



# Teenage pregnancies internationally

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*Evelyn Laue*

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In this third issue of the FORUM series on the subject of 'Teenage pregnancies' the perspective is extended: As well as contributions on current studies in Germany, we are also providing information about representative data and approaches to prevention in other European countries.

First of all the Federal Statistical Office gives an overview of the number of births and terminations of pregnancy by underage women in Germany and shows the development between 2000 and 2006.

Based on a survey carried out amongst some 1,800 underage pregnant women in pro familia information centres, specialists have addressed the risk factors and errors in contraception which are most often the cause of unwanted pregnancies.

We also report on a study, conducted on behalf of the BZgA, in which it was assessed on the basis of 100 expert interviews what provisions and help are available for underage pregnant women in Berlin and Brandenburg, whether the existing services are known and whether they are accepted by the young people. The background to this is that comparisons between German federal states show relatively high numbers of teenage pregnancies in the eastern German regions.

'Pregnant under 18' is a new Internet resource being offered by the BZgA, the basic principles and components of which we present here. It is aimed at pregnant young women, their partners and families, as well as young people who are looking for information on the subject.

Our author Osmo Kontula has undertaken to provide an overview of the developments in fertility and birth rates for underage mothers throughout the whole of Europe. The Council of Europe data evaluated by him show a reduction in underage birth rates since 1990, but at the same time definite differences between western and eastern Europe, which he attributes to factors such as social inequality, poverty, lack of access to advisory services and safe contraception.

Authors from Norway, Ireland and Iceland report on the very varied problems, the general social conditions and approaches to prevention in relation to underage pregnant women and mothers in their countries.

The international contributions to the issue make it clear just how much the field of sexual and reproductive health, and the possibilities and measures involved in sex education and family planning depend on the cultural context from which they originate.

The next issue of the FORUM 3-2007 will be devoted to the subject of youth/puberty.

*Your editorial team*

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# Underage pregnant women in Germany

## Statistical data on terminations of pregnancy and births

The current statistical data on teenage pregnancies in Germany are presented below. On the basis of the results of teenage termination statistics and birth statistics for the 10 to 18-year-old age group during the period from 2000 to 2006, the author presents developments which are broken down by federal state.

### Introduction

Questions are always being asked about the number of pregnancies in Germany, particularly the number of so-called teenage pregnancies. This contribution, with updated figures, should therefore be an essential element of any new publications on this subject.

In official statistics there is no systematic and uniform method of recording pregnancies. Inferences about the numbers involved are basically possible through results from statistics on births and terminations of pregnancy.

### Termination of pregnancy statistics

The results of these statistics provide information on the number, the legal basis and the type of termination of pregnancy as well as the progression of terminations in Germany. The statistics also provide details about selected living conditions (age, marital status, number of children) of the women concerned.

Using the statistical information on terminations of pregnancy and the women concerned, structural conclusions can be drawn. First the total number of all terminations of pregnancy should be considered, and then we can turn our attention to the group of underage women. It should be pointed out here that the actual age of the pregnant women at the time of the termination of pregnancy is recorded directly and not via the details of the year under review and the year of birth of the pregnant women.

### Terminations of pregnancy in 2006

For the year under review, 2006, the Federal Statistical Office was notified of a total of 119,710 terminations of pregnancy in Germany. That was 4,313 fewer (-3.5%) than in the previous year (s. tab. 1).

6,590 underage women had a termination, 657 fewer (-9.1%) than in the previous year. Therefore the absolute number of terminations of pregnancy for underage women reduced for the second year in succession. Of all the women who had a termination of pregnancy in 2006, 5.6% were underage.

As expected, almost all of the underage women were single (99.6%). It is also not surprising that the vast majority of the underage women (97.2%) had not had any children before the termination of pregnancy. However, 2.8% of those concerned indicated that they had already given birth to a child.

In the reason for the termination there was also a different distribution than for pregnant women as a whole: a medical or criminological indication was cited for only 1% of the underage pregnant women; for 99% the counselling regulation was the legal justification for the termination of the pregnancy.

In the duration of the pregnancies too there are differences in the under 18 age group compared with the total number. Overall, pregnancies were terminated before the eighth week of pregnancy in 47.2% of all cases, while for the under 18s the proportion was only 40.8%. The proportion of terminations in the eighth to the twelfth week was 50.9% of the total number of cases, whereas 58.6% of the terminations in underage women were carried out during this period. Thus, overall 98.1% of all terminations were carried out up to and including the twelfth week of pregnancy, but in underage women it was 99.3% of the cases. The average duration of pregnancy for the under 18s is 8.1 weeks, that is 0.2 weeks longer than for the total number of cases, for which the average duration is 7.9 weeks.

Only 72.4% of the terminations of pregnancy for underage women were carried out as day cases in gynaecological practices, 24.9% were carried out as day cases in hospitals (of the total number of terminations of pregnancy only 19.0% were carried out as day cases in hospitals).

The most common method of termination in 2006 was still vacuum aspiration. At 78.4%, this was used slightly more frequently for underage pregnant women than for pregnant women overall, at 77.0%. On the other hand terminations with the active agent mifepristone, which is marketed under the brand name Mifegyne® ('morning-after pill'), were carried out in only 8.7% of cases of underage women.

## Progression of the number of terminations of pregnancy from 2000 to 2006

(s. fig 1)

The number of terminations of pregnancy of women over 18 has basically been falling continuously since 2000, with an outlier in 2004. On the other hand there has only been a definite reduction in the number of terminations in under 18s since 2004 – until then an (almost) annual increase in terminations was recorded.

- The total number of terminations of pregnancy reduced by 11.2% from 2000 to 2006. The total reduced by 10.2% in the former federal territory, by 12.8% in the new states and by 16.2% in Berlin.
- During this time the number of terminations in underage women increased by 4%. In the former federal territory the figure increased by 9% and in Berlin it increased by 4.1%. However, in the new states it fell by 9.9%.
- In the same period the proportion of terminations of pregnancy in under 18s in relation to the total number of terminations increased from 4.7 to 5.5%.

In the individual states there are considerable variations in the rate of change of terminations of pregnancy in the under 18s from 2000 to 2006. However, it should be borne in mind here that these apparently dramatic percentage figures are influenced by the low numbers of cases. The greatest increases are found in Rhineland-Palatinate (+36%, from 200 to 272 cases), in Schleswig-Holstein (+34.2%, from 199 to 267 cases) and in Bremen (+28.4%, from 88 to 113 cases). Even though the total number of terminations in underage women increased in the period under review, there was actually a reduction in half of the federal states, most noticeably in Mecklenburg-Western Pomerania (-26.4%, from 296 to 218 cases), followed by Saarland (-22.5%, from 80 to 62 cases) and Thuringia (-10.8%, from 268 to 239 cases).

Comparison of the absolute figures for the individual federal states is not particularly meaningful, since the states have varying populations which also change over the course of time. In order to counter this demographic component, the so-called quota or indicator calculation is used. This means that the absolute figures (in this case the number of terminations of pregnancy undergone by underage girls) are compared with the main unit, here the female population in the 10 to 18-year-old age group. The lower limit was chosen because in individual cases terminations of pregnancy in 10-year-old girls have been reported.

There was a reduction in the population in this age group. While there were approximately 3.63 million in 2000, this figure had reduced by 4.7% to approximately 3.46 million in 2005. The rate of 'terminations of pregnancy in underage pregnant women per 10,000 women aged 10 to 17' is calculated by dividing the number of terminations of pregnancy by the number of women in this age group and multiplying by 10,000. A provisional rate is calculated for 2006 on the basis of the population figures for 2005, since the population details for this year are not yet available.

Tab. 1

### Terminations of pregnancy in 2006 in Germany

<i>Object of the referral</i>	<i>Quantity</i>	<i>Percentage</i>
<b>Total</b>	<b>119,710</b>	<b>100.0</b>
<b>Age of the pregnant women</b>		
from ... to ... years		
under 15	542	0.5
15-18	6,048	5.1
18-25	37,037	30.9
25-30	26,530	22.2
30-35	21,580	18.0
35-40	19,106	16.0
40-45	8,211	6.9
45-55	656	0.5
<b>Marital status of the pregnant women</b>		
Single	61,919	51.7
Married	51,119	42.7
Widowed	382	0.3
Divorced	6,290	5.3
<b>Reason for Termination</b>		
Medical indication	3,046	2.5
Criminological indication	28	0.0
Counselling regulation	116,636	97.5
<b>Type of procedure</b>		
Curettage	13,204	11.0
Vacuum aspiration	92,146	77.0
Hysterotomy/hysterectomy	7	0.0
Dug-induced termination	2,964	2.5
Mifegyne/Mifepriston	11,389	9.5
<b>Duration of the pregnancy</b>		
from ... to ... weeks		
less than 13	117,390	98.1
13-22	2,137	1.8
23 and above	183	0.2
<b>Location of the procedure</b>		
Gynaecological practice	93,880	78.4
Hospital (day-case)	22,753	19.0
Hospital (inpatient)	3,077	2.6
<b>Number of previous live births</b>		
None	48,760	40.7
1	31,055	25.9
2	27,726	23.2
3	8,776	7.3
4	2,344	2.0
5 or more	1,049	0.9

Fig. 1

**Terminations of pregnancy in Germany by the age of the women**

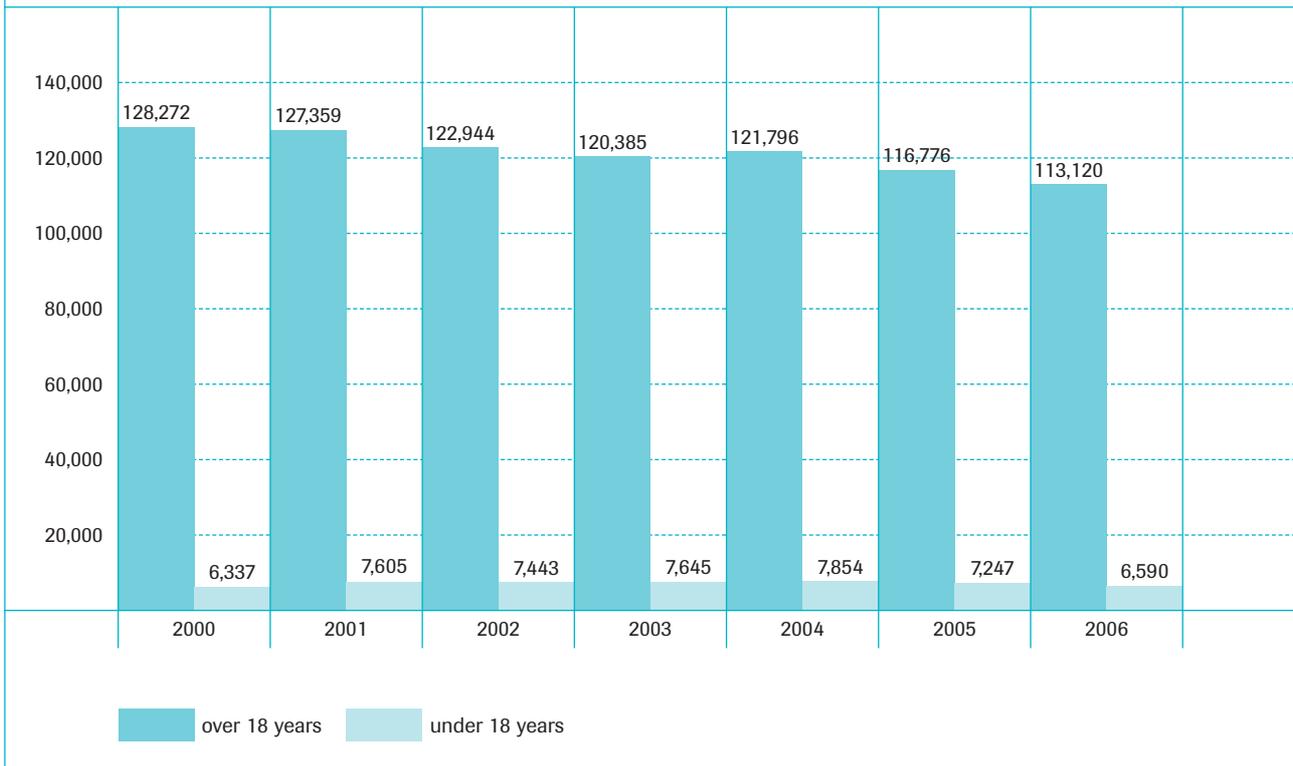
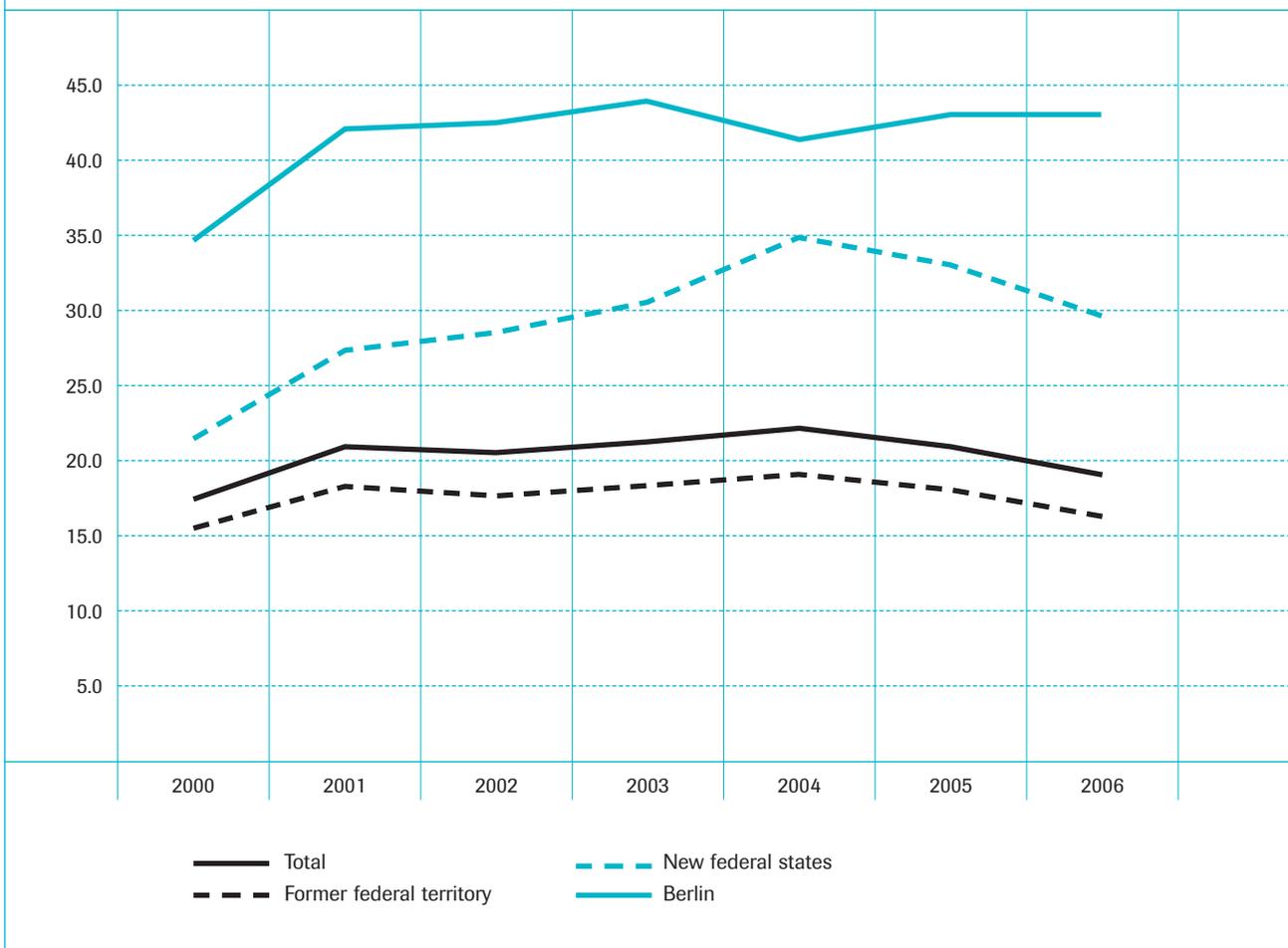


Fig. 2

**Terminations of pregnancy in underage women per 10,000 women aged 10 to 17**



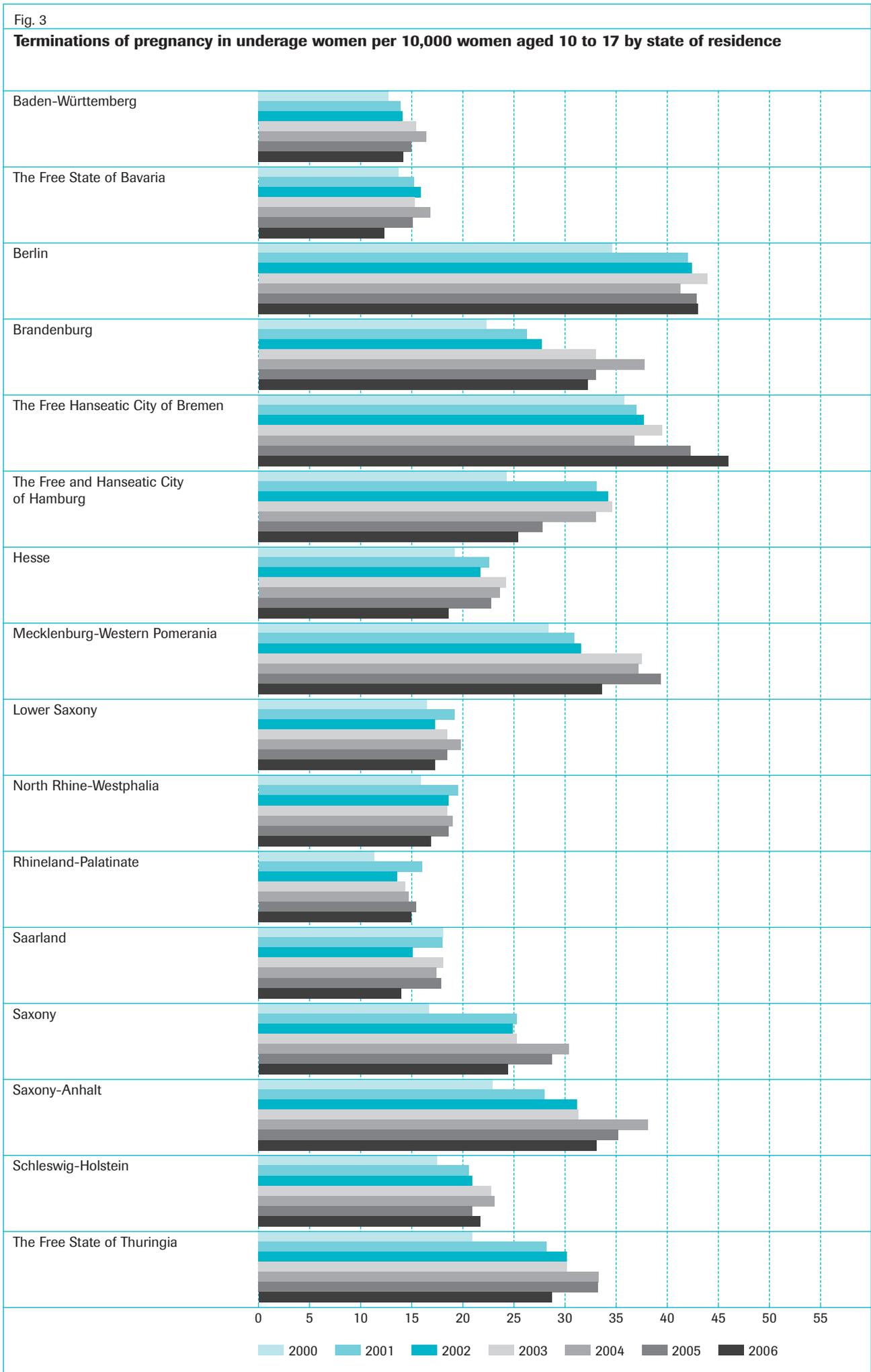
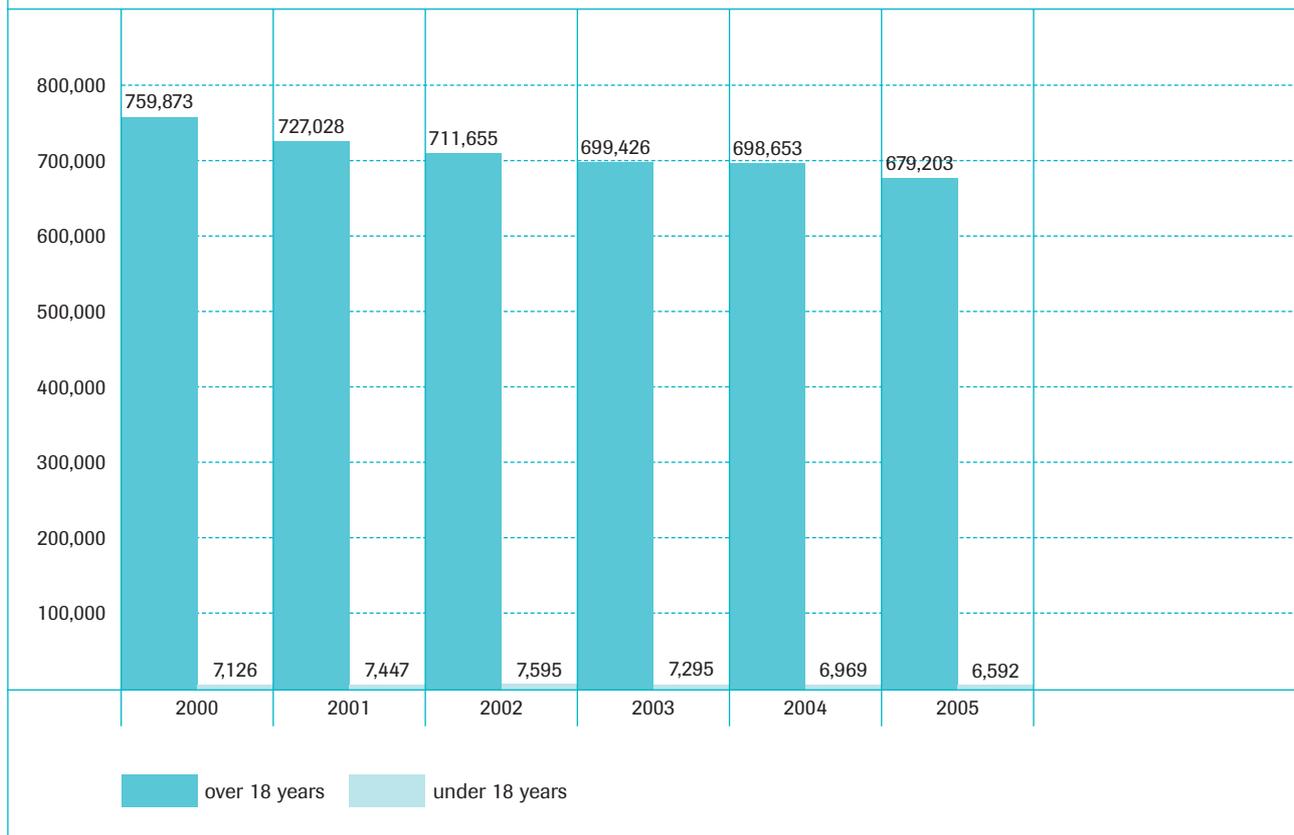


Fig. 4

**Live births in Germany by the age of the women (exact age at the birth of the child)**

In Germany this rate was 17 in 2000, 19 in 2006. The highest level within the period under review, 22, was reached in 2004 (s. fig. 2).

