

Analysis on teenage pregnancy in the uk

[Family](#), [Teenage Pregnancy](#)



Introduction

Teenage pregnancy is a major concern in the UK, and for the last 20 years it has the highest rates in the European Union; other countries with similar rates are New Zealand and Australia (Maticka, 2001 p. 15). The UK is found to have the highest live birth rates among people with the age of 15-19 in Western Europe. It is estimated that even the most prosperous zones in the UK surpasses Netherlands and France in national rates of teenage pregnancy. Between the 1970s and 1980s, there was a record decline with the rates in many European countries. However, these rates did not go down in UK in the period 1979 and 1999 (SEU, 1999), while conception among under 16-olds rose by 1% between 2002 and 2003 (Office of National Statistics, 2005).

The common factors found to influence high levels of teenage pregnancy includes but not limited to: Social economic status especially income distribution across societies, gender equality levels within the societies, the availability of sex education and prevention strategies at schools, access to sexual health services that meets the needs of teenage persons, normalized expectation of continued education beyond the age of 16, Exposure to unhealthy media materials amongst others.

In the year 2000 alone, 38, 690 under the age of 18 years got pregnant in England. 44. 8% of these underwent legal abortion as the conceptions were not planned for. Surprisingly, 7, 617 of the total conceptions involved girls under the age of 16 years out of which 54. 5% ended in legal abortion (Office for National Statistics, 2000).

Many factors influence teenagers' choices to become sexually active and to use contraception considering their ability to obtain them and make use of contraception their choice. These factors operate are exercised at individual's level (e. g. attitudes and beliefs, knowledge, substance abuse and future expectations), the intra-familial level (e. g., social economic factors, family structure, parent-child communication), the extra-familial level (e. g., health services, peer influences, sexual health education at school) and the community level (e. g., values and norms relating to teenage pregnancy). Most of these factors can be changed with time and within respective social institutions individual know-how concerning sexual health, while others are difficult to change or cannot be changed at all.

In most cases, physician groups are left the role to lobby for policy initiatives aimed at changing sexual risky trends among teenagers which includes; enhanced sexual education at schools. However, the important role for physicians is to offer suitable sexual health information and services in their practices when they are providing clinical services to youths (Botting, 1998 p. 21). It is necessary that physicians be familiar with the reality of teenage sexual activity. Conducted studies have indicated that, by completion of high school, the majority of teenagers will have had sexual intercourse (Maticka, 2001 p. 3) and approximately 10% have had intercourse before age 15. It is therefore much important to include as part of the general enquiry into their well-being, their sexual activity too, use of contraception and condoms, their history of sexually transmitted infections and pregnancy. There is need to acquire information about their other sexual health concerns. Adolescents are not necessarily the ones to initiate discussions about sexual health issues,

since to them the process of seeking sexual health advice is a complicated one, and therefore physicians must be proactive in making such an enquiry.

When contraception, including emergency contraception, is indicated for teenagers, it should be provided. Like other women, adolescents also have a right to abortion services, although the availability of such services is not uniform across the country, and teenaged girls of low socioeconomic status or from visible minorities have particularly limited access. Teenagers have the right to confidential health care, including receiving sexual health services, provided their emotional and cognitive maturity allow for this. Their parents do not have an automatic right to know. The right to confidentiality is not always understood by teenagers and should be appropriately communicated during patient encounters. Finally, when teenagers choose to continue their pregnancy to term, exemplary care should be provided before, during and after delivery, to help minimize the risk of negative outcomes that may occur.

Lack of consensus on ways of counterchecking pregnancy problem and sexually transmitted infections (STIs) in respect to teenagers is one of the factors contributing to the high rates of teenage pregnancies in the UK. There are no properly installed structures advocating favorable comprehensive sex and its related education. Low expectations in education which is greatly attributed by the perception that there are few or no employment opportunities lead to teenagers absconding education, engaging in

unplanned sex due to exposure in their neighborhoods and subsequent pregnancy (BBC NEWS, Friday, 27 May 2005).

Ignorance about the use of contraceptives despite their availability often leads to unplanned conception. Although most of the teenage girls are well conversant with the importance of condom use, a large number would go on and engage in sexual activity hoping the worst does not happen. The youth have been found to be inefficient users of contraceptives even when they are offered for free (BBC NEWS, Friday, 27 May 2005). One Jan Barlow was quoted by BBC attributing three factors that help alleviate teenage pregnancy and STI rate as being: better access to young people friendly services, comprehensive sex and relationship education, and offering more open attitudes to sex aimed at influencing young people in making sound decisions (BBC NEWS, Friday, 27 May 2005). The England government for instance had advocated for sex education training but the school authorities are only focused at teaching other subjects. According to him, Sex and relationship that lacks in school curriculum ought to be made a compulsory unit in personal social health education studies. A study conducted for the NHS at the University of York concludes that education prior to sexual activity makes individuals delay in having sex and makes them more likely to use contraception when they do. However, sex education offered in schools is criticized as being too biological and in-adequate to arm the youths with the relevant sex information (Barlow, 2005 May 27).

