16s did not realise they could obtain contraception without their parents' knowledge.

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