In the period under review, the number of terminations of pregnancy per 10,000 women aged 10 to 17 calculated for the former federal territory is between 15 and 16, with an increase in the corresponding population group of 4%. In the new states the female population between 10 and 17 fell in the same period by 35%. Thus there was an increasing rate of terminations: in 2000 it was only 21, while in 2006, purely by calculation, 30 out of every 10,000 young women aged 10 to 17 had had a termination of pregnancy, the highest value of 35 having been reached in 2004. In Berlin the initial rate in 2000 was 35, while in 2006 it reached 43.

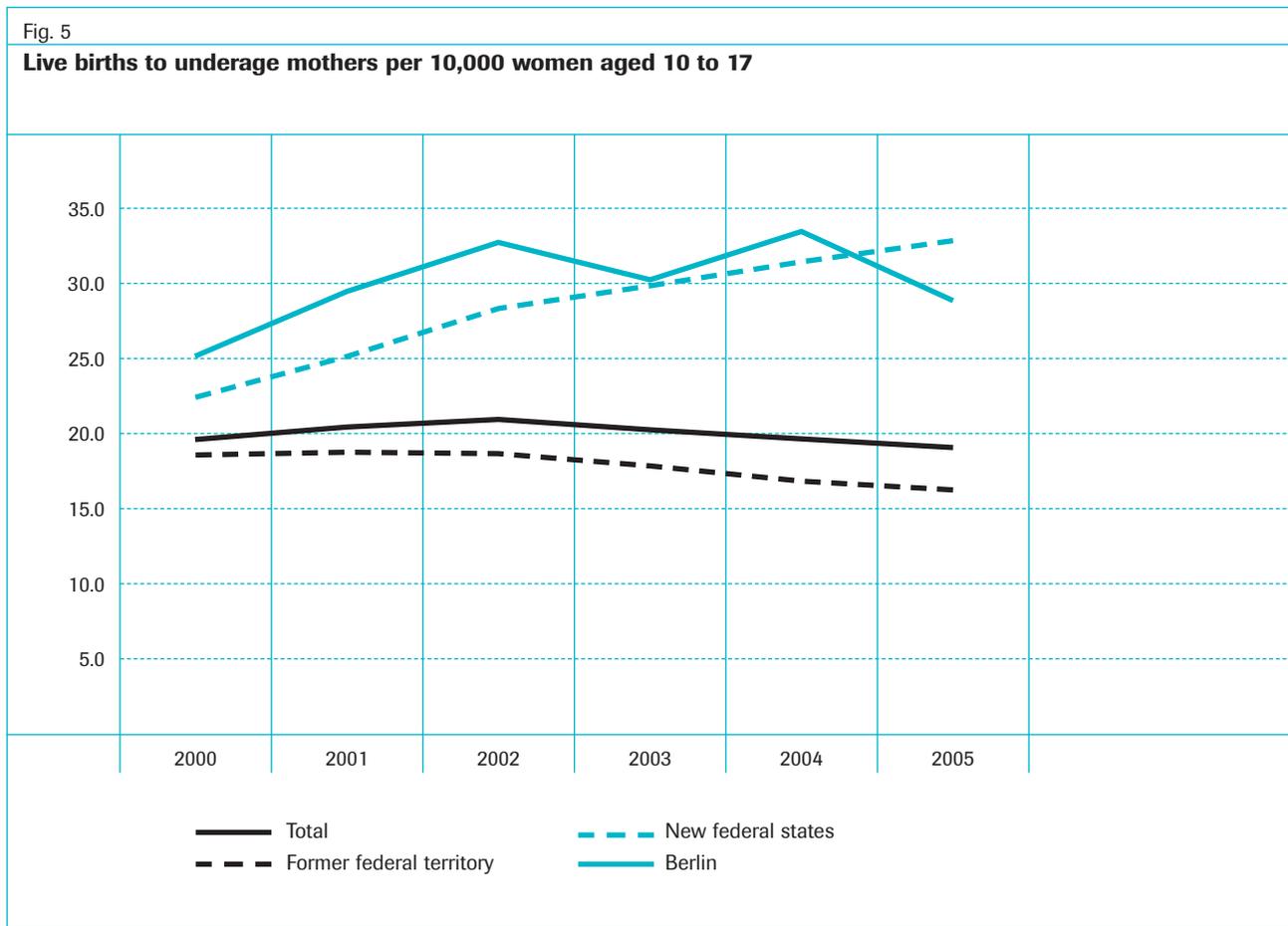
The rates of terminations of pregnancy in underage women for the individual states in relation to the corresponding age group of the female population, that is 10 to 17-year-olds, provide better comparability than the absolute figures (s. Fig. 3) as they indicate how many of 10,000 girls in this age group have a termination. The highest rates for 2006 are found in the city states of Bremen and Berlin, followed by Mecklenburg-Western Pomerania. Bavaria, Saarland and Baden-Württemberg had the lowest rates. In the comparison over time it was found that, with the exception of Bremen, the rates in all the states for 2006 were less than in the previous years.

### Progression of the number of births from 2000 to 2005

Since 2000, in addition to the results by the traditional year of birth method (in which the age is calculated from the difference between the year under review and the mother's year of birth), birth statistics have also been based on assessments which take into account the exact age of mothers at the time of birth. Here – in contrast to earlier publications in the FORUM series – only results which contain the actual (exact) age of the mothers at the time of birth of the child are used. The number of live births to underage mothers according to the year of birth method (in which mothers who are 17 years old at the time of the birth of their child but who reach 18 during the course of the year under review are not counted as underage mothers), is always lower than the number of live births in which the mothers are actually underage at the time of the birth. For this reason there is no direct comparability with earlier descriptions in which the data were used in accordance with the year of birth method. The birth figures are currently available for 2005 (s. fig. 4).

While there is a clear downward tendency over the years in the number of live births to mothers over 18, for live births to mothers under 18 there is initially an increase from 2000 to 2002, then in the years up to 2005 the value reduces to less than the initial value in 2000.

1 Live births by mother's age and by German federal state for 2006 can now be viewed online at [www.destatis.de/GENESIS](http://www.destatis.de/GENESIS). These data were not available by the editorial deadline (ed.).



- The total number of births reduced by 10.6% from 2000 to 2005. In the former federal territory the total dropped by 11.9%, in the new states by 4.4% and in Berlin by 2.4%.
- The number of births to underage mothers reduced in this period by 7.5%. In the former federal territory the figure fell by 8.6%, in the new states by 4.9% and in Berlin by 4%.
- The proportion of births to under 18s in relation to the total number of all births increased slightly from 0.9 to 1% in the same period.

The number of live births to mothers under 18 reduced in all the states with the exception of Schleswig-Holstein (here there were 211 births in 2000 and 220 births in 2005, that is an increase of 4.3%). Within the individual states there are considerable differences in the rates of change from 2000 to 2005 (based on the low number of cases); the values vary between a reduction of 20.2% in Hessen (from 475 to 379 births) and 19.2% in Bremen (from 78 to 63 births) and a reduction of 1.7% in Saxony (462 to 454 births) and 1% in Saarland (102 to 101 births).

In order to counter the demographic component caused by varying population figures in the individual federal states, in this case the rate of live births to underage mothers per 10,000 women aged 10 to 17 is taken into account; this age limit was chosen because of the comparability with the results of the termination of pregnancy statistics (s. fig. 5).

The rate of live births per 10,000 women aged 10 to 17 for Germany as a whole reduced from 20 to 19 from 2000 to 2005 (s. fig. 6), although there was initially an increase from 2000 to 2002. For the former federal territory the calculated number of births per 10,000 women aged 10 to 17 was 19 in 2000 and 16 in 2005, following an increase from 2000 to 2001. In the new states there was a continuous increase in

the rate from 23 to 33 from 2000 to 2005. In Berlin an increase in the rate from 2000 to 2005 was also observed, from 25 to 29, although the figure did not show any continuous progress in recent years.

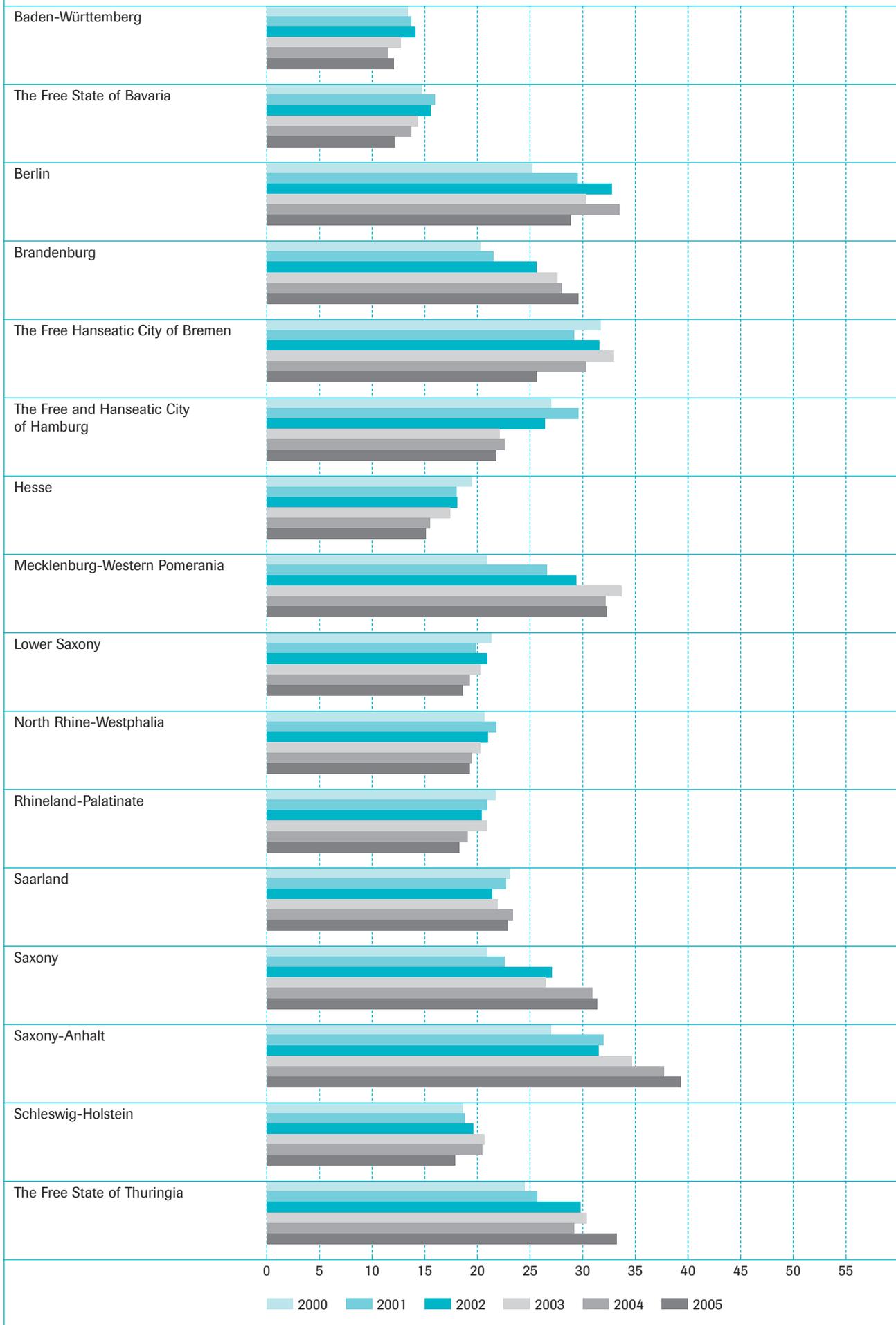
The rates of live births per 10,000 women aged 10 to 17 in the comparison of states from 2000 to 2005 still show a differentiated picture in the rough regional comparison. For the states of the former federal territory there is a consistent finding that the rate for 2000 is higher than that for 2005. However, in the intervening years there is hardly any common ground in the way the rate has developed. In the new states the rate for 2005 is above the value for 2000; with the exception of Mecklenburg-Western Pomerania the highest value for the period under review is achieved in these states in 2005.

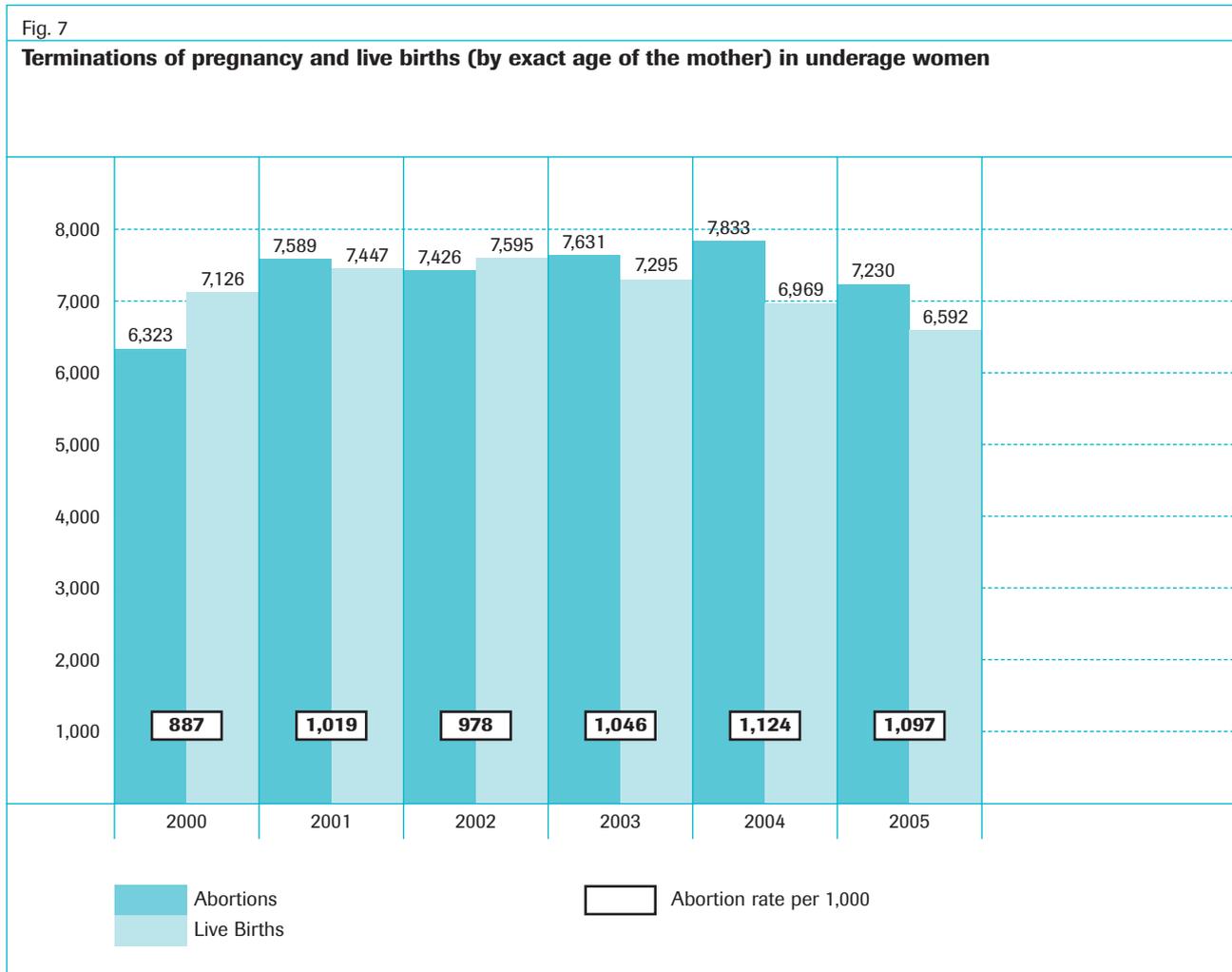
### Summary of the results of both sets of statistics (s. fig. 7)

The number of terminations of pregnancy in underage women and the number of live births to underage mothers by the exact age gives an approximate overview of the scale of 'pregnancies in underage women'. Without taking miscarriages and stillbirths into account, there were at least 13,449 pregnancies of underage women in 2000. From 2000 to 2005 there was an increase of 2.8% to 13,822. It was found that the number of terminations was below the number of live births only in 2000 and 2002, which can also be seen in the rate of terminations of pregnancy per 1,000 live births.

Fig. 6

**Live births to underage mothers per 10,000 women aged 10 to 17 by state of residence  
(exact age of the mother at the birth of the child)**





**How are termination of pregnancy statistics produced?**

The federal statistics on terminations of pregnancy in Germany are produced quarterly on the basis of the pregnancy conflict law, version dated 21 August 1995. In paragraphs 5 to 18 it is stated that the data are obtained directly from the Federal Statistical Office at quarterly intervals, as well as what details are asked for and who has to register for statistics. The owners of doctors' practices and the managers of hospitals in which terminations are carried out are responsible for providing information.

The doctors and hospitals which are subject to registration must give their address on a detachable part of the questionnaire. It is therefore possible to check whether they also register regularly. Any organisations supplying their registration late will be warned.

Questions are often asked about the reasons for a termination of pregnancy which cannot be answered by the official statistics because corresponding questions regarding motivation are not included in the legally specified survey programme.

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Literature

Volume 1, series 1.1 Natural population movement 2003 to 2005

Volume 1, series 1.3 Population update 2000 to 2005

Volume 12 series 3 Terminations of pregnancy 2000 to 2006

(Federal Statistical Office, Wiesbaden)

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# Teenage pregnancies in Germany

## Results of a study of the risk factors and contraception failures in the case of pregnancies of underage women

**In this pro familia study, approximately 1,800 underage women who have had pregnancy counselling or pregnancy conflict counselling were asked about their social and personal life situation and the circumstances surrounding the conception of their children.**

Articles in the popular press are discussing the issue of pregnancies and births to underage women in ever more excited and sensational terms. These reports give the impression that early pregnancies are a new and increasingly common problem. On the contrary, data from the Federal Statistical Office show a slight but continuous reduction in juvenile pregnancies since 2001: Between 2004 and 2005 the rates of pregnancies (per thousand 15 to 17-year-olds) have dropped from 8.3 to 7.9 and the rates of terminations of pregnancy from 5.0 to 4.7. Between 2005 and 2006, this reduction became even more pronounced.<sup>1</sup> At the present time, eight out of every thousand 15 to 17-year-old women in Germany are pregnant, three to four of every thousand will carry the pregnancy to full term, whilst five out of every thousand will decide to seek a termination of the pregnancy. In international terms, these figures are low. Dramatising the problem – the specialists are now agreed on this – is neither in line with the facts, nor is it in the interests of those concerned. Nevertheless, avoiding unwanted underage pregnancies as far as possible is an important social concern in terms of social policy just as, in cases where pregnancies do occur, it is equally important to provide the young women concerned with comprehensive advice and support.

In order to be able to give a better empirical description of the risk factors and social backgrounds of juvenile pregnancies, pro familia has been carrying out a research project since 2005 on Pregnancy and termination of pregnancy in underage women.<sup>2</sup> The aim of the study is to gain practical knowledge aimed at preventing unwanted pregnancies and providing advice and care on the termination of pregnancies as required.

### The study

The investigation comprises two substudies. In substudy I (documentation) a standardised form was used to question 1,801 pregnant women under the age of 18 who attended a pro familia information centre for pregnancy conflict counselling or general pregnancy counselling. The form contained 40 points regarding the social and personal background of the young woman, her partner and the situation that had led to conception. This documentation was carried

out after the counselling interview and was performed by pro familia counsellors. 138 out of the 163 pro familia information centres took part in the nationwide investigation. The participation rate, at 79%, was very high. About 20% of all underage women who were pregnant in Germany during the investigation period were included.<sup>3</sup>

In substudy II (interview study) between September 2005 and January 2007 guideline-based interviews were held with 68 underage women who had had a termination. The interview took place six to twelve weeks after the termination and dealt with the subjects: finding out about and experiencing the pregnancy, the processes involved in deciding on a termination, experience of the termination and the medicinal and advisory care, the sexual situation which led to conception, and previous contraception, sexual and relationship history. Women from all regions of Germany were questioned; 43 interviews were carried out by telephone and 25 in face-to-face discussion with trained interviewers<sup>4</sup> (s. tab. 1).

### Groups at risk

When women under the age of 18 become pregnant, it is taken as self-evident in our culture that the pregnancies are unplanned and mostly also unintentional. This is actually true in almost all cases: 92% of the young women questioned by us did not plan to become pregnant; 4% of the pregnancies were planned and 4% of the young women were unclear about their intentions; they 'took a chance'.

If we look first at the age distribution of the pregnant young women, we see that three quarters of the pregnant

1 This statement is based on the termination of pregnancy rates; when this FORUM was published, no information was yet available on the birth rates for underage women in 2006. Now it can be viewed online at [www.destatis.de/GENESIS.online](http://www.destatis.de/GENESIS.online).

2 The research project is carried out under the direction of Prof. Dr. GUNTER SCHMIDT of the pro familia federal association in cooperation with the Institute for Sexology at the University of Hamburg. It is funded by the Federal Centre for Health Education (BZgA). Current publications are available at [www.jugendschwangerschaften.de](http://www.jugendschwangerschaften.de).

3 For a detailed description of the results of substudy I see SCHMIDT et al. 2006 a & b.

4 Twelve interviews were also carried out with the partners of the women. The results of the interview study have not yet been published.

Tab. 1
<b>pro familia research project: pregnancy and termination of pregnancy in underage women</b>
<b>Substudy I: Documentation</b> <i>Standardised documentation forms</i>
<i>Subjects:</i> Sociodemographic and biographical data, information on the partner, information on the circumstances of conception, sexual experience and experience of relationships up to now
<i>Duration:</i> 10 minutes
<i>Sample:</i> 1,801 pregnant women under 18 years of age
<b>Substudy II: Interview study</b> <i>Guideline-based interviews</i>
<i>Subjects:</i> Finding out about the pregnancy, motives and processes involved in deciding on a termination, experience of the termination, sexual, contraceptive and relationship history
<i>Duration:</i> between 60 and 150 minutes
<i>Sample:</i> 68 women and 12 men following a termination of pregnancy

Tab. 2	
<b>Age of pregnant women under 18</b>	
<i>Age</i>	<i>Pregnancy rate (per 1,000 women)*</i>
12 years	0,05
13 years	0,2
14 years	2
15 years	5
16 years	10
17 years	12
Total	29 **
* Estimated values, based on the assumption that (1) the age distribution of pregnant women in the sample reflects the age distribution in the population of all underage pregnant women, and (2) the populations of the six age groups are approximately the same. ** If this value is reduced by the proportion of multiple pregnancies which underage women have (10% in our sample), an estimated value is obtained for the cumulative distribution of pregnancies before the 18th birthday. According to this, approximately 2.6% of all women currently become pregnant at least once before their 18th birthday.	

women are 16 or 17 years old – only 1% are 13 years old or younger. It is not surprising that it is mainly the older girls who become pregnant, since the risk of a pregnancy increases in proportion to the time of active coitus before the 18th birthday. Put simply: the more sex a woman has before her 18th birthday (and the poorer the contraception), the more likely this is to result in an unwanted pregnancy.

