Chapter Eight

Conclusions, Policy Issues and the Future Research Agenda

Introduction

The purpose of this thesis has been to explore a range of policies relating to teenage pregnancy in Finland and Scotland in an attempt to highlight policy explanations for the noted difference in teenage pregnancy trends between the two countries. It has mapped and located those policies within their national framework and at the local level of implementation before drawing attention through comparative analysis, to the main similarities and differences in policy between the two countries.

The data analysed in this research is not representative of all schools or authorities in either country. The data does, however, raise some important issues in relation to a number of social policies and their connection to the rate of teenage pregnancy in Finland and Scotland. The effects that these policies appear to have had are multifaceted and inter-related. As a result, the conclusions presented within this chapter, are drawn cautiously and further research directions are identified later in this chapter.

The overall aims of this thesis have been: to explore three policy areas relating teenage pregnancy in Finland and Scotland with a view to highlighting potential policy options that could aid in the reduction of teenage pregnancy in Scotland; to add to the existing knowledge base on policy relating to teenage pregnancy, and

finally to consider areas for future research. Consequently, the remainder of this chapter has been divided into three parts, the first of which discusses the potential policy options derived from the analysis of the key similarities and differences between Finnish and Scotland policy, which could aid in the reduction of teenage pregnancy in Scotland.

Reducing the rate of unintended teenage pregnancy in Scotland: Potential Policy Options

Having explored, analysed and discussed the key policy similarities and differences between Finland and Scotland, there are a number of potentially important individual aspects of policy raised, the following highlights those policy options, which stand out as the key findings of this research.

One of the most striking policy differences between the two countries was in their different use of school-based health services and in particular the role played by the school nurse. As highlighted in Chapter two, young people have a range of issues with regard to accessing sexual health services, in particular those services which have been set up for use by whole populations. Issue of concern include, the visibility of a service, confidentiality, appropriate opening times and the perceived attitudes of the service providers, from the receptionist through to the doctor or nurse that they see. The school nurse system in Finland provided a service-model that actually met all of the additional needs and requirements of young people in relation to service access as defined by previous research.

Further to this, the fact that the school nurse was trained specifically to work with young people and would often remain in the same school for many years meant that a relationship could develop between pupils and the nurse over time, enabling an individual context in any advice-giving process.

The fact that the school health service is intended to be the first port of call for young people in Finland when they have any health concerns also means that barriers to accessing health care in general are broken down from an early age and therefore, when a young person needs sexual health advice, concerns about accessing this health service are likely to be have been reduced.

As an intended first port of call for young people with health concerns, this style of service could also be argued to be actively encouraging young people to take individual responsibility for their health, to know that when they are ill or something is not right with their physical or mental health that there is help available. In other words, if an individual has become familiarised with taking responsibility for themselves and their health, the less likely they are to not ask for help when required, or to 'bury their head in the sand' when they know they require help.

In Scotland and Britain as a whole, young people generally do not access health care by themselves. If a child or young person were ill they would usually be accompanied by a parent/ adult to see their family doctor. In this sense young people in Scotland are not encouraged, as in Finland, to be active in accessing health care by themselves. Although every school has a statutory obligation to

provide a school health service only a very few schools across Scotland have set up a system of on-site clinics in the way that every school in Finland provides. There is no service available to children or young people in Scotland that they have ownership of, which is something that research has increasingly shown is an important determinately factor in young people actively accessing a service (Zabin et al. 1986; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997; NHS CRD 1997; Hadley 1998).

The fact that a statutory school health service already exists in Scotland does, however, mean that the foundations for developing such a service already exist. Developing such a system would not only potentially aid in the promotion of sexual health amongst young people but as a generic health service, would also be able to deal with all holistic health issues of concern to young people including diet, self-esteem, smoking, alcohol, bereavement, drugs, bullying and so on.

Despite the cost of developing such a service in the first instance, in relation to lower curative health care costs in general as well as costs specific to sexual health including, the cost of abortions, STI treatments (and longer term infertility complications and costs), as well as costs associated with unintended motherhood, would mean potentially large financial savings in the longer-term.

Perhaps of greatest importance is that it would mean that all young people across Scotland would have equality of access to a health care facility, regardless of whether they lived half a mile or fifty miles from their nearest clinic or service provider.

The second key finding of this thesis is in relation to the provision of sex education and is two-fold. First, the fact that sex education in Finland was incorporated into a number of core curriculum subjects set out at the national level has a number of important implications including:

- Helping to both promote sex education as of equal status to other subjects and to normalise the subject matter,
- Providing young people with a variety of perspectives on issues relating to sex and sexuality,
- Providing regular provision of sex education across each grade of the *Peruskoulu*, rather than as a one-off or small block of lessons,
- Consistency in content, teaching methods and focus across all schools.

