

## Aspects of National Health Service Reforms

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'The Public Government of Private Sex:  
Teenagers, Contraception and the Health of the Nation'

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### Introduction

This paper provides a preliminary discussion of government intervention in relation to teenage pregnancy. It explores a number of dichotomies in government policy and political debate which impinge on the ability to effect a key part of the *Health of the Nation* strategy.

This White Paper was published in 1992 and contained targets for achieving health gain. One of the areas focused upon is sexual health within which there is an explicit target set for reducing pregnancies to young women under the age of 16. This requires direct involvement by statutory agencies in the sexual behaviour of young people. It is clear that without some change to existing behaviour the target will not be reached. Thus here is a government statement about how young people should conduct their sexual activity. This can be seen in three ways.

First as a concern for the health and well being of young people themselves to avoid unwanted consequences of sexual intercourse, a sentiment that has been espoused by groups such as the Brook Advisory Service and Family Planning Association for many years.

Second, it could, as in the USA, be driven by a financial desire to cut public health and social care costs.

Lastly, there is a moral context which relates to the age of responsibility of young people and the interaction of parental and child rights. This was clearly an important factor in the case bought by Victoria Gillick in the 1980s<sup>1</sup> and can be seen in much of the recent political debate about sex education.

This last approach has been very visible in the last year or so with the moral pronouncements made by several government ministers about single parents in particular (Brindle 1993b). But such moralistic views about teenage sexual activity and teenage mothers have been debated for many years although they have not been central in any government policy (Durham 1991).

The question arises, therefore, of why this is a current issue and what has led the government to adopt a target on teenage pregnancy? It is also important to explore the current political interest in teenage sex and teenage mothers.

This paper examines the context of the *Health of the Nation* targets and explores the background to current political views on teenage sexuality. In particular it will address the policy frameworks for these suggesting both a pragmatic approach in developing and achieving policy objectives and how this now operates

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<sup>1</sup> *Gillick v W. Norfolk & Wisbech HA* [1985] 3 All England Law Reports 402.

within, at least publicly, a belief system about the rights and responsibilities of children, parents and society.

In order to do this it is first necessary to explore the nature of the 'problem', for while clearly now seen as a major social problem, teenage pregnancy is by no means a recent phenomenon. In discussing the public policy responses in the USA Rhode (1993) has set the question as 'What choices should adolescents make in sexual relationships, what role should the state play in shaping the choices available, and who should decide those questions?' (p.301).

The debate about these issues occurs at a time when the government is pursuing a 'Back to Basics' campaign as a major plank of its philosophy, much of which is concerned about reinstating parental rights and responsibilities. Yet, as Hugo Young has questioned, what is the meaning of 'back', and to what should we go back to? (Young 1993). There are tensions in the government about the role of the state and what the state can afford. These need to be examined to discern the true nature of policies on teenage sex and motherhood.

'A large component of the [back to basics] slogan refers to the behaviour of the poor, and the basic presumption that they should do more to help themselves. Self-reliance, and the moral decline that follows from dependency, is the message pouring forth from Cabinet ministers.' (*Ibid*)

## Teenage Pregnancy as a 'Social Problem'

In order to determine why there should be particular concern about teenage pregnancy at this time it is worth examining the level of teenage pregnancy in the United Kingdom historically, comparatively with other countries and examine the context and consequences of such pregnancies.

While the conception rate<sup>2</sup> for women under 20 years old in England and Wales rose from 61.9 per 1000 to 69.0 per 1000 between 1979 and 1990 the rate is still lower than in the 1970s. However, conceptions to under 16 year olds are now higher than in the 1970s.

The under 20s birth rate has though, remained fairly constant but the abortion rate rose from 18.8 to 24.6 per 1000. This may suggest that the number of unintended pregnancies has increased. A view supported by the most recent of a series of studies by the Institute for Social Studies in Medical Care, which showed an overall increase of unplanned pregnancies for all mothers from 26.7% in 1984 to 31.3% in 1989 with the major increase being for younger women (Fleissig 1992). In 1991 there was a small decrease in conception rates but figures for later years are not yet available so it is not possible to see if this is the start of a downward trend.

