FREEDOM’S CONSEQUENCES

Reducing teenage pregnancies and their negative effects in the UK

Gerard Lemos
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Gerard Lemos
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Summary

The rate of teenage pregnancies¹ is higher in the UK than in almost any other developed country except the United States. Nearly 42,000 teenagers became pregnant in England and Wales during 2006.² The government has spent more than £250 million (with another £90 million earmarked for dispersal until 2010) in order to achieve its target set in 1998 of reducing the rate³ of teenage pregnancies by 50 per cent by 2010. The rate of teenage pregnancies had been reduced by 13.3 per cent by 2006 in England and Wales. 47.1 out of every 1,000 girls between 15 and 17 became pregnant in 1998. By 2006 the figure was 40.9 per 1,000. Although there has been a reduction, the government’s target will almost certainly not be met. In addition, the social and educational outcomes for teenage mothers (as expressed in the government’s Every Child Matters framework) are still relatively poor.

Negative consequences of teenage pregnancies

The health consequences for a teenage mother and her baby both during pregnancy and afterwards can be harmful. Young mothers’ inexperience of looking after themselves contributes to negative health outcomes, particularly during pregnancies. Immaturity affects the ability to moderate negative behaviour, such as smoking and seeking timely health care. Once the baby is born, not persisting with breastfeeding may also be a harmful consequence of immaturity.

Teenage pregnancy is more common among young people who have low educational attainment. In addition, being pregnant and having a baby often also leads to education being curtailed – for the mother, though not always for the father – and thereby even lower educational attainment. As a result of low educational achievement, inadequate employment training, poor childcare provision and a lack of support, teenage mothers suffer a considerable disadvantage in the labour market and can be highly reliant on welfare benefits and subsidised housing, sometimes following a period of homelessness or temporary housing. They may also be forced to lean on relatives.

Risk factors for teenage pregnancy

The main risk factors for teenage pregnancy come under three headings:

• risky behaviour
• education-related factors
• family and home background factors.

Risky behaviour includes the early onset of sexual activity; irregular or ineffective use of contraception; mental health problems; anti-social behaviour and involvement in crime; alcohol and substance misuse; having already been a teenage mother; and previous abortions. The education-related factors include low educational attainment; disengagement from school; leaving school at 16 with no qualifications; and negative experiences of education in school. Factors in the family and home background include growing up in care; being the daughter of a teenage mother; ethnic differences; low parental aspirations; parental separation; family conflict or violence; frequent moves; and neighbourhood peer pressures.
Changed social context

Stubbornly high levels of teenage pregnancies in the UK should be seen against a changed social context. The trends affecting all sections of society over several decades include having sex at an earlier age; more sexual partners over the life cycle, particularly when young; increased use of contraception and family planning services; increases in sexually transmitted infections; and a significant increase in numbers of abortions accompanied by a rise in post-abortion stress. Above all, perhaps, these changes are underpinned by a wider change in attitudes to gender equality. Women increasingly have the freedoms that men enjoy – and also the possibility of abusing those freedoms, sometimes to their own detriment.

Overall these social changes have been hugely beneficial in permitting people the right to make individual choices without the risk of censure or judgement. But for some, including some teenage parents, more freedom and choice, when combined with social disadvantage, has led to more risky behaviour with long-term negative consequences for themselves and others. These wider social changes are irreversible. Encouraging young people to abstain from sex until they are married is likely to fall on deaf ears. A more profitable approach would be educating all young people, particularly the most disadvantaged young people, to be more knowledgeable and responsible about emotional relationships and the use of contraception.

Attractions of teenage pregnancy

Against a familiar backdrop of multi-generational social disadvantage the negative long-term consequences of being a teenage mother may not seem as great for some women as the short-term attractions of having a boyfriend and a baby. By becoming pregnant, a young woman may be following the example of her own mother whom she might see as a role model. The absence of alternative aspirations may make having a baby feel like an overwhelming aspiration in itself. Being pregnant may also attract welcome care and attention from parents, professionals, friends and, of course, the boyfriend and young father – some or all of whom may have been rather indifferent before. Friends may also either be, or perhaps want to be, young mothers so encouragement may also come from peers. Having a baby stirs powerful emotions of love and tenderness in almost everyone. These feelings will be overwhelmingly positive, regardless of the long-term negative consequences. The young mother to be may also hope that becoming a father will make an honest and good husband out of her unreliable and immature boyfriend.

Young fathers

Much less is known about young fathers than about young mothers and their children. Many young fathers also come from disadvantaged homes and families. The majority of young fathers are known and identified by the mothers and, according to research, can play a positive role as a partner and a father. Many young fathers would welcome being a proactive, involved parent but feel poorly equipped for the role, lacking experience not just in fatherhood but also in life. Little support is offered to them either by professionals, their own families or the family of the mother. A positive, supportive partnership between the young parents would ameliorate some of the most negative social and economic outcomes for mothers and babies.

Ethnic differences

There are variances in the incidence of teenage pregnancies between ethnic groups, which are not simply explained. The differences are not straightforwardly between white and black communities. Key variables seem to be that socially conservative communities tend to have fewer teenage pregnancies and ethnic communities more heavily represented in neighbourhoods of concentrated social disadvantage are those most at risk of teenage pregnancies.

“The likelihood of teenage motherhood is higher among young women of ‘Mixed White and Black Caribbean’, ‘Other Black’, ‘Black Caribbean’, and ‘White British’ ethnicity. All Asian ethnic groups have a lower than average incidence of teenage motherhood.”

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The main explanations for the variable ethnic rates of teenage pregnancy include, a web of ‘cultural’ and parental restraints on embarking on sexual experiences early; different attitudes to the use of contraceptives; peer pressures in certain disadvantaged neighbourhoods; and different attitudes to intimate relationships and monogamy. The ethnic variable arises not from a deterministic view of how certain groups are bound to behave but from the effects of a complex interaction of the above factors on individual lives and choices, for both young women and young men.

International comparisons

Among countries in the developed world, the UK has one of the highest levels of teenage pregnancies, only regularly surpassed by the United States. Other countries with greater extremes of social and economic inequality, such as New Zealand, also seem to have a higher incidence of teenage pregnancies. Two types of countries have a low incidence of teenage pregnancies. They are either countries with strong conservative, often religious, cultural norms – unlike the UK – or they are countries with liberal, secular traditions – more like the UK – but where there has been a persistent official effort (particularly through education) to sponsor a responsible attitude to the benefits of liberal freedom, not only to sexual behaviour, contraception and emotional relationships but also to issues such as alcohol and drugs.

The achievement of greater social and economic equality is a long-term worthwhile goal, but one that still seems distant. In the meantime, the UK could learn a good deal, particularly from the Netherlands, about sponsoring open dialogue on sexual behaviour, not only between parents and children but also through official means such as sex and relationship education. International data points especially strongly to the need to establish key messages about responsible sexual behaviour and contraception in the minds of youngsters of both genders at an earlier age, i.e. while at primary school, than is generally the case in the UK. The British government commissioned a review of sex and relationship education which has recommended earlier, compulsory, better taught sex and relationship education. The government’s response to the review has been equivocal – recognising the merit of the argument but pointing out the difficulties, and then initiating a further consultation process on the review – suggesting a certain wariness about taking on the inevitable backlash from the socially conservative media, regardless of the strength of the evidence or the argument.

Prevention

The UK has hitherto had a poor record on the delivery of sex and relationship education. Ofsted has questioned both the quality of teaching and the materials used (too much emphasis on facts; too little emphasis on feelings). A 2007 survey of a large number of young people gave current educational practice low marks. The emphasis in sex and relationship education needs as much to be on the emotional aspects of responsible intimacy as on the mechanical methods of preventing unwanted pregnancy. Other surveys have reached similar conclusions. Teaching standards also need to be raised. Many sex and relationship education lessons are given by form teachers, rather than specialists, with predictably ineffectual results. Indifferent teachers rarely achieve much in any subject.

A more determined, proactive approach to sex and relationships education is needed among primary school children. Abstinence education generally does not work and can be counterproductive. Similarly peer education for preventing teenage pregnancies does not seem to have achieved much, though peer support can be beneficial once the baby is born. Sexual health services are not well enough known by young people, either before or at the time they are needed. As a result the support available from sexual health services to young women who have become pregnant is almost always too late, and often too little as well.
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Parents also need to be much more engaged in sex and relationship education and to be encouraged to be much more open with children at home about emotional relationships and intimacy, though the manner by which this might be achieved is harder to specify. Many parents seem to believe that sex and relationships should be talked about more at school in order to remove the obligation to talk about such questions at home. Advice or guidance for parents and relatives of young parents is sparse and, as already noted, minimal advice or guidance is offered to young fathers. Since most young parents in the first instance will turn to their nearest and dearest for advice – not to unknown professionals, even if they are aware of the availability of professional advice at all – the failure to support fathers and develop extended family support for teenage mothers is probably the most serious failure of policy and practice. This egregious omission, unless corrected, risks dooming to failure many of the well-intentioned efforts currently in place.

Support

Young pregnant women need more encouragement to use antenatal care, more intensive support at home after the baby is born, and more encouragement to continue education and stay in the labour market. The absence of family support from the father, family members and professional services has wholly adverse consequences. The young mother is too often overly-reliant on public professionals (in infrequent attendance), welfare benefits and public housing. Welfare and housing benefits are only available in the (apparent) absence of family or financial support. No positive conditions (such as attendance at clinics or baby vaccinations) are attached to the benefits. The current structure of housing and welfare benefits encourages as a result, dependency and isolation for young mothers. Current government proposals include coercive measures to insist on young mothers taking training or a job once the baby is one year old or risk losing benefits. They run the risk of creating yet another perverse incentive, as if enough did not already exist: why not have another baby to avoid losing benefit?

Conclusions and suggestions

The government’s current approach to supporting teenage parents will not work, either in preventing teenage pregnancies in future or improving outcomes for teenage parents and their children. First, unrealistic expectations are placed on the ability of education, youth work and health providers to be able to identify and support young people at risk of becoming parents or who already have a baby. Exhortations to greater strategic leadership, partnership working and information sharing, however desirable, are unconvincing. Even if the approaches of the best local authorities were applied everywhere, the government still admits that the target would still not be reached, although local authorities would reduce the rate of teenage pregnancies faster, perhaps twice as fast. Second, the current approach is too atomised, focusing only on the young mother. Insufficient, or even negligible attention is paid to the young father and to the wider network of informal support available to the young mother from her extended family. Last but most significantly, current approaches do nothing to change the active incentives that exist in the current welfare and housing benefit systems for young mothers to isolate themselves from sources of support and to become dependent on welfare. Approaches to preventing teenage pregnancies through sex and relationship education are also deeply flawed and inadequate, relying on non-specialist teachers to deliver mechanical messages – and too late in a child’s life to make much difference.

The emphasis needs instead to be on:

1. a great improvement in the quality, content and availability of compulsory education on relationships and sex, particularly for younger children
2. whole family approaches to supporting young parents: involving the parents of the young parents, the extended family and, most importantly, the fathers in supporting the young mother and child
3. use of the welfare and housing benefit system to reward positive parenting and extended family support rather than maintaining perverse incentives for isolation and dependency by giving welfare benefits in effect for family breakdown and parenting failure.


Introduction

Young women who got pregnant and had babies without being married have long been subject to moral censure in Britain as elsewhere. Not so long ago one might still encounter elderly women who had been involuntarily incarcerated for years in long-stay psychiatric hospitals when they were young, pregnant, unmarried and, notwithstanding their admission to a psychiatric hospital, of entirely sound mind. There they remained, in some instances for up to fifty years, long after the will to leave had been extinguished by institutionalisation. Even more notoriously in the Republic of Ireland, pregnant young women were placed in the ‘Magdalene Laundries’ to give birth to their baby. The baby would be taken away after birth for adoption. Thereafter the mother’s time would be spent in more or less forced labour, subject to cruelty and abuse, cleaning the sacred cloths of the Catholic Church. As fallen women, they were shunned and excluded long after the baby had been born and taken from them, their way back to acceptable society permanently debarred. Such judgments and practices now seem barbaric.

Our society no longer enforces separation of mother and child, nor does the mother face a life of shame and seclusion, nor does being a child born out of wedlock carry the stigma it once did. Nonetheless teenage pregnancy is still perceived as a bad idea that should be prevented if possible. Contemporary objections are not so much expressed in moral or religious terms, though vestiges of these strictures remain, as will be discussed in the section on sex and relationship education in chapter 8. The worry now is that the consequences for mother and child are long-term social deprivation, perhaps extending through several generations thereafter. A feature of a scientific age is the mutation of basically identical moral concerns into apparently empirical concerns: teenage pregnancy is a bad idea, not because the rest of us disapprove but for your own good, of course. Negative perceptions may have been amplified by the later onset of childbearing generally and the increasing number of people who choose to have no children at all, which makes the decision to have children when you are young and have achieved precious little seem perverse and self destructive.

