Chapter Two

Teenage Pregnancy and Social Policy: A review of the literature

Introduction

The purpose of this chapter is to review the available literature focusing on the areas of policy relating to teenage pregnancy under exploration in this thesis. Having presented the various trends in teenage pregnancy and related rates as well as associated and causal factors in the previous chapter, this chapter begins by providing further explanation as to why the three particular areas of policy chosen for exploration were sex education, sexual health and education. The remainder of this chapter then concentrates on reviewing the available literature for those three policy areas.

Why sex education, sexual health and education policy?

In order to become pregnant, generally, sexual intercourse needs to have taken place and contraception to have not been used or not been used effectively or the contraceptive itself has failed. In Chapter One, the most apparent key difference between Finland and Scotland, that may go some way to explaining the differing trends in teenage pregnancy between the two countries, was that of the contraceptive use of young people.

In order to use contraception there are at least three[1] underlying factors which must be present. First, young people must have knowledge of issues relating to sex, sexuality and contraception (in particular effective use) and knowledge of where to obtain contraceptive advice and services. They must also perceive that they have 'real' access to the provisions of such services (including appropriately timed, located and confidential services) and finally they must be motivated enough to use contraception effectively in order to avoid pregnancy (and other negative results of unprotected sex) and parenthood.

Therefore in order to explore the extent to which these factors relate to the lives of young people in both countries, this thesis set out to explore three policy areas that related to these three pre-requisites namely; sex education (knowledge of sex, sexuality, contraception and available services), sexual health (access to sexual health advice and services) and education (motivation).

School-based sex education and teenage pregnancy

Set out in the previous section were a set of pre-requisites to effective contraceptive behaviour, the first of which was knowledge. School-based sex education is one means of providing that information and knowledge to a large proportion of young people. Although there are complex relationships at work between how knowledge

[1] It is important to acknowledge that there are other factors not included within this thesis that will impact upon whether or not contraception is used at all, in particular social factors such as gender equality, levels of parental control exerted over young people's (especially young women's) freedom and self-esteem levels in being able to ask or insist that their partner uses contraception; and also access to public transport for example to be able to access some services.

about sex and sexuality is internalised and translated into the choices young people make with regard to their own sexual behaviour, it is a crucial starting point (Schofield 1994).

Therefore, the next section of this chapter explores sex education. It considers what sex education is, documents the historical development of sex education in Europe, and examines the potential relationships with sexual knowledge, sexual activity, contraceptive use and teenage pregnancy. It concludes by explaining why sex education policy has been explored within this thesis.

What is sex education?

"The meaning, aims and potential effect of 'sex education' vary considerably according to the opinion of research findings, governments, educators, popular culture, media, parents and young people" (Silver 1998:5).

Unintended and unwanted pregnancy and the contraction of STIs can only be prevented if young people are fully aware of the risks involved and are proficient in how to use contraception, before they begin to have sex (Silver 1998). Internationally, researchers are united in acceptance that sex education is a continuous process, which begins when people are very young, and continues throughout the life course (Wall 1994; David & Rademakers 1996; SEF 1997; Silver 1998).

School-based sex education is an important source of information for young people, because "like it or not, children learn about sex by osmosis, from the society we live in" (Hadley 1998:8). What school-based sex education can do is bring together the information that young people learn from other (often less reliable) sources and provide a safe arena for those young people to separate the myth from reality. Sex education can be more than simply learning the mechanics of sex and the adverse effects of sexual intercourse, a view supported widely amongst the professional sexual health field (Silver 1998).

In 1975 the World Health Organisation (WHO) stressed that every person is entitled to receive information about sex and in 1984 a health and social goal for Europe became the education of children and young people in matters of sexuality, psycho-social growth and general health (WHO 1984).

Hadley has stated that "sex education should be about relationships, sexuality and sexual health, information, personal and social skills, forming positive attitudes and beliefs and sexual identity" (1998:8), a definition that is similar to that of many different organisations including the Sex Education Forum in England (SEF 1997), the British Medical Association (BMA 1997) and the Rutger Stichting Institute[1] in the Netherlands (Braeken 1994).

[1] The Rutgers Stichting Institute was established in 1969 in the Netherlands to provide family planning advice for young people.

History of sex education in Europe

The policy debate over the previous three decades surrounding the issue of teenage pregnancy has been differently weighted across Europe, leading to the development of contrasting approaches (Kosunen 1996). In Britain, teenage sexual activity was approached from an ethical and moralistic viewpoint and led to more restrictive sex education aimed at preventing sexual activity amongst teenagers (Kosunen 1996; Silver 1998). On the other hand, throughout much of the rest of Western and Northern Europe, the Nordic countries in particular, the main issue of concern was the health consequences of early sexual activity (Davis 1989; Kosunen 1996), which led to the development of sex education aimed at promoting 'healthy sex and sexuality'. As Kosunen notes, the "European approach [except Britain] was rather to create preconditions for safer sex; to increase sex education, the availability of contraceptive methods and accessibility to birth control services" (1996:12).

On the whole the development of sex education throughout Europe has been varied, in some cases dependent on the ruling political ideology and the tolerance that ideology has of sexual activity, teenage sexual activity in particular, as well as the influence of the church within any given country (Papp 1997).

Sweden was the first country in Europe to formally introduce sex education into the school curriculum in 1956 (Persson 1993). Sex education in Finland, although not formalised in the curriculum until 1976, had however begun to be taught in some schools as early as 1944 (Papp 1997). In 1970 sex education became compulsory in

schools in France, Denmark and the Netherlands (Papp 1997) and in Portugal and Cyprus some attempts were also made to introduce sex education into schools, but without much success (Papp 1997).

By the 1980s the majority of countries in Western Europe had instigated some form of school sex education (Braeken 1988; Risor 1988; Frade & Vilar 1991; Gallard 1991; Koral 1991; Patsalides 1991). Some countries in Eastern European such as Bulgaria and Czechoslovakia then followed suit and introduced sex education into the school curriculum by the mid-1980s (Temelakiev & Vassiljev 1988; Buresova 1991).

In 1986 all Local Education Authority (LEA) schools in England and Wales (but not Scotland) were required by statute to have a policy on sex education. A LEA school's policy could be to chose not to provide sex education, but there had to be documentation of that decision (Thomson & Scott 1992). This was followed in 1993 when a statutory decision made it compulsory for schools in England and Wales to provide sex education for its pupils but also gave parents in England and Wales the right to remove their child from any non-core curriculum sex education (this included everything except biological reproduction which is taught in the biology curriculum) (Thomson 1993).

In response to these changes Thomson noted that "increasingly sex education policy [in England and Wales] is vulnerable to the whims of the wider moral and political climate and policy is made in response to political pressure rather than educational

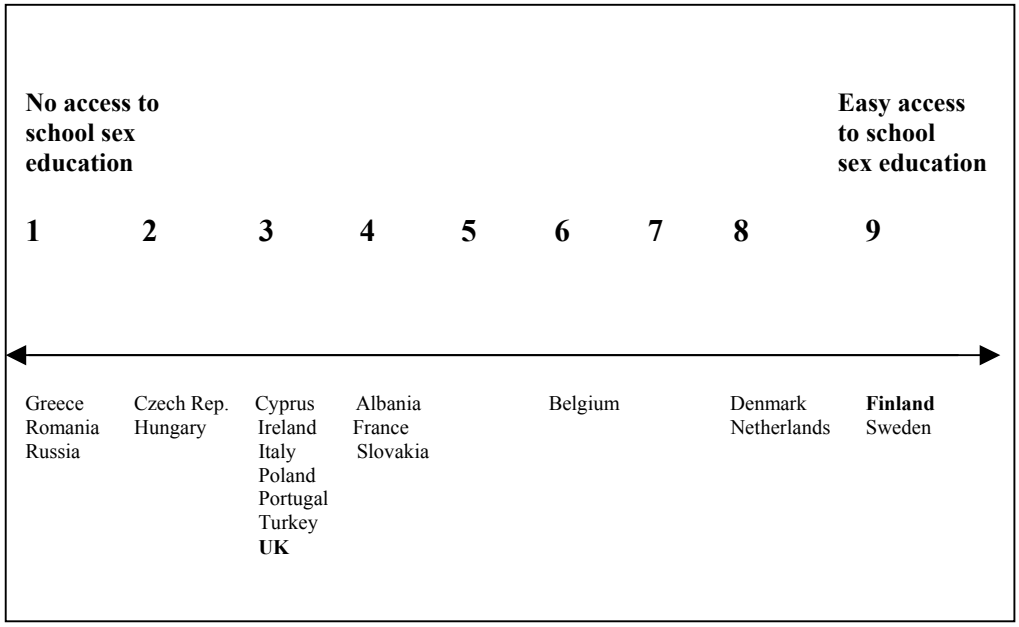
imperative" (1994:124). The influence of the anti-sex education lobby, in particular on public opinion remains strong in England and there remains much popular debate as to whether sex education if provided, should have the prevention of sexual activity as the main aim as a means to preventing pregnancy and the spread of STIs (Silver 1998).

During the early 1990s sex education was legislated into school curricula in Germany, Spain and Hungary (Baross 1994; Berbik 1994; Nieto & Ciria 1996) and around the same time, sex education was introduced into school curricula in Portugal, as part of Personal and Social Development and in Cyprus, as part of a Health Education Programme (Vilar 1994).

