

# Teenage Sexual and Reproductive Behavior in Developed Countries

## Country Report For Great Britain

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## Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior

### Levels of Adolescent Birth, Pregnancy and Abortion

The United Kingdom has the highest teenage birthrate in Western Europe. Although adolescent birthrates have fallen since the 1970s throughout most of Western Europe, the U.K.'s adolescent birthrate has remained relatively stable, with minor fluctuations, between 1980 and 1998 (Appendix A, Table A1). The birthrate peaked at 33.3 per 1,000 adolescent women in 1990, dropping to 28.5 in 1995, but again increasing to 30.9 in 1998—nearly the same rate as in 1980 (30.4). Similar trends can be observed among 15–17 and 18–19-year-olds. Among 15–17-year-olds, the birthrate increased from 13.4 in 1980 to 16.7 in 1990 and dropped to 14.6 in 1995, only to increase again to 16.5 in 1998. The birthrate among 18–19-year-olds decreased between 1980 and 1985 (from 56.5 to 50.6) as well as between 1990 and 1995 (54.4 to 50.2), but increased between 1985 and 1990 and between 1995 to 1998. One possible explanation for this recent increase may have been the Pill scare of 1995. Among 20–24-year-olds, the birthrate began to decrease in 1980 from 112.7 to 91.7 in 1990 and continued to do so through 1998 to 75.5, with an overall decrease of 33% between 1980 and 1998.

The overall pregnancy rate among adolescents increased between 1980 and 1990 from 47.7 to 56.1, and then declined to levels comparable to those attained in 1980 (47.1), but increased again to 52.6 in 1998. Among 20–24-year-olds, the pregnancy rate peaked in 1980 at 131.2 and then attained the lowest level in 15 years with a rate of 102.3 in 1995 and then increased slightly to 104.5 in 1998.

Given the high number of unintended pregnancies, it is surprising that the number of abortions is not higher.<sup>1</sup> In 1997, about 50% of conceptions among under 16-year-olds ended in abortion and close to 17% of teenagers had a “repeat abortion” or an abortion and a live birth.<sup>2</sup> For all age groups, the

abortion rate increased between 1980 and 1990, then decreased in 1995 only to increase again in 1998 and attain higher levels than in 1980. Between 1980 and 1998, a more substantial increase occurred in the abortion rate among 20–24-year-olds (from 18.5 in 1980 to 29.0 in 1998) than among adolescents (from 17.3 to 21.7).

### Age at First Intercourse

Analysis by five-year age groups (data from 1990) shows a marked decrease in age at first intercourse by current age (Appendix A, Table A3). About 19% of women aged 16–19, born between 1966 and 1969, had experienced sexual intercourse before the age of 16, compared with fewer than 1% of those aged 55–59, born between 1931 and 1935. For men, the equivalent proportions are higher: 28% of men in the youngest (16–19) age group compared with 6% of men aged 55–59. More recent data indicate that this trend has continued. In 2000, 26% of women and 30% of men aged 16–19 report having had first intercourse before age 16.<sup>3,a</sup>

Some convergence between men and women can be seen in these data. The gap between men and women narrows with respect to the proportions reporting intercourse before the age of 16. Compared with women, the proportion of men who initiated intercourse before 16 is higher in all age groups, but the ratio of men to women who experienced intercourse before the age of 16 has narrowed from 7:1 in the oldest group, (55–59) to 3:2 in the youngest (16–19). A recent study looking at attitudes towards sex indicated that, for girls and especially for boys in the United Kingdom, factors most likely to influence initiation of first intercourse included peer pressure and opportunity.<sup>4</sup>

<sup>a</sup> The data for 2000 are included for comparison in the text, but were not available when the tables were finalized.

### ***Age at First Intercourse by Socioeconomic Factors***

Initiation of intercourse occurs at earlier ages among those who are in lower income groups, attain lower educational levels, and are in lower socioeconomic groups. Table 1 (page 9) shows marked variation in age at first intercourse, according to education, particularly for women aged 20–24. Young women who attain at least A- level education are less likely to have initiated intercourse by age 18. Among this group, about 42% had intercourse by age 18 compared to 62% among those who completed O levels and 76% among those who left school with no qualifications.

While most recent U.S. studies, and those in other parts of Europe, show a lessening of social class differences in the initiation of sex over time, in the United Kingdom they persisted later than in the United States and in the rest of Europe. Social class has been a key factor in the timing of first intercourse. In 1990, about 55% of young women and 60% of young men aged 20–24 in the professional/intermediate social class initiated intercourse by age 18 compared with approximately 70% of young women and men in the semi/unskilled social class. Compared with the professional/ intermediate social class, a slightly higher proportion of women in the skilled class (59%) initiated intercourse by age 18. This is however not the case for men where the reverse is found: 51% of young men in the skilled social class had sex by age 18 which is 8 percentage points less than those in the highest social classes. Finally, differences in the timing of initiation of sexual activity by social class continue to be evident in 2000—among both young men and young women (aged 16–19) the percentages who had first intercourse before age 16 were 21% for youth whose parents were in non-manual social classes compared with 31–33% of young men and women, respectively, whose parents were in manual social classes.<sup>5</sup>

Young women in Scotland are less likely than women in other regions of Great Britain to initiate sexual intercourse by age 18 (48%) whereas young men in Scotland are more likely to do so (75%). The highest percentage of young women initiating intercourse by age 18 occurs in the East Anglia region (77%) while, among young men, the lowest percentage initiating intercourse by age 18 is found in the West Midlands area (49%). Initiation of intercourse by age 18 in other regions ranges from 56% to 74% for both young women and men.

Data on immigrant status show that the proportion of young women born in the United Kingdom who have initiated intercourse by age 18 is higher (61.7) than among those not born in the United Kingdom (41.4). There is little difference among native born and immigrant young men.

### **Age at First Birth**

In 1990, among women aged 20–24, 15% had a child before the age of 20. In comparison, 20% of 45–49-year-old women gave birth before age 20.

Class differences are also reflected in patterns of childbearing. Only 6% of women from the highest social class groups (professionals and intermediate) had a child in their teens compared with 15% of women aged 20–24 in the skilled class and one quarter of those in the semi/unskilled group who had a birth by age 20 (Table 2, page 10).

Low educational attainment is also associated with higher teenage childbearing. Data show that women aged 20–24 who left school with no qualifications were 3 times as likely as women who attained their O levels and 19 times more likely than women who attained at least A levels or higher to have had a birth by age 20.

Teens in northern regions have higher levels of teenage childbearing than their southern counterparts, reflecting, in part, the fact that the north has a higher number of economically deprived districts when compared to the rest of the country. Twenty-seven percent of 20–24-year-old women in the North region had a birth by age 20, which is 6 times higher than the lowest levels found in the East Anglia region (4%). In the Greater London area and the East Midlands region, 8–9% of young women gave birth by age 20, while in other regions the range is between 13% and 19%.

### **Number of Partners and Frequency of Intercourse**

Among adolescents who have had intercourse in the past year, over 69% of women and 54% of men aged 16–19 reported having had only one sexual partner in the past year (Appendix A, Table A5). Nevertheless, these data show young people in their teens and early twenties to be more likely than older people to be multi-partnered. Thirty percent of women and 45% of men aged 16–19 report having had two or more partners in the past year. Among those aged 20–24, these numbers are lower, in particular among women: 18% of women and 37% of men report having had two or more partners in the past year. The data on

frequency of intercourse (Appendix A, Table A6) confirm that sex for young people, especially men, is more sporadic than it is for those who are older (who are also more likely to be cohabiting or married). Among 16–19-year-olds who were sexually active in the past month, about 30% of women and 44% of men reported that they had intercourse once a week or less frequently. Comparing adolescent women with 20–24-year-olds reveals little difference in frequency of intercourse. Among men, however, the difference is more striking with a noticeable increase in frequency of intercourse from adolescence to young adulthood.

### **Contraceptive Use at First Intercourse**

Contraceptive use at first intercourse varies both with current age and with age at which the event occurred. As Appendix A, Table A7 shows, in 1990, men are more likely than women, and older respondents more likely than younger ones, to report not having used contraception at first intercourse. Non-use has decreased markedly with successive cohorts. Data for 2000 indicate that this trend has continued with even fewer adolescents reporting no contraceptive use at first intercourse.<sup>6</sup>

#### ***Contraceptive Use at First Intercourse in 1990***

Contraceptive use at first intercourse is greater among those in higher social class groups; adolescent women in the lowest social class (semi/unskilled class) were 3 times as likely to not use a method at first intercourse as women in the highest social class (Table 3, page 11). All adolescent men in the higher level social classes reported contraceptive use whereas those in the lower classes (skilled and semi/unskilled classes) reported high levels of non-use (24% and 36% respectively).

As seen on previous measures, the East Anglia region had the lowest proportion of women who had a birth by age 20; and, although a high number of youth here had initiated intercourse by age 18, more of them used a contraceptive at first intercourse than adolescents in any other region. Only 10% of adolescent women in East Anglia did not use a method at first intercourse compared with 31% in Scotland or Wales. Adolescent men in the East Anglia region were also most likely to be using contraception (97%). Young men least likely to use contraceptives can be found in the Northwest region (63%), followed by the Southwest (67%). Within the

greater London area, higher levels of non-use occurred among adolescent men (29%) than women (18%).

Ever sexually active adolescent women not born in the United Kingdom are twice as likely (42%) as women born in the United Kingdom (20%) to have not used a method at first intercourse. Among men, there is little difference between the two groups, however, there are differences in type of method used. Adolescent men not born in the U.K. are more likely to use condoms than men born in the U.K., whereas the reverse is true for adolescent women.

### **Contraceptive Use at Last Intercourse**

Among sexually active youth, method use at last intercourse is high with 97% of adolescent men and 96% of adolescent women reporting the use of a contraceptive. Oral contraceptives are the most commonly used form of contraceptive, reported by 52% of young men and 66% of young women, followed by the condom with just under a quarter using it. Not surprisingly, older teens (18–19) are more likely to report contraceptive use and are more likely to use the pill when compared to younger teens 16–17. Compared to adolescents, older women and men are less likely to be using the pill, less likely to be using a contraceptive method and more likely to use IUDs. A large proportion of older women and men reported that they or their partner was sterilized. Data on condom use among the various age groups show little variation.

#### ***Contraceptive Use at Last by Socioeconomic Factors***

Adolescent contraceptive use and method mix vary according to socioeconomic status and gender. The socioeconomic differences are also present for contraceptive use at most recent intercourse (Table 4, page 12). All of the young men and women in the professional/intermediate social classes used a contraceptive method at last intercourse. However, although still relatively low, those in the semi/unskilled class experienced the highest levels of non-use ranging from 5% among women to 8% among men. For young men, those in the higher social classes were more likely to report use of oral contraceptives and less likely to use the condom. Among young women there is little variation in oral contraceptive use between the different social classes while condom use is somewhat higher among those in the higher social classes.

Regional differences indicate that both adolescent women and men residing in the Eastern area of Great Britain have the highest levels of current contraceptive use (100%) whereas those residing in the West have the lowest levels (ranging from 75% to 93%). These levels of contraceptive use reflect the geographical concentration of teenage pregnancy.

**Table 1. Age at first intercourse by age 18, among women 20-24 by socioeconomic variables, NATSAL 1990-91**

Socio-economic Variables	Age at First Intercourse by Age 18	Age at First Intercourse by Age 18
	<i>Women</i>	<i>Men</i>
<b>Total</b>	60.4	62.8
<b>Education</b>		
None	75.9	79.4
O-level at least A-	62.2	66.6
	42.2	55.4
<b>Class</b>		
Professional/Intermediate	55.4	59.5
Skilled	59.4	51.1
Semi-skilled/unskilled	69.9	72.5
<b>Race</b>		
White	62.2	64.1
Non-white	33.8	43.8
<b>Immigrant Status</b>		
U.K. Born	61.7	61.0
Foreign Born	41.4	58.6
<b>Region</b>		
North	56.4	59.1
Northwest	62.4	66.2
Yorks	61.0	60.2
W. Midlands	58.8	49.1
E. Midlands	63.4	58.5
E. Anglia	77.0	71.4
SouthWest	73.6	63.8
SouthEast	69.8	62.0
Greater London	50.0	62.1
Wales	64.1	67.4
Scotland	47.8	74.8

**Table 2. Age at first birth by age 20 among women 20-24 by socioeconomic variables, NATSAL 1990-91**

Socio-economic Variables	Age at First Birth by Age 20
<b>Total</b>	14.7
<b>Education</b>	
None	36.3
O-level	12.5
at least A-	1.9
<b>Class</b>	
Professional/Intermediate	6.4
Skilled	14.6
Semi-skilled/unskilled	25.2
<b>Immigrant Status</b>	
U.K. Born	15.0
Foreign Born	7.5
<b>Region</b>	
North	27.1
Northwest	18.7
Yorks	17.9
W.Midlands	14.6
E. Midlands	8.9
E. Anglia	4.3
SouthWest	18.0
SouthEast	13.0
Greater London	8.0
Wales	17.4
Scotland	13.8

**Table 3. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (16-19), gender, and socioeconomic variables among ever sexually active, NATSAL 1990-91**

Socioeconomic Variables	Use among Women				Use among Men			
	Contraceptive Method				Contraceptive Method			
	Pills	Male Condom	Withdrawal & rhythm	No Method	Pills	Male Condom	Withdrawal & rhythm	No Method
<b>Total</b>	12.4	60.8	4.9	20.8	8.3	56.2	8.1	25.9
<b>Class</b>								
Professional/Intermediate	16.3	70.1	6.8	10.1	12.5	83.3	4.1	0.0
Skilled	12.5	61.7	5.1	19.2	8.9	57.0	9.0	24.1
Semi-skilled/unskilled	10.7	55.7	2.8	30.2	5.5	48.5	10.2	36.1
<b>Immigrant Status</b>								
U.K. Born	12.8	62.0	4.9	20.2	8.2	55.8	8.9	26.2
Foreign Born	3.8	50.0	3.8	42.4	10.0	65.0	5.0	20.0
<b>Region</b>								
North	11.4	56.8	4.5	27.3	16.6	29.1	16.8	37.5
Northwest	11.3	59.8	11.3	17.8	10.1	50.7	11.6	24.7
Yorks	8.9	63.3	1.5	26.4	13.2	63.1	5.3	18.3
W.Midlands	3.6	69.6	1.7	25.0	3.8	62.8	5.9	27.4
E. Midlands	25.2	53.3	1.8	19.6	11.1	59.2	3.7	25.9
E. Anglia	15.0	70.0	5.1	9.9	0.0	74.2	16.2	3.3
SouthWest	11.9	57.2	4.6	23.8	12.9	51.9	1.9	33.3
SouthEast	12.6	73.9	1.8	11.7	2.1	46.3	7.6	16.3
Greater London	16.4	54.6	10.9	18.3	5.6	37.5	7.0	29.2
Wales	11.4	48.6	8.6	31.4	13.0	26.1	4.3	26.1
Scotland	20.6	48.8	0.0	30.8	1.8	30.9	12.7	14.5

"Method not reported" is not presented in this table. Therefore, numbers may not add up to 100%.

**Table 4. Percentage distribution according to contraceptive method used at last intercourse by age of respondent at the survey (16-19) and socioeconomic variables among currently sexually active adolescent women and men, NATSAL 1990-91**

Socioeconomic Variables	Use among Women					Use among Men				
	Contraceptive Method					Contraceptive Method				
	Pills	Condom	IUD	Other* Methods	No Method	Pills	Condom	IUD	Other* Methods	No Method
<b>Total</b>	65.9	22.8	0.8	2.7	4.0	52.3	20.8	0.7	3.6	3.1
<b>Class</b>										
Professional/Intermediate	68.6	31.7	0.0	0.0	0.0	65.7	31.7	0.0	0.0	0.0
Skilled	65.3	23.6	0.9	2.6	3.9	52.5	36.2	1.0	3.6	6.3
Semi-skilled/unskilled	68.2	17.7	0.9	4.0	4.7	47.4	42.0	0.0	2.4	8.4
<b>Immigrant Status</b>										
U.K. Born	66.8	23.1	1.0	2.0	4.1	52.8	36.5	0.7	3.2	6.7
Foreign Born	53.2	15.7	0.0	16.7	0.0	38.7	61.0	0.0	0.0	0.0
<b>Region</b>										
North	70.4	18.5	0.0	3.8	7.4	58.2	16.7	0.0	0.0	24.9
Northwest	67.4	17.4	0.0	2.1	10.9	40.0	42.8	0.0	2.9	14.3
Yorks	65.0	20.0	5.0	2.4	7.4	47.6	42.2	0.0	5.3	5.3
W.Midlands	54.2	37.1	0.0	2.9	2.9	55.7	26.0	0.0	7.2	7.5
E. Midlands	80.1	14.2	5.7	0.0	0.0	56.6	43.4	0.0	0.0	0.0
E. Anglia	77.8	11.2	0.0	11.0	0.0	66.7	33.3	0.0	0.0	0.0
SouthWest	71.4	17.8	0.0	3.5	7.1	66.7	33.3	0.0	0.0	0.0
SouthEast	69.8	21.5	1.9	3.5	1.9	47.4	44.4	0.0	5.8	5.6
Greater London	57.6	30.8	0.0	0.0	3.9	53.3	26.6	6.6	6.6	6.6
Wales	74.1	11.1	0.0	0.0	7.4	43.4	45.6	0.0	0.0	10.7
Scotland	59.2	24.9	0.0	0.0	3.0	47.9	43.5	0.0	0.0	8.8

\*Other methods include: male sterilization, diaphragm, cap, female condom, foam, jelly, cream, withdrawal, rhythm  
 "Method not reported" is not presented in this table. Therefore, numbers may not add up to 100%.

## Part II. Societal Attitudes about Sexuality

### Society's Attitudes and Norms about Sexuality and Sexual Behavior

The British position on adolescent sexuality was well summarized by the Health Minister for Public Health when the conclusions of the Social Exclusion Unit (SEU) on teenage pregnancy were being discussed in the House of Commons. Tessa Jowell (on “mixed messages”) said:

“We live in a society where children are bombarded with images of sex, which is used to sell them everything from ice cream to videos. The message is clear: being sexually active is the norm—come and join the club. Yet the rest of adult society gives a quite different message about sex. Either we do not discuss it at all or....We discuss it in an embarrassed and diffident way. We hope that if we do not talk to teenagers about sex it will not happen, but we have to accept that all the evidence is stacked against that view.”<sup>7</sup>

When television does address issues of sex education, sexuality and teenage pregnancy it is usually through documentary or debate with a focus on social problems (eg. ITV: *Inside Story: Schoolgirl Mums* (20<sup>th</sup> January, 1998); Channel 5: *What's the Story? Teenagers and the Pill* (3<sup>rd</sup> March, 1998); Phone-ins: ITV, *This Morning* looked at under-age sex (24<sup>th</sup> February 1998); and BBC *Breakfast News* debated sex education (27<sup>th</sup> July 1998)).

These programs present teenage pregnancy and under-age sex as serious social problems. The format generally is to set the views of individuals (such as Mrs. Victoria Gillick) and agencies (such as the Family and Youth Concern), who believe that sex education and the provision of contraception to young people undermines moral values, against those of individuals and agencies responsible for the sexual health of young people such as Brook Advisory Centres and the Family Planning Association. Again, the result is conflict rather than consensus, and the viewer is left in confusion about what values are

acceptable.

Newspaper representations (especially tabloid) also illustrate clearly British attitudes towards teenage sexuality. The tabloids regularly moralize about what should be done about teenage pregnancy, the conclusions of which are often couched in terms of the inadvisability of providing social housing, which is assumed to encourage teenage pregnancy. Teenagers in Britain receive contradictory and ambivalent messages.

### Aspects of Concern

Birthrates are higher among immigrant groups, but this is rarely a focus of public concern. Rape and violence are not accorded disproportionate status as social problems and HIV issues are reported far less sensationally now than was formerly the case. In terms of age differences between partners, generally the phenomenon is so common that it only seems to warrant mention where it favors the woman or involves celebrities.

We are, in Britain, rather susceptible to moral panics. Although often transient, these are taken sufficiently seriously to influence the policy agenda, since politicians have an ear to the concerns of their voting public. This was the case with the issue of child sexual abuse. An influential TV producer, Esther Rantzen, following public response to the feature on her consumer program on child sexual abuse, set up the charity Childline, aimed at providing a helpline for young victims. For a while the issue eclipsed all others on the public agenda.

The current moral panic around sexuality focuses on precocious sexual activity. Acceptance of premarital sex is high. Only 5% of young men and women in the 16–24 year age range believe sex before marriage to be wrong, and the percentage for all ages is 8% for men and 11% for women.<sup>8</sup> Those in upper socioeconomic groups are more accepting than are those in lower groups, which is paradoxical given

that sex is more likely to begin earlier and to lead to teenage pregnancy among girls in lower social classes (unskilled manual and unemployed).

The strongest opprobrium is chiefly reserved for teenage pregnancy, perhaps since it has now entered the British consciousness that our rates are the worst in Europe. Those cases which hit the headlines and receive shock horror treatment involve very young teenagers, aged under 13. In the year 2000, two such cases occurred in Rotherham, a run down area in northeastern England. The girls were closely interrogated, but the police made clear that they were interested only in the best outcome for parents and child, and not in criminalizing the case. Interestingly, the young father in one of the cases blamed the fact that his school sex education had featured pictures of naked men and women making love. Clearly, he had picked up from the media the blame for teenage pregnancy and early sex constantly attached to sex education in the right-wing press.

There is considerable conflict between different factions of society in the extent to which teenage sexuality and fertility are deemed problematic. Though not as large or influential as it is in the United States, a moral majority is active in this country. In terms of abortion, the key players are Life and SPUC; in relation to teenage sexuality and pregnancy, Family and Youth Concern; and the chief lobbyists against sex education are the Family Education Trust.

### ***National Efforts to Change Adolescent Sexual and Reproductive Behavior***

Government agencies have thus far resisted pressure to encourage young people to delay sexual intercourse. During the height of AIDS campaigning, however, the Health Education Authority (HEA) came under strong pressure from the Department of Health to include a “say no” message among messages relating to HIV prevention. In practice however, a fairly watered down version of this message exhorted young people to “remember you don’t have to have sex if you don’t want to.”

Non-governmental efforts in this respect have come mainly from religious groups. In 1994, for example, John Bickwell of Hertfordshire introduced a “Just Say No” campaign entitled True Love Waits, based on a similar campaign designed by a U.S. organization. Employing Church of England youth workers from Berkhamstead, he issued 20,000 credit card style “pledge cards” throughout Britain.

Efforts to prevent teenage pregnancy were launched in the year 2000. Following their election, the Blair government set up the Social Exclusion Unit (SEU) as a means of demonstrating “joined-up working,” i.e. addressing a problem from a variety of perspectives and involving several government departments. In recognition of both the urgency of the problem and its multi-factorial nature, teenage pregnancy was the first social problem to be addressed by the SEU.

There is widespread disapproval of financial support for young mothers in the media, particularly in terms of provision of social housing, but the cause for concern is the extent to which this is likely to encourage teenage childbearing rather than any intrinsic objection. In terms of strategy, the recommendations of the SEU report are still being operationalized, but one immediately acted on was that related to housing. Young mothers will no longer be able to claim social housing (it was never as easy as critics imagined—the queues are long and the minimum age is 18), but will instead be accommodated in sheltered housing.

