# Why the Government's Teenage Pregnancy Strategy is destined to fail

**FAMILY EDUCATION TRUST**

# Contents

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# Teenage pregnancy in Britain

England has the highest teenage pregnancy rate in Western Europe. This alarming statistic has entered the national consciousness. Politicians and commentators frequently remind us of it. In spite of some reservations about the use of statistics in international comparisons (see box below), the claim is probably true.

In June 1999 the government's Social Exclusion Unit (SEU) presented to parliament its report on teenage pregnancy.[1] It acknowledged the seriousness of the situation, in terms of damage to the educational and career prospects of the mothers and the health of their children. It committed the government to a target of halving the number of conceptions occurring in women under 18 by the year 2010 (compared with 1999). It also committed the government to dealing with the 'social exclusion' of teenage mothers.

To achieve the first aim it relied on 'better' sex education, both in and out of schools, and improved access to contraception. To achieve the second aim it relied on a variety of government programmes to provide teenage mothers with a means of returning to education, training, or employment, with a network of agencies providing intensive support in housing and other fields.

## Problems with statistics

In England & Wales statistics on births and abortions are put together to give us conception rates. This entails working out how old the woman was when she conceived, by subtracting nine months from her age at giving birth or the gestational period at the time of an abortion. When this method of calculation was introduced in the 1980s, figures were back-calculated so that we have them from 1969, the first full year of operation of the 1967 Abortion Act. Other countries in Europe do not do this. Consequently the Social Exclusion Unit's report *Teenage Pregnancy* only deals with birth rates. The teenage birth rate for England (the SEU Report only deals with England) is higher than that for all other Western European countries, with only Canada, New Zealand and the USA having higher rates. However, countries with very high teenage abortion rates might overtake England, if pregnancies resulting in births were added to those terminated by abortion. In spite of this, the extent to which England 'leads the field' is so great (twice as high as Germany, three times as high as France, six times as high as the Netherlands) that it is unlikely that England would lose the first place, even if this were done.

# The Teenage Pregnancy Unit

The government set up the Teenage Pregnancy Unit (TPU) to carry out the recommendations of the Social Exclusion Unit's report. The TPU is a cross-government agency, located within the Department of Health. All local authorities and health authorities in England have been required to produce a teenage pregnancy strategy for their areas, stating what action they intend to take to help meet the target of a 50% nationwide reduction in under-18 conceptions by 2010,[2] with an interim target of a 15% reduction by 2004, and to deal with the social exclusion of teenage parents. £15 million has been allocated for these local strategies in 2001/2, with similar levels of funding envisaged for the next two years.

***What is disappointing is the almost complete lack of originality which these strategies display.***

For the purposes of this report, a team of researchers has studied the strategy documents produced by 23 authorities.[3] They represent a mixture of urban and rural, prosperous and deprived areas, north and south. Although the strategies vary in length, emphasis and explicitness, there are many similarities between them, which allow us to discern certain key themes.

It is, of course, inevitable that, in a scheme involving the co-operation of local government bodies with central government in pursuit of a common goal, there will be a similarity of aims and methods. What is disappointing is the almost complete lack of originality which these strategies display. They all start from the basic premise that young women become pregnant because they are ignorant about the facts of life, and are either unable to obtain contraception or unaware of why it should be used. The answer, therefore, is seen to be more sex education and easier access to contraception. If this premise is false, and as we shall see later there is reason to believe it may be, there is nothing in these strategies to fall back on.

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All strategies have to promote the TPU's twin aims of a reduction in teenage pregnancies and support for teenage mothers. There is no recognition, in any of the strategies or in any publication from the TPU, that these two aims may be mutually exclusive. Reducing social exclusion entails improving the housing, educational opportunities, employment training and access to childcare (amongst many other things) of teenage mothers. In so far as additional resources are being directed at teenage mothers, their economic situation improves. There is therefore less of a disincentive for young women to get into this position.

# A quagmire of quangos

The TPU, like its parent body the Social Exclusion Unit, makes much of 'joined-up thinking', and favours multi-agency partnerships and 'stakeholder involvement' in policy delivery. The reader of these strategies may be bewildered by just how many bodies are to be involved in teenage pregnancy: apart from the obvious agencies of the local authority and health authority, there are programmes like Sure Start, Connexions, Excellence in Cities, Education Action Zones, Quality Protects, After-School Plans, Healthy Schools Scheme, New Deal for Communities, Neighbourhood Renewal, Single Regeneration Budgets, Learning and Skills Councils — to name but a few. It is difficult to see how clear, focused policies for dealing with such a complex social issue will emerge from this quagmire of quangos. It is worth noting that, although much is made of the involvement of voluntary bodies, most of the 'voluntary' agencies we come across here are largely or wholly dependent on public funding.