According to Papp (1997) sex education has never featured within school curricula in Greece, Ireland, Italy or Romania. This does not automatically mean however, that the subject is not being taught (Vilar 1994). In 1993 for example, officials in Italy reported that despite several unsuccessful debates in parliament to approve sex education, there had been increasing interest shown by schools in providing more sex education (Vilar 1994). Additionally in Scotland, whilst there has never been a requirement for sex education to be part of schools' curricula (unlike in England and Wales), the Scottish Education Office 'strongly advises' schools to now provide some form of sex education for young people (SOED 1998 personal communication).

To summarise the provision of sex education available in Europe by the mid-1990s, Figure 2.1 below presents a summary of the access young people have to school-based sex education across a number of European countries.

Figure 2.1 Access to sex education in Europe.



Source: Vilar 1994:11.

In 1993 Duarte Vilar undertook a review of the availability of sex education throughout Europe. One of the most important findings was that despite the introduction of sex education into school curricula in a large number of countries throughout Europe by the 1990s, only the Nordic countries, Belgium and the Netherlands were stated to provide adequate sex education (Vilar 1994).

Vilar (1994) further concluded that whilst the majority of countries provided their schools with some form of official guidelines to follow in their provision of sex education, it was generally geared towards the negative aspects of sexual behaviour such as pregnancy prevention, STIs and AIDS. Only Denmark, Portugal, Poland and Sweden were seen to provide guidance pointing to a positive approach to sexuality (Vilar 1994). The Netherlands, which also provides a more positive approach to sexuality in school-based sex education (Silver 1998), was not included within this grouping because there were no official instructions about the teaching of sex education at school until August 1993 (after Vilar's research (1994) was conducted).

How effective is sex education?

Within Britain some still continue to argue that the high teenage pregnancy rate is the result of sex education, accusing it of "a variety of social ills including teenage pregnancy and 'moral decay'" (Silver 1998: 9). The actual effect that sex education is perceived to have on the knowledge and behaviour of young people varies and is the central theme of continued debate in countries such as Britain and the USA. The following sections therefore, explore the available literature surrounding sex education and its relationship with variables such as knowledge and attitudes, sexual activity, contraceptive use and teenage pregnancy.

Sex education and sexual knowledge and attitudes

Ignorance about sex and sexuality places young people at risk of pregnancy, STIs and abuse. In addition a lack of knowledge about sex and sexuality would also not prepare

young people about what to expect in relationships, what it means to be a parent, or provide them with the ability to be in control of their own sexual identities and activities. Wellings et al (1996) and the SEU report (1999) both identify ignorance and misinformation as a key factors in the high teenage pregnancy in Britain and England respectively.

As an example of the ignorance amongst teenagers in England, a study of almost 4000 14 and 15 year olds surveyed by the Health Education Authority in England found that over one quarter believed that the contraceptive pill protected against STIs, a similar number believed that a steady partner also protected against STIs (HEA 1999a).

Silver (1998) defines the level of sexual knowledge as a sign of the effectiveness of sex education. Her research in the Netherlands and England found that where Dutch teenagers showed high levels of overall knowledge about sex, conception, contraception and HIV/AIDS, their English counterparts had relatively poor levels of knowledge. In turn the level of provision, content and perceived effectiveness of sex education by the two cohorts of young people, was seen to be superior in the Netherlands in comparison to England.

Goldman & Goldman (1983) argued that in countries which project more tolerant attitudes towards sex and provide objective information about sex and sexuality to young people from an early age, young people's general knowledge about sexual issues is superior. This view was also supported by the research findings of Jones et

al. (1985, 1986) and Bilsen and Visser (1994) who concluded that sex education had been found to be effective in increasing knowledge about sex and sexuality and contraception as well as encouraging more positive, liberal and tolerant attitudes to sexuality.

Sex education and increased and earlier sexual activity?

Perhaps one of the most contested and emotive debates surrounding sex education in Britain (and the USA) has been whether or not sex education actually encourages sexual activity. It is a heavily debated issue within the national British media, the most popular argument against sex education being, that it will encourage promiscuity and experimentation and the younger a person experiences such education, the younger young people will start experimenting (Thomson 1994; Silver 1998).

Whilst the research evidence explored below contradicts this argument, it remains a prevalent view in Britain. One fifth of parents and one quarter of young people surveyed in the late 1980s by Allen (1987) believed that school-based sex education encouraged earlier sexual experimentation.

Over the last two decades research has been undertaken to determine the potential merits of sex education and in particular, how it affects young people's knowledge, attitudes and behaviour. In 1993, on behalf of the World Health Organisation, Baldo et al (1993) undertook a 35-country evaluation on the provision of sex education. The main finding was that there was no evidence that the experience of sex education had

encouraged earlier or increased levels of sexual activity. Six of the studies reviewed found that after sex education had been provided there was a noted delay of first intercourse or an overall decrease in sexual activity.

Kirby et al. (1994) undertook a review of published peer reviewed studies (predominantly USA based projects). The main finding of this review was that sex education does not hasten the onset of sexual activity. Four of the studies reviewed found no increase of sexual activity as a result of the sex education and one noted a decrease in sexual activity.

In 1997, Fullerton et al. explored the educational and support strategies to tackle teenage pregnancy and reduce the adverse effects where pregnancy occurred. A key point made by this research was that "providing sex and contraceptive education within school settings does not lead to an increase in sexual activity or incidence of teenage pregnancy" (Fullerton et al. 1997:197). Additionally, "programmes which emphasise the postponement of sexual activity but omit guidance on contraceptives and where to access them are rarely effective" (Fullerton et al. 1997:197). This point has been further supported by Cheesbrough et al. (1999), who noted that despite large sums of money having been invested into abstinence projects in the USA, they generally showed no delay or reduction in sexual activity. Additionally the outcomes of a long-term abstinence-based small-group pregnancy prevention programme in the USA found that by the one year follow-up stage, there was no difference between the intervention and comparison groups of young woman with regard to the proportions

who had had first intercourse. For the groups of young men, more from the intervention group than the comparison group had had their first intercourse at the one year stage, although the proportion was not statistically significant (Lieberman et al. 2000).

In 1997, the NHS Centre for Reviews and Dissemination on behalf of the British government, undertook a review of measures to prevent and reduce the adverse effects of unintended teenage pregnancy (NHS CRD 1997). The findings of this review further support the evidence presented thus far, in that "the most reliable evidence shows that it [sex education] does not increase sexual activity or pregnancy rates" (NHS CRD 1997:1).

Wellings et al. (1995) also noted that in Britain, young people who stated that they had obtained most of their sex education from school, were less likely than those who cited parents or friends, to have had their first experience of sexual intercourse before they turned 16. Unfortunately, young people in Britain in a number of studies, report gaining most of their sexual knowledge from friends and peers rather than teachers (Currie & Todd 1993; Dean 1994; SEF 1998).

Finally, Cheesbrough et al.'s study of ways of reducing teenage conceptions in the USA, Australia, Canada, New Zealand and the UK (1999), also found that no study had shown sex education to increase sexual activity at a younger age. Some studies

did show however, that early sex education delayed the onset of sexual activity as it had encouraged young people to wait (Cheesbrough et al. 1999; Wight et al. 2000).

Sex education and contraceptive usage

Education about contraception is an important element of sex education programmes to provide young people with the relevant information that they need to use contraceptives effectively. Wellings et al. (1994) found that for those young people in Britain who recalled having had the most sex education, the higher their contraceptive use was at first intercourse.

Evidence from a variety of sources has indicated that where young people had received contraceptive education at school, the effective use of contraception was higher at first intercourse and amongst young people who had stated that they were already sexually active (Baldo et al. 1993; Kirby et al. 1994; Kirby 1997b; NHS CRD 1997; Cheesbrough et al. 1999).

Sex education and teenage pregnancy

International research has highlighted the fact that the rate of teenage pregnancy is lower in countries where there is a higher availability of sex education at school (Jones et al. 1985, 1986; David et al. 1990; Baldo et al. 1993). Jones et al. (1985) found this to be more significant where the sex education taught included a large component of education regarding the use of contraception.

Using Vilar's ranking of young people's access to sex education across Europe (1994) (see page 70), Figure 2.2[1] explores the relationship between this measure and teenage birth rates across a number of European countries. The live birth rate has been used as a suitable proxy for pregnancy (Kosunen 1996) in this analysis due to the fact that very few countries have accurate abortion data and for many there is no comparable data available. As expected there was a significant relationship found between the two variables, whereby countries which were described as providing easy access to sex education have lower rates of teenage birth. The Spearman's correlation coefficient for this relationship was $r_s = 0.71$.