The government will be spending £10 million of the £60 million set aside for its teenage pregnancy initiative, piloting 15 suspended projects to see which type works best. At present, there are only a handful of such schemes in the country. The aim is to build enough hostels to accommodate 2,000 to 4,000 girls. An existing project that the new hostels are likely to be modeled on, is the Centrepont young mothers project in Lewisham, South London, which comprises five bed-sits with self-contained kitchen areas and three bedrooms with a shared kitchen. The authors of the SEU report were also impressed with the Edmonds Court Foyer in Birmingham which has 48 furnished flats and bed-sits for young people, couples, and single parents. The scheme has a registered crèche; assistance, education and employment are provided for those recently unemployed.

### ***Change in the Level of Openness towards Sexuality***

The AIDS epidemic and the attendant attention paid to sexual behavior and the need for surveillance has probably been the single most important factor in changing the level of openness and concern for adolescent behavior in the past two decades. This has had negative and positive consequences. In terms of ease of communication, it has impacted favorably on the ability of young people to talk about and there-

fore negotiate safer sex. But in terms of visibility, it has brought to the attention of society aspects of sexual behavior revealed in research and through media coverage, which would normally be kept in perspective, but because of society's intensive gaze on the sexual lifestyles of the young, are seized upon as new evidence of decadence and declining moral standards.

Politically, a more relaxed and enlightened approach to sexual lifestyles generally could be expected with the Blair government, though there have been criticisms that the Prime Minister has personally espoused something of a moral crusade.

### ***Indicators of Society's Attitudes and Norms from Survey Data***

Attitudes towards pre-marital sex vary markedly from those towards extramarital sexual relationships. Survey evidence shows the pattern of responses on sex outside marriage to be the reverse of that relating to sex before marriage. Extramarital sex is regarded in a stricter light. Only one respondent in fifty believes extramarital sex to be not at all wrong and some four out of five people (79% men and 84% women) are of the opinion that it is almost always or mostly always wrong.<sup>9</sup> Only marginally fewer people—two-thirds of men and more than three-quarters of women—disapprove of sexual relationships outside a live-in relationship. The majority view on all these issues concerning exclusivity is that monogamy is the acceptable form of behavior. Condemnation of casual sex is also widespread, and here there are greater gender differences: 36% of men view this as always wrong compared with 62% of women.

There is no evidence of widespread support for lowering age at first intercourse. Only one in eight are in favor of sexual intercourse being permitted before the age of 16.<sup>10</sup>

Patterns of communication about sex are remarkably gendered. Twice as many daughters report having spoken to parents about sex as sons.<sup>11</sup>

### ***Laws Related to Sexual and Reproductive Behavior***

• *Laws regulating sex and marriage.* Throughout the U.K., any man (defined as a male over the age of criminal responsibility) who has sexual intercourse with a girl under the age of sexual consent is acting unlawfully. The age of sexual consent is 16 in England, Wales and Scotland and 17 in Northern

Ireland. Under the age of sexual consent, a young woman is deemed in law to be incapable of giving consent and is not acting illegally. Under Section 6 of the Sexual Offenders Act (England and Wales) 1956, if the girl is aged between 13 and 15, the man can plead in his defense:

- that he believes himself to be validly married to the girl (even if he is not);
- that he believes the girl to have been 16 or older (this defense is only permissible if he is under 24 and has not previously been charged with a similar offense).

Sex with a girl aged under 13 is regarded as a more serious offense. Under Section 5 of the Sexual Offenders Act (England and Wales) 1956, it is an absolute offense (ie. one for which no defense of mistaking the age of the girl is allowed) for a man over the age of criminal responsibility (i.e. 10 years old) to have unlawful sexual intercourse with a girl under 13. The Sexual Offences Act does not contain any clause making it an offense for a woman to have sexual intercourse with a man under the age of 16. She could, however, be charged with indecent assault.

Under Scottish law, Section 3 of the Sexual Offences (Scotland) Act 1976, a man who has unlawful sexual intercourse (i.e. outside legally valid marriage) with a girl aged under 13 is guilty of the common law crime of rape which is punishable by life imprisonment.

The Criminal Law Amendment (Northern Ireland) Act 1885 fixed the maximum penalty of two years imprisonment for unlawful carnal knowledge of a girl between 14 and 17 years old. In Northern Ireland, the age of sexual consent is thus 17. An offense against a girl aged 14 or younger carries the maximum penalty of life imprisonment. There is no defense that the man believed her to be 17 or over, whatever the age, although in practice, prosecutions are rarely brought in cases where the girl is already 16.

The Criminal Justice and Public Order Act 1994 amends the Sexual Offences Act 1956 to define rape as non-consensual sexual intercourse (vaginal or anal) with a person, thereby recognizing the crime of rape by men. Because of the way in which rape is defined under existing legislation, women cannot be charged with the offense of rape.

A man may be charged and found guilty of raping a woman to whom he is married, A House of Lords ruling in the case of *R v R* (1991) was endorsed by the Law Commission report on marital rape, which

concluded that a husband's former immunity from rape charged should be abolished and the law relating to rape and certain other sexual offenses should be amended. This became law through the Sexual Offences (amendments) Bill 1992.<sup>12</sup>

The minimum age of marriage, with parental consent, is 16 in England and Wales and Northern Ireland, and 17 in Scotland. Without parental consent, the minimum age of marriage in England and Wales, Northern Ireland and Scotland is 18.

The knowledge that it is unlawful for a man to have sex with a young woman under 16 is virtually universal (96% men and women know this to be so). Furthermore, a majority of men (69%) and women (68%) are under the misapprehension that it is against the law for a man aged under 16 to have sex.<sup>13</sup> In practice prosecutions are rare, and diminishing in number, if there is no evidence of exploitation. In 1985, there were 138, and in 1986, 162 prosecutions of men who had sex unlawfully with girls under 13, compared with 77 in 1995 and 94 in 1996. In 1986 there were 1,426 successful prosecutions of men who had sex with girls aged 14 and 15 compared to 576 in 1996.

- *Laws regulating reproductive health services.* Doctors in the U.K. may prescribe contraception to girls under 16 if, in their clinical judgement, it is in the girl's best medical interests and she is able to give what they consider to be informed consent. This applies equally in Northern Ireland where, although the heterosexual age of consent is 17, the medical age of consent is 16. Under 16s have a right to confidentiality whether asking for contraceptive advice or any other medical treatment.

Department of Health and Social Security (DHSS, now the Department of Health), guidelines on this issue were revised following the Gillick case (1985–86). In England and Wales, doctors and other health professionals may provide contraceptive advice and treatment to young people under 16 under the following conditions, sometimes referred to as the “Fraser Guidelines” (Family Planning Services for Young People). HC (86) Department of Health and Social Security, 1986:

- that the young person understands the advice and has sufficient maturity to understand what is involved;
- that the doctor could not persuade the young person to inform their parents, nor to allow the doctor to inform them;
- that the young person would be very likely to

begin, or continue having sexual intercourse with or without contraceptive treatment;

- that it would be in the young person's best interest to give such advice or treatment without parental consent.

The current guidelines reflect a turbulent period in the recent history of provision to young people. In 1974, the DHSS advised that doctors could provide contraceptive advice to a girl under the age of 16 without advising her parents. In 1980, Section G of the 1974 memorandum was revised, emphasizing that doctors should “*seek to persuade* the child to involve the parents or guardian”, though ultimately, the decision was for the clinical judgement of the doctor.

At the same time, Mrs. Victoria Gillick sought and failed to gain the reassurance of her local area health authority (AHA) not to provide contraceptive advice or treatment to her daughters without her knowledge or consent, and in 1982 sought a High Court ruling against her AHA and the DHSS on the grounds that the 1980 circular was unlawful. In 1983, the High Court ruled in favor of the DHSS declaring their guidelines to be lawful and dismissing Mrs. Gillick's case.

On 20<sup>th</sup> December 1984, the Appeal Court overturned the High Court ruling. Parental consent was judged to be important and except for advice given in an “emergency” or “with leave of the Court”, health care professionals were deemed to be acting illegally if they provided contraceptive advice or treatment to girls under 16 without parental consent. DHSS guidance was immediately suspended, leading to a decline in attendance at family planning clinics by under 16s.

Finally, in 1985, the House of Lords ruled that the DHSS guidance was not unlawful and it was reinstated immediately.<sup>14</sup>

- *Abortion law.* Abortion was decriminalized in Britain in 1967. A girl under age 16 can consent to an abortion if all the doctors concerned agree that the girl has sufficient maturity and understanding to appreciate what is involved. In practice, most doctors require the consent of a parent or a responsible adult before the operation is performed.

- *Pre-natal care.* While the legally enforced ages of consent to sexual acts and to contraceptive provision clearly act as a deterrent to early sexual activity, no such prescriptions surround pre-natal service provision. Every effort is made to ensure that young pregnant women take up pre-natal services, though in practice, late disclosure of pregnancy among young

teenagers may militate against prompt receipt of pre-natal care.<sup>15</sup>

Despite the Lords' ruling in the DHSS's favor, a good deal of uncertainty still surrounds the issue of confidentiality. Research showed that, five years later, half of 16–19-year-olds, and three-quarters of under 16s using family planning or pregnancy counseling services thought that general practitioners would tell their parents that they had been to see them and why. A large proportion of teenagers say they think their parents will be told if they try to obtain contraception, or that it is illegal to ask for contraception because it is illegal to have sex under the age of 16.<sup>16</sup>

### ***Broadcast Standards Related to Advertising of Contraceptives***

The situation in relation to condom advertising has been radically altered by AIDS. Until 1987, condom advertising on British TV was forbidden. The government, however, having encouraged condoms in 1986 as part of the Safe Sex advertising campaign, found itself in the impossible position of not being able to feature condoms on TV, and was forced to repeal the ban in 1987. The time of repeal was the same in France and Ireland.

The public sale of condoms has always been heavily regulated in Britain. The London Rubber Company, now known as the London International Group, and manufacturers of the most popular brand of condoms, Durex, persuaded a brewery chain to install vending machines in its toilets before the end of the 1960s. The company has had to counter oft-made accusations of encouraging sexual promiscuity by developing sex education leaflets and producing information on how to prevent sexually transmitted diseases (STDs).

Until recently, condoms could only be sold from vending machines on private property. Reference to the public sale of contraceptives is made in the “For Good Rule of Government and the Prevention of Nuisances” by-laws 1949–51. Section 35 of the Act says it is an offense to sell contraceptives from an automatic machine in any street to which the public has right of passage and this includes forecourts.

Several City Councils have since repealed these by-laws, with the approval of the Home Office. In 1995, the first step to allow street corner condom machines was put in place by Bristol city counselors, who repealed a 1949 by-law, under which offenders could be fined up to five pounds for a first offense,

and 40 shillings (£2) per day, for continuing offenses, if they sold condoms in public places. Councils in Woodspring, Cardiff, Plymouth and Nuneaton have also repealed by-laws banning condom machines. Lifting the ban enables them to be sold from vending machines in shopping centers and train and bus stations. Nuneaton, for example, installed a machine in a bus shelter in July 1992.

The ever-present controversy surrounding sexual matters is occasionally exploited by those wishing to get their message across. Each year, the British Safety Council runs a safer sex campaign in National Condom Week. In 1995, the campaign used a picture of the Pope wearing a hard safety helmet and looking thoughtful and the words, “Eleventh Commandment: Thou shalt always wear a condom.” The Universe, the Catholic weekly, described the campaign as an insult to the Pope and “deeply offensive to Catholics.”<sup>17</sup> A council spokesperson said the aim of the flyer was to make people think about the fact that the Catholic church is directly responsible for the spread of STDs, as well as unwanted pregnancies among societies which accept its stance on contraception.

The climate surrounding condom advertising has certainly relaxed. In January 1995, the first new Durex ad to return to TV and cinema screens in 6 years was a raunchy new commercial featuring a semi-naked couple which was cleared by advertising authorities. Most opprobrium is now reserved for advertising of condoms for gay sex. In August 1998, an explicit advertisement aimed at promoting condom use among gay men was commissioned by the gay charity Rubberstuffers, promoting free packs of extra strong condoms and lubricants. It was shown by Channel 4 (a commercial TV channel known for a more intellectual approach to program making) for the first time in August 1998 as part of a series of programs called Queer Street, but was immediately branded as “offensive” by the National Viewers and Listeners Association. The Independent Television Commission, the body which regulates advertising standards, received around 30 complaints before the advertisement was ever transmitted, but the Broadcasting Advertising Clearance Centre (an ITC committee) cleared the ad provided it was shown after 11pm.

There is no policy forbidding the portrayal of homosexuality on television or in the press. The public is becoming increasingly concerned about swearing, rude gestures and sexuality in ads, accord-

ing to the Advertising Standards Authority. A survey showed that the number of people offended by gays and lesbians appearing in print ads has doubled since 1996.

Oral contraceptives, as medically prescribed products, cannot be advertised to the general public, only to the health care professionals through medical journals.

The female condom Femidom can be advertised, although not without controversy. In 1992, Alliance Advertising demanded compensation from the Daily Mail after the paper's eleventh hour decision to axe the first ad for the product following its launch. Scheduled to appear in all the tabloids and the Guardian, the advertisement was pulled on the instruction of the deputy editor. Persona, a commercially produced method of calculating the safe period, is also advertised for sale in newspapers, but is available only at Boots the Chemist, a large national chain, who have exclusive rights to the product.

The three taboos in relation to advertising used to be tampons, condoms, and funeral services. Condoms have been advertised on television since 1987, tampons since 1989. Today, only funeral services may not be advertised on television.

### **Young People's Socialization about Sexuality, Sexual Behavior and Sexual Responsibility** *Sources of Information*

The majority of young people, according to NSSAL data, receive information via friends and the media, but would prefer to receive it from teachers and the health care professionals. The criticism that not enough information is provided about personal relationships and sexual pleasure is common.

A 1994 survey by the National Foundation for Educational Research found that 94% of parents and 95% of young people felt that sex education should be taught in schools. Nevertheless, young people in Britain report gaining more sexual knowledge from such sources as friends and magazines than from school, parents or health care professionals, yet the latter are their preferred sources.

Research shows that parents are a more important source of sexual knowledge for young teenagers than older ones. A study involving 3,000 11–16-year-olds found that although a third of boys and nearly half of girls aged 11–12 said that their parents were their main source of information, this had dropped to 15% and 22% respectively by the age of 16. Friends, magazines, TV and films were a more frequent

source of information.<sup>18</sup>

Young people in England tend to be generally dissatisfied with their school sex education, many only referring to having learnt about bodily functions and contraception. Some are confused about their own and others' sexuality, and despite receiving a rounded and interactive school sex education program, they feel it focuses on preventing them from having sex rather than educating them about sexuality and relationships. Many also had very vague recollections of the content of school sex education suggesting that they may not have internalized its messages effectively.<sup>19</sup> Research also shows that young people in England have a narrow concept of sex education, and have to be prompted to talk about topics other than contraception.

Young people report wanting more information about AIDS, sexual relationships, feelings and emotions.<sup>20</sup> Nearly a third of 13–15-year-olds (more girls than boys) believed that sex education was provided too late for them.<sup>21</sup>

### ***Sex Education in Schools***

The 1998 Education reform Act (which was incorporated into the Education Act of 1996) requires that all maintained schools offer a curriculum which promotes the spiritual, moral, cultural, mental and physical development of pupils at the school and of society and prepares such pupils for the opportunities, responsibilities and experiences of adult life.<sup>22</sup>

Sex education, including information about HIV/AIDS and other STDs, is compulsory in all state maintained schools in England and Wales. State primary schools must decide whether to provide sex education in addition to what is in the National Curriculum. Parents have the right to withdraw their children from all or part of sex education except where this forms part of the National Curriculum. National Curriculum includes only biological aspects of HIV/AIDS, STDs and human sexual behavior, under section 405 of the Education Act. Sex education policies and practices are monitored by the Office for Standards in Education (OFSTED) as part of the schools' inspections. Only 85% of schools inspected in 1994 had produced a policy.<sup>23</sup>

The Local Education Authority (LEA) and the head teacher must ensure that sex education “is given in such a manner as to encourage those pupils to have due regard to moral considerations and the value of family life.” The “moral framework” of the National Curriculum encapsulates the British attitude towards

teenage sexuality. In 1994, the mandate was given that the national Curriculum should exclude any “sexual reference to HIV and AIDS, to any other sexually transmitted diseases and to aspects of human sexual behavior other than the biological aspects” (Circular 94/17). The British Medical Association AIDS Foundation asserted “the Department of Education guidelines on sex education in Schools will not promote the health of schoolchildren and runs counter to the Health of the Nation goals.”

That the focus of sex education in England and Wales has been to prevent pregnancies is reflected in the constant complaint that, because the prevalence of teenage pregnancy remains high, sex education has “failed” or is “not working”. Sex education in England and Wales is characterized by controversy surrounding its provision, a failure to acknowledge and react positively to teenage sexuality, and a desire to prevent teenage sexual activity.

Sex education policy is vulnerable to the whims of the wider moral and political climate and policy tends to be made in response to political pressure rather than educational imperative.<sup>24</sup> The influence of the anti-sex education lobby on public opinion is strong. Those who oppose the provision of sex education do so on the grounds that it encourages sexual experimentation, robs children of their innocence and is responsible for teenage pregnancies, despite evidence to the contrary. Opposition comes from organizations like the Family Education Trust. There is also much popular debate as to whether sex education, if given, should aim to prevent adolescent sexual activity as well as teenage pregnancy, abortion and the spread of STDs.<sup>25</sup>

As a result of the continued controversy over teenage sexuality and the provision of sex education, it has never been fully accepted or integrated into British society. Schools continue to bear the responsibility for providing sex education but are often criticized for what they do. A HEA sex education booklet *Your Pocket Guide To Sex* was widely condemned as “smutty” and withdrawn in 1994;<sup>26</sup> a Leeds school teacher was also condemned for the content of her sex education classes for 10-year-olds; and the recent publication of *The Primary School Sex Education Pack—A Whole Approach to Sex Education* produced by Healthwise received similar criticism.

Primary school sex education generally begins at age 10 or 11.<sup>27</sup> Since there is a statutory requirement that they should do so, given the inclusion of sex education in the National Curriculum, all English

children are required to receive sex education from school. Seventy-seven percent report that they have done so in practice, 57% in year 7, 81% in year 9 and 93% in year 11.<sup>28</sup>

### ***Other Sources of Information about Sex and Sexual Behavior***

According to some, the “silence around female sexual pleasure in all areas of formal and family sex education drives many young women to see alternative sources of information.”<sup>29</sup> Teenage magazines such as *Sugar*, *Bliss*, *More* and *Just 17* are an important source of sexual information in England and Wales. These magazines provide comprehensive and detailed coverage of a wide range of sexual, health and emotional issues. This is achieved through “problem pages”, “real life” and fictional stories. Examples relating to sex education include stories titled, “I felt more for my brother than was normal”; “You want love, he wants sex: what do you do?”; *Real Life*: “I didn’t know I was pregnant until I gave birth”; *Real Life*: “Mums a prostitute”; “I’ll do anything to get a lad: How far would you go?” Certainly, young people will find far more information specifically related to enjoyment in teenage magazines, as covered by such features as “position of the fortnight.”

However, in 1996, the Independent Publishing and Advertising Council (IPAC) the governing body of teenage magazines, was threatened with legal action if it did not ensure that a more responsible line was taken in their magazines. The action was started by Peter Luff, a Tory MP, who attempted to bring in a Private Members’ Bill obliging magazines to state an age limit for readership, below which newsagents would be prosecuted if they sold magazines to young women under that age. The Luff Bill failed to obtain a second reading, but magazine editors were obliged by IPAC to print health warnings in the pages of the magazines. The more hedonistic stories are accompanied by the reminder at the foot of the problem pages “Be sure, be safe and remember sex under 16 is illegal.”

The slogan is somewhat ambivalent in encouraging young women to take control over their own sexuality, but at the same time warning them of the constraints. Such contradictions are seen by some to be typical of teenage magazines and reflect the British attitude towards teenage sexuality.

A good deal of research is currently underway into the balance of power in teenage relationships.

Feminist researchers have revealed an imbalance of power favoring young men.<sup>30</sup> Research comparing young people's relationships in the Netherlands and in Britain has shown a greater tendency to segregation rather than solidarity in couples relationships in Britain, compared with the Netherlands. The provision of sex education in British Schools is characterized by a desire to find its origins in a marked distinction between childhood and adulthood. In the Netherlands, for example, there is by contrast, an almost unusual acceptance of teenage sexuality and sexual activity.

### **Interventions on Sexual Behavior and the Socialization of Adolescents about Sex** *Teenage Pregnancy Strategy*

A major initiative has been launched in 2000 to tackle the problem of teenage pregnancy. Recognition that the U.K.'s position was worsening vis à vis other nations led the government to set up a task force in the Social Exclusion Unit (SEU) to examine the problem. The SEU reported in June 1999. A Teenage Pregnancy Strategy was developed on the basis of the findings.

The main goals of the strategy are to:

- reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under 18s by 2010;
- getting more teenage parents into education, training or employment, to reduce the risk of long term exclusion.

The action plan for achieving these goals falls into four categories:

- a national campaign, including government, media, voluntary sector and others to improve understanding and change behavior;
- joined up action with new mechanisms to coordinate action at both national and local levels and ensure the strategy is on track;
- better prevention of the causes of teenage pregnancy, including better education in and out of school, access to contraception, and targeting of at-risk groups, with a new focus on reaching young men, who are half the solution, yet who have been overlooked group in the past;
- better support for pregnant teenagers and teenage parents, with a new focus on returning to education with child care to help, working to a position where no under 18 lone parent is put in a lone tenancy, and pilots around the country providing intensive support for parents and

child.

Other sections of this report contain details of other components. In this section, the "prevention" component is elaborated.

- attempts to improve prevention are founded on the premise that to reduce the teenage pregnancy rates, young people have to be prepared far more effectively for sex and relationships, ensuring that they have the means to deal with pressures to have sex before they are ready. Parents are recognized as vital to ensuring this happens, and need help in talking to their children, young men and groups at risk.

Specific measures include:

- new guidance for schools on sex and relationships education which helps young people to deal with pressures to have sex too soon, and encourages them to use contraception if they do have sex;
- new schools inspection and better training for teachers to bolster the new guidance;
- a new emphasis on consulting parents about what their children should be taught about sex and relationships, and practical help for them to talk to children about sex themselves;
- information campaigns to explain what support is available to parents in talking about sex and relationships with their children;
- local implementation fund for integrated and innovative programs (including peer mentoring) in high rate areas;
- new health service standards for effective and responsible contraceptive advice and treatment for young people;
- clear and credible guidance for health professionals on the prescription supply and administration of contraceptives to under 16s, including a duty to counsel them when they seek advice on contraception;
- a new national helpline to give advice to teenagers on sex and relationships and to direct them to local services;
- a national publicity campaign to tell young people they can talk to health professionals about sex and contraception in confidence;
- targeting young men with information about the consequences of sex and fatherhood including the financial responsibility to support their children;
- sex and relationships education in and out of school with particular attention to young men;

- getting social services to give priority to preventing teenage pregnancy for the children in their care;
- Young Offenders Institutions all offering parenting and sexual health classes;
- giving sex and relationships education to children excluded from school;
- improving the overall framework for 16–18-year-olds not benefiting from education, training or employment.

Funding of £60 million has been identified for the next three-year period.

## Part III. Reproductive Health Services for Adolescents

There is no apparent problem in Britain regarding the availability of services. One catalogue of sexual health services contains nearly 3,000 entries.<sup>31</sup> A HEA compendium contains information on different services dedicated to young people.<sup>32</sup> Nor are there barriers relating to cost, since contraceptive advice, information and supplies are available free of charge on the National Health Service (NHS). A clue to the real barriers can be found in studies of the reasons why young people delay seeking advice. These typically feature fears relating to confidentiality, reflecting the ambivalence in our society over provision for young people (see text and case studies in this section).