Teenage girls and boys are misguided approach from TV programs relating sex with celebrities and portraying it as a fashioned activity. It is noted that

teenagers particularly those not participating in co curricular activities are likely to spend most of their time watching romantic programs. The media sets them adrift in the sexualized society without giving them the tools to look after themselves. The outcome is indirect influence when the affected youth fail to differentiate action scenes from real life (BBC NEWS, Friday, 27 May 2005).

Teenage pregnancy comes handy with various complications. The adverse effects include miscarriage, premature births, babies are born underweight for gestational age whereas others are born small (Horgan, 2007). Teenage mothers are also found to have higher risks of contracting STIs, being victims of alcohol and substance abuse, smoking and poor nutrition in addition to suffering higher rates of postnatal depression (Horgan, 2007).

Gynecological immaturity in teenage mothers is one of the reasons attributed to the adverse effects following births. Adolescent girls continue to grow when pregnant. The babies they carry face food and nutrients competition required for their growth with the growing bodies of their mothers. There is also increased risk of obstructed labor during birth because of their undeveloped small pelvises (Horgan, 2007).

These effects are adverse and their effects are prone to have a long term effects therefore preventive measures are by the far advisable measures. Family planning and sexual health clinics should be easy to access amongst these women and facilitated with a wide range of the relevant services, including diet advice, cessation on smoking behavior and embarking back to studies after birth. As a matter of fact, they should be encouraged to attend

antenatal classes and care which should offer them medical care as well as social support. It is believed that postnatal management for teenage mothers is placed better in offering essential counseling and education on crucial aspects of motherhood such as breastfeeding and nutrition for babies. As many teenage mothers tend to be single and often feel isolated in bringing up their babies, they require special attention from the health and social services (Horgan, 2007).

An Obstetrician and Gynecologist; Louse Kenny working at Cork University Maternity Hospital attributes that the figures indicates that death rate for babies from very young mothers is 60% more higher than those from the older women. Further, teenage mothers are more likely to be faced with postnatal depression as compared with their counterparts-the older women. Some 44% of mothers under the age of 20 breastfeed compared to 64% amongst 20-24 and up to 80% in older mothers. There is a need therefore to conduct further studies to ascertain whether the poor outcome from teenage mother births is entirely a link with biological challenges resulting from their bodies not being fully developed; or it is a combination of other factors such as social demographic factors (Horgan, 2007).

Teenage mother are at risk of indulging with malpractices that poses uncondueveenvironmentto their newborns like smoking due to the associatedstressand their vulnerability to peer pressures. At their age, they are not entirely dependent in making sound decisions, a reason why close attention should be directed to them to safeguard their heath and that of the newborns. Awareness towards the dangers associated with smoking for

instance is paramount to them, risks of contracting sexually transmitted infections and the need to use contraception in future sexual activities (Horgan, 2007).

There is challenge presented by teenage mothers toward health workers. Most stay for a long time before presenting themselves to health facilities for diagnosis, only to avail themselves at the late stages in the pregnancy. They thus fail to receive timely attention to any possible presenting risk and guidance on how to take care to ensure healthy newborns and safe delivery.

Both the teenage mother and the child are prone to undergo negative short term, medium and long term health and mental health outcomes that are as a result of unpreparedness in the encounter and dilapidated exposed conditions thereafter (Botting et al., 1998). The mother's education and future employment may be brought to prejudice. There is more likelihood of teenage mothers running into trouble in school before getting pregnant and possible failure to complete studies after delivery. As a result, they may not be having academic qualifications at the age of 33, a situation that renders them find difficulty in looking for a job or subject to low payments and poor benefits as opposed to their peers (SEU, 1999).

An estimated 80% of teenage mothers do not own their own housing arrangements. They are either housed by their parents, relatives or others sponsors who are added an extra burden towards meeting additional expenses. This is more likely to result into domestic conflict in addition to failure to provide the desired space environment for both the mother and the child which may the related cost may not be within reach (SEU, 1999). Young

fathers also face similar difficulties although their extent is less severe compared to that of young mothers. They are however faced with similar economic and employment outcomes in their post parenthood (Kiernan, 1995).

