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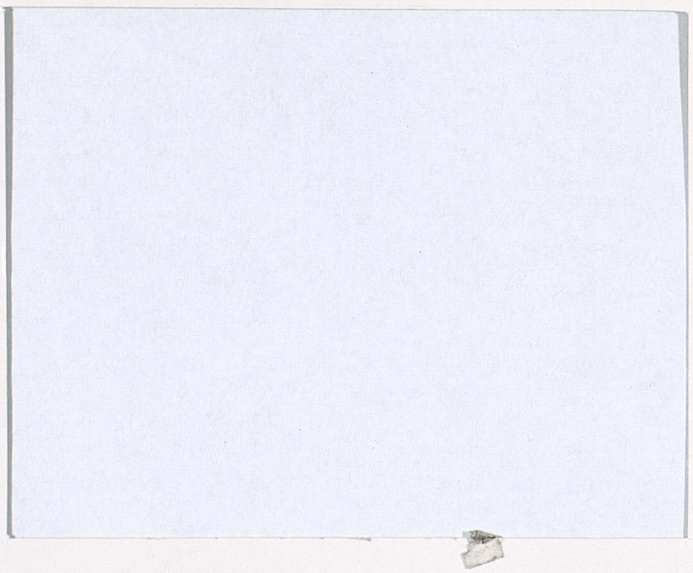
Can we have a policy on sex? Setting targets for teenage pregnancies

by

Roger Ingham

Occasional Paper



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Can we have a policy on sex? Setting targets for teenage pregnancies

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The White Paper published earlier this year (HMSO, 1992) sets targets for various health-related outcomes. Included in these are figures relating to unwanted teenage pregnancies and sexually transmitted diseases, which are used as a surrogate measure of HIV-infection. By the year 2000 it is hoped to reduce the rates of conception (of women aged between 13 and 15 years) by 50 percent of the 1989 level of 9.5 per thousand women per year - and the numbers of new infections of gonorrhoea amongst those aged 15 to 64 years by 20% - from 61 new cases per 100,000 per year to no more than 49 new cases per 100,000. These are undoubtedly laudable aims, and I am sure that we would all wish the government well in its endeavours.

However, what the White Paper does not provide is a clear policy lead on how these targets are to be reached. It is one thing to say what *should* be done, but quite another to say *how* it should be done. The White Paper does, however, refer to the *structures* through which it hopes progress will be made. For the Government's own part, there is a comprehensive five part strategy coordinated across all Departments, including (i) prevention, (ii) monitoring, surveillance and research, (iii) treatment, care and support, (iv) social, legal and ethical issues, and (v) international cooperation. The AIDS Action Group, chaired by a Department

of Health Minister, will provide some central coordination. Other areas covered (albeit briefly) include the Monks Report on standards of provision of GUM services, a reminder of the need for comprehensive drug related services, including counselling on safer sexual practices, a summary of the position relating to sex education in schools, and a section on the need for comprehensive family planning services.

What I want to do today is to consider some of the policy options which are available within some of these structures. Although my title mentions the first of the targets mentioned above - that relating to teenage pregnancies - it is clear that changes in behaviour relevant to this particular target should also have an impact on the rates of STDs, including HIV-infection. I shall be drawing on recent research into the sexual behaviour of young people, and primarily on a project funded by the Economic and Social Research Council (award number XA44250012), which I have been conducting here with my colleagues Dr Alison Woodcock and Ms Karen Stenner. Since I realise that there are people in the audience from different agencies and backgrounds, I have adopted a fairly general approach to the issues involved; we can go into more detail during the discussion at the end, and I would also like to mention that the Institute will be organising a one-day conference to explore the whole area sometime next year, probably early in July.

But, before I start I'd like to say something about methodology in this area. Sexual behaviour is not an easy area to study, for a number of reasons. Firstly, it clearly involves probing into areas of life which are normally regarded as being private and personal, and it is difficult to see why people should be willing to take part in such studies. Secondly, the motivations of researchers may be called into question if they show too much interest in such matters. Indeed, Kinsey and Pomeroy. two of the early American pioneers in this area, have both documented some frightening accounts of the personal abuse which they suffered from colleagues and others, including having their houses attacked, receiving abusive mail and phone calls, and having to move their children to different schools. Media publicity accused

them of being paedophiles and 'peeping Toms'. Given this, it is not altogether surprising that few researchers followed up their work, and that funding agencies were reluctant to get involved.