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Perhaps it is owing to the plethora of statutory and publicly-funded agencies involved that some of these strategies display a regrettable tendency to make the sort of grandiose statements which we usually associate with the five-year and ten-year plans so beloved of the old communist bloc countries. For example:

> "In ten years' time all young people in Cornwall and the Isles of Scilly will have access to education, services and support to enable them to make positive, healthy choices about sex, relationships and parenthood" (Cornwall p.3) . . . "In ten years' time . . . young people and young parents will have wide choices available to them and high aspirations regarding education, training, career and housing opportunities" (North Somerset p.7) . . . "In ten years' time Birmingham will be a city where all young people and their families are enabled to aspire to achieve their fullest potential life choices" (Birmingham p.3).

In describing how they intend to meet government targets, it is natural that these strategies should explain what they are already doing, before going on to what they intend to do with the extra funding from central government. Sometimes they seem to get carried away and present their current activities in such a glowing light that it seems hard to imagine how they could possibly be improved upon. However, in most of these strategies, perfection is just around the corner. All that is needed is another injection of funding, then these authorities will provide sensitive, culturally appropriate education tailored to the teenager's needs, comprehensive packages of support from social services, high quality housing and access to childcare. We need to set these visions against the reality of an education system in crisis, in which teachers in some areas are more pre-occupied with preventing violence in the classroom than with having sensitive discussions with pupils about their private lives; with social services departments which are so chronically understaffed and demoralised that essential services like child protection are in chaos; and with a health service which is unable to treat life-threatening conditions within a reasonable time-span.

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The vision of a country in which sexually active teenage girls will have every need sympathetically attended to, both before and after they become mothers, is part of the Neverland of the public sector. Statutory bodies promise whatever is being demanded by central government in order to get the funding which is on offer.

***In a sense, teenage pregnancy has become the AIDS of New Labour.***

In a sense, teenage pregnancy has become the AIDS of New Labour. It offers local authorities and quangos the promise of lavish funding if only they will go along with the current policy obsession. But whereas the AIDS 'pandemic' owed more to hype and scare-mongering than to epidemiology, teenage pregnancy is a serious problem. Irrational campaigns telling the nation that 'AIDS doesn't discriminate' represented a waste of public money, but not much more than that (see box below). A failure to deal sensibly with teenage pregnancy will result in more young lives blighted by poor prospects, which it may prove impossible to correct.

## AIDS funding

By the middle of the 1980s, reputable bodies were making dramatic predictions of the spread of AIDS in the UK. In 1985 the Royal College of Nursing published a report predicting a million cases by 1991 (there were in fact just over 19,000 cases of HIV diagnosed by the end of 1991[4]) and in 1986 the Communicable Diseases Surveillance Centre predicted between 20,000 and 40,000 deaths per year from AIDS by 2000 (there were 318 deaths in 2000). These predictions triggered research funding and health education on an unprecedented scale. By 1989/90, expenditure on health education and research into AIDS in relation to the number of deaths that year from AIDS amounted to £289,755 per death.[5] By contrast, comparable expenditure on heart disease, the nation's biggest killer, amounted to £50 per death. Every district health authority was expected to employ an HIV prevention co-ordinator. By the end of the 1980s, some authorities had more people employed on HIV work than they had cases. As of today, more people die from falling down stairs in the UK than from AIDS.[6]

# Support for teenage parents

The teenage pregnancy strategies are meant to address two aims: reducing the number of pregnancies and combating the 'social exclusion' of teenage mothers. Most of them give far more attention, and make much more explicit proposals, in relation to the first aim. The reason is not hard to guess. Support for teenage mothers on any considerable scale is extremely expensive. The majority of lone-parent households are a charge on the welfare state, simply because it is difficult to look after a child and do the sort of full-time work which will bring in a sufficient income to support mother and baby. However, teenage mothers are the most expensive of all in terms of the demands they make on welfare services. They may not have finished their education, in which case 'support measures' will have to include plans to put them through their schooling, while providing care for the baby. They may have finished their education without any qualifications. If they are ever going to work in well-paid employment they need to get some, so there is a need for training, again with provision for childcare. They need to be accommodated, with considerable support from social services if they are to learn how to parent successfully.

These measures will all cost a great deal of money, and it is no doubt for this reason that most of the strategies content themselves with some standard remarks about childcare and supported housing, without being specific about the number of places to be provided or the total cost. The Birmingham strategy is fairly typical. It gives a detailed budget for the next three years, starting at over one million pounds for 2001/2 (one of the most expensive of all the local strategies). However, the section on housing is left blank: 'bids being prepared' (p.31). The Derby and Derbyshire strategy promises massively expensive programmes — 'All teenage parents will have access to free, high-quality childcare . . . All teenage parents aged 16 and 17 years will have access to a range of high-quality housing in areas which are safe and acceptable' — but allocates only £50,000 for North Derbyshire and £41,000 for South Derbyshire in the first year, with similar sums for the next two years (Derbyshire pp.37–8 & 45). These amounts would not scratch the surface of such grandiose schemes.