The age distribution of our sample can be used to estimate pregnancy rates for the various age brackets. According to this, five out of every 100,000 12-year-olds and twelve out of every thousand 17-year-olds are currently getting pregnant each year. This means that pregnancies or births to very young girls (13 years old or younger) are an extremely rare occurrence.<sup>5</sup> The cumulative distribution of pregnancies in underage women is currently 2.6%, meaning that this many women become pregnant at least once before their 18th birthday (s. tab. 2)

What factors influence the distribution of juvenile pregnancies, and in what circumstances and situations is the risk of an unwanted pregnancy particularly high?

Education has a massive effect on the probability of becoming pregnant while underage. According to our results

the underage pregnant women predominantly come from the group attending secondary general schools (54%); high school pupils (11%) are considerably less often affected.<sup>6</sup> Since there are approximately the same number of female pupils at secondary general schools and high schools in the youth population as a whole, we may conclude that the risk of underage pregnancy is about five times as high for secondary general school pupils than it is for those at high schools.<sup>7</sup>

These findings must be taken seriously, but they do not need to be over-dramatised. Even for secondary general school pupils pregnancy before their 18th birthday is a very rare event. Our data enable estimates of the pregnancy rates for the various levels of education. According to these, 15 out of every thousand 15 to 17-year-old secondary general school pupils become pregnant each year. In international terms, these figures are quite low (but definitely higher than for high school pupils, for whom this rate is three out of every thousand). It is important to note this so as to avoid stereotyping and discriminating conclusions about the group of secondary general school pupils.

Nevertheless, the fact that a low level of education dramatically increases the risk of pregnancy and that the occurrence of juvenile pregnancies depends to a large extent on the social background cannot be ignored, since underage pregnant women are not only disadvantaged in terms of education (s. tab. 3). Of the interviewees who are no longer attending a general education school, 51% do not have a job or a training position. A disproportionately high number of parents are unemployed (19% of fathers and 22% of mothers). Secondary general school pupils are particularly frequently affected by unemployment, both in terms of their own employment situation and that of their fathers and mothers.

The social situation of the partners, with whom the young women have become pregnant, again duplicates this finding of social disadvantage: disproportionately many partners,

5 From a statistical viewpoint they mark the extreme end of a distribution which, like all sociosexual phenomena, has a large spread.

6 The group of secondary general school pupils includes: secondary general school with or without school leaving examination, still at the secondary general school or special school.

7 According to information from the Federal Statistical Office on types of schools, in 2005 25% of 14 and 15-year-old girls attended a special school or a secondary general school, 28% an intermediate school, 38% a high school and 9% a comprehensive school. If the comprehensive school pupils are divided equally among the three types of school, then we get proportions of approximately 30% (secondary general school or less), 30% (intermediate school) and 40% (high school). According to this the risk for a secondary general school pupil is rather higher and the risk for high school pupils rather lower than that given in the above rough estimate.

Tab. 3	
<b>Who is becoming pregnant? Social disadvantage (%)</b>	
<i>Pregnant women</i>	
Secondary general school pupil	54
No training position/unemployed*	51
<i>Partners</i>	
Secondary general school pupils	59
No training position/unemployed*	31
<i>Parents</i>	
Father unemployed	19
Mother unemployed	22
* Only women or men who no longer attend general education school.	

59%, are secondary general school pupils, and of those who are no longer attending a general education school, disproportionately many, 31%, do not have a job or a training position. The overall picture that emerges indicates that juvenile pregnancies are strongly associated with social disadvantage. Prevention of teenage pregnancies therefore also means increasing the social opportunities and prospects of young women and their partners.

### Contraception failures during the coitus which led to conception

From the high number of unplanned pregnancies it follows that in the vast majority of cases contraception failed or was not practised at all. How was contraception carried out on the occasion that the young women got pregnant? It goes without saying that it was less effective than is normally the case amongst young people (s. tab. 4): in the case of the coitus which led to conception, contraception was not practised in a much larger number of cases than during the most recent sexual intercourse of young women who are not pregnant, and the pill was used in far fewer cases. Only about a quarter of the pregnant women had taken the pill, while the figure was 50% in the control group. This again shows the great significance of the pill in the prevention of teenage pregnancies.

However, more important than these rather trivial findings is the following: 63% of the underage pregnant women – older as well as younger ones – state that they were protected either with the pill or a condom. So the majority became pregnant in a situation in which they had used so-called 'safe methods' of contraception. This applies to all age groups and educational groups. This suggests that mistakes often occur when using the condom or pill and that the information provided must be improved.

Tab. 4		
<b>Contraception used in the sexual intercourse that led to conception (pregnant women under 18) and the most recent sexual intercourse (population of 14 to 17-year-old women who have experienced coitus) (in %)</b>		
	<i>Pregnant women*</i>	<i>Population**</i>
None	34	1
Unsafe method of contraception***	2	1
Coil, diaphragm	0,2	-
Condom	34	22
Pill	26	50
Other hormonal method of contraception	1	-
Condom und Pill	2	25
* Three women said they had become pregnant with petting.		
** BZgA 2006, own assessment		
*** Coitus interruptus, 'safe days', suppositories		

### Risky situations

Which groups have taken a particularly high risk in the coitus leading to conception? Figure 1 demonstrates that the risk of becoming pregnant unintentionally is particularly great in the following circumstances and situations:

#### The inegalitarian nature of relationships

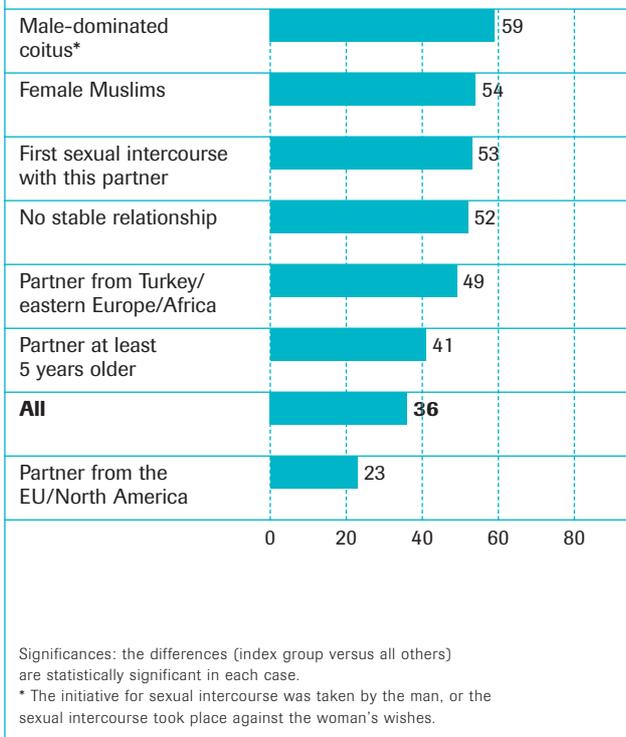
The contraceptive behaviour is particularly at risk when the initiative for sexual intercourse is predominantly taken by the man, or coitus even takes place against the woman's wishes. In relationships in which the equality of the sexes is compromised or does not exist, contraception is practised unsafely or not at all with above average frequency. Such a situation can occur when the partner is considerably older than the woman. The partners of the interviewees are on average 3.3 years older; 20% of the women report having a partner who is five or more years older than she. Two interpretations of this finding are possible: on the one hand it may be that young women have a poorer negotiating position in relation to their older partners and therefore have greater difficulties in insisting on safe methods of contraception. On the other hand contraception may be pursued less diligently and reliably with a considerably older man because the possibility of having children with him appears more realistic.

As well as a great age difference, cultural differences also play a role in the inconsistent use of safe methods of contraception. Women who are used to traditional gender roles (Muslims) and couples in which the man comes from a culture group with traditional gender roles (eastern Europe, Turkey, Africa), often use unsafe contraception or none at all. It is possible that in these situations inequalities of power between the genders and cultural differences affect the woman's ability to take decisions and implement them.

In summary it can be stated that the risk of an unwanted pregnancy in heterosexual relationships is increased if the women's 'personal power' is compromised or limited.

Fig. 1

**Contraception used in the sexual intercourse which led to conception (pregnant women under 18): proportion of women who were unprotected or used unsafe methods, in various groups (in %)**



### Social and sexual strangeness

At the beginning of a relationship or in the case of sex outside firm relationships, the risk of pregnancy is particularly high: the couple have not yet got used to each other and have not discussed or dealt with contraception sufficiently. Of the pregnant girls interviewed, 10% conceived in their very first intercourse with a new partner. The risk of getting pregnant with the first sexual intercourse with a partner is thus three times greater than on the fifth occasion and ten times greater than on the 15th occasion. The age differences are particularly significant in this respect. Almost half of the 12 to 14-year-olds, but only just under 20% of the 17-year-olds became pregnant on one of the first five occasions of sexual intercourse with their partner. Conclusion: at the beginning of sexual activity, at the beginning of a new relationship and on the first occasions of sexual intercourse with a new partner the risk of pregnancy is significantly increased – that is in situations in which the couple are not yet familiar with each other socially and sexually.

8 Figure 2 gives an overview of the spectrum of scenarios in which young women become pregnant. It is based on the provisional assessment of 40 interviews from substudy II.

9 All names have been changed.

### Failed contraception – various scenarios

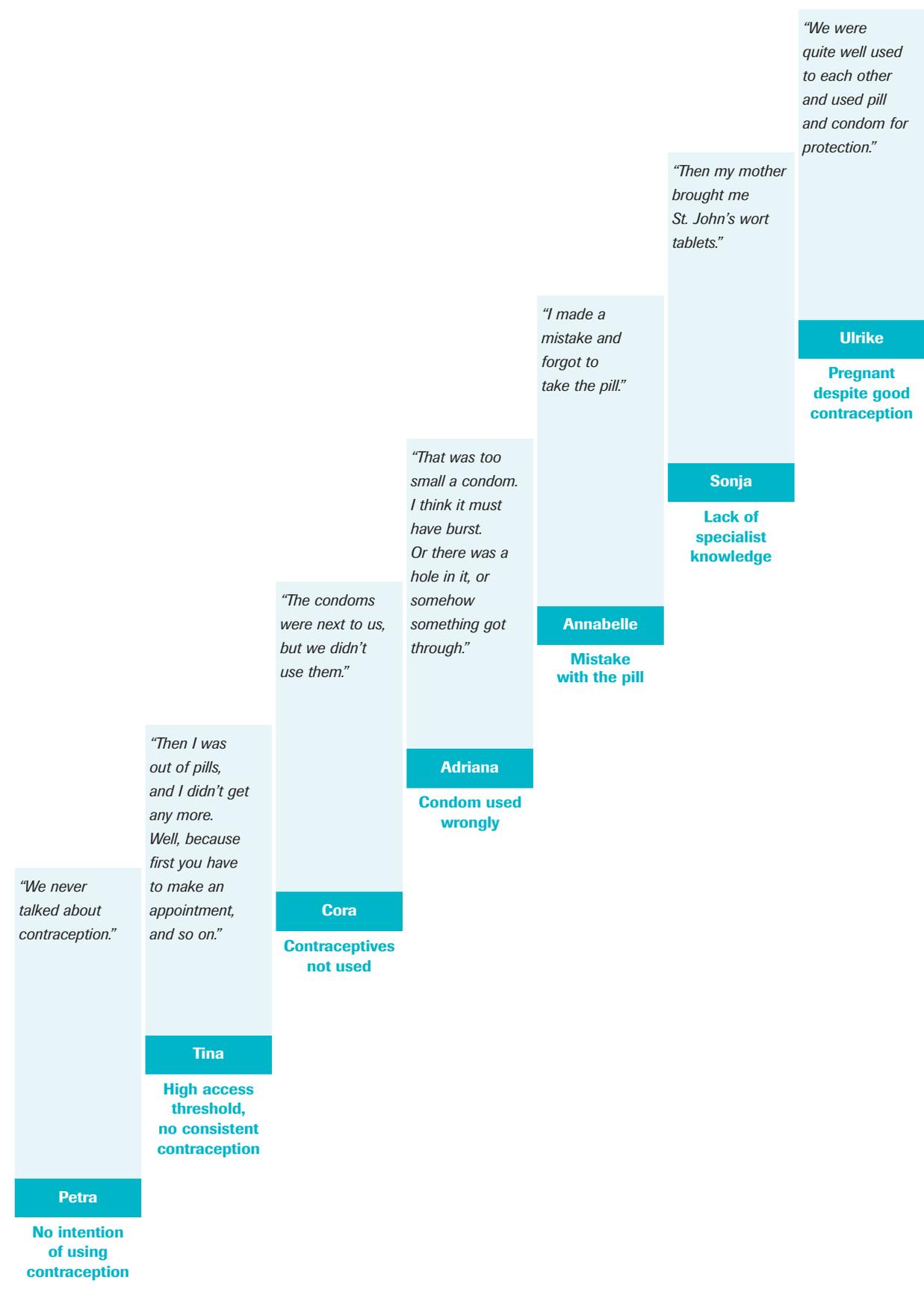
Up to now we have only examined the risk factors of unwanted underage pregnancies in terms of sociodemographic, partnership and sociocultural variables. However, if contraception fails, reasons from another level play a role: individual experiences from the person's sexual history, the emotional context of each particular sexual situation, constraints, shame and fears, or even simply forgetfulness or bad luck. The interview study enables a differentiated view of the special situations in which contraception fails.<sup>8</sup> If we take a detailed look at the sexual situations and the particular life circumstances of young women, it is striking how heterogeneous the situations are in which failures of contraception or mistakes in usage lead to an unwanted pregnancy (see figure 2). The spectrum ranges from those who had no intention of using contraception and slept with their partner completely recklessly, through those who responsibly and competently paid attention to contraception, only to fail due to a lack of specialist knowledge, to those who credibly ensured that they were protected with pill and condom, but still got pregnant. Here are two case histories as illustrations:

**Petra**<sup>9</sup> (15 years old, special school) became pregnant by her steady boyfriend (15 years old), with whom she was together for about three months. After an argument and reconciliation they had sex – secretly, since they both live in a youth centre where the young people are not allowed to sleep together. The sexual intercourse was initiated chiefly by the boy; Petra's own motives for agreeing to sex remain unclear. Really, after he had started to undress her, she wanted to leave. But she stayed, and then 'it happened'. In Petra's life sexuality 'just happens', without her being able to take any active, formative role. She has never taken any precautions with the boyfriend by whom she became pregnant. In earlier relationships too she often had unprotected sexual intercourse. In the sex which led to conception, she tried to 'shove the boy off' before he had an orgasm. 'Well, I did manage to shove him off, but just at the moment when I shoved him off, I suppose it must have happened.' Petra took the pill for a short time, but then stopped it because she was getting 'fat'. She had used condoms as contraceptives if the boys brought them. Petra's attitude to sexuality, and consequently to contraception, is very passive. She lacks the communication skills to protect herself actively from getting pregnant.

**Ulrike** (16 years old, intermediate school) became pregnant with her ex-boyfriend (17 years old), whom she had known for three years. They were together for one year; he was her 'first great love'. Ulrike met her ex-boyfriend by chance after quite a long period apart. She went with him to his new home where they talked for a long time and then spontaneously slept together. Ulrike was on the pill at that time. She explained that she was just 'at the end of her period', meaning that she had taken the pill for 21 days and had then stopped taking it for seven days for the so-called withdrawal bleeding. She explained this to her partner who, without being asked, used a condom. As they have had quite a long sexual history together, they are 'used to each other' and did not have any difficulty in talking about contraception in this situation. With the pill and condom, Ulrike felt very safe, believing that 'one way or another, nothing can happen'.

Fig. 2

**Failed contraception – various scenarios**



Afterwards she speculated that the condom was defective or it had a hole in it. 'I just don't know, nothing like this has ever happened to me before. Maybe they were leaky. It probably was leaky, or something like that, but neither of us noticed anything.' Ulrike has been on the pill since she first had sex and it has 'always been reliable'. She is well informed about possible usage errors.

Petra and Ulrike are extreme examples of cases in which a failure of contraception occurred; cases like these are rare. Much more often it is a case of mistakes in using the pill or condom, for which a few examples are given in the middle of the illustration. With their often chaotic living conditions, routines which are difficult to plan and considerable organisational hurdles, many young people fail with contraceptive management, that is to get their contraceptives in the right place at the right time and not to forget them. Contraception is a learning process which requires responsible interaction with one's own fears and inhibitions, as well as a high level of logistical competence and continuous active use. As shown by our illustration, unplanned and unwanted pregnancies are not always due to negligence or incompetence. They happen because specialist knowledge is lacking or is poorly communicated, because passion and spontaneity cannot be avoided in sexual situations and because contraceptives can fail even when used correctly.

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# Services provided and help required for underage pregnant women and mothers in Berlin and Brandenburg

## Results of a survey of experts

**The services and help provided to underage pregnant women in Berlin und Brandenburg were the subject of a study carried out on behalf of the Federal Centre for Health Education (BZgA) from September 2005 to September 2006. The aim in 100 interviews was to establish the know-how of experts who are involved in a professional capacity in mentoring and advising underage pregnant women.**

The central question was what services and help are available for young pregnant women in Berlin und Brandenburg and how the specialists that are active in this field consider the situation. Whether the existing services are known and accepted by the young people, or why they do not reach the underage pregnant women, what groups are particularly disadvantaged, as well as the situation of foreign underage women, were additional major questions.

The study was developed by researchers from Saxony and Saxony-Anhalt in a cooperative association of Mittweida and Merseburg colleges with the University of Leipzig. The investigation is based on a pilot study in Saxony (HÄUSSLER-SCZEPAN et al. 2005), which was established with a similar central question and target group predominantly in 2004. A comparison of the surveys shows clearly that, in a short period of one to two years, the perception of the phenomenon of teenage pregnancies in particular has changed: Despite lower numbers of cases overall it has become a more normal event for the specialists, it is more widely accepted in 2006 and is integrated in the advisory work. The following statement from an advisor from Brandenburg clearly shows the current paradigm shift away from unconditional contraception and prevention to more acceptance and equanimity: 'If young women want to do it, then I think no-one has the right to want to prevent it.' (1-02 Information Centre Brandenburg).

The following are the results and recommendations of the statistical analysis and survey of experts in Berlin und Brandenburg for 2006.

### Statistical analysis and comparison with other studies

For the last ten years in the Federal Republic of Germany the proportion of underage mothers has been around three in every 1,000 young women. In Berlin und Brandenburg, the rates are considerably higher. In Berlin, 4.2 live births per 1,000 young women were registered to women between 13 and 17 in 2005 and in Brandenburg the corresponding number for this age group was 3.9 births. When compared with other countries, the German rate of teenage births to 15 to 19-year-old girls, at 13 births per 1,000 girls in the

age group, is clearly in the lower area for industrialised countries (USA 52, Great Britain 31, Netherlands/Sweden 7, see UNICEF 2001).

If terminations of pregnancies are included, we can observe a slight increase in pregnancies in underage women in Germany from 2000 to 2005. While the rate for terminations increased in this period from 2.8 to 3.2 (per 1,000 girls between 13 and 17), the birth rate stayed virtually constant. It should be borne in mind here that the rate is pushed down by the inclusion of 13 and 14-year-olds<sup>1</sup>. The vast majority of terminations and live births to teenagers are in the 16 to 17-year-old age group. The increases described in the literature in the very young age groups (KLUGE 2002) therefore cannot be confirmed owing to the too small absolute figures on which they are based.

Comparative observations between the federal states show great regional differences. A state-specific analysis of the data material shows particularly notable developments in the East German federal states and the city states of Hamburg, Bremen and Berlin. Here the numbers of teenage pregnancies, both in terms of terminations of pregnancy and live births, are considerably higher than in the majority of West German federal states. Amongst the city states, Berlin is the most notable. While terminations for 13 to 17-year-old girls increased in West German federal states from 2.5 to 3.0 between 2000 and 2004, in the East German federal states they increased from 3.1 to 4.7 and in Berlin from 5.5 to 5.9. During the same period the number of live births in West Germany fell from 3.1 to 2.4 per 1,000 girls in the age group, in East Germany it increased from 3.5 to 4.2 and in Berlin from 4.0 to 5.0 per 1,000 girls in the age group.

Looking at the young women's decision-making between a termination or carrying to full term, it is interesting to see how the number of terminations compares with that of live births: whereas in the West German states the ratio of terminations to live births in 13 to 17-year-old young women increased from 0.8 to 1.3 between 2000 and 2004, in Berlin it fell from 1.4 to 1.2 and in east Germany it only increased

<sup>1</sup> In the study 'Teenage pregnancies in Saxony' for statistical reasons 10 to 17-year-old young women and girls were included. As the rates are thus considerably reduced, this study looks at the 13 to 17-year-old age group.

from 0.9 to 1.1. This is an indication that in the East German federal states underage pregnant women are indeed more likely to decide on a termination rather than carrying the baby to full term, but in comparison to the whole of Germany there is a greater tendency to carry the pregnancy to full term.

These figures justify the assumption that difficult social living conditions and lack of future prospects for young people in particular have an influence on the occurrence of teenage pregnancies and on the decision regarding termination or carrying the pregnancy to full term.

In the pilot study in Saxony in 2004 it was confirmed that underage pregnant women frequently come from a socially disadvantaged background and therefore the feasibility of the opportunity of participation forms a fundamental basis for successful preventive sex education work (HÄUSSLER-SCZEPAN et al. 2005, p. 20). Young women who only have limited opportunities of participation see early parenthood as their future and identity as adults. There is a lack of services to support young families beyond the time when they come of age and that aim to avoid long-term poverty and to promote social and economic independence (ibid.). The UNICEF study (2001) demonstrates that schooling and vocational training, and therefore the opportunity of a skilled job, take a back seat, with the result that the risk of poverty increases. It has been established that 54% of former teenage mothers are living in the poorest 20% of households in Germany at the age of 30 (Cologne 2002). These figures point to a lack of advisory services and help aimed specifically at these girls' circumstances and requirements. In addition to this result, there is also a current study that was carried out in pro familia information centres: 'The prevention of pregnancies in underage women therefore quite clearly has a strong social component' (PRO FAMILIA 2006, p. 24). Accordingly, the risk of an underage Secondary General School pupil becoming pregnant is about five times as high as for High School pupils (ibid.).

### Results of the survey of experts

In the period from November 2005 to April 2006, 100 partially structured interviews (50 in Berlin and 50 in Brandenburg) were carried out with experts who are involved in a professional capacity in advising and mentoring underage pregnant women. The selection of persons and establishments included in the survey was based on the possible 'route' for underage pregnant women seeking help in Germany. The following summary (s. tab. 1) shows the interviews carried out, differentiated by federal states, professional groups and establishments.

When selecting discussion partners, the different regional and social characteristics of the two federal states were taken into account.

In the conurbation of Berlin, districts with a high proportion of foreigners were particularly considered, so as to be able to record the situation of female migrants. In Brandenburg regions near Berlin and distant rural areas were included in the investigation in equal measure in order to be able to examine the effect of structural differences of the services offered and the infrastructure.