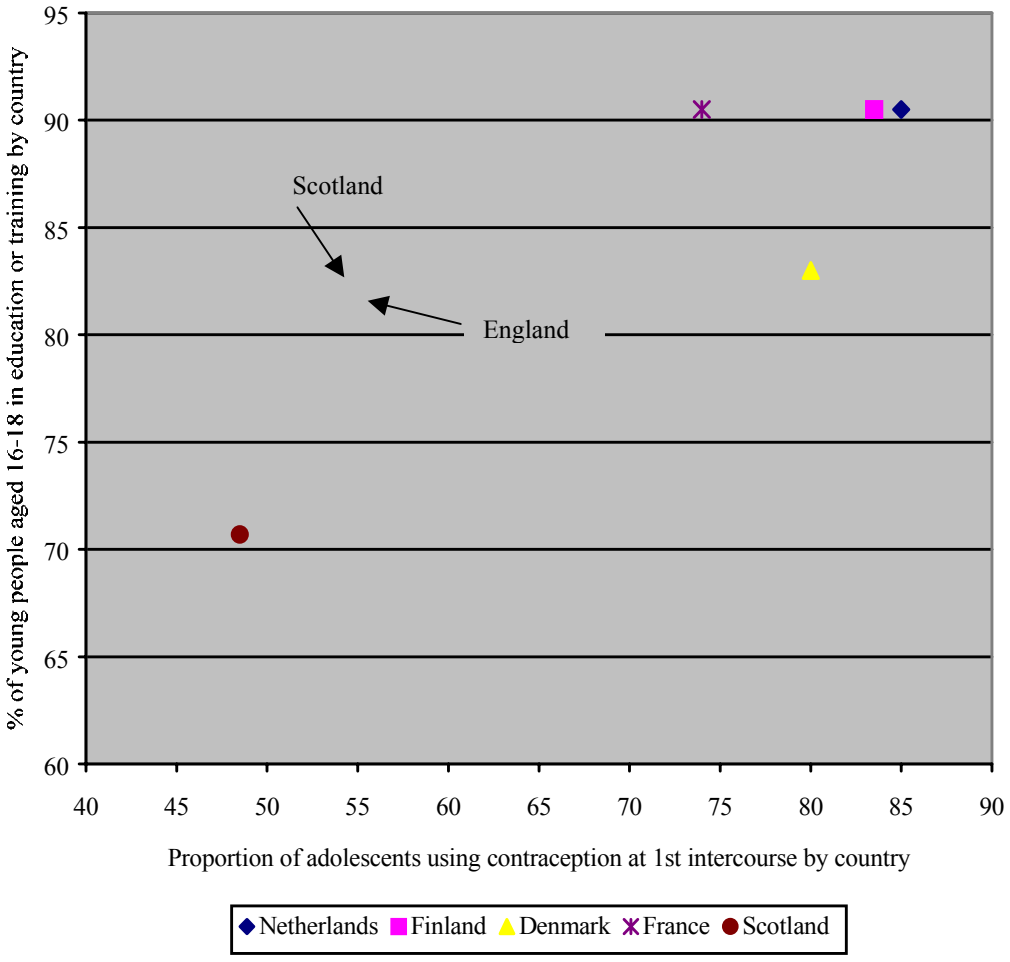
Providing effective sex education

What is it that makes some sex education programmes more effective than others? What are the key elements that make a sex education programme effective? These are important issues to consider when evaluating current sex education programmes and developing sex education programmes in the future.

[1] Data for this figure can be found in Appendix i.

Figure 2.2

Access to sex education and live birth rate per 1000 women aged 15-19 in a selection of European countries



r_s= 0.71

General Notes
Data on access to sex education - Vilar 1994.
Vilar (1994) only referred to the UK and so the UK access has been used to calculate both the Scottish and English and Welsh correlations.
Data on live Birth rates - UN Demographic Yearbooks 1995, 1996, 1997, 1998.
Year for birth rate is 1996 unless noted below:
1995 - Belgium, Czech Rep., France, Italy and Russia.

Socio-sexual attitudes

Silver (1998) noted in her comparison of sex education in the Netherlands and England, that a positive socio-sexual attitude and a pragmatic approach to sex education underlies its effectiveness. She further argued that if sexuality is not regarded as a 'normalised' aspect of life, then the message that it conveys to young people is not likely to have the desired impact.

Thomson (1994:125) suggests that "the political kernel of the 'problem of sex education' is how society reacts to the reality of adolescent sexual activity and socio-sexual change" and "the way a society deals with the challenge of sex education is inevitably culturally specific".

This does leave open the question of whether cultural specificity will prevent the successful transportation of sex education policy from a more liberal country, such as the Netherlands or one of the Nordic countries, to a more conservative country, such as Britain. As Silver (1998) notes the attitudes to sex and sexuality in general culture will reflect and affect the provision of sex education.

The public climate towards sex education plays a central role in how well it is accepted into schools and regarded by young people as an issue of importance (Vilar 1994). In turn if it is valued by young people this may help them better to internalise the messages presented (Silver 1998).

Curriculum location

There are two main ways of incorporating sex education into school provision. It can either permeate through the school curriculum, being taught in a variety of subjects as defined nationally or by each school, or alternatively, it can be provided as a separate subject, usually taught within the context of a subject such as Health Education or Personal and Social Education (or an equivalent).

The advantages of the permeation approach have been noted in the Netherlands whereby the inclusive approach has helped to 'normalise' the topic. As Silver (1998) noted, in the Netherlands they treat "sex education as equal to other subjects by refraining from separating and subsequently differentiating it from the experience of learning about any other topic… this in turn perpetuates the culture; young people consider sex as a normal and healthy part of human life, it is neither taboo nor sensation" (Silver 1998:33). She further argues that sex education, situated within the curriculum in this way, has come about as a direct result of the Netherlands' acceptance of the normality of teenage sex and sexuality (Silver 1998)

The 'permeation' approach however may not be successful within cultures where teenage sex and sexuality are not socially accepted to the degree that they are in the Netherlands. This becomes a likely outcome when sex education is expected to be taught within a range of subjects, and where there is a lack of general acceptance of teenage sex and sexuality. In this instance there may be a subtle disappearance of sex education from the curriculum. This is where the 'separate' approach to the provision

of sex education may be more appropriate, in that it would be visibly noticed were it not being taught.

Teaching environment

Providing a suitable teaching environment is a major key to the provision of effective sex education. As Silver states "it is widely accepted that an 'open and safe' classroom environment is necessary for effective learning" (1998:15). Staff that are both willing and capable of providing sex education are therefore key ingredients to success (HEA 1998) and teacher training on the provision of sex education is therefore an essential ingredient (Hadley 1998).

The Royal College of Obstetricians and Gynaecologists (RCOG) have suggested that all schools should have at least one member of staff who is dedicated to the provision of sex education and who has been specifically trained for that job (RCOG 1991). The Sex Education Forum has further added to this by stating that the definition of a good sex educator is one who "knows his or her stuff; doesn't get embarrassed; has a sense of humour - he or she makes it fun; doesn't ridicule or embarrass pupils; is able to control the class; is either male or female, but with male input for certain aspects of sex education" (SEF 1997:5).

In addition to a well-qualified teacher, the methods used to teach sex education are also important. According to Kirby (1995), traditional methods, such as 'talk & chalk' style lectures are largely ineffective. He has described the most effective learning

methods as 'active learning methods', which would include discussion and reflection and role playing of 'real-life' stories. Kirby states that these types of methods are more successful in helping young people to develop the skills they need in sexual negotiation as well as increasing their knowledge and developing positive attitudes and values (Kirby 1995). The notion of using a multitude of effective methods when providing sex education is supported by both the Sex Education Forum (1997) and the Health Education Authority in England (HEA 1998).

Content

In order for sex education messages to be effectively internalised by young people, the sex education should not 'scare' young people (David & Rademakers 1996). Oakley et al.'s systematic review of the effectiveness of sexual health interventions (1994, 1995) highlighted that education needs to be positive in its presentation of sex and sexuality rather being negative in either tone or content.

Sex educators should also avoid presenting a programme, the content of which is based on adult perceptions of what young people want and need to know (Sex Education Forum 1997). Sex education needs to incorporate what young people want (HEA 1998) or they are less likely to be receptive to the messages that are presented. Unfortunately, a further finding of Oakley et al's review was that "the data that exist suggest a substantial gap between what educators think is important to provide and what young people want to know" (1994:35).

The Health Education Authority suggests that sex education should have regularly reviewed and clearly stated, aims and objectives (HEA 1998). Some of the characteristics that the HEA argue represent 'sexual competence' include those listed below, and they argue that this 'sexual competence' is associated with consistent provision of sex education in school (HEA 1998). Discussion around these characteristics should therefore be represented within the content of school-based sex education.

1. Maintain friendships with both sexes,
2. Discuss problems with both sexes,
3. Communicate effectively with sexual partner/ potential partner,
4. Think about, plan and implement safer sex strategies,
5. Negotiate use of contraception,
6. Agree the status of a relationship,
7. Discuss the meaning and importance of sex in a relationship (HEA 1998:2).

Young men

"The focus of sex education has historically been teenage women because of their reproductive capacity, but it is increasingly considered that in order to maximise the effectiveness of contraception usage amongst young people, boys must not be left out of, or marginalised from, the educative process" (Silver 1998:15).

The SEU report (1999) identified boys to be half of the problem and therefore half of the solution with regard to teenage pregnancy. The policy recommendations, however, were focused on 'threatening' young men about the consequences of their actions, rather than acknowledging that they have specific needs when it comes to sex education. If boys are to be encouraged to have responsible attitudes with regard to their sexual behaviour and respectful attitudes towards their partners, they cannot continue to be marginalised in the provision sex education (Hadley 1998).

To highlight just how much need there is for young men in the UK to be able to discuss issues relating to sex, *Sex Wise*, a British government funded free-phone line receives on average 2500 daily calls, 50% of which are from 13-15 year old men (Hadley 1998).

It does not appear that young men's needs are currently being met by school-based sex education in Britain (Winter & Breckenmaker 1991; Hadley 1998; Meyrick & Swann 1998). Wood warns however, that if attempts are to be made to incorporate young men into meaningful discussion of sex education "it is necessary to acknowledge some of the powerful pressures which are prevalent during their formative years" (Wood 1998:96).

One of the largest of such pressures on young men in many countries including Britain arises through the inherent gender stereotypes that exist. In other words, there are extraordinary pressures on young men, to prove that they are just that, 'men'. Young

men and young women are both faced with gender stereotypes as they grow up and the need to conform to these stereotypes cannot fail to impact upon their sexual behaviour and their relationships (HEA 1998).