The second important factor is how Finnish sex education has been provided with an acute awareness of young men's sex educational needs. The English SEU report (1999) highlights that young men are half of the problem of teenage pregnancy and therefore must be half of the solution, however, young men have specific needs, which are often not addressed by sex education. When it comes to what young men want to know about sex, their agenda often varies considerably from the agenda of what adults think they should know. What recent work with young men has revealed, however, is that if you begin with the agenda of young men, which is often wanting knowledge about masturbation and pornography, and

deal effectively with that agenda, you will eventually get around to the 'adult' agenda of respect, responsibility and safer sex (Selman et al. 2001; Kell 2001)[1] .

In Finland, through the provision of health education as a single-sexed environment (in most schools), teachers have been able to address the agendas of both young men and women separately, providing a platform for discussion about their interests and concerns. If sex education is to be effective in impacting upon young people, especially young men, future development of sex education must take these issues into consideration. Young people are often curious about sex, what it is, what it's like, how to be good at it, and unless these points are addressed first, there is the risk that young people will disengage from what is being taught and an opportunity to eventually reach discussion of the 'adult' agenda, will be lost.

Finally, the third key finding of this research is in relation to education policy. What was most striking about the education system in Finland was the overriding normalised expectation portrayed at both the national and school level that young people would continued their studies for at least three years post compulsory schooling, which was reflected both in the national stay on rates and those of the four schools explored. The fact that high stay on rates at the school level is strongly correlated with lower rates of teenage pregnancy is important and suggests that by continuing in education for longer, young people in Finland are indirectly delaying parenthood.

[1] Personal communication with Chris Kell, Boys and young men's development worker, Northumberland Health Authority.

There are a number of potential reasons as to why the stay-on rates are so high in Finland, but the fact that there was no significant relationship found between the rate of unemployment and staying on at school, lead to a focus on the structure of schooling and the potential influence of careers guidance (student counselling). The findings of this research appear to suggest that the over-riding focus within student counselling on continued education as opposed to careers pursuits at the *Peruskoulu* level, may explain in part the expectation of continued education is normalised.

In addition, the fact that vocational education does have along history in Finland and is a valued form of education offering a great range of choice beyond purely academic study, in comparison to Scotland, where vocational education is still in the early phase of development and not as highly valued by young people, may add further explanation as to why the stay-on rates are considerably higher in Finland, than Scotland.

A final important factor, however, is likely to be related to the access that young people in Finland do/ do not have to welfare benefit when they leave school. Unlike Scotland, where a person must be seen to be actively seeking work to obtain benefits, in Finland, the fact that young people (who have never been employed post-school) must be actively seeking a place in education, is telling young people in Finland that the expected normalised route for them at that stage in their life is continued education.

Teenage pregnancy and social policy: revisiting the literature

Sex education policy

The question of how effective school-based sex education is in helping to reduce the rate of teenage pregnancy has been and remains an issue for debate. Whilst it has been generally acknowledged that sex education can help increase knowledge on issues relating to sex and sexuality (Goldman & Goldman 1983; Jones et al. 1985, 1986; Bilsen & Visser 1994), what remains contested is the relationship between the acquisition of that knowledge and its effect on personal behaviour (Allen 1987; Thomson 1994; Silver 1998).

Despite the debates surrounding this issue, as can be seen from the discussion within Chapter Two, there does exist a range of evidence to support the view that the effectiveness of sex education is dependent on a number of factors and that the provision of sex education which incorporates those factors has been related to safer sexual behaviour amongst young people.

In relation to the factors associated with effective sex education, previous research has illustrated that the public climate towards sex education plays a key role in the level of acceptance of that provision in schools (Vilar 1994). In countries which are generally supportive of pragmatic sex education such as the Netherlands, sex and sexuality are presented as ‘normalised’ aspects of life, which Silver (1998) suggests underlies the effectiveness of sex education. Further to this, research has identified two key components of sex education that are more successful in helping young people to internalise the messages that they are receiving. First, presenting sex education from a positive ‘sexual health’ perspective rather than focusing

solely on the potential negative outcomes of teenage sexual activity (Oakley et al. 1994, 1995; David & Rademakers 1996). Second, providing sex education that is based on what young people want to know, rather than on adult's perceptions of what they need to hear (Oakley et al. 1994, 1995; Sex Education Forum 1997; HEA 1998).

In relation to this research, whilst Scottish provision appears to moving towards a more pragmatic and normalised approach, based upon what young people in Scotland have stated that they want to know (Burtney 2000b), sex education had not been an issue of national policy focus until the mid-1990s. Rather, it appeared to have developed in a piecemeal fashion and was generally focused on biological reproduction and the negative aspects of sexual behaviour. The provision in Finland, however, presented a picture more in line with that of effective provision. Sex education at school had been a focus of national policy for two and a half decades and had developed from a narrow biological focus in the 1970s to sex education that aimed to promote good practice in sexual health. Sex education in Finland did not aim "to forbid sexual activity, but to reduce health risks involved and emphasise responsible behaviour" (Väestöliittö 1994:27). Therefore the findings of this research support the suppositions of existing literature discussed above, with regard to these specific factors relating to effective provision.