Children of teenage mothers are more likely to have the experience of being lonely in the family. They are further faced by generalized risks of poverty, poor housing, and poor nutrition and consequently face inadequate upbringing standards. Evidence shows that daughters of teenage mothers are likely to become teenage parents themselves (Botting et al., 1998).

It is thus noted that having children at a young age can damage a young woman's health and well-being. Her education and career prospects are severely affected too. While young people can become competent parents, a variety of studies reveal that children born of teenagers are more likely to experience a wide range of negative outcomes later in life. They are also three times more likely to become teenage parents themselves (Hughes, 2010). As a matter of fact, at the age of 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth at the age of 24 years and above. They are less likely to be employed or be living with a partner (Hughes, 2010).

Teenage mothers are less likely to have academic qualifications at the age of thirty as compared to mothers who get children after having attained the age of 24 years. Due to their vulnerable condition, they are more likely to partner with men who are poorly qualified and less likely to secure employment (Hughes, 2010).

Statistics have shown that teenage mothers have three times the rate of post natal depression compared to older mothers and at higher risk of poor mental health for at least three years after birth. In addition, the infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to old mothers. Compared to older mothers, they are likely to smoke throughout their pregnancy while 50% are found not to breastfeed both which poses negative health consequences to the child (Hughes, 2010).

Children born of teenage mothers have approximate 63% increased risk of being born into poverty compared to babies born to mothers at their twenties. They have higher mortality rates and are more likely to have accidents and behavioral problems (Hughes, 2010).

Owing to the increased the increased teenage pregnancy as a social problem in the UK, policy makers, politicians and health educators have been borrowing measures applied in Netherlands to alleviate the situations. These measures are selected on the merit of their suitability.

Statistics

In 2000, the birth rate to young women with the age of 15-19 was 37. 7 in every 1000 in England and Wales Compared to 5, 5 in every 1000 in Netherlands. On the other hand, the conception rates were four times higher at 62. 2% per 1000 compared with 14. 1 % in every 1000 in the Netherlands. (Figure insert)

Sex Education

Sex education in schools is greatly attributed to the reduced teenage pregnancy occurrences in many countries where it if effectively applied. This

hypothesis have been assumed and highly promoted in the media by birth control and abortion lobbies and without the support of the research evidence. In the UK; Sex education has been politicized in many educational centers and political leaders too. The UK parents are not free to set up their own publicly fund schools independent of the state according to their own beliefs and values where there is a high degree of autonomy in terms of curriculum development and policy making. UK lacks diversity in didactics, pedagogical strategies and content and influences of the churches and the involvement of parents are not much stronger. As a result, sex education has not impacted a lot towards reducing teenage pregnancy (LDM, 2003). It is found that:

Sex education is not open as it is often suggested though it is often taught within a firm moral framework.

The most liberal and open classes were found in the more social and economically derived areas where teenagers were already more sexually active and teachers felt there was little they could do to compensate for family structures that were inadequate to guide streetwise young people in the increasing sexual culture.

Of the teachers interviewed, none was comfortable with the idea of opening up open classes for sex education curriculum which would entail sexually explicit materials.

The schools where the sexual activity was less a problem were not on the welcome of sex education but were positive on building on the moral frame work provided by parents within stable family structures

Further evidence has exposed sex education as not being that permissive as it is often perceived. A considerable figure of sexual health experts are critical of traditional views of sexual morality widely held among teachers and parents. The experts are concerned that an emphasis on setting the expression of sexual morality firmly within the context of committed enduring relationships is too restrictive when teenagers may want to experiment which sexual activity (LDM, 2003).

There lacks evidence to support the ascertain that the teenage pregnancy rate has been reduced by easy availability of contraception to the young people in what is described as an almost imperfect contraceptive population where condom use rose among the sexually active from 17% in 1981 to 85% in 1994 (Ketting, 1994). There is no corresponding relationship found in the reduction rates of either teenage pregnancies or abortions whereas there are early signs of an overall rise in the rate of sexually transmitted infection (STIs) occurrences: in particular, Chlamydia which affects the young people disproportionately (Van der Laar, 2002). More findings show that during the 1990s, the abortion rate rose despite a wide increase in contraceptive use (CBS, 2000).

It therefore cannot be attributed that the decline trend of teenage pregnancy is a result if sex education, open culture and contraception use rather a combination of factors not related to the above. Since teenage pregnancy is

a result of teenage sex, then it goes hand in hand that a society that has more of one of the two is going to experience more of the other. It is thus necessary to consider factors that are known to influence the age at which young people starts sexual relationships (LDM, 2003).