According to the HEA (1998) young men and young women are faced with similar and different stereotypes. Both young men and young women pick-up cultural stereotypes about the gender roles that they are expected to fulfil, women being passive, men, active. Young women are taught that people will make judgements about their sexual behaviour, whereas young men learn that people will make judgements about their lack of sexual behaviour. Where young women are taught to believe in 'prince charming' and invest in their relationships, young men learn to think about sex, solely in terms of their needs and desires (HEA 1998).

"Manhood and sexuality are not innate but learned and therefore able to be changed (Anderson 1997:391). The notion of masculinity however, is rarely talked about in sex education and as Wood notes, there is a real need to start to acknowledge the issue and understand what sexuality means to young men, otherwise sex education will continue to have little impact on their attitudes (Wood 1998).

Sex education is one place where young people can be encouraged to challenge gender stereotypes in a 'safe' environment and where young men can learn that 'getting a girl pregnant' is not the only way to prove that 'I am a man'.

Inter-agency collaboration

Within the context of sex education the main role of inter-agency collaboration under exploration within this part of the chapter is the role of sexual health experts in the teaching of sex education. The issue of the potential effectiveness of combining the sex education that young people receive in school with sexual health services inside or outside of the school is explored below in relation to sexual health services.

There have been questions raised as to the value of utilising sexual health or health care professionals in the teaching of sex education. Mellanby et al. (1995) had success when piloting a sex education programme with medical involvement in England. Their programme used medical professionals and peers to deliver sex education and found a relative decrease in the sexual activity of teenagers involved in comparison to the control group.

Papp (1997) in her study of sexual knowledge, moral beliefs and sexual experiences amongst young people in Finland and Estonia argued that medical professionals should be used more in sex education provisions in school, as this had been identified by young Finns as an effective style of provision.

Within Britain, the potential of the school nurse to act as a bridge between health care and education provision and potentially help teachers to provide sex education, was highlighted in government studies during the mid-1990s (Few et al. 1996; PHPU 1996), as well as having risen in profile within academic writings throughout the mid-

late 1990s (Gulland 1996; Hunt 1996; Sex Education Forum 1996; Whitmarsh 1997; Lightfoot & Bines 1998; Mayall & Storey 1998).

In particular, discussion has focused on two aspects of this potential resource. First, the school nurse's ability to form "complementary teaching partnerships" with teachers in the provision of sex education (Whitmarsh 1997:35). Second, the potential of the school nurse in providing a primary health care resource for young people in school-based clinics (discussed in relation to sexual health services).

The Sex Education Forum (1996) argue that the school nurse has the potential to act as a positive support role for teachers involved with the teaching of sex education, both in supporting the teachers themselves, as well as providing classroom sex education directly.

There are however contrasting views on the subject of the school nurse's potential as a sex educator. Whilst the Royal College of Nursing has been quoted as stating that "school nurses are willing and able to take up the challenge of providing sex education in schools" (Whitmarsh 1997:35), there is no published empirical evidence to support this claim.

Whitmarsh (1997) further notes that whilst many nurses in her study have been more than willing to undertake such a role, questions were raised however, as to their actual ability to do so. This aspect was raised as an issue of contention due to the fact that

you cannot realistically "expect a school nurse to arrive in a classroom with inherent teaching skills" (Whitmarsh 1997:41). Training was therefore seen to be a key issue if school nurses or any other 'sexual health expert' were expected to take on this 'teaching role'.

Sexual Health Services and Teenage Pregnancy

In order for young people to be sexually responsible, in addition to adequate knowledge about sex and sexuality, there are certain sexual health provisions that must be available to them, that they can access with relative ease. For example, they need access to contraceptive advice and free or low cost contraceptives. In addition where contraceptive use has failed to be effective or contraception has not been used, young women need to have access to emergency contraception and if required, free or low cost termination services.

When it comes to the provision of sexual health services for young people however, there are additional aspects to those provisions that need to be given further consideration. It is the extent to which service providers consider these additional aspects, which could prove to be a crucial piece of the 'joined-up' policy perspective.

An increasing amount of research has been undertaken both nationally and internationally in recent years, in an attempt to determine the needs and wants of young people with regard to sexual health service provision. There is a growing view

that to encourage young people to access and use sexual health services, they need to be provided in a format that is acceptable to young people, or they will not be used.

Overcoming the First Hurdle - Access

In most countries throughout Europe, sexual health services are provided through a primary care facility such as general practice in Britain and/or through specific family planning service clinics. In some countries, all or a selection of services are provided free/ low cost by the state, such as in Belgium, Finland, the Netherlands, Norway, Portugal, Sweden, Scotland and England and Wales. In others such as Austria, only private facilities are available and in countries such as Germany, there are both publicly funded and private facilities, although according to Kane & Wellings (1999) most Germans pay for private services. Finally in countries such as England and Wales, France, Greece, Iceland, Italy, Luxembourg, Scotland and Switzerland, access to services (public and/or private) varies greatly depending on where you live (Kane & Wellings 1999).

Young people often have additional needs when it comes to accessing sexual health service services, needs which may not be met by the services that are available to the general public. If young people do not or cannot access sexual health services when they need to, this will prevent them from using contraception within their sexual relationships.

Research looking at the issues of sexual health service provision internationally has documented for many years, that ease of access to services is a pre-requisite to their use by young people (Zabin et al. 1986; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997; NHS CRD 1997; Hadley 1998). What, however, does ease of access actually mean?

Geographical location & Equality of access

One of the first elements of ease of access derives from young people being geographically able to access a service. In countries like Scotland, England and Wales, where service provision is free and widely available from a range of sources, there are still areas where a young person may have to travel a considerable distance in order to access a service. A distance that may be deemed too far by many (Hadley 1998).

Cheesbrough et al. (1999) in reviewing research on the issue of access found that young people who were already sexually active, were more likely to attend a sexual health service when those services were located in places that were geographically convenient for them.

Clements et al. (1997) conducted a study in Wessex (England) to explore the rates of teenage pregnancy by postcode area and their potential relationship with the distance a young person in that postal area would have to travel to a general practice, family planning clinic and a specialised youth clinic. The main finding of this research was

that teenage pregnancy rates were lowest in areas where young people lived within three kilometres of a 'youth' orientated service.

A further concern of many young people when they are considering accessing sexual health services however, is that they are hidden from 'parental view'. In other words, they would not use services which they knew their parents used, or where they were likely to encounter someone who knew their parents (McIlwaine 1994; Hadley 1998). The SEU (1999) therefore highlighted that for some young people, it was important that the services they used were not in their local areas, but rather that the services were far away from areas where they may be recognised. Alternatively it has been suggested that services such as school-based provisions may help to 'hide' young people when they access such a service (Zabin et al. 1986; Fullerton et al. 1997).

Suitable opening times

Young people have limited windows of opportunity when it comes to seeking advice or contraception (Hadley 1998). This occurs for two specific reasons, first, many services will only be available at times when young people are expected to be attending school (Turner 2000). Clements et al. (1997) noted that young people were more likely to use contraception if there was a contraceptive service within a 20-minute walk or a 30-minute bus ride. They highlighted that longer opening hours are critical if young people who are in school and have to rely on public transport are to be able to access sexual health services (Clements et al. 1997).

Second, sexual activity, especially amongst younger teenagers is often sporadic and unplanned and therefore young people will often be in need of immediate advice. The unplanned nature of many younger teenagers' sexual activities also means that emergency contraception plays an important role, especially for under-16s (Zabin et al. 1986).

According to Hadley (1998), young people in Britain have often reported difficulties in obtaining an appointment within the 72-hour period required for the effective use of emergency contraception. She highlighted that young people will decide whether or not to use a service, based on how easy it is to access (including location and when it is open) (Hadley 1998).

Confidentiality

One element that was continually and unanimously presented as one of the most important keys to access for young people was confidentiality. Even in countries where attitudes to teenage sexual activity are more liberal, young people still need and want confidentiality (Jones et al. 1985, 1986; Papp 1997; Fullerton 2000). The overall conclusion of researchers that have explored this issue is that for young people to access services, confidentiality is essential (Jones et al. 1985; Wulf & Lincoln 1985; Jones et al. 1986; Zabin et al. 1986; FPA 1994; Lo et al. 1994; McIlwaine 1994; Dickson et al. 1997a; Fullerton 1997; Liinamo et al. 1997: Hadley 1998; SEU 1999; Turner 2000).

In England and Wales this issue became very complicated during the early 1980s when Mrs. Victoria Gillick took her local health authority to court for prescribing the contraceptive pill to her daughter who was under the age of 16. The Gillick ruling in favour of young people's rights to access contraception under the age of 16 in 1985, paved the way for young women under 16 to be able to access a service for contraceptive advice and contraceptive supplies without the consent or knowledge of her parents (Schofield 1994). A large degree of confusion, however, still remains amongst young people and medical professionals in Scotland[1], England and Wales as to their rights and responsibilities in this area (Hadley 1998).

The extent of this confusion amongst young people is visible in the results of teenage opinion poll. A survey by the Family Planning Association in 1993 found that 66% of pregnant young women surveyed said that they had not approached a family planning clinic or their GP because they had thought it was illegal for them to do so (FPA 1993). Whilst this should not be the case, young people in England have experienced being told that they are not allowed to make an appointment without a parent present (SEU 1999).

Informal and User Friendly

In addition to concerns over confidentiality, young people in England have commented on the lack of 'friendly' reception staff and too formal an atmosphere when

[1] Despite the Gillick ruling being a case within English Law, the advice to medical professionals as a result of this ruling are provided to all medical professionals in Scotland, England and Wales by the ethical committee of the British General Medical Association.

they have attended a service (SEU 1999). Therefore an informal and friendly atmosphere instead of an intimidating one, is a further recommendation from researchers in this area (Zabin et al. 1986; Peckham 1993; Fullerton 1997; Hadley 1998; SEU 1999).