With regard to how sex education is provided in schools, existing literature has illustrated that utilising a permeated approach, whereby sex education is located within a range of curriculum subjects can help to normalise the topic, provide a wider range of perspectives on similar issues, provide higher levels of provision

and help promote sex education as of equal importance to other subjects (Silver 1998). Additionally, for sex education to be most effective previous research has highlighted that provision needs to be situated within a suitable teaching environment (Sex Education Forum 1997; Hadley 1998; HEA 1998; Silver 1998). Three key elements of that environment have been identified as; provision being taught by staff who are both able and willing (RCOG 1991; Sex Education Forum 1997; HEA 1998), the use of active-learning based methods such as role-play and small group discussion (Kirby 1995; Sex Education Forum 1997; HEA 1998) and the provision of an "open and safe" classroom environment (Silver 1998) which can be aided by the use of both single and mixed-sex arenas.

In relation to this research, the provision found within the four schools in Scotland did not generally incorporate many of the 'effective' factors presented above. As sex education in Scotland does not form part of the Scottish Syllabus (national curriculum), a separate subject approach had been utilised in all four schools rather than a permeation approach. In turn, teachers were aware that the separated provision was not viewed by pupils as of equal status to curriculum subjects. One of the main reasons given by teachers for not having undertaken much in-service training on sex education was because it was more important that they received training about the curriculum changes to their 'main' subjects.

In relation to the development of an effective environment, although there did appear more opportunity for in-service training in Scotland than in Finland, for the reason noted above, the uptake of such training had not been high. There was also no substantial pre-service training available to teachers in Scotland, suggesting that

this factor, relating to the provision of effective sex education was missing from the schools explored. In relation to teaching methods, although active-learning techniques were beginning to be utilised, the most common methods remained traditional 'chalk & talk' style lecturing. Finally, only a mixed-sex arena was available to pupils at the four schools explored.

In Finland, all schools explored (and all schools nationwide) utilised a permeation approach providing sex education within Health Education, Family Education and Biology. This had, according to those interviewed, helped to normalise the topic, provided a range of different viewpoints, enabled a high level of provision, and presented sex education as a topic of equal value to other subjects.

With regard to the teaching environment, the most interesting finding in Finland had been that teacher training was not an issue of policy importance at the national or school level. Although there were opportunities for teachers to undertake training on sex education, it was down to the individual teacher to organise his/ her own training and only one third of teachers interviewed had done so. With regard to effective teaching methods, all four schools explored did utilise methods which have been suggested to be more effective and finally, in three out of the four schools explored, both single and mixed-class arenas had been utilised (which was common throughout Finland), therefore providing an opportunity for different levels of discussion for pupils.

Therefore, although the findings of previous research do suggest that there are elements that can make for a more effective teaching environment, the lower extent

than would be expected of teacher training in Finland and the fact that although the learning methods utilised in the four schools were of the more effective style, recent research has illustrated that these schools may have been the exception rather than the norm in Finland (Liinamo 2000), perhaps suggests that other elements related to effective provision are more important.

Existing literature has suggested that some of those additional elements include; sex education programmes with content that is positive in its presentation of sex and sexuality and goes beyond discussion of biological reproduction (Oakley et al. 1994, 1995; Sex Education Forum 1997; HEA 1998), programmes which provide sex education aimed at young men's issues in relation to sex and sexuality (Winter & Breckenmaker 1991; Hadley 1998; HEA 1998; Meyrick & Swann 1998; Silver 1998; Wood 1998) and the use of trained sexual health experts in the provision of sex education (Mellanby et al. 1995; Few et al. 1996; Sex Education Forum 1996; Papp 1997; Mayall & Storey 1998).

In relation to these factors, this research found that in the Scottish schools with the exception of Arbourness High School, the focus of the content was generally on the potential negative outcomes of teenage sexual activity, before any discussion on relationships (if provided at all). The focus of the content was around biological reproduction and pregnancy prevention, which as discussed in Chapter Two, is not the best approach for engaging young men. Finally, whilst teachers valued sexual health experts, use of them was limited due to financial constraints of both parties and time constraints of the experts.

In relation to Finland, this research found that the content of provision was wider in focus and number of perspectives (social, health, biological, ethical), and focused on positive as well as negative outcomes of teenage sexual activity, which was consistent across the four schools. There was an overt awareness of the need to provide sex education that would engage young men and help to raise their awareness of sexual health, respect and responsibility. Finally, whilst the only sexual health expert that was utilised in the Finnish schools was the school nurse, due to her location in school, gaining access to her was considerably easier than accessing sexual health experts in Scotland. Whilst only one nurse interviewed actively taught sex education in the classroom, all four nurses were available to pupils on a one to one basis if they needed advice and they also provided information to teachers who were involved in providing sex education.

It would therefore appear that the findings of this research add weight to the existing knowledge in respect to programme content, young men's needs in sex education and the availability and use of sexual health experts, all being factors of importance with regard to the provision of more effective sex education. The use of the school nurse in Finland as an additional educational resource, trained to work specifically with young people, adds further weight to current discussions about the suitability of such individuals to provide this resource at the school level (Hunt 1996; Whitmarsh 1997), when they have been appropriately trained to do so.