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Some of the strategies (e.g. North Yorkshire, Bath and Bolton) list abortion as a means of supporting teenage mothers, which suggests a distinct lack of ideas. Furthermore, there is now an extensive and high-quality literature, mostly from the USA, indicating that restricting teenagers' access to abortions has the effect of reducing the conception rate.[7] Making abortion more easily available, as the TPU's Independent Advisory Group has recommended,[8] will therefore not achieve the TPU's goal of reducing teenage pregnancies.

# Prevention

Most of the strategies give more space to their plans for preventing teenage pregnancies than they do to their plans for supporting teenage mothers. These prevention strategies involve the use of more comprehensive sex and relationship education (SRE), both in schools and in out-of-school settings such as youth clubs, coupled with easier access to contraception. It is not possible to treat these two issues separately because of the way in which all of the strategies see them as inter-dependent. The notion that sex education might discourage sexual activity, and thus reduce the need for contraception, is not seriously entertained by any of them.

As all of the strategies are at pains to point out, sex education is already being delivered in schools in their area. The plan, therefore, is to take it lower down the age range, to primary schools, to make it more comprehensive within the school curriculum, and to target 'hard-to-reach' groups like residents of young offenders' institutions, those with learning difficulties, and travellers. This type of sex education is linked to the provision of contraception, and there is a stated intention in a number of these strategies to use school nurses and clinics for this purpose. 'Within the life of the Strategy, young people will have access to contraceptive services via the school setting' (South Lancashire p.20). There is also a heavy emphasis on the prescription of the morning-after pill, particularly within school clinics.

Problems arise when schools are unwilling to go along with the sort of permissive, contraceptive education and provision which the strategies want to promote. In Southwark the solution was to leave Roman Catholic schools out of the loop altogether (Southwark p.29), but in the Birmingham strategy we hear the authentic note of irritation which local authority bureaucrats feel when they come up against people who won't fall into line:

> "Work with 'resistant' schools is very time-consuming, particularly when there are religious and cultural issues involved, as there is often a need for an educational process with governors, staff and parents . . . Part of our strategy will be to identify these schools and to look at what else could be done in terms of access to SRE through other settings such as local youth centres" (Birmingham p.13).

***The idea that abstinence education could be used to dissuade young people from engaging in sexual relationships is either ignored or treated with scorn by the strategies.***

The idea that abstinence education could be used to dissuade young people from engaging in sexual relationships is either ignored or treated with scorn by the strategies. 'Scare tactics and telling young people to abstain from sexual activities is (*sic*) likely to be counter-productive' (Newham p.17); 'There is no mileage in "just say no" messages — teenagers already know this is how adults want them to behave. They are also counterproductive in that they discourage teenagers from seeking help and advice when needed' (Southwark p.37).

Leaving aside the fact that sophisticated programmes of abstinence education developed in the USA do not consist of 'just say no' messages, the hostility towards abstinence education comes from the centre, probably owing to the close links between the Teenage Pregnancy Unit and the Sex Education Forum (see pp.15–16).

# Tucking them up in bed

Far from trying to discourage teenage sexual activity, some of these strategies take the line that the role of local authorities and quangos is to make this activity as pleasant as possible. The 'strategic vision' of East Kent is that 'children and young people' should 'be aware of and enjoy their sexuality' (p.35), while the Essex strategy 'is designed to … provide appropriate advice and support for young people in their physical, emotional and moral development as they begin to explore their own sexuality and become sexually active' (p.15). The Swindon strategy promises that 'community responsibility and positive attitudes towards sex and relationships in young people will be fostered across Swindon' (p.4).