Strong social prejudices nevertheless persist that young people in some neighbourhoods are feckless and irresponsible. Girls who live in deprived council estates and neighbourhoods, either white or black, are believed to have harmfully relaxed attitudes to sex. They are also believed to hitch up with irresponsible and promiscuous young men. Both young women and men in these communities are said to have casual, ill-informed and irresponsible attitudes to the proper use of contraception. In short, these young people are believed to be in a kind of moral decay, though re-defined for a modern age. This moral decay, according to some, has been brought about by the generally lax social and sexual attitudes of the ‘permissive society’ and the easy availability of welfare benefits and council housing, which apparently make it positively attractive to be unemployed, on benefit and living in a council flat – at least when compared to the alternatives. These stereotypes are, broadly speaking, rubbish. There are ethnic and neighbourhood factors which, however, do influence young people’s behaviour and make it likely that some young women from some backgrounds are more likely to become pregnant. It is also true that aspects of the UK benefits system do encourage dependency and isolation.
Government efforts have had disappointing results

Early in the life of the New Labour government reducing teenage pregnancies was made a priority in the intended onslaught on social exclusion. The strategies, plans and resources deployed have been one of the less successful aspects of the attempt to reduce relative poverty and inequality (among other disappointments). In 1998 the government set a target that by 2010 the rate of teenage pregnancies would be reduced by 50 per cent. By 2006 reaching this target was still a long way off. The rate of teenage pregnancies had been reduced by 13.3 per cent between 1998 and 2006 and then only in a geographically patchy way (with some local authorities having had a substantial impact and others having hardly any impact at all). Improvements are also far from irreversible. This poor performance has not been for want of government expenditure, about £250 million so far with another £90 million to come. Meeting the target by 2010 now looks outside the bounds of possibility. Although targets can be fairly arbitrary and therefore failing to meet them may not mean much, plenty of other evidence points to the failure of UK policy and practice to make much impact on reducing teenage pregnancies or their negative consequences.

The government’s claim that ‘steady progress’ is being made in reducing the rate of teenage pregnancies depends to a great extent on how the statistics are used and interpreted. It would be fair to say that the 13.3 per cent fall in the rate that the government uses as its headline figure is the most flattering interpretation. A closer inquiry reveals that the absolute number of teenage pregnancies has not fallen by 13.3 per cent, as shown below. The fall in the total number of teenage pregnancies has only, in fact, been 5.3 per cent. The year-on-year change in the total number is in figure 1.

Fig 1: Number of teenage pregnancies 1998-2006

Between 1998/99 and 2006/07 the total number of teenage pregnancies has fallen in four years and risen in four years as figure 2 shows.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Absolute number</th>
<th>Year-on-year change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998/99</td>
<td>44,119</td>
<td></td>
</tr>
<tr>
<td>1999/00</td>
<td>42,028</td>
<td>-4.74%</td>
</tr>
<tr>
<td>2000/01</td>
<td>41,348</td>
<td>-1.62%</td>
</tr>
<tr>
<td>2001/02</td>
<td>40,990</td>
<td>-0.87%</td>
</tr>
<tr>
<td>2002/03</td>
<td>41,951</td>
<td>2.34%</td>
</tr>
<tr>
<td>2003/04</td>
<td>42,162</td>
<td>0.50%</td>
</tr>
<tr>
<td>2004/05</td>
<td>42,198</td>
<td>0.09%</td>
</tr>
<tr>
<td>2005/06</td>
<td>42,325</td>
<td>0.30%</td>
</tr>
<tr>
<td>2006/07</td>
<td>41,768</td>
<td>-1.32%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>378,889</strong></td>
<td></td>
</tr>
</tbody>
</table>
Reducing teenage pregnancies and their negative effects in the UK

As well as this rather more dispiriting interpretation, the biggest fall in the number or the rate of teenage pregnancies, whichever is measured, occurred in 1998/99 before the government’s strategy was really underway and before any government funds came on stream. Figure 3 below shows when expenditure began and that the rate of decline has slowed as the rate of government expenditure has increased.

Fig 2: Year-on-year change in teenage pregnancies 1999-2006

Fig 3: Government funding for teenage pregnancy compared with the fall in teenage pregnancy rates
So if 1999/2000 is taken as the baseline year, i.e. the year that extra government funds became available and the strategy was implemented, the fall in the rate is much less than 13.3 per cent, as this figure shows. If that year is taken as the baseline year, the fall is 9.4 per cent and if 2000/01 is treated as the baseline year, the fall would only be 6.9 per cent.

International comparisons also demonstrate the extent of UK policy and practice failure on teenage pregnancies. The UK has the highest incidence of teenage pregnancy in the developed world with the exception of the United States. Other countries fall broadly into two categories. The first group of countries are those that have still extant socially conservative traditions (such as Ireland, Italy or Spain) and which have always had lower rates of young motherhood outside marriage than socially liberal countries. Social censure has been traditionally very strong (as exemplified by the Magdalene Laundries in Ireland mentioned earlier). These countries are perhaps a less relevant comparison for the UK. Even if a Herculean effort was undertaken, turning back the clock of social attitudes would almost certainly fail (for reasons to be discussed later) as well as causing a great deal of misery in the process. The second group are countries are those which are at least as socially liberal the UK (perhaps even more liberal) and have also had high rates of teenage pregnancies from the 1970s onwards, such as Sweden and the Netherlands. The difference between this second group of more socially liberal countries and the UK is, broadly speaking, that they have successfully substantially reduced teenage pregnancy rates since the 1970s but the UK has not.
Purpose and structure of this paper

Bearing in mind this policy failure, the purpose is to approach an old problem from some new angles. The paper sets out a new philosophy and approach to tackling teenage parenthood, focusing on improving prevention through education, working with extended families to support young families, mothers, fathers and their children, and reforming the benefits system to encourage positive parenting.

The first chapter is about the consequences of teenage pregnancies and the second is about causes. Chapter 3 is about changing social attitudes and sexual behaviour – an essential backdrop against which to see contemporary concerns about teenage pregnancies. Chapter 4 considers whether teenage pregnancies can be seen in some circumstances as an attractive option for some young people, regardless of the potential negative consequences later. Chapter 5 looks at the experiences of young men as fathers and chapter 6 discusses the reasons for the ethnic differences. Since there are significant variations between patterns of teenage pregnancies in different developed countries, chapter 7 makes international comparisons, some of which have already been referred to.

Chapter 8 deals with prevention, and chapter 9 with the effectiveness of support services. The final chapter sets out the conclusions from this analysis and key themes that need to be developed in future approaches. The bibliography follows chapter 10.
1. Negative consequences of teenage pregnancies

In most western European countries birth rates for teenage mothers fell during the 1970s. In the UK, however, rates have been fairly consistent, staying relatively stable since 1969.\textsuperscript{10} As a result of this failure to keep pace with international downward trends the UK has the highest rate of teenage pregnancies in western Europe.\textsuperscript{11} From 1998 onwards the government has had a concerted drive on the problem, complete with substantial public expenditure. Between 1998 and 2006 the under 18-conception rate has fallen by 13.3 per cent in England and Wales. Nevertheless it still remains higher than other western European countries, three times higher than in Germany, for example. The government certainly hoped for a better return in reduced birth rates from their additional investment of £340 million between 1998 and 2010.

The annual statistics for the UK are disturbing. In 2006, 41,768 under-18 year olds in England and Wales became pregnant. Of those, nearly half ended the pregnancies by legal abortion. And of those that chose termination 4,399 were conceptions to young women under the age of 16. Young pregnant women under the age of 16 were more likely to have legal abortion than older teenage mothers. Of conceptions by girls under-16 years of age a majority ended in legal abortion. A significant number of young women conceive more than once in their teens. Around 20 per cent of births conceived by girls under the age of 18 are second or subsequent births. In total the government estimates that there were 50,000 mothers aged under 20 living in England in 2005. Over 80 per cent were not in education, employment or training and they were much more likely to live in deprived neighbourhoods.\textsuperscript{12}

Regardless of the various moral perspectives about sexual behaviour, these figures are disturbing because teenage pregnancy is both a cause and a consequence of social exclusion. Teenage parents are more likely to come from deprived or socially excluded backgrounds. The risk of becoming a teenage mother is almost ten times higher for a girl from the lowest social class compared to a girl from a professional background. Becoming a teenage parent tends to exacerbate and amplify these inequalities.

Social disadvantage is not the only characteristic that leads to a greater likelihood of teenage pregnancy. Other young people more likely to becoming teenage parents include young people in or leaving care,\textsuperscript{13} homeless young people,\textsuperscript{14} truants and young people under performing in school or excluded from school\textsuperscript{15} children of teenage mothers,\textsuperscript{16} some ethnic minorities\textsuperscript{17} and young people involved in crime.\textsuperscript{18} These risk factors also contribute to other forms of exclusion among young people: homelessness, unemployment and offending for example.

Many of the partners of teenage mothers are a little older than them.\textsuperscript{19} Young fathers, like young mothers, are more likely to come from lower socio-economic groups, from families that have experienced financial difficulties and are more likely than average to have left school at the lowest age possible and the first available opportunity.\textsuperscript{20} Conception rates are slightly higher in the north of England than the south, though this might be explained by socio-economic factors rather than being related to location.\textsuperscript{21} There are however large variations between wards in the same region or local authority area. Half of the conceptions under-18 in England occur in the 20 per cent most deprived wards. Teenage pregnancy rates among the most deprived 10 per cent wards are nine times higher than in the 10 per cent least deprived wards.\textsuperscript{22} This significant spatial concentration is one of the most striking facts about the rate of teenage pregnancies.
Health consequences

Teenagers who may be pregnant tend to seek medical advice much later in pregnancy than older mothers. As a result they may miss out on pre-conception and first trimester health care such as taking folic acid supplements. This could adversely affect the health of both mother and baby. Teenage mothers are also three times more likely to smoke throughout their pregnancy and 50 per cent less likely to breastfeed than older mothers, both of which have negative health consequences for the child. For these and other reasons birth weights of babies of teenage mothers are more likely to be lower and the rate of infant mortality for a baby born to a teenage mother is 60 per cent higher than for babies of older women. Children of teenage mothers have a 63 per cent increased risk of being born into poverty compared to babies born to mothers in their twenties, and also have higher mortality rates under the age of eight and are more likely to have accidents and behavioural problems. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth. In short, the experience of being a parent can lead some young mothers (perhaps unwittingly) to take greater risks with the health and well being of both themselves and the baby. This can result in many adverse consequences, some of which materialise a long time after the birth.

Longer-term education and employment outcomes

Of the estimated 50,000 mothers aged under 20 living in England in 2005, over 80 per cent were aged 18 or 19; over 60 per cent were lone parents; 70 per cent were not in education, employment or training; and they were much more likely to live in deprived neighbourhoods. By the age of 30, teenage mothers are 22 per cent more likely to be living in poverty than mothers giving birth aged 24 or over and are much less likely to be employed or living with a partner. Teenage mothers are 20 per cent more likely to have no qualification at the age of 30 than a mother giving birth aged 24 or over. According to the Department for Work and Pensions around 70 per cent of mothers aged 16 to 19 claim income support.

Housing outcomes

Forty per cent of teenage mothers under 20 years of age live in someone else’s household, including their parents. For under 18s this rises to 80 per cent. Teenage mothers are more likely to become homeless, live in temporary accommodation and have difficulty in securing move-on accommodation. As a result they are more likely to move house during pregnancy, sometimes more than once. Teenage mothers are six times as likely as other households to live in areas dominated by local authority housing.

In a nutshell, teenage parents tend to come from poor backgrounds often from households with single parents; they often live in social rented housing in places where there are lots of other young parents; they frequently don’t receive a good education and don’t get a good job; some don’t look after their babies as well as they might and so they don’t give their children a good start in life – thus starting the whole depressing cycle again.
2. Causes of teenage pregnancies

The relatively high rates of teenage pregnancy in England compared to other western European countries are a result of a complex interaction between an individual, their family, their peer group, where they live, their experience of poverty and disadvantage and a series of cultural factors. Research has identified the key factors which increase the likelihood of teenage pregnancy. These can be broadly grouped into: risky behaviours; education-related factors; and family and social circumstances.