The area became more acceptable in the US, however, when the rates of teenage pregnancies started to rise, and a general moral panic set in. Funds were released to explore why young people appeared to take so little interest in their own welfare, and why the increasing number of sex education programmes in the schools did not appear to be working. In Britain, Michael Schofield's work in the late 1960s was unique (Schofield, 1968, 1973). More recently, of course, the realisation of the enormity of the threat of HIV infection has led to an increase in the amount of research, and to a change in the social climate in which such research is conducted, although as you know there has been strong resistance to some of this work by leading politicians (or at least one ex-leading politician) both in this country and in the United States.

But the methodological issues remain. The vast majority of the research activity which started in the 1960s and 70s was based on questionnaire surveys; some were designed purely to determine the extent of different sexual activities at different ages and in different demographic groups. Others were model-driven, and attempted to account for different sexual lifestyles in terms of levels of knowledge, perceived risk, and other psychological variables. Few showed clear results, which meant that when the HIV threat rose nearer to the top of the agenda, there was little to go on in terms of designing effective interventions. Even where there were some indications of promising directions, moral objections were raised from various quarters. I shall have more to say about these later.

There are, however, some problems associated with relying on questionnaire data in this area. First, there is the issue of the language to be used. Clinical terminology may not be understood by some or many of the respondents, and yet more colloquial 'street' language

may cause offence. (By the way, the UK government had a similar problem during the early mass media campaigns regarding HIV and AIDS, and coined the marvellously imaginative phrase of 'rectal sex', which nobody had ever previously used, and nor have they since.) A further problem with questionnaires is that many of the terms that are necessarily used are ambiguous by their very nature. Thus, for example, we may wish to find out the level of sexual activity amongst our respondents, so we ask 'how many sexual partners have you had ('in the last year', or 'in your lifetime'?). Apart from the issue of what sort of response ranges are offered, there is the more fundamental problem of what is a sexual partner (Coxon, 1988)? What do you need to do, or have done to you, to constitute being a 'sexual partner'? It may seem obvious to people who are in relatively stable sexual relationships, but is certainly not obvious to those who are either starting out in their sexual careers, or who engage in more varied forms of sexual expression. In terms of assessing risk of pregnancy or infection transmission, such fine distinctions are, of course, very important.

A further example is provided by Lorraine Sherr (1987), who conducted an evaluation of the early UK campaigns, regarding the phrase 'intimate kissing'. This phrase featured in mass media campaigns in lists of what was safe and what was unsafe as far as risk of transmission of HIV. But what or where is 'intimate kissing'? Sherr, as part of her work, asked a group of gynaecologists what they understood by this phrase (why she thought gynaecologists should know more about this than others is not immediately clear); she obtained three completely different sets of answers; but I'm not going to tell you what (or where) they were!

The point about questionnaires is, of course, that they are non-interactive. So, if there are any misunderstandings or ambiguities, then there is no chance of clarification. It may be for these reasons that recent surveys in the UK regarding levels of sexual activity amongst young people have come up with some rather disparate results. A recent review by Fife-Schaw and Breakwell (1992) summarised the results from a number of such studies. I have produced this overhead by selecting out only those studies which gave separate data by specific age,

rather than by grouped ages (such as 16-19 year-olds). Each of these surveys was conducted, by the way, in the South or SouthWest of England. These are the data for 16 year olds, and refer to the percentages of non-virgins in the samples.

OVERHEAD 1 (see Table One at end of this paper)

They range, amongst males, from 23% to 74%, and , amongst females, from 25% to 55%. The studies also differ, by the way, in terms of response rate, with the Breakwell and Fife-Schaw (1992) data coming from a random postal survey with a 37% response rate, and the Curtis *et al* (1989) being a school based study with a claimed 99% response rate. The extent of this variation does not just raise technical methodological issues, of course. In attempting to assess progress towards the targets set by the White Paper, it will be important to monitor the rates of sexual activity, since, presumably, one way of reducing pregnancies by half is to reduce the level of sexual activity by half! But if there is so much variation on similar items on similar samples, then this will be a rather difficult area to monitor. The Health Education Authority's recent MORI survey of 10000 young people, by the way, reported that 31% of the 16 year-olds reported having experienced intercourse (HEA/MORI, 1990), and we await the more detailed data from the British National Survey, which are expected to be released shortly.