Research in Britain and the U.S.A. has shown that teenage mothers are more likely to have low weight babies, be dependent on state benefits, have poor knowledge of child development, a higher prevalence of fetal distress and premature/postmature babies. In their first 5 years of life children of teenage mothers are twice as likely

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<sup>2</sup>Conception rates are the total of all pregnancies leading to maternities or abortions expressed as a rate per 1000 women in age group.

to be admitted to hospital as a result of an accident or gastroenteritis and score less well on verbal and non verbal ability tests (Peckham 1993).

It is questionable though, whether 'teenage pregnancy' is a problem by definition. In reality it is merely a descriptive term, as there are substantial differences in pregnancy, abortion and birth rates between younger and older teenage women. Neither is it clear whether age is the determining factor giving rise to these negative consequences of pregnancy. Research has clearly shown that certain social factors are associated with increasing the likelihood of teenage pregnancy. These include incomplete education, lower educational attainment and fewer qualifications, lower socio-economic class background, coming from larger families and coming from families where the parents had separated (Hudson & Ineichen 1991, Estaigh & Wheatley 1990). However, it has been suggested that by controlling for the various factors known to be correlated with social class the differences between younger and older mothers are greatly reduced (Phoenix 1991).

While it may be inappropriate to define teenage pregnancy as a problem, clearly there are health and social problems associated with it, and it these, together with more moralistic views, which are inherent in the pronouncements of many politicians. Also while *The Health of the Nation* takes a fairly non-contentious view by targeting under 16 year olds, the high rate of terminations for pregnant teenagers may suggest a failure of family planning and sex education services.

International comparisons show substantial variations between teenage pregnancy rates in different countries. The study by Jones et al (1985) of six industrialised countries in the 1980s showed that there was little difference in teenage sexual activity rates. Generally though, more young people are sexually active at an earlier age than before. In the United Kingdom estimates vary between 25% and 55% of under 16 year olds being sexually active.

However, in the mid 1980s there was a variation in median age at first intercourse of nearly two years. Sweden had the lowest at about 17 years old with about 33% of Swedish girls having had intercourse by the age of 16. By contrast, in Canada the median age was nearly 19 and only 20% of girls were sexually active by the ages of 16-17. In Great Britain, the USA, the Netherlands and France the median was just under 18 years old. It is likely that in all these countries the median age has fallen.

Comparisons of pregnancy and fertility rates<sup>3</sup> show significant variations between countries which appear to be unrelated to sexual activity rates. For example in the mid 1980s the pregnancy rate in the USA was 96 per 1000, in England and Wales it was 45 per 1000 and in the Netherlands it was 14 per 1000. Also whilst abortion rates vary considerably in these countries they do not account for the significant changes in fertility rates. For example, in Denmark and the Netherlands there has been little variance in the abortion rate since 1980 yet in these countries, between 1980 and 1987 the fertility rates have reduced from 15.2 to 9.4 per 1000 and 6.8 to 5.2 per 1000 respectively.

Thus within the United Kingdom, teenage conception rates have been increasing over the last decade but are not as high as they were in the mid 1970s and birth rates are lower than in the 1960s and early 1970s. International comparisons show that the United Kingdom's teenage pregnancy rates are slightly higher than most European countries but are substantially lower than in the USA. However, com-

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<sup>3</sup>Fertility rates are for live births only.

pared to the Netherlands the United Kingdom rate is some three times as high. But such international comparisons have shown discrepancies for many years without the same political and governmental interest being shown.

While there does not seem to have been an enormous increase in births to teenagers the fact that over a third of all teenage pregnancies are aborted is a key concern. In addition 90% of conceptions to teenagers were to single women. This fact was emphasised by Charles Murray in *The Emerging British Underclass* where he defined illegitimacy as a key social problem, an issue taken up by Dennis & Erdos (1992). It was these publications, beyond all others, which have provided the intellectual backdrop to comments made by government ministers over the last 18 months. Clearly increasing single parenthood represents a challenge to commentators such as Murray, in terms of ensuring on the one hand that all the children are wanted, and on the other the concept of the two parent family.

It is interesting that the focus is on never-married mothers rather than single parents *per se*, who represent about one third of all lone parents, of which only about 5% are teenagers although 25% started as teenagers.

Given the political and media interest it could be construed that the current interest in teenage sex is a moral panic (Cohen 1972), but with a focus on single teenage mothers. It is difficult though, to follow Cohen's mechanism completely, although many of the reinforcing factors do seem at play. It can be seen that the level of teenage pregnancy is not high by historical standards so we need to seek other reasons for both the moral criticism of teenage parenthood and sexual activity and for the Health of the Nation.