As noted in Chapter Two, the provision of effective sex education has been related to a number of positive outcomes in personal behaviour. This included evidence that the provision of effective sex education does not hasten teenage sexual activity

and in some studies there was found to be a delay in first intercourse (Baldo et al. 1993; Kirby et al. 1994; Fullerton 1997; NHS CRD 1997; Cheesbrough et al. 1999) and increases effective contraceptive usage (Baldo et al. 1993; Kirby et al. 1994; Wellings et al. 1994; Kirby 1997b; Fullerton 1997; NHS CRD 1997; Cheesbrough et al. 1999). Countries with lower teenage pregnancy rates generally have more sex education at the school level (Jones et al. 1985, 1986; David et al. 1990; Baldo et al. 1993) and countries described as providing easy access to sex education (Vilar 1994), in turn were found to have significantly lower birth rates to teenagers.

In relation to previous research findings on the range of factors which culminate to produce more effective sex education, this research has shown that the sex education provisions found within the Finnish schools could be classed on the whole, as more effective than the provisions found within the Scottish schools. This therefore, adds weight to the relationship between the availability of effective sex education and lower rates of teenage pregnancy and in part, adds explanation as to why there has been a noted difference in pregnancy rates amongst teenagers in Finland and Scotland.

The developments in sex education policy during the mid-1990s however, as discussed in Chapter Seven, highlighted a direction of change in sex education policy in both countries. In light of the evidence of previous research and the analysis of the findings of this research, if these patterns of change continue in their current direction, the future may witness a decrease in the effectiveness of Finnish sex education and an increase in the effectiveness of the Scottish provision.

In turn, this change in effectiveness may manifest itself within the rate of teenage pregnancy in each country.

Sexual Health Policy

In order for young people to take responsibility for their sexual health, in addition to adequate knowledge about sex and sexuality, they also require access to advice and contraceptive services to enable them to respond. Chapter Two presented a range of evidence from previous research illustrating that when accessing sexual health services, young people have a number of additional requirements of services, which if not met, act as potential barriers to their accessibility and use.

These additional requirements included; the suitable geographical location of a service and equality of access (Zabin et al. 1986; McIlwaine 1994; Clements et al. 1997; Fullerton et al. 1997; Hadley 1998; Cheesbrough et al. 1999; SEU 1999), suitable opening times (Zabin et al. 1986; Clements et al. 1997; Hadley 1998; Turner 2000), confidential services (Jones et al. 1985; Wulf & Lincoln 1985; Jones et al. 1986; Zabin et al. 1986; FPA 1994; Lo et al. 1994; McIlwaine 1994; Dickson et al. 1997; Fullerton 1997; Liinamo et al. 1997: Hadley 1998; SEU 1999; Turner 2000), informal and user-friendly services (Zabin et al. 1986; Peckham 1993; Fullerton 1997; Hadley 1998; SEU 1999), services provided by professionals trained to work with young people who held positive attitudes towards young people and their sexual health and who used terminology that young people could understand (Liinamo et al. 1997; HEA 1998; Aggleton et al. 1999; SEU 1999) and services which were inclusive and recognised the needs of young men (Nelson 1997; Hadley 1998; SEU 1999).

Further to this, previous research has illustrated that young people would prefer services that are aimed at young people, (Peckham 1993; Liinamo et al. 1997; Aggleton et al. 1999; Turner 2000), preferably located near to or in school and/or youth settings (Zabin et al. 1986; Allen 1991; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997) and that are exclusively for the use of young people (Liinamo et al. 1997; Turner 2000).

The findings of this research revealed in Chapters Four and Five, that the basic health and sexual health services available to young people in Finland and Scotland were very similar. In both countries young people had access to primary health care facilities, family planning clinics and a small number of clinics set up for the exclusive use of young people. Previous research discussed in Chapter Two, however, highlighted that these types of services all had potential barriers to access, such as, the issues of geographical location, the visibility of the services to the public (parental) eye, concern over confidentiality and unsuitable opening times.

The main difference in access and service provision for young people that this research identified however was the school health service. As noted in Chapters Four and Five, although both countries have a statutory provision of school health services, the service in Finland was set up as a primary care resource for young people whereas in Scotland, it was set up as a health screening service not intended for primary care use. In relation to what previous research has identified as key factors in relation to young people's ability and willingness to access services, the

school health service in Finland was shown in Chapter Six, to fit all of the requirements identified by young people in general and in Finland (Liinamo et al. 1997) as necessary for their needs.

Although previous research has identified that there is a lack of sound methodological evaluation of the effectiveness of school-based provision (Oakley et al. 1994, 1995), those interviewed in Finland for this research, believed that the school health service in combination with the provision of permeated sex education had played a central role in the reduction of teenage pregnancy in Finland over the last thirty years. This is a viewpoint supported unanimously by researchers in the field of teenage sexual health and general health care in Finland (Hemminki 1995; Kosunen 1996; Kosunen & Rimpelä 1996a; Rehnström 1997; Kosunen 2000a, 2000b).