Tab. 1

#### Selected establishments

Area	Berlin	Brandenburg
<b>Counselling</b>	<b>17</b>	<b>21</b>
Pregnancy information centres	16	21
Hospital social services	1	-
<b>Youth welfare services</b>	<b>10</b>	<b>11</b>
Youth welfare offices	6	7
Mother and Child centres	4	4
<b>Schooling and vocational training</b>	<b>10</b>	<b>9</b>
General and training schools	6	6
Employment agencies (U25 teams)	4	3
<b>Medicinal care</b>	<b>9</b>	<b>9</b>
Gynaecologists	4	5
Midwives	5	4
<b>Associations working with youth, girls and migrants</b>	<b>4</b>	<b>-</b>
Total	50	50

Source: Teenager B&BB 2006

### Interviewees in Berlin and Brandenburg

Social activities and professions are still the domain of women in Germany, and this is reflected in the counselling and mentoring of underage young people in crisis situations, including underage pregnancies. Of the 100 interviewees, only six were men.

Professions in the social domain attach great importance to experience of work and life and this was reflected very clearly in our sample.

Half of the interviewees are 48 years of age or over and in terms of the generation to which they belong are frequently older than the grandparents-to-be, that is the parents of the underage pregnant women (s. tab. 2).

In our sample, this applies particularly to specialists in gynaecology and to a large proportion of the employees in the educational establishments and the youth welfare offices. On the other hand, only about a quarter of the interviewees are less than 40 years old. These 'younger' advisors predominantly work in mother and child centres.

Most of the interviewees have a great deal of work experience. The average work experience in the chosen profession is 20 years, and the average time working in the establishment concerned is twelve years.

### Situation of underage pregnant women from the point of view of the specialists

As in the pilot study in Saxony, the information on the social background of the underage women is based on the experience of the interviewees, rather than gathering of social information in the establishments concerned. The following are

Tab. 2

**Social information about the interviewees**

<i>Social information</i>	<i>Berlin</i>	<i>Brandenburg</i>
Average age	47,6 years	47,1 years
Below the average age	Employees in mother and child centres, midwives	Employees in mother and child centres, youth welfare offices, employment agencies
Above the average age	Gynaecologists, employees in educational establishments, youth welfare offices, employment agencies	Gynaecologists, midwives
Average work experience	20 years	20 years
Distribution between the sexes	47 women 3 men	47 women 3 men

Source: Teenager B&BB 2006

the experiences of experts with the families of origin of the young persons, their educational situation, some information on the motives behind the pregnancies and statements on the babies' fathers.

In the assessment, the answers to the question: 'What can you say about the families of origin?' can be divided into the main categories of family climate, social class and specific characteristics. The most frequently and spontaneously given reply in the Saxony study, 'They come from all social classes' (HÄUSSLER et al. 2005, p. 99) was only given occasionally in this study. On the contrary, the statements show a very differentiated picture of the families of origin, differing by federal states only to the effect that in Berlin the term 'lower class' occurred quite frequently and in Brandenburg the families were more often described as 'confrontational'. Otherwise there was essentially a consensus that the families of origin of the underage pregnant women and mothers appear basically unstable and confrontational or originate from a certain social class: 'The information centre is frequented by clients from all social classes, but there is a tendency for it to be mainly families which I would put in the lower social class and the mid-level.' (2-12 Information Centre Berlin).

The social situation of the families can be seen by examining particular characteristics such as unemployment and poverty in the form of receipt of ALG II [*unemployment benefit II*] and single parent benefits. There is also information about a large number of children and 'that [...] the mother herself very quickly became pregnant' (5-13 Information Centre Brandenburg). In Berlin, there were also statements to the effect that the families already claimed child or family benefits, or that they have addiction problems, and the phenomenon of patchwork family was mentioned quite frequently.

The phenomenon of class-specific decision behaviour described in the pro familia study (2006) and in the Saxony study was also observed in the answers given by the interviewees from Berlin and Brandenburg: 'Young women who are in a protective environment and become pregnant more often decide on a termination than young mothers who do not come from such a sheltered environment [...], who have their children.' (7-09 Information Centre Brandenburg), so it can be stated that underage pregnant women with a

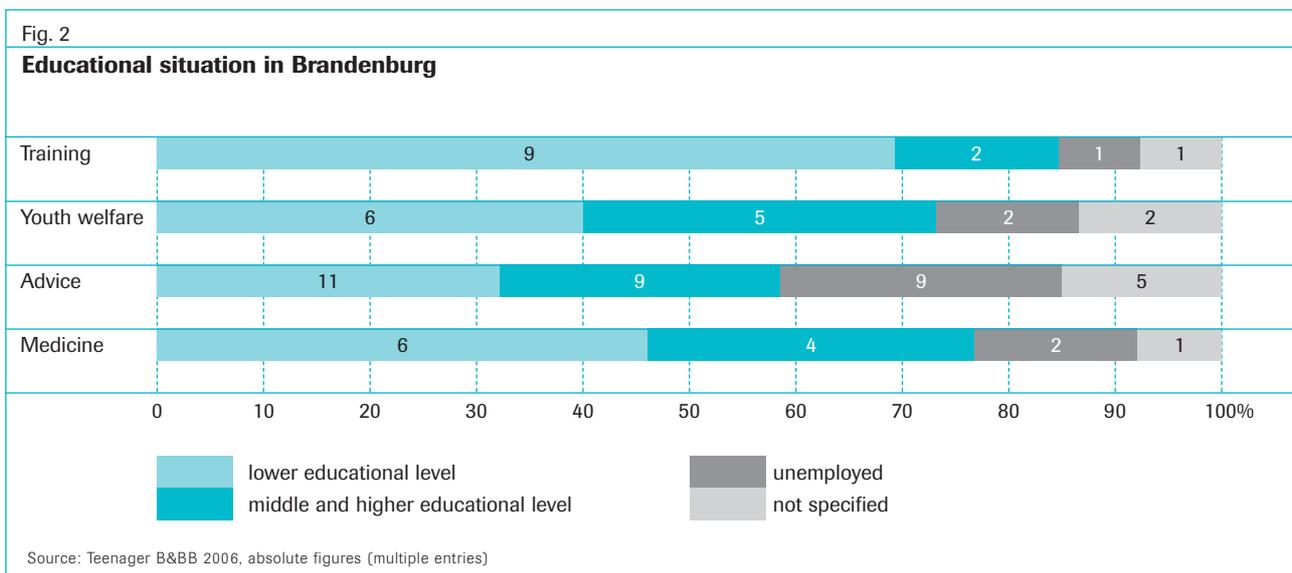
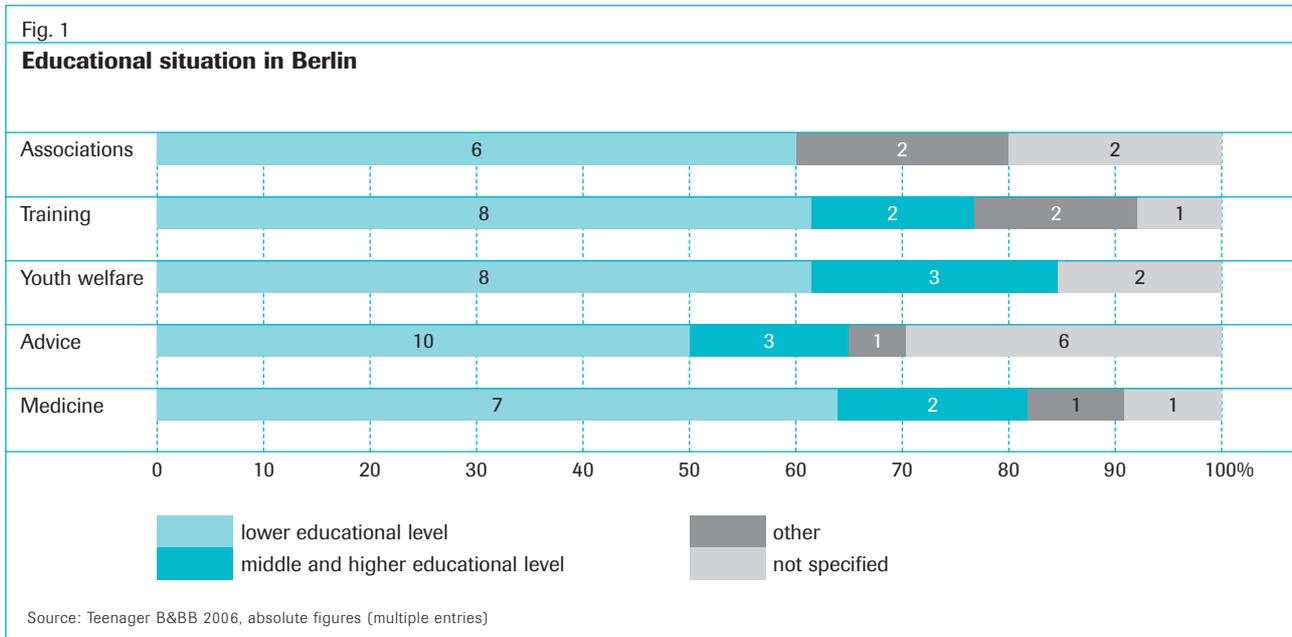
precarious background are increasingly opting for motherhood.

A similar result is provided by analysing the educational situation. 'They are likely to be girls with a low intellectual status and from lower social conditions. The girls are often from Special Schools.' (8-10 gynaecologist Berlin). In Berlin 72% of the interviewees rank the underage girls as having a low educational level, while in Brandenburg it was 64% of the interviewees. The term 'low educational level' is made up of pupils from Secondary General Schools and Special Schools, but the vocational preparatory year and early school leavers are also included here. In comparison, 20% of the interviewees from Berlin rank the young women as having a medium or high educational level, while those in Brandenburg estimate it to be 40%. This leads to the conclusion that in the state of Brandenburg, the phenomenon of teenage pregnancy is more heterogenic with respect to education and is therefore more broadly based, while in Berlin the interviewees refer very clearly to the non-academic class.

Thus, according to expert opinion, pregnant teenagers most probably originate from a socially deprived environment with many serious problem areas. They scarcely develop any alternative means of escape from this environment since, firstly, their academic background is insufficient and, secondly, their family examples do not move in the direction of an autonomous lifestyle which would be independent of aid money. For socially disadvantaged young women, looking for the solution in motherhood appears to be a worthwhile and achievable alternative.

The motives for underage pregnancy or motherhood as described in various places in the literature (see HÄUSSLER et al. 2005, FRIEDRICH/REMBERG 2005, FRANZ/BUSCH 2004, GARST 2003) are also described by the experts who took part in our survey, even though the young women repeatedly report having unplanned pregnancies (see PRO FAMILIA 2006).

The most quoted reason for carrying the pregnancy to full term is the desire for emotional warmth and stability, which was not experienced or only insufficiently experienced in their parents' house: 'That is definitely a point which particularly affects me, when I see that this pregnancy, the fact that they are having a baby, keeps them alive. They need



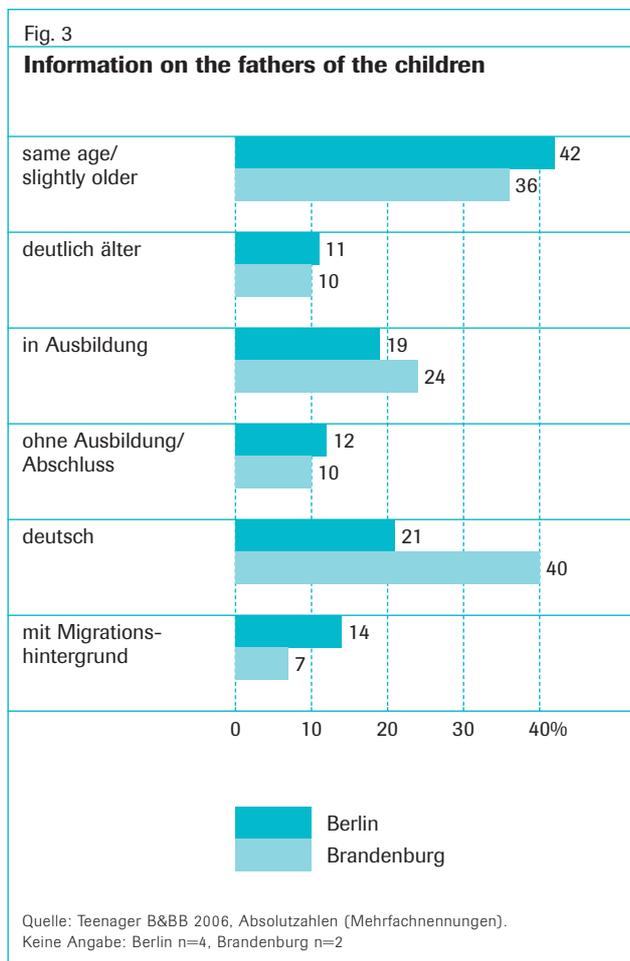
something, and the baby gives them so much of what they have been looking for: warmth, security, closeness, someone who is always there, with whom they can be tender, and so on.' (2-07 Information Centre Berlin).

Alongside the desire to compensate for a deficiency, there is clearly also an attempt, with the establishment of one's own family, to create a demarcation or even a separation from the parents' house. These desires symbolise the hopes and high expectations associated with the pregnancy and the child. At the same time, early motherhood provides a good opportunity to demonstrate one's own adulthood, thereby obtaining the desired regard and esteem. In Berlin the poor work opportunities and the resulting lack of prospects were also accepted as reasons for early motherhood, whereas this was mentioned less often in the state of Brandenburg. There the second most commonly quoted motive was the impossibility of a termination, based on moral principles, fear or acquiescence. A further motive is the traditional concept of life, provided on the one hand by a self-image and an idealisation of motherhood on the basis of the person's own experience in her family of origin, and on the other hand by examples in the media.

Amongst the fathers (to be) there is a similar picture to the underage pregnant women and mothers: 'The fathers are mostly also in the same age range, between 16 and 18. Rarely they may be 20 or 21, but no older. [...] The fathers are generally still going to school, have discontinued their apprenticeship, are at home or are on unemployment benefit II. The young pregnant women do not receive much help or support from them.' (1-03 Information Centre Brandenburg).

As can be seen in figure 3, the fathers (to be) are either the same age or only slightly older; most rarely they are considerably older. The statements also allow us to draw the conclusion that the young fathers are predominantly not yet established professionally or financially. They are either still in education, although with a not entirely successful record up to now, or have discontinued their education and are already unemployed. The proportion of young men with a migratory background in Berlin can be classified as very high.

It is also reported that there are fathers who provide support and others who evade their responsibility. A clear tendency in this regard cannot be identified.



### Expectations of the counselling

It is not rare for young people to visit an information centre or to seek out other forms of advice completely independently, but mostly they appear in the company of a person who is close to them. This is most often the mother, but also a female friend, the partner or specific qualified personnel such as a teacher or home carer may accompany the young woman on her first visit.

The initial process of getting acquainted normally therefore involves three persons: the counsellor, the companion and the underage woman. If we take the most common case, this means that there is often not only an age difference, but a generation gap. The underage woman therefore sees herself confronted not only by the older companion (her mother), but also by an older qualified person, who on the one hand is trying to offer her future prospects based on years of professional experience, while on the other hand being very far removed in her life from the world which the young woman inhabits. This problem makes particular demands on a professional dialogue.

Only a small proportion of the interviewees criticised the young women for having very few or no questions and going into the counselling session uninformed. On the contrary, the majority of them stated that the young people's concerns cover all the areas involved in a pregnancy at this age. From the interviewees' answers it is clear that questions of financial support and accommodation are amongst their main concerns, while matters relating to education or training are pushed somewhat to one side.

A comparison between the persons seeking help and the persons providing the help shows clearly that the major

concerns of underage pregnant women and mothers focus principally on questions of basic existential security, even though the demands associated with pregnancy and motherhood may be many and varied and the assistance provided is wide-ranging. 'They are led to some extent by their gynaecologist, but, having said that, they can walk into the information centre and apply for money for essential baby equipment.' (7-04 Information Centre Brandenburg). This means that, through their need for financial support, young pregnant women are aware of the range of assistance and at the same time can be given comprehensive and detailed advice about social security claims, pregnancy and birth, education, mentoring options, etc. Dealing with the varying expectations and goals of the persons concerned is the particular challenge of the advisory situation. Professional counselling respects the clients' concerns about counselling while at the same time offering additional services, for example through appropriate information, which increase the ability of the underage pregnant women and mothers to take action and make decisions.

### Recommendations

The information given by the experts interviewed confirms that underage pregnant women who decide on carrying a pregnancy to full term form a numerically small group. Social and family structures in particular have changed, as have the perception and acceptance of this phenomenon amongst the (specialist) public. The results of this study are a reflection of the great demographic and social structural changes in our society: increasing age, the change in generational relationships, as well as educational segregation and social disadvantage.

At the time of the survey, the beginning of 2006, the average age of the interviewees was 48. The specialist advisory personnel are therefore often older than the grandparents-to-be. This means that the advisors have to adjust themselves to the professional requirements of a cross-generational discussion in which the young pregnant woman does not have a contact person and partner of the same age. To provide for 'peer counselling', or 'peer support' it would also be desirable to have a counselling concept which provides for the participation of a young woman in an intergenerational counselling team. This could for example be a student trainee or, ideally, a young woman who herself has experience of underage pregnancy.

The current counselling concept does not take into account the complex interdependences and changes in the family structure and the concerns of underage pregnant women. This becomes clear when assessing the content of the counselling. The young women above all expect financial support and information about such supportive facilities, while the counsellors want to advise, that is to use their skilled professional knowledge about partnerships, family, education, work and organising life, from the point of view of a different generation. This conflict of interests between young advice seekers and older advisors arises from the different worlds of experience of the parties involved. Particularly young women with low educational qualifications and from socially-disadvantaged groups see prospects in motherhood which would otherwise often remain closed to them in society. However, in addition to adequate counselling services, including peer counselling in relation to realistic

concepts of life, one of the main things that are required are policy measures in order to prevent teenage pregnancies. Young people need employment prospects and opportunities to participate.

### **Special services for poorly educated young people and young people with a migratory background**

Underage pregnant women and their partners who are generally of a similar age frequently come from a disadvantaged social environment. Pregnancy is encouraged not only by a lack of knowledge of contraception, but it also occurs against the background of a lack of employment prospects and life chances (see also HÄUSSLER-SCZEPAN et al. 2005; PRO FAMILIA 2006). Socially-disadvantaged young women see early parenthood as their future and their identity as adults. The most effective means of preventing pregnancies in underage women would be the creation of training places and jobs, and realisable opportunities to participate. There is a need to promote and support young families after they reach their majority. New means of support and help must be found so as to prevent the consolidation of social segregation and getting into 'poverty careers'.

In the opinion of the interviewees, a high proportion of the underage pregnant women have a low educational level. This is also confirmed by the results of the current pro familia study (2006), according to which women with a low level of education and a high level of social disadvantage have a particularly high risk of becoming pregnant while underage. According to the statements by the experts there are large deficits in knowledge, particularly in the use of contraception and regarding interactions with other medicines. They demand an early start on educational work, which should be age and gender-specific and should be based on the world in which they live. Target-group-specific prevention concepts should be developed and offered particularly for poorly educated young people and young people with a migratory background. Educational modules should be supplemented by competence training units and training in the demands and requirements of parenthood.

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# 'Pregnant under 18'

## A new Internet service from the Federal Centre for Health Education

**In November 2007 the 'Pregnant under 18' channel will be online. The channel is aimed at underage pregnant women, mothers, fathers and couples with a child and, in both form and style, is accessible to young people. The authors explain the backgrounds to this service and present the component parts of the programme in detail.**

Teenage pregnancies are a delicate subject in Germany. They go against the current social image of young women having successful lives, including a period of good education and training before starting a family. Underage pregnancies have therefore been well covered in the media in recent years.

Although the percentage increase in pregnancies under the age of 18 sounds dramatic, in absolute terms they are a less spectacular phenomenon and are at a low level when compared to other countries (see the contribution from Ms. LAUE in this issue).

### Double challenge

Of the approximately 13,800 underage pregnancies in 2005 the number of pregnancies carried to full term and the number of terminations were roughly equal (ibid). Every underage pregnancy, whether wanted or unwanted, presents serious psychological and social problems for which a great deal of support is required.

From a psychological point of view, an underage pregnant woman has to come to terms with two development processes: puberty, that is the transition from a child into a young woman, and also the transition from a young woman into a mother, both at the same time. Each of these development stages on its own can be seen as a crisis of maturity, but when they arise simultaneously, they represent a major challenge to body and soul, which it is very difficult to meet alone. This also applies to the father to be, although in a lesser form as he does not have to cope with the physical effects.

### Backgrounds and motives

Young people get into this complicated and complex situation for various reasons: They rarely become pregnant deliberately, more often it is through ignorance of reproductive processes and incorrect use of contraceptives. The lack of employment and future prospects also plays a role in deciding on early parenthood. The ideal of an unspoiled family as an alternative to the lack of prospects and the lack of devotion and love experienced by the young person concerned act as a strong impetus. In many cases, the necessary detachment

process is also provoked unconsciously by the parents. It becomes possible for young people to get a home of their own and a certain financial independence with assistance from the state. The achievement of adult status can therefore be accelerated by having a child, but then it can also be delayed and prevented again by false expectations and excessive demands of day-to-day life.

What is clear is that the psychological and social situation of the girl or the couple and their families of origin, their level of education and their life prospects play a decisive role in how they deal with the conflict of pregnancy; those with poorer future prospects are more likely to opt for carrying the pregnancy to full term, while those with better future prospects more often decide on a termination.

Since there had still not been any comprehensive empirical investigations including social demographic, biographical and psychological aspects, the BzGÄ [Federal Centre for Health Education] initiated various studies and surveys which examine the world inhabited by the underage pregnant women, mothers and couples with a child/children, analyse the social and individual relevance of the subject and draw application-oriented conclusions. A summary of these can be found in the information package on the prevention of underage pregnancies (see INFOTHEQUE).

### The Internet service

On the basis of these empirical results, the experiences of information centres and reports of the experiences of young pregnant women, mother/fathers and parents, the BZgÄ is now offering a channel for underage pregnant women and their partners on its Internet portal [www.familienplanung.de/](http://www.familienplanung.de/) [www.schwanger-info.de](http://www.schwanger-info.de), which is intended to deal with the serious life changes and requirements and to support the processes of adaptation to the new situation. The channel's primary target group are underage pregnant women and their partners and their immediate social environment (friends, family, advisers or carers). However, it is also aimed at young people who are not affected, but who are looking for information.

Using language that is appropriate to the target group, the channel offers support in the further progress of the pregnancy, whether it is decided to carry the pregnancy to full

term or to have a termination. No judgmental attitude is taken to any existing pregnancy. Support without telling people what to do, strengthening existing resources, encouraging of independence and consideration of the consequences of self-determined action are the guiding principles of the channel.

### Requirement for advice

Practical experience of advice and the studies and surveys carried out have shown that the majority of those affected have a considerable requirement for advice. This mainly relates to

- Pregnancy conflict discussions,
- Financial and material support,
- Discussion and analysis of parents' reactions, development of autonomy,
- Psychosocial aspects/prevention of social isolation,
- Questions about pregnancy and birth/interaction with the child.