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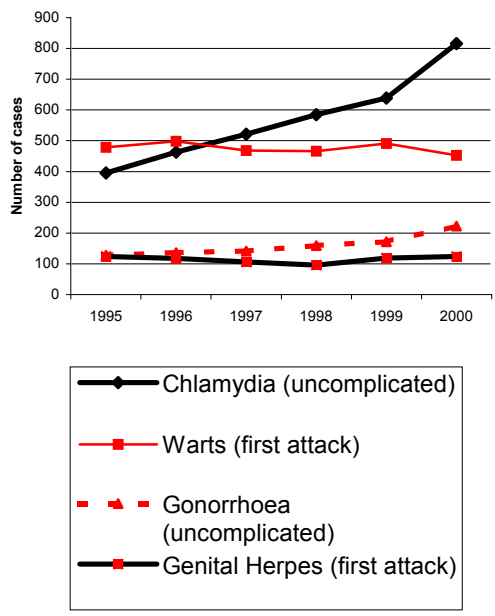
Whether it is appropriate for local authorities to facilitate the sexual adventures of juvenile Lotharios and their Lolitas is a matter of opinion, but some of the assurances which they are giving to young people verge on the irresponsible. Swindon takes the view that: 'Young people have the right to freedom from disease' and that 'Young women have the right to freedom from unplanned pregnancy and a fulfilling sex life' (p.4), while the Kingston and Richmond strategy believes 'it is a young person's right to expect that . . . all unwanted teenage conceptions are prevented, as much as possible, by different agencies working together . . . in the most effective way' (p.7). Whilst it is unlikely that young people hold the officers of their local authority in such high esteem as these people hold themselves, it would be extremely imprudent for teenagers to embark on a vigorous sex life under the impression that anyone can guarantee them a 'right' to escape unplanned pregnancies and sexually transmitted infections (STIs). All methods of contraception have known failure rates, and the failures increase as you go down the age range. Considerable efforts have been made to promote condoms, but adolescents are known to be particularly inefficient at using them.[9] Furthermore, even the most efficient contraceptive practice offers only limited protection against STIs, which are currently at epidemic levels amongst young people. For example, in England, Wales and Northern Ireland, there was a 74% increase in cases of gonorrhoea in girls under 16 between 1995 and 2000, and a 107% rise in diagnoses of chlamydia in under-age girls over the same period (Figure 1).

# The role of parents

What is missing from the strategies is perhaps more significant than what is included. For example, whilst most of the strategies make the link between high rates of teenage pregnancy and areas of economic deprivation, we have not come across one which makes the more obvious and important connection between the family background of young people and the likelihood of them being sexually active and, in the case of young women, becoming pregnant. This is in spite of the fact that there is now a significant body of literature which links the children of single-parent and step-families with higher rates of sexual activity and teenage pregnancy. The idea that teenage pregnancy is an issue that can be addressed without looking at the larger problem of the increasing numbers of children growing up in such households is, to say the least, short-sighted.

**Figure 1: New episodes of selected diagnoses of STIs in girls aged under 16: England, Wales and Northern Ireland 1995-2000**




Source: PHLS, *Data on STIs in the United Kingdom* (1995-2000)

Unfortunately, the idea that parents have any significant role to play in their children's development, other than support the line being taken by the local teenage pregnancy strategy,[10] is almost completely missing. When these documents talk of parents, they usually mean the teenage parents themselves. The fact that these young women and men have parents of their own somewhere, who might be concerned about their well-being, is either ignored or downplayed. According to one strategy: 'All those in contact with young people — teachers, youth workers, social workers, voluntary-sector workers, parents and carers — will be supported to develop the skills, knowledge and confidence required to offer information and support to young people' (Cambridgeshire p.16). Parents bring up the rear behind numerous individuals who have no legal or blood relationship to their children. The issues are all of information or services and are between the authorities and the children. Legal issues about under-age sex are scarcely mentioned, and moral issues which could lead to self-imposed restraint or abstinence are completely ignored.

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There is a common 'feel' to these documents. They perceive young people to be autonomous individuals entitled to choose from a range of options. This is summed up in the message of the TPU's media strategy, quoted in several of the local strategies: 'It's your choice and no one else's when it comes to sex'.[11] All the choices are presumed to be of equal validity, and the community at large is called upon to pick up the cost of the negative consequences following on from these choices. There is no question of expecting young people who are growing to maturity to accept

responsibility for their sexual and reproductive capacity. Sexuality is accepted as an activity like eating or sleeping that you grow into as a teenager. Teenage pregnancy is treated as a clinical issue, not a behavioural one, and in some cases young people are scarcely regarded as moral agents: 'We do not believe that young parents are to blame' (Bolton p.26).

The most worrying thing about this is that young people, including in some cases children who are under the legal age of consent to sexual intercourse, are being expected to negotiate their way through the sort of relationships which can seriously disrupt adult lives. They are actually supposed to be in charge of the teenage pregnancy strategy themselves: 'To be successful, young people must feel that they own the strategy and that they are equal partners in its implementation. A paternalistic "we know best" attitude by adults and agencies will fail. We will place young people at the centre of the strategy' (Southwark, p.6). 'In ten years' time we will expect the delivery of Confide Young Peoples' specialist services to be shaped by young people themselves through a process of evaluation' (Swindon, p.16). The idea that parents and other authority figures might have something to transmit to the younger generation by virtue of their greater experience of life is now, apparently, taboo: 'it is a young person's right to expect that ... they are treated as an individual without being patronised, in a way that promotes independence and self-esteem, so that they can make informed life, health and sexual decisions' (Kingston and Richmond p.7).