Whilst evaluating the effectiveness of a school-based health provision has not been an aim of this research, the findings of this research have highlighted that in relation to the factors that are more likely to enable young people to access sexual health services, the provision of the school health service in Finland is a key difference between the provisions available to Finnish and Scottish young people.

Further in relation to sexual health policy, previous research has illustrated that in countries where there is a general acceptance of teenage sexual activity and young people's sexual health rights, there are also generally lower rates of teenage pregnancy and related rates (Jones et al. 1985, 1986; David et al. 1990).

This research has illustrated that until the late 1990s, there was no visible direct policy commitment to the promotion of teenage sexual health in Scotland. Despite the setting of the 1992 target to reduce teenage pregnancy set by the British government (DoH 1992), there was little policy development to enable or encourage this target to be met (Ingham 1992).

Additionally, this research indicated that in Finland, since the early 1970s, there has been a visible pragmatic commitment to helping young people take responsibility for their sexual health. In addition to the development of the school health service as discussed above, in response to the teenage abortion rate in the 1980s, the Ministry of Health and Welfare developed the magazine *Sexteen*, which was sent out to the homes of every sixteen year old in the country. Although a target for reduction was set, unlike in Britain, the target was to reduce the rate of teenage abortion not teenage pregnancy, therefore implying an acceptance that it is not teenage pregnancy that is the issue of concern, but rather those pregnancies which resulted in abortion and therefore should have been prevented.

The findings of this research therefore appear to suggest that the level of government commitment to promoting the sexual health rights of young people and in turn the level of provision for young people developed at the national and the local level, act as a reflection of the level of that acceptance. This research therefore adds weight to the suggestion from previous research, that for effective sexual health policy to be developed, there first needs to be an acceptance of teenage sexual activity. Without that acceptance, the will to develop policy that

enables young people to take responsibility when they have sex, will be missing as well (Silver 1998).

In Finland, the issue of concern has not been that young people are having sex, but rather that, the use of abortion shows that not all young people are taking adequate responsibility when they have sex (Väestöliittö 1994). In Britain teenage pregnancy has been presented as an issue of concern for many reasons, including the costs of welfare (Selman 2001), as evidence of the breakdown of the traditional family (Selman 2001) and the loss of childhood innocence (Turner 2000). Policy therefore, has developed from a desire to prevent teenage pregnancy by preventing the teenage sexual activity rather than by accepting it and promoting the responsibility that comes with that activity (Silver 1998).

As discussed within Chapter Seven however, there have been interesting developments in sexual health policy since the mid 1990s in both countries. Within Finland, there has been a move towards de-centralisation of budgets and responsibility for policy development and implementation. Therefore even although there remains a strong belief in prevention and sexual health promotion at the national level, with the downshift in control, there is less control at the national level over how health budgets should be spent.

The findings of this research have illustrated that the cutbacks in funding for school health services have already been stated to have resulted in some instances in reduced time for school nurses to work in schools and also in the training of school nurses moving from the specific youth-orientated training to general broad-

based training. This research further shows that concern has already been voiced at national and local level that a degree of complacency has set in amongst those responsible for budget prioritisation, that teenage abortion is no longer an issue of concern in Finland, and that without a return to previous levels of provision, there is a risk that the abortion rate may begin to rise, a concern that has already materialised (although not yet significantly).

In Scotland, the development of sexual health policy since the mid-late 1990s, as with sex education policy, has been considerable. Although policy relating to education, health and sex education in Scotland has always been separate from the rest of Britain, the creation of the Scottish parliament has provided a platform for change that is distinct and physically distant from Westminster and British policy, a key example being the repeal of Section 2a[1] in Scotland, but not the equivalent Section 28 in England.

The recent and current developments in sexual health policy in Scotland appear to be moving in a direction that accepts teenage sexual activity, which, as previous research has shown is a central underlying factor in the success of sexual health policy for young people (Silver 1998). Within Chapter Seven analysis of those interviewed on the subject of current and future developments, gave the impression that there is a keen desire at the national and local level to develop policy that is based on the needs and wants of young people in Scotland. There also appeared to

[1] In June 2000, Section 2a, which prohibited the 'promotion of homosexuality' by local authorities, was repealed in Scotland. This is a good example of where Scotland and England have parted company in official opinion. While the House of Lords in England have twice voted to keep the Clause, Scottish MSPs voted overwhelmingly (99-17) in favour of its repeal. This was the first major piece of legislation since devolution that differed from Westminster.

be a growing understanding that basing provision on what young people have expressed that they need and want is crucial to the effectiveness of future policy development and implementation.

Further to this, recent discussion with an official of the Scottish Executive responsible for developing the future policy strategy on teenage sexual health in Scotland (Nigel Lindsay – Personal communication November 2000) revealed that attention is being paid to examples of good practice in Europe, where teenage pregnancy rates are lower than Scotland, rather than focusing on the USA, where rates are higher, as the British government continues to do[1].