Professional attitudes to young people and their sexual activity

Young people need to feel that they are being treated with respect. The main evidence that this respect exists, has been identified by young people themselves, as service providers who are friendly, who talk to them rather than at them, who listen objectively to what they are saying, who do not judge them for their sexual activity and who are genuinely interested in what they are saying (Liinamo et al. 1997; HEA 1998; Aggleton et al. 1999). Young people have also reported that they would be more likely to access services where professionals expressed positive attitudes to sex in general (Aggleton et al. 1999).

Young people need to feel equally comfortable with the providers of a service as they are with its location and the type of service, in order that they will use it. Treating young people with respect and not judging them because they are sexually active, is likely to help foster the development of self-esteem. A lack of self-esteem amongst young women in Britain and the USA has been associated with increased likelihood of pregnancy at a younger age (Thomson 1990; Pearce 1993; Lees 1994; Hadley 1998). One area of importance that has been identified is the need for medical professionals

to be adequately trained to work and deal with young people and their needs (Liinamo et al. 1997; HEA 1998).

'Sex-speak' - youthful linguistics

A further criticism made by young people of sexual health services is that the language that professionals often use during consultations is too formal. The use of medical jargon is often confusing and not fully explained to young people (Hadley 1998). Research undertaken by Aggleton et al. (1999) found that young people would prefer professionals to use language and words that they use themselves, or to use a mixture of professional language (if explained) and less formal, more colloquial language.

In addition to the language spoken, there have also been questions raised as to the suitability of the names given to services. Clements et al. (1997) noted that the term 'family planning' is not relevant to most young people and their sexual health. Hadley (1998) notes that young people are not planning families, they are developing their sexual identities. The SEU consultations (1999) found that young people thought that family planning clinics were for married (or soon to be married) couples. Therefore regardless of whatever guise a service is provided to young people, careful consideration should be given to its name, to make sure that it is inclusive not exclusive (Clements et al. 1997).

Inclusive access for and recognition of the needs of young men

It has been argued that the appropriate use of language is even more pertinent for young men. Hadley (1998) has noted that 'family planning' alienates young men, as it is perceived as a 'female domain'. Young men also informed the Social Exclusion Unit during their consultation period that these services were further alienating because they were predominantly run as services for and by women (SEU 1999).

Service provision in this area has historically been aimed at the needs of women. When women visit their GP or family planning clinic for sexual health advice in Britain they are routinely asked about their sexual and contraceptive history and often whether they have had children or an abortion. Men on the other hand are not generally asked their contraceptive or sexual history let alone whether they have been responsible for an abortion (Nelson 1997). Having raised awareness of this issue, taking the sexual health history of male visitors is something which is being piloted within Chelsea and Westminster Healthcare NHS Trust (Nelson 1997).

An ONS survey in 1997 revealed that 61% of men believe that in practice, women should be responsible for contraception and a further 40% had never discussed contraception with friends (Nelson 1997). There is a gap in provision and if men in general are to be able to take responsibility for their own and their partner's sexual health, they need services which are targeted at them and provided for them (Hadley 1998).

Alternative service provision options

Young people's services

Young people have identified a need for services which are youth orientated and have specified a preference that these services are provided within localities that are for young people only (Liinamo et al. 1997; Aggleton et al 1999). Evidence from Europe further supports the promotion of youth clinics. In the Netherlands and in Sweden services are aimed specifically at young people (Peckham 1993). In the Netherlands there are special services targeted at young people provided by the Rutger Institute and in Sweden, there are separate systems of provision for the general population as well as for young people (Peckham 1993). Other countries such as Denmark, Finland, Germany, Norway and Switzerland all provide services specifically aimed at young people (Kane & Wellings 1999).

In England during the early 1990s there was a period of development of youth clinics which was reported to be well received and used by young people (Bloxham et al. 1999). The main expansion of such services between 1990 and 1995 was followed by the first decline in pregnancy rates in ten years (Hadley 1998). They were, however, not universally provided across the country resulting in a lack of equality of access for young people. Those most noted as likely non-attendees were "younger teenagers, young men and those living in areas of deprivation for whom the motivation to avoid pregnancy may be undermined by high levels of unemployment" (Hadley 1998:14).

Jones et al. (1995, 1986) suggested that specialised youth clinics which were fully integrated advice centres, providing young people with access to contraceptive services and counselling and linked to schools, were likely to be the most effective in helping to reduce teenage pregnancy. Their research concluded that "teenagers living in countries where contraceptive services, sex education in and out of schools, and abortion services are widely available have lower rates of adolescent pregnancy and do not have appreciably higher levels of sex experience than do teenagers in the United States" (Jones et al. 1986: 233).

This view is supported by Zabin et al. (1986), Allen (1991) and Fullerton et al (1997). Further to this, recent research on young women's views about service provision in Scotland, highlighted the desire for a clinic specifically run for young people in order that there was a provision that they could attend that they knew would not be used by their parents and/or run by medical staff who they knew personally (Turner 2000).

School-based service provision

It is widely acknowledged that knowledge about sex, is not in itself a sufficient pre-requisite for behavioural change (Rademakers 1997; Papp 1997; Silver 1998). Through international comparisons, researchers have generally concluded that the most effective sex education is found in countries where there is an official sex education policy that is linked to sexual health services offering confidential advice and provisions (Jones et al. 1985, 1986).

One of the earliest evaluated school-based programmes of sex education combined with an on-site sexual health advice and contraceptive service was in Baltimore, USA (Zabin et al.1986). The main finding of this study was that there was a delay in onset of sexual activity amongst the young women involved. There was also found to be increased contraceptive use amongst young men and women who were already sexually active and the pregnancy rates for the surrounding locale witnessed a decline. The main conclusion of the study, was that linking sex education with school-based sexual health services could be effective in increasing contraceptive efficiency and its use by young people. When the programme was discontinued however, the pregnancy rates returned to the levels that had been witnessed prior to the programme (Zabin et al. 1986).

Kirby et al. (1991, 1994, 1997) found that in the USA, using a combination of approaches was much more likely to bring about positive results than sex education alone. David et al. (1990), in a comparison between provisions in Denmark and the USA noted that teenage pregnancy rates were found to be lower in countries that provided the combination of easily accessible contraceptive services, more sex education and generally more open attitudes to sex and sexuality.

The main reviews conducted by UK researchers over the last decade, have reached the conclusion that adopting an inter-agency approach is the most effective means of encouraging safer sexual behaviour (Winter & Breckenmaker 1991; Fullerton et al. 1997; NHS CRD 1997; Hadley 1998; Meyrick & Swann 1998).

Some have argued that the school nurse is in a unique position to take on a special role within a school setting of being able to provide discrete, confidential one-to-one sex education to pupils, the confidential aspect of which cannot be guaranteed by teachers (Gulland 1996; Hunt 1996; SEF 1996). The school nurse has also been viewed as a positive resource by young people themselves as s/he is not viewed as an authoritarian figure (as teachers often are); s/he is easy to access if school-based and s/he is perceived as approachable and friendly (Hunt 1996). There have however been questions raised as to the suitability of school nurses to provide a clinic-style provision in school when they have not been specifically trained to do so (Whitmarsh 1997). Therefore, if school-based services were to be encouraged, the issue of training would be of utmost importance.

Having reviewed literature discussing the merits of school-based provision, there was a general lack of sound methodological evaluations of such a service (Oakley et al. 1995). Despite this fact there was, however, overwhelming support from researchers internationally for this style of service (Wulf & Lincoln 1985; Zabin et al. 1986; Allen 1991; Pearce 1993; Visser & Bilsen 1994; Fullerton 1997; Fullerton et al. 1997; Papp 1997; Turner 2000).

The provision of school-based clinics would also mean that a confidential resource was brought to young people instead of the young people having to go to an external service. It may solve the concern that many young people have, of being seen by

someone who knows their parents (McIlwaine 1994; SEU 1999; Turner 2000). It may also encourage more young women to access emergency contraception if the need arises rather than adopting a fatalistic approach and hoping nothing will happen (Hadley 1998). Further to this, it presents a unique opportunity for young men to gain easy access to a (sexual) health service.

It must be remembered, however, that not all young people will attend school even if they are legally required to do so. Schofield (1994) therefore notes that providing school-based clinics should not be the only option for young people and that there would be a need for services aimed at young people both within and outwith the school setting.

General acceptance of young people's sexual activity and the need for young people's services

It is widely accepted that Britain as a whole lacks 'cultural openness' about sex and sexuality and about teenage sexual activity in particular (HEA 1998). It is also widely accepted that countries which are more open with regard to sex and sexuality, including the provision of sex education and contraceptive services for young people, are the countries which have low teenage pregnancy rates (Jones et al. 1985, 1986; David et al. 1990).

Jones et al. (1985) used the following criteria to measure the level of openness of any given society:

1. Media presentations of female nudity,
2. The extent of nudity on public beaches,
3. Sales of sexually explicit literature and
4. Media advertising of condoms.

According to Jones et al.'s study (1985), the UK fits the general pattern for high teenage pregnancy with regard to its relative lack of cultural openness. Scotland escapes the extremist moralistic views of the USA, but it is well behind the more open and pragmatic approach to teenage sexual activity found in many European countries.

Education and Teenage Pregnancy

In the set of pre-requisites to effective contraceptive use outlined at the beginning of this chapter, the final pre-requisite was motivation. Young people need to have motivation to use contraception so as not to become pregnant or place themselves at risk of contracting an STI. Hadley (1998) in her review of sexual health and sex education policy in Britain, highlighted the fact that adults frequently underestimate the high level of motivation required for young people to access and use contraception effectively.