A more fundamental issue remains, however. Even if we could develop suitable forms of wording and could have rather more faith in the results from surveys, there is still the problem of interpretation. Simple percentage data do not give us any clue as to the circumstances or contexts in which the various activities occurred, the degree of volition involved, nor the means to intervene in any effective manner. For these reasons, and because there was so little known about sexual activity amongst young people when we started our own work, we

adopted qualitative methods.

The project involved the collection of detailed accounts from over 200 young people of their sexual activities, knowledge of, and attitudes towards, the risks associated with HIV-infection and pregnancy, sources of information and values regarding sexual activity, and other relevant issues. The interviews were tape-recorded and transcribed by Brenda Colwell. Through careful analyses of these transcripts, we attempted to identify not only the actual nature and extent of different forms of sexual activity, but also the social and sub-cultural norms and shared meanings which constitute the reality of young people's social and sexual worlds.

I shall summarise some of the main findings from this research, and then go on to consider some of the policy implications which appear to follow from these findings. I should add that the levels of sexual activity amongst our sample were similar to those obtained in larger survey based studies, in terms of age at first sexual experience, reported numbers of partners, and so on (at least in as far as it is possible to have faith in such survey data), so there is no clear evidence that the young people who chose to talk to our interviewers were in any sense unusual in their sexual activities.

Clearly, I don't have the time to go into too much detail, so I have grouped the main findings around a series of impediments. These relate to impediments which come between, on the one hand, knowledge about the risks of pregnancy and infection and, on the other hand, young people's actual behaviour (see Ingham *et al*, 1992 for further details). In other words, many young people know about conception and about the major routes of transmission of HIV, and yet a high proportion do not take adequate contraceptive or infection avoiding precautions.

The first impediment, which we have considered more in relation to HIV than to pregnancy,

is that of perceived invulnerability. Questionnaire work by Abrams and his colleagues (Abrams *et al*, 1990) showed that a large number of young people made very pessimistic predictions about the likely impact of HIV and AIDS on their age-group, and yet rated their own personal chances of infection as being very low indeed. We analysed our own transcripts in order to explore the ways in which such perceptions of invulnerability appeared to be maintained, and identified eighteen separate reasons (Woodcock *et al*, 1992a), shown on the overhead.

OVERHEAD 2 **Table Two** (elaborated with some quotes)

I only have time for a couple of examples - one is drawn from the category relating to the general risk of living. Although quotes should be selected as being typical in some way of the type of responses found in particular areas, I select this one unashamedly as just one example of the varied ways in which people arrive at risk-related decisions. This is a young man of 20:

I can't go through life being scared of everything ... I mean I could be run over by a bus ... I read somewhere that I've got more chance of being run over by a bus than of dying of AIDS ... so I think ... I think if I got run over by a bus I would worry and think 'Jeez, I could get AIDS', but until a bus actually comes for me, I shan't bother, I don't think. (20 year-old male)

The second example comes from an 18 year-old man and is slightly less idiosyncratic; it illustrates a not uncommon reaction to the nature of what is called internal versus external control over situations and outcomes:

No, I think, Oh Christ, sometimes you think it might be up here (points to his head), do you

know what I mean - mind over matter. You think you ain't going to get it, like some girls getting pregnant, know what I mean, but if you're going to get it, you're going to get it ...
(18 year-old male)

The second impediment concerned misunderstandings of some of the key terminology in the area. I have already mentioned some examples, and I shall give just one more. A couple of years ago, the government launched a campaign based on the advice "use a condom, if you don't know your partner". Sir Donald Acheson appeared on all the major news programmes, and pieces appeared in all the newspapers. We looked specifically at how our young people understood this advice, and especially as it related to the circumstances of their first ever intercourse (Ingham *et al*, 1991). Although around a quarter of the sample had intercourse within 24 hours of being in a relationship with the partner, the vast majority reported that they did indeed 'know' their partner. What they meant by 'knowing' was not, however, what Sir Donald had intended. They meant that they had known the person through being at school with them, living in the same neighbourhood, 'hanging out', or whatever. Sir Donald presumably meant either that they should know their partner well enough to be able to make a reasonable risk assessment, or (which is more relevant in the case of pregnancy) that they know them well enough to be able to discuss what they would like to do and when and how they would like to do it, including the use of adequate contraception. Because of this misunderstanding of what was intended by this campaign, and since most of the young people did indeed feel that they 'knew' their partners, the second part of the advice (that is, 'use a condom') was regarded as being unnecessary.