As was discussed in relation to the changes in sex education policy, the outcomes of the changes in direction of sexual health policy also remain to be seen. Analysis of the findings of this research prior to those changes and the evidence of previous research findings in relation to sexual health policy and young people do suggest, however, that the current policy developments in both countries (if continued in line with the developments discussed in Chapter Seven) have the potential to impact upon the rate of teenage pregnancy, negatively in Finland and positively in Scotland.

Education policy

Previous research as discussed in Chapter Two, highlighted that a variety of relationships exists between education and teenage pregnancy. This included

[1] A noted example of this point being that after the Deliberative Seminar in March 2000, referred to in Chapter Seven, at which findings of this research were presented to various delegates including members of the Scottish Executive, a fact finding trip was made to Finland by members of the Executive to explore provision for young people.

associations between higher levels of education and; higher levels of sexual knowledge (Kontula & Rimpelä 1988, Turner 2000), higher age of first intercourse (Kane& Wellings 1999), more effective contraceptive efficiency (Hoffman 1984; Morrison 1985; Kraft et al. 1991), abortion as the more common outcome of pregnancy (Kane & Wellings 1999) and a higher age of first birth and smaller number of children over a woman's fertile life course (NHS CRD 1997; Westall 1997; Beets 1999a, 1999b).

As was illustrated in Chapters Two and Four, in countries where there was a high level of continuation of education or training for those aged sixteen to eighteen, there were found to be; significantly lower rates of teenage pregnancy, significantly higher rates of contraceptive use amongst young people at first intercourse, significantly higher proportions of abortion to birth as an outcome of pregnancy and significantly higher age of first birth.

A number of researchers have supported the hypothesis that the availability of good educational and employment prospects beyond the compulsory school level are required to enable and encourage young people to have the motivation required to continue their education (Simms 1993; Selman & Glendinning 1996; Hadley 1998) and in turn to delay pregnancy and parenthood.

This research therefore set out to explore further the relationship between educational policy and teenage pregnancy. In particular, having noted the considerable difference that existed between the stay-on rates at the school level

between Finland and Scotland, Chapters Four and Five went on to explore whether there were differences in school structure and/or careers guidance that actively required or encouraged young people to remain in education for longer.

The overall key difference between the two countries was found to be the level of normalisation of continued education. In both countries, continuing in education beyond the age of sixteen was voluntary and yet in Finland, young people were expected to, encouraged to and most did continue their education for at least three years after the compulsory level. In Scotland, the only point at which continued education was presented as normalised, was for those young people who had already taken the decision to continue to S5 and S6, the normalised route thereafter being to university or college.

The findings of this research imply that there are a number of factors that have encouraged this normalisation in Finland including; the structure of post-sixteen education, the strong emphasis on continued education as a valued commodity during student counselling at the *Peruskoulu* level and the requirement for young people aged sixteen to twenty-four, who have never been employed since leaving the *Peruskoulu*, to be applying for a place in continued education in order to obtain welfare benefit.

The findings of this research further imply that the relative lack of normalisation of continued in education in Scotland, has resulted from a range of factors including; the pre-1990s focus on academic (examination-based) pursuits at the pre and post-sixteen level, the perception that vocational options are second rate to academic

qualifications, the principal emphasis in careers guidance on career pursuits with a lesser focus on continued education, the welfare incentive from age eighteen plus being that of applying for employment rather than a place in continued education and finally, the lack of focus at the comprehensive level on continued education as the 'normal thing' for young people to do.

Whilst there were changes to education policy in both countries during the 1990s, of significance, in relation to continued education, were the changes that occurred in Scotland[1]. In particular, the increasing availability of mixed examination and coursework-based qualifications of academic and vocational variety is opening up a wider choice for young people at the school level in Scotland. Teachers interviewed for this research, had already begun to note amongst their pupils, an increasing desire to and perception of the value to remain in school for longer. The teachers believed this partially explained the annual growth in young people remaining at school for longer.

Previous research has identified that the longer young people remain in education, the less likely they are to enter parenthood at a younger age (Jones et al. 1985, 1986; Bynner & Parsons 1999; SEU 1999). In other words, by remaining in education, pregnancy and parenthood are being delayed indirectly. The findings of this research have illustrated that there exists a considerable difference in the proportions of young people who remain in education in Finland (and other European countries with low pregnancy rates) and Scotland. The fact that the continuation is voluntary is of importance, as whilst the structuring of an

[1] The impact of the changes to education policy in Finland as discussed in Chapter Seven, were noted in relation to the effect that they have had on the provision of sex education.

educational provision will play a role in young people's continuation, there must also be a degree of motivation present, for young people to voluntarily undertake something that is not compulsory. The findings of this research were such that it is not possible to separate at a policy level, the potential effect that school structure and the potential influence of careers guidance (student counselling) may have had on young people in Finland and Scotland. There were, however, noted differences in both areas of policy which warrant further research as will be explored in the final section of this chapter.

Future research agenda

In relation to research on sex education, there have a number of projects through the late 1990s in Scotland (e.g. the SHARE project[1]) and in England (e.g. APAUSE[2]) that have explored the merits of different styles of providing sex education in schools. It would be beneficial for a future sex education pilot to evaluate a programme that permeates the curriculum rather than another separate approach.