It has been widely acknowledged through international research that educational achievement is one of the strongest determinants of teenage pregnancy (Jones et al. 1985; Zabin et al. 1986; Hayes 1987; Hofferth 1987; Kirby et al. 1994; Westall 1997; Kane & Wellings 1999; SEU 1999). It would therefore seem appropriate to suggest

that educational achievements and aspirations may provide a young person with strong motivation to avoid pregnancy and parenthood.

Therefore, throughout the next section of this chapter, consideration is given to some of the literature surrounding education and its potential relationships with teenage parenthood, teenage pregnancy, contraceptive use, sexual knowledge and sexual activity, as well as the literature about why young women delay parenthood.

Educational level and achievement

Low level of educational achievement and teenage parenthood - cause or effect?

International research has highlighted throughout many industrialised nations that young women are twice as likely to become teenage mothers if they are low academic achievers (Hayes 1987; Hofferth 1987; Kirby et al. 1994; Kiernan 1995; Moore et al. 1995). Although this relationship exists, however, it has often been assumed that the low achievement occurs after the pregnancy, in other words, the young women drop out of school or fail to finish their education because they have become pregnant. What has become apparent in recent research, however, is that most often the young women who become pregnant have been suffering academic problems including low education attainment, truancy, dropping out of school or having been excluded from school, prior to pregnancy (Phoenix 1991; Kirby et al. 1994; Moore et al. 1995; Selman 1998, 2001).

Recent research consultation undertaken by the Social Exclusion Unit (SEU) in England found that young women who truant or are excluded are at a particularly high risk of pregnancy (SEU 1999). One small-scale study of 50 young women excluded from school undertaken by *Include* in response to the SEU's consultation work, found that 14% of those young women had become pregnant during their period of exclusion (1998). From examination of studies of both young men and young women in the 1958 UK birth cohort, Kiernan (1995) identified that low educational attainment was a risk factor for young parenthood.

Educational level and sexual knowledge

It has been widely accepted that having a good sexual knowledge will not automatically translate into safe heterosexual behaviour (Silver 1998). If and how that knowledge is internalised into safe behaviour has been discussed in relation to sex education, but the knowledge must first be there in order to be internalised. In relation to general levels of education, Kontula & Rimpelä (1988) found in their study of young Finns that the higher the level of their general knowledge the higher the level of their sexual knowledge.

Additionally, Turner (2000) in her research on young never pregnant women's perceptions of motherhood found that young women attending an institution of private school education as opposed to state (comprehensive) school, generally had a higher level of knowledge with regard to contraceptive/sexual issues. In particular young

women attending private school[1] were significantly more able to assess the risk of pregnancy when having sex for the first time; to know that emergency contraception should be used within 72 hours and that a young woman can become pregnant when having sex standing up and when using the withdrawal method, than those attending state school (Turner 2000).

Educational level and age at first intercourse

Research has found that an increased level of educational achievement has been significantly related to a higher age of first intercourse (Kane & Wellings 1999). In addition, for a young person who has a record of interrupted education or truancy there is an increased likelihood that they will first have intercourse at an earlier age than a young person who remains in education (Croydon Community Trust 1994 in SEU 1999; Westall 1997).

Educational level and contraceptive use

Research conducted during the 1980s in the USA found that the lower the educational level of a young person, the higher their ineffective use of contraception (Hoffman 1984; Morrison 1985). This relationship between educational level and contraceptive use, and the noted difference in contraceptive use between young people in Finland

[1] Whilst attending a private rather than a state school does not guarantee a higher level of general education, pupils attending the private school were found to be significantly more likely than those attending one of the two state schools to predict that they would go on to some form of further education (sign of educational aspiration). Additionally, the young women attending the private school appeared academically more ambitious than those attending the state school and were significantly less likely to predict that they would be mothers within four years of being interviewed (age 15-16) (Turner 2000).

and Scotland was one particular reason that lead to the exploration of education policy in both countries.

Educational level and outcome of pregnancy

There are a large number of reasons as to why a young woman may choose to abort her pregnancy. One association that has been documented is that of educational level and aspirations, in that abortion is much more common amongst high educational achievers (Kane & Wellings 1999). Whether this is due to parental pressure because they want their child to continue in education without the burden of a child (Lucey in Rattansi & Phoenix 1998; Turner 2000); because the young woman herself has educational aspirations that would be hindered by having the child (Brazzell & Acock 1988; Moore and Rosenthal 1993; Turner 2000); because being more educated, that young woman has more choices or is more aware of her choices and is more aware of how to obtain an abortion; because of a perceived lack of parental and educational support if a pregnancy was continued (Turner 2000); or because of the socio-cultural background and attitudes of significant others of the young woman being more accepting of abortion than birth (or vice versa) (Brazzell & Acock 1988; Simms 1993; Turner 2000), is unclear. The more common outcome however for higher achievers has been documented to be an abortion rather than birth (Kane & Wellings 1999).

Educational level and timing of first birth and number of children

According to Beets (1999a,b) women postponing the birth of their first child is a widespread phenomenon throughout most of the Western world, with the Netherlands

being coined "world champion [of] later parenthood" (1999a:1). Throughout most of Europe over the last two decades, starting in Northern and Western Europe before spreading to Southern and Eastern Europe, fertility rates have dropped and the ages at which women across Europe now have their first child have risen.

Beets (1999a, b) suggests that the low, declining and late fertility rates are the result of increasing levels of education amongst consecutive generations of women of childbearing age, the declining importance of having children in comparison to other life pursuits and an increasing desire amongst women to be economically active and independent. Further to this, the difficulties for women in many countries which do not provide free or low cost childcare, to combine work and motherhood as well as the desire to be financially secure prior to starting a family, provide additional explanation to the pattern of fertility rates.

The level of education, however, is believed to be one of the strongest influences on the timing of first births across Europe, "as higher education achievements tend to go hand in hand with stronger preferences for labour force participation, education may be an important factor in 'explaining' the delay of first birth" (Beets 1999a: 1).

International research indicates that a woman's educational level strongly relates to the age at which she will marry, the age at first birth and the number of children she will have, with a higher level of education equating to a higher age at marriage and first birth and fewer children overall (Westall 1997; NHS CRD 1997; Beets 1999a,b).

Continued education and teenage pregnancy

International research has indicated that in countries where there are higher levels of young people in education or training beyond the age of 16, there are lower rates of teenage pregnancy (Jones et al. 1985). There is strong evidence in England, that not being in post-16 education or training is closely associated with teenage parenthood for 16 and 17 year old women (SEU 1999). In a study of young women in England, almost half of those who were not in education or training were mothers in comparison to only 4% of young women who were mothers and in education or training (Bynner & Parsons 1999). Further analysis of this relationship revealed that approximately one third of those young women who had become mothers, became pregnant whilst they not in education, training or work (Bynner & Parsons 1999).

It is plausible to suggest given this evidence, that the longer a young woman remains in education or training, the longer she is indirectly delaying pregnancy and parenthood. It could, however, be that the delay is deliberate because a young woman has the desire to pursue a higher level of education or a career prior to parenthood. It may also be that remaining in education has offered more opportunities and choices for a young woman beyond becoming a parent at a young age.

Aspirations for the future

In addition to the relationships shown to exist in previous sections above, between educational level and contraceptive use, abortion ratio and age of first birth, previous

research has also illustrated that similar relationships exist between these variables and educational aspirations.

Educational aspirations and contraceptive use

Research conducted during the 1980s in the USA found that young people who had high educational aspirations were more consistent in their use of effective contraception. Morrison (1985) in considering the relationship between educational aspirations and current contraceptive practices also found that there was a positive association between young people who had higher educational goals and aspirations for themselves and the use of several measures of effective contraception. More recently in Norway, Pål Kraft found that the only factor that related to contraceptive efficiency in the most recent intercourse was the educational aspirations of the young person, the higher the educational aspirations, the higher the contraceptive efficiency (Kraft et al. 1991).

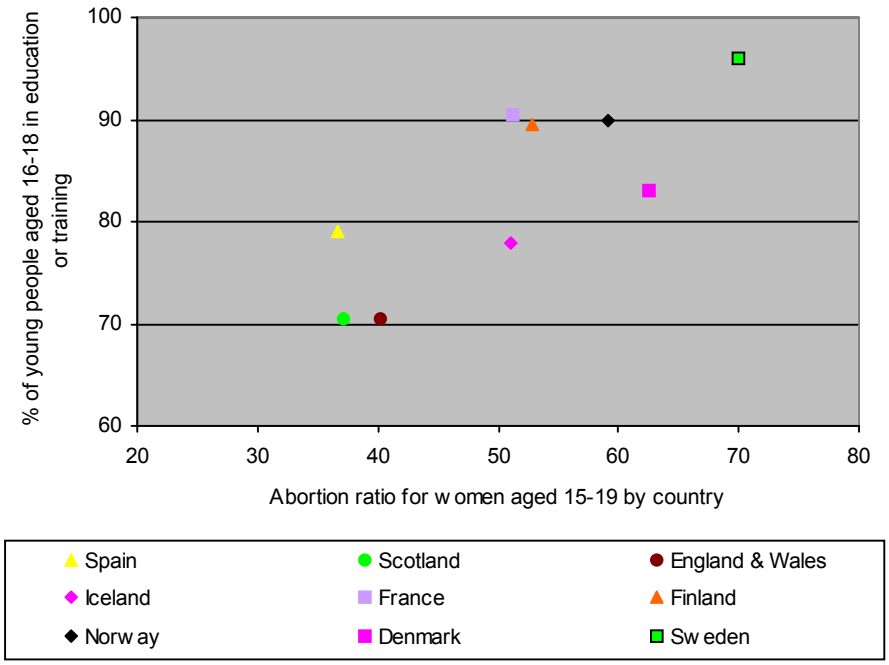
Figure 2.3[1] below, using the proportion of young people in education or training at age 16-18 as a measure of educational aspiration, explores this relationship further. In many European countries, the age of compulsory schooling ends at 16 and therefore if young people stay beyond the age of 16, this suggests voluntary continuation and a sign of aspiration. This chosen measure is rated against contraceptive use at first intercourse in five European countries.