Thirdly, we found some positive reasons for <u>not</u> following the various pieces of official advice even amongst people who did know what the advice was. For example, again using the area of 'getting to know your partner' (including their sexual histories), there were various reasons why this was avoided. Some people who were not sexually experienced did not want to reveal this to a partner, for fear of appearing 'wimpish', childish, or whatever. Thus, for

example, a young man who has never had intercourse may, for these reasons, be reluctant to admit to a partner that he does not know how to use a condom, thereby increasing the chances of inefficient use. Similarly, a young woman in such a situation who does indeed know what to do, may be reluctant to appear too worldly-wise for fear of giving the 'wrong impression'. Other reasons for not wishing to reveal too much related to feelings of jealousy about previous relationships, for example:

.. In the early days I was concerned .. because I was too emotionally wrapped up in it all, so it would really hurt me to think about the guys that had been there before me. Now I don't bother because I'm a guy that has been there before somebody, you know. (25 year-old male)

and the fear that talking about earlier partners would encourage future talking about them when they eventually became previous partners themselves! For example,

Like I always say to him, 'if we finish, you better not tell anyone .. you know, the things we have done and everything', and he always says 'oh, as if I would', he says 'do I say anything about, you know, other girls?', which is true. So I do trust him. I don't know, and I still don't feel real comfortable. (17 year-old female)

One of the most powerful effects on young people's sexual activities - especially in the early encounters - is concerned with the area of reputations and identities. Our data on the reasons given for the first ever sexual intercourse reveal that just under one half of males, and a substantial minority of females, report external pressure as the main motivation.

OVERHEAD 3 (Table Three)

There were many references to the perceived need to 'keep up with their mates', to escape from being ridiculed, and other nasty happenings. Another frequent reason provided related to what we have called 'situational pressure'; this category relates to cases in which there was no intention of engaging in sexual intercourse prior to the actual event itself, but that pressure - either physical or psychological - was too strong to resist. As can be seen from the overhead, this category was much more frequently reported by females than by males. Females were also much more likely to report 'relationship' variables - that is, being in love, infatuated, or similar emotions - although it is of relevance to note that in the vast majority of cases, females expressed regret at events quite soon afterwards. In other words, they quite quickly realised that such emotional feelings had been mistaken or misplaced. This is of great relevance, by the way, in the light of other research, which has suggested strongly that lowered self-esteem (as may result from a feeling of lack of control) is associated with more active, and more risky, patterns of sexual activity.

We have many quotes to illustrate these areas, but I shall give just two. The first is a 16 year-old woman who describes at some length the circumstances of her first intercourse, how she hadn't expected it to happen, and how much it had hurt. She said:

... I always believed it would be someone I loved first, and it wasn't, so I felt a bit out of order for that, so I cheated myself more than anything, nobody else (16 year-old female)

The second quote comes from a 17 year old, again describing her first ever intercourse:

I regretted it, I really did. I thought, 'Oh God, this is not the way to lose it' ... you are supposed to lose it in a meaningful relationship you know. You're supposed to do it after you've known a guy five months, six months, you know. There's me on my one night stand, pissed as hell, and lose it in someone else's bedroom, you know. I thought 'great, well done' (17 year old woman)

I should add that although alcohol is mentioned here, it appeared to be a major factor in far fewer cases than might be imagined.

What characterises both of these examples, is not only the apparent loss of self-esteem and the self-blame which occurred, but also a reference to some imagined circumstances under which sexual activity should occur. This introduces the next area which has emerged from the research, both our own and also that carried out by the Women's Risk and AIDS Project, directed by Janet Holland and Caroline Ramazonoglu (Holland et al, 1991, 1992a, 1992b), as well as some work at McQuarrie University in Sydney .

Drawing on some previous work by Wendy Hollway (Hollway, 1984), clear evidence has been found relating to the importance of discourses as a way of understanding many of these interactions. In simple terms, discourses relate to clusters of taken-for-granted assumptions in particular social worlds which endow meanings and structures on particular activities. Such discourses are created and maintained through the media, through talk, magazines, and other sources. Hollway considered the discourses which appeared to apply to heterosexual relations, and I shall briefly describe the three that she identified. First is the *have-hold* discourse, in which the aim of young women is to obtain and hang on to a young man for the purposes of childrearing and protection. Second is the *male sexual drive* discourse, in which it is assumed that males have a right to regular sexual gratification, and it is the female's role in life to provide it. Third is the *permissive* discourse, in which sexual pleasure can be experienced by either sex for its own sake, and there is no assumed obligation on either side to enter any other form of commitment.