There is relatively little requirement or a completely negative attitude by the majority of those concerned with regard to prenatal and postnatal services (e.g. preparation for the birth). They expressed uncertainties about the older participants in the course and fear of being told what to do. The services are seen as 'senseless' and 'excessive' and the prevailing view is that it would be better to get the necessary information in their own surroundings.

The channel's task here is to communicate the value of professional services by means of texts and field reports. Information regarding target group-specific advisory facilities and courses is also made available.

There is a long-term or recurring requirement for advice regarding the following matters:

- Return to original training courses or alternative training and work, part-time vocational training
- Securing a livelihood
- Stabilisation in difficult life situations (taking drugs, etc.)
- Partnership in terms of organising living together and financial aspects
- Organising the mother's and father's roles and setting priorities when there are excessive demands
- Help in coping on a day-to-day basis and caring for the child
- Help in disengaging from the parents' home, development of independence
- Help with the danger of social isolation.

### Main focal points of the channel

#### Love, lust and passion

The subject area of 'Love, lust and passion' deals with the first experiences of love, from the first infatuation to the first sexual intercourse, with their dreams and disappointments. It provides information on the legal situation regarding sexual intercourse involving young people and addresses borderline situations and negative experiences with sexuality. It provides references to sources of assistance and information centres.

#### Sexuality and contraception

This subject area provides target group-specific information about reproduction and contraception. The texts also serve particularly to prevent unwanted pregnancies and sexually transmitted diseases.

Since most studies and surveys showed a lack of basic knowledge about the connections between fertility and physical and hormonal development in men and women, and about sexual experience and means and methods of contraception, it appears that education must be made more appropriate to the target group, particularly for socially disadvantaged young people. Young males and young fathers are the particular target audience here, since in the main they still see contraception as being the woman's responsibility. The matter of contraception imposes a level of consequences and perseverance on girls which can hardly be expected of them and which, certainly in some cases, is too much for them.

By including young men here, the channel fulfils a particularly important function.

#### I am pregnant – what now?

This section deals with the first physical signs of pregnancy and the possible feelings and mixed emotions involved with arguments with parents and reactions of the peer group, fear of being excluded and coping with the child alone. First-hand accounts are intended to provide a realistic picture of possible feelings and reactions to the pregnancy.

#### Pregnant – no drama

The 'Pregnant – no drama' subject area is used to take the drama out of the situation and helps in keeping as clear a head as possible. The young people are provided with guidelines to support them in approaching the often very confusing situation, based upon their many questions and fears. Getting over the obstacle of talking to their parents, having some idea of future possibilities and considering them are important aspects. Introducing the girls to sources of assistance and information centres is intended to help them to deal with the pregnancy and come to a decision which is correct for them.

#### Deciding for or against a child

The decisive question in the case of pregnancy for the underage girl and the father to be is often difficult to answer: Can I see myself becoming a mother/father now or do I feel that my capabilities would probably be overstretched on a long-term basis?

The subject area 'I can't be a mother/father yet' illustrates the various options if the decision is taken not to keep the child: legal requirements and medical methods of terminating the pregnancy, adoption, fostering, baby boxes and anonymous birth are dealt with briefly in an easy to understand manner.

This section also goes into the psychological effects of the experience of parting from the unborn child and possible feelings of guilt, and the users are referred to information centres which can help in the case of severe psychological stress.

The range of topics 'I want to be a mother/father' provides a broad overview in the form of guidelines of what has to be considered when a decision is taken to opt for motherhood: antenatal care, dealing with various agencies, tips and suggestions, the birth and the time after birth (e.g. antenatal classes, midwife clinic, psychological advice and monitoring).

### **Pregnancy**

Here, the young people are given detailed information about the progress of a pregnancy in language appropriate to the target group. This section includes basic texts regarding the development of the pregnancy, prenatal foetal development, a healthy lifestyle and nutrition, as well as help in avoiding smoking, alcohol and other drugs.

The advantages to the infant of breast feeding are also discussed in detail in this section with the aim of creating a positive attitude and acceptance of breast feeding.

In a virtual diary the young people are encouraged to consider their subjective perception and handling of the pregnancy, contact and feelings towards the unborn child.

### **Birth**

This subject area provides information on the birth itself. The various stages of labour and measures to ease labour are described. This knowledge is intended to counter any unnecessary fears which the young pregnant women may have before the birth, while at the same time giving a realistic description of the procedure.

### **Medical care**

In the surveys of underage pregnant women as part of a study (FRIEDRICH/REMBERG 2005) it was found that the gynaecological examinations during pregnancy and after birth are accepted by young pregnant women, but in many cases with great reluctance or even feelings of anxiety, shame or disgust. In many cases, the young women hope for a high level of sympathy, time, care, sensitivity and a relaxed atmosphere in the surgery and the medical staff. However, this hope is rarely fulfilled.

Where possible, after the birth, surgery visits are avoided. The reason for surgery visits, if they happen at all, is that contraceptives are wanted, rather than health reasons.

Here the channel has the task of explaining, both technically and visually, the facilities of a gynaecological treatment room, and also to provide assistance in speaking to the doctor about any wishes or feelings regarding the treatment.

### **Fathers**

The Friedrich study comes to the conclusion that adolescent fathers had up to now not been considered in the (popular) scientific literature and that there is virtually no data on them. However, as a starting point, there is recognition of changes in the acceptance of early fatherhood in young men.

In the survey young fathers stated that they knew of no support for biological or social fathers which goes beyond financial considerations. However, more than three quarters of the interviewees felt that such advice would be a good thing. It is not widely known that § 2, para. 1 of the pregnancy conflict law (SchKG) also provides fathers with a legal right to professional emotional support when they have anxieties and problems. However, most fathers said that while they considered such an advisory facility a good idea, they would not make use of it themselves. They seek or hope for help, if at all, from their circle of friends and relations. For the most part, they do not consider that the information centres or the advice schemes address their concerns. The channel therefore aims to go into the special requirements, but also the responsibilities of young fathers and to make them aware of the importance of communicating their feelings and wishes.

### **Social environment**

In the end, the majority of young parents receive more support from their immediate environment than they expect (e.g. emotional support, money, gifts, childcare, free accommodation and food, support in dealing with authorities).

The families of origin of the young couple, their peer groups and other social contacts are thus a considerable factor in the success of the pregnancy and their life with a child.

This element promotes confidence in the pregnant women to accept and organise help without giving up their own autonomy.

### **Professional support**

The majority of the young people questioned have an ambivalent attitude to the agencies and feel overwhelmed by bureaucracy and forms. They expect to be treated as needy applicants and not to be respected. Social services, youth welfare, housing and benefits offices, job centres, occupational counselling, employment agencies – the functions of all these contact points are difficult for lay persons and the uninitiated to comprehend. A simply structured 'How to get through the agencies jungle' should help in contacting the right agency in any given situation.

### **Combining having a child, training and work**

This section shows the possibilities and conditions of combining parenthood, training and work, such as part-time vocational training, as well as options for childcare and possible social educational support to overcome the double burden.

It is shown through examples that, even with a child, vocational training can be continued, but also what organisational requirements and personal discipline are needed.

### **At home with the child**

This subject area for the most part provides the young mothers with a practical introduction to dealing with the child. During the initial stages, young mothers in particular quickly feel that they are having to cope with excessive demands. The mother's emotions after the birth, the physical processes in the postnatal period, postnatal medical examinations for the mother and child, and home care by the midwife are all covered. Breast feeding is also discussed here.

A particularly important aspect here is the reference to sources of assistance (information centres, family midwives).

### **Supervised housing**

For everyone with a child or family who feels stressed by the housing situation, various types of housing are presented here which can provide a way out of the current capacity overload and a means of moving towards independence: mother and child facilities, supervised housing, apartment with an institutional link, own apartment with supervision.

### **Living as a family, being parents**

This section deals with the partnership after the birth and legal questions around the recognition of fatherhood, personal care, legal representation of the child, maintenance obligation, visitation rights, etc. Possible obstacles to the partnership and common problem areas in life as a family are discussed. The need to have negotiating processes with the partner, parents and the social environment is made clear and possible solutions are demonstrated by means of examples.

## Design, form and style

The design of the 'Pregnant under 18' channel differs from that of the other channels in the [www.familienplanung.de/](http://www.familienplanung.de/) [www.schwanger-info.de](http://www.schwanger-info.de) portal, which conform to the information practices of adults. In contrast, the mode of address, style, length and compression of the texts in 'Pregnant under 18' are all in a form that is accessible to young people. Since it is less well educated girls in particular who tend to have early pregnancies, it is important to ensure that the format of the contents is easily understood. For this reason, methods other than solid text have been selected to display the information, as far as possible. FAQs – frequently asked questions, field reports and the editorial involvement of relevant young people liven up the compact factual information and, in both language and style, provide a connection with the world inhabited by the young people. The channel also includes visual displays: photographs, charts, image maps and attractive interactive elements such as polls, quiz questions, chats and forums. There are also plans to set up a 'surgery', in which questions can be put to experts at specified times.

The initial version of the 'Pregnant under 18' channel will be online in November; the full content will be available by the end of the year.

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# Trends in teenage live births and their determinants in Europe

**Two thirds of all European countries experienced a decrease in births to underage mothers between 1990 and 2003, but the levels in the less-developed regions still remained considerably higher than in Western Europe. The author analyses socio-economic and other factors which can cause early pregnancies, and summarises them as follows: ‘Very often unwanted pregnancies and health risks in underage women resulting from sexual contacts are associated with social inequality and poverty.’ He also points to the importance of confidential advisory services for sex education and the availability of safe contraception.**

Traditionally, female sexual initiation was closely linked with marriage.<sup>1</sup> Women were supposed to be initiated into sex by their husbands, especially in southern European countries. Spread of reliable birth control methods, the rise in women’s level of education, women’s rapidly growing participation in the labour force, and more tolerant values in sexual issues have caused a notable increase in female sexual autonomy. As a consequence, the age of first intercourse has decreased in Europe. At the same time, the period from the first intercourse to cohabitation or marriage has increased. Modern age teenagers and young adults have less committed sexual experiences than the generation of their parents. As a consequence, young people face also more often a risk of pregnancy in their sexual encounters.

Regardless of this increased risk of pregnancy, average age at which women have their first child has risen, on the average two years from 1980 to 1998. Before the population transition youth in the Central and Eastern Europe tended to marry young and have a first child relatively young. During the transition years, the picture has changed substantially. Youth are less likely to marry, but more likely to have sex at a younger age; teen birth rates have fallen across the region overall, but more of these births are occurring outside marriage and to very young teenage mothers. (UNICEF 2000.)

The UK Health Development Agency argues that it is now widely recognized that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. It is also increasingly clear that socio-economic disadvantage can be both a cause and a consequence of teenage parenthood. (KONTULA 2004.)

In this article trends in live births in Europe and some of their determinants from 1980s to early 2000s will be presented. Focus is in teenagers. The trend information on live births of the teenage women (age group <20) in Europe are mostly based on the publication ‘Recent demographic developments in Europe 2005’, Council of Europe.

## Trends in teenage fertility and pregnancies in Europe

It is estimated that about 14 million women aged 15–19 worldwide gave birth each year in 1995–2000. In 1995–2000 the adolescent fertility rate was 54 births per 1,000 women for the world as a whole. In the more developed regions, the rate was 29 per 1,000 while in the less developed regions the adolescent fertility rate was nearly twice as high, 58 births per 1,000 women. In Eastern Europe, more than three-quarters of the total fertility (79%) is contributed by women below age 30, whereas in Western Europe, the corresponding percentage is 56%. Births to adolescents make up a smaller proportion of births now than in 1980 in most industrialized countries (SINGH/DARROCH 2000.)

Through the 1980s teenage birth rates tended to remain stable or decreased in Western Europe (s. fig. 1). In some Central European countries birth rates decreased considerably. In early 1990s teenage fertility rates decreased a lot also in most Western European countries. United Kingdom and Iceland had the highest rate, round 30 per 1,000. To the second category belonged Austria, Portugal, Greece and Ireland where the rate was round 20 per 1,000. In other European Union countries the rate was round 10 per 1,000 or even lower (in the Netherlands and Switzerland it was 6–7 per 1,000). The percentage of 20 year-old women who had already given birth, ranged from 2% (Switzerland) to 13% (UK).

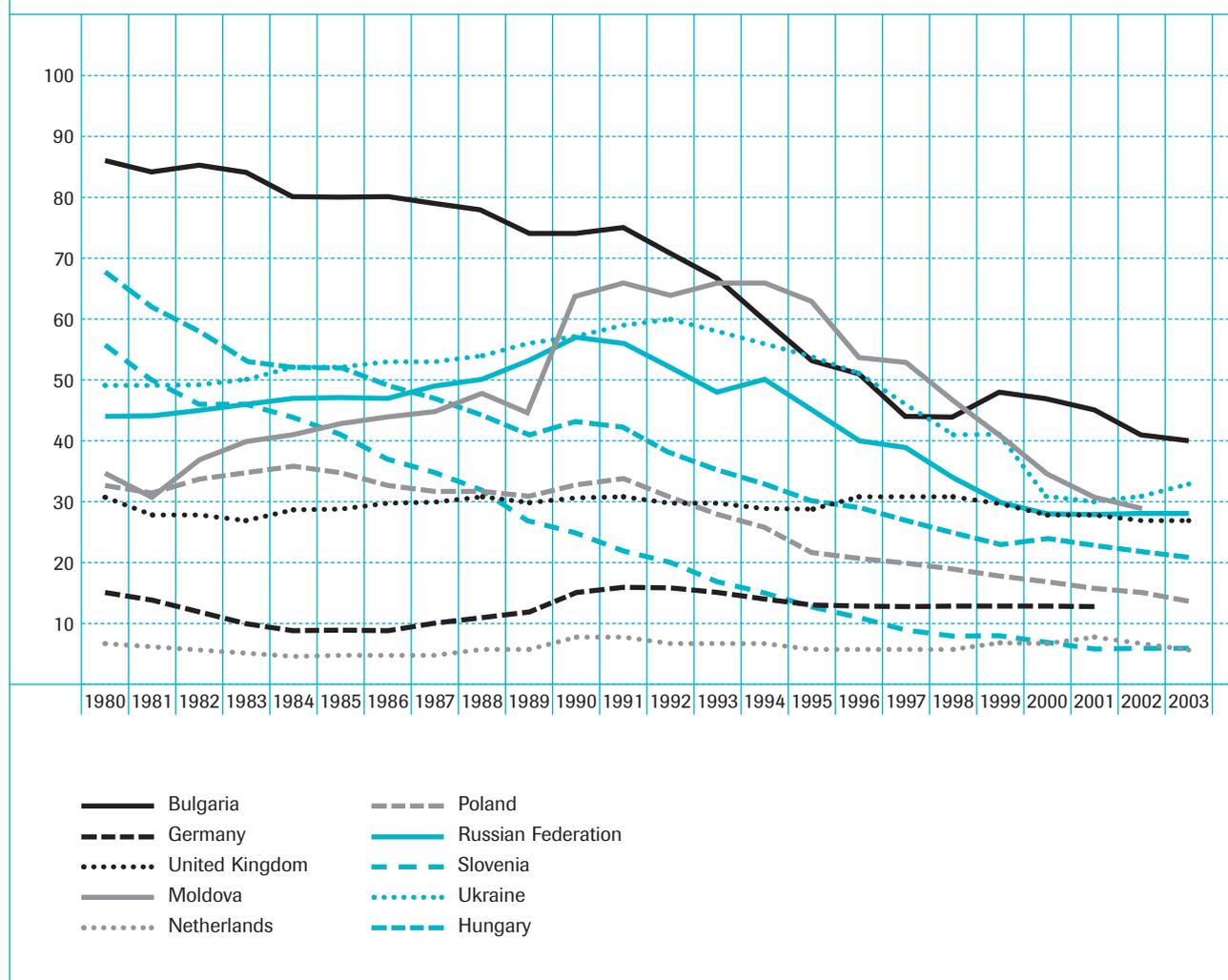
In the 1990s teenage birth rates were highest in Eastern Europe, second highest in Central Europe and the lowest in Western Europe. The UK was an exception; it had as high rate as Russia. In addition, the UK teenage birth rate did not decrease since the early 1980s. On the contrary, Slovenia is a great success story; its teenage birth rate was only one tenth in 2003 compared to 1980. Hungary and Bulgaria had also been able to halve their rates during this time period. Quite the contrary to this, in Moldova teenage birth rates were higher in 1990s than in 1980s.

In the 1990s and the early 2000s the rate of teenage births was generally decreasing in the EU (actual rate between 12 and 25 per 1,000 girls aged 15–19 years), with the lowest rates (5–7) to be found in Italy, Switzerland, Netherlands, Sweden, Denmark and Slovenia, and lately also in Cyprus. (s. tab. 1). The highest rates were to be found in United Kingdom (27), Portugal (20) and Ireland (19). Second highest rates (13–16)

<sup>1</sup> This is still true in most countries in the developing world (Kontula 2000).

Fig. 1

## Live births per 1,000 females (age 15–19)



were in Austria, Iceland, Germany, Norway and Greece. The differences in teenage pregnancies e.g. the UK 27 per 1,000 girls aged 15–19 years and the Italy and Switzerland, 5–6 per 1,000, were striking.

Teen birth rates are still high in most transitional countries relative to Western countries. The birth rate is currently close to 40 per 1,000 for women aged 15–19 in Ukraine, Turkey, and Bulgaria. Rates are round 30 per 1,000 for women in Armenia, Azerbaijan, Macedonia, Georgia, the Republic of Moldova, Romania, and Russian Federation. Rates are close to 20 in Belarus, Estonia, Hungary, Lithuania, and Slovak Republic. The highest decreases have taken place in 1990s in some Central European countries.

Birth rates were higher in 1995 than in 1970 in only eight of the countries with data for both years; all of these are in Eastern Europe – Armenia, Belarus, Estonia, Georgia, Lithuania, Macedonia, the Russian Federation and Ukraine (SINGH/DARROCH 2000). In 19 of the 28 nations under UNICEF review, births to teenagers had more than halved in 30 years. Giving birth while still a teenager was strongly associated with disadvantage in later life (UNICEF 2001).

The rate of teenage pregnancies was as high as 60–70 per 1,000 women still in early 1990s in many Eastern European countries and in countries of former Soviet Union. During the times of socialism, the centrally planned economy could easily be directed towards restricted supply of market contra-

ceptives, and the state imposed restrictions on the implementation of clinical contraceptive methods (sterilisation). Reason was also economic: the regime could not afford the import of modern contraceptive devices (PHILIPPOV/DORBRITZ 2003). One of the consequences was the high rate of teenage pregnancies.

In the period of 1990–2003 two thirds of European countries (totally 43 countries) had faced decrease in teenage live births. In seven countries (Armenia, Cyprus, Czech Republic, Latvia, Lithuania, Moldova and Slovenia) this decrease was substantial. Almost in third of countries the rate of teenage live births remained stable. In four countries, Denmark, Italy, Netherlands and Switzerland, the rate of teenage live births was very low through the whole period.

In all developed nations in Europe but in Ireland teenage birth rates were in 1998 lower than in 1970. Other countries with low decrease (less than 50%) in teenage birth rates during these 30 years were the U.K., Slovak Republic, Poland, and Portugal. The decrease had been at least four times in the Netherlands, Switzerland, Italy, Denmark, Sweden, France, Norway, Germany, and Austria. Actual teenage birth rates were higher than expected on the basis of each country's total fertility in Czech Republic, Slovak Republic, Hungary, Poland, Portugal, and the U.K. These countries had not promoted actively sexual health among their teenage population.

Tab. 1

**Live births per 1,000 females in the age group < 20 in the European countries in 1990–2000**

<i>Live Births</i>	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Albania	15	15	16	17	21	23	23	19	17	16	15	-	-	-
Armenia	70	77	83	77	68	56	53	44	43	31	29	27	-	-
Austria	20	22	22	21	19	17	16	15	14	13	13	13	14	13
Azerbaijan	26	32	36	39	42	38	37	42	38	33	30	28	28	28
Belarus	44	45	46	43	43	39	36	33	30	30	28	27	24	23
Belgium	11	11	11	10	10	9	10	10	-	-	-	-	-	-
Bosnia/H.	38	-	-	-	-	-	31	36	26	20	17	17	-	-
Bulgaria	74	75	71	67	60	53	51	44	44	48	47	45	41	40
Croatia	29	25	22	20	19	18	21	20	16	16	16	15	15	14
Cyprus	34	31	32	24	21	18	16	14	13	13	11	8	7	5
Czech Rep	50	51	46	42	32	24	19	17	15	14	13	11	11	11
Denmark	9	9	9	9	9	8	8	8	8	8	8	8	7	6
Estonia	50	48	50	43	39	36	34	30	27	26	26	24	22	-
Finland	12	12	12	11	10	10	10	9	10	10	10	11	11	10
France	12	12	11	11	10	10	10	10	9	10	11	11	11	-
Georgia	60	62	53	61	74	72	66	61	58	51	39	32	33	34
Germany	15	16	16	15	14	13	13	13	13	13	13	13	-	-
Greece	20	18	17	15	14	13	12	12	12	11	11	11	11	-
Hungary	43	42	38	35	33	30	29	27	25	23	24	23	22	21
Iceland	39	35	26	23	23	23	22	24	25	25	22	19	18	16
Ireland	17	18	17	17	16	16	16	18	19	20	19	19	19	-
Italy	8	8	7	7	7	6	6	5	6	7	7	7	-	-
Latvia	48	50	49	44	33	30	26	22	19	20	19	18	16	17
Lithuania	41	46	46	42	41	40	37	32	29	26	24	22	21	21
Luxembourg	12	13	12	13	11	10	10	9	9	10	13	12	13	11
Macedonia	44	43	42	47	46	44	39	37	34	31	32	27	-	-
Malta	11	12	12	13	11	10	17	17	17	17	18	17	-	-
Moldova	64	66	64	66	66	63	54	53	-	-	-	35	31	29
Netherlands	8	8	7	7	7	6	6	6	6	7	7	8	7	6
Norway	17	16	15	14	14	13	13	13	12	12	12	11	10	9
Poland	33	34	31	28	26	22	21	20	19	18	17	16	15	14
Portugal	24	24	23	22	21	20	20	21	21	21	22	20	20	-
Romania	52	52	50	49	46	42	40	40	39	39	39	37	35	34
Russian Fed	57	56	52	48	50	45	40	39	34	30	28	28	28	28
Serbia and Montenegro	43	41	37	36	34	33	30	28	26	25	25	25	25	24
Slovak Rep	49	53	49	46	39	33	30	29	27	25	24	21	21	21
Slovenia	25	22	20	17	15	13	11	9	8	8	7	6	6	6
Spain	12	11	10	9	8	8	7	8	8	8	9	9	10	-
Sweden	14	13	11	11	9	8	8	7	6	7	7	7	7	6
Switzerland	6	8	7	6	6	6	6	6	6	6	6	6	5	-
Turkey	57	56	55	54	53	52	51	50	49	57	56	45	44	44
Ukraine	57	59	60	58	56	54	51	46	41	41	31	30	31	33
United Kingdom	31	31	30	30	29	29	31	31	31	30	29	28	27	27

Source: Recent demographic developments in Europe 2005, Council of Europe.