### *The Structure and Financing of Health Care*

In Britain, the NHS provides medical care to all, free of charge, funded by means of flat rate contributions (National Insurance) from the salaries of the workforce. There is a parallel private system of health care which increasing numbers of wealthier middle class members of the population are subscribing to, because of the long wait for treatment for many ailments on the NHS. No reliable data exists, however, on the scale of use of the private system because the private health care agencies are understandably wary of divulging data which could affect their market position. The proportion of people using private health care is, however, unlikely to affect the situation with regard to contraception which has been available under the NHS since 1976, and the prescription as well as the consultation is free of charge. Contraceptive services for young people do not differ from those for older members of the population, with regard to cost and payment.

A woman may go to a family planning clinic for contraceptive advice and treatment or she may go to a general practitioner. The two services are funded quite differently. Community family planning clinics are funded from central government funds devolved

to local health authorities, who have considerable autonomy in terms of how they spend their money. In different parts of the country, or even in neighboring communities, the emphasis in terms of priorities can vary considerably. This means that family planning clinic provision across the country can be quite patchy and there have been swathing cuts in family planning clinics in the past decade.

General practitioners (GPs) are reimbursed according to a fairly complicated procedure. GPs get an “item-of-service” fee for ordinary contraception i.e. oral contraception and an intrauterine device (IUD) fee.

In addition, an annual fee is paid in four quarterly installments for a female NHS patient, where the GP:

- gives advice, carries out an appropriate examination, prescribes a form of contraception and provides follow-up care;
- gives advice and follow-up care on rhythm methods and condoms;
- counsels before referral for cap fitting or insertion of an IUD in a district health authority clinic. The claiming GP is responsible for after care;
- counsels before tubal ligation;
- counsels a woman whose male partner is considering a vasectomy.

A fee can be claimed by a GP if he or she fits an IUD and provides any necessary follow-up. No other fee for contraceptive services can be claimed for 12 months.

Figures for the total spend on contraception are difficult to collate, and hence somewhat unreliable. Periodically, when someone asks a question about contraceptive spending in the House of Commons, the data are made available. The calculations are an aggregate of health authorities’ expenditures on family planning services and estimated net costs of contraceptive drugs prescribed by GP’s and dispensed by retail pharmacy and appliance contractors.

**Table 5. Estimated total expenditure on contraceptive provision in England**

Year	£ million at 1992–93 prices
1979-80	65.7
1980-81	66.4
1981-82	70.8
1982-83	69.6
1983-84	75.0
1984-85	75.1
1985-86	75.7
1986-87	79.4
1987-88	83.7
1988-89	79.6
1989-90	83.1

Source: Hansard 14/12/92 Vol 216 (94)

### Sources of Health Care Services for Adolescents

In recent years there has been a move towards increasing the provision of sexual health services for young people. The trend has been partly driven by the high rates of teenage pregnancy in Britain compared with the rest of Europe. The need to inhibit the transmission of HIV has further motivated efforts to improve sexual health provision and to improve cost effectiveness. It has been given further momentum by the setting of Health of the Nation targets in this area.<sup>b</sup> An estimated 85% of Regional Health Authorities (RHAs), have set up young people's sexual health services as a direct result of that initiative.<sup>33</sup> As a result, young people currently have access to sexual health services in a number of different settings.

### General Practitioners (GPs)

GPs do not keep records of clients by age and the claim forms submitted by general practitioners to family health service authorities for contraceptive visits only differentiate between fitting of an IUD and all other forms of contraceptive advice. A survey for the Family Planning Association, however, found that for 68% of a sample of 16–24-year-olds, GPs were the first port of call to discuss contraceptive use. In

<sup>b</sup> The publication of the Health of the Nation White Paper focused on sexual health and set targets and objectives for STDs and conceptions to under 16s. The targets were a reduction in the incidence of gonorrhoea among men and women aged 15–64 by at least 20% by 1995 (from 61 new cases per 100 000 population to no more than 49 new cases per 100 000) and a reduction in 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).

addition, 54% of 16–24-year-olds said they would prefer to talk to their GP if they had difficulties using their contraceptive method.<sup>34</sup> A survey of teenage girls (aged 16–19) registered at GP practices in the Southwest of England showed that more than half had consulted their GP for contraceptive advice.<sup>35</sup> The increasing use made by young people of their GP for sexual health services reflects a number of factors. The workload may reflect a restoration of faith in the family doctor, after the possible loss of trust caused by the Gillick campaign in the early to mid-1980s. To ensure the continuation of this trend, it has been recommended that GPs should target their services for teenagers.<sup>36</sup> Some GPs are now providing specialist sessions for young people.<sup>37</sup> Despite the increasing number of young people making visits to their family doctor, issues relating to confidentiality are still, apparently, a deterrent.

### Family Planning Clinics<sup>c</sup>

Attendance by women under 20 at family planning clinics in England has been increasing steadily in recent years (except for a brief period in the three years following the Gillick case in 1983). The number of teenagers visiting community family planning clinics in England has nearly doubled since 1990. In 1996–97, approximately 10% (59,000) of women under 16 and nearly 20% (220,000) of women aged 16–19 used the clinics. An additional 6,000 women under 16 and 19,000 women aged 16–19 used Brook Advisory Centres. These figures represent 10% and 19% respectively of the total resident population of those age groups. In 1975, the corresponding figures were 8,000 women (1.1%) aged 16 and 207,000 (15.9%) of 16–19-year-olds.

Figure 1 (see page 24) shows clearly the steady increase in the proportion of teenage women attending for first visits, suggesting the increasing importance of family planning clinics as a source of contraceptive advice for young women. A recent survey of contraceptive services in London showed that approximately 17% of the total family planning clinic hours per week in London are designated specifically for young people's services.<sup>38</sup> Data were collected for the first time in 1994–95 disaggregating under 16s into those who were aged 15 and those under age 15. An estimated 41,000 women aged 15 attended i.e. about 14% of the total population of that

<sup>c</sup> All the data in the following section were obtained from: DoH Family Planning Clinic Services, summary information for 1995–96, England

age. The corresponding figure was 20,000 for those under age 15 i.e. representing 7% of the total female population aged 14.<sup>39</sup>

Reviews of those attending family planning clinics show sizeable proportions to be at risk of infection.<sup>40</sup> The Department of Health has also recognized that an appropriately organized range of family planning services has the potential to play a part in combating sexually transmitted infection.<sup>41</sup> Another DoH circular (EL(90)MB115) stated “clinics can provide condoms for contraceptive and other prophylactic uses and authorities may want to consider the role of family planning clinics in local HIV prevention programs.” Further evidence of the expanding role of family planning clinics can be seen in client reasons for attending clinics. The proportion of clients at family planning clinics receiving condoms has risen dramatically from only 6% in 1975 to 32% in 1995–96.<sup>42</sup>

While the client group most often seen at family planning clinics are young single women, among GP

providers the largest client groups are women (other than teenagers) without children, and women who have children and wish to delay or space future pregnancies.<sup>43</sup>

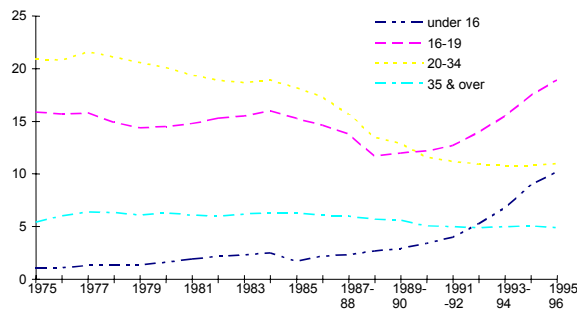
The Brook Advisory Centres are specifically designed for young people up to the age of 25, though regular clients may be kept on beyond that time if the need exists. In addition, a large number of dedicated sexual health services for young people are being set up around the country.

**Genito-urinary Medicine (GUM) Clinics**

Young people also have access to sexual health services through traditional GUM clinics. Such clinics are based on self-referral and are usually operated on a walk-in basis. Several clinics now hold sessions which are specifically dedicated to young people. There is also increasing liaison between GUM and family planning clinics.<sup>44</sup> A recent survey of 254 GUM clinics showed that 71.4% of clinics provided emergency contraception, 48.1% provided

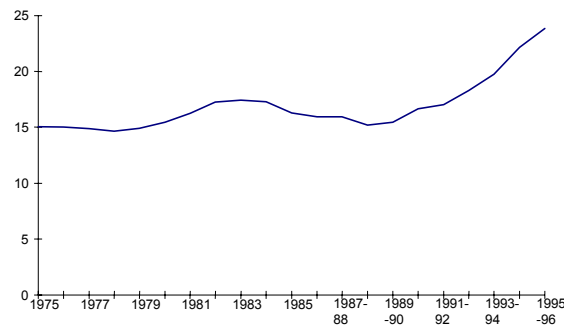
**Figure 1**

Percentage of female population attending family planning clinics by age, England, 1975 to 1995/96



**Figure 2**

Proportion of all first contacts (female) who were aged under 20 at family planning clinics. England 1975 to 1995/96



Source: Family Planning Clinic Services, Summary Information 1995-96 England Government Statistical Service Department of Health

**Table 6. Family planning clinic activity, England, numbers and percentages**

	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99
Women seen (1000s)	1,081	1,095	1,129	1,160	1,182	1,191	1,179
Women seen (rate per 100 pop)							
Total all ages	10.5	10.8	11.1	11.4	11.6	11.7	11.6
Under 16	3.8	4.9	6.4	7.2	7.4	7.6	7.4
16-19	15.2	16.8	18.8	20.3	21.5	22.2	22.1
20-24	14.2	14.5	15.2	16.2	16.9	17.5	18.3
25-34	9.9	9.7	9.3	9.5	9.5	9.4	9.2
35 and over	7.4	7.5	7.9	7.6	7.4	7.4	7.0
Prescription of EC: occasions (1000s)	70.4	85.0	104.6	149.3	198.7	210.2	217.5

general contraception, 88% of those who responded (202/206) provided free pregnancy testing and 65% of those who responded (195/206) provided direct referral to abortion services.<sup>45</sup> Family planning provision varies between clinics; most clinics provide condoms and emergency contraception and some provide female condoms.

### ***Young People's Advice Centres (YPACs)***

An increasing number of YPACs have been established recently, normally offering generic advice in a variety of areas, and referrals to specialist services. Research has shown great demand amongst young people for facilities which offer a range of services and not just those which fall strictly within the remit of sexual health. West J et al. for example asked clinic users what other services they would like to see provided and respondents expressed a desire for services on relationship counseling (66%), family problems counseling (60%), other health risks (59%), other worries (54%), drugs information (53%) and smoking information (37%).<sup>46</sup>

YPACs have appeared largely as a response to research which has recommended that services for young people need to be designed to meet users' needs in an environment which is acceptable to young people, appealing to young people, particularly by avoiding the "clinical" atmosphere often associated with hospitals and hospital-based care.<sup>47</sup> These centers have a diversity of service organization with many providing outreach services which are felt to be particularly appropriate for reaching the young people who would otherwise be reluctant to access services themselves.

### ***Integrated Services***

A number of centers are now emerging in which family planning and GUM services are completely integrated. Integrated services are thought to be of particular importance to young clients as there is evidence that consumers appreciate the advantages of a one-stop service providing coordinated sexual health care.<sup>48</sup> Indeed, studies have shown that there is an expectation on behalf of consumers that staff will counsel them in all areas of sexual health.<sup>49</sup> There is also evidence that young people experience many practical difficulties in accessing appropriate sexual health care. They may not decode the meaning of family planning when they have no immediate interest in producing a family and may have little understanding of what GUM means.

### ***Abortion Services***

Abortion services, like family planning services, are available to young people free of charge through the NHS. In practice, the provision of abortion services is patchy across Britain. Abortion numbers vary markedly with type of area. In the poorest areas, young women tend to have fewer abortions. Generally, disapproval of abortion increases with decreasing socioeconomic position. For less advantaged women, the stigma of abortion is likely to outweigh apprehension about the idea of raising a child on their own.

The same conditions apply to under 16-year-old women as for contraception, i.e. every effort must be made to persuade a young woman to inform her parents, but where these efforts are not successful, the practitioner may, if she or he deems the young woman capable of understanding the consequences, carry out a termination.

### ***Use of Contraceptive Methods and Availability of Contraceptives to Youth***

The condom is the most commonly used method at first intercourse and its use has been increasing over recent years. About a half of men and women aged 16–24 report using a condom when they first had sexual intercourse, compared with little more than a third of other groups.<sup>50</sup> The most dramatic increase in use began in the mid-1980s.

Overall, oral contraceptives and condoms are the most popular methods among young people in Great Britain. Twenty five percent of 16–17-year-olds and 37% of 18–19-year-olds use the pill, while 13% and 26% respectively use condoms.<sup>51</sup> Primary methods of contraception differ for women in different age groups. In 1995–96, oral contraception was the primary method for about 60% of women aged 16–19 or 20–24, about 50% of women aged 25–34 and about 35% of women aged 35 and over. The condom accounted for about 30% in each of these age groups. Interestingly, about half the clients at family planning clinics in 1995–96 aged under 16 were advised to use oral contraception and half the condom, suggesting that family planning clinics are most important to this age group as a source of wider sexual health advice and supplies. Only if condoms or spermicides are bought in commercial outlets such as pharmacies or vending machines, must they be paid for. Otherwise contraceptive provisions are available free of charge.

Data suggest that the use of emergency contraception by teenagers has increased in recent years. The

number of occasions when emergency contraception was provided to women under 16 in family planning clinics in England increased from 3,000 in 1990–91 to nearly 20,000 in 1996–97, and from 15,000 to 66,700 for women aged 16–19.<sup>52</sup> If all Brook Advisory Centres are included, the 1996–97 figures are 22,300 and 76,100 respectively.

**Services for Young Men**

General practitioners do not appear to offer contraceptive services for men and only a very few practices in London have free condom schemes.<sup>53</sup> Furthermore, specific fees to GPs have only ever been payable for contraceptive services provided to women patients. GPs do give advice to men on family planning and may provide counseling to their patients. Yet in Paragraph 29.1 of the Statement of Fees and Allowances (the “Red Book”) gender is specified. Paragraph 2 defines contraception services as “the giving of advice to women on contraception, medical examination of women seeking such advice, the treatment of such women and provision for the supply of such women of contraceptive substances and appliances.”

Interestingly, the number of men attending family planning clinics has been increasing in recent years although this information is not available by age group. The number of first contacts by men was about 20,000 per year until the mid-1980s and then climbed to over 30,000 by 1987–88. In the early 1990s the number started to rise again and in 1995–96 there were 67,000 first contacts recorded. This is illustrated in Figure 3.

These figures may also under-represent the numbers of men utilizing this service as many more

clinic contacts with men will be as part of a couple where the woman is registered as the first contact. Although it is encouraging that men are now beginning to use family planning services, men nevertheless account for only 7% of family planning clinic clients in London.<sup>54</sup>

Young fathers have been the subject of some blame in official policy changes. As part of Tony Blair’s “moral crusade,” teenage fathers are to be specifically targeted by the Child Support Agency (CSA) which has been ordered to make it a priority to pursue the fathers of babies born to teenage girls. This could cost them up to a quarter of their income for 18 years. Downing Street has said that boys who fathered children when they were under 16 would be “pursued vigorously” by the CSA. These changes were included in a Child Support Agency Bill in the Queens speech in November 1999.<sup>55</sup>

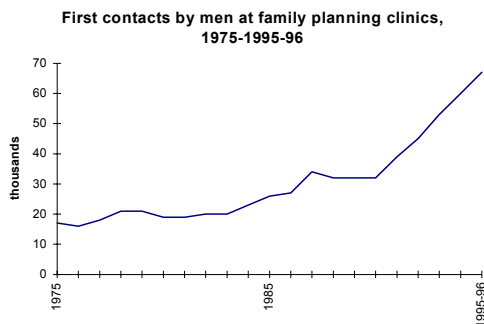
A study of 40 fathers aged 16–24 suggest that the image of teenage fathers as reckless and irresponsible is not borne out by the facts. They wanted to become involved, but little effort was made to encourage them to develop and maintain involvement, they did not feel welcome at family support groups, and mothers were often reluctant to involve them.<sup>56</sup>

**Delivery of Messages that Encourage Responsible Sexual and Reproductive Behavior  
Public Education Campaigns**

Until 1987, condom advertising on British TV was forbidden, but the need to feature condoms in AIDS campaigns forced a change in the regulations. The government’s Safer Sex campaigns of the late 1980s featured condoms.

Condom advertising is also carried out by commercial condom manufacturers, and Durex ads were common in the mid-to-late 1980s. In January 1995, a new Durex ad returned to TV and cinema screens—the first in 6 years, but this was motivated more by commercial than public health concerns. The Durex brand name was registered in 1929 by the London Rubber Company (LRC) now known as the London International Group. The company’s condoms were first imported from Germany, and a manufacturing plant was set up in Britain in 1932. Although LRC had a monopoly on British sales, and was brand leader with 95% of the market in 1982, a decade later, in 1993, the company had only 75% of the market. LRC has often been accused of encouraging sexual promiscuity. It has countered this by developing sex education leaflets and producing

**Figure 3**



Source: Family Planning Clinic Services, Summary Information 1995-96 England Government Statistical Service Department of Health

information on how to prevent STDs.

The female condom can be advertised, and advertisements for Femidom have appeared in the women's press. There have, however, been complaints. One irate doctor complained that one of the posters was on a school bus route and a national newspaper refused to carry the ad. The first ad for the launch of the new female condom had been scheduled to appear in all the tabloids and the Guardian in 1992, but was pulled by the Daily Mail's editor. Editors have complete control over what appears in their papers. Alliance Advertising demanded compensation from the Daily Mail.

Most opprobrium is now reserved for advertising of condoms for gay sex. An explicit advertisement aimed at promoting condom use among gay men commissioned by the gay charity Rubberstuffers, to promote their free packs of extra strong condoms and lubricants was shown by Channel 4, a commercial TV channel known for a more intellectual approach to program making. It was shown for the first time in August 1998 as part of a series of programs called Queer Street. It was immediately branded as "offensive" by the National Viewers and Listeners Association. The Independent Television Commission, the body which regulates advertising standards, received around 30 complaints before the advertisement was even transmitted. It was cleared by the ITC provided it was shown after 11pm.

Each year, the British Safety Council, a registered British charity runs a safer sex campaign during National Condom Week. In 1995, this campaign used a picture of the Pope wearing a hard safety helmet and looking thoughtful and the words, "Eleventh Commandments: Thou shalt always wear a condom." *The Universe*, a Catholic weekly newspaper, described the campaign as an insult to the Pope and "deeply offensive to Catholics." A council spokesperson said that the aim of the flier was to make people think about the fact that the Catholic church is directly responsible for the spread of sexually transmitted diseases, as well as unwanted pregnancies among societies which accept its stance on contraception.

Reference to the public sale of contraceptives is made in the For Good Rule and Government and the Prevention of Nuisances by-law 1951. Section 35 of the Act says it is an offense to sell contraceptives from an automatic machine in any street to which the public has right of passage—and this includes forecourts. Under this by-law, offenders could be

fined up to five pounds for a first offense, and 40 shillings (£2) per day, for continuing offenses. Attempts have been made recently to repeal this by-law. In 1995, the first step to allow street corner condom machines to be put in place was taken by Bristol City counselors. Approval was needed from the Home Office to repeal the by-law, but they were fully in favor of doing so. Councils in Woodspring, Cardiff, Plymouth and Nuneaton have also repealed by-laws banning condom machines, and Nuneaton installed one in bus shelter in July 1992.

It is rare for schools in Britain to have condom machines or contraceptive facilities on school premises and this would only happen in the most liberal and progressive authorities (see Case Study 2 below).

### ***Outreach Education Encouraging Male Use and Involvement in Use***

There have been sporadic attempts to increase male involvement in contraception, mainly by NGOs. In 1983, the U.K. Family Planning Organisation ran a "Men Too" campaign, using famous men, such as footballer Justin Fashanu, to promote and endorse the male message. Two years later, the International Planned Parenthood Federation in London also mounted a program to increase male involvement. More recently, Brook Advisory Centres have launched an initiative to heighten young men's involvement. Efforts will be stepped up from 2000 onwards, because of the government's Teenage Pregnancy Strategy which focuses on young men.

### ***Discussion of Contraceptive Use by Media Personalities***

The U.K. Family Planning Association has tried hard, with varying degrees of success, to persuade television producers to incorporate messages about contraceptive and condom use. We have a large number of soaps: Brookside, East Enders, Coronation Street, which are generally relatively publicly spirited and do introduce health related messages, particularly with regard to cancer screening, infertility, etc. Contraceptive messages have not, however, been greatly in evidence.

### ***The Nature of Public Messages***

It is difficult to generalize about messages. We do not have deliberately sex negative messages as, for example, in "just say no campaigns." However, it is important to note that, in Britain, we cannot rely on

consensus in relation to public messages. We have a vociferous minority of self-appointed moral guardians to the nation, and everyone, from government ministers down to the press, is conscious of their power. There are many examples cited in this section of mixed messages being transmitted to young people.

One issue which should be noted is the teen media, and its gender-specific nature. Young women's magazines (*Bliss*, *More*, *Just 17*, etc.) convey a tremendous amount of sex positive information to young women, and have no counterpart in young men's culture.

### **Policies and Intervention Programs** ***North of England Initiatives***

In the North East of England, which has the highest pregnancy rate among under 16s in the country, the health authorities have been piloting a number of initiatives to try to tackle the problem. These include:

- *After school health club.* An after school health club, open to all pupils from 11 onwards, provides information and advice on sex and contraception. Gateshead Health NHS Trust set up a weekly clinic for 11–18-year-olds. A classroom at Hookergate Comprehensive School, Tyneside has been converted into a health advice center where pupils can get confidential information on issues including contraception. Doctors offer pupils pregnancy tests and advice on all aspects of health, and dispense contraceptives after careful counseling. The project was aimed at cutting the high number of teenage mothers in the area around the 900 pupil Comprehensive School. The plan to issue condoms and contraceptive pills from the health clinic in the secondary school playground is the first such initiative in Britain. The decision was taken after pupils at the school were asked what health guidance they needed, and advice and information featured prominently in their replies. This pilot scheme, if successful will be rolled out further.
- *Electronic baby dolls.* In County Durham and on Teeside there are proposals to let girls and boys take home life-size electronic dolls which cry to show young people the reality of having a baby.
- *Raising girl's self-esteem.* Efforts are being made in County Durham to boost the self-esteem of young girls through counseling sessions aim at encouraging resistance to pressure to have sex.
- *Contraceptive access.* On North Tyneside, teenagers have been issued special plastic cards to obtain

contraception without seeing a doctor at clinics across North Tyneside.

### ***Welsh Helpline***

A cheap-rate telephone helpline offering contraceptive advice to teenagers has been launched in Wales. The advice line, run by the Family Planning Association, aims to help cut the number of teenage and under-age pregnancies in Wales, currently running at 4,000 per year. The Family Planning Association helpline costs only a local charge rate, with what is described as a user-friendly number (0845 600 1213). The sexual health advice service is available from 9am–5pm, Monday to Friday, and is to be expanded to include “teen-friendly” hours such as early evening.