To do this we need to explore the historical perspective of the government's involvement in regulating sex, sexual activity and services for sexually active young people. What is clear though, is that in terms of choices young people are more sexually active today than 20 or 30 years ago.

## **Policing Sex, Government Intervention and Sexual Activity**

Weeks (1981) has argued that:

'Victorian morality was premised on a series of ideological separations: between family and society, between the restraint of the domestic circle and the temptations of promiscuity ... This was the basis of the dichotomy of "the private" and "the public" upon which much sexual regulation rested.'

The legacy of the 1800s was a clear delineation between the control and regulation of public vice and the non-intervention in private heterosexual relations. The late 1800s and early 1900s saw some statutory regulation on the age of consent (raised from 12 to 16), making homosexuality illegal, and regulating sexually transmitted diseases – which acted more as controls on the poor and armed forces (Weeks 1991). On the whole this remained the legal framework until the 1950s when the *Sexual Offences Act, 1956*, came into force. The effect of this was to necessarily make pregnancy in young women under the age of sixteen the result of criminal

activity. The main offence is unlawful sexual intercourse<sup>4</sup>. This is committed by a boy or man who has sex with a girl under sixteen, the girl herself is not guilty of the offence.

Even consensual sexual activity between fifteen year olds will be criminal in the eyes of the law. For those advising and supporting young people the implications of the fact that there is unlawful activity where under sixteen year olds are sexually active raises both moral and legal questions as the Act specifically creates an offence of encouraging unlawful sexual activity (s.28).

There is a wide ranging moral debate about young people and sex, influencing the way individuals act and how organisations draw up guidance (Durham 1991). This has added to the confusion over the legal position of those people who are giving advice and contraception to young people under the age of 16. The key two issues where concern arises are in relation to advising about and providing contraception, and maintaining confidentiality. These concerns most clearly arose with the Gillick case in the mid 1980s which although making such services and advice legal for under 16 year olds, left many people unclear about the status of young people's right to confidentiality, ability to obtain contraception and whether advice can be given about contraception and sexual matters because of need to establish the individual's maturity.

In 1991 the Royal College of Obstetricians and Gynaecologists report on unplanned pregnancy highlighted the ambiguities in advice between the General Medical Council and the British Medical Association (RCOG 1991). The result of this ambiguity was found in a recent study for the Family Planning Association and Health Education Authority which suggested that some GPs are unclear about what they can say and provide to young people under 16 and suggest that there is '...a need for more information for general practices on the rights and confidentiality aspects of providing contraception to people less than 16 years old' (Institute for Population Studies 1993). However, the evidence suggests that it is not only GPs who are unsure of the law but also Family Planning clinic staff, practice and community nurses, teachers and youth workers (Allen 1991).

The question of the legality of providing advice and information on contraception to under 16 year olds is currently a key issue within education following the draft guidance issued by the Department for Education following the 'Stallard Amendment'. The draft guidance warns teachers of the possibility of breaking the law by providing advice and information on contraceptive advice and has left many teachers and educational policy makers unsure of the law.

The current state of the law means that a morally contentious issue has a range of legal interpretations and it is possible to draw both a narrow and broad view of the obligations implicit in the *Sexual Offences Act* and the general United Kingdom tradition of the law relating to advice to, and medical intervention with young people. Essentially it is one of parental versus children's rights, again illustrated by the Gillick case.

The legal tide in the United Kingdom is towards children's rights and the idea that maturity is a developing process and that there can be no fixed age of maturity. Neither has the law been amended to fit the growing sexual activity of under 16s, although there have been calls for lowering the age of consent. On the whole the law is there to protect young women from the exploitation of older men, a clear

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<sup>4</sup> *Sexual Offences Act, 1956, s.6.*

link with the role of government in the late 1800s.

There is, however, another side to government and sex relating to the growth of family planning services. These were first supported by the government in the 1930s (Cabinet Memorandum 153/MCW) with an acknowledgement that married women could obtain contraceptive advice from welfare clinics. However there had been a long battle to gain government recognition by both local authorities and voluntary groups, with both civil and criminal legal action throughout the 1920s. After the Second World War the Family Planning Association rapidly expanded its clinics but only for married women.