[1] Data for this figure can be found in Appendix i.

The relationship for the data available is very significant (r_s= 0.90), however this should be viewed with caution as there are only a small number of countries included due to lack of available data. Additionally, the definition of young person varied for each country from 'young people' to specifically 15 year olds.

Figure 2.3

Proportion of adolescents using contraception at first intercourse and percentage of those aged 16-18 in education or training, by country.



r_s=0.90

General notes
Definitions of adolescents vary by country as follows:
Netherlands - 'young people' (year not stated)
Denmark - 15-16s (year not stated)
France - 'young people' (year not stated)
Finland - 15s (1992)
Scotland - 15-16s (1992)
Source of data on contraceptive use - McIlwaine 1994, Papp 1997 and SEU 1999.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

Educational Aspiration and outcome of pregnancy

In relation to academic achievement and educational level, previous research has shown that the more common outcome for higher achievers has been abortion rather than birth (Kane & Wellings 1999) and Figure 2.4[1] below, was constructed to explore this relationship further. As with Figure 2.3, the measure of educational aspirations is taken to be the proportion of young people in education or training aged 16-18. As expected, in countries where the overall stay-on rate in education or training was higher, the outcome of pregnancy was found to favour abortion as opposed to birth. The Spearman's correlation coefficient was found to be very significant r_s=0.73.

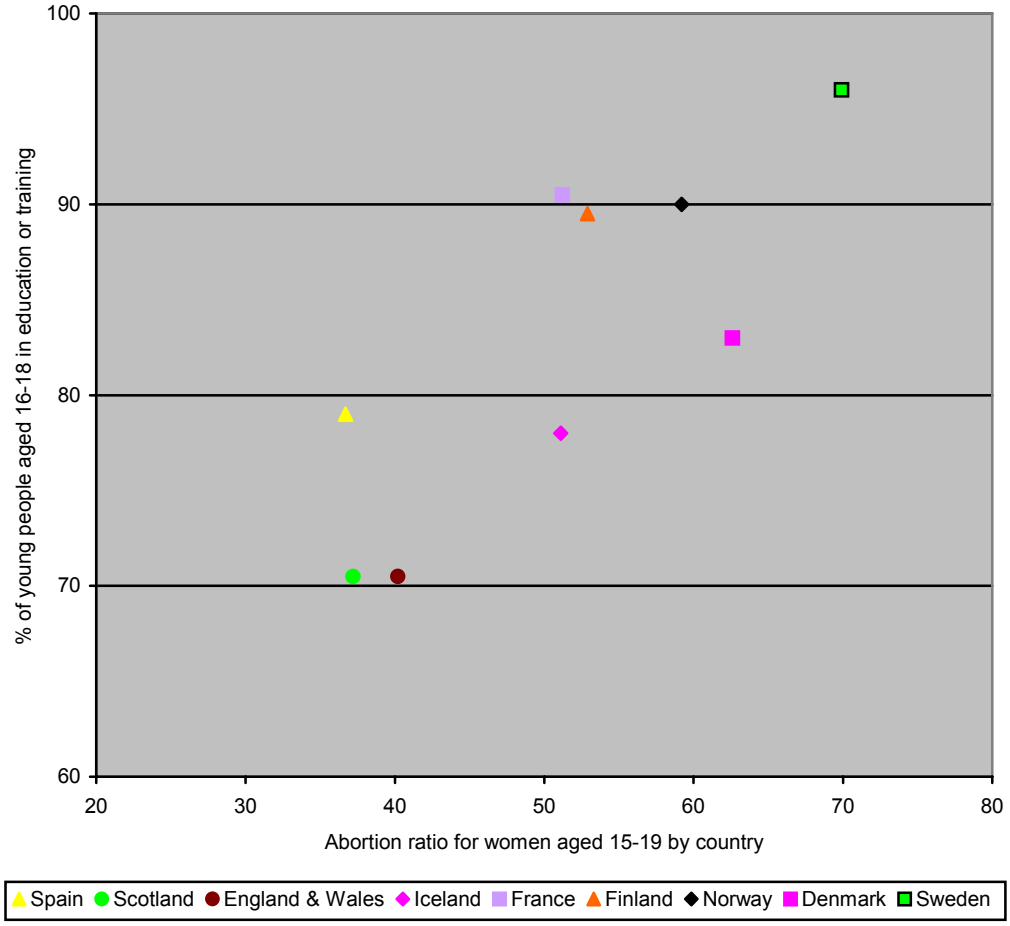
Educational aspiration and age of first birth

One final relationship explored above in relation to educational achievement and level was that of age of first birth, where previous research suggested the age of first birth was higher, the higher the educational level of a woman. Therefore again, having taken the measure of educational aspirations to be the proportion of young people in education or training aged 16-18, Figure 2.5[2] below compared this measure with the age of first birth across a range of European countries. The relationship was once again found to be significant with a Spearman's correlation coefficient of r_s= 0.74.

[1] Data for this figure can be found in Appendix i.
[2] Data for this figure can be found in Appendix i.

Figure 2.4

Abortion ratio and percentage of those aged 16-18 in education or training, by country in 1995/1996 (or latest available year).

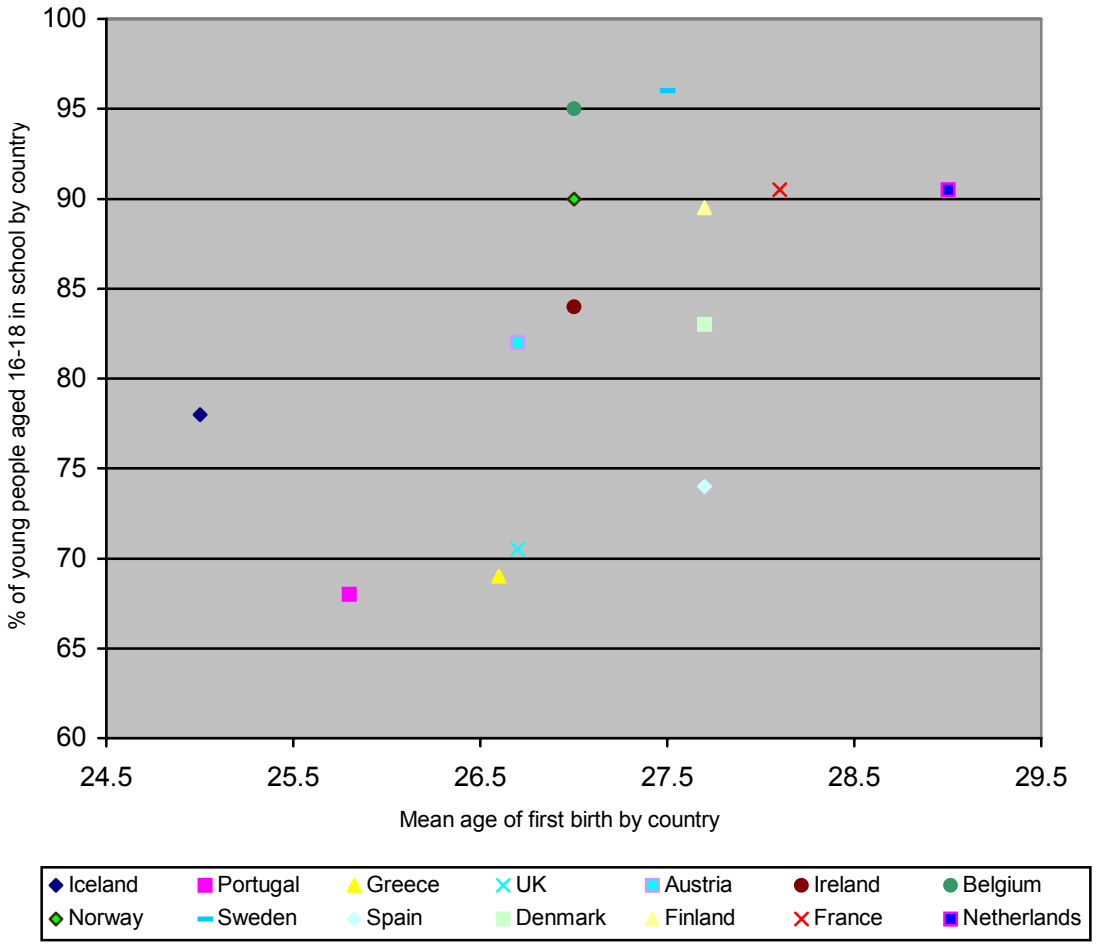


r_s= 0.73

General notes
Source for data on abortion ratios - Singh & Darroch 2000.
Year for abortion ratios is 1995 unless noted below:
1996 - Finland, Iceland, Norway and Sweden.
Abortion data for France and Spain are only 80% complete.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.
Data on Scotland - % education rates are for the UK as a whole, abortion ratio data is for women under 20, not just 16-19.
Data for England and Wales - % education rates are for the UK as a whole.