### ***Sexual Health Service in Boots the Chemist***

In October 1998, a pilot project, a joint venture between Boots and the Glasgow Health Trust, was set up to run a twice weekly “drop-in” clinic at the Boots store in Glasgow's St Enoch's Centre at which young people could seek advice and information. The clinic offered free advice and contraception—including the morning after pill.

Family planning agencies endorsed the project. The Family Planning Association of Scotland said: “This is a brave initiative and a great step forward in providing services which truly meet the needs of the young people in a place where they feel comfortable.” The Family Planning Association of London issued a press release: “Boots and the Trust are to be commended for their spirit of pragmatism and report for young people. We would like to see similar initiatives across the U.K.”<sup>57</sup>

Elsewhere, however, the project provoked a heated debate.<sup>58</sup> The Chemist, in Glasgow's St. Enoch Centre, was subjected to a barrage of threats after launching the young people's clinic, a joint venture between Greater Glasgow Health Trust and Boots in October 1999. Staff were subjected to streams of hate mail and threats from extremist groups. Protesters sent a fake fetus in a bottle to staff at Boots head office, launched a malicious hate mail campaign and picketed the store on weekends. Security professionals had to be consulted on how to safeguard workers.

In the press too, the scheme produced an outcry, and totally contrasting points of view. Yvonne Roberts in *The Guardian* (2/12/98), under the headline “Too young to unwrap a condom” asked

“What’s my response as the mother of a teenage girl to the news that Boots in Glasgow is offering free confidential contraceptive advice to 13-year-olds and up? Yes, yes and yes.” In contrast, Lynda Lee Potter, writing in the *Daily Mail* (2/12/98) complained of “This dogma that blights girls’ lives,” adding “I find it depressing, destructive and defeatist.”

*The Mail* carried a front page headline: “School-girl sex clinic at Boots” (1/12/98) in which campaigner Victoria Gillick was quoted as saying “Pharmaceutical companies must be rubbing their hands in glee at this, but it will do nothing to help vulnerable children.” *The Guardian* (“Boots offers birth control to the young;” 2/12/98) reported the reactions of the anti-abortion charities, who called for a boycott of Boots, as did *The Times* (2/12/98) “Pro-lifers call for boycott of Boots.” Life was quoted as saying “It is disgraceful that Boots are promoting under-age sex that will undoubtedly result in more abortion and an increase in sexually transmitted diseases.”

GPs also condemned the scheme. The Glasgow Local Medical Council Secretary and General Practice Committee member said there had been no consultations with local GPs, and feared the store might be breaching prescribing regulation. There were accusations that the Greater Glasgow Family Planning and Sexual Health Services were gaining financially from it, which was not the case. Father Danny McLoughlin, spokesman for the Roman Catholic Church in Scotland, said he was shocked.

Not surprisingly, the year-long pilot was not extended. Again, the case study illustrates clearly Britain’s problem with regard to services for the young. Health care provision cannot be bettered, but the views of this vociferous minority, who have the ear of the right wing press instill such fear and terror into the hearts of providers that they are reluctant to take any initiatives for fear of such reprisals and rebuffs.

### ***School for Teenage Mothers, Ashlyns School, Newcastle***

This school, opened 15 years ago, is one of a very small number in this country in which young pregnant mothers may continue their education. It currently accommodates 25 pupils between the ages of 14–17. On average pupils at the school start when they reach their 20<sup>th</sup> week of pregnancy, continuing their school work until the legal age to leave at 16. The school is legally obliged to look after the

education of girls only up to 16 years, though in practice they are allowed to stay on after their 17<sup>th</sup> birthday.

The headmistress may be present at the birth if the girl has no partner to support her. Faced with the choice of having a crèche where the girls could leave their children when they attended lessons, or letting them keep them beside them as they were taught, the school opted for the latter. If the birth of their child happened when they should have been sitting for their General Certificate of Secondary Education (GCSE) they will take them one year later.

The atmosphere is informal and flexible. Girls sit on comfortable chairs with their babies beside them. Teachers and staff call one another by their first names. There is no blackboard. Toys and games are provided. The atmosphere is nevertheless academic and the emphasis is on exams. No evaluation has been undertaken.

### ***Case study: APAUSE***

This is probably the closest in Britain to an abstinence-based sex education program, though it rather imperfectly meets that description. The instigators received funding on the understanding that this goal would be pursued. There was, however, some doubt over whether those responsible for executing the program were convinced that this goal was appropriate. The intervention was piloted in comprehensive schools in Devon in the South West of England, an essentially rural area. School children were taught from ages 12–16.

The experimental program of sex education consisted of 25–30 one hour lessons delivered to secondary school students, mostly in national curriculum years 9 (13–14 years) and 10 (14–15), and evaluated in year 11 (15–16). The program team, a doctor and a senior teacher, directly taught six lessons, providing training and support for the school’s own teachers in delivering part of the intervention (15–20 lessons) and trained and supervised peer leaders (four sessions).

The content incorporated strategies identified as potentially successful from a review of health educational literature and projects. Subjects covered included puberty, reproduction, contraception, and negotiation in relationships. Including training in assertiveness skills. The emphasis on avoidance of risks came not from instruction but from “empowered” personal choice gained through involving young people in role play and group work.

The evaluation showed that students in the intervention group were more likely to be knowledgeable about contraception and STDs, less likely to think that sexual intercourse was beneficial to them, and less likely to report sexual activity.

Question marks must be raised over the replicability and generalizability of this intervention. Firstly, questionnaires probing knowledge, attitudes and behavior were completed under “examination conditions,” and supervised by the research team and other trained medical staff. This may have increased the social desirability bias, with students’ responses being influenced by the presence of the program staff. Secondly, this was not a strictly controlled evaluation with a control and exposure group. So popular was the program seen to be, that the program staff were under strong pressure to allow non-participating schools to use it, which on occasions they were unable to resist. Thirdly, the originators, Fran Phelps and Alex Mellanby were extremely committed educationalists and physicians. They adopted an anti-authoritarian approach, which may have counteracted the implicit message the program was intended to carry. They themselves state explicitly their antipathy to the authoritarian approach taken in some North American programs.<sup>59</sup>

## Part IV. Public Policy and Programs for Disadvantaged Groups

### Extent of Inequality and Disadvantage

Inequalities in status are deep-rooted in British social life. Recognition of this, and attempts to demonstrate inequalities in an unequivocal way, have a long history in this country. The dividing up and labeling of the various strata of society has been common since Charles Booth devised an eight-fold division of the population of London, ranging from 18% of “middle class” at the top to the 1% of “loafers,” drunkards and semi-criminals at the bottom. The current system, based on occupational status, rejects these moral overtones, but still raises many problems and contains many anomalies. Increasingly, research shows that social inequality is complex, perception of deprivation is relative and what appears from the outside to be homogenous, is, when viewed from the inside, highly differentiated.

A number of different measures can be used as indicators of socioeconomic position. These include occupation, amount and type of education, access to or ownership of various assets, and indices based on residential area characteristics. Despite the reasoned debate as to which of these is most satisfactory, the choice of measure is often dictated by what is available. In Britain, occupational social class is most

frequently used; Table 7 shows examples of the occupations in each social group.

Both class I and class V cover only a small proportion of the population at the extremes of the social scale. However, social deprivation cannot be adequately measured by taking one factor in isolation. Factors relating to disadvantage tend to compound one another in effect. The quality of the social environment is worst, for example, when financial deprivation is compounded by the difficulties of life in the inner cities. Similarly, in Britain as a whole, there are “black spots”—pockets of old manufacturing industry, especially in the North, where prospects are poor, where skills relate to a former material livelihood economy, and where traditional sub-cultural values are strong and persistent (for example, the tendency to start childbearing early). In terms of health status, these areas are especially vulnerable. Analysis of the NATSAL I 1990 data, for example, in the context of teenage pregnancy, showed area of residence to be the strongest socioeconomic variable, in terms of determining whether young women became mothers before the age of 20. After controlling for residential area, the effect of social class on likelihood of teenage motherhood was weakened to the point of being no longer statistically significant.<sup>60</sup>

**Table 7. Occupations within social and class groupings**

Social Class	Men	Women
I Professional	8%	3%
II Intermediate	27%	23%
III Skilled non manual	12%	31%
III Skilled manual	27%	7%
IV Partly skilled	14%	16%
V Unskilled manual	10%	16%
Other (armed forces, not stated and no work past 8 years)	10%	16%

Source: Social Trends 2000

### Income Distribution

Over the past twenty years, household disposable income per person has grown both in actual and real terms. Between 1961 and 1994, average household disposable income (in real terms) rose by 72%. However, this has not been experienced to the same extent across the whole of the income distribution. The median real household disposable income, before housing costs, rose over the period 1961 to 1994 from £136 per week, to £234 per week. The top

decile point more than doubled, from £233 per week to £473 per week. The bottom decile point rose by 62% from £74 per week to £119 per week.

The proportion of people whose income is below average has been about 60% for the last 35 years. However, the proportion of people below half of the average income (the European Union definition of poverty) has grown over this period from 10% in 1961 to 20% in 1991. It has decreased since then and was at 17% in 1995.

**Education**

Since the early 1970s, the proportion of children aged 3 or 4 who attend school has tripled from 20% to nearly 60%. This proportion varies from 84% in the North East, to 43% in the South West. In 1997, 16% of men and 21% of women of working age had no qualifications. There are large differences in educational attainment between residential areas (Table 8).

**Table 8. School leavers' examination achievements by gender and region, no qualification achieved (ie. no graded results)**

	Males	Females
U.K. (Whole)	7.1	6.0
North	7.7	5.9
Yorkshire & Humberside	7.9	7.5
East Midlands	4.6	4.3
East Anglia	5.0	5.9
South East	5.3	5.0
South West	3.4	2.3
West Midlands	6.5	4.7
North West	7.0	7.0

**Employment**

The seasonally adjusted unemployment rate for those aged 16 and over stood at 6.2 per 100 in the summer of 1998, almost three times the level 30 years ago. Youth unemployment is still at higher rates now than it was in 1991 and unemployment rates are four times higher among unskilled workers than among professional groups. Rates of unemployment among all ethnic minority groups are higher than among the white population, and are particularly high among black men, and Pakistani and Bangladeshi women.

**Housing**

Conditions of the housing stock vary considerably. In 1996, about 14% of all households were living in poor conditions. About 8% of dwellings in England

**Table 9. Unemployment rates, by ethnic group, Great Britain, Winter 1997-98**

	Percentage Men	Percentage Women
White	6.5	5.0
All minority ethnic groups	14.1	13.1
Black	20.5	14.8
Indian	7.4	8.4
Pakistani/Bangladeshi	15.9	22.1
Other	15.0	14.0

Source: Office for National Statistics

were unfit, and about 7% of households were living in unfit dwellings. The proportion of households in unfit dwellings varied with the type of tenure. In urban areas, 8% of dwellings were deemed unfit whereas in rural areas, 5% were deemed unfit.

Recent research suggests that, in addition to the ill effects due to absolute poverty, societies in which there is a wide gap between the rich and the poor suffer additional social problems, for instance, through high rates of violence and crime, and truancy.<sup>61</sup>

**Effect of Inequality on Health**

In England, although information based on an occupational definition of social class has been available since 1921, other data identifying differences in longevity by position in society have been available for at least two hundred years. Despite the dramatic fall in mortality rates in the last century, social differences have not only persisted, but increased.<sup>62</sup> Inequalities in health exist, whether measured in terms of mortality, life expectancy or health status; whether categorized by socioeconomic measures or by ethnic group. Patterns of inequality vary by place, gender, age, year of birth and other factors, and differ according to which measure of health is used.<sup>63</sup> There are seemingly intractable class differentials in every health-related condition, whether it be teenage pregnancy, dental caries or perinatal mortality. Although every cause of death has its own pattern, overall mortality rates still rise regularly from social class I to social class V.

Over the last twenty years, death rates have fallen among both men and women and across all social groups.<sup>64</sup> Again, the difference in rates between those at the top and bottom of the social scale has widened. For example, in the 1970s, the mortality rate among men of working age was almost twice as high for

those in class V (unskilled) as for those in class I (professional). By the early 1990s, it was almost three times higher (Table 10). This increasing differential is because, although rates fell overall, they fell more among the high social classes than the low social classes. Between the early 1970s and the early 1990s, rates fell by about 40% for classes I and II, about 30% for classes IIIN, IIIM and IV, but by only 10% for class V. So not only did the differential between the top and the bottom increase, the increase happened across the whole spectrum of social classes.

**Table 10. Standardized mortality rates, by social class, selected courses, men aged 20–64, England and Wales, selected years, all causes, rates per 100,000**

Social class	1970–72	1979–83	1991–93
I Professional	500	373	280
II Managerial & technical	526	425	300
IIIN Skilled (non-manual)	637	522	426
IIIM Skilled (manual)	683	580	493
IV Partly skilled	721	639	492
V Skilled	897	910	806
England & Wales	624	549	419

Recent efforts to compare the level and nature of health inequalities in international terms indicate that Britain is generally around the middle of comparable western countries, depending on the socioeconomic and inequality indicators used.<sup>65</sup>

The Acheson report on inequalities in Britain made some important policy recommendations which have relevance beyond the national context of England and Wales. The authors of the report made the point that a focus on disadvantage opens up a range of policy options. Policies to reduce social inequalities and to promote social networks are as important a part of a strategy to reduce inequalities in health as are improvements in the material environment of disadvantaged communities. These include, for instance, policies which reduce unemployment in areas of social need, those which improve the availability of social housing for families close to their social networks, the provision of family support services which help parents protect their children from the effects of disadvantage, freedom from prejudice or discrimination, a respect for individual worth and a sense of belonging to society. The idea of providing positive discrimination in favor of those at greatest need has been advanced as the only solution to the problem.<sup>66</sup>

### Public Attitudes toward Benefits for Disadvantaged Groups

In 1981, the Black report was published on social class differences in health. This was clearly a great embarrassment to the government and only 200 typewritten copies of the report were disseminated. Wider dissemination was suppressed, though a Penguin Publications version of the report, edited by a journalist, was published in 1981. Six years later, Margaret Whitehead produced a follow up report under the aegis of the Health Education Council, a quasi-governmental agency responsible for health education, showing that social differences had increased still further. Not only was publication of the report suppressed, but this was widely held to be one of the factors which led to the demise of the old HEC in July 1987, and its transmutation into the HEA under direct governmental control.

Initiatives to explore the health-related implications of social inequality were undertaken during the Conservative administration, in the mid-1990s, but the terminology used was social variations. Not until the Blair administration came to power in 1997 were inequalities back on the social and health agenda. Then, the arguments went one further, and the term social exclusion was embraced, the first time in Britain that it had been publicly acknowledged in policy documents that a minority of people were barred, by dint of their social and material position, from the benefits in life enjoyed by the majority.

Such political differences of perspective still persist, however, and are reflected in media coverage of issues. In the right wing press, there are numerous and regular scrounger-bashing articles, deploring the financial support by the left/right government of certain groups in society. The stereotypical target of such attacks are work shy unemployed people who are accused of taking up social or council housing and driving expensive cars. The object of such attacks are also very often likely to be teenage mothers, who are accused of becoming pregnant in order to secure social or council housing.

However, such views do not align themselves neatly along a left/right access:

“Girls who find themselves pregnant are often obliged to leave their family home, simply because, in that way, the welfare system will pick up the bills. Why should parents who live in crowded accommodation encourage their daughter to stay at home, with the extra costs, the inconvenience and a noisy mouth to feed—when the welfare state dictates otherwise? When Governments do more, people do less, and when something is subsidized we lend more to get more of it. I do not believe that young women have babies to get flats. That is a fallacy; it is not true, and we should stop saying it. I certainly do not support the tabloid press, which often makes that extremely chauvinistic point. However, we must stop subsidizing teenage sex so much and must promote the role of the conventional family.....”<sup>67</sup>

It was probably in response to political pressure relating to such accusations that the SEU’s report on Teenage Pregnancy,<sup>68</sup> recommended that under 18-year-old teenage parents should not be given lone tenancies for council housing. Instead, those who do not live with their parents should be offered supervised semi-independent housing with support, the nature of which is to be decided as a result of piloting exercises.

The current Blair government considers that the need for change to the benefits scheme is overwhelming. The government’s Labour party’s view is that, despite increasing levels of spending, the present system has failed to prevent poverty, dependence and social exclusion. One person in five now lives on half of the average income, compared with one in 10 in 1979. Similarly, the proportion of households with only one working has doubled since 1979 to one in five.

The present system of welfare is criticized as passive, concentrating on processing claims and paying benefits (without helping people improve their position); and as having failed to adapt to social change, consigning lone parents and long term sick and disabled people to a life of dependence. It is also susceptible to fraud.

The Welfare Reform Green Paper *New Ambitions for our Country* published in March 1998, sets out the framework for welfare reform, based on eight principles, each with a measure of success, to chart progress over the next 10–20 years. The central aim is to replace a cycle of dependency and insecurity with an ethic of work and savings. Reforms will tackle three key problems:

- inequality and social exclusion (especially

among children and pensioners);

- barriers to work, including financial disincentives;
- fraud.

There have been major changes in the distribution of benefits in the past 50 years. In 1948, two-thirds of claimants drawing national assistance—as Income Support was then called—were over retirement age. Now over two-thirds are below retirement age. While the numbers drawing the state retirement pension have doubled since 1948, the main growth in disability benefits, for example, has been among people below retirement age. The same is true of housing benefits, and the number of children living in households drawing the minimum income benefit has increased over threefold since the 1960s.

The change of government in 1997 to Labour, after 18 years of Conservative rule, has marked the start of many changes to the welfare system, many of them too recent to have made their impact felt. Some of these are described below. It should be remembered, however, that the Blair administration is very much a center party, and some of the cornerstones of the policy—such as the affirmation of family values—resemble those of the Tory party in all but name. The implications of this for welfare reform in the area of teenage parenthood are predictable. This government is sensitive to political pressure from the right that we should not be seen to be encouraging births outside of stable unions.

### **Great Britain's System of Social Welfare**

The social security system is designed to secure a basic standard of living for people in financial need by providing income during periods of inability to earn (including periods of unemployment), help for families and assistance with costs arising from disablement. As the largest single area of government spending, social security amounts to about 30% of all public expenditure, compared with 14% in 1949–50, the first full year after the introduction of the Welfare State. The fastest growing area of expenditure is spending on people over working age. There are many reasons for this growth in expenditure, not least the increasing number and range of benefits, as social security has expanded to cover both a wider range of contingencies and the changing shape and expectations of society.

Administration of social security in Great Britain is handled by five separate executive agencies of the Department of Social Security (DSS), including the

Benefits Agency and the CSA. Personal social services are administered by local authorities but central government is responsible for establishing national policies, issuing guidance and overseeing standards. Joint finance and planning between health and local authorities aims to prevent overlapping of services, and to encourage the development of community services. The statutory services are provided by local government social services authorities in England and Wales, social work departments in Scotland, and health and social services boards in Northern Ireland. Alongside these providers are the many contributions made by independent private and voluntary services.

### ***Who Qualifies for Non Financial Public Support?***

- *Elderly people.* Elderly people are the fastest growing section of the community. The proportion aged 75 and over rose from 5% in 1971 to 7% in 1996. In 1995–96, nearly 50% of local authorities spending was on the elderly. Support includes: advice and help from social workers; domestic help; home meals; sitters-in; night attendants; laundry services and recreational facilities.
- *Disabled people.* About 8.6 million disabled adults live in private households. In 1995–96, 7% of local authorities spending was on disabled people. Support includes: rehabilitation and provision of day, domiciliary and respite support services.

People with learning disabilities account for 13% of spending. Support includes short-term care, support for families in their own homes, residential accommodation and support for various types of activity outside the home.

- *Children.* Family Related Benefits, see below.

### ***Benefits Provided***

Social Security benefits can be grouped into three types:

- means-tested, available to people whose income and savings are below certain levels;
- contributory, paid to people who have made the required contribution to the National Insurance Fund, for which benefits are paid;
- benefits which are neither means-tested nor contributory (mainly paid to cover extra costs, for example of disability, or paid universally, for example child benefit);
- unemployment benefits;
- jobseekers' allowance: The Jobseekers'

allowance (JSA) is a benefit for people needing support because of unemployment. Claimants must be actively seeking work, and be capable of, and available for work. They must normally be at least 18 years of age and below pension age. JSA can be contribution-based or income-based;

- contribution-based JSA: those who have paid enough NI contributions are entitled to a personal JSA for up to six months (£50.35 for a person aged 25 or over), regardless of any savings or partners income;
- income-based JSA: those on low income are entitled to an income-based JSA (£50.35 for a person aged 25 and over, allowances on dependant children);
- back-to-work bonus: Recipients of JSA (see above), and people aged under 60 who receive income support, receive a bonus intended to increase the incentive to take up or keep part-time work, and encourage people to move off benefit and into employment. Those who have been unemployed for three months or more, or are working part-time, may keep the first £5 of their earnings (£10 for couples, £15 for lone parents), and tax incentives if the person moves towards full-time work;
- income support: Income support is payable to certain people aged 16 or over who are not required to be available for work, and whose income and savings are below set levels. They include lone parents, pensioners, carers, and long term sick and disabled people. The criteria for determining whether an individual is entitled to income support, and how much they are entitled to is complex and not simply calculable in terms of basic income. Income support is made up of a personal allowance based on age

**Table 11. Total benefit expenditure by age group 1998-99**

	Expenditure (£m)	%
Expenditure on people over working age	49,218	50
Expenditure on people of working age	41,760	42
Expenditure on people under working age	7,299	7
<b>Total</b>	<b>98,277</b>	<b>100</b>

Source: Social Security Departmental Report: The Government's Expenditure Plans 1998-99

and whether the claimant is single, a lone parent or has a partner, age related allowances for dependent children and additional sums known as premiums and housing costs.

- *Family related benefits.* Most pregnant working women receive Statutory Maternity Pay (SMP) directly from their employer. Women who are not eligible for SMP may qualify for a weekly Maternity Allowance, payable for up to 18 weeks, at £57.70 per week for employees, and £50.10 for self-employed and those not in work.

The main social security benefit for children is Child Benefit, a tax-free non-contributory payment of £14.40 a week for the eldest qualifying child of a couple, and £9.60 for each other child. A higher rate of £17.10 is payable for the eldest qualifying child of a person bringing up a child on his or her own, whether the person is the child's parent or not. Child Benefit is payable for children up to the age of 16, and for those up to 19 who continue in full-time non-advanced education.

An estimated 1 million lone parents in the U.K. bring up 1.7 million children in households where no one is working. The CSA is the body responsible for assessing child maintenance and collecting and enforcing child maintenance payment from absent partners. If any person is living with and caring for a child, and one or both of the child's parents are living elsewhere in the U.K., he or she may apply to have child support maintenance assessed and collected by the CSA. The CSA has been hugely criticized in the U.K. for being heavy handed, punitive and for causing more problems between parents that it solved. A green paper *Children First: A New Approach to Child Support* was published in 1998, setting out suggestions for a simpler method of assessment. The scheme, which is to be introduced in 2001, will include a more efficient process for making decisions and reorganization of the CSA to centralize processing work and free local staff to concentrate on meeting clients face to face.

- *childcare costs:* Families claiming Family Credit, Disability Working Allowance, Housing Benefit and Council Tax Benefit, and who pay for childcare for children aged under 12, can have up to £100 per week in formal childcare costs offset against their earnings;
- *family credit:* Family Credit, which was replaced by the new Working Families' Tax Credit in October 1999, is a tax-free benefit payable to low-income working families with

children whose net weekly income is less than £80.65;

- *social fund:* Payments, in the forms of loans or grants, may be available to people on low incomes to help with expenses which are difficult to pay for out of regular income;
- *benefits specifically for teenage parents:* A mother under 16 cannot claim benefit in her own right. However, if her parents are getting Income Support they can claim extra for any grandchildren living with them. Grandparents can also claim Child Benefit.

