Teenage pregnancy in the United Kingdom: Are we doing enough?

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ABSTRACT The teenage pregnancy unit’s strategy for dealing with the increasing problem of unwanted pregnancy is rather prescriptive and simplistic for such a complex problem. It is not surprising that despite its recent recommendations, the problem has worsened. It is ludicrous to promote efficient ways to provide oral contraceptive pills to teenagers when good evidence of its inconsistent use among this age group is common knowledge. In addition, increasing access to emergency contraception could undermine teenagers’ perception of the importance of commitment in relationships and thus send them a wrong message. This paper reviews the available evidence on the subject and highlights some good practices from other parts of the western world, which have not been incorporated into the UK strategy. It challenges the various stakeholders to show better commitment by providing a more rigorous and effective strategy.

KEYWORDS Teenage pregnancy, Contraceptive services, United Kingdom

INTRODUCTION

In recent years, there has been concern about the high rate of teenage pregnancy in the United Kingdom. Britain has the highest rate of unwanted pregnancy in Europe, despite the provision of free contraception. One-half of the pregnancies in the UK are unplanned, and one-quarter are terminated; 38% of those remaining result in unwanted children. The annual abortion rate of 13:1000 and teenage pregnancy rate of 33:1000 are surpassed in the developed world only by Canada and the United States1,3.

The social, economic and health sequelae of unwanted pregnancy have been well described. Long-term adolescent maternal health effects include pelvic inflammatory disease, infertility, cervical cancer and susceptibility to HIV infection. Psychosocial problems implicated in adolescent pregnancy include school interruption, limited vocational opportunities, separation from the child’s father, divorce, and repeat pregnancies. Single parenting, welfare dependence, unemployment and poverty are the long-term economic implications3. The British Government, under pressure, commissioned the Social Exclusion Unit to address the problem.

WHY DO UNPLANNED TEENAGE PREGNANCIES OCCUR?

While associated factors of teenage pregnancy are myriad and complex, the suggested direct causal links include lack of sex education, peer pressure, pressure from older partners, delay in accessing contraceptive services, poor relation of teenagers with available services, and contraceptive failure1.
Teenagers are generally poor contraceptive users\(^4,5\); they tend to delay accessing the service until they have been sexually active for about a year or when they have been motivated by a pregnancy scare\(^6\). Many admit to technical difficulties with their chosen method. A few adopt a defeatist attitude after many contraceptive crises, and simply abandon attempts to use contraception regularly\(^6\).

A UNICEF report blamed the higher rates in the UK on the poor quality of sex education, the lack of openness and embarrassment, and the high level of social inequality\(^7\). Concerning parental roles and sexual health it is believed that in countries with low teenage pregnancy rates, such as the Netherlands, there is a culture of openness and communication within families\(^8,9\).

Teenagers have poor perception of risk and are ill-equipped to evaluate consequences. Teenage pregnancies have been linked to adolescent behavioural traits of reckless experimentation and risky living\(^10\). Adolescent males consider risky behaviour and sexual experience with multiple partners as ‘being tough’\(^10\). Young people are more likely to indulge in risky sex under the influence of alcohol and studies link young women having multiple partners and binge drinking\(^5,11,12\). The UK apparently has the highest level of alcohol consumption among teenagers in Europe.

**CONTRACEPTIVE USAGE**

The commonest contraceptive methods used by teenagers in the developed world are the combined oral contraceptive (COC) and barrier methods. COCs are effective, but unfortunately less so in young users because of poor comprehension, lack of direction and motivation\(^4,6\). The sexual culture of the UK teenager is one of a fairly early age at first intercourse, moderately frequent partner change, and low levels of condom usage\(^13\). This common sexual pattern of ‘serial monogamy’ greatly interferes with the continued usage of the pill, thereby increasing the need for emergency contraception\(^13\).

Teenage contraceptive usage is also limited by the inappropriateness of permanent methods and the alleged risk of sterility with intra-uterine contraceptive devices. It is claimed that the use of condoms has increased, but the fact that the incidence of gonorrhoea and chlamydia infections has more than doubled, with the most significant rise amongst young people, casts doubt on this assertion. While women currently seem to use COCs less and injectable contraceptives more frequently, this trend has not been identified yet in the UK\(^6\). As already mentioned, adolescent girls who have had repeated contraceptive crises or abortions may abandon attempts to apply effective contraception\(^6\).