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# ‘Consulting’ the community

Many of the local strategies make much of the process of consultation which they have been through. However, the marked similarity between the various strategies, and the absence of any evidence of fundamental disagreement amongst those consulted, gives cause for concern that only those likely to be sympathetic towards the approach being adopted were consulted, as was found by some parents who wished to involve themselves. This was the experience of Eric Hester, a recently retired head teacher in Bolton:

> My wife and I wrote a polite letter to our local health authority on 3 April 2001 asking for details of the policy for reducing teenage pregnancies, including who would make decisions and when. The reply we received on 10 May stated that ‘consultation is an important part of any strategy’ but did not include a copy of the actual consultation document. We wrote again, asking for copies of relevant documents and for a list of those who were on the committees. We had an acknowledgement on 4 June and a reply only on 25 June stating that ‘we have no wish to keep anything secret but as you will appreciate, there are procedures that have to be followed before policies and strategies can become public documents’. Again, no documents were enclosed and the procedures were not explained.
>
> In our third letter (30 June), we again requested a copy of the Bolton strategy and asked specifically whether any Christian or Moslem groups or organisations representing ethnic minorities had been involved in the consultation. Over a month later, we received a reply, but no answer to our questions and no copy of the document. Our fourth letter (30 August), repeated our requests for information. We received an acknowledgement and a promise that the information would be forthcoming ‘shortly’. This period of ‘shortly’ meant that we received a letter, dated 5 November, two months later. We finally received a copy of the strategy and were informed that it was now ‘the accepted formal strategy for the borough of Bolton’. The strategy did not give any date of acceptance, although it did give the original date of its publication as March 2001, meaning that it had been in existence all the time we had been asking for information.
>
> *Eric Hester, 2 April 2002*

# A reliance on failed methods

The whole teenage pregnancy prevention strategy is based on the assumption that, if only we can teach young people about sex in more explicit detail, and make contraception more easily available to them, there will be fewer pregnancies. There is no basis for making this assumption.

Several of the strategies refer to their policies as 'evidence-based' — clearly a phrase they have picked up from the TPU — without realising how weak the evidence is in support of their proposals. This is true both of the effectiveness of sex education, and of the easy provision of contraception.

The evidence that sex education is effective in reducing teenage pregnancy and the spread of sexually transmitted diseases is so shaky that it is unwise to make any claims for it. There is no academically sound UK research at all. Most of the limited amount of research we have comes from the USA, and much of that measures changes in attitude rather than changes in behaviour. In other words, exposure to a sex education programme may result in young people *knowing* more about contraception, but not necessarily *using* it when they have sexual intercourse. Sex education lobbyists have contrived to conceal this lack of evidence, or even to misrepresent the state of the research.[12] This lack of any measurable evidence of effectiveness is not surprising when we consider

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(a) the ineffectiveness of health education generally, whether dealing with diet, smoking, drugs or any other issue, and

(b) the extent to which young people's attitudes towards sex are the result of exposure to the mass media, advertising and the peer group.

It would be surprising if sex education had anything more than a marginal influence, particularly as the sort of permissive sex education programmes we are talking about here can turn into yet another pressure on young people to become sexually active, by implying that such behaviour is expected of them. In March 2000 the Gloucestershire Community Health Council published the results of a survey administered to 410 students at the Royal Forest of Dean College. One of the questions was: 'When you first received sex education did you feel the need to experiment?' Only 1.5% of the girls, but 45.4% of the boys, said yes. The majority of the boys (77%) had received sex education by the age of twelve.[13]

With regard to the provision of contraception, recently published research by Dr David Paton of the University of Nottingham has shown that this is not necessarily associated with a fall in teenage conceptions, and may indeed have the reverse effect.[14] A survey of more than 2,000 young people aged 13–15 carried out by the Family Education Trust found that, of those who were sexually active, about two thirds said that their first sexual relationship had not been the result of conscious decision-making. For 30% 'it just happened'; 19% were drunk; 6% were talked into it by their partners; 3% cited peer pressure; and 4% (all girls) said they had no choice.[15] Under these circumstances, the availability of contraception is not an issue, as these young people would not be using it.

If young people are not motivated to avoid pregnancy, contraception is still not the issue. In the Family Education Trust survey, 45% of those girls who had become pregnant had either wanted to get pregnant, or didn't mind if they did.[16] This is confirmed by the Plymouth strategy: 'Several of the teenage parents interviewed said that although their pregnancies were not planned, they were not unwanted' (p.12). The strategy also cites a study of 167 pregnant teenagers in Devon[17] which found that: '92% admitted using contraceptives prior to their pregnancy and nearly all knew where to obtain contraceptives and advice' (Plymouth p.37).

# The problem with the Teenage Pregnancy Unit

It would be unfair to blame the local authorities for the failings in their strategies, when they were acting in accordance with guidelines issued by the Teenage Pregnancy Unit in London. The TPU has been constituted in such a way as to ensure that the government's attempt to reduce teenage pregnancy will end in failure, because it reflects only one strand of thinking on the subject. New research and new approaches have been ignored.