Sexual attitudes among young people

Casual attitude to physical relationship is ever growing. However, the UK teenagers appear not to be guided by moral principles to a large extent than their counterparts in for example the Middle East that abstain from sexual intercourse until a much later age. A comparative study of sexual attitude among teenagers found that a majority of both males and females in Netherlands for instance gave love a commitment as their primary reason for first intercourse. Physical opportunity and attraction and peer pressure are not leading factors to sex in Netherlands. In UK however, while love and commitment have high ranking in girls, boys are found to be more influenced by peer pressure, opportunity and physical attraction (LDM, 2003). From the perspective of young people in such circumstances, early parenthood can appear a rational choice, providing a means for making their transition to adulthood or having somebody to love in their lives.

Welfare benefits

A welfare benefit is another factor that makes teenage pregnancy level to be high in the UK. The teenage parents receive income financial support from the government when they are less than 18 years and do not have to depend on their parents. The babies born are put under the care of a legal guardian who happens to be the parent of the teenage mother in most circumstances. The legal guardian becomes the receivership of the

governments support allowing their mothers to continue with schooling. In addition to this, the teenage parents enjoy housing benefits, educational opportunities, employment training and free medical care. With the provision of all these, a disincentive to engage in irresponsible sexual behavior lacks (LDM, 2003).

Social-economic deprivation

Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young peoples' lives such as poor family relationships, low esteem and unhappiness at school also put them at higher risk. It is in record that acute levels of social economic deprivations are associated with high frequency of teenage sex activities and associated risks behavior. The concentration of areas with magnificent levels of poverty and social inequality in some areas of the UK has lead to the emergent of a desperate culture in which there is only little to lose in early parenting. The loss is further reduced from compensations of social welfare benefits that alleviate the costs of living and upkeep. An income support and housing allowance for instance makes the cost of having a baby not too much (LDM, 2003).

Lack of Stigma

In recent years, teenage pregnancy relatively lacks stigmatization in the UK. Stigmatization is known to discourage undesirable habits where the involved persons are subjected to humiliation in the past. Social services makes it hard for one to access most services, people disregard one making him/her always indebted. Lack of stigma associated with pregnancy in the UK is a major contributory factor to higher teenage pregnancy rates (LDM, 2003).

There are also some communities in which early parenthood is seen as normal and not a concern.

Lone parenthood

In the year 2000, single parents in Great Britain accounted for 21% of all families that had children. Children in Britain are more likely to be raised by a lone parent as compared with other European countries. A study of over 2000 young people in England aged 13-15 years found that in families headed by married couple, only 13% of the children were sexually active. The number doubled for young people living within single families. The figure was 24% for the children of cohabiting couples, 26% where the children had separated, 23% where the children divided their time between two parents living apart, 24% where the parents were divorced and 35% where the children did not live with either of the parents (Hill, 2000). Evidence is therefore placed in increase of teenage sexual activity in lone parenting or no parenting at all. Great Britain having single parent's levels of 21% (in relation to year 2000) inclines that the sexually active youths are very many.

Out of wedlock births

In western Europe, children are more likely to be born to an unmarried mother. Children born in this context are prone to be raised in poorer environments where sexual activeness is high. Daughters from single mother are also likely to bear children out of wedlock during their teenage years.

Divorce

In the year 2000, 12.7 in every 1000 married men obtained a divorce in England and Wales. Children in Britain are more likely to have experienced

the divorce of their parents. This is important considering that people not living with both biological parents are more sexually active in their early ages than those from intact families. Other factors like race, religion, age and social class are closely based from a family setup (Demo, 1998).

Working mothers

The UK had 18. 3% of mothers with children under the age of five employed full time in the year 2000. The figure was higher for mothers with children aged between five and eight years with 31. 9%. Europe, 75% of the population believes that women should contribute to the family income (Schulze, 1999). In the year 1999, UK had approximate 35% of the mothers of pre school children using some form of daycare and approximate 27% of mothers of children aged between 5 -12 using some form of out-of-school care (SCP, 2000). This finding suggests that many children in Britain are left under the care of a third party having no one at home. Once out of school, they have low levels of parental supervision and are more likely to indulge in reckless behaviors, premature sex included.

Conclusion

Teenage pregnancy poses a societal problem in the UK with the statistics of cases recorded alarming. Teenage pregnancy is caused by a wide range of factors surrounding young people. However, parenting and social economic issues are the major categories that contribute towards the high levels of teenage pregnancy. Due to the adverse effects experienced by the young mothers some of which are long term, it is vital that collective measures that best suit the phenomenon are adopted. By doing this, many teenagers will

be saved the misery of upbringing children while being disadvantaged by numerous factors discussed.