TEENAGE PREGNANCIES IN SCOTLAND

Most individuals and societies view sexual behaviour and sexuality with circumspection because these matters strike sensitive chords at the very core of human values. What perturbs me, no matter which country we talk about, is that there are double standards when the talk turns to sexual behaviour—of women as compared to men, or of ‘lower’ socio-economic groups (the poor) compared to ‘higher’ socio-economic groups (the rich). Societies cope with sexuality and sexual behaviour in different ways—through liberal approaches such as those in Scandinavian countries or the Netherlands, through less liberal ways as in India or countries which follow an Islamic code, and through a split-personality approach which seems to operate in the USA, where sexual conservatism and liberalism seem to co-exist.

Certainly I am aware of the problems faced by unmarried girls and women in India, although I think these are much smaller than in some developed countries. I thought it would be important to report to you about teenage pregnancy and abortion in Scotland, as both are hot topics of current debate. Pregnancy makes people think. Some think of the (potential) baby, some think about what the mother is going through, and others think of the impact the new baby will have on a family. I suspect that these and other issues are writ even larger when the mother is a teenager.

The Health Minister in the Scottish Executive, Ms Susan Deacon, has come under attack from the Catholic Church and a militant new anti-abortion group, ‘Precious Life’, for her views on sex education and the right of girls and women to access sexual health services including contraception and abortion. Ms Deacon has made it clear that although she respects the rights of organizations to hold views on contraception and abortion contrary to hers, when groups such as Precious Life make threats against women using sexual health services and health staff providing those services, this will not be tolerated in Scotland.

Scotland has one of the highest rates of teenage (women aged 13–19 years) pregnancy among developed countries. Historically, it has been higher than the Scandinavian countries and considerably higher than the Netherlands but lower than the USA and Eastern Europe. In 1998, the teenage pregnancy rate was 44.4 per 1000 teenagers in Scotland, which is a decrease from the early 1990s’ rate of nearly 50 per 1000. The rate for young women aged 13–15 years was 8.7 per 1000.

But does Scotland have a ‘problem’ of teenage pregnancies? Pregnancy in a teenager is not a problem in itself. It is only a problem if the pregnancy is unwanted or unplanned, if it happens at a particularly young age when girls may have matured physically but not emotionally or socially, or if the stigma attached to it by society is oppressive. Many people use the terms ‘teenage pregnancy’, ‘unwanted pregnancy’ and ‘unmarried mothers’ interchangeably. Reflection tells us this is not so and that teenage pregnancies can be wanted, planned, and happen to married women. Furthermore, like other pregnancies, teenage pregnancies need not end in the birth of a baby. There may be a miscarriage or the pregnancy may be terminated by abortion. In Scotland, a high proportion of teenage pregnancies end in abortion which implies that these are unwanted and hence a problem.

As I hinted above, it is not just teenage pregnancies we need to look at—we must look at the sexual behaviour of young people more generally and recognize the differences that exist between countries. In general, the factors which influence sexual behaviour are well known and include:

1. prevailing ethical standards (both cultural and religious),
2. attitudes to sexuality during childhood at home, in school and in the community,
3. the status of women at home and at work, and
4. the availability and effectiveness of contraception.

Apart from unwanted or unplanned pregnancy, there are other consequences of sex which teenagers may be ill-prepared for. Guilt, the risk of sexually-transmitted infection through unprotected sex including HPV, HIV, gonorrhoea and chlamydia, and emotional and psychological stress are all associated with teenage sexual activity. Yet many teenagers take these risks and it is incumbent on adults and health professionals to understand why teenagers behave as they do.

In Scotland, the factors known to be associated with teenage pregnancy are (and there are no great surprises here):

1. sexual behaviour (such as a decreasing age of first sexual experience), and around 20% of girls aged 13–15 years were estimated to be sexually active,
2. use of contraception,
3. educational attainment—median age at first intercourse increases with educational attainment, and
4. social background, with increased teenage pregnancy in deprived areas.

Medically, teenage pregnancies face an increased obstetric risk but these need to be considered in the context of major social problems such as disruption of education or employment, being ostracized by peers, loss of self-esteem, and economic problems. Peckham reiterated the point that not all teenage pregnancies are unwanted and noted the substantial differences in pregnancies, abortions and birth rates between younger and older teenagers—the conception rates in older teenagers are much higher than in younger teenagers and of those teenagers who become pregnant, the termination rate is lower in older teenagers.