The third category is relatively rare amongst the samples studies in these research projects. The other two, as I am sure you realise, both involve gendered power relations; in other words, it is the males who call the tune and take the lead role in determining outcomes. Here

is one example of a woman describing her first intercourse at age 15 years with a man who was much older:

I So .. did he try and force the pace for you to have intercourse with him?

R In a way, and then I took it, because he was older ... sort of went along with it, I suppose ... I said 'aren't you going to use anything' and he said 'I'll just pull out'

I Did you worry that you might get pregnant at all?

R No, I had so much confidence in him - because he was older than I was and he always seemed to know what he was on about

I Because he looked confident and knew what he was doing?

R Yeah, but all he was was a bighead, you know.

This issue of male domination, by the way, is confounded to a large extent with age. Of our sample, almost half of the females who had their first intercourse within 24 hours (which was much more frequent amongst those aged 15 years and under than those aged 16 years and above) had partners who were at least ten years older than themselves.

There are some further issues which I should like to mention briefly before moving on to consider some of the policy implications of all this. The first relates to the way in which sex and sexuality are treated in the media and elsewhere as something full of mystique. Young people are confronted with double entendres, coy language, embarrassment on the part of parents and teachers, and other evasive reactions. This not only makes it difficult for young people to talk about the issues sensibly and responsibly (either to each other or to adults), it also has another effect. This construction of sexual activity as being mystical 'gives permission' to people to feel that it is beyond their control. Thus, justifications such as '*I don't know what came over me*' or '*it just happened*' or '*I'm not usually like that*' crop up frequently in the ways in which young people talk about their sexual activities. In many cases, they feel that *they* cannot be expected to have control over events, or that sexual

activity, by its very nature, is something that no-one can be expected to control.

This issue is directly related to the notion of rationality (cf Ingham *et al*, 1992). Many of the psychological health behaviour models are built on an assumption of individual rationality; in other words, so long as individuals have a sufficient level of information, a sufficient level of perceived threat (or fear) and perceived severity, and other 'properties', then they will behave rationally and adopt health-preserving behaviours. Apart from the issue identified just now regarding the effects of the mystification of sex, there is another problem with this type of individual model. This is that sexual activity (or at least the types that are likely to lead to pregnancy or infection) takes place in a social setting; it requires two people.

I mentioned earlier that much of the work in the field of sexual behaviour has used questionnaire approaches, covering areas such as knowledge, intentions, risk perception, and so on, It is fair to say that such studies have not been particularly successful in identifying which variables lead to the adoption of safer sexual activities. Further, it is clear that many of the government inspired mass media campaigns have been heavily influenced by this kind of thinking about health-related decisions, and there is evidence that the majority of teachers regard information-provision as the most effective means of education (Clift and Stears, 1991). But these individually based approaches do not address many of the immediate and wider social contexts in which early sexual activity takes place; whilst a certain level of information is certainly necessary, it is by no means sufficient to enable young people to deal adequately with these contexts. Much greater attention needs to be paid to what might be called 'interactional competencies'.

This is the key for the policy implications which I believe follow from the sorts of results we have been getting in our own project, as well as the others to which I have referred. I shall spend the remainder of the time in considering some of these.

My title was 'can we have a policy on sex?'; the simple answer is that we do already have not one, but quite a number of policies. There are fragments of policies which are contained in various documents arising from the Department for Education, for example, and various guidelines covering the activities of the Health Services. There are also many more local policies; indeed, the current statutory position enables a great deal of local discretion, which means that there are many points in the process at which individual views can and do intervene. Such individual views will of course be affected by implicit assumptions regarding what would and would not be effective, as well as by various moral, ethical and religious considerations

Thus, for example, schools (at least those in the public sector) have been obliged (since last year) to cover certain rather basic areas as part of the National Science Curriculum, but beyond this they are simply obliged (through the Education (No. 2) Act of 1986) to have a policy relating to sex education. This policy might be that the particular school does not deal with such issues over and above the statutory minimum. The justification for this policy is that ' ...this gives schools a good deal of flexibility to take account of local circumstances and the views of parents'. In practice, however, there is evidence that very few parents are actually involved in the construction of the policies, and that many parents do not know what they contain. Further, despite the fact that having such a policy has been a statutory requirement since 1987, there is no central monitoring system, and the recent work by the Sex Education Forum demonstrates that many local authorities do not know whether or not their schools are fulfilling these obligations (Thomson and Scott, 1992). With the further demise of the role of local education authorities after April 1993, there will be even less opportunity to implement an effective monitoring system. Indeed, many of the specialist advisers who have been encouraging and assisting schools to develop their policies are uncertain as to whether they will have a job after next April.