**TYPE, ACCESSIBILITY AND FUNDING OF FAMILY PLANNING SERVICES**

In the UK, family planning is provided primarily by general practitioners and family planning clinics. The Brook Advisory Centres also provide birth-control to young people. Anonymous young persons service has not been a popular concept until recently, and is still unavailable in most parts of the country, partly because of cost implications\(^14\). A study in the Trent region showed that opening hours of the family planning services are unsuitable for youngsters attending school\(^15\). Recent research has shown that comprehensive community based programmes, which have links with local schools, optimize contraceptive compliance. Unfortunately, such links are not well established in the UK.

Funding for family planning services in the UK has been unsteady and inconsistent. The current Government funding for teenage pregnancy services is only protected until 2006, after which these services will have to compete with other agencies for Social Services allocations\(^16\). Unless a clear political will is demonstrated to provide consistent and steady funding for teenage contraceptives services, it will be impossible to devise long-term strategies that would have a significant impact. Lessons should be learnt from Sweden and Finland where cutbacks in family planning services budget were associated with a rise in teenage pregnancies, abortions, school non-attendance, smoking, drug abuse, and first intercourse at an earlier age\(^17,18\).

**THE DUTCH AND SCANDINAVIAN EXPERIENCES**

The Dutch have had a low teenage pregnancy rate for a long time. Similar trends are noted in Scandinavian countries. Since the 1970s, sex education in Danish schools has been mandatory. Family planning clinics
are run by nurse-midwives who have direct authority to prescribe oral contraceptives. The clinics offer hotlines for advice. Teachers and school doctors/nurses collaborate in this effort. Even pharmacists promote sex education by instructing students about various contraceptive methods. These countries attribute their low teenage pregnancy rates to close collaboration between schools and family planning services, and easy access to contraception.

Most women in The Netherlands use reliable contraception; non-use coincides with the absence of a male partner. Teenage pregnancy is not socially accepted and thus best avoided. The Dutch example demonstrates that relevant health-related behaviours (e.g. consistent condom use) are determined not only by the conscious rational choice of well-informed individuals, but also by broader contextual factors. Thus, the challenge for health promotion lies in developing social and community contexts that enable and support health-enhancing behaviour.

SEX EDUCATION AND ETHICS

Sex education, teen contraception and abortion ignite emotional comments from both proponents and critics. Studies in the US and across Europe have demonstrated declining teenage pregnancy if sex education in schools is instituted, and contraception made readily available. Critics argue that Japan, with no national sex education programme, has a very low teenage pregnancy rate. It may be due to that country’s conservative norms about pre-marital sex. There is no evidence that sex education increases promiscuity.

Comprehensive sex education is implemented in most western countries with a low teen pregnancy rate, but the content, context and extent of instructor training and participation vary. The issue of content is complicated by the huge variation in adolescent pregnancy rates around the UK, and no uniform educational programme will suit all. Controversies surrounding sex education should not prevent us from addressing this area of adolescent health.

THE MAIN ISSUES AND WAY FORWARD

With our current strategy, the 2010 deadline is unachievable; a complete re-think of the services is needed. Lessons must be learnt from around the world.

Regarding sex education, the real issues in the UK are:

1. The resistance of some schools and parents to a universal sex educational programme.
2. The content of educational programmes and the assignment of the responsibility to teach these (teachers or family planning staff trained in youth counselling).
3. The adoption of a more open culture and the lifting of the secrecy and embarrassment surrounding teen sex education.

The teenage pregnancy unit’s guidelines have addressed most of the issues but clearly lack rigour, indeed:

1. They acknowledge the erratic use of contraception by teenagers, but fail to propose relevant steps to overcome this behavioural problem.
2. They overlook the importance of the parental role of guidance and support.
3. They ignore the importance of promoting commitment as a way of reducing the incidence of sexually transmitted infections (STIs) and unintended pregnancies.

The key areas that need improving include the enlistment of parents in this governmental effort, the promotion of school-based and school-linked teenage clinics, comprehensive sex education, the adoption of local solutions to solve local problems, the promotion of reliable long-term contraception among teenagers, and the provision of consistent long-term funding for all these efforts.