Fig. 5: Risky Behaviour

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Evidence</th>
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| Early onset of sexual activity             | • Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16.34  
  • Around 60 per cent of boys and 47 per cent of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20 per cent for both sexes leaving school at 17 or over with qualifications.  
  • Early onset of sexual activity is also particularly associated with some ethnic groups (see Fig. 7, below).                                                                                           |
| Poor contraception use                     | • Around a quarter of boys and a third of girls who left school at 16 with no qualifications did not use contraception during first intercourse, compared to only 6 per cent of boys and 8 per cent girls who left school at 17 or over with qualifications.  
  • Survey data demonstrates variations in contraceptive use by ethnicity. Among 16 to 18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32 per cent), Asian females (25 per cent), Black African females (24 per cent) and Black Caribbean males (23 per cent).35                                                                 |
| Mental health/conduct disorder/involvement in crime | • A number of studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17.36  
  • Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police.37                                                                 |
| Alcohol, drugs and substance misuse        | • Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for both young men and women.  
  • A study in Rochdale showed that 20 per cent of white young women report going further sexually than intended because they were drunk.38  
  • Other studies have found teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience.39                                                                 |
| More than one teenage pregnancy            | • A significant proportion of teenage mothers have more than one child when still a teenager. Around 20 per cent of births conceived under-18 are second or subsequent births.                                                                 |
### Fig. 6: Education-related factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat abortions</td>
<td>• Around 7.5 per cent of abortions under-18s follow either a previous abortion or pregnancy. In London this proportion increases to around 12 per cent of under-18 abortions.</td>
</tr>
<tr>
<td>Low educational attainment</td>
<td>The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment: 80 per thousand girls aged 15 to 17, compared with 40 per thousand.</td>
</tr>
</tbody>
</table>
| Disengagement from school         | • A survey of teenage mothers showed that disengagement from education often occurred prior to pregnancy, with less than half attending school regularly at the point of conception. Dislike of school was also shown to have a strong independent effect on the risk of teenage pregnancy.40  
• Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20 per cent of local authorities, areas with more than 8 per cent of half days missed had, on average, an under-18 conception rate 30 per cent higher than areas where less than 8 per cent of half days were missed. |
| Leaving school at 16 with no qualifications | • Overall, nearly 40 per cent of teenage mothers leave school with no qualifications.41  
• Among girls leaving school at 16 with no qualification, 29 per cent will have a birth under 18, and 12 per cent an abortion under 18, compared with 1 per cent and 4 per cent respectively for girls leaving at 17 or over.42 |
| Negative experiences of school education | Apparent dislike of school, bullying and non-attendance ultimately result in poor educational attainment. This lack of educational achievement can lead to growing perceptions about limited life-options regarding further education and/or employment. Indeed, some young women report that in the context of not knowing what else they can do, the decision to have a baby seems like a positive step forward. Many young mothers do not want to do a ‘boring’ or mundane job with no direction, meaning or room to progress. This often leads them to choose to keep the baby instead, possibly to give them a real sense of purpose in life and some future direction. |
### Freedom’s Consequences

**Fig 7: Family and background factors**

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in Care</td>
<td>• Research has shown that by the age of 20 a quarter of children who had been in care were young parents, and 40 per cent were mothers. The prevalence of teenage motherhood among looked-after young women under-18 is around three times higher than the prevalence among all girls under-18 in England.</td>
</tr>
<tr>
<td>Daughter of a teenage mother</td>
<td>Research findings from the 1970 British Birth Cohort dataset showed being the daughter of a teenage mother was the strongest predictor of teenage motherhood.</td>
</tr>
</tbody>
</table>
| Ethnicity                        | • Data on mothers giving birth under age 19, identified from the 2001 Census, show rates of teenage motherhood are significant higher among mothers of ‘Mixed White and Black Caribbean’, ‘Other Black’ and ‘Black Caribbean’ ethnicity. ‘White British’ mothers are also over-represented among teenage mothers (89 per cent of mothers aged under-19), while all Asian ethnic groups are under represented.  
  • A survey of adolescents in east London showed the proportion having first sex under-16 was far higher among Black Caribbean men (56 per cent), compared with 30 per cent for Black African, 28 per cent for White and 11 per cent for Indian and Pakistani men. For women, 30 per cent of both White and Black Caribbean groups had sex under-16, compared with 12 per cent for Black African, and less than 3 per cent for Indian and Pakistani women. |
| Parental aspirations             | Research shows that a mother with low educational aspirations for her daughter at the age of 10 is an important predictor of teenage motherhood.                                                               |
| Parental separation              | • Some young women reported that their parents’ separation had affected them negatively, made them feel unsettled and often seemed to be a catalyst for further disruptive experiences. Parental separation often led to a new father figure, a stepfather, or their mother having a new boyfriend. This was almost always reported as problematic and most young mothers reported bad family relationships and arguments. In some more serious cases, the situation made the young woman leave home. Leaving home early for these reasons seemed to make them more vulnerable to further disruption and involvement in behaviours risky to health. This is perhaps due to experiencing a lack of parental closeness and guidance. In many cases, their lives were stabilised by meeting a partner who would ultimately become the father of their child.  
  • While some young women recalled the upset of missing their father, others also mentioned that they did not know who their ‘real’ father was. These distressing experiences were often drawn on when explaining their own choices for parenthood, as a desire for wanting a ‘complete’ family of their own. The young women perceived pregnancy as an opportunity to correct these disruptive and unstable experiences, and enable them to focus their attention on having a better relationship with their own child. |
<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult relationships within the family</td>
<td>Data from research by the Trust for the Study of Adolescence showed that some young women had experienced physical and sexual violence while growing up, either in the family or towards them personally. The number of interviewees reporting such experiences was more frequent than expected, with a significant proportion reporting physical and sexual abuse. These situations often led the young woman to feel depressed and distant from her family. It generally led to problems at school, sometime leaving home early, meeting the father of her child, wanting something better for her own child, and becoming pregnant.</td>
</tr>
<tr>
<td>Moving location frequently</td>
<td>Many young women reported they often moved home when growing up. Not only was the area new but also this usually meant starting a new school and making new friends. The move was often due to changing family circumstances (for example, having a new stepparent). This was often reported by young women as distressing, and some reported this change leading to loss of friends, a sense of depression and generally feeling unsettled.</td>
</tr>
<tr>
<td>Social and family norms in local area</td>
<td>The young women’s own childhood and background experiences had also shaped their views towards teenage pregnancy as a life-choice. With reference to the local vicinity and neighbourhood, young women commonly report being surrounded by a norm of settling down early. For most, becoming pregnant appeared, therefore, to be a normal life-choice, and any recrimination or negative judgment of their decision is less likely.</td>
</tr>
</tbody>
</table>
3. Wider Social Changes in Sexual Behaviour

The consequences and causes of higher rates of teenage pregnancies in the UK must be set against a social backdrop that has radically changed since the 1960s. Many people point to a sexual revolution. That is taken to mean, in a nutshell, that both men and women have sex earlier and with more partners, particularly when young, using mechanical and chemical forms of contraception to avoid unwanted conception. Unwanted conception is not always avoided and lawful abortion is more readily available, and more common. The pattern of increased sexual activity is the same for both men and women, but the change in behaviour has probably been more radical for women. That people only had sex with their spouse once married was probably never true. But even if one is unsentimental and objective about the past, things have undoubtedly changed. A less judgmental attitude to sex before marriage (both heterosexual and homosexual) has become a byword for personal freedom in contemporary British society – and many, perhaps most, welcome that.

Young people have more sex, with more partners, younger

The second National Survey of Sexual Attitudes and Lifestyles undertaken in 2000 with over 11,000 men and women aged 16 to 44 in Great Britain,47 found that the median age at first heterosexual intercourse was 16 for both men and women, although nearly a third of men and a quarter of women aged 16 to 19 had heterosexual intercourse before they were 16. About 80 per cent of young people aged 16 to 24 said that they had used a condom when they first had sex. Less than one in ten had used no contraception at all when they first had sex. One in five young men and nearly half of young women aged 16 to 24 said they wished they had waited longer to start having sex. They were twice as likely to say this if they had been under-15 when they first had sex. Both young men and women aged 16 to 24 had an average of three heterosexual partners in their lifetime.48 About one per cent (0.9 per cent men, 1.6 per cent women) of 16 to 24 year olds had had one or more new same-sex partners in the previous year.49 These figures show that although social attitudes and sexual behaviour have changed, by no means everyone has started having unprotected sex younger or with more partners. Promiscuity among young people has hardly risen to epidemic proportions. Of those that do start young, some may be less likely to take precautions against unwanted pregnancy and many seem to regret it.

Use of contraception

An Office for National Statistics survey50 of women aged 16 to 49 in Great Britain found that among 16 to 17 year olds in 2005/06, 51 per cent said they used contraception. The most common reason given for not using a contraceptive method was not being in a sexual relationship. Among those who used contraception 78 per cent said they used the pill and 61 per cent used condoms (some used both). Ninety-one per cent had heard of emergency hormonal contraception (more commonly known as the ‘morning after pill’). Fifteen per cent had used emergency hormonal contraception at least once in the previous 12 months. Again, these figures suggest a widespread sense of knowledge and responsibility about sexual activity and its consequences; hardly a crisis.

Use of family planning services

Eighty-three thousand women aged under-16 attended family planning clinics in England in 2005/06, over eight per cent of the resident female population. This has increased from nearly seven per cent in 1995/96.51 277,000 or 21 per cent of the resident female population in England aged 16 to 19 years of age visited a family planning clinic in 2005/06. The proportion attending has remained steady since 1996/97.52 Considering the effort the government has made on teenage pregnancy, of which contraceptive advice is an essential part, these figures for young people seeking advice could have been expected to rise. Evidently the message has not always got through to those who needed to hear it.
Knowledge of sexually transmitted infections (STIs)

In an Office for National Statistics survey of over 7,000 adults in Great Britain,\(^53\) 83 per cent of men and 85 per cent of women aged 16 to 19 years knew that Chlamydia is an STI. However, of those respondents who recognised Chlamydia as an STI, 52 per cent of men and 37 per cent of women aged 16 to 19 years old did not know that it doesn’t always cause symptoms. Sixty-two per cent of men and 43 per cent of women aged 16 to 19 years old did not know that antibiotics easily treat it. In a survey of over 620,000 school children across the UK\(^54\) six per cent of male and female pupils aged 14 and 15 years old thought that AIDS or HIV can be treated or cured, whilst 17 per cent thought that Chlamydia can be treated or cured.

The picture being painted here is subtle. While attitudes to sex do seem to have become more relaxed, most people – including young people – are knowledgeable and behave responsibly in relation to having sex, using contraception, dealing with unwanted pregnancies and (to a lesser extent) sexually transmitted infections. But a significant minority of young people, either through ignorance or for other reasons (discussed in chapter 4), behave without adequate regard for the negative consequences to themselves of casual sexual behaviour.

Abortion

Abortion (sometimes called termination) is the surgical\(^55\) or medical\(^56\) ending of a pregnancy and, in England, Scotland and Wales has been legal since 1967. It is legally available up to 24 weeks of pregnancy (or beyond if a disability is diagnosed in the foetus). Abortions can take place in NHS hospitals or in private clinics. Most abortions take place around 10 to 12 weeks of pregnancy. About 180,000 abortions are performed each year in this country. In Northern Ireland abortion is illegal unless there is a threat to the life of the woman or a risk of real and serious harm to her long-term physical and mental health. The Department of Health estimates that there are between 70 and 80 illegal abortions performed every year in Northern Ireland and about 2,000 women travel to the mainland for an abortion.

Health risks of abortion

Although abortion can be used to deal with unwanted pregnancies and is an expression of ‘a woman’s right to choose’, it is not without consequences, many of them deleterious. The risks of abortion to physical health include infection (up to 10 per cent of cases); haemorrhage (bleeding) (in 1.5 per 1,000 abortions); perforation of the womb (between one and four per 1,000 abortions); damage to the cervix (up to 1 per cent of abortions). If complications ensue, especially infection, relative infertility is not unknown. Total infertility is rare but does occur. Other problems include a higher risk of ectopic pregnancy, miscarriage and premature labour in later pregnancies. There have been suggestions that abortion is linked to breast cancer. Since abortion is more likely in a teenage pregnancy so are its negative consequences.
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How women may feel about abortion afterwards

Many women may initially feel relieved after an abortion because they believe that their immediate preoccupying problems are solved. Some understandably feel sadness about the abortion but over time come to cope with what has been done. Some do not cope as well, however, and experience symptoms of post-abortion stress. When the abortion is being considered, for example, they may feel they are being pressurised by someone else into the decision or feel that they have no choice because circumstances feel overwhelming. An alternative but also disturbing set of emotions is feeling that, although the mother wants the baby, they have to have an abortion because a disability has been diagnosed in the baby. Some pregnant women have strong motherly feelings or maternal instincts even after the termination. Some women also simply feel instinctively uncomfortable with the idea of abortion.

After the abortion has taken place symptoms of post-abortion stress can include feelings of guilt, grief, or a sense of loss and anger. Some women may be feeling the need to ‘replace’ the baby. They may also feel a sense of distance from their other children. They may have difficulties in maintaining a normal routine and feel rather more depressed than just ‘a little sadness’. Other negative reactions can include sleeping problems, flashbacks, tearfulness, disturbing dreams or nightmares and an inability to be near babies or pregnant women. In severe cases, a woman can become suicidal, self-harming, indulge in risk-taking behaviours, become dependent on drugs or alcohol or suffer anxiety or panic attacks. These symptoms can occur at any stage after an abortion, sometimes triggered by another loss later on.

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Sexual behaviour has become more relaxed and for most people that’s fine. But for some others the consequences, including abortion and its physical and psychological effects, are depressing, even distressing. This seems to point to the need to discourage sexual intercourse too young – but to ensure, when sexual relations begin, that effective contraception is used to avoid unwanted pregnancies. These seem simple enough goals to enunciate but the methods of achieving them and influencing the behaviour of young people in the groups most at risk have so far often proved elusive, at least in the UK.
4. Attractions of Being a Young Mum

The foregoing analysis would suggest that all the experiences and outcomes of teenage pregnancy and parenthood are unpleasant and negative. That might imply that those young women who embark on sexual relationships, do not take effective contraceptive precautions, become pregnant and do not have an abortion are naïve, ignorant and self-destructive. Such a perspective would be dangerously limited. In fact, other less talked about motives attract young people towards parenthood – and it is these that are considered in this chapter. These attractions must be taken into account if young people are to be persuaded that the downside exceeds the upside.

Teenage parents as role models for teenage parents

The data already noted indicates that many teenage parents are the children of mothers who were teenage parents themselves. Almost all young children love their mothers. Not to love your mother is at best counter-intuitive and at worst dysfunctional. In adult life, of course, some people come to feel anger, bitterness and resentment at the perceived shortcomings of their mothers but during childhood almost all children seek the approval of their parents (interrupted by occasional bursts of self-centredness and self-righteousness).