The findings of this research have highlighted the potential importance of sex education programmes that provide a dual-arena for the teaching of sex education, i.e. providing pupils with a mixed-sex as well as a single-sex environment, that place a particular focus on engaging young men and that utilises more active learning-based methods. Whilst previous research has indicated that these are all important aspects in the provision of more effective sex education, further research is required in these areas, before any firm conclusions can be drawn. This could be

[1] See Wight et al. 2000
[2] See Rees et al. 2000

achieved by undertaking randomised control studies exploring the potential of each aspect as well as one that combines all three.

One further issue that was raised within this research, was the effect that one individual in a position of power (e.g. the head teacher at Scotallen Secondary School) can have on the provision of sex education at the school level, as these individuals are effectively the gatekeepers in relation to sex education provision. What warrants further research, especially in light of the fact that the provision of sex education remains an area outwith statutory provision in Scotland, is the attitude of head teachers and senior management teams within all Scottish schools.

One method of undertaking such research would be to develop and adapt the audit undertaken in Glendale local authority (which all schools were required to participate in) for all local authorities in Scotland. This would achieve three objectives; first it would provide a picture of the level of sex education provision in all Scottish schools, second, it would enable the opinions of head teachers and senior management teams towards the provision of sex education to be sought and third, this would allow an analysis of how those opinions related to the actual provision of sex education in schools to be determined.

One issue that warrants particular attention in relation to sexual health is the attitude of sexual health providers towards the sexual health of young men. As was identified within the review of the literature in Chapter Two, there is a lack of understanding and appreciation of young men's needs in both the provision of sex education and sexual health services. As was further highlighted throughout this

thesis, in Finland there was an acute awareness of young men's needs in both sex education and sexual health service provision. Whilst this was addressed through interviews with the teachers and the school nurses, in order to develop understanding on this issue further, future research should focus on the level of understanding and appreciation of young men's needs and in turn provision geared at young men within sexual health services at the local level outwith school.

Further in relation to sexual health services, it was noted in Chapter Five that variations existed across municipalities as to whether school nurses could provide contraception within the school-clinic. It would therefore be of value to explore whether any significant relationship exists between the rate of teenage pregnancy and whether or not school nurses are able to provide contraception on-site, as this would potentially provide evidence of the importance of the school nurse's role in reducing and maintaining low teenage pregnancy rates in Finland.

One method of carrying out such a project would be to undertake a large-scale short questionnaire of school nurses' contraceptive dispensing capabilities in Finland and then map the results by municipality for differences in pregnancy rates.

An exploration into the different types of sexual health provisions available to young people (and their opinions of such provision) in other developed countries would potentially be another area warranting further research. In particular, exploring the availability of sexual health services for young people in a range of countries with varying rates of teenage pregnancy would offer more scope to

highlight exactly what types of services encourage the greatest level of use by young people.

After the initial analysis of the data on education policy it became apparent that whilst there were noted differences within the school structure and the emphasis placed on continued education in careers guidance (student counselling), there are potentially many other factors which could also have an effect upon the proportion of young people who chose to continue their education beyond the age of sixteen and the extent to which that continued education was perceived as the normal thing for young people to do. This may include, the wider social context within young people live, such as general standards of living, economic support for families, the state of the labour market and the level of parental education.

Therefore future research in this area is both necessary and important and should incorporate a qualitative exploration of young people's views as to their future educational aspirations and the factors they perceive as aiding or preventing them from continuing in (or wanting to continue in) education.

An issue that has become more apparent towards the final stages of writing up this thesis is the role that the self-esteem of young people may play both in their motivation to remain in education as well as the more acknowledged effect on sexual behaviour (Thomson 1990; Pearce 1993; Lees 1994; Hadley 1998). Therefore in order to develop a greater understanding of why young people choose to remain in education (or not) beyond sixteen, another area of future research would be to focus on the issue of self-esteem. Of particular value would be an

evaluation of a range of programmes that have been developed to raise young people's self-esteem both within schools and the local communities in which young people live. Valuable outcome measures could be tested through the use of pre and post self-esteem profiles as well as exploring young people's aspirations through in-depth discussion regarding their choices in life and their understanding of self and 'fate' in relation to those choices.

Further in relation to education policy, the relationship between a higher rate of continued education and a lower rate of teenage pregnancy has been established in this thesis. Therefore an area of particular interest for further research would be to explore the 5% of young people in Finland who annually do not progress on to (or drop out quickly from) High school, Vocational school or a tenth grade. Further research would need to explore who these young people are and of particular interest would be to determine if these individuals are more heavily represented within the small proportion of young people in Finland who are young parents.