We do have some information from young people on what they think of the current provision

in schools. Our own research (Woodcock *et al*, 1992b) generally supported the results of earlier work by, for example, Isobel Allen (Allen, 1987), in pointing to the general dissatisfaction with the ways in which the issues were covered. Reasons for dissatisfaction included that it was too biological, too early, too late, not detailed enough on practicalities, insufficient attention paid to the role of emotions, too little opportunity to discuss the issues, teachers who were clearly not prepared to deal with the issues, and so on. We heard of videos apparently being deliberately timed so that they would end just as the bell went for lunch so that there was no risk that the teacher would actually have to talk about the issues raised. We heard about many cases in which the biological details were provided fairly early on, but more relevant issues (for the young people concerned) - such as where to get and how to use contraception - being dealt with at much later ages.

Various comments were received about the occasions on which outsiders went in to talk about different forms of contraception; these were generally welcomed, although their effectiveness is clearly variable as demonstrated by one young man who referred (we assume) to a diaphragm as 'that glass dish'! Others commented that they appreciated being shown condoms, but the chance to actually practice unrolling one would have been welcomed.

Schools are probably the place where most attention should be devoted, since they have contact with the majority of young people. There are, however, various problems which need to be addressed. The first concerns finding the space in the curriculum to deal adequately with the issues. There is a severe risk that the attention given to examination result league tables will have the effect of 'squeezing out' areas which are regarded as being non-essential. At a conference last year organised by the National AIDS Trust, I did suggest, only a little bit facetiously, that schools should also publish league table showing their pregnancy and abortion rates, so that parents could see how well they are dealing with these particular issues. As an aside, let me quote to you one of the intentions of the National Curriculum, as stated in the preamble to the 1988 Education Reform Act: 'Schools must provide a balanced and

broadly based curriculum which ... promotes the spiritual, moral, cultural, mental and physical development of pupils at school and of society, and prepares pupils for the opportunities, responsibilities and experiences of adult life'. Whilst not wishing for one moment to deny the importance of a literate, numerate and widely educated population, we could ask how many young people will actively use history or geography in their future careers, compared with the proportion who will have sexual careers.

Second, what should be included in sex education programmes? I hope that I have provided enough examples of the contexts and dynamics of early sexual relations to make it clear that we need to go way beyond simple information provision, important though this is. The White Paper does make reference to the need to improve health education to enable 'people to make informed decisions about their own health' (p.36), and also points to the 'important role' of the media in 'providing the information necessary to make decisions which affect their own health and that of their families' (p.25). The data relating to the contexts of sexual behaviour, however, suggest that rather more than information will be needed to overcome the immense impact of gendered power relations. There has been much attention recently regarding the concept of 'negotiation'; I'm not altogether sure that this is the right word, since it normally applies to situations in which two or more parties are roughly equal in terms of bargaining positions. I realise that the term 'empowerment' does tend to frighten some people, but it is really no more than helping to put an equal opportunities policy into place. The introduction of assertiveness skills courses for young women to encourage and enable them better to exercise their own choices are important, but there is a risk of 'victim-blaming' in expecting those who suffer most to take the responsibility for the solution. We need also to consider ways to 'empower men to be de-powered'.

The preferred forms of delivery raise issues. On the one hand, norms within social worlds can be addressed through group discussions, bringing out into the open issues relating to power relations, media representations of gender (to address the dominant discourses referred

to earlier), alternative forms of sexual expression which do not involve penetration if either party does not wish it, issues relating to the search for reputations, status and identities within groups, role-playing different possible situations, and other relevant matters. But there is a fundamental problem. That is that schools are arranged by year group, and yet we know that in any one particular year, there will be a range of knowledge and experiences. Thus, in any class of 15 year-olds, say, there will be roughly 25-30% who have already started on their sexual careers, a further third who are pretty close to it, and the remainder some long way off. It is not surprising that some of our own respondents reported that their sex education had come too late, whilst others reported that it had come too early. Indeed, when considered from this point of view, it is likely that the input at any one particular time is actually appropriate for a only a very small percentage of those present.