In return for pleasing their parents, children receive security combined with what should be a carefully calibrated entitlement to independence and freedom as they get older. Good parenting – and being a good child for that matter – resides in balancing security and independence. When these elements are balanced the experts would say there is a pattern of secure attachment between parent and child. Patterns of insecure attachment that flow from imbalance, inconsistency and confusion lead, it is said, to a range of neuroses and dysfunctional behaviour. All of this remains true for teenage parents and their children as it is true for all parents and their children. Why should the children of teenage parents nevertheless not feel good about their parents even if they were also teenage parents? Perhaps their parents have been good parents, all the time, most of the time or some of the time – or at least they have been kind, even if sometimes chaotic. In the light of that strong, instinctive, persistent and universal bond between parent and child, young people may see their young parents as role models. They will not necessarily see, understand or be concerned by long-term consequences of social exclusion, seeing instead the short-term attractions. After all, one of the most debilitating aspects of social exclusion is that the excluded don’t always recognise the extent of their exclusion. On the contrary, with reference to their immediate peers, they may feel that their choices and lifestyles are quite mainstream, not deserving of criticism, censure or change at all.

Lack of alternative aspirations

Britain has in many ways become a dynamic, aspirational country, where people can aspire to social mobility, to living a different and better life than their forebears, however, the reality is that in some places so-called ‘neighbourhood effects’ have combined to create communities that have headed in the opposite direction. In the past, these communities would have been made up of people on low incomes, but who, despite that, had a degree of social solidarity that has now largely gone. Perhaps it was a constraint on social mobility that, like father like son, everyone went down the pit, to work in the shipyard, the steel mill or the car factory. Jobs were secure, improved terms and conditions were collectively negotiated and, broadly speaking, standards of living rose over time. Subsidised public housing meant that housing was warm, comfortable, you were not going to get thrown out by a rapacious landlord and the rent was held down to an affordable level. If there were aspirations they were shared communal aspirations. For many, there was no strong urge to escape. But all that has changed.

The factories, the mills and the pits have closed, but the schools have not improved enough to give people an education that might provide a chance to escape to the more anonymous, individualistic pleasures of middle class life and jobs in the knowledge and service economy. Those that could leave, have left. Those that could not, have remained. Poverty and exclusion has been concentrated and young people’s horizons in poor communities have closed in, perceiving professional lives and middle class ambitions as distant and alien.
Freedom’s Consequences

If they do venture out of the barracks of exclusion that large council estates in former industrial communities have become they sense a wider world where they don’t fit. They retreat to the safer certainties of knowing that nothing much will change for you and yours, even if you dimly perceive (perhaps resentfully) that things seem to be changing for others far away.

In the absence of a sense of alternative possibility it is easy to nurse feelings of being left behind and forgotten, with little to look forward to. Set against this kind of communal ‘depression’, getting pregnant in a way represents a positive choice: a way of getting noticed. Teachers, social workers, health visitors and GPs all start to show an interest in your welfare. Their interest may be censorious, but it’s better than being completely ignored or, worse still, treated as a no-hope troublemaker. Parents, possibly young themselves, may also have lost interest and turned away before you become pregnant, feeling that you are now old enough to get on with things for yourself. The fact that you are not getting on with much at all may be troubling to your parents, but they may feel that they can’t do much about it. But on the other hand if you are pregnant, they will start to take notice, concerned for your well being and that of the child. Other factors may also stay criticism. If your mother had been a teenage mum herself, she may not be in much of a position to criticise without seeming to be hypocritical. Or your parents may feel that what’s done is done and the best must be made of a bad job. Indeed they may welcome the arrival of a baby, giving some meaning to their lives too. Almost everyone’s heart melts at the sight of a baby. Babies are pure emotion and instinct, with little reflection, manipulation or articulation. And that emotional action and reaction from the baby brings forth an emotional, not a rational, reaction and action in those around. To protect the youngest of our young is one of humanity’s deepest instincts. For all these reasons, while getting pregnant may have been inadvertent, continuing with the pregnancy is a functional choice. You may think that having the baby will make your life better (and, who knows?) perhaps it might when compared to the (lack of) alternatives. Feelings are, after all, facts.

Unrealistic expectations of boyfriends

The stereotype of teenage mothers is that they are probably promiscuous and do not know the identity of the father; they are isolated and in conflict with their parents. On the contrary, in many cases, getting pregnant may be perceived as a way of making an embryonic and uncertain relationship with a boyfriend more permanent and secure. The person whose affection you may crave most of all, your boyfriend and the father of the child, will hopefully have his interest renewed and redoubled if you get pregnant. Teenage motherhood is much less problematic when accompanied by a stable, secure relationship between the young parents. Sadly it seems that teenage fathers often don’t stay with teenage mothers and more’s the pity; nor are they given much official encouragement to stay on the scene. The subject of teenage fathers will be discussed more fully in the next chapter.

Peer influences

Perhaps some young friends are also pregnant or have a child. That will bring empathy if you become pregnant. Even if not, they will be interested in the drama your life has become and they will, if they are good friends, feel protective and a caring urge for your physical and emotional vulnerabilities. The new baby is itself an attraction. In a life lived without much to call your own, here comes something that is indisputably yours and, heaven forbid, yours alone. Something to love and cherish; something that will undoubtedly love you back. What, in a way, could be nicer?

Some of these expected benefits, of course, may turn out to be more perceived than actual. Reality may bite hard and prove to be all too different to what has been imagined. But perhaps the most important point is about timescales. As far as teenage pregnancy is concerned, all the attractions and incentives are immediate and all the depredations and disadvantages are in the future. A feature of being young is only being aware of short-time horizons. In the light of all this, teenage motherhood can be seen as a positive (though perhaps misguided) choice, not as an unhappy and foolish accident.
5. Young Fathers

Every child has a father as well as a mother. The profile and behaviour of young fathers needs also to be considered when discussing teenage pregnancies. Fatherhood is not well researched when compared with the enormous amount of information available on motherhood, both young and old. The (incomplete) available data suggests that a quarter of young fathers were aged under 20, about half are between 20 and 25 years old and a further quarter are over 25. In the past young parents would have been cajoled or coerced into ‘shotgun weddings’. Today, it would seem that not only is less social pressure exerted on young men to commit to a relationship and take on the responsibility of parenting, but also less support and guidance is available for them if they want to rise to that challenge. Large-scale studies reveal a number of social disadvantages in young fathers’ families, such as low levels of parental education, large family size, not being raised by both birth parents and financial hardship. There are also links with low educational attainment, psycho-social adjustment, anti-social behaviour and low self-esteem.

Benefits of young parents staying together

Thirty per cent of young parents do live together but more than 60 per cent say they are single parents. Around a fifth of young fathers have never lived with their child, though put the other way round, that means that 80 per cent have at some time lived with their child, so that hardly confirms a lack of interest on the part of young fathers. The depredations of teenage parenthood are greatly reduced when the parents stay together. When young men do not take on the responsibilities of fatherhood, the consequences for the child’s development, the mother’s resources and the costs to society can be serious. In contrast, stable intimate partnerships can help both young men and women overcome feelings of social alienation and problems associated with poor childhood experiences. Becoming a parent can result in young men desisting from negative behaviours, such as offending, change their lifestyle and become interested in supporting their own family, sometimes becoming better fathers than their own fathers were. Research by the University of Bristol explored how first time fathers aged between 17 and 23 experience pregnancy, birth and early parenting. The research examines the factors that keep a father involved with the mother and the baby, how fatherhood affects young men’s identities, and how services could be improved to include prospective fathers and encourage commitment.

Impact of adverse family backgrounds

About one third of the young men in the study had experienced unhappy or discordant family relationships, and the majority had hated school or found it boring (though hindsight may play a part here). Nearly two-fifths showed problems in their work patterns and almost a third had difficulties with their social functioning prior to the pregnancy. Previous research has suggested that such poor family experiences lead to poorer social functioning, and therefore to early and less protected sexual activity, lower commitment to the mother and baby and less involvement after the birth. Contrary to these earlier findings, in the Bristol study there were links between adverse family backgrounds and poorer social functioning, but not between poorer social functioning and fathers’ involvement nine months after the birth.

Relationships with extended family

Extended family support can be particularly helpful to a young couple as they seek to cope with the birth of their first child. Their own parents were still part of these young men’s lives: 36 per cent lived at home during their partner’s pregnancy and another 51 per cent saw one or both parents weekly. Relationships with parents, however, were often poor and unsupportive. About a third of both the young women’s and the young men’s parents responded to the first news of the pregnancy negatively. Less than half of the prospective grandparents were clearly positive and supportive in the early days of the pregnancy. Relationships between the young men and women and a fifth to a sixth of their own mothers and nearly a third of their fathers were persistently cool. These lower proportions do, however, indicate that many extended families grew to accept the new, young family.
Feelings about the pregnancy

For the majority of young men, the pregnancy was a complete surprise and feelings at first were negative or mixed. By the time of the first interview, many (71 per cent) had positive feelings about the pregnancy, but two-thirds (66 per cent) had no clear image of themselves as a father.

Young fathers excluded

The research pointed to a lack of support from health services for young men preparing for parenthood. There are examples of good practice, but men are mostly ignored, marginalised or made uncomfortable by services, despite their desire for information, advice and involvement. Just over half the young men attended most clinic appointments and even more wanted to attend. Very few had any contact with preparatory or advice services, however, even though they reported significant worries about aspects of the pregnancy and birth. Clinic staff often talked only to the mother-to-be and did not engage with the prospective father. Interviews with health visitors revealed that 53 per cent knew little or nothing about the father. In addition, health professionals rarely saw work with young fathers as central to their task, and often felt that they lacked the skills to engage with men. The government’s review of its teenage pregnancy strategy in 2007 confirmed this negative picture.

“Young fathers often reported very negative experiences of midwifery and health visiting services. They felt very strongly that they were made to feel unwelcome and were often ignored completely. This is particularly worrying given the evidence that the fathers’ involvement during the pregnancy can be a strong protective factor and influence the degree of contact with the child after the birth, even if the relationship with the mother changes.” 61

These findings underline the importance of developing the skills of health service professionals, specifically in working with young men to help support and stabilise their intimate relationships in the early months of their transition to fatherhood. That would do a great deal to reduce the pressure on the mother during the pregnancy, at the time of the birth and for a long time thereafter.

Involvement after the birth of the child

The Bristol study investigated whether couples were living together nine months after the birth as well as the extent to which young men were involved in parenting and supporting the mother, whether or not they were living together. Research showed that 69 per cent of couples were living together, 37 per cent of men were not involved as fathers, 32 per cent were involved in a rather routine way and 31 per cent were active fathers. So more than two-thirds of young fathers were supportive. These commitments could be strengthened and deepened. Much more could be done by health workers, youth workers and teachers to strengthen the involvement of the seemingly indifferent young fathers – who may be more confused and marginalised than indifferent.

Significance of age and residence

The age of the young couple had a significant bearing on young men’s involvement. When both the man and woman were aged 17 and under, only 12 per cent of young men were involved with the child nine months after the birth. But as men’s ages rose, so did their involvement, regardless of the age of the young mother. For women in the youngest age group, the proportions of involved men grew to 43 per cent for men between the ages of 18 to 21 and 100 per cent for men aged 22 and over. When both partners were age 20 and over, the proportion of involved men was also high, at 82 per cent. Men were much less likely to be involved after the birth if the mother lived with her parents during the pregnancy. This is related to the woman’s age, as 63 per cent of the youngest group of women were living at home, compared with only 13 per cent of those aged 22 or over.
Quality of the young couple’s relationship

The Bristol study explored how couples felt about their relationship during the pregnancy, asking: how committed each of them felt towards their partner; how compatible they thought they were; and how stable and secure they felt their relationship was. Couples were overwhelmingly positive about their relationship during the pregnancy:

- 72 per cent of men and 67 per cent of women rated their commitment as moderate to high.
- 93 per cent of men and 84 per cent of women said they were generally compatible.
- 90 per cent of men and 84 per cent of women said their relationship was moderately to highly stable.

Women were somewhat more cautious than men (but not significantly so) and both men and women saw the younger men as less committed. Neither poor childhood family relationships nor poorer social functioning prior to the pregnancy affected young men’s involvement nine months after the birth. Nor did the quality of relationships with the man’s and the woman’s family. The couple’s own evaluation of their relationship was, however, related to post-natal involvement. Young men often had problems seeing themselves as fathers. About a third had not become involved with their child after the birth. When people rated their relationship in pregnancy as particularly stable, the man was much more likely to still be involved nine months after the birth. So whatever the histories of the young parents, if they can be supported to keep their relationship stable and continuing during the pregnancy, that bodes well for the future.

This important research by Bristol University draws on a sample of couples where paternity has been acknowledged and where the young men were sufficiently interested in the impending birth to take part in the research. Nevertheless, over one third (37 per cent) of the young men were not involved or only very weakly involved in parenting nine months after the birth. The young men in the study had high rates of adverse family experiences, poor school experiences, poor social functioning and poor relationships with parents. So although young fathers are interested in staying involved as parents and partners, some of their own past experiences have not taught them the lessons in life to allow them to do this. So they fall by the wayside and little encouragement is offered. All the more reason why their own uncertainties should be ameliorated by encouragement and support from professionals. In fact, professional indifference to young fatherhood just pushes them away and, combined with their own insecurities, excludes them from a positive journey to adulthood and parenthood.