A mother aged 16 or 17 who is living with her parents can claim Income Support of £74.80 per week. A mother aged 18 or over can claim Income Support of £85.50 per week. A couple both over 18 with one child can claim income support of £114.75 a week. Child Benefit is not paid on top of Income support. Those getting Income Support get help with their rent and council tax.<sup>69</sup>

## Policies and Programs

Young people have two routes they can follow—one based on school and college education, and the other based on learning through work.

About 70% of 16-year-old pupils choose to continue in full-time education in school or college. Having completed compulsory school education, students can continue to study for examinations leading to higher education, professional training or vocational qualifications. These include the academic GCE A level, the AS examination, General National Vocational Qualifications (GNVQs) and National Vocational Qualifications (NVQs). NVQ awards recognize work-related skills and knowledge.

The government program currently encompasses: Modern Apprenticeships, offering an NVQ level 3 qualification, National Traineeships, introduced in September 1997 and offering an NVQ level 2 qualification, and other training opportunities for those unable to access these two. New legislation is giving 16 and 17-year-olds, in a job, the right to paid time off to pursue approved qualifications.

The Government's New Start Strategy launched in November 1997 and a key strand in the Investing in Young People program aims to tackle dissatisfaction and re-engage 14–17-year-olds in learning.

The objectives of the two main work-based training programs, National Traineeships and Modern Apprenticeships are to:

- provide participants with training leading to

vocational qualifications at National Vocational Qualification levels 2 and 3 or above, and with the broad-based skills necessary to become flexible and self-motivating employees;

- meet the needs of the national and local economies.

Over 210,000 young people have begun Modern Apprenticeships, which are in operation in 80 industry sectors. Evaluation studies have found that Modern Apprenticeships are of high quality, are popular and have met with the expectations of both employers and young people.

Youth credits are on offer from Training and Enterprise Councils in England and Wales. These enable 16 and 17-year-olds leaving full-time education to obtain vocational education and training through their employer or a specialist trainer.

The Blair government has stated that all young people should have access to high quality training after the age of 16. Under the welfare-to-work program (see below) all young unemployed people are going to be guaranteed education and training opportunities, while those with poor basic skills have the option of participating in full-time study on an approved course.

All young people in full-time education are entitled to career information, advice and guidance. The national computer based Educational Counseling and Credit Transfer Information Service (ECCTIS) provides prospective students and their advisers with free access to information on course opportunities and universities and colleges throughout the U.K. ECCTIS can be found in most secondary schools with sixth forms, as well as most further education colleges, universities, careers offices, etc.

From 1998–99, however, the government has asked career services to focus on young people who are in need of most help. From September 1998, all schools are required to provide programs of career education for children as young as 9–11.

Efforts have been made, recently, to create effective learning opportunities outside school hours to complement and support the work of education in the classroom. National Lotteries money has been invested to help expand study support activities for pupils outside normal lessons, both in schools and in the wider community. Study support centers have been set up to provide the opportunities for quiet study which may not be available at home. They can also offer a suitable place for mentors (whose purpose is to inspire and motivate young people) to

give help and advice, or provide access for pupils to information and communication technology. In the London Borough of Tower Hamlets, for example, study support centers are a significant strand of the Local Education Authority's strategy to tackle underachievement among pupils. Another initiative is the establishment of support centers within some Premier League football clubs, focusing on improving pupils' literacy and numeracy.

In the majority of cases, all educational and training is funded centrally by the government, from money levied in taxes and rates. The study support activities described above are an exception to the rule, having been funded by £200 million from the National Lotteries New Opportunities Fund, as is the Welfare to Work scheme, funded by a windfall tax on the excess profits of the privatized utilities, yielding over £5,000 million.

### **Programs Focused on Impacting the Sexual or Reproductive Behavior of Disadvantaged Youth** *Investing in Young People*

Investing in young people is the Governments' strategy to improve participation and attainment of those aged 16–19, including measures affecting schools, colleges and work-based training, as well as a new focus for the career services. As part of this strategy, the government plans to ensure that all young people have access to high quality education and training irrespective of whether they opt to take up education in a school sixth form or further education college or work-based training through an apprenticeship, traineeship or other arrangement. In addition, under the welfare-to-work program (see below), all young unemployed people are guaranteed education and training opportunities, while those with poor basic skills have an opportunity to participate in full-time study on an approved course.

In September 1999, the Department for Education and Employment (DFEE, now the Department of Education and Skills) introduced the Learning Gateway for 16 and 17-year-olds. The Learning Gateway's priority group is those in danger of dropping out of learning because of the lack of the right skills or who have other personal and social obstacles. Every young person is assigned a personal adviser who helps them improve their basic skills and sample jobs and courses aimed at assisting them to enter mainstream learning opportunities. The government allocated £37 million for the Learning Gateway to the 72 Training and Enterprise Councils

in England and Wales.

### ***Welfare-to-Work***

The governments' welfare-to-work program is a series of new deal measures designed to tackle youth and long-term unemployment, to promote employability and develop skills, and more people from welfare into jobs. The program is being funded by a windfall tax on the excess profits of the privatized utilities, yielding over £5,000 million. More detail is provided below on the new deal schemes of most relevance in the context of teenage pregnancy.

- *Young unemployed.* Initially introduced in January 1998 in 12 "pathfinder" areas, the new deal for the young unemployed was extended throughout the U.K. in April 1998. It is available to young people aged 18–24 who have been unemployed for more than six months. The scheme offers four options to young people, all of which include an element of training. For each young person, the program begins with a "Gateway" period of career advice and intensive help with looking for work, and with training in the skills needed for the world of work. By October 1998, over 160,000 young people had joined the program, of whom more than 30,000 had moved into jobs.

- *Lone parents.* The new deal for lone parents provides job search help, advice and training for lone parents whose youngest child is over age five. It was extended to all lone parents on income support from October 1998. This scheme, however, does not address the need of teenage parents. It does not, for example, support child care for education; lone teenage parents aged 16 and 17 claiming benefits are unlikely to be automatically referred to the new deal for lone parents because the program is currently marked to lone parents with children of school age or above; and the National Childcare Strategy gives priority to the development of out-of-school child care (i.e. older children) and teenage parents were not identified as a priority group.

### ***Social Exclusion Unit Strategy for Teenage Pregnancy***

In the past, government intervention on social problems has been piecemeal and one-dimensional. Recognizing that the location of problems in only one government department (the Department of Health, in the case of teenage pregnancy) has contributed to this problem, the Cabinet Office set up a Social Exclusion Unit in the Cabinet Office in 1997, to

coordinate and improve government action to reduce social exclusion in England. The unit works closely with officials in Wales, Scotland and Northern Ireland. A strategy for teenage pregnancy is the first of the initiatives produced so far. The SEU was asked to build on work already done by the Department of Health and make recommendations aimed at cutting the rates of teenage parenthood—particularly to the under 16s—to the European average and to propose better solutions to combat the risk of social exclusion for vulnerable teenagers and their children. The focus of the SEU's Teenage Pregnancy is on both girls and boys. A £60 million package of measures includes:

- a new task force of ministers, led by the Ministries for Public health, to coordinate the policy across government, supported by an implementation unit in the Department of Health;
- a national publicity campaign to reinforce the reports' key messages;
- improved access to contraceptive and sexual health services for teenagers.
- new guidance on sex and relationships education;
- special action targeted on prevention for the most vulnerable groups, including children looked after by a local authority, those excluded from school, and young offenders.

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## Appendix A

Table A1. Birthrates and abortion rates per 1,000 women aged 15–19, 15–17, 18–19 and 20–24 for selected years

Table A2. Birthrates and abortion rates per 1,000 women aged 15–19, 15–17, 18–19 and 20–24 by marital status, 1995

Table A3. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender

Table A4. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey

Table A5. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender

Table A6. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender

Table A7. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender

Table A8. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender

Table A9. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15–19 and 20–24), gender and socioeconomic variables

Table A10. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15–19 and 20–24) and socioeconomic variables

Table A11. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15–19 and 20–24), gender and socioeconomic variables

Table A12. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15–19 and 20–24), gender and socioeconomic variables

Table A13. Percentage distribution according to socioeconomic measures by age

**Table A1. Birth and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 for selected years**

<b>Year and Age Group</b>		<b>All Women</b>			
<b>1980</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Pregnancy Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>
15-19	30.4	17.3	47.7	60,754	34,595
15-17	13.4	14.2	27.6	16,254	17,195
18-19	56.5	22.2	78.7	44,275	17,400
20-24	112.7	18.5	131.2	201,541	33,014

<b>1985</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Pregnancy Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>
15-19	29.4	19.2	48.6	56,929	37,186
15-17	14.2	16.0	30.2	16,052	18,058
18-19	50.6	23.8	74.4	40,638	19,128
20-24	94.6	20.4	115.0	193,958	41,880

<b>1990</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Pregnancy Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>
15-19	33.3	22.8	56.1	55,541	38,069
15-17	16.7	17.4	34.1	15,603	16,260
18-19	54.4	29.8	84.2	39,734	21,809
20-24	91.7	28.1	119.8	180,136	55,281

<b>1995</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Pregnancy Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>
15-19	28.5	18.6	47.1	41,938	27,269
15-17	14.6	13.8	28.4	13,201	12,460
18-19	50.2	26.2	76.4	28,452	14,809
20-24	76.8	25.5	102.3	130,744	43,394

<b>Most recent year 1998</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Pregnancy Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>
15-19	30.9	21.7	52.6	48,285	33,957
15-17	16.5	16.1	32.6	15,494	15,108
18-19	51.8	30.1	81.9	32,504	18,849
20-24	75.5	29.0	104.5	113,537	43,700

Data source(s): Office for National Statistics

**Table A2. Birth and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 by marital status, 1995**

<b>Year and Age Group</b>		<b>Currently Married Women</b>			
<b>1995</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>	
15-19	444.0	25.6	5,623	324	
15-17	581.4	39.9	714	49	
18-19	429.0	24.0	4,907	275	
20-24	216.6	12.1	61,029	3,402	

		<b>Currently Cohabiting Women</b>			
<b>1995</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>	
15-19					
15-17					
18-19					
20-24					

		<b>Women Not Currently Married</b>			
<b>1995</b>	<b>Birth Rate</b>	<b>Abortion Rate</b>	<b>Number of births</b>	<b>Number of Abortions</b>	
15-19	24.9	18.5	36,315	26,945	
15-17	13.9	13.8	12,487	12,411	
18-19	42.4	26.2	23,545	14,534	
20-24	49.0	28.1	69,715	39,992	

**Data source(s):** Office for National Statistics

**Definition of Marital Status:** Not currently Married includes cohabiting, single, widowed and divorced women

If birth rates are not available for cohabiting women separately, please indicate whether cohabiting women are included with "married" or "unmarried" women. Also, please indicate whether "separated" women are included with "married" or "unmarried" women.

**Table A3. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender**

**Females**

Percent who first had intercourse at age:	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	0.4	0.6	0.4	0.8	0.3	0.3	0.3
13	1.2	0.6	0.7	0.4	0.3	0.3	0.1
14	5.4	2.5	2.0	2.4	1.1	1.2	1.0
15	11.7	11.0	7.0	5.2	4.2	2.6	2.2
16	21.5	23.9	19.2	16.8	15.0	9.7	7.5
17	15.2	21.8	18.7	21.5	19.0	12.6	10.4
18	4.3	15.8	19.4	19.1	19.5	17.3	13.9
19	0.7	7.8	11.8	10.1	13.7	13.9	13.8
20		5.3	6.2	6.5	7.5	13.2	12.7
21 or older		3.3	10.8	14.8	17.8	26.6	35.5
Never had intercourse	38.5	6.5	2.7	1.4	0.6	0.8	0.8
Age not reported	1.1	0.9	1.1	1.1	1.1	1.9	2
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	1,263	1,536	1,363	1,276	1,300	1,093
Number-unweighted (N)	712	1,176	1,693	1,580	1,371	1,233	992

**Males**

Percent who first had intercourse at age:	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	2.0	0.7	1.0	1.0	1.5	1.4	1.7
13	2.8	2.8	3.5	3.9	1.5	1.5	2.5
14	8.2	8.1	7.3	6.4	5.6	4.1	3.4
15	15.0	12.0	12.0	12.0	9.6	8.0	6.9
16	17.4	21.7	20.7	17.3	15.2	16.3	11.0
17	12.5	17.5	16.9	16.5	15.0	14.2	12.5
18	5.2	11.6	13.1	15.8	15.9	16.6	12.4
19	0.8	7.8	7.3	6.7	8.6	8.3	10.2
20		4.2	4.2	3.1	7.4	8.3	7.5
21 or older		3.1	9.3	14.0	16.1	19.3	29.1
Never had intercourse	35.9	9.0	4.0	1.9	1.9	1.8	1.1
Age not reported	0.1	1.3	0.8	1.6	1.5	1.0	1.9
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	831	1,153	1,137	1,029	998	1,054	845
Number-unweighted (N)	554	935	1,222	1,146	1,094	1,049	794

**Source(s):** National Survey of Sexual Attitudes + Lifestyles (NATSAL)

**Year of survey:** 1990/91

NB: Age at first heterosexual intercourse only

**Table A4. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey**

**Females**

Percent whose first birth was at age:	Age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
<15	0.0	0.0	0.0	0.0	0.0	0.1	0.1
15	0.4	0.3	0.1	0.0	0.2	0.2	0.1
16	1.6	0.9	0.7	1.1	0.9	0.6	0.5
17	3.4	3.0	2.7	3.2	2.6	3.1	2.4
18	2.3	4.6	3.8	4.5	6.7	4.2	3.9
19	0.4	5.9	4.6	5.1	6.4	7.5	5.6
20		4.7	4.4	4.7	7.0	7.1	7.5
21 or older		10.2	40.5	57.3	62.9	67.1	71.3
Never had a birth	91.5	70.3	42.8	23.4	12.9	9.9	8.4
Age not reported	0.3	0.2	0.4	0.7	0.4	0.5	0.2
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	1,263	1,536	1,363	1,276	1,300	1,093
Number-unweighted (N)	712	1,176	1,693	1,580	1,371	1,233	992

Source(s): NATSAL  
Year of survey: 1990/91

**Table A5. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender**

**Females**

Number of sexual partners in past year	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	38.5	6.5	2.7	1.4	0.6	0.8	0.8
No partners past year	2.2	4.0	4.2	5.0	6.2	7.1	10.7
1 partner	40.6	73.8	83.5	85.8	86.0	86.9	84.2
2 partners	10.3	9.5	5.3	3.9	3.7	2.6	2.3
3 or more partners	7.2	6.2	4.2	3.8	3.5	2.5	1.9
Not Answered	1.2	0.0	0.1	0.2	0.1	0.1	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	1,263	1,536	1,363	1,276	1,300	1,093
Number-unweighted (N)	712	1,176	1,693	1,580	1,371	1,233	992

**Males**

Number of sexual partners in past year	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	35.9	9.0	4.0	1.9	1.9	1.8	1.1
No partners past year	4.9	7.7	5.8	5.2	4.7	5.2	5.9
1 partner	31.9	54.3	70.7	79.5	82.0	81.1	83.9
2 partners	12.9	13.7	8.9	7.6	6.4	5.4	5.3
3 or more partners	13.7	18.1	10.5	5.5	4.9	6.2	3.8
Not Answered	0.7	0.0	0.3	0.1	0.0	0.2	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	831	1,153	1,137	1,029	998	1,054	845
Number-unweighted (N)	554	935	1,222	1,146	1,094	1,049	794

Source(s): NATSAL  
 Year of survey: 1990/91

NB: Heterosexual partners only

**Table A6. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender**

**Females**

Frequency of intercourse in past month*	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	38.5	6.5	2.7	1.4	0.6	0.8	0.8
0 times in past month	19.2	18.1	14.7	13.7	14.3	15.4	19.7
<1/week	11.0	17.3	20.4	20.1	22.4	27.7	28.9
1 time/week	2.9	5.3	9.0	10.0	9.1	9.4	10.4
2-4 times/week	18.7	41.2	42.6	43.6	43.5	36.9	30.0
5+ times/week	4.1	6.4	4.0	3.8	2.9	1.2	1.3
Don't Know	0.0	0.1	0.3	0.7	0.1	0.2	0.1
Not reported (missing)	5.6	5.1	6.4	6.7	7.0	8.5	8.8
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	1,263	1,536	1,363	1,276	1,300	1,093
Number-unweighted (N)	712	1,176	1,693	1,580	1,371	1,233	992

**Males**

Frequency of intercourse in past month*	Respondent's age at survey						
	16-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	35.9	9.0	4.0	1.9	1.9	1.8	1.1
0 times in past month	29.1	25.8	17.3	14.7	12.3	12.5	15.4
<1/week	13.6	16.8	16.4	19.9	22.8	24.4	28.0
1 time/week	2.2	5.0	8.1	8.8	9.4	10.0	11.0
2-4 times/week	12.4	32.1	43.7	41.9	43.5	39.5	34.0
5+ times/week	2.6	7.3	5.6	5.3	3.1	4.1	1.4
Don't know	0.4	0.2	0.0	0.1	0.0	0.0	0.1
Not Reported (Missing)	4.0	3.8	4.8	7.4	6.9	7.8	8.8
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	831	1,153	1,137	1,029	998	1,054	845
Number-unweighted (N)	554	935	1,222	1,146	1,094	1,049	794

Source(s): NATSAL  
 Year of survey: 1990/91

NB: Heterosexual intercourse only

**Table A7. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender**

<b>Females</b> Percent using each method at first intercourse*	<b>Respondent's age at survey</b>							
	16-19			20-24	25-29	30-34	35-39	40-44
	Total	16-17	18-19					
Other	7.6	2.9	11.8	21.7	27.6	25.2	17.8	15.2
Condoms	37.4	25.7	47.7	41.0	36.5	36.4	36.4	35.4
Withdrawal	2.9	3.3	2.5	4.7	6.6	5.3	8.8	9.3
Rhythm (periodic abstinence)	0.1	0.0	0.2	0.6	1.2	1.3	0.9	1.6
Method not reported	0.1	0.0	0.2	1.7	1.3	2.8	2.0	2.5
No Method	12.8	9.1	16.1	23.9	24.1	27.7	33.5	35.2
Never had intercourse	38.5	58.7	21.2	6.5	2.7	1.4	0.6	0.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	457	526	1,263	1,536	1,363	1,276	1,300
Number-unweighted (N)	712	312	400	1,176	1,693	1,580	1,371	1,233
Percent using both condoms and selected medical methods**	1.4	1.3	1.5	0.7	1.4	0.7	0.7	0.3

<b>Males</b> Percent using each method at first intercourse *	<b>Respondent's age at survey</b>							
	16-19			20-24	25-29	30-34	35-39	40-44
	Total	16-17	18-19					
Other	5.3	1.6	8.4	14.8	18.1	18.1	13.4	8.1
Condoms	36.0	27.5	43.0	37.0	31.8	31.3	31.1	31.2
Withdrawal	5.2	4.0	6.2	4.9	7.4	8.0	10.8	9.2
Rhythm (periodic abstinence)	0.6	0.8	0.2	0.6	1.7	0.8	0.5	1.8
Method not reported	0.5	0.5	0.4	1.8	1.5	1.5	2.2	3.0
No Method	16.6	9.9	21.7	30.3	34.9	38.2	39.9	44.5
Never had intercourse	35.9	54.9	19.9	9.0	4.0	1.9	1.9	1.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	831	378	453	1,153	1,137	1,029	998	1,054
Number-unweighted (N)	554	252	302	935	1,222	1,146	1,094	1,049
Percent using both condoms and selected medical methods**	0.0	0.0	0.0	1.5	0.6	0.2	0.2	0.3

\* If multiple methods are reported, classify according to the most effective method used.

\*\* Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): NATSAL

Year of survey: 1990/91

NB: No method includes 'respondent none but partner may have used some' & 'both none'

**Table A8. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender**

Females Percent using each method at last intercourse *	Respondent's age at survey							
	16-19			20-24	25-29	30-34	35-39	40-44
	Total	16-17	18-19					
Sterilization	0.2	0.0	0.3	1.8	8.0	19.9	32.0	40.0
Oral contraceptives	31.5	18.6	42.8	52.3	46.6	25.9	13.9	5.1
IUD	0.4	0.1	0.7	3.2	5.0	7.2	7.3	7.3
Condoms	10.9	8.6	12.8	12.0	14.1	16.5	14.4	13.5
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.7	1.1	2.0	2.0	1.2
Foam/jelly/cream/suppository	0.1	0.3	0.0	0.0	0.0	0.1	0.1	0.0
Withdrawal	1.0	1.2	0.8	0.8	1.7	1.1	1.8	1.1
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.3	0.3	0.5	0.7	0.7
Other	0.7	0.2	1.2	0.9	0.9	1.2	0.8	0.9
No method used	1.9	1.3	2.3	7.2	8.8	10.7	11.8	13.6
No intercourse-past 3 mths	13.7	10.3	16.6	13.5	12.1	12.7	13.6	14.2
Never had intercourse	38.5	58.7	21.2	6.5	2.7	1.4	0.6	0.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	982	457	526	1,263	1,536	1,363	1,276	1,300
Number-unweighted (N)	712	312	400	1,176	1,693	1,580	1,371	1,233
Percent using both condoms and selected medical method***	13.1	8.8	16.8	17.4	14.7	7.3	4.3	1.9

Males Percent using each method at last intercourse *	Respondent's age at survey							
	16-19			20-24	25-29	30-34	35-39	40-44
	Total	16-17	18-19					
Sterilization	0.0	0.0	0.0	0.8	3.4	13.6	28.9	34.1
Oral contraceptives	21.6	11.1	30.3	44.1	48.1	33.8	17.9	12.6
IUD	0.3	0.0	0.5	1.5	2.5	3.5	5.6	5.9
Condoms	15.5	12.7	17.7	17.8	17.9	20.5	19.4	16.1
Diaphragm/Cap/f.condom	0.4	0.8	0.0	0.4	0.7	0.5	1.3	1.1
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.2	0.1	0.1
Withdrawal	0.4	0.8	0.0	0.7	1.5	1.4	1.9	2.0
Rhythm (periodic abstinence)	0.5	1.1	0.0	0.1	0.2	0.0	0.3	0.2
Other	0.0	0.0	0.0	0.5	0.4	0.6	0.6	1.4
No method used	2.7	1.2	3.9	4.3	7.0	9.1	9.5	11.9
No intercourse-past 3 mths	22.8	17.3	27.3	20.0	13.9	13.4	11.5	12.1
Never had intercourse	35.9	54.9	19.9	9.0	4.0	1.9	1.9	1.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	831	378	453	1,153	1,137	1,029	998	1,054
Number-unweighted (N)	554	252	302	935	1,222	1,146	1,094	1,049
Percent using both condoms and selected medical methods***	13.5	6.9	19.2	21.7	20.2	13.2	7.2	5.4

\* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

\*\* Not at risk because currently pregnant, postpartum, seeking pregnancy, infecund or sterile.