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We must first note the close connection between the TPU and the Brook (formerly known as Brook Advisory Centres). Brook has always been a deeply controversial organisation. Set up in 1964, it pioneered the provision of contraception to teenagers, including those under the legal age of consent to sexual intercourse, long before this was official government policy.

Brook has devoted much of its energies to producing sex education material of the most controversial nature, presenting sexual activity for teenagers, devoid of commitment and completely detached from marriage, as normal and unobjectionable. Brook has consistently been in the forefront of the battle to remove parents' rights to know what was being done to their children with respect to contraception. In its Annual Report for 2001 Brook describes its mission as: 'Equipping young people to enjoy their sexuality without harm . . . and influencing public policy to create a healthy environment for young people to explore their sexuality positively'.[18] It is therefore a matter of some concern that Alison Hadley, the Local Implementation and Contraceptive Services Manager of the TPU, was for several years a key figure in the running of Brook, and that young people visiting the TPU website are advised to contact Brook for advice on sexual issues, with a link to the Brook website.

Another questionable alliance is that between the TPU and the Sex Education Forum. This body, which is part of the National Children's Bureau, has become the voice of one particular and influential section of the sex education lobby. It promotes the sort of permissive, contraceptive education which has had official sanction for the last 30 years, and it is referred to by the Department for Education in its publications as a body for parents and teachers to consult.[19]

Although the Sex Education Forum purports to be a collaborative body, drawing 'on the best existing practices to identify positive strategies and approaches'[20] it does not represent or respect all perspectives. It is implacably opposed to abstinence education, and has published a booklet called *Just Say No! To Abstinence Education*.[21] The authors spoke with sixteen individuals or organisations interested in sex education in the USA, of which only three could be described as advocates of abstinence-only education. They lump together many programmes of varied quality and focus on the weakest as if they represent the lot. In the United States the term 'abstinence education' comprises a broad range of programmes, the best of which do not tell children to 'just say no'. Many abstinence programmes teach negotiation skills, and

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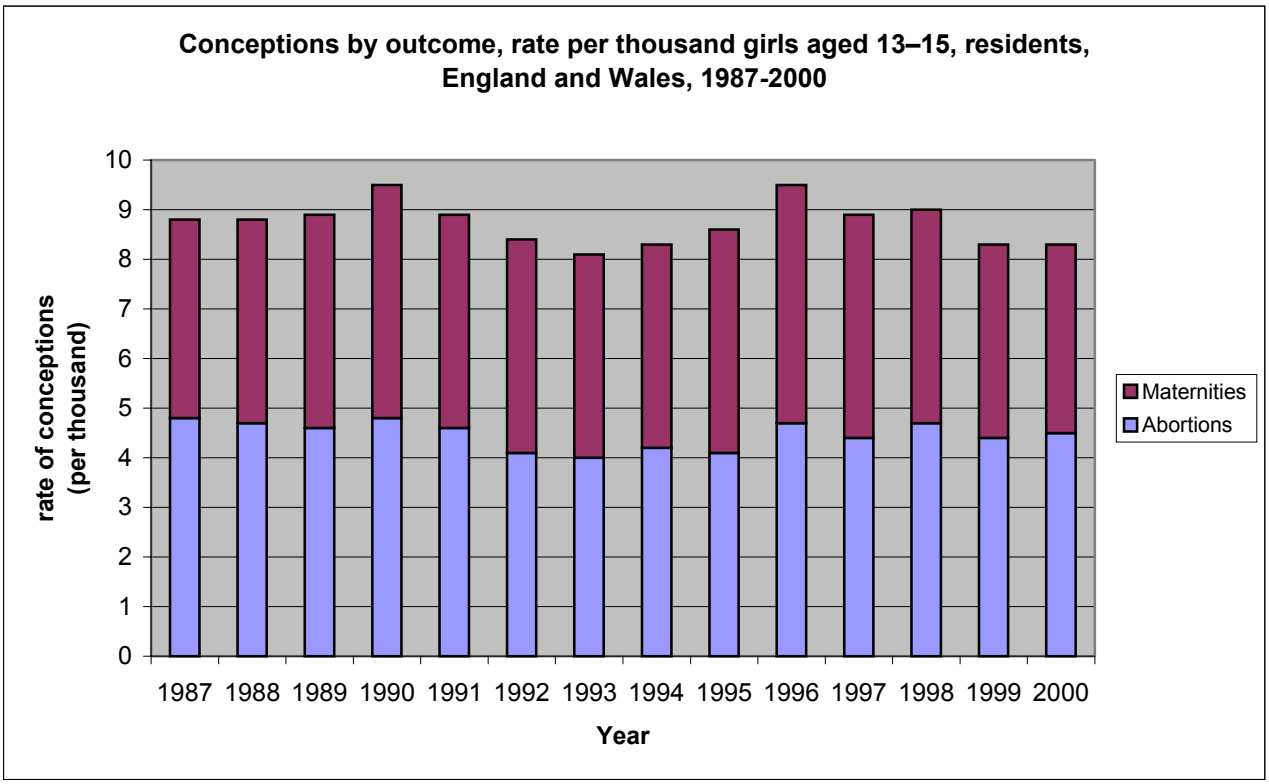
they call upon teens to think through the issue for themselves. Most importantly, the best abstinence education programmes focus on how to develop self-esteem, self-respect and respect for others.