The transition from adolescence to parenthood is clearly a process and not an event. It is a complex process with many influences at work. Results from this research point to a more positive view of young fathers than the stereotypes of feckless irresponsibility sometimes allow. The Bristol study also offers the encouraging possibility that teenage motherhood would be far less of a problem for mother, father and child if relationships between all three, and indeed members of the surrounding extended family, were positive and supportive – and professionals worked actively to keep young fathers involved.
6. Ethnic Differences

There are ethnic differences in teenage pregnancy rates in the UK. Bangladeshi and Black Caribbean teenage pregnancy rates are higher than those for White British young people. Those of Pakistani teenagers are similar to White British young people, but four times greater than those of Indian young people. Teenage pregnancy within marriage particularly among Bangladeshis and some Pakistanis, however, may still be a cultural norm as a result of marriage at an earlier age. Teenage pregnancy within marriage and with extended family support does not suggest the same adverse long-term consequences as teenage pregnancy followed by single parenthood, isolated and poor.

What is already known about ethnic differences among teenage parents?

The vast majority (89 per cent) of mothers aged under-19 are White British, although in local authority areas with large black and minority ethnic populations the picture is different. In London, less than 60 per cent of young mothers are classified as 'White British' and less than a third in six of the London boroughs. The likelihood of teenage motherhood is higher, however, among young women of 'Mixed White and Black Caribbean', 'Other Black', 'Black Caribbean' and 'White British' ethnicity. All Asian ethnic groups have a lower than average incidence of teenage motherhood.

Fig. 8: Ethnicity of mothers giving birth under age 19 between 1991 and 2001

[Diagram showing the ratio of proportions (mothers under 19/all females aged 15-19) for different ethnic groups.]
Reducing teenage pregnancies and their negative effects in the UK

Earlier onset of sexual behaviour in some ethnic groups

Approximately 26 per cent of young women and 30 per cent of young men report first sexual intercourse before age 16 in Britain. Research on behaviour and expectations of sexual intercourse among 18 to 20 year-old South Asians and non-South Asians living in Greater Glasgow described young South Asian women as reporting less experience of sexual intercourse than white women and South Asian men as reporting similar levels to white men. In another study, in-depth interviews with 36 South Asian and 25 white British showed that young women were influenced by cultural traditions, religious beliefs and the expectations of community and family, suggesting that young Muslim and Sikh women had more restrictive cultural norms in terms of teenage sexual behaviour than did Hindus.

In one study, young people of both sexes in Bangladeshi, Pakistani and Indian groups reported significantly lower proportions of ever having had sex than White British young people. On the other hand, Black Caribbean and Mixed Ethnicity young men were more likely to say they had had sex than White British young men were. Of those young people who reported starting sex, 38 per cent reported having first done so at 13 years or younger. Starting sex at or below age 13 was more common in White Other and Black Caribbean groups. Having a boyfriend or girlfriend put both young men and women at a higher risk of early onset of sexual activity. While White British young people were more likely to have sex if they were in longer-term rather than shorter relationships, this did not appear to be the case for Bangladeshi, Black Caribbean and Black African groups. These reported ethnic differences in ‘having sex’ may not account for other kinds of intimate relationship. Many teenagers flagged up the importance of “knowing” someone before becoming involved with them sexually.

More sexual partners in some ethnic groups

There were significant ethnic differences in young people’s reports of the number of sexual partners. White Other, Black African and Mixed Ethnicity young people were more likely to have had sex with two or more people compared to White British young people. Some young people said that their parents’ expectations of them, linked to their ethnic background and cultural values, would prevent them from having sex before they were married. Others made it clear, however, that the influence of ethnicity, culture and family varies within as well as between ethnic groups.

Ethnicity, starting sex and using contraception

According to one study religion and traditional cultural identification appear to protect young men when making decisions about starting sex, but these may also operate as risk factors in not using contraception. A strong connection with parents' traditional culture was associated with lower risk of starting sex in both young men and young women. The area or country where young people were born was less important for predicting sexual risk behaviour. Traditional cultural identification, as indicated by friendship choices, was protective against starting sex in young men but not in young women. However, once such young men had started sex, they were at increased risk of having unprotected sex. The same was the case for religion. Young men claiming higher religious observance were less likely to have started sex, regardless of their religion. Again, once such young men started having sex, however, they were more likely to have had unprotected sex than young men who have never attended a religious meeting.
Ethnicity and use of contraception

There are differences in contraception use between ethnic groups, and also within ethnic groups commonly categorised as ‘Black’. In comparison to White British young men, Black Caribbean young men were no more likely to have unprotected sex (indeed there was a trend for them to be more likely to use contraception) and Black British young men were less likely to have ever had unprotected sex. Black African young men had similar rates of starting sex and unprotected sex to White British young men. Mixed Ethnicity young men reported similar levels of unprotected sex to White British males, although they were more likely to have had sex than White British young men. Young men from Bangladeshi, Pakistani and Indian ethnicities were less likely to have had sex than White British males, and no more likely to use contraception once they did have sex. Among young women, there were no significant ethnic differences in reports of having had unprotected sex.

Attitudes in the family

In one study, teenagers across all ethnicities described difficulties in talking with parents about sex. Those who were least likely to talk to their parents were young people from Bangladeshi, Indian and Pakistani backgrounds. Where young people reported difficulty talking to mothers and fathers about sex, however, this reduced the likelihood of having had sex among young men though not young women. This effect was also seen for talking to fathers in White British and Black Caribbean young people but not in Bangladeshi or Black African teenagers. The belief that their parents would disapprove of them having a physical relationship was highly protective against having sex for both young men and women. Young people described drawing on the support and advice from relatives in their wider families; Black African, Black Caribbean and particularly Bangladeshi and Pakistani teenagers mentioned members of their extended families.

Peer attitudes and influences

Young people described in various studies talking to their friends (sometimes friends of the opposite sex) to find support and advice about their intimate relationships. Teenagers reported listening to trusted peers, though ultimately making their own decisions. Young people also mentioned times when their friends disapproved of people they fancied. Some young women described pressure from female friends and boyfriends to have sex. Young men also reported being pressured by male peers to have sex. Eleven per cent of young women and seven per cent of young men reported being pressured by their partner when they first had sex. There were no significant ethnic differences between young men and women in reports of being pressure into sex.

Casual sex

A small number of young men and even fewer young women described having or seeking casual sex. Young people, especially young women, suspected by their peers of engaging in casual sex were sometimes described in disparaging terms. The length of time partners had known one another seemed a defining factor here. Particularly for young women, the earlier she is willing to have sex, the lower the degree of respect afforded her by her peers.

Starting sexual activity later helps

The patterns suggested so far by this range of studies seems to lead to the conclusion that young people from some ethnic groups are more likely to become teenage parents, particularly white young people and young people from some black ethnic groups. The reason for this seems to be that the communities with a lower incidence of teenage pregnancies are also the communities in which, for a variety of reasons including religious and cultural reasons, sexual relationships at an early age outside of marriage are actively disapproved of and effectively discouraged (including by use of the old-fashioned technique of simply not talking about it; this seems to discourage more young men from having sex than young women, who have stronger peer bonds with other young women).
In the communities where the risks are higher, it is not that young people want to get pregnant but that they are more likely to start sexual relationships earlier without the maturity to always take adequate contraceptive precautions. Failing to be totally responsible in the use of contraceptives seems to be a general problem, not confined to some ethnic groups. There may also be some peer pressures, or lack of peer restraints, that make sexual relationships more likely to occur earlier in some communities than others.

In summary there are ethnic differences when considering who becomes a teenage parent, but it is not between black and white young people. It derives from a complex and paradoxical interaction of causes and effects. Culture and religion do play a part, particularly with inter-generational relationships, but peer and locational influences are also strong. Broadly speaking, in south Asian communities relationships between boys and girls in the early teenage years are actively discouraged by their elders thereby delaying the onset both of intimate relationships and sexual activity. This norm, which could be seen as cultural or religious, has a protecting effect against the risk of teenage pregnancy outside marriage. So family values play a part. In addition, exposure to peer pressures to begin sexual activity also seem to encourage the earlier onset of sexual activity. This can create locational patterns which overlay or counterbalance ethnic patterns. In other words, young people of all backgrounds living in a particular neighbourhood are more likely to be influenced by peer pressures to have sex. If those neighbourhoods are also ones with high concentrations of black and minority ethnic communities, ethnic groups will show a higher incidence of teenage pregnancies. A neighbourhood pattern becomes an ethnic pattern. Ethnic variations are also discernible in responsible attitudes to using contraception and to the number of sexual partners.

Concluding that some ethnic groups have some kind of predilection towards teenage pregnancy and single parenthood is wrong. There is no evidence that casual adolescent sex or teenage pregnancy is encouraged in any ethnic group or by any cultural tradition. The interplay of cause and consequences does however seem to produce a higher incidence of teenage pregnancies and single parenthood in some ethnic communities in some neighbourhoods – Black African, Black Caribbean, Mixed and White British. This seems to reflect different cultural and family norms about teenage sexual relationships. This trend is exacerbated by stronger peer effects promoting the acceptability of teenage pregnancy in certain poor neighbourhoods.

These ethnic differences point to the need to challenge all these causes and consequences rather than simply taking a negative and culturally deterministic view based on ethnicity, which, in the end, is a counsel of despair: that nothing can be done because everyone is stuck with their ethnic origin. Socially conservative cultural norms do seem to restrict early sexual behaviour and teenage pregnancies. It is hard to imagine, however, that those communities which have adopted more liberal norms could be convinced of a different value system or returned to an earlier era. As we shall see later in this paper, simply preaching abstinence with all the moral rectitude that can be mustered does not seem to do the trick. Promoting more responsible attitudes to sex, contraception and relationships to both boys and girls seems much more promising.
7. International comparisons

Aside from the United States, the UK has the worst record on teenage pregnancies in the developed world, according to Unicef’s Innocenti Research Centre, as shown in their league table of rich nations below.

**Fig. 9: Number of births to women aged 15 to 19 per 1,000 women**

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<tr>
<th>Country</th>
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**Spread of liberal values across the developed world**

The particular difficulty of analysing international trends in teenage pregnancies is that the social context has changed so rapidly that analysis and policy response can quickly become outdated. The social changes include, for example, the spread of cheap effective contraception and the liberalisation of abortion law. In terms of gender and attitudes to women, great progress has been made by women towards educational and career equality. There has also been a widespread rejection of traditional sexual codes, and the emergence of a more sexualised society as old taboos have fallen away.
All of these liberal changes are generally for the good especially because people have more personal freedom, more choice and a greater right to be themselves.

Freedom of this kind, at least for some, has come nonetheless at a price. Young people have gained the right to behave in ways that are risky, ways that may not be in their long-term best interest and the consequences of which they do not fully understand. At the same time they have acquired the obligation to be more responsible; an obligation not always understood or acquitted. Over the same period, powerful economic pressures have favoured two-income households, raised the opportunity costs of having children, placed an increasing premium on education and knowledge, and deepened the relative economic disadvantage of the low skilled, to the point where some have become detached from the mainstream labour market altogether.

**Sexualised society**

Some argue that the overall effect of the transformation of social attitudes to sex and gender in the western world since the 1960s has been to bring strong downward pressure to bear on teenage birth rates. Young people are generally more open and knowledgeable about sex and its consequences, even if they do not have a similar mature clarity about the emotional ramifications. This greater knowledge means that, though they may have more sex with more partners, in general they will also take precautions against unwanted pregnancies. But not all of the factors have been pulling in the same downward direction. The weakening of traditional attitudes, in particular, has combined with commercial pressures to create more sexualised societies in which old taboos serve mainly to add to the allure of the formerly forbidden. Sexual imagery and content are increasingly permeating the information and entertainment environments within which today’s teenagers develop awareness, experiment with identity, and live out their aspirations towards adulthood. Surmise (though without much evidence) might suggest that this could lead to a greater readiness among young people to take risks they barely understand, some of which are dangerously self-harming.

Unsurprisingly in such a context, sexual activity among teenagers has increased. In the United Kingdom the average age at first intercourse is 17 for both sexes (it was 20 for males and 21 for females forty years ago). Statistics suggest that the number of girls having under-age sex (i.e. below 16 years old) has doubled in the last 10 years, and that almost 40 per cent of 15 year-old girls have had full sexual intercourse. In 10 out of 12 developed nations with available data, more than two thirds of young people have sexual intercourse while still in their teens. In Denmark, Finland, Germany, Iceland, Norway, the United Kingdom and the United States, the proportion is over 80 per cent.

The greater incidence of teenage sex could have been expected to produce significant increases in teenage birth rates. Countries with low teenage birth rates tend either to be countries that have travelled less far from traditional values or countries which have embraced the liberalisation of sexual and gender values but have also taken educational steps to equip their young people to cope with freedom’s consequences. Something similar may be said about the ethnic and cultural variables already discussed in chapter 7.

**Traditional values**

Some social conservatives would still argue for a return to more traditional values, perhaps for ideological as well as pragmatic reasons. Norman Wells of the Family Education Trust told the Sunday Telegraph:

“The problems associated with teenage pregnancy will never be solved so long as the government persists with its reliance on yet more contraception and sex education. What we need is a radical change away from a culture which has reduced sex to a casual recreational activity.”
Freedom’s Consequences

The method by which such a radical change in ‘culture’ would be brought about is, however, far less clear. No country in the world has so far succeeded in a universal reversal of liberal values. The only options would in fact not be ‘cultural’ changes, but profoundly oppressive and coercive legislative approaches, which may or may not bring about the desired result and even then, only at a huge cost in individual liberty. Since no political party is currently proposing such a course, (rather, in fact, the opposite), one can safely assume that polling and research data does not confirm any general appetite for such a change. Some may be nostalgic but policies to build a better yesterday are elusive and difficult to define, let alone implement.