By the late 1950s the FPA clinics were beginning to provide a service to older single women, but it was not until the creation of the Brook Advisory Service in the 1960s that young single women could obtain contraception. In 1974 the NHS took over the responsibility for family planning with free provision of contraceptives. However, services for young people have not been developed uniformly across the country despite government guidance. In addition because of the *Sexual Offences Act, 1956*, and the ambiguity about provision of advice and contraceptives to under 16 year olds, there is still confusion about the legality, as well as the morality of services for this age group. Thus the inclusion of a target in The Health of the Nation is of great interest in terms of focusing attention on this group of young people from a health perspective, where there is clearly a major moral debate which has been developing over the last 20 or 30 years.

More recently the government has taken an interventionist approach in relation to public health issues of HIV/AIDS and in stimulating preventive measures. Young people are seen as a key at risk group and have been specifically targeted in preventive work. There has been a public emphasis on safe sexual practices which has caused outrage for many moral campaigners who wanted to portray HIV/AIDS as relating to deviant behaviour only (homosexuality and drug use) and campaigned for sexual abstinence outside of marriage (Durham 1991).

More than any thing though it was the concern over HIV and AIDS that led to the sexual health targets in the Health of the Nation.

## The Health of the Nation

The *Health of the Nation* was an attempt to focus attention and resources on strategies which would improve health. In this sense it can be seen as a rational policy approach. However, there has been much contentious debate about the targets included within the document both in terms of whether they can be achieved, and whether the correct topics had been addressed<sup>5</sup>. It is not my intention here to examine the *Health of the Nation* in its entirety in any detail but rather focus on the inclusion of the reduction in teenage pregnancies as one of main six targets.

In the *Health of the Nation* Green Paper, published in 1991, there was no mention of a possible target relating to teenage pregnancy. However, there is a section on the health of pregnant women, infants and children which raises the issue of effective family planning services and identifies a number of health problems which have been associated with unplanned pregnancies (RCOG 1991), although this link is not made in the Green Paper.

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<sup>5</sup> See *Health Service Journal* 1992

Interestingly there was no national campaign, before or after the publication of the Green Paper, to ensure that the issue of teenage pregnancy was addressed. While groups such as the Brook advisory Centres and the Family Planning Association have been campaigning for improved services for young teenagers they had not specifically pressed the government for action within the *Health of the Nation*.

The key driving force for including the teenage pregnancy target came from the comparison with achievements in the Netherlands where there had been a substantial reduction in teenage pregnancies and abortions. The Department of Health's view was that all pregnancies to under 16 year olds were both unintended and unwanted, and had serious social and health care implications for the teenager and any children. This was viewed alongside the increasing incidence of sexually transmitted diseases among young people and abortions for young women under the age of 20. It was therefore felt important to act positively to reduce the consequences of sexual activity for young people.

Within the *Health of the Nation* there is a specific target to reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13-15 in 1989 to no more than 4.8).

However, while most attention has been focused on this key aim it is important not overlook the general objectives of this target which are:

- To reduce the number of unwanted pregnancies;
- to ensure the provision of effective family planning services for those people who want them.

These broader objectives are extremely important, particularly as achieving the key target of a 50% reduction in the under 16 conception rate will be very difficult, if at all possible in some areas. This is partly due to the complexities surrounding teenage conception but also relates to problems in reducing conceptions where the numbers of young women under 16 becoming pregnant is already very small.

There is, however, a broader agenda which can be seen in the philosophy behind the target and the objectives. In the *Key Area Handbook: HIV/AIDS and Sexual Health* the government sets out its philosophy and how they see this as being achieved.

‘Planned parenthood provides benefits for the health of individuals, families and communities. Family planning services aim to promote this by providing access to contraception, sterilisation and advice on unplanned pregnancy. Additionally, education, counselling and health promotion can enable prospective parents to choose healthy lifestyles and increase the chances that their children will be wanted and healthy. Delaying and spacing pregnancies and limiting family size contributes to the physical and mental health of mothers and children and general family well-being. The effective use of condoms or other barrier methods of contraception also promotes sexual health by giving protection against sexually transmitted diseases.’ (Para. 5.1.3)

While the thinking behind the *Health of the Nation* is one of concern for health and social wellbeing it is easy to see that the aims could be achieved in a number of ways. For the moralists the solution would lie in less sexual freedom, more

parental control, deterrence and abstinence. This contrasts sharply with the approach adopted within the Health of the Nation where there has been focus on the provision of advice, information and contraception.