### Concluding remarks on the trends and their determinants

National sex surveys conducted in Europe in late 1980s and in 1990s showed that the teenage sexual initiation was in transition (KONTULA 2003). This transition started first in Nordic countries and secondly in most other Western European countries. Mean age of women at first intercourse decreased after 1960s by 2–3 years in all Western European countries. Since 1980s this age was rather stable. However, in the first part of 1990s, there was some decrease in the mean age at first intercourse. Similar transition started in

Eastern Europe one generation (20–30 years) later. Mean ages at first intercourse are 17–18 years for men and women in Western and Central Europe, and 20 years for women in some Eastern European countries.

In most Western Europe countries age at first sexual intercourse was almost completely unrelated to marriage. In Eastern European countries they were much more inter-linked. Women had sexual initiation older, they married younger and they gave the birth of first child five years younger than in West. Teenage birth rates were 3–4 times higher in Eastern Europe than in West. The highest rates were in late 1990s 50 per 1,000 and the lowest 5–6 per 1,000

in Europe. In most countries birth rates had decreased in 1990s, but there were also countries where these rates had been rather stable at a high level. High rates were due to missing and unreliable contraceptive devices.

Decrease in teenage births rates is partly explained by the general postponing trend in childbearing and at the age of first birth. This has been found both in western and eastern Europe. In most European countries the mean age at first birth has increased 1–2 years from 1990 to 2002. The mean age of women at first marriage has increased as much or even more around the Europe. On the other hand, these means are still much lower in Eastern Europe and childbearing and marriage are there more closely linked to each other. Teenagers are now everywhere in Europe sexually more active than before but thanks to contraceptives, they get pregnant, and they marry at the older age than what was the pattern previously.

The pragmatic European approach to teenage sexual activity, expressed in the form of widespread provision of confidential and accessible contraceptive services to adolescents is viewed as central factor in explaining the more rapid declines in teenage childbearing in northern and western European countries (SINGH/DARROCH 2000). Shifts in value orientation resulting from greater individual autonomy in all domains are consistent with a life style in which people make their own choices about marriage and cohabitation, in which they are free to have children within or outside marriage, to raise them alone or with a partner, and can have them early or late in life or not at all.

Factors that play important role in explaining recent trends include the greater importance ascribed to educational achievement, the increased motivation among young people to delay pregnancy and childbearing in order to achieve higher education levels and to gain job skills before forming a family, as well as the improvements in knowledge of and access to the means of preventing unplanned pregnancy (SINGH/DARROCH 2000). There is lower motivation to avoid pregnancy among teenagers who have lower educational and job aspirations and expectations, among those who are not doing as well in school and among those in poor and single-parent families.

The trend toward smaller families is related to the utilitarian significance of childbearing: the practical advantages and disadvantages. People will seek self-expression and will focus on their own well-being and on actions they perceive as giving meaning to their lives (VAN DE KAA 2001). In Russia the decrease in adolescent fertility was caused by rising social aspirations of young adults. This was observed in a series of surveys carried out in Moscow and the provinces (MAGUN 1995). The 'new home economics' approach (BECKER 1994) argues that rising costs of children bring about a decrease in natality, and that is what was observed.

Many of the countries of Central and Eastern Europe and the Baltic States have experienced rapid declines in adolescent fertility during the 1990s. The family planning organisations grew up and developed large-scale activities for the spread of knowledge on modern contraceptive methods. Towards the end of the 80s and during the 90s usage of modern contraceptive methods increased considerably. The right of the parents to have the number of children that they desired was legally formulated. The higher education raised women's human capital and hence their earnings. The opportunity costs of time spent for the

family and for rearing children raised. Thus births decreased (PHILIPOV/DORBRITZ 2003).

In Western Europe decreasing trends in teenage pregnancies and STIs were due to secularisation of sex and liberalization of attitudes. They made possible the distribution of relevant information on sexual issues, sex education and related public health services. HIV prevention campaigns in 1980s were very important in providing to the young generation the knowledge and skills that they needed in order to protect themselves from health hazards. Unfortunately similar knowledge was not available in Eastern Europe. After the transition in Eastern Europe in early 1990s the new generation was freer to make their personal choices but usually without knowledge and means to protect them. At the same time public health resources were cut down. One of the consequences were the increasing trends in teenage STIs in the East (KONTULA 2003). Teenage pregnancies remained also at a high level.

Very often unwanted pregnancies and sexual health hazards have to do with social inequalities and poverty among teenagers. Young women need realistic options to gain social status, other than teenage motherhood. There is a serious need to increase the school enrolment and motivation to education especially among young women living in poverty. Education provides cognitive and other resources that help to gain better control with one's life.

Countries should ensure the provision of unbiased, scientific and clearly understandable information and counselling on sexual and reproductive health, including the prevention of unwanted pregnancies and the risks involved in unsafe abortions carried out under unsuitable conditions. Advice and counselling must be confidential and non-judgmental (Van Lancker 2002). Counseling will be needed also for preventing and treating sexual abuse as well as for gaining control of own sexuality. Young people often need also help to enabling the acceptance and enjoyment of the full potential of one's sexuality.

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# Teenage Fertility in Ireland<sup>1</sup>

This article examines statistical information available on teenage pregnancy in Ireland. It begins by documenting teenage fertility rates in Ireland and internationally. This is followed by section 2 which looks at the number of teenagers who travel to the UK for an abortion. Data is finally presented in section 3 looking at births and abortions together and giving an overall picture of trends relating to teenage pregnancy in Ireland and internationally. The last section, of this article briefly covers initiatives in the area of sexual health and crisis pregnancy.

## 1. Teenage fertility

Teenage fertility is often voiced as an area of concern by both analysts and policy makers, and there is a common misconception that teenage fertility is increasing in Ireland. In fact it has been decreasing over the last 5 years. The fertility rate for women aged 15–19 years from 1973 to 2005 is examined in this section. Unless otherwise indicated, the term ‘teenagers’ refers to persons between the ages of 15 and 19. The teenage fertility rate is calculated as the number of births to teenagers per thousand of the population, aged 15 to 19. A very small number of pregnancies take place to younger aged teenagers, for example in 2005, just 2% (42) of all births to teenagers took place to those aged 15 and under. This section also compares the teenage fertility rate in Ireland with that of other countries. There are geographical variations in the teenage fertility rates in Ireland and these are presented. The age of maternity is examined as it highlights the fact that the majority of births taking place to teenagers occur to women aged 18 or 19. The marital status and birth order of those giving birth as teenagers is also examined.

The teenage fertility rate is the number of live births per 1,000 females aged 15 to 19. This rate does not include the number of pregnancies aborted, which are accounted for in the teenage pregnancy rate (see section 3), nor does it include miscarriages. The teenage fertility rate increased from 16.3 in 1970 and reached its peak of 23.0 in 1980. The teenage fertility rate declined throughout the 1980s. From 1995, the fertility rate steadily increased to 20.2 births per 1,000 in 1999 and has since decreased to 16.8 in 2005 (s. fig. 1 and tab. 2).

Figure 2 provides international comparative data on teenage fertility rates between 1985 and 2002. In some countries the teenage fertility rate was low throughout the entire period. For example, the teenage fertility rate in Sweden was reported to have decreased marginally from 10.35 in 1985 to 6.9 in 2002. Other countries witnessed a dramatic decline in the teenage fertility rate over two decades, for example, teenage fertility rates in Portugal decreased from 32.87 in 1985 to 20.44 in 2002. The teenage fertility rate in the UK remained high between 1985 and 2002 and was 27.34 in 2002. The teenage fertility rate in Ireland marginally increased during this time period from 16.6 in 1985 to 19.0 in 2001. KANE and WELLINGS (1996) examined variations in

teenage fertility rates over a 40 year period across Europe and concluded that Ireland’s rate, like that of Belgium, the Netherlands, Luxembourg and Switzerland, has been ‘consistently low’.

As mentioned above, teenage fertility rates do not take account of abortions to teenagers. Therefore, the low teenage fertility rates in Norway and Sweden may be partly as a result of the high rates of teenage abortion in these countries (see section 3 for international comparison of the teenage fertility and abortion rates).

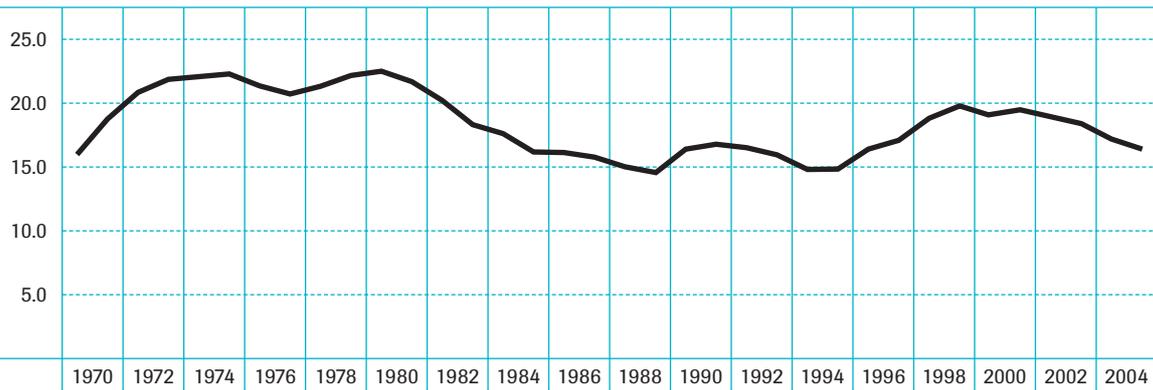
## Geographical variations

Geographical variations in the teenage fertility rate in Ireland can be observed. Table 1 shows the age specific fertility rates for females aged 15–19 years in all Counties/County Boroughs in Ireland for 1996 and 2002 (Census data [2006] is as yet unavailable to update this table). Counties/County Boroughs with the highest fertility rates in both 1996 and 2002 included Limerick City (30.6 and 40.9), Dublin City (25.2 and 32.1), Waterford City (20.8 and 27.2) and Carlow (24.2 and 26.5). Counties/ County Boroughs with the lowest fertility rates included Roscommon (7.1 and 7.2), Galway County (6.8 and 9.9) and Sligo (11.4 and 10.5). The majority of Counties/County Boroughs recorded an increase in fertility rates for 15–19 year olds. Limerick City and Offaly recorded particularly large increases.

Research in other countries has indicated a link between teenage pregnancy and socio-economic deprivation (e.g. LEE et. al. 2004). Unfortunately, investigation of this aspect of teenage pregnancy in an Irish context is hampered due to the unavailability of key data.

<sup>1</sup> This article examines teenage fertility in Ireland and is largely based on a statistical report (O’Keeffe/ McGrath/Smith 2006) published by the Crisis Pregnancy Agency [http://www.crisispregnancy.ie/pub/statistical\\_report2006.pdf](http://www.crisispregnancy.ie/pub/statistical_report2006.pdf).

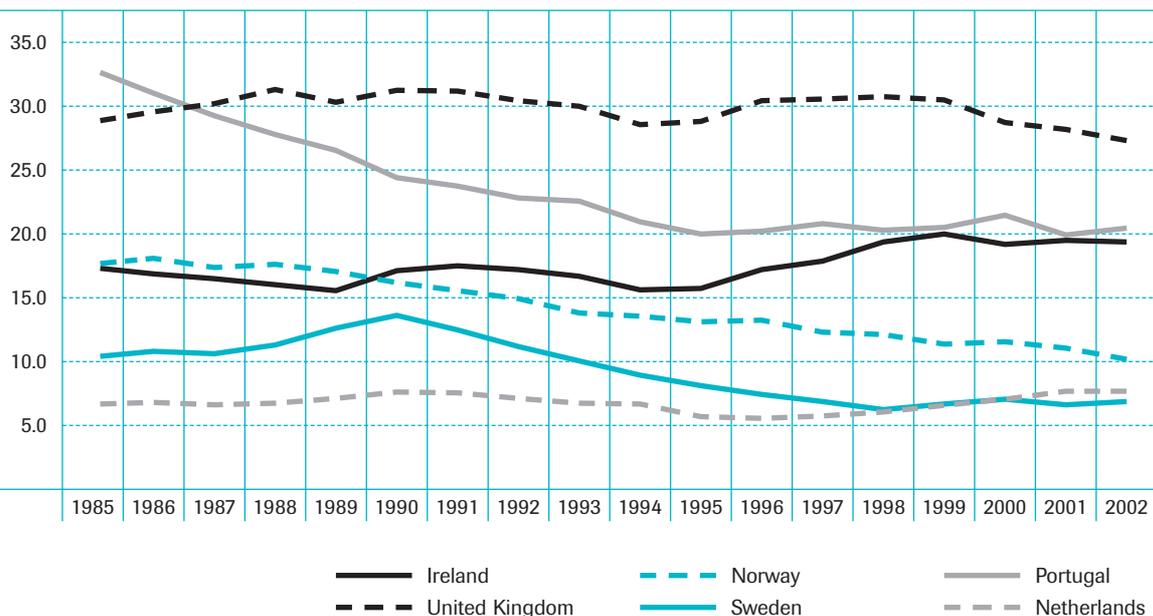
Fig. 1

**Fertility rates (number of live births per thousand women)  
for women aged 15 to 19 years in Ireland 1970–2005**


Source: Central Statistics Office (CSO)

The teenage fertility rate in Ireland has been relatively stable over the course of the last 35 years.

Fig. 2

**International comparative data on teenage fertility rates 1985–2002**


Source: Central Statistics Office (CSO)

### Age at maternity

The majority of teenage births in Ireland take place to females aged 18 or 19 years. For example in 2005, 75% of all births to females under 20 years of age were to women aged 18 or 19 years (1,815 of the 2,427 births to teenagers). A very small number of pregnancies take place to younger teenagers. In 2005, there were 42 births to teenagers aged 15 and under, which represented 2% of all births to teenagers that year.

Table 2 gives a breakdown of the number of births to those teenagers aged 12–14 between 1991 and 2005. It high-

lights the very small number of teenage births that take place to teenagers aged 12–14.

### Births to teenagers inside and outside marriage

While the rate of teenage fertility has not varied considerably over the past three decades, the marital status of teenage parents has changed dramatically. In 1984, 39.8% of births to women under the age of twenty were marital births. By 2005, just 7% of births to those under the age of twenty were marital births (CSO VITAL STATISTICS YEARLY SUMMARY 2005). Thus, while the number of births to teenagers has

Tab. 1

**Age specific fertility rates for females aged 15–19 by area of residence of mother in 1996 and 2002**

Area of residence	1996	2002
Limerick City*	30.6	40.9
Meath	13.5	17.6
Dublin City*	25.2	32.1
Cavan	12.5	17.4
Waterford City*	20.8	27.2
Leitrim	12.2	17.2
Carlow	24.2	26.5
Kerry	12.3	16.7
Louth	21.5	26.1
Clare	9.1	16.4
Offaly	14.3	25.4
South Tipperary	18.8	16.2
Dublin South	24.5	25.0
Monaghan	15.3	15.3
Laois	15.4	22.7
Galway City*	12.3	13.7
Wexford	22.3	22.9
Cork County	11.5	12.8
Westmeath	21.4	22.3
Limerick County	12.5	12.8
North Tipperary	17.3	21.0
Mayo	12.6	12.8
Kildare	17.0	20.7
Kilkenny	10.0	12.5
Donegal	16.1	19.9
Waterford County	14.1	12.2
Dublin Fingal	14.2	19.7
DL/Rathdown	12.5	10.7
Longford	16.1	19.3
Sligo	11.4	10.5
Cork City*	19.1	18.9
Galway County	6.8	9.9
Wicklow	18.5	18.8
Roscommon	7.1	7.2

Source: CSO Report on Vital Statistics, 2001 and 2002.

\* Cities were known as County Boroughs in 1996.

remained relatively stable, there has been an increase in the proportion of these births taking place outside of marriage and a corresponding decrease in the proportion of teenage births that occur within marriage. However as noted by FAHEY and RUSSELL (2001), there is a lack of information concerning the status of non-marital births in Ireland, i.e. whether they represent births to women not involved in a stable relationship.

#### Birth order

As illustrated by figure 3, the majority of births that take place to teenagers are first births. In 2005, 90% of births to teenagers (2,188) were first births. There were 211 second births to teenagers in 2004 and 19 third births to women under twenty.

Tab. 2

**Number of births to teenagers aged 12–14 between 1991 and 2005**

Year	No of births to teenagers aged 12–14
1991	7
1992	6
1993	11
1994	10
1995	11
1996	3
1997	10
1998	11
1999	11
2000	10
2001	9
2002	8
2003	12
2004	3
2005	7
2006	unavailable

Source: Central Statistics Office (CSO)

**The majority of teenage births in Ireland take place to females aged 18 or 19 years.**

## 2. Teenage (15–19 years) abortion

The previous section looked at the teenage fertility rate. As noted previously, the fertility rate does not include abortions. This next section looks at the number of Irish women aged 15–19 years giving addresses at UK abortion clinics.

The abortion figures only reflect the number of teenagers giving Irish addresses at UK abortion clinics. The number of teenagers giving Irish addresses at UK abortion clinics has declined since 2001. This may partly be explained by teenagers travelling to countries other than the UK for termination. The Crisis Pregnancy Agency is currently undertaking a study to look at the extent of this phenomenon. It is important to note, however that since 2001 the number of live births to teenagers is also decreasing.

It should be noted that by international standards, Ireland has a very low rate of teenage abortion. International comparisons of abortion rates can be found below.

Fig. 3

**Birth Order for Teenagers 2005**

First births	
Second births	9% (211)
Third births	1% (19)
Fourth births	0%* (3)
Not stated	0% (6)

Source: CSO Vital Statistics Yearly Summary 2005  
\* Note percentages are rounded: Actual percentage of 4th births is 0.12%.

**The majority of births that take place to teenagers are first births.**

### 3. Teenage pregnancies (births and abortions) 15–19 years

The previous sections have looked at teenage fertility rates (births per 1,000 females aged 15–19) and abortion rates (abortions<sup>2</sup> per 1,000 females aged 16–19). The teenage pregnancy rate is an aggregate of the birth and abortion rates (15–19 years). This section examines the pregnancy rate for women aged 15 to 19 years in Ireland and compares the teenage pregnancy rate in Ireland with international data.

#### Teenage pregnancy rate

There were 21.17 pregnancies per 1,000 females aged 15–19 in 1991. The teenage pregnancy rate increased during the second half of the 1990's, to reach a high of 25.67 in 2001 (s. fig. 6).

Please note that very slight variations can occur when calculating fertility rates over time. This is due to the population estimates sourced at the time of calculation and the age range included in the calculation.

#### International comparisons of teenage fertility and abortion rates

By international standards, Ireland has a low rate of teenage abortion. Figure 7 illustrates that teenage conception is less likely to result in abortion in Ireland than other countries, particularly in comparison to countries such as Norway, Sweden and Denmark, suggesting that abortion is a more likely outcome of teenage pregnancy in these countries.

When examined in relation to the conception rates in other European countries, Ireland's teenage conception rate is lower than that of England and Wales, Scotland, New Zealand, Norway, Sweden and the USA.

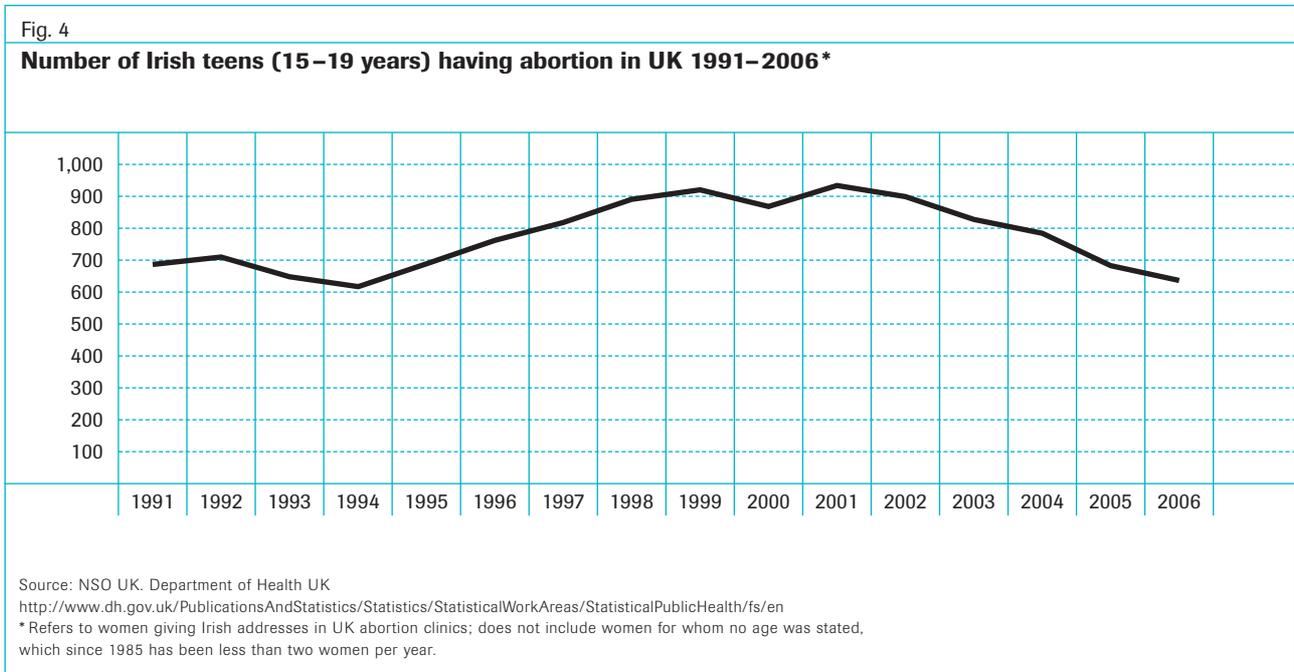
### 4. Irish initiatives to promote positive sexual health and the work of the Crisis Pregnancy Agency

There are a range of state departments, non-governmental organisations and charities that play a part in either promoting positive sexual health among young people or supporting teenage parents in Ireland. Ireland has no national sexual health strategy, nor does it have a policy on teenage pregnancy or parenting. Ireland does have a comprehensive sex education programme in primary and post primary schools. Implementation levels of this programme are inconsistent but improving. Data collected in 2005 demonstrated that 41% of post-primary schools were found to be implementing the programme to a high level, 36% to a moderate level and 24% to a poor level (MAYOCK/KITCHING/MORGAN 2007). Implementation of the programme is higher in first year (81% of schools report to have a programme and decreases as children grow older with 30% of schools reporting not teaching the programme in third year and 48% of leaving certificate year reported not teaching the programme.