So, in addition to the need for group discussion of the issues, there is a strong need for the opportunity for individual sessions with trusted and reliable adults. Given the other roles that teachers have in relation to their pupils, we need to consider carefully who would be the appropriate people to fulfil this role. There may be place for peripatetic staff to visit schools on a regular basis so that they get known and trusted, and to ensure that within the time of their visits there is room for individual sessions. It is of particular interest from our own research that whereas we were of course extremely grateful for the time and energy that our respondents had afforded us, many of them actually thanked our interviewers for having been the first people to whom they had been able to talk about these issues. The opportunity for individual sessions also allows, of course, cases of abuse to be identified, talked through and suitable counselling offered.

Given the early onset of sexual activities by a fairly high proportion of young people, this move towards openness regarding sexual and related issues needs to start rather earlier than it appears to at the moment. This, of course, is an area not without controversy. The Reagan and Bush regimes in the US were quite clear in their intentions to delay the onset of sexual

activity as the means to reduce pregnancy rates, and their periods of office have been characterised by political backing and federal funding for what have been called 'abstinence-only' approaches. Such approaches generally exclude the provision of sexual and contraceptive education. One of the major recipients of funding has been the programme entitled 'Sex Respect: the Option of True Sexual Freedom', although this title is, to say the least, misleading.

Given that there has been a tendency in this country to copy ideas from the US, you might be interested in this organisation. It is a for-profit organisation, and has had its textbook accepted into more than 1800 schools in all 50 states, as well as several other countries. The Instructor's Guide 'informs' teachers to disallow discussion of such issues as masturbation, homosexuality, birth control and abortion. The leading promoter writes 'there is a basic sense of modesty and shame that comes with discussing intimate sexual topics ... in order to enhance that sense of shame and not break it down and make sex seem trivial, there are certain things that would be best discussed in the privacy of home'. Given what we learned in our own study, as well as others, many parents do not feel equipped nor comfortable (and in some cases not willing) to discuss these areas and, in any case, trying to affect social norms cannot be done on the private basis recommended. Certainly, of course, parents do potentially have a very important role to play, but we do also know from surveys that 96% of parents do expect schools to provide the major input into sex education.

It is not, of course, just in the US that such organisations exist. In this country, the Conservative Family Campaign receives rather a lot of publicity and does a lot of political lobbying, They play down the risk of heterosexual transmission of HIV, for example, ignoring the fact that the world-wide figures show that roughly half of those infected are women. Their recent newsletter included a scathing attack on their own government's recent policy of introducing even the limited degree of coverage of HIV and AIDS into the Science Curriculum. The lead article states: 'The new Autumn Term has recently started throughout

the nation's secondary schools with the introduction of perverted sex education for 11 to 14 year-olds. A Department of Education Order which introduces AIDS education as part of the National Curriculum for Science, is now enforcing new guidelines for secondary school teachers. These guidelines contain crude, inaccurate, condom-based information and deal with perverted sexual practices which would not occur to normal 11 to 14 year-olds.'

One of the advantages of belonging to organisations such as these is that one can express views and opinions unrestrained and unconfused by the data that are available. But for those of us whose job it is to consider data and empirical evidence before considering policy options, the position is rather different. There is absolutely no evidence that early open discussion of sexual matters encourages greater levels of sexual activity amongst young people. Indeed, the evidence points in the other direction. Recent comprehensive reviews of specific interventions in the US show that more open programmes introduced before young people were sexually active were more likely to lead to delays in the age at first intercourse (Allgeier, 1989). Further, young women who received sex education were less likely than those who had not to become pregnant, and higher proportions used contraception at first intercourse.

Cross-national studies by Jones and her colleagues (1986, 1988) show that countries with more open attitudes to sexual matters, and greater availability of contraception for young people, are characterised by *no* higher levels of sexual activity, but considerably *lower* rates of unwanted pregnancies and abortions. This overhead shows the data from just three countries for women aged between 15 and 19 years.

OVERHEAD 4 (Table Four) Pregnancy and abortion rates for US, E and W, Netherlands

In other words, there is no more sexual activity, but what there is appears to be more

responsible. Given that reducing the rates of pregnancies by half involves either half as much sex, or more responsible activity, and given that there are no obvious ways to achieve the former, then success in the latter of these options must provide some promise.