Figure 2.5

Mean age of first birth and percentage of those aged 16-18 in education or training, by country in 1996 (or latest available year).



r_s=0.74

General notes
Age of first birth data - Beets 1999a
Year for which first birth information is available is 1996 unless noted below:
1997 - Finland, Greece, Iceland, Netherlands, Norway, Switzerland.
1995 - France, Spain.
% of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

'Opportunity costs' - reasons to delay pregnancy and parenthood?

"The proposition that early motherhood hinders a young woman's education and employment prospects assumes that those women who become young mothers had educational and career ambitions prior to entering motherhood" (Turner 2000:41). As Hadley (1998) notes, however, there first need to be good educational and employment prospects available to young people if they are to believe in the value of obtaining educational qualifications at school and to therefore delay parenthood.

Having already noted that the majority of young women who become mothers were not achieving academically prior to becoming mothers, Stevens-Simon & Lowly (1995) therefore argued that for many young women, delaying motherhood would in fact make little difference to their educational or future employment situation. In other words, as Simms (1993) suggests, there is no perceived sacrifice in not delaying pregnancy and parenthood.

Moore et al. (1995) describe this as the 'opportunity costs' dilemma, in other words the process by which young women have to decide the costs of delaying pregnancy against the perceived benefits of motherhood. For some young women, if they do not see themselves as having the aspiration to, or being capable of higher education or financial independence or having any solid career aspirations, but rather they see little education and an underpaid and repetitive job as their future, then Simms suggests that they may perceive that having a child potentially becomes an attractive option (Simms 1993).

This, however, suggests that there is an indication of intention to become pregnant which is not supported by research (Turner 2000; Selman 2001). What Turner (2000) has suggested is rather, that "the fewer the opportunities that a young woman has, the less motherhood is viewed as problematic" (Turner 2000:309), and that rather than the fewer opportunities being viewed as a reason to conceive, findings of her research suggest that "once pregnant, the reasons for avoiding motherhood [as opposed to abortion] may seem less significant" (Turner 2000:310).

Simms has noted, in Britain there is a need to "give girls a motive for avoiding too early pregnancy by making further education attractive (affordable) to them with the chance of a good job and independence at the end of it" (Simms1993:1750). Selman & Glendinning (1996) and Hadley (1998) both support this notion within a British context, expressing the real need for adults and educators to provide young people with reasons that they will perceive as valid, to enable them to want to stay on in education.

For young women an increase in gender equality in the labour market may be one such incentive. Research has shown that in countries where there exists a higher level of gender equality in pay and there are higher female wages, there are in turn lower rates of fertility amongst all women, younger women included (Beets 2000b, Papp 1997). Additionally Turner (2000) found that a young woman's increased enjoyment of education at the school level increased her prediction that she would be in further education in the near future.

According to Cheesbrough et al. (1999) some of the most effective teenage pregnancy reduction programmes (internationally) have been those which attempted to understand and tackle the causes of low self-esteem and low aspirations, starting at an early age. The philosophy behind those programmes is that if young people feel that their future is bleak, then they are not likely to be as receptive to and internalise safer sex messages, or to perceive any incentive to delay parenthood (Cheesbrough et al. 1999).

'Fatalism' Vs 'Being in control'

The previous paragraph introduced the notion of 'self-esteem' and this is a further issue that has been related to teenage pregnancy. Again research has shown internationally that young people in general (women in particular) who have higher educational achievements and aspirations are noted to also have higher levels of self-esteem and a feeling that they are in control of their lives instead of simply accepting 'fate' (Jones et al. 1985; Visser & Bilsen 1994; Hadley 1998; Cheesbrough et al. 1999).

In relation to teenage pregnancy, the notion of 'accepting fate' could translate to non-use of contraception with the attitude that 'if I get pregnant then that's what's meant to be' and the outcome therefore being perceived as a 'passively conceived' pregnancy[1] (Turner 2000), instead of approaching life from the perspective of 'being in control' and understanding that one has the ability to control the directions in which one's life

[1] Turner (2000) uses the term 'passively conceived' to describe a pregnancy that 'just happened', i.e. it was neither 'planned' or 'unplanned'.

may go. Jones et al. (1985) described this fatalistic approach as a response to social anomie, whereby uncertainty about one's future or the perception of a bleak future resulted in a more fatalistic approach to life and in turn lowered contraceptive motivation.

Further to this Turner (2000) found that of the two young women she interviewed who had 'passively conceived', both were noted to have had "little else to structure their lives" (Turner 2000:347). Further to this, "it was apparent that neither interviewee had enjoyed school, nor had a job, or any intention of seeking employment [and therefore] it is also possible that these pregnancies had not been avoided because the women viewed motherhood as a role which could bring them a sense of purpose" (Turner 2000:347).

Summary

This chapter has explored a range of relevant literature surrounding the issue of teenage pregnancy and its potential relationship to three particular areas of policy: sex education, sexual health and education. Each of the three areas identified are important pre-requisites to effective contraceptive use and it is therefore important to consider them in combination, as well as separate areas of policy. It is hoped that in doing so, more light will be shed on the nature of the relationships between the different policy areas and the important role that they play in the prevention of unintended teenage pregnancy, both as individual policy areas as well as jointly in relation to each other.

In order for young people to be prepared for the choices that they are to make in their lives regarding relationships and sex, in particular the effective use of contraception when they decide to begin their sexual lives, they need to first have a comprehensive understanding of sex, sexuality and how to prepare themselves emotionally and physically for a sexual relationship.

Compulsory school-based sex education is one means of providing some of that knowledge and because of its school-base, it has the potential to reach almost all young people. Within both Finland and Scotland national school health studies have been undertaken to explore the levels of sexual knowledge and attitudes of each country's respective cohorts of young people (Kontula et al. 1992; Pötsönen 1993; Liinamo et al. 1999c; Liinamo et al. 2000b: Currie & Todd 1993; Currie et al. 1998).

In addition, there have been evaluations undertaken in both countries on the effectiveness of certain types of provision and the levels of provision in schools (Hämäläinen & Keinänen-Kiukaanniemi 1991; Kontula 1997; Liinamo et al. 1998a; Liinamo et al. 1998b; Liinamo 1999a; Liinamo et al. 1999b: Bagnall & Lockerbie 1995; Wight & Scott 1994; Wight 1996; Wight et al. 1999).

So far the emphasis of research has been on the extent of provision, its content, and effectiveness in both countries. As yet there has not been a comparative exploration between the two countries of sex education policy looking at the wider remit of policy

frameworks at government, municipality/ local authority, and school levels and the potential relationships at work between the different levels. This thesis has therefore included an exploration of sex education policy in Finland and Scotland from this wider perspective.

In addition to having an adequate knowledge about sex and sexuality before becoming sexually active, young people also need to perceive that they have 'real' access to sexual health services for advice, support and contraception. In Britain, young people have frequently reported difficulties in taking responsibility for their sexual health (Hadley 1998). Many of the difficulties encountered by young people have to be addressed through social policies. The decision to include an exploration of sexual health policy in this thesis was taken in the first instance because whilst both countries had a school health service, there were apparent differences between the ways in which each country used this service. Given the increased interest as noted above, in the utilisation of school health services in teenage pregnancy prevention, this warranted further research.

Additionally as was found to be the case with sex education, there has not been a comparative study undertaken between Scotland and Finland, or any other country. Nor has there been any research published in English that has compared Finland and any other country.

Finally, in response to the evidence presented in Chapter One and in the education section within this chapter on the relationships that previous research have shown to exist between educational level and/ or aspiration and many variables including, levels of sexual knowledge, in/efficient contraceptive use, age at first intercourse, teenage pregnancy rates, outcome of pregnancy, age of first birth and motivation to delay pregnancy and parenthood, education policy was chosen as an area of focus in this thesis.

There were two main assumptions I wanted to explore within the remit of education policy. First, as the relationship (see Chapter One) between continued education rates and unemployment amongst young people under 25 was weak, I wanted to explore whether differences existed within general education policies that perhaps promoted the educational prospects of young people, women in particular. The rationale being that in doing so they may encourage continued voluntarily attendance at school, beyond the age at which compulsory schooling ends, hence providing young people with the aspiration and motivation to delay parenthood. In order to examine that assumption the decision was taken to explore in particular, policies relating to the provision of careers guidance within Finland and Scotland's education systems.

The second assumption under consideration in this thesis was whether the school leaving age and the structure of the education system in each country could potentially be indirectly affecting the rate of teenage pregnancy in each respective country. In other words, was there something about the structuring of education that required

young people to remain in education, be that legally by age or structurally by the normalised educational paths and opportunities on offer to young people at school, in both countries, hence encouraging an indirect delaying of pregnancy and parenthood. In order to examine that assumption the decision was taken to explore policies relating to both the legal age at which young people can leave compulsory schooling as well as the structure of education in both countries.

The final reason for including education policy as an area of exploration was due to the lack of focus upon this area in combination with other areas of policy that may relate to teenage pregnancy. So often research has focused on the means of acquiring knowledge about sex and sexuality (sex education policy) and/ or the means of achieving access to sexual health services (sexual health policy), only very recently (Hadley 1998; SEU 1999) has research acknowledged that the motivation to apply the knowledge and access the services, (one source of motivation potentially being education), is just as important as the other two pre-requisites to effective contraceptive use. Therefore whilst recognising educational achievement and aspiration may be only one potential source of motivation, the decision was taken to undertake a comparative exploration of education policy between Finland and Scotland.

The next chapter sets out the methodological issues of concern in this thesis as well as the methods by which the research design was achieved and the research itself was conducted.