Another centre of objection to advising and guiding young people on coping with freedom’s consequences is religious. The Roman Catholic Bishop of Lancaster, Patrick O’Donoughue, for example, wrote in a document called Fit for Mission, which was distributed to the Catholic schools in his diocese during 2007:

*The secular view on sex outside of marriage, artificial contraception, sexually transmitted disease, including HIV and AIDS, and abortion, may not be presented as neutral information.* 83

The means of achieving these alternative goals are unclear. What is not acceptable and the grounds for objection are clearly stated but teaching abstinence from sex outside of traditional marriages has had no impact on reducing either the frequency of pre-marital sex or the use of contraception or, for that matter, on sexual habits generally. Even people in countries with strong Catholic traditions, such as Spain and Italy, have enthusiastically embraced the use of birth control resulting in some of the lowest fertility rates in the world (though it does seem, as already discussed, that the persistence of traditional and religious social values, even if not followed to the letter, do have some general social effects which reduce the rate of teenage pregnancies).

Turning back the clock to more traditional values is almost impossible and (for a host of other reasons) is undesirable. The best alternative consequently for the UK is to ensure that young people understand sexual freedom and how to prevent its negative consequences while enjoying not just the ‘recreational’ pleasures, but also the opportunity that sexual relationships provide for a deeper intimacy and a fuller exploration of what it means to value the person and to share a relationship. The emotional aspects of that require preparation. This will be considered more thoroughly in the discussion of sex and relationship education later in chapter 8.

Unequal impact

The context of economic and social inequality in terms of income, wealth and their close cousin, educational achievement, is also important. Indeed even the attempt to prepare young people for life in a more sexualised society can itself become a sphere in which relative disadvantage operates. There is a strong association between teenage pregnancy and a disadvantaged background. The likelihood of teenage pregnancy in the UK is ten times higher for girls whose parents are unskilled manual workers than for girls whose parents are middle class professionals.84

‘Index of hope’

UNICEF’s international league table of teenage is an index not just of success in equipping teenagers to prevent births but also of success in building a more inclusive society. It is, in one dimension, an index of hope, of teenagers’ own sense of current well-being and future prospects. This table shows the teenage birth rate of 28 OECD nations alongside two common indicators of ‘inclusiveness’.
Reducing teenage pregnancies and their negative effects in the UK

Fig. 10: Teenage births, income inequality, and youth out of school

<table>
<thead>
<tr>
<th>Country</th>
<th>Teenage birth rate</th>
<th>Income inequality index</th>
<th>Percentage of 15 to 19 year olds not in education</th>
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Structural inequalities and the absence of aspirations

Of the top ten countries all, except Italy and Switzerland, could be described as ‘inclusive societies’ as judged by the degree of income equality. Korea, Japan, Italy, Switzerland, and Spain would appear in addition, to enjoy positions in the top ten not because of changes in the sexual education of young people but more probably because traditional values remain a significant influence. Other top ten countries, such as Netherlands, Sweden, Denmark, Finland, and France, have travelled a long way from traditional values and have widely accepted liberal values in sexuality and gender but have achieved a rapid fall in teenage birth rates by fully exposing young people to the forces that have tended to make early childbearing a disadvantage, but by also being relatively inclusive societies, as well as by making conscious and apparently successful efforts to prepare and equip their young people to cope with a more sexualised society through sex and relationship education.

High teenage birth rates in countries such as the Czech Republic, Hungary, Poland, Portugal, and the Slovak Republic may include a significant proportion of married teenagers. At the very bottom of the table are countries such as New Zealand, the United Kingdom, and the United States – all less inclusive societies as measured by high levels of income inequality and the proportion of older teenagers not in education. It appears likely, therefore, that a large proportion of young people in these latter three countries may be less strongly motivated by their social and economic aspirations to delay childbearing (see earlier discussion about the relative attractions of teenage parenthood in chapter 4).

Lessons from the Netherlands

Several northern European nations (Denmark, France, Norway and Sweden) have achieved low teenage birth rates partly by relying on relatively high levels of abortion. The level of abortion may reflect the acceptability of terminating pregnancies in a given society; but abortion is no one’s first choice (as already discussed), and therefore must also be seen as evidence of failure to educate and equip young people to use contraception effectively. The Netherlands, on the other hand, not only has one of the lowest teenage birth rates in Europe but also one of the lowest teenage abortion rates in the developed world. The Dutch have managed to reduce teenage births by 72 per cent in 30 years.

Studies of the Dutch experience have concluded that the underlying reason for success had been the combination of a relatively inclusive society with more open attitudes towards sex and sex education, including contraception. This has paved the way for sexual relationships to be discussed at an early age, before barriers of embarrassment can be raised and before sex education can be interpreted as sending a signal that the time has come to start having sex. Teenage boys in the Netherlands are two to three times more likely to discuss contraception with their sexual partners than teenagers in the United Kingdom, and their parents are twice as likely to discuss sex with their children. Young people in the Netherlands have a higher average age at first intercourse, lower levels of subsequent regret, higher levels of contraceptive use and effectiveness, and report more discussion and forward planning between partners. The United Kingdom has a higher rate of teenage birth than other European nations but lower rates of contraception use: only about 50 per cent of under-16 and two thirds of 16 to 19 year olds use contraception at first intercourse.
Reducing teenage pregnancies and their negative effects in the UK

Motive and means
Lowering teenage birth rates is a matter of both motivation and means. The ‘means’ of avoiding teenage pregnancies involve not only availability of contraception but also sex education which enables young people to make informed and mutually respectful choices, including the choice to delay having sex or to insist on safe contraception. Motivation is less tractable. In the main, the incentive to avoid early parenthood in liberal societies without the social disapproval of conservative societies stems from a stake in the future, a sense of hope, and an expectation of inclusion in the benefits of living in an economically advanced society. The absence of aspiration reduces the incentive to behave responsibly.

Lessons from Mexico
An important range of policies towards encouraging positive parenting (not specifically teenage parenting) have been implemented in Mexico and (in a different way) Brazil. The Mexican experience is particularly germane. Known by its Spanish acronym ‘PROGRESA’, Mexico’s Programme for Health, Nutrition and Education was initiated in 1997. In essence the programme makes cash benefits conditional on being a good parent. The first pilot phase involved 24,000 households in 506 villages. In these villages mothers of poor families were eligible for three years of cash grants and nutritional supplements if the children made regular visits to health clinics and attended school at least 85 per cent of the time. Since Mexico is a country where child labour is still prevalent, the cash benefits were set at two thirds of what children could earn in the labour market (a very laissez faire environment in Mexican cities). Attendance at school increased radically. Improvements in health were even greater and the most marked beneficial effects were in weight and height: well-known proxies for healthy child development and well-being. The programme has a 97 per cent take-up rate and is popular with the parents participating. It is not seen as coercive or stigmatising. Within four years the programme had been extended to cover two million families.

Perverse welfare incentives in the UK
The comparison with the British approach to social handouts and welfare benefits is instructive. The amount of money and help (in the form of housing benefit, for example) reduces in the UK when your child and you do better. If you get a job, or the child starts attending school more regularly, or problems of early years nutrition are overcome, the amount of assistance you receive, both professional and financial, is reduced. This is done in the name of a means test. The idea is that your newly-acquired greater resources mean you can help yourself and state aid should be reserved for those who can do least to help themselves. While this is based on a well-meaning principle of equity, the effect is to create perverse incentives. The isolated young mother, without help from the father or her own extended family, who is coping poorly with looking after the child is the one who will receive the most help: social housing; a nursery place and the full complement of welfare benefits. The hard-working young parent who pays for her own accommodation is trying to keep her relationship together with a young man in a poorly paid job and continuing to show respect and affection for her family, while giving the child the best chance she can will get less material and emotional help. The world has been inadvertently turned upside down.

In the realm of unemployment benefits experiments in the United States with welfare to work have led to a belated but now general recognition in the UK that work, not unemployment, needs to be incentivised. Similar thinking on parenting is so far absent. The failure to support teenage parents effectively with a view to improving their own life chances and those of their children is largely the result of targeting negative behaviour with tools that don’t rectify the behaviour, rather than encouraging good relationships and good parenting. There are no incentives to be a good parent but there are some financial and social incentives to be a bad one.
8. Prevention

The previous chapter drew attention to the big structural factors that tend to destroy young people’s aspirations and therefore to create the conditions in which teenage pregnancies – and other forms of behaviour with negative consequences – can grow and spread among young people. This chapter considers the instrumental approaches to policies and practice that can prevent teenage pregnancies, and looks at the extent to which approaches followed in the UK have succeeded – or failed.

Sex and relationship education (SRE)

The discussion of international comparisons, particularly the experience of the Netherlands highlights the importance not only of sex and relationship education at an early age, which facilitates young people in being more open about sex, but also about the emotions of intimacy. Against a more emotional background, messages about the importance of shared responsibility for, and planning of, contraception are much more likely to be heeded. A focus on the mechanics of contraception isolated from emotional context is unlikely to have much impact.

There is good evidence that school-based SRE, particularly when linked to contraceptive advice and services, can have a positive impact on young people’s knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates. On the other hand, there is no evidence to support the view that increased provision of SRE increases the onset or frequency of sex or the number of sexual partners. Ofsted’s 2002 report of inspections on sex and relationship education in schools found schools had tended too often to focus on the factual rather than the emotional aspects of SRE. Ofsted also noted that lessons delivered by teachers with specialist skills in SRE tended to be a better experience for pupils than those delivered by form teachers. Lessons delivered by non-specialist teachers have tended, unsurprisingly perhaps, to focus on behaviour rather than emotion and purvey simplistic abstinence messages.

Ofsted felt that school programmes need to do more to develop values and attitudes and the personal skills needed to make sensible choices, in other words, to focus on emotional as well as rational aspects of maturity. In more than half the lessons observed pupils were given no opportunities to communicate a point of view; make sensible choices about what to do in a particular situation manage relationships with friends and act responsibly as an individual and as a member of a group. The educational methods were a long way out of kilter with the hoped-for message. One student told inspectors:

"We are taught about reproduction but not about being in a loving relationship and making love. It's no wonder some don't use condoms." (Year 10 girl in a mixed school)

According to teachers many parents are reluctant to play a greater role in discussing sex and relationships with their children because they feel they lack the necessary knowledge and skills. Two thirds of primary schools and over half of secondary schools offer parents the opportunity to become involved in planning and reviewing SRE. Few accept it. Evening events for parents to discuss SRE are thinly populated. The media, especially magazines for teenagers, are an increasingly important source of information and have a significant bearing on pupils’ attitudes. Teachers and schools clearly need to be more aware of the role of these media.
What do young people think of SRE?

Recent evidence about what young people think of the sex and relationship education they have received is discouraging. In 2006/07, the UK Youth Parliament surveyed thousands of young people under 18 through an online questionnaire. More than 2,000 young people (a substantial though not representative amount) responded to the simple survey of six questions which attempted to ascertain the level of sex and relationship education (SRE) in schools across the country and what young people thought of it. Nationally 40 per cent of young people between the ages of 11 and 18 thought that their SRE was either poor or very poor, while a further 33 per cent thought it was average. Fifty-five per cent of all 12 to 15 year olds and 57 per cent of girls between the ages of 16 and 17 had not been taught how to use a condom. Only 49 per cent of respondents knew where their local sexual clinic was. In addition, young people reported that sexual health clinics were often open at inconvenient times for young people. Overall 55 per cent of the respondents said they had been taught about teenage pregnancy. Many knew the impact having a baby could have on their lives, but knew little about the development of a baby in the womb and the impact that pregnancy could have upon their bodies. Alarmingly 61 per cent of boys and 70 percent of girls over the age of 17 reported not having received any information about personal relationships at school. Overall 43 per cent of all young people surveyed said that they hadn’t been taught about personal relationships at school. Seventy- three per cent of all respondents felt that SRE should be delivered under the age of 13, with 56 percent of boys under 11 wanting SRE in primary schools.

This survey, like the 2002 Ofsted report of inspections, tends to confirm the need for a radical and redoubled effort on sex and relationship education as the best method of preventing teenage pregnancies by giving young people a proper emotional context and vocabulary for discussing sex and by helping them to make sensible joint decisions about the use of contraception. Without that, all other approaches are unlikely to succeed as they may be operating effectively in a vacuum.

This survey drew the attention of the government to the shortcomings of SRE and a review was commissioned. The steering group for this review in turn commissioned research of its own from the Sex Education Forum, which found:

- Significant numbers of young people did not feel that the SRE they had received was adequate: 34 per cent rated it as poor and a further 43 per cent said it was only OK.
- There was a strong view that SRE was too biological. Topics taught well included: the biology of sex and reproduction together with the physical changes that occur during puberty. Broader aspects of SRE that were taught least well included: skills for coping with relationships, as well as feelings and emotions that are experienced during relationships.
- Most respondents felt that many topics were introduced too late and that SRE should continue to be taught in post-16 learning.

The review steering group also commissioned an international evidence review of what works in SRE that suggested that (1) SRE programmes in schools needed to be combined with improved access to contraceptives; (2) abstinence messages were not effective; (3) trained teachers are more effective than generalists; (4) SRE is more effective if begun before the onset of sexual activity and (5) SRE should focus on skills and attitudes, rather than narrow ‘knowledge’. This led the review to recommend that sex and relationship education should be part of the curriculum in key stages 1 to 4, i.e. for children between the ages of five and 16.

