

# Teenage pregnancy — commonsense begins to pay off at last

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**R**ecently, moral concern about teenage pregnancy and single mothers has reached the level of panic. However, there is more than a hint of cant and hypocrisy in the comments of politicians and public figures. What really are the facts?

## The problem

In 1986, a major international study of teenage pregnancy in 37 developed countries was published.<sup>1,2</sup> The study was carried out in two stages: the first was a statistical comparison of teenage sexual behaviour and pregnancy in 37 countries, the second an indepth examination of the situation in the USA and five comparable countries — Sweden, France, The Netherlands, England and Wales, and Canada.

The study identified a large variation in annual rates of teenage pregnancy, ranging in the 15- to 19-year-old age group from 14 per 1,000 in The Netherlands to 96 per 1,000 in the USA (rates for the other countries were Sweden 35 per 1,000, France 43 per 1,000, Canada 44 per 1,000, and England and Wales 45 per 1,000). The reasons for the variation cannot be explained by differences in sexual activity by teenagers in different countries, nor by the variation in the number of abortions performed. Rather it seems that teenagers in different countries vary in how effectively they use contraception.

The researchers concluded that there seemed to be three major factors determining how effectively contraception was used:

- the degree of openness about sexuality and the extent to which teenage sexuality was accepted by the adult community;
- the availability of good-quality information and education about sexual matters;
- the provision of high-quality, user-friendly clinical services for young people.

These findings have clear implications for any policies designed to reduce the rates of teenage pregnancy and the associated high incidence of sexually transmitted diseases.

Primary healthcare teams in the UK have had an important role in reducing rates of teenage pregnancy since 1974,

when family planning provision became part of general medical services. Typically, 20 years ago 50% of women obtained their family planning advice from a general practitioner and 50% from a community family planning clinic. Today, that ratio is likely to be 70:30, and in future it could be 80:20. As general practitioners and practice nurses have become more skilled in offering birth control, so older and married women have come to expect a full range of advice on contraception and sexual health from their own practice. To this extent, making birth control part of normal adult and married life, has been a success.

However, we are still failing with teenagers. A significant proportion still prefer to look elsewhere for advice or are deterred from seeking it at all.

## The health of the nation and teenage pregnancy

The publication of the Government's health strategy and inclusion of targets for HIV/AIDS and sexual health represent a belated recognition of the significance of these issues.<sup>3</sup> The Government has set a target to reduce the rate of conceptions among those aged under 16 years by at least 50% by the year 2000.

The challenge posed by the Government's target is a real one. It has been said that combining medicine with anything to do with sex has a paralytic effect on human resourcefulness. Traditional health education, a mechanical focus on contraception, appeals to traditional moral values, and keeping teenagers in ignorance, have all failed. The need for adults to fulfil their practical responsibilities to young people by providing information, acceptance and services is clear.

## The Swedish experience

In Sweden, a community-based programme has been developed that seeks to influence the multidimensional environment that shapes sexual choice, behaviour and experience.<sup>4,5</sup>

The aim is to create community-wide initiatives, which spread 'like rings on the water'. The general approach is through intensive residential workshops that bring together

key opinion-formers, decision-takers, role models, doctors, teachers and counsellors of young people. The agenda for these workshops includes factual information about human biology, personal relationships and the family, pornography, prostitution and sexually transmitted diseases. The methods used include lectures, role play, discussions, group work, theatre and film. The intention is to provide a non-threatening environment where attitudes may be explored, ignorance avoided and common ground sought.

With the focus very much on relationships and living together rather than on the mechanics of sex and contraception, the Swedish initiatives have had considerable success. Not only has there been a 40% reduction in rates of teenage conception in Sweden, but this has been accompanied by a decrease in the incidence of sexually transmitted diseases and reduced drug abuse and delinquency.

### The approach in Mersey

In the 16- to 19-year-old age group in Liverpool, 81 in every 1,000 get pregnant every year, of whom seven get married, 24 have an abortion and 50 have a child outside marriage.<sup>5,6</sup> Within the city, some areas have much higher rates of teenage pregnancy than others; paradoxically, the areas with higher rates are relatively well provided with family planning clinics,<sup>7</sup> which raises questions about the style and effectiveness of their work.

These findings prompted the regional health authority to review its policy on family planning services in 1992, and to encourage district health authorities, family health service authorities and primary-care teams to reshape and develop their services to respond more effectively to the needs of teenagers.

What has emerged is a two-pronged strategy. First, the strategy emphasizes the need to strengthen sexual health services in primary care. Second, it emphasizes the need for those services based in the traditional community clinics to refocus on special groups of women who may always need alternatives to general practitioner-based services. These groups include:

- young women;
- women with learning disabilities;
- ethnic minorities;
- women who are registered with a practice where there is no woman doctor;

- women in conditions of particular social stress;
- women who for whatever reasons choose to attend a clinic rather than their general practitioner.

Accordingly, resources have been moved from some existing clinics to strengthen and extend the services provided in others. At the same time, six general practices with a special interest in developing sexual health services, have been identified on a locality basis. Each practice has been allocated a family planning nurse who has been redeployed from an existing family planning clinic. These practices are committed to extending the range of services they provide, to making them user friendly to young people and to establishing effective pathways into clinical services from the local schools and youth and community services.

Above and beyond the NHS contribution to solving the problem of teenage pregnancy, there has been collaboration with the education authorities, schools and school governors.

Wider still, the health authorities, general practices and clinics have been developing strategies to promote the new-style services, and contact with the services is already much increased.

### Conclusion

All this work has illustrated repeatedly that the closer services can get to what the public actually wants the more likely they are to help reduce the toll of suffering from unplanned pregnancies and sexually transmitted diseases. It is important for primary healthcare to ensure that this central task is tackled properly. □

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