## The Battlefields – Sex Education and contraception

While the public attention has focused on the circumstances of single mothers, particularly teenagers, there has been a substantial political debate, and pressure group activity around sex education and the provision of advice and contraception for young people. In the early 1980s an amendment was introduced to the then *Education Bill* allowing parents to inspect sex education teaching materials and to withdraw their child from sex education lessons, an aspiration that may finally be achieved this year. In fact throughout the 1980s there were sustained campaigns on the content of sex education materials (Durham 1991).

Interestingly the views of such moral campaigners for less explicit material and a focus on abstinence is at odds with the sexual practice and views of young people. Surveys of young people in this country consistently show that the current level of sex education is inadequate. Common complaints are that too much is missed out, especially relating to the value of relationships, that the lessons are too late or too early, it is too biological in nature, and that there is a need for single sex, as well as mixed sessions. In addition most surveys show that the majority of parents want schools to provide sex education.

Many others have expressed similar concerns about the quality of sex education and both the Royal College of Obstetricians and Gynaecologists and the House of Commons Health Committee amongst many others have recommended that the syllabus should be broadened to include a greater emphasis on the importance of responsible and caring relationships. Many senior members of the government have also talked about the moral framework of sex education, notably the Secretary of State for Education who has recently spoke about the need for more emphasis on moral values and relationships.

Such an approach has been accepted by the Department for Education and some secondary schools already incorporate this in their sex education curriculum, however, many do not and it is even more unusual in primary schools.

Until recently, despite central guidelines on sex education, the ultimate responsibility lay with individual schools. Thus the provision of sex education varies considerably. The RCOG argued that this was not sufficient and that there should be a nationally developed curriculum providing a comprehensive and co-ordinate sex education programme involving the support of health education and other appropriate medical staff.

As part of the new *Education Act* sex education will become compulsory. This follows the Stallard amendment. This amendment could create substantial confusion within schools as it will allow parents to withdraw children from sex education lessons. More interestingly the draft guidance from the Department for Education takes a very strict or narrow view of the law, perhaps reflecting the current moral overtones of the government, although the second draft avoids the moralistic overtones of the original. Whether this is the correct interpretation is of course debatable but a strict reading of the law may deter teaching staff from giving information and advice on contraception and sexual issues to young people for fear

of breaking the law.

The tone of the debates in the House of Lords provide an interesting insight into parliamentary discussion on sex education as they were not about health issues but morality, fear, innocence etc, and the emphasis on the rights of parents to be able to ensure that their children are not exposed to sex education. The amendment which has been taken up by the government, but for which only draft guidance is still available, raises a number of concerns about the rights of children and parents over sex education and the role and duty of schools and society in general. Do we want to go down the same road as the projects referred to by Lord Stallard? He quoted the following American correspondence:

‘... American children are learning the A to V of a new kind of sex education – A for abstinence and V for virginity ... students are told to “just say no” in an estimated 5000 of the country’s 16000 districts ... In California, teenagers following a course called Sex Respect chant a “chastity pledge” – “Do the right thing! Wait for the ring”, while in New York the city school board... has just demanded that health educators going into schools to teach about AIDS must sign a commitment to emphasise abstinence over safe sex in their classroom presentation.’

Yet what we do know is that in the USA pregnancy rates continue to rise.

The situation regarding contraceptive advice and provision is however very different. The *Health of the Nation* has provided a catalyst for the development of health authority and other services for young people and most areas now have some provision specifically for teenagers. But for moral campaigners, such as Victoria Gillick, the state is removing parental rights and

‘... usurping their role and the innocence of the young is being destroyed ... a movement that held it was taking power away from doctors and from young men and restoring it to its “rightful place” – the mother and father – came up against the opposition of the medical establishment and those who favoured young women’s sexual autonomy.’ (Durham 1991, p.56)

In some areas of the country local services have been picketed by protesters from LIFE, SPUC, and other campaigning groups, although this is not widespread. This may have more to do with advice on abortion than contraception although these and other groups have campaigned against contraceptive services because they are thought to encourage under age sex. This view is not, however, supported by research (Peckham 1992).

Interestingly the provision of advice and contraception services seems to have remained absent from comments on teenage sexual activity. It is not clear why this should be so. In the USA there is some evidence to suggest that anti-abortionists have been backing contraception services as a way of reducing abortion. In the United Kingdom though such evidence is not forthcoming and neither is known whether those government ministers who have attacked single parenthood and sexual promiscuity in young people are anti-abortion or pro-contraception.