\*\*\* Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): NATSAL  
 Year of survey: 1990/91

**Table A9. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables**

<b>Females</b>	<b>Variable name:</b> Education		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
<13	0.0	0.5	0.5
13	0.0	0.5	0.0
14	3.7	3.9	1.8
15	16.7	10.7	9.6
16	29.6	27.2	19.7
17	25.9	19.4	10.6
18	3.7	13.1	25.2
19	7.4	6.8	6.4
20	0.0	5.8	4.1
21 or older	7.4	1.0	5.5
Never had intercourse	5.6	9.2	15.6
Age not reported	0.0	1.9	0.9
Total Percent	100%	100%	99.9%
Number-weighted (N)	54	206	218
Number-unweighted (N)	69	206	171

<b>Males</b>	<b>Variable name:</b> Education		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
<13	1.3	0.2	0.9
13	6.6	3.3	1.4
14	16.6	11.0	4.0
15	15.9	15.8	8.8
16	25.8	19.6	21.4
17	13.2	16.7	18.9
18	5.3	14.6	11.0
19	3.3	3.8	12.2
20	1.3	3.1	5.9
21 or older	0.7	3.3	3.6
Never had intercourse	9.9	7.2	10.4
Age not reported	0.0	1.4	1.4
Total Percent	99.9%	100%	99.9%
Number-weighted (N)	151	419	556
Number-unweighted (N)	134	353	433

**Table A9. Age at First Intercourse continued**

<b>Females</b> Percent who first had intercourse at age:	<b>Variable name:</b> Household Social Class							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	1.0	0.5	0.2	0.0	1.9
13	0.0	0.0	0.0	0.0	1.3	0.6	1.3	0.9
14	0.0	0.0	3.1	2.3	5.0	2.4	8.2	3.2
15	0.0	10.0	21.9	7.8	11.2	11.3	12.7	13.0
16	100.0	20.0	28.1	22.5	19.1	21.7	30.4	34.7
17	0.0	13.3	21.9	23.4	13.9	23.2	19.6	16.2
18	0.0	20.0	15.6	18.3	3.8	15.5	4.4	14.4
19	0.0	6.7	0.0	11.5	0.6	6.9	1.3	7.4
20		10.0		2.8		6.3		3.7
21 or older		13.3		5.6		3.1		0.0
Never had intercourse	0.0	6.7	9.4	5.0	43.1	7.4	22.2	4.2
Age not reported	0.0	0.0	0.0	0.0	1.4	1.2	0.0	0.5
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	30	31	220	785	795	159	218
Number-unweighted (N)	1	25	25	200	562	739	121	211

<b>Males</b> Percent who first had intercourse at age:	<b>Variable name:</b> Household Social Class							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	1.6	1.2	0.4	5.4	0.9
13	0.0	0.0	0.0	2.1	3.3	3.0	1.8	3.2
14	0.0	0.0	22.7	9.5	6.7	7.6	11.4	9.9
15	0.0	10.3	22.7	7.9	13.3	13.0	21.1	12.6
16	0.0	7.7	13.6	28.6	16.7	19.5	21.1	26.1
17	50.0	17.9	13.6	14.8	13.5	7.6	8.4	19.8
18	0.0	15.4	27.3	11.1	3.9	12.5	6.6	8.1
19	0.0	2.6	0.0	10.1	0.9	8.2	0.6	5.9
20		12.8		3.7		4.6		1.8
21 or older		5.1		4.3		3.3		1.4
Never had intercourse	50.0	25.6	0.0	5.8	40.2	9.2	23.5	8.6
Age not reported	0.0	2.6	0.0	0.5	0.2	1.2	0.0	1.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	39	23	190	639	699	167	223
Number-unweighted (N)	2	33	16	163	426	558	110	178

**Table A9. Age at First Intercourse continued**

Females	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	0.0	0.0	0.7	1.4	0.2	0.0	0.0	0.4	1.5	0.0	4.0
13	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.4	7.7	0.0	2.2	1.2	0.0	0.0
14	0.0	0.0	0.0	2.4	0.0	2.7	6.0	2.6	11.5	0.0	4.9	2.4	5.0	4.0
15	0.0	9.1	30.0	16.7	36.1	6.8	9.5	9.6	19.2	10.7	12.9	12.1	10.0	0.0
16	100.0	9.1	20.0	22.6	19.4	14.4	26.7	22.0	26.9	21.4	30.4	31.5	20.0	28.0
17	0.0	0.0	40.0	19.0	13.9	19.2	20.0	25.1	7.7	25.0	16.1	18.8	10.0	36.0
18	0.0	36.4	10.0	20.2	13.9	21.9	7.7	16.0	0.0	14.3	2.7	13.0	0.0	20.0
19	0.0	0.0	0.0	7.1	0.0	14.4	1.4	7.2	3.8	4.8	0.9	8.2	0.0	0.0
20	n.a.	9.1	n.a.	4.8	n.a.	4.8	n.a.	6.0	n.a.	9.5	n.a.	3.6	n.a.	8.0
21 or older	n.a.	18.2	n.a.	3.6	n.a.	6.2	n.a.	3.6	n.a.	6.0	n.a.	1.2	n.a.	0.0
Never had intercourse	0.0	18.2	0.0	3.6	16.7	8.2	26.0	6.2	23.1	8.3	29.5	5.5	40.0	0.0
Age not reported	0.0	0.0	0.0	0.0	0.0	0.7	0.7	1.2	0.0	0.0	0.0	0.9	15.0	0.0
Total Percent	100%	100.1%	100%	100%	100%	100%	100.1%	100.1%	99.9%	100%	100%	99.9%	100%	100%
Number-weighted (N)	2	11	10	84	36	145	286	500	27	85	224	329	20	26
Number-unweighted (N)	1	11	8	75	25	134	208	443	24	75	168	321	12	26

Males	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	0.0	5.0	2.2	2.2	0.5	0.0	0.9	3.9	0.8	5.1	0.0
13	0.0	0.0	0.0	4.3	0.0	2.2	1.5	0.0	7.3	3.2	1.7	3.8	2.6	2.9
14	0.0	0.0	0.0	14.5	25.0	1.1	9.6	4.8	11.2	8.4	10.6	10.0	10.3	8.6
15	0.0	9.1	27.3	10.3	10.0	4.4	15.6	8.6	15.6	18.9	20.1	10.5	35.9	14.3
16	0.0	13.6	18.2	27.4	5.0	27.5	14.1	24.6	27.9	19.2	18.4	20.1	20.5	31.4
17	50.0	15.9	18.2	16.2	15.0	16.5	17.8	11.2	15.6	21.5	16.2	18.4	2.6	17.1
18	0.0	13.6	36.4	6.0	30.0	14.3	1.5	13.9	4.5	12.2	7.3	10.9	0.0	11.4
19	0.0	2.3	0.0	8.5	0.0	13.2	3.0	16.6	0.0	4.9	0.6	6.7	0.0	5.7
20	n.a.	15.9	n.a.	6.0	n.a.	3.3	n.a.	7.0	n.a.	1.2	n.a.	2.9	n.a.	5.7
21 or older	n.a.	4.5	n.a.	3.4	n.a.	5.5	n.a.	3.2	n.a.	3.5	n.a.	2.9	n.a.	0.0
Never had intercourse	50.0	22.7	0.0	2.6	10.0	9.9	34.1	7.5	17.9	5.8	21.2	10.9	23.1	2.9
Age not reported	0.0	2.3	0.0	0.9	0.0	0.0	0.7	2.1	0.0	0.3	0.0	2.1	0.0	0.0
Total Percent	100%	99.9%	100.1%	100.1%	100%	100.1%	100.1%	100%	100%	100.0%	100%	100%	100.1%	100%
Number-weighted (N)	2	44	11	117	22	91	134	187	180	343	179	238	40	36
Number-unweighted (N)	2	35	9	97	15	74	91	144	119	285	116	181	28	31

**Table A9. Age at First Intercourse continued**

<b>Females</b> Percent who first had intercourse at age:	<b>Variable name:</b> Race			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
<13	0.1	0.6	4.2	1.3
13	1.3	0.6	0.0	1.3
14	5.0	2.5	11.1	2.6
15	12.7	11.0	0.0	7.8
16	22.1	24.5	13.9	15.6
17	15.6	23.0	6.9	5.2
18	4.4	15.9	1.4	15.6
19	0.8	7.5	n.a.	13.0
20	n.a.	4.7	n.a.	15.6
21 or older	n.a.	3.2	0.0	6.5
Never had intercourse	37.1	5.8	58.3	15.6
Age not reported	0.9	1.0	4.2	0.0
Total Percent	100%	100.3%	100%	100.1%
Number-weighted (N)	902	1,180	72	77
Number-unweighted (N)	663	1,101	44	68

<b>Males</b> Percent who first had intercourse at age:	<b>Variable name:</b> Race			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
<13	2.2	0.7	0.0	0.0
13	3.0	2.8	0.0	1.6
14	8.6	8.0	1.9	10.9
15	15.2	12.6	13.5	3.1
16	18.1	21.7	7.7	21.9
17	12.7	18.3	7.7	6.3
18	5.3	11.8	3.8	6.3
19	0.9	7.4	0.0	14.1
20	n.a.	4.2	n.a.	4.7
21 or older	n.a.	3.3	n.a.	3.1
Never had intercourse	33.8	8.4	65.4	20.3
Age not reported	0.1	0.9	0.0	7.8
Total Percent	99.9%	100.1%	100%	100.1%
Number-weighted (N)	779	1,089	52	63
Number-unweighted (N)	521	885	33	48

**Table A9. Age at First Intercourse continued**

<b>Females</b>	<b>Variable name: Region</b>											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	0.7	0.0	0.8	0.0	0.0	0.0	0.0	2.4	0.0
13	0.0	0.0	2.9	0.7	0.0	0.0	1.0	0.0	0.0	0.0	2.4	0.0
14	0.0	1.4	4.8	1.4	11.6	3.3	3.0	2.4	6.5	3.9	4.9	0.0
15	16.9	14.5	11.5	12.9	13.7	9.8	8.9	15.3	10.4	9.1	9.8	15.4
16	23.1	18.8	22.1	19.4	27.4	26.0	23.8	22.6	27.3	28.6	14.6	38.5
17	13.8	21.7	13.5	27.3	12.6	21.1	14.9	18.5	26.0	20.8	9.8	23.1
18	12.3	15.9	3.8	22.3	7.4	14.6	3.0	12.1	1.3	19.5	7.3	7.7
19	0.0	10.1	1.9	2.9	0.0	11.4	1.0	8.9	0.0	3.9	2.4	3.8
20	n.a.	1.4	n.a.	5.8	n.a.	2.4	n.a.	5.6	n.a.	3.9	n.a.	3.0
21 or older	n.a.	7.2	n.a.	3.6	n.a.	1.6	n.a.	1.6	n.a.	2.6	n.a.	0.0
Never had intercourse	33.8	7.2	39.4	2.9	27.4	6.5	39.6	8.1	28.6	7.8	46.3	7.7
Age not reported	0.0	1.4	0.0	0.0	0.0	2.4	5.0	4.8	0.0	0.0	0.0	0.0
Total Percent	99.9%	99.6%	99.9%	99.9%	100.1%	99.9%	100.2%	99.9%	100.1%	100.1%	99.9%	99.2%
Number-weighted (N)	65	70	104	139	94	123	101	123	77	78	40	25
Number-unweighted (N)	51	81	81	140	69	121	73	115	60	79	32	26

<b>Females continued</b>	<b>Variable name: Region</b>									
	South West		South East		Greater London		Wales		Scotland	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.0	0.0	0.0	0.9	0.0	0.5	0.0	0.0	3.8	2.2
13	0.0	0.0	1.5	1.4	1.7	0.5	0.0	1.6	0.0	0.0
14	6.8	0.0	5.6	4.2	6.0	3.5	2.1	0.0	5.0	2.2
15	22.0	11.5	11.6	14.0	9.5	4.5	14.9	12.5	6.3	8.7
16	30.5	32.2	19.7	29.3	11.2	21.0	23.4	23.4	20.0	15.9
17	6.8	29.9	16.7	20.0	15.5	20.0	19.1	26.6	13.8	18.8
18	6.8	6.9	0.5	13.0	1.7	16.5	17.0	17.2	2.5	21.0
19	0.0	12.6	0.5	5.1	1.7	9.5	0.0	7.8	0.0	9.4
20	n.a.	4.6	n.a.	4.7	n.a.	8.5	n.a.	1.6	n.a.	8.0
21 or older	n.a.	1.1	n.a.	2.3	n.a.	7.5	n.a.	1.6	n.a.	3.6
Never had intercourse	27.1	1.1	43.4	5.1	50.0	7.0	21.3	7.8	47.5	10.1
Age not reported	0.0	0.0	0.5	0.0	2.6	1.0	2.1	0.0	1.3	0.0
Total Percent	100.0%	99.9%	100.0%	100.0%	99.9%	100.0%	99.9%	100.1%	100.2%	99.9%
Number-weighted (N)	60	89	201	216	116	199	47	64	78	137
Number-unweighted (N)	45	91	131	196	64	138	41	65	65	124

**Table A9. Age at First Intercourse continued**

<b>Males</b> Percent who first had intercourse at age:	Variable name: Region												
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia		
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	
<13	5.4	0.0	5.4	1.7	0.0	0.8	0.0	0.0	0.0	0.0	3.1	4.3	0.0
13	2.7	2.0	12.9	4.1	1.6	4.1	1.1	1.7	1.3	3.1	0.0	5.7	
14	8.1	12.2	9.7	12.4	8.2	8.3	7.9	6.9	14.7	3.1	4.3	11.4	
15	21.6	24.5	17.2	18.2	27.9	14.0	9.0	12.1	13.3	1.5	17.4	5.7	
16	10.8	16.3	17.2	12.4	9.8	14.0	21.3	15.5	18.7	32.3	23.9	25.7	
17	10.8	4.1	5.4	17.4	13.1	19.0	13.5	12.9	17.3	15.4	10.9	22.9	
18	2.7	8.2	5.4	9.9	0.0	14.0	2.2	14.7	8.0	20.0	6.5	0.0	
19	0.0	14.3	0.0	6.6	1.6	8.3	1.1	10.3	0.0	6.2	0.0	5.7	
20	n.a.	6.1	n.a.	6.6	n.a.	3.3	n.a.	2.6	n.a.	1.5	n.a.	0.0	
21 or older	n.a.	0.0	n.a.	1.7	n.a.	4.1	n.a.	2.6	n.a.	3.1	n.a.	2.9	
Never had intercourse	37.8	8.2	26.9	9.1	37.7	9.1	42.7	15.5	26.7	10.8	32.6	17.1	
Age not reported	0.0	4.1	0.0	0.0	0.0	0.8	1.1	5.2	0.0	0.0	0.0	2.9	
Total Percent	99.9%	100.0%	100.1%	100.1%	99.9%	99.8%	99.9%	100.0%	100.0%	100.1%	99.9%	100.0%	
Number-weighted (N)	38	49	93	122	62	120	90	116	74	64	46	36	
Number-unweighted (N)	29	43	59	90	44	106	61	99	48	53	31	32	

<b>Males continued</b> Percent who first had intercourse at age:	Variable name: Region									
	South West		South East		Greater London		Wales		Scotland	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<13	4.2	2.4	1.8	0.5	2.1	0.0	0.0	0.0	0.0	0.0
13	0.0	4.8	1.2	0.9	1.1	0.6	3.4	6.1	3.2	4.3
14	9.7	7.2	5.9	7.8	7.4	9.3	3.4	10.2	9.7	5.8
15	18.1	7.2	16.0	14.7	11.7	5.0	10.3	14.3	8.1	12.9
16	18.1	20.5	18.9	23.4	20.2	29.8	3.4	18.4	14.5	26.6
17	11.1	21.7	12.4	14.7	13.8	17.4	34.5	18.4	8.1	25.2
18	12.5	9.6	3.6	12.8	5.3	12.4	0.0	16.3	8.1	5.8
19	1.4	12.0	1.8	5.0	0.0	9.9	0.0	4.1	0.0	5.0
20	n.a.	1.2	n.a.	6.9	n.a.	6.2	n.a.	2.0	n.a.	2.2
21 or older	n.a.	0.0	n.a.	3.7	n.a.	3.1	n.a.	4.1	n.a.	6.5
Never had intercourse	25.0	10.8	38.5	9.2	38.3	5.0	44.8	6.1	48.4	5.8
Age not reported	0.0	2.4	0.0	0.5	0.0	1.2	0.0	0.0	0.0	0.0
Total Percent	100.1%	99.8%	100.1%	100.1%	99.9%	99.9%	99.8%	100.0%	100.1%	100.1%
Number-weighted (N)	73	84	169	217	94	160	29	49	63	138
Number-unweighted (N)	49	70	105	162	52	108	23	47	53	125

**Table A9. Age at First Intercourse continued**

<b>Females</b> Percent who first had intercourse at age:	<b>Variable name:</b> Immigrant Status			
	Born in UK		Not born in UK	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
<13	0.3	0.7	1.8	0.0
13	1.3	0.5	0.0	2.4
14	5.8	2.6	0.0	1.2
15	11.5	11.3	16.1	7.3
16	21.5	24.2	21.4	19.5
17	15.5	22.4	7.1	11.0
18	4.6	16.0	1.8	14.6
19	0.8	7.7	0.0	11.0
20	n.a.	4.7	n.a.	14.6
21 or older	n.a.	2.9	n.a.	9.7
Never had intercourse	37.9	6.3	46.4	8.5
Age not reported	0.9	1.0	5.4	0.0
Total Percent	100.1%	100.3%	100.0%	99.8%
Number-weighted (N)	918	1,178	57	82
Number-unweighted (N)	674	1,103	32	70

<b>Males</b> Percent who first had intercourse at age:	<b>Variable name:</b> Immigrant Status			
	Born in UK		Not born in UK	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
<13	2.1	0.7	0.0	0.0
13	2.9	2.7	0.0	3.7
14	8.1	8.2	10.0	7.3
15	15.2	11.6	12.5	3.7
16	17.9	20.5	10.0	24.4
17	12.6	17.3	10.0	19.5
18	5.1	11.4	7.5	14.6
19	0.9	7.9	0.0	7.3
20	n.a.	4.3	n.a.	3.7
21 or older	n.a.	5.4	n.a.	3.6
Never had intercourse	35.0	8.8	50.0	12.2
Age not reported	0.1	1.4	0.0	0.0
Total Percent	99.9%	100.2%	100.0%	100.0%
Number-weighted (N)	790	1,069	40	83
Number-unweighted (N)	526	873	27	61

**Table A9. Age at First Intercourse continued**

<b>Females</b> Percent who first had intercourse at age:	<b>Variable name:</b> School Status					
	Full-time		10+hours paid work		Else & Missing	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.5	0.0	0.8	0.3	0.0	1.6
13	1.6	0.0	0.8	0.0	0.9	1.9
14	2.6	2.1	5.8	1.5	9.4	4.5
15	6.1	8.2	11.5	9.1	21.4	15.4
16	13.2	13.4	27.8	22.2	24.6	30.3
17	10.6	17.5	19.4	24.1	16.1	18.4
18	1.6	25.8	7.1	16.2	4.0	12.2
19	0.0	9.3	1.8	8.9	0.0	5.3
20	n.a.	8.2	n.a.	5.2	n.a.	4.8
21 or older	n.a.	2.1	n.a.	4.2	n.a.	1.9
Never had intercourse	62.7	13.4	24.7	7.1	21.0	2.9
Age not reported	1.1	0.0	0.3	1.1	2.7	0.8
Total Percent	100%	100%	100%	99.9%	100.1%	100%
Number-weighted (N)	377	99	381	788	224	377
Number-unweighted (N)	248	60	275	678	189	438

<b>Males</b> Percent who first had intercourse at age:	<b>Variable name:</b> School Status					
	Full-time		10+hours paid work		Else & Missing	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24
<13	0.3	0.0	3.0	0.4	3.4	2.4
13	0.6	2.4	3.8	3.0	5.5	2.0
14	3.2	0.0	10.8	7.9	12.3	14.1
15	11.7	4.0	16.7	12.4	17.8	15.6
16	9.8	18.4	22.8	22.5	19.9	20.0
17	11.1	18.4	15.1	17.7	8.9	16.6
18	3.5	10.4	7.8	13.1	2.7	6.3
19	1.3	9.6	0.8	8.7	0.0	3.4
20	n.a.	12.0	n.a.	3.5	n.a.	2.4
21 or older	n.a.	1.6	n.a.	3.0	n.a.	4.4
Never had intercourse	58.4	20.8	19.4	6.7	28.8	11.7
Age not reported	0.0	2.4	0.0	1.1	0.7	1.0
Total Percent	99.9%	100.0%	100.2%	100.0%	100.0%	99.9%
Number-weighted (N)	315	124	370	827	147	203
Number-unweighted (N)	202	84	247	686	105	165

\* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.

\*\* Not at risk because currently pregnant, postpartum, seeking pregnancy, infecund or sterile.