Final thoughts

As was highlighted within Chapter Three, the purpose of exploring policy development and implementation comparatively is to provide policy developers with a variety of choices and strategies. As Kuronen notes "implicitly or explicitly, the practical and political aim of comparative research, especially in social policy is to find models of policies or provision in one country, to learn from the experience and develop the system in another" (1999:303)

Further illustrated was the fact that ‘policy borrowing’ can be potentially ineffective for a number of reasons, the most important being a lack of attention paid to the culture from which suggested policy solutions are being drawn. Throughout this thesis, the issue of attitudes towards teenage sexual activity was raised in relation to policy development in sex education and sexual health services for young people. If Scottish officials are to entertain many of the policy solutions presented within the Finnish system, such as a permeated, broader based sex education provision for all schools and a school health service that could provide sexual health advice when required, then policy development must derive from an accepting stance (Silver 1998).

For the implementation of such policies then to be effective at the school level, it will require an acceptance of teenage sexual activity at a wider level throughout Scottish society and its institutions. In particular, to facilitate this process of increasing the acceptance of teenage sexual activity, the attitudes of those who are in the position to develop and implement policy, such as head teachers in schools, are crucial.

As pointed out in Chapter Seven, it does appear that there is a growing acceptance of young people’s sexual health rights, teenage sexual activity and the need to listen to what young people say they require in service provision, not only at the level of the Scottish Executive and Scottish Office Education Department, but also within the local authorities and the schools explored. It is, however, important to remember that the sample interviewed for this research was limited and the officials interviewed all had a particular remit for sex education/ health education

and would therefore be expected to be more pragmatic about and accepting of teenage sexual activity. At a wider institutional level, however, the findings of the Deliberative Seminar[1] referred to in Chapter Seven also appear to support a growing acceptance of teenage sexual activity and young people's sexual health rights, as the delegates at this seminar were from a range of backgrounds including Scottish Executive and local authority officials, teachers, researchers, members of health promotion and church ministers.

What needs to be developed further however, is an understanding that whilst acceptance needs to underlie policy development, there also needs to be co-operation between the agencies of health and education and at the different levels of policy development and implementation. The reduction of unintended teenage pregnancy cannot be achieved by focusing on one particular area of policy in isolation or independently of other developments. The recent SEU report (1999) has placed a great deal of emphasis on 'joined-up' policy, thinking and action to pursue the reduction of teenage pregnancy in England, however, the focus is only in relation to the issue of teenage pregnancy. What needs to be considered from a wider perspective is not just the future policy approach but also its focus.

Whilst teenage pregnancy has been the primary focus for the English government with the development of the *Teenage Pregnancy Strategy*, there is a risk that by focusing on pregnancy alone, rather than a more holistic promotion of good sexual health, the strategy may fail to impact on a large proportion of young people, specifically young men, who often perceive 'pregnancy' as a female issue not

[1] For further details on the findings of this seminar, see Appendix ix.

relevant to their lives (Hadley 1998). Further to this from a political point of view, use of the phrases 'teenage pregnancy' and 'sexual health' does not simply highlight two different policy foci; there is also underlying meaning to both (Silver 2001: personal communication). Within the British policy context, 'teenage pregnancy' has continually been used to portray a negative situation. An example of this overtone is noted in the foreword to the SEU report (1999) where the British Prime Minister, Tony Blair, states "Britain has the *worst* record on teenage pregnancies in Europe. It is not a record in which *we can take any pride*… Our *failure* to tackle this problem has cost… As a country, we can't afford to continue to ignore this *shameful record*" (SEU 1999:4). 'Sexual health' (although use is also made in terms of illness) can be more positive terminology. If used in the correct context, 'sexual health' can portray to young people both an acceptance of their sex and sexuality, and their right to be healthy in that sphere of life. As was found to be the case in Finland, both at the national and local level the overall focus of policy was on the positive promotion of healthy sex and sexuality and never a focus on the negative.

The pursuit at the outset of a 'sexual health strategy' rather than a 'teenage pregnancy strategy'[1] by the Scottish Executive is an important first step down a policy road that is more likely to impact upon the lives of young people in Scotland for two key reasons. First, the focus on broader 'sexual health' portrays an inclusiveness of all young people not just young women. Second, it provides a platform from which to promote 'good practice' in sexual health, whereby young people can learn that sex is a normal healthy aspect of life and that in appreciating

the value of their own sexual health, they can develop an understanding appropriate to their lives about respect, responsibility and safer sex.

The findings of this research have opened up as many new questions as it has tried to answer. Due to the exploratory nature of the research, the conclusions that have been drawn are tentative ones, although they do point to a number of important policy differences and illustrate the need for a more pragmatic approach the issue of reducing the rate of unintended pregnancy amongst teenagers in Scotland. Hopefully recent and future developments in sex education, sexual health and education policy in Scotland will translate into a reduction in unintended and unwanted teenage pregnancy. This would then go some way towards achieving the Scottish Executive's desire to see a Scotland where sexuality is accepted in a cultural context which supports sustainable improvements in the sexual health of Scottish young people (Burtney 2000[a]).

[1] The English government have now launched their sexual health strategy, but because of the pre-existence of the teenage pregnancy strategy, the sexual health strategy contains very little emphasis on young people or the issue of unintended pregnancy.