The fact that the TPU website contains a link to this partial piece of work gives some idea of why the local teenage pregnancy strategies do not attach any weight to abstinence education. However, there are no grounds for the patronising attitude which the authors of *Just Say No! To Abstinence Education* adopt towards the USA. Teenage pregnancy rates there declined by 19% between 1991 and 1997, so they must be doing something right.

If we compare the National Campaign to Prevent Teenage Pregnancy in the USA with the UK Teenage Pregnancy Unit, one striking difference is immediately apparent. The National Campaign is a coalition. It comprises organisations which approach the problem from different perspectives, and does not pretend that there is only one possible solution. Organisations promoting abstinence work alongside organisations promoting access to contraception, and some promote both at the same time. The Teenage Pregnancy Unit, by contrast, represents only one, narrow perspective. It is ideologically driven and does not take into account several critical factors. That is why it is destined to fail.

Figure 2




Source: ONS, *Health Statistics Quarterly*, Spring 2002; and *Birth Statistics*, various years.

# We have been here before

We have already witnessed some official celebrations of the supposed success of the government strategy to halve under-18 conceptions by 2010 which may prove to be extremely premature. First of all, it is far too early to claim success for a strategy which was only being put into place at the beginning of 2001, when the latest conception figures we have are for 2000. Secondly, one potentially embarrassing fact has been conveniently forgotten. We have been here before, several times.[22] In 1992 the then Conservative government published *The Health of the Nation*, a strange document which, very unwisely, set the government a number of specific, time-limited targets. One of these was: 'To reduce the rate of conceptions amongst the under-16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13–15 in 1989 to no more than 4.8)'.[23] The policy relied upon the use of sex education and easier access to contraception. As Figure 2 shows, the target was not met. In 2000, under-16 conceptions stood at 8.3 per thousand.

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The rising numbers of teenage girls who are becoming pregnant represent a problem which is neither clinical nor educational, but cultural. The taboos which used to surround extra-marital sexual activity, particularly involving young people, have been removed. Not only is such activity no longer discouraged, it is effectively celebrated by the mass media. Young people are growing up in an environment in which they find that it is expected that they should become sexually active, and even become parents, at a very young age, and that the public authorities are making appropriate arrangements for such activity. Sex education and the availability of contraception are, at most, only side-issues which can never come close to addressing the real problem. Because the government's teenage pregnancy strategy has chosen to concentrate on them, it has no realistic chance of achieving its extremely optimistic target of halving under-18 conceptions by 2010.

# Notes

1. *Teenage Pregnancy*, Cm 4342, Social Exclusion Unit, June 1999.

2. Local authorities are expected to contribute towards an overall national fall of 50%, rather than aim for 50% themselves. The strategy is intended to target those areas with the highest teenage pregnancy rates, where falls in excess of 50% are sought. Thus, Southwark, with the highest teenage pregnancy rate in the country (85 conceptions per 1,000 females aged 15 – 17, compared with a national average of 45) promises a reduction of 60% by 2010. On the other hand Kingston (29 conceptions per thousand) and Richmond-upon-Thames (21 conceptions per thousand) only aim for a 40% reduction by 2010. [Office for National Statistics, *Population Trends 103*, Spring 2001].

3. Bath & North East Somerset, Birmingham, Bolton, Bristol, Calderdale, Cambridgeshire, Cornwall & The Isles of Scilly, Derby & Derbyshire, Devon, East Kent, East Sussex: Brighton & Hove, Essex, Kingston & Richmond, Newham, North Somerset, North Yorkshire, Oxfordshire, Southend on Sea, South Lancashire, South Staffordshire, Southwark, Swindon, Warwickshire.

4. 'HIV infection and AIDS in the United Kingdom: monthly report – October 2001', *CDR Weekly*, 25 October 2001, Vol 11, No 43.

5. Whelan, R., 'The AIDS Scandal', *Economic Affairs*, Vol 11, No 4, June 1991.

6. Craven, B., Dixon, P., Stewart, G., Tooley, J., *HIV and Aids in Schools*, London: Institute of Economic Affairs, 2001, p.61.