Curiously, one aspect which has not been explored so rigorously in teenage sexual behaviour and pregnancy is the male teenager. The needs of heterosexual boys and young men have not been addressed although this may be changing. Sex education and sexual health services (very often provided through ‘well woman clinics’) are not geared up for men in general or young men in particular. Of course, there may be some reasons for this ignoring of men—certainly the power structures are such that in most societies men have more power, double standards apply to men and women’s sexual behaviour, and very often women alone are left to pick up the consequences of sexual behaviour and pregnancy.

So what is the answer—just tell young people to say ‘no’ to pre-marital or ‘early’ sex? Adults and health professionals have to understand the needs of young people—not what adults or health professionals would like—in relation to sex education and sexual health services. Sex education and sexual health services for young people need to incorporate a spiritual and ethical dimension. This should be done in an open way to ensure that the choices...
that young women (and young men) have in these matters are informed decisions and that sex education and sexual health services are accessible, available, appropriate and non-judgmental. It will not be an easy task but is critically important. Young people, whether in Scotland or elsewhere, deserve nothing less.

REFERENCES

Letter from London

On 24 June 1859, Napoleon III watched the progress of the battle of Solferino from a tower in the town of Castiglione, about 40 km west of Verona, in northern Italy. In this battle, a combination of French and Sardinian troops defeated the Austrian forces. The casualties were enormous, the Franco-Sardinian army lost 24,000, and the Austrians 22,000. The repulse of the Austrians was instrumental in the subsequent unification of central Italy.

More important, however, was the presence in Castiglione of a young Swiss businessman, Jean Henri Dunant. Dunant was appalled by the suffering of the wounded, who were brought to Castiglione and, aided by the local curate, Don Loren Barzizza, helped with the treatment of the soldiers, making no distinction between nationalities. In 1862 he published a booklet, Un souvenir de Solferino, in which he described his experiences, and expressed the hope that he might live to see the leaders of the military art of different nationalities agree upon some sacred international principle, sanctioned by convention, which, once pressed the hope that he might live to see 'the leaders of the military art of different nationalities agree upon some sacred international principle, sanctioned by convention, which, once

Dunant's ideas were received sympathetically and in 1864, the Swiss Federal Council convened in Geneva a diplomatic conference at which 26 governments were represented. The outcome was the Geneva Convention which laid down certain principles; the wounded were to be respected, military hospitals were to be regarded as neutral and personnel and materials of medical services were to be protected. Subsequent conferences in 1899, 1906, and 1929 extended and revised these principles. The International Red Cross was founded and the league of Red Cross Societies was formed in 1919. Since then, the work of the Red Cross has expanded and it has been particularly active in the welfare and supervision of prisoners of war. The Geneva Convention of 1949 consolidated the principles of the previous conferences and imposed certain restraints on the conduct of war and protection of civilians.

A feature of the last two decades has been the emergence of conflicts within a single state in which neither party pays regard to any conventions, and in which genocide has been an objective of one or both participants. A particularly horrible example of the abuse of civilians was the amputation of limbs in Sierra Leone. All these conflicts—in Bosnia, Kosovo, Rwanda and elsewhere—have been facilitated by the ready availability of cheap and easily manufactured small arms, such as the Kalashnikov, which can be bought for a chicken in Uganda. In Africa particularly, the arming of boy soldiers has been a repulsive aspect of many of these civil wars.

The role of physicians is potentially important in influencing public opinion and national policies on the prevention of war, human rights, prevention of torture and the rights of refugees. Sadly, in some countries, doctors have connived at or actively assisted in these abuses, while professional associations have failed to object publicly. Nevertheless, progress has been made. In a number of countries, there are specialized units for the treatment of victims of torture and there are associations of physicians dedicated to the prevention of war and the alleviation of its results. The legal mechanisms for dealing with perpetrators of war crimes and crimes against political opponents are still insecure, as shown by the confusion over the Latvian, Conrad Kalejs, and Chile's General Pinochet.

The United Nations, notwithstanding the disasters in Rwanda and Somalia, has accepted the principle of interference in the affairs of a sovereign state when it is clear that gross abuse of civilian rights is occurring; intervention in Kosovo and East Timor was, however, too late to prevent the loss of thousands of lives.

The incoherence of the international community in the face of these problems has led to initiatives which should result in the setting up of an International Criminal Court, while the European Community, frustrated at its dependence upon the USA for logistics, personnel and transport in Kosovo, has decided to set up a rapid reaction force of 40 to 60 thousand men for crisis intervention and peace-keeping, capable of deployment within 60 days.

At the level of the individual, the aetiology of the Gulf War Syndrome has yet to be elucidated and the treatment of post-traumatic stress disorder (PTSD) is still unsatisfactory. A recent survey of doctors involved in the Omagh bombing in Northern