A careful assessment of the rising teenage pregnancy rate in the UK exposes a complex interplay of developmental, behavioural, socio-economic and ethnocultural dimensions. A multi-faceted approach would be more promising than a simplistic methodology that just advocates sex education and prescription of more contraceptives.

The role of parents is not at all featured in the current strategic guidelines. However, parental support and communication are known to increase teenage clinical attendance, to encourage the choice of a more reliable contraception, and to help teenagers to avoid sexual risk behaviour and pregnancy.

Parents must accept the evidence, whatever their personal inclination, that the age and rate of sexual
activity among teenagers is similar across most countries in Europe and the US. Comprehensive sex education cannot be dissociated from STI (including HIV) prevention education, so that parents objecting to the former must be educated to increase their awareness.

Acceptance of sexuality in some countries is by no means value free. There is widespread expectation that sexual intercourse will take place within committed relationships, and appropriate protection used. The reduced rates of unwanted pregnancies in the Nordic countries may possibly be influenced by the social rejection and reduced support for teenagers in such situations. The Dutch believe that teenagers must obtain contraception at a small fee to help them to take some responsibility for its provision. A Dutch girl would find it cheaper to obtain contraception at a small fee to prevent pregnancy, which would only be supported by herself and her immediate family. A British teenager would not feel equally responsible if contraception is provided freely; when she fails to use it and gets pregnant, she can obtain state support through her pregnancy and thereafter.

Several studies have confirmed teenagers’ unwillingness to access family planning services which serve women of all ages. The concept of teenage pregnancy services is gaining acceptance in the UK, but most are still community based and tend to operate in isolation. An ideal teenage contraceptive service has a multi-disciplinary staff that is friendly and non-judgemental, guarantees confidentiality, and is located close to the teenagers’ residences and schools. It must have flexible hours, provide psycho-sexual counselling, make outreach efforts to inform teenagers about services rendered, and have close links with local schools. It should also link with agencies dealing with alcohol and drug abuse, etc. Finally, it must deliver continuing care. Situating family planning clinics close to schools removes the hindrances due to lack of transportation. Also it is ludicrous to promote efficient ways to provide oral contraceptive pills to teenagers when good evidence of its inconsistent use among this age group is common knowledge. Reliability would most certainly be improved by encouraging teenagers to choose long acting contraception (e.g. implants).

Some believe that the aim of school based sexual health programmes should be to lower the level of sexual activity and to raise the rate of contraceptive use amongst sexually active teens. The content must provide teenagers with the facts, the need for commitment, the dangers of HIV and the increased likelihood of pregnancy when a young girl relates to an older partner, and the associated links with alcohol/drugs.

Pathways for obtaining contraception should be made known. In Sweden and The Netherlands, teenagers have access to family planning through two well known pathways. In Britain, a wide variety of services provide family planning, many of which are not necessarily designed for nor receptive to teenagers, and are unable to provide a confidential service.

Within the UK there are large differences across areas and groups in teenager pregnancy rates; social inequality is a major contributing factor in this regard. Disadvantaged adolescents are more likely to have children. The use of contraception also differs among ethnic groups. Therefore, each local authority must draw up specific guidelines relevant to the needs of the area. The government’s commitment to social welfare and equality can improve individual well-being, including that of teenagers.

In Sweden, family planning professionals are assured of their Government’s continued support; they are able to plan and develop a meaningful career around family planning services, and they have a sense of pride and a greater job related prestige than staff in Britain. Their staff are said to have described funding of family planning services as adequate. In Britain, family planning clinics are steadily closing down. The Brook Advisory Centres decreased from 80 to 19 between 1985 and 1999. Family planning staffs are poorly paid compared to their colleagues with a similar level of training working in other units. The opening hours of late evening clinics are not attractive to most women GPs. Adequate funding is mandatory.

CONCLUSION

Reducing teenage pregnancy is a complex problem with many facets. Isolated strategies are less likely to yield satisfactory results. Parents, schools, health workers and the government must all address their individual responsibilities with regard to teen health. In the UK, this would involve tackling poverty and social inequality, a stronger political commitment to uninterrupted funding, and more rigorous and effective strategies.

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