The government has responded to the review, broadly accepting its findings but commissioning an extensive consultation, which does not necessarily bode well for early action. The government’s response, while accepting the strong evidence of the need for and effectiveness of relationship education in primary schools, suggested an obvious wariness of accusations of ‘sex lessons for infants’ and other alarmist headlines. Schools Minister, Jim Knight, explained to the BBC:

“We are not suggesting that five and six year olds should be taught sex. What we are saying is we need to improve in particular the relationship education, improve the moral framework and more understanding around which we then talk about sex later on in a child’s education.”
A curriculum review is underway. One hopes that reactionary prejudice does not triumph over reason and evidence and result in continuing with ineffectual approaches to SRE: too little, too late.

Involving parents

There is good evidence that including teenagers’ parents in information and prevention programmes is effective. Further, young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse.95 As already noted this is hard to achieve either in school or in the home.96 Evidence from discussion with pupils in visits to schools and from national surveys confirms that parents are less and less the pupils’ main source of advice on sexual matters.97

The result of parental silence, diffidence, embarrassment and taboo may, of course, lead everyone to agree with Philip Larkin that, ‘they fuck you up, your mum and dad’. But being fucked up (probably universal) fortunately does not lead everyone to irresponsible sexual behaviour. Or to put it another way, just because people do not behave irresponsibly, doesn’t mean that they were helped to gain any firm grasp on emotional maturity by their parents. It may just be a happy fluke.

Supporting individual pupils

Schools provide support and advice for individual pupils in a number of different ways. Boys feel that this support and advice on teenage pregnancies is often aimed only at girls. While not necessarily true, the perception discourages them from seeking help. Support for pregnant schoolgirls varies in quality. The most effective support is comprehensive and ensures that the impact of pregnancy on educational progress is minimised. School-age fathers do not receive enough guidance, as already noted in chapter 5. Pupils need to be given better access to individual advice from specialist professionals.98

Information, advice and access to contraceptive services

An important aspect of sex and relationship education is ensuring that young people, both girls and boys, who are thinking of having sex know where to get advice and guidance on contraception. Again, the UK does not seem to have a good track record here. The old taboos and shame that have long surrounded ‘family planning’ (even that phrase is a euphemism) seem to be taking a long time to disappear, partly because some parts of public opinion find a frank discussion and availability of advice on contraception distasteful, and, as far as young people are concerned, positively immoral. While these views are not officially approved of, they have perhaps stayed the hand of the authorities before pursuing a more proactive and explicit approach to the availability of contraception and advice. Notwithstanding these concerns, there is no evidence to support beliefs that use of family planning clinics, school-based health clinics and school-linked clinics increases sexual activity rates.99

Peer education doesn’t seem to work

There is only weak evidence at present that peer-led approaches to SRE are effective.100 Despite that lack of evidence of success many voluntary organisations are seeking to develop and implement these approaches, more because they believe they will work as part of a wider ethos about ‘listening to young people’, rather than evidence that they have or that they might. Arguably, peer education may counter-productively reinforce the attractions of teenage pregnancy already discussed. One can imagine that the presence of a small baby might make anyone feel that they want one too.
Reducing teenage pregnancies and their negative effects in the UK

Abstinence education doesn’t work

Abstinence education does not seem to achieve much. The Health Development Agency’s review of reviews concluded that there is no strong evidence for the effectiveness of abstinence education approaches. Another review suggested that abstinence approaches might actually increase pregnancy rates.

Youth development programmes show potential

American youth development programmes have been shown to be the most promising approaches to teenage pregnancy prevention intervention. They are now being piloted in the UK. Reviews suggest that effective approaches should combine some or all of the following: self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports and arts activities, and SRE. This confirms the view that the long term way to change sexual behaviour is by widening young people’s horizons and increasing their aspirations. This requires structure, method and content – not just good intentions and government money. Just as teachers need to do a better job of SRE, youth workers in the UK need to do a better job of youth development.

An authoritative analysis by the Alan Guttmacher Institute explored the main contributing factors of an effective approach to tackle teenage pregnancy. They suggested that increased abstinence among young women made some difference but, more significantly, the biggest beneficial difference was made by increased use of newly available, more effective, long-acting hormonal methods of contraception in sexually active young women, in place of other less effective methods. The Institute’s report concludes:

“These findings suggest that the best strategy for continuing the declines in teenage pregnancy levels is a multifaceted approach. It states that although policies and programmes should encourage young people to delay first intercourse, they should recognise that most young people become sexually active in their teens. As a consequence, services should be in place that helps them adequately to prevent pregnancy and STIs, that means providing adequate education and information about sexual behaviour and its consequences, as well as confidential, affordable and accessible sources of contraceptive services and supplies.”

More recent research by the Alan Guttmacher Institute compared the rates of teenage pregnancy in five developed nations and their approaches to the issue. It concluded that comprehensive and balanced information about sexuality is one of the hallmarks of countries with lower levels of adolescent pregnancy. Easy access to contraceptives and other reproductive health services were seen to contribute to lower rates. A consistent pattern is beginning to emerge about what can be done and what makes an effective difference.

In summary, approaches to sex and relationship education in the UK need a radical overhaul. Trained teachers need to deliver SRE, which is emotionally literate and reflective, to children of all ages particularly to younger children who have not yet embarked on sexual relationships. Parents need to be encouraged and supported to be open with younger children about intimacy and emotional relationships. Parents are the most important source of relationship education, both in what they do and what they say. Young people need much better information and advice about the availability of contraception. Half-baked ‘peer education’ schemes have little impact; indeed they may be counter-productive, drawing attention to the indisputable fact that babies are delightful, rather than discouraging unprotected sex. A return to abstinence education will not work. Again it may encourage the very behaviour it seeks to discourage, by making it seem transgressive and exciting, both feelings which appeal to adolescents. Structured, content-rich approaches to youth development could have an impact on raising aspirations, making lives bigger and thereby creating alternatives to a disadvantaged life in a poor community, going the same way as the others.
9. Support for Young Parents

Once a young mother has decided to proceed with the pregnancy she needs the support that all mothers need; perhaps she needs more support because she is young. A young mother may also need the kinds of support that reflect her relative youth and immaturity. She may need greater antenatal care, emotional support and home visits. She is also likely to need more education and support about how to be a good parent. Reducing a young mother’s own negative behaviour, such as smoking, which may be harmful to the baby and to herself, may also need encouragement and support.

Antenatal care

The review of reviews\textsuperscript{106} conducted by the Health Development Agency concluded that there is strong evidence that good antenatal care improves pregnancy outcomes for young mothers and their children.

Home visiting and emotional support

Home visiting and emotional support for disadvantaged mothers can decrease the incidence of incomplete immunisation, severe nappy rash, hospitalisation in the first year of life, childhood injury, and the number of suspected victims of child abuse and non accidental injuries.

Parenting education

A review of parenting programmes\textsuperscript{107} concluded that both individual and group-based parenting programmes are effective in improving a range of outcomes for both teenage mothers and their children, including mother and infant interactions (such as talking to children at meal times), language development, parental attitudes and knowledge, maternal self-confidence and identity.

Smoking

A Scottish study\textsuperscript{108} that analysed routine hospital records found that the first teenage births to non-smokers did not result in poorer perinatal outcomes compared with similarly non-smoking older women. Those young women having a second birth were, however, more likely than older women to have a premature birth or stillbirth. First births to teenagers who were smokers were slightly more likely to be premature, as were second births which were, additionally, more likely to result in newborn deaths compared with those to older women. This paper suggests that smoking, and the fact that more teenage mothers are likely to smoke, may be a key risk factor associated with adverse maternal outcomes for teenage mothers. Teenage mothers are more likely than older mothers to smoke during pregnancy. Over a third (39 per cent) of mothers under the age of 20 participating in the 2000 Infant Feeding Survey\textsuperscript{109} reported smoking throughout the pregnancy, compared with 29 per cent of mothers aged 20 to 24 and 19 per cent of mothers aged 25 to 29.

Young fathers

Young fathers can have a significant impact, as this paper has already noted, on the outcomes experienced by teenage mothers and their children. But their ability to make a positive impact is sometimes hindered by service providers who do not appreciate the important role they could or do play and consequently do not take into account young fathers’ needs when designing services. The consequent lack of support for young fathers means that too often young fathers do not live with their children, nor do they have a meaningful input to their children’s lives. Parenthood can act as a trigger for young father to desist from other negative behaviours, change their lifestyle and become interested in how they can better support their family. Work with young fathers is currently patchy and in many areas there is limited commissioning of discrete work to support them. Its funding is insecure and it is often not sustained.
Reducing teenage pregnancies and their negative effects in the UK

The government’s Green Paper, Joint Birth Registration: Promoting Parental Responsibility outlined its commitment to increase significantly the number of joint birth registrations. It argues that joint birth registration can make a significant contribution to child welfare. The Green Paper recognises that joint registration may not be suitable for all parents and that any system will have to contain safeguards to protect the vulnerable. The aim, however, is that joint registration will embed a new culture that places more equal weight on the role of both parents in supporting their children. It is hoped that this will help young fathers to feel that they have a real stake in their children’s lives and lead to fewer fathers having no clear accountability or commitment to their children, and support better outcomes for the children of young parents.

Conditional cash transfers for positive parenting

All these aspects of positive parenting could be incentivised by attaching financial benefits to them in the way described in the Mexican model in the chapter 8. ‘Conditional cash transfers’ (as they are called in the jargon) are now being piloted in New York to incentivise positive parenting but similar measures have yet to be implemented in the UK. The British government has accepted the case for conditions being attached to welfare benefits and has announced that the many support and training programmes to help people get back into work will in future be unified with the benefits system. This will make it practically mandatory that most people (except the most vulnerable, people with disabilities and carers) will not just have to look for a job, which is the current requirement, but will also have to engage with support and training services to improve their readiness for work. Failure to do so may mean that benefits are reduced or removed. If this approach to conditionality can work for getting people back into work, it could also work for improving the quality of parenting and the beneficial consequences for the children and the parents. However, if the conditions are applied only to the obligations to seek work and acquire skills, the risk is that young parents will, by complying with these requirements, have even less time and commitment for their child. Getting young people, including young parents, permanently into the labour market is indisputably a good thing and initiatives and incentives to encourage that are welcome. However, without a similar positive parenting incentive alongside the training and employment incentives, the risk of losing benefits may override parenting obligations. Professional childcare is much more widely available and receives a greater subsidy than in the past; a most welcome development. Professional childcare is not, however, entirely a substitute for positive parenting, especially when the young parents are already finding the obligations of parenthood hard to cope with.

Extended family support for teenage parents

Perhaps the least developed area of policy and professional practice in supporting teenage parents is the role that their own parents could play in supporting them. A young mother and father need somewhere secure to live, some advice and guidance on looking after the baby and bringing up the child and some help with childcare once the baby is old enough for them to return to training or employment. So, the welfare argument goes, temporary and permanent affordable housing, both supported and independent housing, should be provided by social landlords; advice on parenting and child development should be provided by health visitors and childcare should be provided by a subsidised nursery. This is, more or less, the method advocated by many experts and lobbyists and promoted by government policy. The immediate problem is that all these services are in short supply. Though the government has, and continues to increase spending on and availability of these services, they will always remain scarce nevertheless. Elementary economics confirms that demand for free or heavily subsidised services is by definition enormous and probably insatiable, so supply can never match demand.

Although becoming pregnant while a teenager will invariably lead to family disputes, those disputes do not inevitably and universally lead to the teenage parent being ejected from the family home. On the contrary, in most cases, people learn to live with these tensions and the teenage parent remains at home during the pregnancy and after the baby is born. In chapter 1 it was noted that 40 per cent of mothers under 20 live in someone else’s house, usually their own parents. Many of those living away from their parents’ home will be married or settled although still teenagers. They may not therefore need much support and may receive all the support they need from their family at a relative distance, though most people still live close to their parents. Among teenage parents under 18 (the most vulnerable group) 80 per cent live in someone else’s home, usually their
parents. So, although the stereotype might be that young mothers are thrown out by their parents, become homeless and then have to seek council housing, the opposite is in fact the case. Even though they would receive priority for social rented housing, in fact they stay, in many cases out of choice, with their parents. Making the choice to stay in your parents’ home is, subject to tension being reduced to a tolerable level, by far the most rational and beneficial alternative.

You will be housed in familiar surroundings with people you know and trust. Looking after the baby, which would be a frightening prospect if undertaken alone, is a responsibility shared with the grandparents. They are more knowledgeable, more experienced, more confident and – in most cases – are delighted to have become grandparents, once they have recovered from the shock and accepted the consequences. There is a special bond between grandparents and grandchildren, different to the bond between parents and children. The obligation of parents are to balance safety and security for the child against giving the child the independence and the appetite for risk that will allow them to grow and learn. That balance, as every parent will confirm, is hard to consistently strike. Grandparents, by contrast, have no such obligations for seeking out subtle balances. Their only responsibilities are to nurture the child when it is left in their care and to support the parent when called upon. So the relationship of the grandparent to the grandchild is more unconditional, uncritical and unrestrained. No wonder that children are generally eager to spend time at their grandparents’ homes and grandparents are keen to have them. No wonder, also, that many parents are aghast and annoyed to find that their parents are vastly more indulgent towards their grandchildren than they ever were to them.