\*\*\* Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): NATSAL

Year of survey: 1990/91

**Table A10. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15-19 and 20-24) and socio-economic variables**

Females Percent whose first birth was at age:	Variable name: Education		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
<15	0.0	0.0	0.0
15	1.8	0.5	0.0
16	3.6	0.5	0.5
17	9.1	2.4	0.5
18	9.1	4.8	0.0
19	12.7	4.3	0.9
20	10.9	4.3	0.5
21 or older	12.7	7.2	1.4
Never had a birth	40.0	75.8	96.4
Age not reported	0.0	0.0	0.0
Total Percent	99.9%	99.8%	100.2%
Number-weighted (N)	55	207	220
Number-unweighted (N)	69	206	171

Females Percent whose first birth was at age:	Variable name: Household Social Class							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15	0.0	0.0	0.0	0.5	0.1	0.3	1.3	0.5
16	0.0	0.0	0.0	0.5	1.5	0.9	2.5	1.8
17	0.0	0.0	6.5	1.8	3.1	2.3	3.8	7.8
18	0.0	3.3	0.0	2.3	2.3	4.8	3.1	6.4
19	0.0	0.0	0.0	1.8	0.1	6.3	2.5	8.7
20		0.0		3.6		4.4		7.8
21 or older		3.3		9.6		9.7		13.3
Never had a birth	100.0	93.3	93.5	80.0	92.5	71.3	86.8	53.2
Age not reported	0.0	0.0	0.0	0.0	0.4	0.1	0.0	0.5
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	30	31	220	785	795	159	218
Number-unweighted (N)	1	25	25	200	562	739	121	211

**Table A10. Age at First Birth continued**

Females Percent whose first birth was at age:	Variable name: Socioeconomic Group (SEG)															
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual			
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey			
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24		
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	4.0	
16	0.0	0.0	0.0	1.2	0.0	0.0	0.4	0.4	0.0	0.0	0.9	1.2	0.0	4.0		
17	0.0	0.0	0.0	1.2	0.0	0.7	4.2	1.6	7.7	1.2	3.6	3.7	5.0	0.0		
18	0.0	0.0	0.0	0.0	8.3	0.0	1.4	3.6	0.0	2.4	4.0	6.4	15.0	12.0		
19	0.0	0.0	0.0	2.4	0.0	2.1	0.0	5.4	3.8	4.7	1.8	9.1	0.0	8.0		
20	n.a.	0.0	n.a.	2.4	n.a.	3.4	n.a.	4.0	n.a.	7.1	n.a.	6.7	n.a.	16.0		
21 or older	n.a.	0.0	n.a.	9.8	n.a.	6.9	n.a.	8.6	n.a.	12.9	n.a.	14.0	n.a.	24.0		
Never had a birth	100.0	100.0	100.0	82.9	91.7	86.9	94.0	76.4	88.5	69.4	89.7	58.5	80.0	32.0		
Age not reported	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	0.0	0.0	0.0	0.0		
Total Percent	100%	100%	100%	99.9%	100%	100%	100%	100%	100%	100.1%	100%	99.9%	100%	100%		
Number-weighted (N)	2	11	10	84	36	145	286	500	27	85	224	329	20	26		
Number-unweighted (N)	1	11	8	75	25	134	208	443	24	75	168	321	12	26		

Females Percent whose first birth was at age:	Variable name: Race			
	White		Not White	
	Age at survey		Age at survey	
	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0
15	0.4	0.2	0.0	1.3
16	1.7	0.8	0.0	1.3
17	3.3	3.1	2.8	2.6
18	1.8	4.7	9.7	2.6
19	0.4	5.9	0.0	5.2
20	n.a.	4.9	n.a.	2.6
21 or older	n.a.	9.9	n.a.	16.9
Never had a birth	92.3	70.4	83.3	67.5
Age not reported	0.0	0.2	4.2	0.0
Total Percent	99.9%	100.1%	100%	100%
Number-weighted (N)	902	1,180	72	77
Number-unweighted (N)	663	1,101	44	68

**Table A10. Age at First Birth continued**

<b>Females</b> Percent whose first birth was at age:	<b>Variable name:</b> Region											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15	0.0	0.0	1.0	0.0	0.0	0.0	0.8	0.0	0.0	1.3	0.0	0.0
16	7.7	5.7	3.9	0.7	2.2	0.0	0.0	0.8	1.3	0.0	0.0	4.3
17	6.2	7.1	1.0	4.3	8.6	5.7	4.0	2.4	5.2	5.1	2.5	0.0
18	3.1	5.7	2.9	7.2	2.2	4.1	1.0	3.3	1.3	0.0	5.0	0.0
19	0.0	8.6	1.0	6.5	0.0	7.3	0.0	8.1	0.0	3.8	0.0	0.0
20	n.a.	7.1	n.a.	3.6	n.a.	7.3	n.a.	8.9	n.a.	3.8	n.a.	0.0
21 or older	n.a.	10.0	n.a.	12.3	n.a.	13.0	n.a.	8.9	n.a.	15.4	n.a.	13.0
Never had a birth	83.1	54.3	90.0	65.2	87.1	61.8	92.1	67.5	90.9	71.8	92.5	82.6
Age not reported	0.0	1.4	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0
Total Percent	100.1%	99.9%	99.8%	99.8%	100.1%	100%	100.1%	99.9%	100.1%	99.9%	100%	99.9%
Number-weighted (N)	65	70	104	139	94	123	101	123	77	78	40	25
Number-unweighted (N)	51	81	81	140	69	121	73	115	60	79	32	26

<b>Females continued</b> Percent whose first birth was at age:	<b>Variable name:</b> Region									
	South West		South East		Greater London		Wales		Scotland	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15	0.0	0.0	0.0	0.0	0.9	0.5	0.0	0.0	0.0	0.7
16	1.7	0.0	0.5	0.9	0.9	0.5	0.0	1.6	0.0	0.0
17	0.0	2.2	1.0	1.9	0.9	0.5	8.7	3.2	3.8	2.9
18	0.0	7.9	0.5	5.6	5.3	3.0	8.7	6.3	1.3	4.4
19	0.0	7.9	0.0	4.6	0.0	3.5	6.5	6.3	0.0	5.8
20	n.a.	3.4	n.a.	4.2	n.a.	2.5	n.a.	9.5	n.a.	2.2
21 or older	n.a.	12.4	n.a.	9.3	n.a.	7.0	n.a.	3.2	n.a.	10.9
Never had a birth	98.3	66.3	98.0	73.6	92.0	82.0	76.1	69.8	94.9	73.0
Age not reported	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0
Total Percent	100%	100.1%	100%	100%	100%	100%	100%	99.9%	100%	99.9%
Number-weighted (N)	60	89	201	216	116	199	47	64	78	137
Number-unweighted (N)	45	91	131	196	64	138	41	65	65	124

**Table A10. Age at First Birth continued**

Females Percent whose first birth was at age:	Variable name: Immigrant Status			
	Born in UK		Not born in UK	
	Age at survey		Age at survey	
	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0
15	0.4	0.3	0.0	0.0
16	1.7	0.9	0.0	0.0
17	3.0	3.2	7.3	0.0
18	2.1	4.8	5.5	0.0
19	0.4	5.8	0.0	7.5
20	n.a.	4.9	n.a.	1.3
21 or older	n.a.	10.0	n.a.	11.4
Never had a birth	92.3	69.7	81.8	80.0
Age not reported	0.0	0.2	5.5	0.0
Total Percent	99.9%	99.8%	100.1%	100.2%
Number-weighted (N)	918	1178	57	82
Number-unweighted (N)	674	1103	32	70

Females Percent whose first birth was at age:	Variable name: School Status					
	Full-time		10+hours paid work		Else & Missing	
	Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24
<15	0.0	0.0	0.0	0.0	0.0	0.0
15	0.0	0.0	0.0	0.0	1.8	1.1
16	0.0	0.0	0.5	0.5	5.8	1.9
17	0.0	0.0	2.6	0.9	10.8	8.2
18	0.0	0.0	0.8	0.9	8.5	13.5
19	0.0	0.0	0.0	2.4	1.8	14.3
20	n.a.	0.0	n.a.	1.7	n.a.	12.5
21 or older	n.a.	0.0	n.a.	6.7	n.a.	19.9
Never had a birth	100.0	100.0	96.1	86.9	70.0	28.1
Age not reported	0.0	0.0	0.0	0.0	1.3	0.5
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)	377	99	381	788	224	377
Number-unweighted (N)	248	60	275	678	189	438

Source(s): NATSAL  
 Year of survey: 1990/91

**Table A11. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables**

<b>Females</b>	<b>Variable name: Education</b>		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
Other	13.0	19.6	24.3
Male condom	25.9	37.8	35.8
Withdrawal	7.4	2.9	6.9
Rhythm (periodic abstinence)	0.0	0.0	0.0
Method not reported	0.0	1.0	1.0
No Method	48.1	29.4	16.6
Never had intercourse	5.6	9.3	15.6
Total Percent	100%	100%	100.2%
Number-weighted (N)	54	204	218
Number-unweighted (N)	69	203	170
Percent using both condoms and selected medical methods**	0.0	1.5	0.0

<b>Males</b>	<b>Variable name: Education</b>		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
Other	6.6	14.5	17.0
Male condom	20.5	37.4	44.2
Withdrawal	4.0	6.5	4.2
Rhythm (periodic abstinence)	2.0	0.7	0.0
Method not reported	0.0	1.9	2.4
No Method	57.0	31.7	21.7
Never had intercourse	9.9	7.2	10.5
Total Percent	100%	99.9%	100%
Number-weighted (N)	151	414	552
Number-unweighted (N)	133	348	431
Percent using both condoms and selected medical methods**	0.0	1.9	1.6

**Table A11. Contraceptive Method used at First Sex continued**

<b>Females</b>	<b>Variable name:</b> Household Social Class							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	100.0	16.7	9.4	23.2	7.1	21.5	8.3	21.7
Male condom	0.0	53.3	65.6	51.4	35.1	39.8	43.3	33.6
Withdrawal	0.0	3.3	6.3	4.1	2.8	4.7	2.5	6.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.5	0.1	0.6	0.0	0.0
Method not reported	0.0	0.0	0.0	0.5	0.1	2.3	0.0	0.9
No Method	0.0	20.0	9.4	15.4	10.9	23.5	23.5	33.7
Never had intercourse	0.0	6.7	9.4	5.0	43.1	7.4	22.2	4.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	30	31	220	785	795	159	218
Number-unweighted (N)	1	25	25	200	562	739	121	211
Percent using both condoms and selected medical methods**	0.0	0.0	0.0	0.0	1.4	0.9	1.3	0.9

<b>Males</b>	<b>Variable name:</b> Household Social Class							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	0.0	13.2	13.6	22.3	5.3	15.0	4.2	8.2
Male condom	38.8	34.2	81.8	42.0	34.1	39.0	37.1	34.2
Withdrawal	0.0	2.6	4.5	3.2	4.9	5.3	6.6	5.5
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.5	0.5	0.6	1.2	0.5
Method not reported	0.0	2.6	0.0	0.5	0.6	1.3	0.0	4.6
No Method	0.0	21.0	0.0	25.5	14.4	29.5	27.6	38.3
Never had intercourse	61.2	25.6	0.0	5.8	40.2	9.2	23.5	8.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	39	23	190	639	699	167	223
Number-unweighted (N)	2	33	16	163	426	558	110	178
Percent using both condoms and selected medical methods**	0.0	0.0	0.0	0.5	0.0	1.7	0.0	1.8

**Table A11. Contraceptive Method used at First Sex continued**

Females	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	100.0	18.2	10.0	12.0	5.4	22.6	12.7	21.4	11.5	22.4	7.1	26.0	5.9	26.9
Male condom	0.0	63.6	80.0	49.4	51.3	53.2	44.1	45.6	23.0	29.4	43.3	27.5	23.5	50.0
Withdrawal	0.0	0.0	0.0	7.2	5.4	2.1	4.6	3.6	15.4	4.7	1.3	8.3	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	2.1	0.0	0.4	0.0	2.4	0.0	0.0	0.0	0.0
Method not reported	0.0	0.0	0.0	0.0	0.0	2.1	0.4	2.2	0.0	0.0	0.0	1.2	0.0	0.0
No Method	0.0	0.0	10.0	27.7	21.6	9.6	12.0	20.2	26.9	32.9	18.7	31.5	23.5	23.1
Never had intercourse	0.0	18.2	0.0	3.6	16.2	8.2	26.1	6.5	23.1	8.2	29.5	5.5	47.1	0.0
Total Percent	100%	100%	100%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	100%	99.9%	100%	100%	100%
Number-weighted (N)	2	11	10	84	36	145	286	500	27	85	224	329	20	26
Number-unweighted (N)	1	11	8	75	25	134	208	443	24	75	168	321	12	26
Percent using both condoms and selected medical methods**	0.0	0.0	0.0	0.0	5.4	0.0	2.1	1.0	3.8	0.0	0.4	0.9	0.0	0.0

Males	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	0.0	11.6	33.3	25.0	31.8	20.9	3.8	19.5	7.2	12.3	6.1	9.9	0.0	5.6
Male condom	50.0	34.9	50.0	38.8	54.5	41.8	38.3	46.0	41.1	38.9	40.0	36.1	56.1	22.2
Withdrawal	0.0	2.3	0.0	5.2	4.5	3.3	9.0	3.2	5.0	6.4	6.7	6.4	4.9	5.6
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.9	0.0	0.0	0.0	0.0	1.1	0.6	0.6	0.4	4.9	2.8
Method not reported	0.0	2.3	0.0	0.0	0.0	1.1	0.0	2.2	0.0	1.8	0.0	2.6	0.0	5.6
No Method	0.0	25.6	16.7	27.8	0.0	23.1	14.3	21.6	27.8	34.2	25.5	33.5	12.2	55.5
Never had intercourse	50.0	23.3	0.0	2.6	9.1	9.9	34.6	7.6	17.8	5.8	21.1	11.2	22.0	2.8
Total Percent	100%	100%	100%	100%	99.9%	100.1%	100%	100.1%	100%	100%	100.1%	100.1%	100.1%	100.1%
Number-weighted (N)	2	44	11	117	22	91	134	187	180	343	179	238	40	36
Number-unweighted (N)	2	35	9	97	15	74	91	144	119	285	116	191	28	31
Percent using both condoms and selected medical methods**	0.0	4.7	0.0	0.9	0.0	1.1	0.0	2.2	0.0	0.6	0.0	1.3	0.0	0.0

**Table A11. Contraceptive Method used at First Sex continued**

<b>Females</b>	<b>Variable name: Race</b>			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
Other	7.7	22.4	5.7	13.0
Male condom	39.4	41.6	11.4	33.8
Withdrawal	2.9	4.7	2.9	5.2
Rhythm (periodic abstinence)	0.1	0.6	0.0	0.0
Method not reported	0.1	1.9	0.0	0.0
No Method	12.4	23.1	20.0	31.2
Never had intercourse	37.4	5.8	60.0	16.9
Total Percent	100%	100.1%	100%	100.1%
Number-weighted (N)	902	1,180	72	77
Number-unweighted (N)	663	1,101	44	68
Percent using both condoms and selected medical methods**	1.6	0.8	0.0	0.0

<b>Males</b>	<b>Variable name: Race</b>			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
Other	5.4	15.4	3.8	3.4
Male condom	36.8	39.4	23.1	23.7
Withdrawal	5.5	5.1	0.0	1.7
Rhythm (periodic abstinence)	0.6	0.6	0.0	0.0
Method not reported	0.3	1.7	3.8	3.4
No Method	17.5	29.5	3.8	45.8
Never had intercourse	33.8	8.4	65.4	22.0
Total Percent	99.9%	100.1%	99.9%	100%
Number-weighted (N)	779	1,089	52	63
Number-unweighted (N)	521	885	33	48
Percent using both condoms and selected medical methods**	0.0	1.6	0.0	0.0

**Table A11. Contraceptive Method used at First Sex continued**

Females	Variable name: Region											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	7.6	17.9	6.8	22.3	6.4	22.5	2.1	18.6	18.1	23.1	7.7	20.0
Male condom	37.9	31.3	36.0	41.0	45.8	33.3	40.6	45.8	38.3	37.2	35.9	56.0
Withdrawal	3.0	4.5	6.8	5.0	1.1	4.2	1.0	2.5	1.3	5.1	2.6	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	0.0	0.0	1.4	0.0	1.6	0.0	0.0	0.0	3.9	0.0	0.0
No method used	18.2	38.8	10.7	25.9	19.1	31.6	14.6	24.5	14.1	23.1	5.1	16.0
Never had intercourse	33.3	7.5	39.8	2.9	27.7	6.7	41.7	8.5	28.2	7.7	48.7	8.0
Total Percent	100%	100%	100.1%	99.9%	100.1%	99.9%	100%	99.9%	100%	100.1%	100%	100%
Number-weighted (N)	65	70	104	139	94	123	101	123	77	78	40	25
Number-unweighted (N)	51	81	81	140	69	121	73	115	60	79	32	26
Percent using both condoms and selected medical methods***	0.0	0.0	1.0	1.4	1.1	0.0	1.0	0.0	5.1	1.3	0.0	0.0

Females continued	Variable name: Region									
	South West		South East		Greater London		Wales		Scotland	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	8.6	24.1	7.1	18.6	8.0	20.9	8.9	17.2	10.4	30.7
Male condom	41.4	52.9	41.6	43.7	26.6	47.4	37.8	48.4	24.7	25.6
Withdrawal	1.7	1.1	1.0	5.1	5.3	5.1	6.7	7.8	0.0	7.3
Rhythm (periodic abstinence)	1.7	1.1	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.5
Method not reported	1.7	1.1	0.0	4.2	0.0	0.5	0.0	0.0	0.0	1.4
No method used	17.2	18.4	6.6	23.3	8.9	18.4	24.4	18.8	15.6	23.4
Never had intercourse	27.6	1.1	43.7	5.1	51.3	7.1	22.2	7.8	49.4	10.2
Total Percent	99.9%	99.8%	100%	100%	100.1%	99.9%	100%	100%	100.1%	100.1%
Number-weighted (N)	60	89	201	216	116	199	47	64	78	137
Number-unweighted (N)	45	91	131	196	64	138	41	65	65	124
Percent using both condoms and selected medical methods***	1.7	2.3	1.5	0.0	0.9	1.0	2.2	0.0	0.0	1.5

**Table A11. Contraceptive Method used at First Sex continued**

<b>Males</b>	<b>Variable name: Region</b>											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	10.5	14.9	7.4	13.9	8.2	16.1	2.2	19.3	8.1	23.1	0.0	8.3
Male condom	18.4	27.6	37.2	31.8	39.3	33.0	36.0	35.8	43.2	44.6	50.0	50.0
Withdrawal	5.3	2.1	8.5	3.3	3.3	4.2	3.4	3.7	2.7	1.5	10.9	5.6
Rhythm (periodic abstinence)	5.3	4.3	0.0	0.8	0.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0
Method not reported	0.0	0.0	2.1	3.3	0.0	1.6	0.0	0.0	0.0	1.5	4.3	2.8
No method used	23.7	42.6	18.1	37.9	11.4	35.6	15.7	24.8	18.9	16.9	2.2	16.7
Never had intercourse	36.8	8.5	26.6	9.0	37.7	9.3	42.7	16.5	27.0	10.8	32.6	16.7
Total Percent	100%	100%	99.9%	100%	99.9%	99.8%	100%	100.1%	99.9%	99.9%	100%	100.1%
Number-weighted (N)	38	49	93	122	62	120	90	116	74	64	46	36
Number-unweighted (N)	20	43	59	90	44	106	61	99	48	53	31	32
Percent using both condoms and selected medical methods***	0.0	2.1	0.0	1.6	0.0	0.8	0.0	0.9	0.0	0.0	0.0	0.0

<b>Males continued</b>	<b>Variable name: Region</b>									
	South West		South East		Greater London		Wales		Scotland	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Other	9.7	22.2	1.8	14.0	4.3	14.4	10.3	4.1	1.6	10.2
Male condom	38.9	40.8	39.8	38.6	29.0	43.1	20.7	44.9	27.0	40.2
Withdrawal	0.0	2.5	5.3	6.0	5.4	7.5	3.4	12.2	11.1	5.1
Rhythm (periodic abstinence)	1.4	0.0	1.2	0.9	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	0.0	0.0	3.3	0.0	1.9	0.0	0.0	0.0	0.7
No method used	25.0	23.5	14.0	27.9	22.6	28.2	20.7	32.6	12.7	37.9
Never had intercourse	25.0	11.1	38.0	9.3	38.7	5.0	44.8	6.1	47.6	5.8
Total Percent	100%	100.1%	100.1%	100%	100%	100.1%	99.9%	99.9%	100%	99.9%
Number-weighted (N)	73	84	169	217	94	160	29	49	63	138
Number-unweighted (N)	49	70	105	162	52	108	23	47	53	125
Percent using both condoms and selected medical methods***	0.0	2.5	0.0	1.4	0.0	2.5	0.0	0.0	0.0	1.5

**Table A11. Contraceptive Method used at First Sex continued**

<b>Females</b>	<b>Variable name: Immigrant Status</b>			
	<b>Born in the UK</b>		<b>Not born in the UK</b>	
	<i>Age at survey</i>		<i>Age at survey</i>	
	<b>16-19</b>	<b>20-24</b>	<b>16-19</b>	<b>20-24</b>
<b>Percent using each method at first intercourse*</b>				
Other	7.9	22.2	1.9	15.7
Male condom	38.3	40.9	25.0	43.4
Withdrawal	2.9	4.6	1.9	6.0
Rhythm (periodic abstinence)	0.1	0.6	0.0	0.0
Method not reported	0.1	1.7	0.0	1.2
No Method	12.5	23.6	21.2	25.3
Never had intercourse	38.2	6.4	50.0	8.4
Total Percent	100%	100%	100%	100%
Number-weighted (N)	918	1,178	57	82
Number-unweighted (N)	674	1,103	32	70
Percent using both condoms and selected medical methods**	1.5	0.8	0.0	0.0

<b>Males</b>	<b>Variable name: Immigrant Status</b>			
	<b>Born in the UK</b>		<b>Not born in the UK</b>	
	<i>Age at survey</i>		<i>Age at survey</i>	
	<b>16-19</b>	<b>20-24</b>	<b>16-19</b>	<b>20-24</b>
<b>Percent using each method at first intercourse*</b>				
Other	5.3	14.7	5.0	16.9
Male condom	36.3	39.6	32.5	22.9
Withdrawal	5.2	5.1	2.5	2.4
Rhythm (periodic abstinence)	0.6	0.7	0.0	0.0
Method not reported	0.5	1.9	0.0	0.0
No Method	17.0	29.2	10.0	45.8
Never had intercourse	35.0	8.9	50.0	12.0
Total Percent	99.9%	100.1%	100%	100%
Number-weighted (N)	790	1,069	40	83
Number-unweighted (N)	526	873	27	61
Percent using both condoms and selected medical methods**	0.0	1.6	0.0	0.0

**Table A11. Contraceptive Method used at First Sex continued**

Females	Variable name: School Status					
	Full-time		10+hours paid work		Else & Missing	
	Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24
Other	3.2	11.2	11.6	22.7	8.3	22.1
Male condom	26.8	58.2	46.1	44.1	40.4	30.1
Withdrawal	2.1	5.1	2.9	4.5	4.1	5.1
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.5	0.5	0.8
Method not reported	0.0	0.0	0.3	1.7	0.0	2.4
No Method	4.3	12.2	14.3	19.4	25.3	36.3
Never had intercourse	63.5	13.3	24.8	7.2	21.6	3.2
Total Percent	99.9%	100%	100%	100.1%	100.2%	100%
Number-weighted (N)	377	99	381	788	224	377
Number-unweighted (N)	248	60	275	678	189	438
Percent using both condoms and selected medical methods**	1.3	0.0	1.8	0.8	0.5	0.8

Males	Variable name: School Status					
	Full-time		10+hours paid work		Else & Missing	
	Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24
Other	2.5	14.0	8.6	15.1	2.8	13.8
Male condom	29.8	38.8	42.7	40.5	32.6	30.6
Withdrawal	2.2	5.8	5.7	5.3	9.7	3.0
Rhythm (periodic abstinence)	0.3	0.0	0.8	0.7	0.0	0.5
Method not reported	1.3	0.0	0.0	1.6	0.0	3.4
No Method	5.4	19.8	22.7	30.1	25.7	37.0
Never had intercourse	58.4	21.5	19.5	6.7	29.2	11.8
Total Percent	99.9%	99.9%	100%	100%	100%	100.1%
Number-weighted (N)	315	124	370	827	147	203
Number-unweighted (N)	202	84	247	686	105	165
Percent using both condoms and selected medical methods**	0.0	4.1	0.0	1.3	0.0	1.0

Source(s):

NATSAL

Year of survey:

1990/91

**Table A12. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables**

Females	Variable name: Education		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
Percent using each method at last intercourse*			
Sterilization	0.0	1.9	0.0
Oral contraceptives	44.9	50.0	52.0
IUD	7.2	5.8	1.2
Condoms	8.7	7.8	12.9
Diaphragm/Cap/f.condom	1.4	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0
Withdrawal	1.4	0.5	0.6
Rhythm (periodic abstinence)	0.0	0.5	0.0
Method not reported	1.4	3.4	1.8
No method used	13.0	6.8	3.5
No intercourse-past 3 mths	17.4	17.0	12.9
Never had intercourse	4.3	6.3	15.2
Total Percent	99.7%	100%	100.1%
Number-weighted (N)	52	208	219
Number-unweighted (N)	69	206	171
Percent using both condoms and selected medical methods***	7.3	13.5	27.7

Males	Variable name: Education		
	None	O-level/CSE	At least A-levels/Higher
	<i>Age at survey</i>	<i>Age at survey</i>	<i>Age at survey</i>
	20-24	20-24	20-24
Percent using each method at last intercourse*			
Sterilization	1.3	1.0	0.5
Oral contraceptives	34.9	48.6	43.3
IUD	1.3	2.1	1.1
Condoms	16.4	17.1	18.3
Diaphragm/Cap/f.condom	0.0	0.2	0.5
Foam/jelly/cream/suppository	0.0	0.0	0.0
Withdrawal	0.7	1.4	0.2
Rhythm (periodic abstinence)	0.7	0.0	0.0
Method not reported	2.0	1.9	1.1
No method used	13.2	5.5	1.1
No intercourse-past 3 mths	19.7	15.0	23.4
Never had intercourse	9.9	7.1	10.4
Total Percent	100.1%	99.9%	99.9%
Number-weighted (N)	152	420	556
Number-unweighted (N)	134	353	433
Percent using both condoms	23.0	22.6	13.1