The battlefield here is essentially that identified by Gillick and the House of Lords debate on the Stallard amendment, is the issue of parental rights. Here, the

state does seem to have made a statement of pursuing intervention to maintain the rights and choices of young people to engage in sexual activity while at the same time politicians are making moral statements about the role of the family and parental responsibility and rights over their children. What these areas clearly demonstrate is the inherent dichotomy between these two views.

## Morals or Money?

Last September Michael Portillo, the Chief Secretary to the Treasury, stated that:

‘Teenage pregnancy often leads to a whole life of state dependence, with few luxuries. The teenage mother is rarely able to gain a full education or develop a career.’

The previous year at the Conservative Party Conference Peter Lilley, Social Security Secretary, read out his ‘little list’ which included ‘Young ladies who get pregnant just to jump the housing list’.

Other government ministers have also commented on the financial burden of single mothers. Even Tim Yeo defended his part in fathering an ‘illegitimate’ child by saying in an interview on the *Today* programme that it was alright because he would ensure that he took financial responsibility. Presumably it is not alright if the child and mother would need to rely on state benefits!

What is clear is that the issue of single teenage motherhood is bound up with the cost of social benefits and general welfare provision such as housing. Yet a young single mother is unlikely to be better off with a child than as a single person drawing benefit so this cannot be seen as an incentive. Evidence also suggests that it is not the promise of public housing which encourages young women to have a baby. The view of welfare dependency argued by Murray (1990) and supported by many government ministers has been refuted by Joan Brown (1990) who has shown that never-married mothers were less likely to be on long term benefit than divorced mothers.

Broader economic criteria may also conspire to cut across moral and health care issues. Recently there has been debate within medical and government circles about the possibility of making contraceptives only available on prescription as a way of reducing NHS costs. If this was to happen there are serious issues about whether young people (mainly women) could afford to continue using contraceptives and for under 16 year olds the question of the parental counter-signature on prescriptions would endanger confidentiality.

## The Public and the Private

There is then a series of dichotomies which permeate discussions of teenage sexuality. These relate to the question of rights, health care *versus* moral views of control and how far sexual relationships are private or public. These can be seen as coming from the question set by Rhode in the introduction ‘What choices should adolescents make in sexual relationships, what role should the state play in shaping the choices available, and who should decide those questions?’

The history of the government views on regulating sexual activity in this country has been somewhat ambivalent. However, the government is also interventionist in terms of providing a framework of services for young people to make choices about their own sexual activity, except of course for gay men (lesbians have never been subject to legal controls), although the age of consent is to be debated in the current session of Parliament. It is also clear that young people are sexually active in their teens and that in a sense they make choices about sexual involvement. The role of government through the Health of the Nation has been seen to be one of minimising the harm to young people while accepting that they can make choices about contraception and conception.

With the rise of single parenthood though this is now beginning to change. The perceived unwelcome affects of single parenthood, or more precisely motherhood, are seen to be too great to bear. Is this consistent with the *Health of the Nation*? It would seem that given the philosophy behind the target that these are not incompatible. However, it would be wrong to conclude that the *Health of the Nation* grew from a concern about single parenthood. Rather it developed from a concern about the adverse circumstances of unwanted children, it is about improving the ability of young people to make choices about sex and conception without moralising about whether the choice to conceive is wrong.

In discussion with civil servants there is a wish to keep these issues separate but given the moralistic overtones of the 'Back to Basics policy' this may become increasingly difficult. It is unlikely, given recent discussions within the Conservative Party and the media, that the Prime Minister's denial that the 'policy' is not about individual morality will have much impact on how it is viewed. In reality the right to withdraw children from sex education is unlikely to be exercised to any great extent. However, it is possible that a concerted focus on moral issues and parental rights and responsibilities could work against the Health of the Nation.

This could mean a controlling of choices made by young people about sexual relationships which removes the access to services which can support individual choices and replaces them with an emphasis on abstinence which is unlikely to change actual behaviour. The state would move from an advisory and supportive role to one of trying to set the moral framework, somewhat in the face of reality. For parents the results of responsibility could be the forcing of young mothers to live with them where housing is unobtainable or benefits are withdrawn. This is likely to lead to more poverty and an increase in young mothers, and therefore frustrate the government's attempt to achieve the *Health of the Nation* sexual health targets, including that for teenage pregnancy.

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