This general line of reasoning has received support from the Royal College of Obstetricians and Gynaecologists; in their report on Unplanned Pregnancy last year (RCOG, 1991) they called for higher priority for sex education in schools, all initial training for teachers to include input on health issues, including sexuality, relationships and contraception, and for each school to have one or more specialists in sex education to coordinate inputs.

Obviously health services also have a crucial role to play, both through working with schools but also as alternative resources. There are many problems with assuming that young people can and will readily use general practice provision, especially in the light of the ambiguities which still surround the Gillick case, and the confusing situation regarding the legal position on confidentiality of records. Specialist youth advisory centres, whether operated directly by the family planning services or by charitable bodies, are essential, although it is relevant to note that the numbers of these available are decreasing, and that there are too few to provide an effective local service for all those who need it at the time they need it. For example, the Brook Advisory Centres were forced to close a third of their sessions as a result of reduced funding in 1988, and the Family Planning Association's survey earlier this year shows that half of the 1600 family planning clinics that responded offer one or fewer sessions per week, and only two percent run weekend sessions, a time which is convenient for teenagers and working people.

The recent reviews and research by the Department of Social Statistics (Cooper *et al*, 1992) here has identified a number of important issues regarding the consumers' views on contraceptive provision, and implies that the changes in funding arrangements will lead to a shift towards greater use of GP services, a move which wlll not necessarily benefit younger

people, nor, by the way, is it thought that it will save money. The level of specialist training in GP providers is generally lower than amongst clinic staff, and there is less time available for the possibly more complex needs of young people.

I have not been able, in the time available, to consider other important issues which are very relevant. These include issues relating to ethnicity, social class, family composition, and other factors which introduce variability into young people's needs and requirements. There are particular issues such as homelessness and prostitution which need specific attention and greater use of outreach work. These simply support the need for provision to be flexible and available, and for there to be the time and expertise to treat each individual appropriately. Funding is, of course, a problem, although a transfer of money away from mass campaigns towards more local expertise would appear to lead to improved cost effectiveness.

Finally, let me end with a quote from one of our respondents who had described at some length how she had become pregnant and had an abortion when she was fourteen and a half years old. She said:

... at school we had sex education ... (but) it was after it happened that they started talking about it ... I thought 'Oh great, now you tell me!'

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TABLE ONE

PERCENTAGES OF 16 YEAR OLDS WHO REPORT BEING SEXUALLY EXPERIENCED

	M	F
BOWIE AND FORD (1989)	45	49
CURTIS *ET AL.* (1989)	23	25
FORD (1990)	74	49
BREAKWELL AND FIFE-SCHAW (1992)	54	55

(Data taken from Fife-Schaw and Breakwell, 1992)

TABLE TWO

PERCEPTIONS OF VULNERABILITY

Acknowledgement of risk:

1. *General admission that one's own behaviour has been risky*
2. *Worry dismissed on the grounds it would show by now*
3. *Worry dismissed on the grounds that riskiness was in the past*

Denial of risk:

1. *Dismissal of HIV message generally*
   - It's been blown out of proportion
   - AIDS is a risk you take in living
   - Part of the advice is impossible to put into action

2. *General comments about not applying HIV risk to oneself*
   - It doesn't affect me
   - It's never going to happen to me
   - Pregnancy was a greater worry
   - Not knowing anyone who was infected / low incidence in one's neighbourhood

3. *Comments made about partners*
   - Partners were (or are) not promiscuous
   - My partner is faithful
   - Partner(s) only had long and/or serious relationships before me
   - Partner gave the impression of being safe (appearance, general impression, family, job, etc)
   - Partner has been tested
   - I knew all my partners
   - If my partner had AIDS, he or she would have told me

4. *Comments made about oneself*
   - I am not in a high risk group
   - I am not promiscuous / I don't go in for one-night stands
   - I always use condoms / I always use condoms when I think it's necessary
   - I have been tested
   - I do not have sex in risky geographical areas

(from Woodcock, Stenner and Ingham, 1992a)

TABLE FOUR

SOME COMPARATIVE DATA ON SELECTED MEASURES REGARDING PREGNANCY AND ABORTION RATES IN THE MID 1980S

(RATES PER THOUSAND WOMEN AGED 15 TO 19 YEARS)

COUNTRY	CONCEPTIONS	ABORTIONS
U. S. (TOTAL)	96.0	45.7
U. S. (WHITE)	83.0	-
ENGLAND AND WALES	45.0	20.9
THE NETHERLANDS	14.0	4.2

(various sources)

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