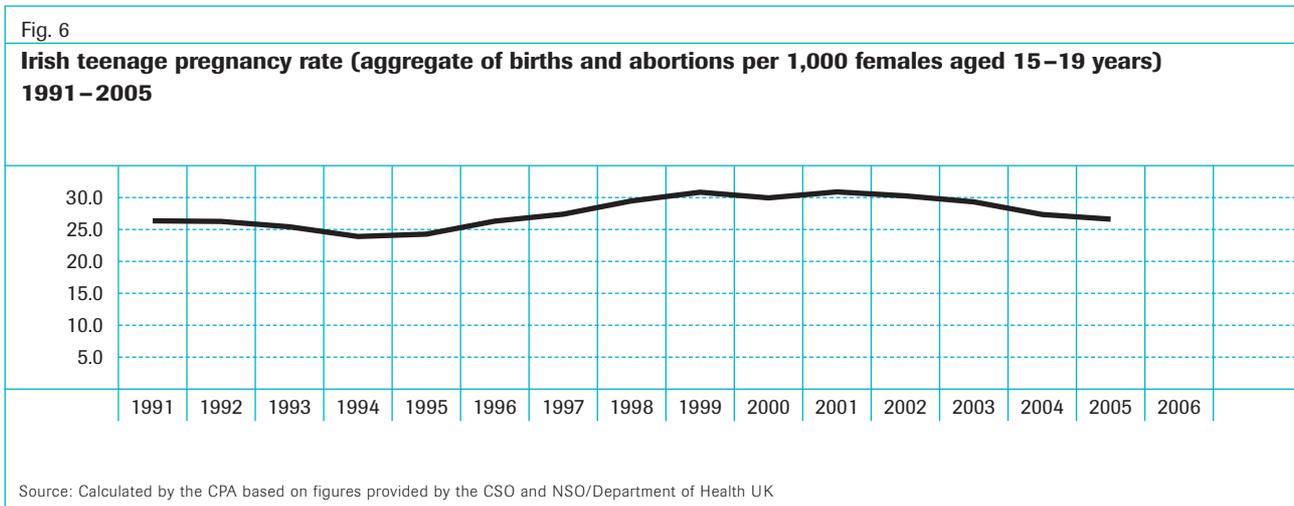
In 2001 the Government of Ireland established the Crisis Pregnancy Agency which became fully operational in 2002. The primary function of the Agency is to prepare and implement a strategy to address the issue of crisis pregnancy, in consultation with relevant Departments of State. Crisis Pregnancy is defined as pregnancy that is neither planned nor desired by the women concerned and which represents a personal crisis for her. The Agency also understands that this definition can include women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances. The purpose of the Crisis Pregnancy Agency is to bring strategic focus to the issue of crisis pregnancy and so to add further value to the work of existing service providers. The Crisis Pregnancy Agency does not deal exclusively with preventing crisis pregnancy among teenagers. In fact, most young women and men experience crisis pregnancy in their early 20s and furthermore, not all teenage pregnancies can be classified as crisis pregnancies (O'KEEFE 2004)<sup>3</sup>. The following paragraph gives a brief synopsis of the work of the Crisis Pregnancy Agency.

2 The abortion figures only reflect the number of teenagers giving Irish addresses at UK abortion clinics and thus the data in this regard may be incomplete.

3 Research suggests that some teenagers may have a positive or ambivalent attitude towards pregnancy (JACCARD/DODGE/DITTUS 2003; CONDON/DONOVAN/CORKINDALE 2000), that some teenagers respond positively to the news of being pregnant and see it as a positive direction in their lives (DEMPSEY/HESLIN/BRADLEY 2001).



**There has been a substantial increase in the number of teenagers travelling to the UK for abortions over the last three decades, with a decrease noted every year from 2001 to 2006.**



**The teenage pregnancy rate in Ireland has remained relatively stable between 1991 and 2005.**

Tab. 3

**Number and rates of: births, abortions and pregnancies for 15–19 year old females in Ireland**

Year	Estimated number of females in the population aged 15–19	Total Births*	Fertility rate**	Total Abortions*	Abortion rate**	Total Pregnancies* ((births and abortions)	Pregnancy rate** (births and abortions)
1991	163,618	2,804	17.1	693	4.2	3,497	21.4
1992	162,600	2,740	16.9	711	4.4	3,451	21.2
1993	161,000	2,623	16.3	650	4.0	3,273	20.3
1994	161,800	2,435	15.0	619	3.8	3,054	18.9
1995	163,800	2,472	15.1	691	4.2	3,163	19.3
1996	165,586	2,767	16.7	760	4.6	3,527	21.3
1997	167,568	2,926	17.5	812	4.8	3,738	22.3
1998	167,986	3,230	19.1	891	5.3	4,121	24.5
1999	164,687	3,303	20.2	919	5.6	4,222	25.6
2000	160,509	3,106	19.3	874	5.4	3,980	24.8
2001	156,165	3,078	19.6	932	6.0	4,010	25.7
2002	152,775	2,940	19.4	901	5.9	3,841	25.1
2003	149,767	2,816	19.0	826	5.5	3,642	24.3
2004	146,700	2,490	17.1	787	5.4	3,277	22.3
2005	144,567	2,420	16.8	682	4.7	3,102	21.5

Source: Calculated by the CPA based on figures provided by the CSO and NSO/Department of Health UK

\* Females aged 15–19 years

\*\* Fertility rate: births to females aged 15–19 per 1,000 females aged 15–19; Abortion rate: abortions to females aged 15–19 per 1,000 females aged 15–19; Pregnancy rate: pregnancies to females aged 15–19 per 1,000 females aged 15–19 years

The Agency has three mandates:

1. *prevention of crisis pregnancy*  
To achieve a reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services.
2. *services and supports for women experiencing a crisis pregnancy*  
To achieve a reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive.
3. *post crisis pregnancy services*  
To ensure the provision of counselling and medical services after crisis pregnancy.

In the five years since its establishment the Crisis Pregnancy Agency has made concrete attempts to put the issue of crisis pregnancy on the national agenda.

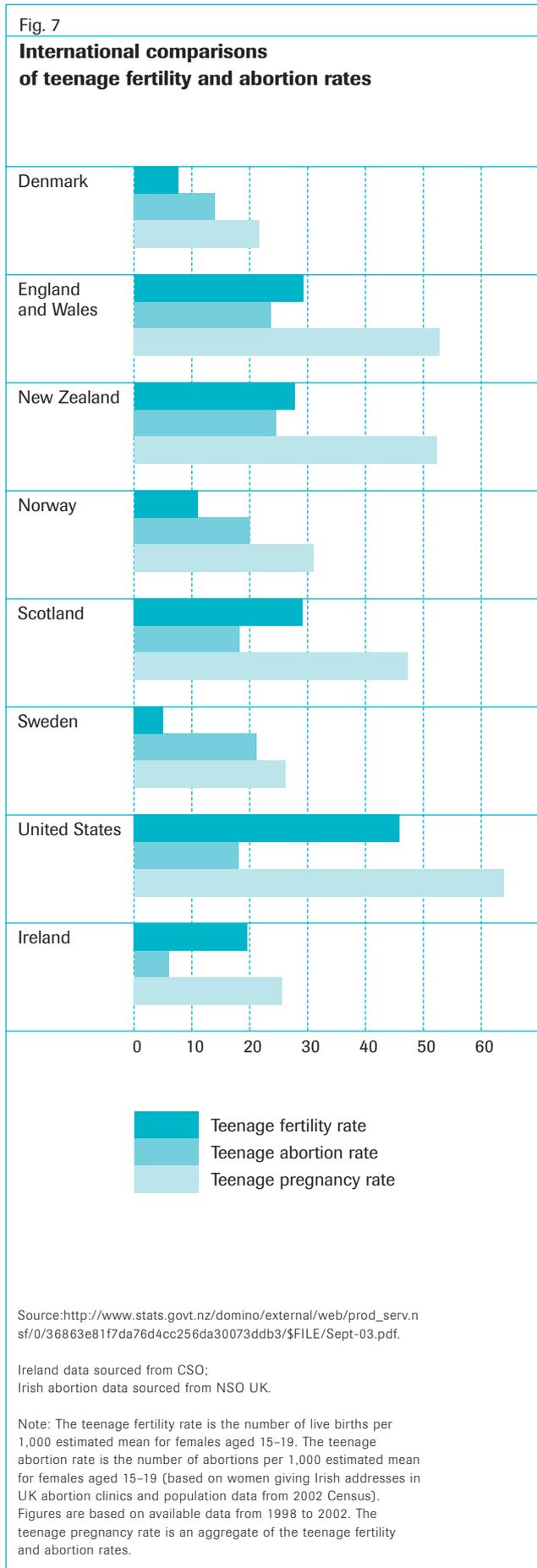
When the Crisis Pregnancy Agency was established in 2001 there was a dearth of research on sex and crisis pregnancy in Ireland. Research gaps have now been addressed, over 20 research reports are published on the Agency's website and the Agency has a good knowledge of the factors contributing to crisis pregnancy. Significant new trends have emerged in the last five years, such as the widespread support for sex education (over 90% among the general population<sup>4</sup>), the decrease in the age of first sex and the increase in use and knowledge of contraception.

The Agency runs two national advertising campaigns, one aimed at preventing crisis pregnancy (Think Contraception [www.thinkcontraception.ie](http://www.thinkcontraception.ie) aimed at 18 to 24 year olds) and one directing women to crisis pregnancy counselling services (Positive Options). The Agency develops resource materials for the public and for professionals with the aim of preventing crisis pregnancy and supporting women with a crisis pregnancy. Resource materials directing women to post-abortion medical check-ups and counselling have also been developed.

The Agency provides funding to organisations to provide services and undertake innovative projects. The Agency's first mandate – prevention of crisis pregnancy – is addressed primarily through funding innovative educational and information projects targeted at young people aged 13 to 24. For example the Agency funds a number of youth health cafes. In addition, the Crisis Pregnancy Agency and the Health Service Executive have funded the first integrated sexual health service for young teenagers based in Cork city. The second mandate – to provide services and supports for women experiencing a crisis pregnancy – is primarily addressed by funding crisis pregnancy counselling but is also addressed by funding support services for new parents and for those who are considering adoption. The third mandate – to provide post crisis pregnancy services – is primarily addressed by funding post-termination medical and counselling services.

Ensuring that young people get comprehensive sex and relationships education on contraception, sexual intercourse and sexual feelings, in school and at home, will be a main priority for the work of the Agency in the coming years. This is a key long-term measure to successfully prevent unplanned pregnancies. Delivering comprehensive sex education to

4 See: LAYTE/McGEE/QUAIL et al. (2006); RUNDLE/McGEE/LAYTE (2004).



every young person, so that they know how to conduct happy, safe and respectful sexual relationships is a challenge. This is not a job that the Crisis Pregnancy Agency can do alone. We work in partnership with and support the work of the Department of Health and Children, Department of Education and Science, the Health Service Executive, and the teachers, parents, principals and boards of management of our schools. This is a main strategic priority for the work of the Agency for the coming years.

The Health Service Executive (HSE) is the state agency responsible for the prevention and treatment of Sexually transmitted Infections (STIs) in Ireland and the Health Protection Surveillance Centre (part of the HSE) provides information on infectious diseases including sexually transmitted infections in Ireland. It does this through surveillance and epidemiological investigation.

*Stephanie O’Keeffe, Mary Smith*

**By international standards, Ireland has a very low rate of abortion amongst teenagers aged 15 to 19.**



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# Sexual and reproductive health. Preventing unwanted pregnancies and abortion in Norway

**Maternal mortality and morbidity in Norway is extremely low. The same applies to infant and child mortality. Healthcare services for mother and child are available and easy accessible at community level all over the country. The author presents the Norwegian strategy of preventing unwanted teenage pregnancies and abortions.**

## Safe abortion

From 1979, women in Norway have had the legal right to induced abortion on demand until the 12th week of pregnancy. Abortions are performed in public hospitals within the health insurance scheme. The woman has a right to good counselling. After the 12th week of pregnancy, the approval of a local medical committee is necessary.

## Preventing unwanted pregnancies and abortion in Norway

A wide field of measures to prevent unwanted pregnancies accompanies the Abortion Act. Since the middle of the 1990s the Norwegian government has financed and carried out 3 national strategic plans. The basic goals are:

- To ensure the sexual and reproductive rights for the whole population.
- To reduce the rates of induced abortion; especially among teenagers and young adults.

## Strategies of prevention – empowerment

The key concepts in the preventive work in Norway are empowerment and sexual autonomy. To promote young peoples ownership, self-confidence and pride of their bodies and sexuality. To encourage young people to take control over their fertility and sexual health. Key principle: all work and projects are oriented towards the gender, age and the specific cultural setting of the target groups

## Strategies – main directions

The main strategies of prevention include:

- an open and ongoing dialogue with young people on issues of sexuality,
- training boys and girls to choose and act with competence in sexual situations,
- easy accessible consultation – and contraception services age,
- low barrier offer of good contraception education and

gender specific education on sexuality for children and young people

- contraception free of charge for young people age 16–19
- preventive work is carried out as an ongoing process.

## Education and counselling

The work is carried out nationally as well as locally. Sexual education in school is obligatory in Norway and starts in the fifth grade. Norwegian studies show that teenagers prefer contraception education given by healthcare personnel. Contraception education and -counselling is carried out by the local youth healthcare services.

## Contraception – accessibility

Easy accessibility to safe contraception:

- young people can obtain contraceptives free of charge from the local youth healthcare- and youth social services all over the country
- hormonal contraception is available free of charge for girls between 16–19 years of age. To increase accessibility midwives and local district nurses with a special training course can prescribe hormonal contraception
- since 2000 emergency contraception has been available OTC in all local pharmacies

## Gender oriented programs

### Programs – boys

As boys use other information channels, and seem to profit from other kinds of information and training, we have tried new ways to reach them. In the past years we have launched different interactive information and training programs - on the internet, SMS and computergames.

### Programs – girls

A main strategy that seems to be profitable to most young girls is practical oriented, basic training in self-assertiveness. How to draw your own lines, how to decide over your own body, how to learn to assert yourself in close relationship physically as well as psychologically. This kind of training programme is carried out all over the country.

### Local peer education groups – both sexes.

Young people are encouraged to be directly involved in the preventive work, and local peer educational groups has been established many places. Training is given by the national volunteer organisation of young medical students specialised in sexual issues.

A few projects are conducted on a national basis. For example a leaflet on safer sex, developed by a local group of 15–16 year old boys, is used all over the country. Boys in Russia also use it.

## Results

### Pregnancy and abortion

With the exception of 2001 the general abortion rate has declined steadily in the last ten-year period:

- Since the beginning the 1990es the overall abortion rate in Norway has declined 19%. In 2004 the abortion rate was 12.6 per 1,000 women.
- The abortion rate for the age group 20–24 has declined 24% totally from 1992 to 2000, the degree of reduction varying from 12% to 31% in different parts of the country. From 2002 there has been a slight increase.
- There has been a dramatic decline in the abortion rate among teenagers from 20 per 1,000 in 2000 to 13 per

1,000 in 2005 – which is the lowest abortion rate ever in this age group.

- Overall teenage pregnancy has shown a steady decline since 1990. Teenage births are exceptionally rare and amounts to less than 5% of the total annually births. The mean age of women having their first child is 28 years.

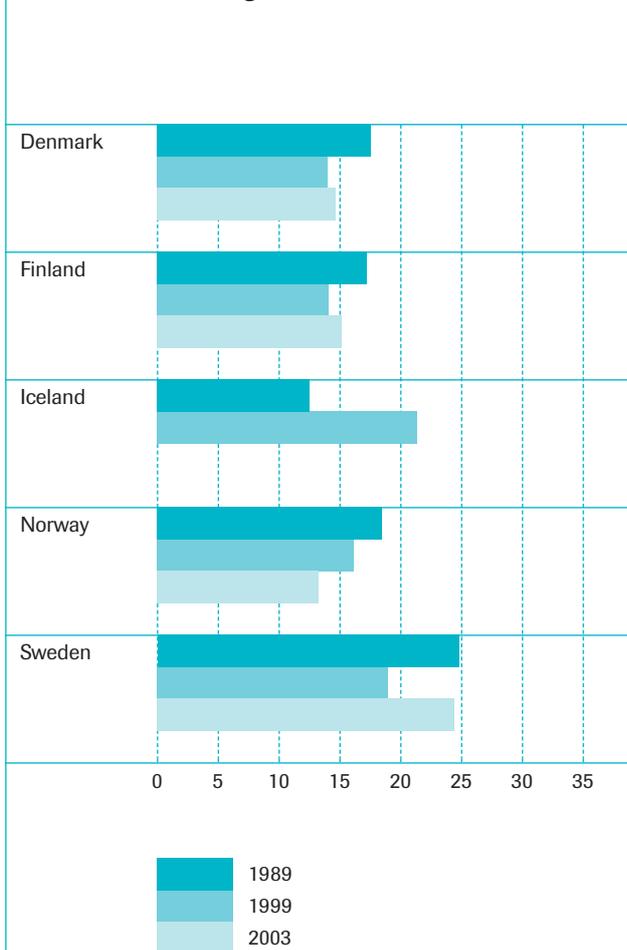
### Use of contraception

Contraceptive use have inclined in the last five year period and most studies report a high contraceptive prevalence among teenagers in all the Nordic countries. The indicators are however not fully reliable:

- There has been a slight rise in the use of condoms among boys and young men.
- There has been a definite increase in the use of hormonal contraception among women in all age groups – and especially among young women since these became easy accessible and free of charge. The user rate among young girls being 588 per 1,000 in 2005.

Fig. 1

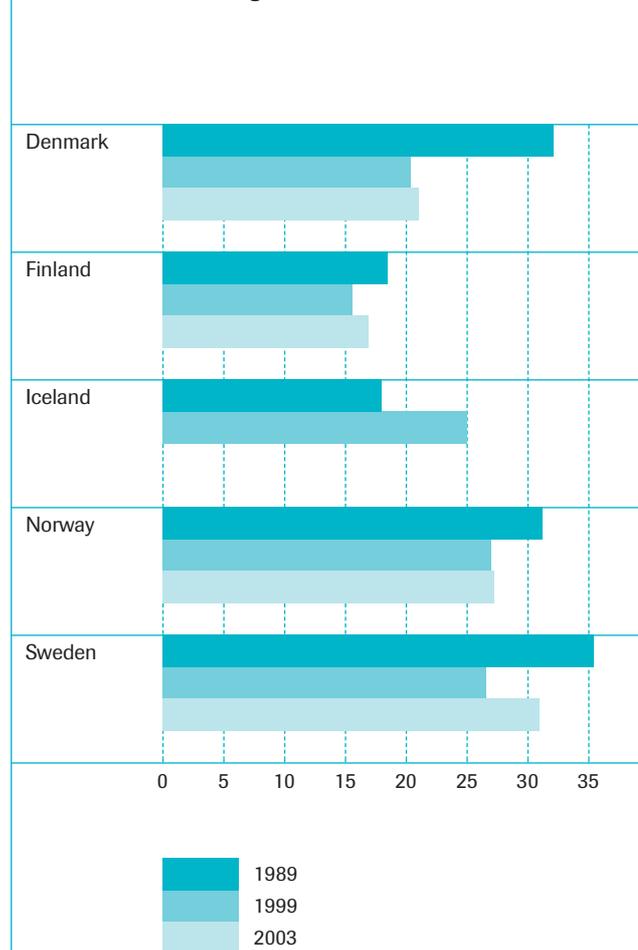
### Abortions per 1,000 women 1989/1999/2003 (age 15–19)



Source: Finn Egil Skjeldestad, Sintef Unimed 2004

Fig. 2

### Abortions per 1,000 women 1989/1999/2003 (age 20–24)



Source: Finn Egil Skjeldestad, Sintef Unimed 2004

## Conclusion and challenges ahead

The results from Norway show that good education is not enough to improve the sexual health of young people. Strategies to promote sexual health have to be based on an orchestration of specifically targeted measures, which aims at empowerment, sexual autonomy and easy access to contraception and contraceptive services. The main challenge in the years to come is to provide the same means for young women as those for teenagers. Today young women – often living far away from their local county while studying – have to see their family doctor to get a prescription for hormonal contraception, and they have to pay for the consultation as well as for the contraception.

*Ulla Leth Ollendorff*

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# Adolescent pregnancy in Iceland

During the past decades adolescent pregnancy rates in Iceland have been dropping but still are the highest compared to the other Nordic countries. Adolescent pregnancy has to a great extent been accepted within the framework of pronatalism but views of non-acceptance have been emerging. Three explanatory factors of higher pregnancy rates in Iceland are described; the cultural context, the early sexual experience and the lack of youth friendly sexual and reproductive health services (SRHSs).

Young people in Iceland seem to have sexual debut earlier than young people in the other Nordic countries and to have less access to youth friendly SRHSs. Studies have shown that they experience many hindrances in accessing the routine services and receive mixed messages about the service provision. Therefore they need easier access to the services and to have contraceptive methods of low or no cost. It is of importance to find new ways to deliver high quality SRH services to young people which can contribute to easier access and to more responsible sexual behavior of this age group.

## Introduction

In Iceland there have been over the last decades the highest adolescent pregnancy rates compared to the other Nordic countries (Denmark, Finland, Norway and Sweden) (BENDER/GEIRSSON/KOSUNEN 2003a). Although the rates have been declining from the high of close to 70 per 1,000 in 1976–80 down to just less than 40 in 2001–04 (s. fig. 1) this lower rate is close to double the rates in Denmark at the same time (s. fig 2) (BENDER 2005a). These higher rates in Iceland raise several questions. Do young people desire pregnancy at a

young age? Based on findings from a national study great majority of young people do not desire pregnancy when they are too young (BENDER/KOSUNEN 2005). But why do they become pregnant if they don't want to? Is it because there is something in their environment which does not stimulate responsible sexual behavior? In this article two issues regarding the external environment will be described, i.e. Icelandic culture and SRHSs.