7. For example: 'We find that restricting access to abortion is consistently associated with a small but significant decline in the teen birthrate, with most of the decline occurring among in-wedlock births' (p.469), Kane, Thomas J. and Douglas Staiger (1996), 'Teen Motherhood and Abortion Access', *Quarterly Journal of Economics*, vol.l. 111, part 2 (May), pp. 467–506; and 'parental involvement laws appear to reduce the adolescent abortion rate relative to the abortion rate for older teens or adults not subject to the laws. "Best model" estimates imply that such laws reduce the adolescent abortion rate by about 18 percent, other things constant ... A smaller (8 percent) reduction in the adolescent pregnancy rate is estimated to result from parental involvement laws' (p. 75), Ohsfeldt, Robert L. and Stephan F. Gohmann (1994), 'Do Parental Involvement Laws Reduce Adolescent Abortion Rates?', *Contemporary Economic Policy*, vol 12 (April), 65–76.

8. Independent Advisory Group on Teenage Pregnancy, First Annual Report, p.8.

9. Fu, Darroch et al, 'Contraceptive Failure Rates: New estimates from the 1995 National Survey of Family Growth', *Family Planning Perspectives*, 1999, 31, pp.56–63; Carnell, D, 'Condom failure is on the increase', *BMJ*, 312, 1059 (1996): *AIDS Care 2000,* 12, 221–4, quoted in *BMJ,* 17 June 2000, 320, 1680.

10. For example, North Yorkshire gives as an objective of the media campaign to 'produce parent information packs, as a means of supporting the messages given out through the media' (p.14). But what if parents don't agree with these messages?

11. For example, East Kent p. 30.

12. See Whelan, R., 'Teaching Sex in Schools: Does It Work?' in Danon, P., *Tried But Untested*, Oxford: Family Education Trust, 1995.

13. Royal Forest of Dean College with Gloucestershire Community Health Council, 'Sex Education & Family Planning Services Survey Results', March 2000, pp. 16 & 17. See also Oettinger, G.S., 'The effects of sex education on teen sexual activity and teen pregnancy', *Journal of Political Economy*, Vol 107, No 3, 1999, p.606: '. . . enrolment in sex education was associated with earlier sexual activity for females in this cohort [US teenagers in the 1970s]. Sex education also was associated with earlier pregnancy for some groups of females, but these effects are smaller and not always statistically significant'.

14. Paton, D., 'The Economics of Family Planning and Underage Conceptions', *Journal of Health Economics*, Vol 21, No 2, March 2002, pp. 27 – 45.

15. Hill, C., *Sex Under Sixteen?*, London: Family Education Trust, 2000, p.50.

16. *Sex Under Sixteen?* p.52.

17. Pearson, V.A.H. et al, 'Family planning services in Devon, UK: awareness, experience and attitudes of pregnant teenagers', *British Journal of Family Planning*, Vol 21, 1995, pp.45–9. A more recent study of 240 teenagers who became pregnant found that 93% had seen a health professional at least once during the previous year, and 71% had discussed contraception. The researchers concluded that: (1) 'Most teenagers who become pregnant do access general practice in the year before pregnancy, suggesting that potential barriers to care are less than often supposed; (2) 'Teenagers who become pregnant have higher consultation rates than their age-matched peers, and most of the difference is owing to consultation for contraception; and (3) 'Teenagers whose pregnancies end in termination are more likely to have received emergency contraception.' See Churchill D, Allen J, Pringle M, Hippisley-Cox J, Ebdon D, Macpherson M et al. 'Consultation patterns and provision of contraception in general practice before teenage pregnancy', *BMJ* 2000; 321:486–489.

18. 'More Than Just a Pill', Annual Report 2001, Brook, p.7.

19. For example, see *Sex and Relationships Education Guidance*, Department for Education and Employment, July 2000, DfEE 0116/2000, p.6.

20. http://www.ncb.org.uk/sexed.htm

21. Blake, S. and Frances, G., *Just Say No! To Abstinence Education: Lessons learnt from a sex education study tour to the United States*, London: Sex Education Forum, 2001.

22. For example, in 1976 the Family Planning Association set itself the target of halving the number of unwanted pregnancies, estimated as being 200,000, by 1986. This target was included in the FPA's annual reports until 1981/2, after which no more was heard of it. This did not prevent the FPA from stating in its 1987–88 annual report that: 'In recent years there has been much talk within and around the FPA of the organisation having achieved its aims and needing new ones.' (Annual Report 1987/88 p.4).

23. *The Health of the Nation: A Strategy for Health in England*, Cm 1986, July 1992, p.95. From 1999, a slightly different methodology was employed to calculate teenage conceptions. There is therefore a small discrepancy between the rate of conceptions to under-16s referred to in *The Health of the Nation* report and the later published figures on which Figure 2 is based.