A single parent living alone will often seek out the support of the grandparents, but for a teenage mother with a tiny baby, the best thing probably is to remain in the family home, where all the benefits set out above are instantly available. The alternative of an isolated existence in a flat on your own, with an occasional visit from a health visitor, is a frightening prospect for any parent, let alone an isolated young parent. Professional support can never be as readily or unconditionally available as support from the extended family. Professional support can supplement family support and can take up some of the strain in situations where conflict or other factors have resulted in little or no family support being available, but, alas, it will never be a substitute.

The prevalence of informal extended family support is too readily either ignored on the assumption that everyone needs professional support (a false and financially untenable proposition; professional support services will always be rationed) or, paradoxically, simply taken for granted. Policy and practice could encourage the maintenance and growth of extended family support for teenage parents by, for example:

• Providing family mediation services to families where an unexpected pregnancy has led to tension or conflict and created the risk of homelessness

• Giving financial aid to grandparents who keep teenage parents and their children in their home; this would cost a fraction of providing temporary supported housing and permanent rented accommodation. This could readily be achieved through a small change in the rules for Supporting People funds.

• Encouraging health visitors to support the whole extended family in developing parenting skills, not just the mother. There would be a high return on helping young fathers and grandparents also to improve their imperfect skills in child rearing.

• Developing parenting classes for three generations of the family, not just for the young parents.

• Pay grandparents for providing childcare if the young mother wanted to undertake training or employment.
10. Conclusions and Suggestions

The most illuminating way of understanding the relatively higher and intractable rates of teenage pregnancy in the UK is perhaps as a failure of policy and practice to help people in socially disadvantaged communities to understand the responsibilities, as well as the manifold benefits, of greater freedom. Hence the title of this paper: Freedom’s Consequences. The world of sex has changed and there is no going back. Even if going back was possible, it would be a good deal worse for most of us. The days when not talking about sex and encouraging abstinence, even were they desirable ends, have now gone forever in most communities in the UK. ‘Just say No’ to sex is a futile and counter-productive message. It is also misguided to suggest that the practice of teenage sex and parenthood is a cultural norm in some communities and cannot therefore be changed.

The government set out its current thinking on teenage pregnancies in July 2007.112 Its strategy is built on the expectation that all areas will have a ‘stronger focus’ on the following six elements:

- “Ensuring that midwifery and health-visiting services provide tailored support for teenage parents – both teenage mothers and young fathers (who frequently report feeling ignored by midwifery and health-visiting services) – to address problems such as late ante-natal booking by young mothers, poor levels of nutrition and high levels of smoking during pregnancy, and low rates of breastfeeding – all of which contribute to the poor health outcomes experienced by children born to teenage mothers, such as low birth weight and higher rates of infant mortality and morbidity”
- “The role of children’s centres and other community-based children and young people’s services in reaching out to the most vulnerable teenage mothers, and providing them with easy access to a broad range of support in one place”
- “The role of targeted youth support services in helping teenage parents to cope with the challenges of early parenthood, by providing co-ordinated support from a lead professional who can act as an advocate for the young mother and father and put them in touch with any specialist support they may need. This support will help to address the poor emotional health that leads to worse outcomes for them and their children”
- “Ensuring that we offer high quality support to all mothers aged under 18, who cannot live with their own parents, in particular by seeking to avoid situations where young mothers become isolated by being placed in independent tenancies, without support”
- “Making services more attractive to young fathers and recognising the implications of fatherhood when helping them to overcome barriers to engagement in education, employment and training”
- “At the same time, strengthening the focus on helping teenage mothers to re-engage in employment, education and training.”
Reasons for policy and practice failure

Much of the government’s plan is welcome, however, its approach in the last few years has had a few fatal flaws that have limited its effectiveness, notwithstanding considerable public funding being dispensed. Some of the reasons for the lack of success include:

1. Conceptual confusion: has the key message been abstinence or better access to and use of contraception? Neither seems to have got through to every young person.

2. Poor quality sex and relationship education in schools, which is the foundation stone of any plan to prevent and reduce teenage pregnancies. In particular, there has been a failure to focus on emotions and relationships; to work with parents on SRE and a failure to get key messages about emotional relationships and sex through to children at primary school.

3. Lack of access to advice and guidance easily available everywhere on contraception for young people.

4. Unfocused service development: the governing orthodoxy of social policy in recent years has highlighted the need for ‘strategy’, ‘partnership’ and ‘joined-up working’. These ideas have found a shaky life in institutional form as public service agreement targets, local strategic partnerships and local area agreements. In the particular case of young people there are also local children and young people’s plans. The problem with trying to make a particular problem a part of everyone’s jobs through a shared strategy and a joint partnership is that it can too easily wind up not really being anyone’s job – and an almost limitless amount of money can go in the attempt. Teenage pregnancies have fallen victim to this unproven managerial orthodoxy, as have other important social policy failures, such as school exclusion and violent crime reduction. In all these areas the evidence seem to suggest that relying on the presence of managerial leadership and resolution in many different agencies has left too much to chance with inevitable patchy results.

5. An exaggerated and unrealistic emphasis on the role of education, health and youth work professionals in a complex alphabet soup of local agencies to reach and change the behaviour of young parents for the better, as well as those most likely to become young parents.

6. A complete absence of whole family methodologies to support teenage mothers, actively involving their parents and extended family member

7. Lack of professional support for young fathers to become good partners and parents

8. A failure to structure benefit to provide positive incentives to be a good parent.

Why the government approach may continue to fail

The approach set out by the government in 2007, summarised above, is unlikely to remedy these deficits. The focus is on the welfare of mother and child but despite government protestations this is narrowly defined and instrumental: post-natal care from health professionals; giving up smoking; breastfeeding; attendance at education or training; accessing benefits, housing support and childcare; peer support from other teenage parents. While these may be good intentions, the methods by which they are being pursued are essentially old-fashioned, welfare-based approaches. This, like so many other attempts to change behaviour, is doomed to fail and may, in the end, prove counter-productive, making attractive the behaviour that the professionals are seeking to deter by introducing perverse incentives. Negative, not positive, behaviour seems to be the way to access support and services.
Reducing teenage pregnancies and their negative effects in the UK

There are three erroneous assumptions behind these approaches. The first is that health, education and youth work professionals know who and where the young mothers are, including those at risk of becoming teenage mothers. Secondly, the young mothers need the support of those professionals and cannot cope with the support of their own parents, relatives and the father. Thirdly, that young mothers will want to spend their time with women in the same boat as them. This may not be conducive to raising aspirations, producing instead a peer-induced lowest common denominator of alienation and a lack of ambition.

The implicit stereotype being addressed is of a young woman with no support from family or father who therefore has to rely on professionals. Since there are only 50,000 teenage mothers in the UK and many of them are married and/or well supported and well housed, the number that fits this stereotype is likely to be small. Even if this stereotype were a true reflection of reality, it would require a vast increase in the number of professionals and even greater improvement in the information available to them for these approaches to make a lasting difference to prevention and support. That scenario is implausible. All of these doubts about efficacy do not include doubts about value for money. Such an approach would be enormous costly and therefore restrictions on funds would mean that intensive multi-agency support of this kind could only ever be available in a patchy and uncoordinated fashion, as is currently the case.

What’s really going on?

The truer, more complete picture is that young mothers, generally know who the father of their child is and are on reasonably good terms with him, though they may not be ready to make a lasting commitment. They will also, often, have some parental and extended family support, including staying in the family home. The more effective approaches to supporting young parents would therefore be to shore up these networks of home support from the partner and family and work through those networks to improve the outcomes the mother and the father seek for themselves and their child. The best chance, presumably, of a young mother continuing with her education would, for example, be the father and her own parents and relatives assisting with childcare, perhaps in combination with a paid-for nursery place. Paid-for childcare is unlikely to be sufficiently extensively or cheaply available on its own. Similarly, on breastfeeding and desisting from smoking: young mothers are much more likely to welcome and act on those messages from people close to them whom they trust and see frequently, rather than from youth workers or health visitors whom they might see briefly once or twice a week in a group of other young people. A substantial proportion of young mothers remain in their parents’ home after the baby is born, which in most cases will be vastly preferable to an isolated and miserable flat on a housing estate. In addition cash benefits could be attached to the child achieving developmental milestones.

Improving prevention

The best measures with regard to the prevention of teenage pregnancies seem to be to encourage an open and non-stigmatised conversation about emotional relationships and sexual behaviour (preferably conducted in that order) between parents and pre-teenage children, and to ensure that messages about responsibility for contraception being shared between boys and girls can be effectively reinforced through sex and relationship education at school. The UK at present seems to have mechanistic sex education delivered too late to make much difference. Professionals should try to enable and assist family support for teenage parents. Seeking to replace it, is doomed.

Improving support

As far as supporting teenage parents and their children to achieve better social outcomes, this paper argues for a fundamental re-think of the arrangements for accessing housing, welfare benefits and child support, such as nursery places. The point too readily made in discussions of welfare incentives is the need to penalise bad behaviour. For example, government ministers and officials have repeatedly suggested that ‘neighbours from hell’ should receive less benefit. This depressing and wrong-headed approach has not been implemented only because of a lack of ingenuity in how to make it work.
Freedom’s Consequences

The approach proposed in this paper is the encouragement of good behaviour, not pointless and reprehensible attempts to cut people adrift into a moral twilight zone where the practical consequence will be that they drift from pillar to post without assistance like social lepers accompanied only by the censorious cry of the mob: “It’s all your own fault”. That guarantees to make a bad situation worse. The best prospectus for teenage parents and their children is offered by the informal emotional and practical support from partners and extended family members, supplemented by benefits that increase as the well-being of the parents and the children increase until they can really stand on their own two feet, insofar as any of us are capable of that.

Future policy and practice

This critique argues for a much more direct, focused approach to be developed. The plethora of research and the confusing and contradictory moral debate produces a complex picture. The outlines for future beneficial action in policy and practice can, however, be clearly identified under the following four headings:

1. Better sex and relationship education in school, including lessons at a younger age (perhaps pre-puberty) and in the home. The focus needs to be on the emotional context for sex, not just the mechanics. It is best delivered by specialist teachers, not generalists and seen as part of a compulsory PSHE and Social and Emotional Aspects of Learning curriculum, not the science curriculum, of which it currently forms a part.

2. Involving parents and extended family members in preventing teenage pregnancies by encouraging more open dialogue about sex and contraception between parents and children, including children before they become teenagers. Teachers have an important role to play here, as do GPs and health visitors.

3. Helping young men to be good partners, including sharing joint responsibility for contraception and helping young fathers to become good parents. Schools and health professionals need better approaches to supporting young mothers and fathers as individuals and couples while keeping them in education and encouraging them to retrain and develop high aspirations and positive relationships with a varied group of friends.

4. Rewarding young parents for being good parents through the social and welfare benefits system. Access to subsidised housing, for example, should not only depend on being homeless (or appearing to be). Instead priority should be given to finding homes for the young couples who are staying together and making a success of their relationship and bringing up their child; similarly with nursery places. Child benefit could also be tapered upwards and increases could be made conditional on the child meeting developmental and educational milestones, including school attendance. Being a good parent currently brings its own reward, but that reward is emotional not material. For those in material need, a material reward would also be appreciated and socially beneficial.

5. Building up informal extended family support through family mediation services for families in conflict over their daughter getting pregnant; encouraging health visitors to support the extended family in parenting and child development, not just the young mother; providing financial support through Supporting People funds for three generation families living as one household; paying grandparents for childcare when teenage parents enter training or employment.

A more general social change would be necessary for the UK to improve irreversibly trends and outcomes for teenage pregnancies. The extent of poverty and inequality and the particular spatial concentrations of disadvantage that are a persistent and now a long – term scar on the British social landscape would have to be drastically reduced. Reducing poverty and inequality is a good thing in itself. From the point of view of the subject being discussed here, reducing inequalities would mean transforming aspirations and reducing negative peer influences in disadvantaged neighbourhoods. The ultimate solution to the problem of teenage pregnancies, as with most of the UK’s most intractable social problems, is not just that the people affected should change their behaviour, but also that they change the way they see themselves. The best contraceptive is the insight and awareness to value long-term ambitions higher than short-term pleasures – what in this and other contexts may be called maturity.
the developing baby is larger so surgical dilatation and evacuation (D&E) is used. After 20 weeks of pregnancy, first is an injection to the developing baby to stop its heart or cutting the umbilical cord to ensure that it is dead. The next day, a dilatation and evacuation procedure is done.

56. This procedure can be done under 9 weeks of pregnancy and is not usually given to women aged over 35. It involves taking two drugs at an interval of 48 hours.


58. *ibid*

59. *ibid*


61. Teenage Parents Next Steps: op cit

62. Quinon et al., op. cit.

63. The category descriptions used within the term ‘ethnic difference’ are those derived from each sourced report, which often highlight significant distinctions based on national or religious backgrounds/ origins. By comparison, the National Statistics interim standard classification of ethnic groups in the UK is; White, Mixed, Asian or Asian British, Black or Black British, Chinese, Other Ethnic Group.


66. Department for Children, Schools and Families, op. cit.


72. Elam et al., op. cit.

73. Elam et al., op. cit.

74. Aggleton P., Oliver C., Rivers K., ‘The implications of research into young people, sex, sexuality and relationships’, *Health Education Authority, 1998.*

75. Aggleton et al., op.cit.


82. *Sunday Telegraph,* ‘Ministers fail on teenage pregnancies’. 30 December, 2007


84. Botting B. et al., *op cit.*


94. BBC News, 23 October 2008


96. Ofsted, op. cit.

97. Balding J., School Health Education Unit, 2003

98. *ibid.*


101. *ibid.*


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