**Table A12. Contraceptive Method used at Last Sex continued**

<b>Females</b>	<b>Variable name: Household Social Class</b>							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	1.3	0.2	2.2	0.0	1.1
Oral contraceptives	100.0	68.1	49.4	58.8	28.2	50.5	44.6	49.7
IUD	0.0	0.0	0.0	1.2	0.4	3.5	0.6	4.7
Condoms	0.0	18.8	25.0	14.8	10.2	11.3	11.6	10.8
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.4	0.0	0.6	0.0	0.4
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Withdrawal	0.0	0.0	0.0	0.0	0.7	1.1	2.6	0.6
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.4
Method not reported	0.0	0.0	0.0	0.0	0.5	0.8	2.0	2.6
No method used	0.0	3.1	0.0	5.3	1.7	7.2	3.1	9.8
No intercourse-past 3 mths	0.0	3.3	16.4	12.5	13.6	13.7	12.3	15.6
Never had intercourse	0.0	6.7	9.4	5.0	43.2	7.4	22.3	4.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	30	31	220	785	795	159	218
Number-unweighted (N)	1	25	25	200	562	739	121	211
Percent using both condoms and selected medical methods***	0.0	13.3	32.3	21.0	11.8	18.4	16.4	11.0

<b>Males</b>	<b>Variable name: Household Social Class</b>							
	Professional		Intermediate		Skilled		Semi/Unskilled	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	0.3	0.0	0.7	0.0	1.3
Oral contraceptives	0.0	38.9	52.9	49.5	20.0	45.0	23.7	37.7
IUD	0.0	0.0	0.0	1.5	0.4	1.8	0.0	1.0
Condoms	38.8	11.5	19.1	24.0	13.8	16.2	21.0	18.7
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.2	0.2	0.4	1.2	0.5
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.0	0.0	0.0	0.5	1.1	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.7	0.0	0.0	0.4
Method not reported	0.0	3.6	0.0	0.3	0.0	0.5	0.0	0.0
No method used	0.0	1.5	0.0	1.5	2.4	4.5	4.2	6.6
No intercourse-past 3 mths	0.0	19.3	25.9	16.4	21.8	19.8	26.4	23.1
Never had intercourse	61.2	25.2	0.0	5.9	40.1	9.2	23.6	8.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)	2	39	23	190	639	699	167	223
Number-unweighted (N)	2	33	16	163	426	558	110	178
Percent using both condoms and selected medical methods***	0.0	12.8	47.8	22.2	12.5	23.8	13.2	16.6

**Table A12. Contraceptive Method used at Last Sex continued**

Females	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	1.3	0.0	0.0	0.5	0.9	0.0	4.0	0.0	2.2	0.0	3.8
Oral contraceptives	100.0	54.5	62.5	68.0	56.0	54.5	46.6	56.0	45.8	49.3	41.7	50.5	41.7	46.2
IUD	0.0	0.0	0.0	1.3	0.0	2.2	0.5	3.8	0.0	5.3	0.6	5.9	0.0	3.8
Condoms	0.0	27.3	12.5	16.0	16.0	9.0	10.6	11.3	12.5	13.3	10.7	10.0	8.3	15.4
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.0	0.0	0.7	0.0	1.4	0.0	1.3	0.0	0.0	0.0	3.8
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.0
Withdrawal	0.0	0.0	0.0	0.0	0.0	0.0	0.5	1.6	4.2	1.3	2.4	0.6	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	1.3	0.0	0.3	0.0	0.0
Method not reported	0.0	0.0	0.0	0.0	4.0	0.7	1.0	2.2	0.0	1.3	2.4	2.5	8.3	0.0
No method used	0.0	0.0	0.0	4.0	0.0	8.8	3.4	5.4	4.2	5.3	3.6	10.6	0.0	15.4
No intercourse-past 3 mths	0.0	9.1	25.0	6.7	8.0	16.4	14.4	12.2	12.5	10.7	11.3	13.1	0.0	11.5
Never had intercourse	0.0	9.1	0.0	2.7	16.0	7.5	22.6	5.0	20.8	6.7	26.8	4.4	41.7	0.0
Total Percent	100%	100%	100%	100%	100%	99.8%	100.1%	100%	100%	99.8%	100.1%	100.1%	100%	99.9%
Number-weighted (N)	2	11	10	84	36	145	286	500	27	85	224	329	20	26
Number-unweighted (N)	1	11	8	75	25	134	208	443	24	75	168	321	12	26
Percent using both condoms and selected medical methods***	0.0	18.2	25.0	18.7	36.0	21.6	18.3	19.2	16.7	9.3	14.9	13.1	25.0	15.4

Males	Variable name: Socioeconomic Group (SEG)													
	Professional		Employers & Managers		Interm & Non-Manual		Junior & Non-manual		Skilled Manual		Semiskilled Manual		Unskilled Manual	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	1.0	0.0	1.4	0.0	0.0	0.0	1.4	0.0	1.6	0.0	0.0
Oral contraceptives	0.0	42.9	55.6	54.6	46.7	47.3	25.3	50.7	30.3	47.7	25.9	42.9	21.4	32.3
IUD	0.0	0.0	0.0	1.0	0.0	1.4	0.0	0.7	0.8	2.8	0.0	1.6	0.0	3.2
Condoms	50.0	17.1	22.2	18.6	26.7	23.0	13.2	15.3	15.1	16.5	23.3	16.8	14.3	16.1
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.7	0.0	0.7	1.7	0.5	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.8	1.4	0.0	0.0	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.8	0.0	0.0	0.0	3.6	0.0
Method not reported	0.0	2.9	0.0	2.0	0.0	1.4	1.1	0.7	0.0	1.5	0.0	1.6	0.0	3.2
No method used	0.0	2.9	0.0	4.1	6.7	0.0	3.3	1.4	3.4	7.4	4.3	6.8	3.6	12.9
No intercourse-past 3 mths	0.0	17.1	22.2	15.5	6.7	17.6	19.8	22.2	30.3	16.1	23.3	18.3	35.7	29.0
Never had intercourse	50.0	17.1	0.0	2.1	13.3	8.1	35.2	8.3	18.5	4.6	21.5	9.9	21.4	3.2
Total Percent	100%	100%	100%	99.9%	100.1%	100.2%	100.1%	100%	100%	100.1%	100%	100%	100%	99.9%
Number-weighted (N)	2	44	11	117	22	91	134	187	180	343	179	238	40	36
Number-unweighted (N)	2	35	9	97	15	74	91	144	119	285	116	191	28	31
Percent using both condoms and selected medical methods***	0.0	20.0	33.3	26.8	33.3	24.3	16.5	30.6	17.6	22.5	14.7	16.8	14.3	16.1

**Table A12. Contraceptive Method used at Last Sex continued**

<b>Females</b>	<b>Variable name:</b> Race			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
Percent using each method at last intercourse*				
Sterilization	0.2	1.9	0.0	39.8
Oral contraceptives	32.4	53.1	22.9	2.3
IUD	0.5	3.3	0.0	12.1
Condoms	11.6	12.1	0.0	0.8
Diaphragm/Cap/f.condom	0.0	0.7	0.0	0.0
Foam/jelly/cream/suppository	0.1	0.0	0.0	0.0
Withdrawal	1.1	0.9	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.3	0.0	0.0
Method not reported	1.2	1.9	8.8	1.4
No method used	1.9	7.4	1.3	5.4
No intercourse-past 3 mths	13.7	12.8	9.6	22.3
Never had intercourse	37.3	5.8	57.4	16.0
Total Percent	100%	100.2%	100%	100.1%
Number-weighted (N)	902	1180	72	77
Number-unweighted (N)	663	1101	44	68
Percent using both condoms and selected medical methods***	13.3	17.6	12.3	16.9

<b>Males</b>	<b>Variable name:</b> Race			
	White		Not White	
	<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24
Percent using each method at last intercourse*				
Sterilization	0.0	0.8	0.0	0.0
Oral contraceptives	22.3	45.3	10.5	21.3
IUD	0.3	1.6	0.0	0.7
Condoms	15.4	17.4	16.5	25.0
Diaphragm/Cap/f.condom	0.4	0.4	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0
Withdrawal	0.4	0.7	0.0	0.0
Rhythm (periodic abstinence)	0.5	0.1	0.0	0.0
Method not reported	0.2	1.2	0.0	5.2
No method used	2.9	4.3	0.0	3.7
No intercourse-past 3 mths	23.8	19.8	6.9	23.2
Never had intercourse	33.8	8.4	66.1	20.8
Total Percent	100%	100%	100%	99.9%
Number-weighted (N)	779	1,089	52	63
Number-unweighted (N)	521	885	33	48
Percent using both condoms and selected medical methods***	14.0	22.1	7.7	14.1

**Table A12. Contraceptive Method used at Last Sex continued**

Females	Variable name: Region											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	2.5	0.0	1.4	0.0	3.3	1.4	3.5	0.0	2.5	0.0	0.0
Oral contraceptives	37.3	48.1	38.3	51.4	37.7	56.2	26.0	47.0	46.7	60.8	43.8	69.2
IUD	0.0	8.6	0.0	4.3	2.9	5.0	0.0	2.6	3.3	1.3	0.0	0.0
Condoms	9.8	9.9	9.9	10.0	11.6	9.9	17.8	9.6	8.3	12.7	6.3	3.8
Diaphragm/Cap/f.condom	0.0	1.2	0.0	0.7	0.0	0.8	0.0	0.9	0.0	0.0	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.1	0.0
Withdrawal	2.0	0.0	1.2	0.7	1.4	1.7	0.0	2.6	0.0	0.0	3.1	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	4.9	1.2	0.7	0.0	3.4	1.4	3.5	0.0	1.3	0.0	0.0
No method used	3.9	7.4	6.2	9.3	4.3	4.1	1.4	9.6	0.0	7.6	0.0	7.7
No intercourse-past 3 mths	17.6	13.6	7.4	17.9	15.9	10.7	16.4	13.0	16.7	8.9	3.1	11.5
Never had intercourse	29.4	3.7	35.8	2.1	26.1	5.0	35.6	7.8	25.0	5.1	40.6	7.7
Total Percent	100%	99.9%	100%	99.9%	99.9%	100.1%	100%	100.1%	100%	100.2%	100%	99.9%
Number-weighted (N)	65	70	104	139	94	123	101	123	77	78	40	25
Number-unweighted (N)	51	81	81	140	69	121	73	115	60	79	32	26
Percent using both condoms and selected medical methods***	17.6	11.1	14.8	17.1	10.1	14.0	5.5	13.0	16.7	16.5	25.0	30.8

Females continued	Variable name: Region									
	South West		South East		Greater London		Wales		Scotland	
	Age at survey		Age at survey		Age at survey		Age at survey		Age at survey	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	1.5	0.0	1.4	0.0	0.0	0.0	0.0
Oral contraceptives	44.4	63.7	29.8	53.6	23.4	50.0	48.8	49.2	29.2	52.4
IUD	0.0	7.7	0.8	3.1	0.0	3.6	0.0	6.2	0.0	4.0
Condoms	11.1	7.7	9.2	15.8	12.5	11.6	7.3	15.4	12.3	12.9
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.5	0.0	1.4	0.0	1.5	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	2.2	0.0	1.5	0.5	0.0	1.4	0.0	1.5	0.0	0.8
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	2.2	0.8	1.5	3.2	1.4	4.8	1.5	6.1	0.8
No method used	4.4	9.9	0.8	6.1	1.6	3.8	4.9	10.8	1.5	8.1
No intercourse-past 3 mths	11.1	7.7	17.6	11.7	7.8	18.1	14.6	6.2	9.2	12.1
Never had intercourse	26.7	1.1	39.7	4.1	51.6	7.2	19.5	7.7	41.5	8.9
Total Percent	99.9%	100%	100.2%	99.9%	100.1%	99.9%	99.9%	100%	99.8%	100%
Number-weighted (N)	60	89	201	216	116	199	47	67	78	137
Number-unweighted (N)	45	91	131	196	64	138	41	65	65	124
Percent using both condoms and selected medical methods***	17.8	17.6	13.7	18.9	14.1	20.3	19.5	13.8	13.8	14.5

**Table A12. Contraceptive Method used at Last Sex continued**

<b>Males</b>	<b>Variable name: Region</b>											
	Northern		North West		Yorks/Humberside		West Midlands		East Midlands		East Anglia	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	3.8	0.0	0.0
Oral contraceptives	24.1	39.5	23.7	41.1	20.5	56.6	24.6	41.4	27.1	54.7	25.8	43.8
IUD	0.0	2.3	0.0	1.1	0.0	1.9	0.0	2.0	0.0	1.9	0.0	3.1
Condoms	6.9	18.6	25.4	20.0	18.2	16.0	11.5	16.2	20.8	15.1	12.9	15.6
Diaphragm/Cap/f.condom	0.0	0.0	1.7	0.0	0.0	0.9	0.0	0.0	0.0	1.9	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	2.3	0.0	1.1	0.0	0.0	1.6	2.0	0.0	0.0	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	0.0	1.1	2.3	0.0	1.6	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	4.6	0.0	0.0	0.0	1.9	1.6	4.0	0.0	0.0	0.0	3.1
No method used	10.3	7.0	8.5	6.7	2.3	2.8	3.3	6.1	0.0	3.8	0.0	3.1
No intercourse-past 3 mths	17.2	18.6	13.6	19.9	20.5	13.2	14.8	14.1	25.0	11.3	22.6	18.8
Never had intercourse	41.4	7.0	27.1	8.9	36.4	5.7	41.0	12.1	27.1	7.5	38.7	12.5
Total Percent	99.9%	99.9%	100%	99.9%	100.2%	99%	100%	99.9%	100%	100%	100%	100%
Number-weighted (N)	38	49	93	122	62	120	90	116	74	64	46	36
Number-unweighted (N)	29	43	59	90	44	106	61	99	48	53	31	32
Percent using both condoms and selected medical methods***	3.4	11.6	16.9	21.1	11.4	23.6	19.7	13.1	16.7	30.2	19.4	25.0

<b>Males continued</b>	<b>Variable name: Region</b>									
	South West		South East		Greater London		Wales		Scotland	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24	16-19	20-24
Sterilization	0.0	0.0	0.0	1.9	0.0	0.0	0.0	0.0	0.0	0.8
Oral contraceptives	32.7	52.9	16.2	43.8	15.4	43.5	17.4	51.1	20.8	44.0
IUD	0.0	1.4	0.0	1.2	1.9	0.0	0.0	0.0	0.0	4.0
Condoms	16.3	14.3	15.2	16.7	7.7	18.5	18.3	14.9	18.9	16.0
Diaphragm/Cap/f.condom	0.0	1.4	0.0	0.0	1.9	0.0	0.0	2.1	0.0	0.8
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	0.0	1.0	0.0	0.0	0.0	0.0	2.1	0.0	0.0
Rhythm (periodic abstinence)	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Method not reported	0.0	4.3	0.0	0.6	0.0	0.9	0.0	2.1	0.0	0.0
No method used	0.0	1.4	1.9	5.6	1.9	6.5	4.3	10.6	3.8	2.4
No intercourse-past 3 mths	24.5	14.3	28.6	22.2	28.8	25.0	19.4	12.8	17.0	24.8
Never had intercourse	26.5	10.0	36.2	8.0	42.3	5.6	40.5	4.3	39.6	7.2
Total Percent	100%	100%	100.1%	100%	99.9%	100%	99.9%	100%	100.1%	100%
Number-weighted (N)	73	84	169	217	84	160	29	49	63	138
Number-unweighted (N)	49	70	105	162	52	108	23	47	53	125
Percent using both condoms and selected medical methods***	14.3	24.3	11.4	23.5	13.5	25.0	8.7	27.7	9.4	21.6

**Table A12. Contraceptive Method used at Last Sex continued**

<b>Females</b>	<b>Variable name:</b> Immigrant Status			
	<b>Born in UK</b>		<b>Not born in UK</b>	
	<b>Age at survey</b>		<b>Age at survey</b>	
	<b>16-19</b>	<b>20-24</b>	<b>16-19</b>	<b>20-24</b>
Percent using each method at last intercourse*				
Sterilization	0.2	1.9	0.0	0.0
Oral contraceptives	32.4	53.2	22.7	39.1
IUD	0.5	2.9	0.0	7.6
Condoms	11.2	11.8	6.7	13.9
Diaphragm/Cap/f.condom	0.0	0.8	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	2.2	0.0
Withdrawal	0.8	0.8	4.9	1.0
Rhythm (periodic abstinence)	0.0	0.3	0.0	0.0
Method not reported	1.5	1.9	6.1	0.5
No method used	2.0	7.5	0.0	3.3
No intercourse-past 3 mths	13.4	12.7	10.9	26.4
Never had intercourse	38.1	6.3	46.4	8.1
Total Percent	100.1%	100.1%	99.9%	99.9%
Number-weighted (N)	918	1178	57	82
Number-unweighted (N)	674	1103	32	70
Percent using both condoms and selected medical methods***	13.3	17.9	12.3	10.8

<b>Males</b>	<b>Variable name:</b> Immigrant Status			
	<b>Born in UK</b>		<b>Not born in UK</b>	
	<b>Age at survey</b>		<b>Age at survey</b>	
	<b>16-19</b>	<b>20-24</b>	<b>16-19</b>	<b>20-24</b>
Percent using each method at last intercourse*				
Sterilization	0.0	0.8	0.0	0.6
Oral contraceptives	22.0	45.0	13.9	31.5
IUD	0.3	1.6	0.0	0.6
Condoms	15.2	17.0	21.9	27.8
Diaphragm/Cap/f.condom	0.4	0.4	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0
Withdrawal	0.4	0.4	0.0	3.4
Rhythm (periodic abstinence)	0.5	0.1	0.0	0.0
Method not reported	0.2	4.0	0.0	0.0
No method used	2.8	1.6	0.0	7.8
No intercourse-past 3 mths	23.3	20.3	13.5	16.3
Never had intercourse	35.0	8.8	50.6	12.0
Total Percent	100.1%	100%	99.9%	100%
Number-weighted (N)	790	1069	40	83
Number-unweighted (N)	526	873	27	61
Percent using both condoms and selected medical methods***	13.7	21.7	10.3	22.6

**Table A12. Contraceptive Method used at Last Sex continued**

<b>Females</b>	<b>Variable name: School Status</b>					
	Full-time		10+hours paid work		Else & Missing	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24
Percent using each method at last intercourse*						
Sterilization	0.0	0.0	0.0	0.0	0.5	1.6
Oral contraceptives	15.7	48.3	47.6	59.8	43.3	47.3
IUD	0.0	1.7	0.4	2.5	2.1	7.3
Condoms	9.3	18.3	13.8	12.2	8.5	9.6
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.2	0.0	0.5
Foam/jelly/cream/suppository	0.4	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.8	0.0	0.7	0.6	1.6	1.6
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.1	0.0	0.5
Method not reported	0.8	0.0	0.4	1.8	3.2	2.5
No method used	0.4	1.7	0.7	3.7	7.9	13.7
No intercourse-past 3 mths	12.1	11.7	13.1	12.1	14.8	13.5
Never had intercourse	60.5	18.3	23.3	6.2	18.0	2.1
Total Percent	100%	100%	100%	100.2%	99.9%	100.2%
Number-weighted (N)	377	99	381	788	224	377
Number-unweighted (N)	248	60	275	678	189	438
Percent using both condoms and selected medical methods***	7.3	33.3	20.7	18.4	14.3	11.4

<b>Males</b>	<b>Variable name: School Status</b>					
	Full-time		10+hours paid work		Else & Missing	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	16-19	20-24	16-19	20-24	16-19	20-24
Percent using each method at last intercourse*						
Sterilization	0.0	0.0	0.0	0.7	0.0	2.4
Oral contraceptives	12.9	28.6	30.4	50.7	20.0	37.6
IUD	0.0	0.0	0.4	2.0	0.0	1.2
Condoms	12.4	19.0	17.8	17.2	18.1	13.3
Diaphragm/Cap/f.condom	0.5	0.0	0.4	0.7	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	0.0	1.2	0.0	0.4	1.9	0.6
Rhythm (periodic abstinence)	1.0	0.0	0.4	0.0	0.0	0.6
Method not reported	0.0	1.2	0.0	1.7	1.0	1.8
No method used	0.0	1.2	4.5	4.8	5.7	7.3
No intercourse-past 3 mths	15.3	27.4	25.9	16.0	23.8	25.5
Never had intercourse	57.9	21.4	20.2	5.8	29.5	9.7
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)	315	124	370	827	147	203
Number-unweighted (N)	202	84	247	686	105	165
Percent using both condoms and selected medical methods***	8.4	20.2	19.4	24.5	9.5	13.9

Source(s):  
Year of survey:

NATSAL  
1990/91

**Table A13. Percentage distribution according to socioeconomic measures by age**

Age and gender	Marital/cohabitation status				Total percent	Number (n)
	Currently married	Currently cohabitating	Formerly married/cohabiting	Never married/cohabited		
Youth aged 16-19	1.8	3.7	3.3	90.8	100%	1,813
males	0.6	1.9	2.2	95.2	100%	881
females	2.9	5.2	4.3	87.2	100%	982
Youth aged 20-24	20.4	16.3	10.0	52.0	100%	2,418
males	14.2	11.6	8.1	64.8	100%	1,153
females	26.1	20.6	11.8	40.3	100%	1,265

Age	Family income/poverty status					Total	Number
	Professional, employer, managerial	Intermediate, non-manual & INR non-manual	Skilled manual	Semi/unskilled manual	Unclassifiable		
Youth aged 16-19	1.4	26.4	11.4	25.6	35.2	100%	1,813
Youth aged 20-24	10.6	38.2	17.7	26.0	7.4	100%	2,418

Age	Social class/parent's occupation				Total percent	Number (n)
	Professional/intermediate	Skilled, manual, non-manual	Semi/ unskilled	Other		
Youth aged 16-19	3.3	30.8	18.0	48.0	100%	1,813
Youth aged 20-24	19.9	47.6	18.3	14.3	100%	2,418

Age	Region/province of the country				Total percent	Number (n)
	Wales + SW	London + SE	Midlands + N	Scotland		
Youth aged 16-19	11.5	36.7	44.1	7.8	100%	1,813
Youth aged 20-24	11.8	35.3	41.5	11.4	100%	2,418

Age	Race/ethnicity - groups as applicable for country					Total Percent	Number (n)
	White	Black	Asian	Other	Missing		
Youth aged 16-19	92.7	1.9	3.6	1.4	0.4	100%	1,813
Youth aged 20-24	93.9	1.7	2.4	1.6	0.3	100%	2,417

Age	Immigrant status		Total Percent	Number (n)
	Native born	Foreign born		
Youth aged 16-19	94.2	5.4	100%	1,813
Youth aged 20-24	93.0	6.8	100%	2,417

Age and gender	School status				Total Percent	Number (n)
	In School Only	School + employed	Employed only	Else		
Youth aged 16-19	38.2	na	41.4	20.5	100%	1,813
males	37.9	na	44.6	17.7	100%	831
females	38.4	na	38.8	22.8	100%	982
Youth aged 20-24	9.2	na	66.8	24.0	100%	2,418
males	10.7	na	71.7	17.6	100%	1,153
females	7.8	na	62.3	29.8	100%	1,265

Source(s): NATSAL

Year of survey/census: 1990/91