According to the literature adolescent pregnancy is multifactorial and no attempt will be done here to try to explain all those factors. It is, however, of importance to understand this complexity. Three main factors have been identified (BENDER 2005a, b). Firstly, it is the adolescent (intrapersonal); secondly the interactions of the adolescent with others (interpersonal) and thirdly the society at large (extrapersonal) (BENDER 2005a,b). The intrapersonal factors refer to the background of the individual (e.g. socioeconomic), also cognitive and psychosocial maturity, attitudes, beliefs, knowledge, decision-making and behaviour (e.g. sexual activity and contraceptive use). The interpersonal factors are the interactions and possible influences from important others like parents, friends and partners. The extrapersonal factors are factors pertaining to the external environment which for instance have to do with cultural and societal norms, public

Fig. 1

Fertility, abortion and pregnancy rates per 1000 women in Iceland, 15–19 years, 1976–2004

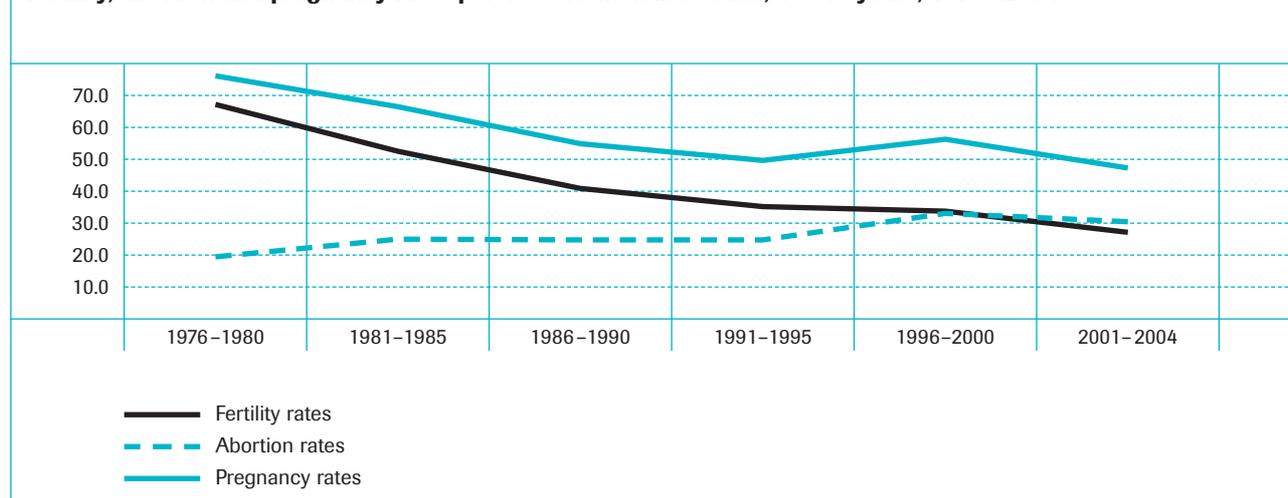
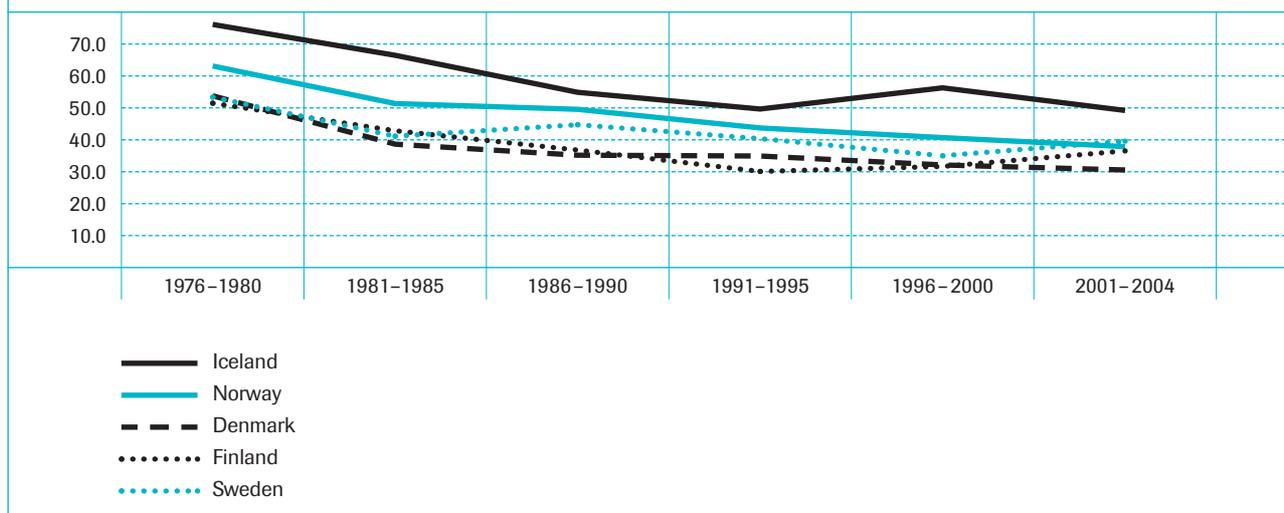


Fig. 2

## Pregnancy rates per 1,000 women in five Nordic countries, 15–19 years, 1976–2002



policy, sexuality education and sexual and reproductive health services (SRHSs). These three factors (intra-, inter- and extrapersonal) are not easy to separate. For each individual they are mixed in various ways. Also, two levels of decision making are of importance. One has to do with the decision to become sexually active and the other of using contraceptive methods. There are three factors which are highlighted here which make Iceland different to the other Nordic countries. First it is the Icelandic culture, secondly it is early sexual activity and thirdly it is the lack of youth friendly SRHSs.

### Cultural context

Childbearing has been highly valued within Icelandic culture from early on. The general attitude towards childbearing is 'Every child is a blessing' [*Blessun fylgir barni hverju*]. High fertility rates prevailed in Iceland until recently and for a much longer time than in other countries in Europe (during 1960–2000). A Gallup study in Iceland showed that about 70% of the study population wanted to have three or more children and 85% considered it necessary to have a child to feel happy (GALLUP ICELAND 1999). Also, childbearing has not been considered a big deal as is reflected in the common attitude 'Things will take care of themselves' [*Thetta reddast*]. The general acceptance of childbearing within the framework of pronatalism may have been a contributing factor regarding adolescent childbearing over the past decades. However, in the earlier days (1856–early 1930s) it was not common that young girls were having children in Iceland (s. fig. 3).

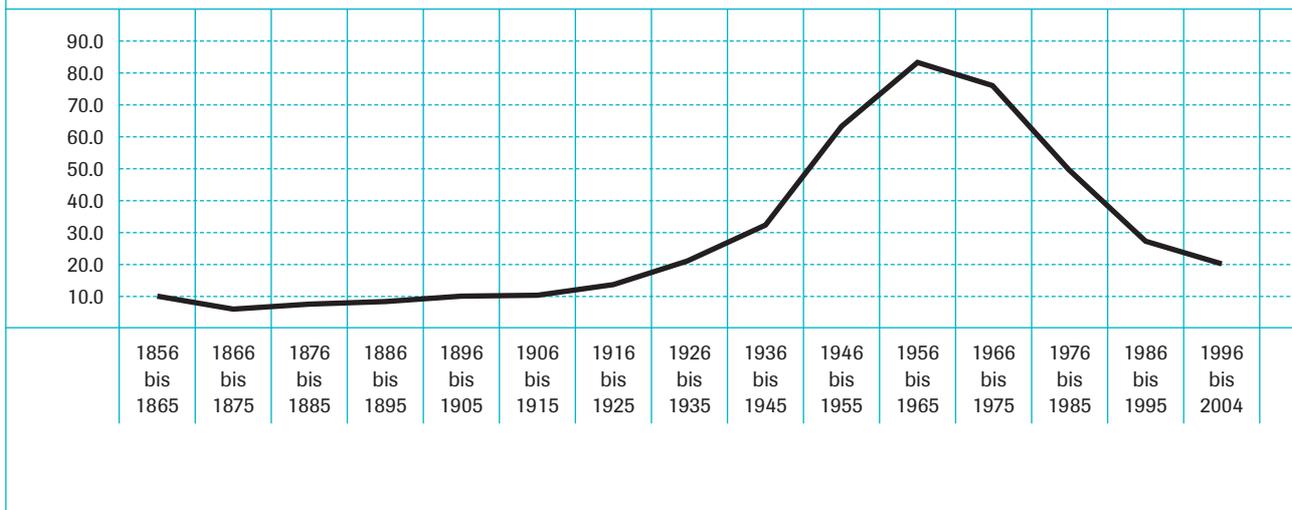
Figure 3 shows that the rates began to rise in the early 1930s and reached a peak around the 1960s and early 1970s (STATISTICS ICELAND 1997). Since then it has been dropping (BENDER 2005a). The attitude towards early childbearing over the past decades has within Icelandic culture to a great extent been of acceptance, especially in certain regions of Iceland where adolescent pregnancy is of higher frequency (BENDER 2005a). There have also been some growing notions of non-acceptance. The acceptance-view seems to be based on the perspective that children should grow up fast and become adults soon so they can contribute to the work force and to the survival of their community. This view may be especially

prevalent in places where there has been good income based on the fishing industry. The non-acceptance more urban view has been developmentally oriented and considered the need of the young girls to grow up, pursue their education before making childbearing plans and thus having a more promising future. Interviews with young mothers by the author of this article have revealed that often times they experience a negative attitude and comments of distrust from others towards their childbearing demonstrating the non-acceptance view (SVEINSDOTTIR/GUDMUNDSDOTTIR 2000).

### Early sexual behaviour

The latest two studies in Iceland about sexual activity of adolescents show that in 2006 (preliminary results), compared to eleven years earlier, more girls and boys say they started sexual debut at the age of 15 or younger (girls: 66% in 2006 and 54% in 1996; boys: 54% in 2006 and 45% in 1996) (BENDER 2002; BJARNASON et al. 2006). The earlier study (1996) among teenagers 17–20 years, showed that the mean age of sexual debut among those being sexually active ( $n=1405$ ) was 15.4 years, insignificant gender difference (BENDER 1999; 2004). Based on this study young people commence sexual intercourse at an earlier age compared to their age mates in neighbouring countries, such as in Norway and Sweden, where the mean or median age was 17–18 years at a similar time as the previously mentioned study (KRAFT 1991; WEINBERG/LOTTES/SHAVER 1995). What is of importance here is that studies have shown that early age of sexual relationship may relate to risk taking behaviour such as cigarette smoking, alcohol consumption and less contraceptive use (MÅRDH et al. 2000; MANNING et al. 2000; MOTT et al. 1996; ROSENTHAL et al. 1999). The national study in Iceland (1996) revealed that older age at sexual debut predicted contraceptive use among girls. Those who were between 15 and 16 years of age when they started sexual intercourse were more than two times more likely to use contraceptives and those who were 17 and older were more than five times more likely to do so compared to those who were 14 and younger (BENDER/KOSUNEN 2005).

Fig. 3

**Fertility rates per 1,000 women in Iceland, 20 years and younger, 1856–2004****Sexual- and reproductive health services**

Over the years health care authorities in Iceland have been reluctant towards the issue of developing SRHSs since they have not enforced any action plan about it. In the latest abortion law from 1975 (LOG UM RADGJOF NR 25/1975) SRHSs for all should be developed within the primary health care (PHC) and in hospitals. This preventive focus has to a small degree been enforced. Adolescent pregnancy has not been regarded a public health problem although the pregnancy rates have been highest in Iceland compared to the other Nordic countries. The notion may have been that because of the close-knit family ties in Iceland, young mothers were expected to be supported by their families. This non-realization of the public health problem of early motherhood has in particular halted the development of special adolescent pregnancy prevention programs and also specialized programs for teenage mothers. It was not until the year 2001 that for the first time in Icelandic history an objective was included in the National Health Care Plan for 2010, aiming at the reduction of adolescent pregnancy by 50% (MINISTRY OF HEALTH AND SOCIAL SECURITY 2001). Following the new abortion laws in the early 1970s in the Nordic countries the importance of preventing abortion was stressed by providing improved sexuality education and SRHS for young people. In Sweden, for instance, the SRHSs provision was delivered into the hands of midwives which made services easier to access. Also contraceptive methods have been subsidized. Compared to the other Nordic countries there has been less emphasis on preventive initiatives in Iceland especially regarding the development of youth friendly SRHSs and young people have up to now had to pay full cost of all contraceptive methods.

The first specially organized youth service within a PHC was opened in 1999 in Akureyri, in the north of Iceland, and later others have followed in the greater Reykjavik area. This service has been broadly based, including sexual and reproductive health services along with other health promoting efforts relating to physical and mental health. However, it has from the beginning had its limitations such as very short opening hours (one hour a week). Also, no regular funding was provided for the service. In the year 2000, direct provision of emergency contraception through the pharmacies,

was encouraged by the Director of Public Health in Iceland and the Icelandic medicines Control Agency. Since the year 2002 the policy of the PHCs in the greater Reykjavik area is to emphasize youth services aimed at the age group 14–18 years, within PHC and in the grammar schools (PRIMARY HEALTH CARE 2002). Although these recent policies are good signs of improvement there exists a gap in the service provision, more services are needed than are provided. Also, their quality should be ensured.

According to the present health care system general practitioners (GPs) within PHC should be the ones to go to for prescription contraceptives. Focus group studies in Iceland have shown that young people experience many hindrances in accessing their service (BENDER 2000; 2003b). They have described difficulties in getting an appointment and when they finally go there they sometimes experience lack of service quality, regarding client-provider interaction. They also are very much concerned about confidentiality. What they find especially difficult is to go for the first time to the service provider since they are concerned about what the GP is thinking about them and wonder about how the service is provided. They sometimes find the service provider not understanding and experience getting no opportunity to ask questions. Some young people have even been refused to obtain a prescription for a contraceptive method from a GP, without him suggesting another method. Also, they get several mixed messages about the legal age of obtaining prescription contraceptive methods and about parental consent. Some think the legal age is 18 years while others have received different information. There is no regulation about this legal age in Iceland and it is therefore in the hands of the GP to decide. Furthermore, young people may have heard that they need to have a parental consent to obtain the service. These hindrances already mentioned have to do with the intrapersonal factors of the adolescents (own identity, their inexperience, etc.) but mostly the extrapersonal factors (administration and quality of the services). These extrapersonal factors are possible to improve since they depend on the training of the service providers and the service organization.

The findings of the national study about SRHSs (1996) and another study in the spring of 2007, among young

people attending the only organized STI clinic in Reykjavik, showed that young people want to have an easily accessible service of low cost, with convenient opening hours, where confidential services are provided by friendly people (BENDER 1999; HAFSTEINSDOTTIR/INGVARSDOTTIR 2007). Focus group studies about SRHS among young people in Iceland have revealed that they would also like to have SRHSs provided within the schools (for ages 16–20) but it is of vital importance to them how they should be organized. A very important aspect is the quality of care. They want the service provider to be understanding, show them respect, talk clearly, be non-judgemental, friendly and not become shocked of what they say or have done.

### The way forward

There is a very clear legal frame (LOG UM RADGJOF NR 25/1975) for preventive SRHSs in Iceland and there are currently two policies by the MINISTRY OF HEALTH AND SOCIAL SECURITY (2001) and the PRIMARY HEALTH CARE in the greater Reykjavik (2002) both emphasizing the preventive focus. The limitations of both of these policies is that neither of them has any action plan. There is no plan of training people who are working within PHC in order to have the necessary skills to provide high quality youth SRH services and there is no action plan of organizing the services in such a way to become more accessible and attractable. Young people find it hard to get an appointment to see the GP at the PHC and the STI clinic in Reykjavik. Also, young people have experienced lack of service quality. The evidence presented here shows that there are service providers who seem to lack the motivation to serve young people. There also exists some inconsistency in the care provided which gives young people mixed messages. The lack of motivation and basically the lack of training of service providers in order to provide high quality youth SRHSs needs attention since young people should not be the ones to suffer. One solution might be to have other service providers, who have a different educational background for example in the field of prevention and health promotion than GPs, who may turn out be more motivated to provide the needed services. By training nurses and midwives in the special field of providing sexual and reproductive health services to young people could be the way forward in order to make the access to the services easier and to raise the standard of care.

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## BROCHURES

### Pränataldiagnostik

[Prenatal diagnostics]

The brochure on prenatal diagnostics produced by the Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege e.V. [Federal Association of Non-Statutory Welfare Services], on which we reported in detail in FORUM 1/2007, is now available. The 48-page publication, which is sponsored by the BZgA, provides information on prenatal investigations, answers many important questions and above all shows what the various advisory services can provide in terms of prenatal diagnostics.

A summary table in the appendix shows how, why and when the individual prenatal diagnostic processes are used, what exactly they (can) establish and what has to be considered in each case.

#### Address for orders:

BZgA  
51101 Köln  
order@bzga.de  
www.bzga.de  
Order no. 13625300

### Informationspaket zur Prävention von Schwangerschaften bei Minderjährigen

[Information package on the prevention of underage pregnancies]

The BZgA information package contains comments by the BZgA on teenage pregnancies in Germany, frequently asked questions on the subject of underage pregnancies, a reprint of 'Schwangerschaft und Schwangerschaftsabbruch bei minderjährigen Frauen' [Pregnancy and termination of pregnancy in underage women], a further reprint of the material list, issue 2/2007 of the periodical Forum Sexualaufklärung und Familienplanung [Sex education and family planning forum]

on the subject of 'Teenagerschwangerschaften international' [Teenage pregnancies internationally] as well as a flyer on selected publications. The information package is aimed at advisory personnel and is available free of charge (maximum of five copies). The modules can also be ordered individually, some of them in English, via the homepage [www.sexualaufklaerung.de](http://www.sexualaufklaerung.de).

#### Address for orders:

BZgA  
51101 Köln  
order@bzga.de  
www.bzga.de  
Order no. 13050000

### Migration und öffentliche Gesundheit

[Migration and public health]

The BZgA issues a quarterly printed version of the information service 'Migration und öffentliche Gesundheit' [Migration and public health] which is available on the Internet and is regularly updated. It has developed from the study group of the same name (see the item by Dorothea Grieger in FORUM 3/2006), which is coordinated by the office of the Federal Government Commissioner for Migration, Refugees, and Integration

One A4 page is devoted to each of the publications, projects, target dates, conferences, further training, etc. The editorial team welcomes contributions and orders.

#### Contact:

T/S/ Text und Service  
Infodienst Migration  
Horst Heinemann  
Postfach 23 02 72  
45070 Essen  
TextServ@web.de  
www.textundservice.de  
www.infobrief-migration.de  
Fax +49 (0)20 54 9 35 79 46

### Frauenrat

(Women's council)

The information service of the Deutscher Frauenrat reports in Issue 1/2007 on the life plans of 12 to 29-year-olds in Germany. The main themes of the publication are education and employment. Amongst other things it deals with girls' attitudes to work and family, the education of girls, gifted and talented girls, girls' day, young mothers between child and work and the special situation of teenage mothers. Internationally, the consequences of the one child policy in China ('China gehen die Mädchen aus' [Girls are disappearing from China]) and the struggle against people trafficking in Albania are covered.

The magazine appears six times a year at a subscription rate of 23,52 euro including postage.

#### Address for orders:

Deutscher Frauenrat  
Axel-Springer-Straße 54a  
10117 Berlin  
Telephone +49 (0)30 2 04 56 90  
Fax +49 (0)30 20 45 69 44  
kontakt@frauenrat.de  
www.frauenrat.de

### Deine Sexualität – deine Rechte

[Your sexuality – your rights]

'Can my parents forbid me from sleeping with my girlfriend?', 'What do I do if I think I am pregnant?', 'Can I get the pill without my parents knowing about it?' – information on these questions is provided by the new brochure from the federal association pro familia.

'Deine Sexualität – deine Rechte' [Your sexuality – your rights] goes into the rights of young people to experience their sexuality, irrespective of their origin, religion or skin colour, to get information about contraceptives and to use them. These rights also include getting confidential advice and medical

care, as well as protection against sexually transmitted diseases. Appropriate addresses and sources of assistance are provided.

In order to get as close as possible in practice to everyday questions regarding sexuality and partnerships, young people were involved in the production of the brochure, which is available free of charge.

**Address for orders:**

pro familia Bundesverband  
Stresemannallee 3  
60596 Frankfurt  
Telephone +49 (0)69 63 90 02  
www.profamilia.de

**Präventionspaket  
Zwangsheirat**

*[Forced marriages  
prevention package]*

The human rights organisation 'Terre des Femmes' has produced a flyer and postcards which are intended to encourage girls with a migratory background to contact one of the advisory bodies listed if they face the threat of a forced marriage or being taken abroad to be married. The flyer entitled 'Wer entscheidet, wen du heiratest?' [*Who decides who you marry?*] contains important advice as well as an emergency number for the Foreign Office.

The postcards, with two different motifs on the subject of 'honour' and 'forced marriage', are available in German, Arabic, Albanian, Persian and Turkish. 100 flyers cost 4.90 euro, 10 postcards 1.00 euro plus postage.

**Address for orders:**

Terre des Femmes  
Menschenrechte für die Frau e.V.  
Konrad-Adenauer-Straße 40  
72070 Tübingen  
www.frauenrechte.de  
vertrieb@frauenrechte.de

**Und wo bleibe ich? Eltern im Spannungsfeld sexuellen Missbrauchs**

*[And what about me? Parents in the conflict area of sexual abuse]*

This brochure, which probably a one-off, is aimed at parents whose children have been subjected to sexual abuse. Since most of these criminal offences occur in a close social environment, the aspect of 'family dynamics' is covered in a detailed chapter which is intended to strengthen and encourage parents to

withstand pressure, even within the family, in order to provide the child with effective protection. Feelings of fear, shame, anger and guilt are covered, as well as dealing with authorities and much more. The 52-page brochure is available for 2 euro plus postage.

**Address for orders:**

Fachberatungsstelle bei sexuellem Missbrauch und sexualisierter Gewalt  
Verein Pfiffigunde e.V.  
Telephone +49 (0)71 31 16 61 78  
Fax +49 (0)71 31 77 29 22  
info@pfiffigunde-hn.de

**'Liebe verdient Respekt – Sevgi Saygiya Deger'**

*[Love deserves respect]*

This 68-page bilingual leaflet provides the most important information on the subject of homo-sexuality and coming out: causes, preconceptions, religion, HIV/AIDS, culture, history, politics, parents, as well as addresses, sources of assistance and tips. It is intended as a guide for young gays, lesbians and their relatives, and all the texts are in German and Turkish.

It is published by the Lesben- und Schwulenverband Deutschland e.V. (LSVD) [*Lesbian and Gay Association Germany*], Berlin-Brandenburg.

**Address for orders:**

LSVD-Zentrum MILES  
Telephone +49 (0)30 22 50 22 15  
miles@lsvd.de  
www.miles.lsvd.de

**BOOKS**

**Volle Fahrt voraus. Schwule und Lesben mit Behinderung**

*[Full speed ahead. Gays and lesbians with a disability]*

In this reader by Thomas Rattay and the youth network Lambda e.V. young people and adults with a disability talk about their lives.

The book is based on an interview project in which 18 women and men report on their life with a disability and at the same time on their homosexuality and the time of their coming out. The personal life experiences, the individual methods of coping with everyday problems, longings and hopes produce a multiplicity of striking portraits.

There is a comprehensive addresses, literature and media section in the appendix.

'Volle Fahrt voraus' is published in 2007 by Querverlag; it has 188 pages and costs 14.90 euro.

**Available from:**

Bookshops

**MAGAZINES**

**Balanceakte. Psychische Grenzerfahrungen von Mädchen und jungen Frauen**

*[Balancing act. Psychological borderline experiences of girls and young women]*

The latest issue of the nationwide specialist magazine 'Betrifft Mädchen' [*For Girls*] deals with the significance and effects of psychological borderline experiences in educational work with girls. The contributions provide specialist knowledge about the psychological stresses of girls and young women and give practical examples of work carried out with the girls concerned. The magazine includes articles on the following subjects: Psychological problems and crises of children and young people in gender comparison, self-harm as a coping strategy for young women, anorexia as a borderline experience, depression in childhood and youth from a gender-specific perspective, working with traumatised children and young people, treatment groups for girls with a borderline tendency. The publisher is LAG Mädchenarbeit in NRW e.V. (lag@maedchenarbeit-nrw.de, www.maedchenarbeit-nrw.de).

**Address for orders:**

Juventa Verlag  
Telephone +49 (0)62 01 90 20 13  
steinmetz@juventa.de  
www.juventa.de

**NEWSLETTER**

**Women. Men. Equal Opportunities**

Equal opportunities constitutes the principal theme of the current third issue for 2007 of the newsletter from the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth [*Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ)*].

The newsletter provides information on the German Federal Government's National Integration Plan. The plan's aims include improving the lives of migrant women and girls and implementing equal opportunities in this respect. Within this context, the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth is sponsoring somewhere in the region of 70 million euros worth of projects. These projects cover areas including the promotion of early language development and the strengthening of community involvement by, for and in cooperation with migrants. However, German Federal Minister Ursula von der Leyen views supporting the integration of migrant women and girls, for example, through a sponsored mentoring programme for school pupils and students, as the German Federal Government's most important contribution. Further issues include the Ministry's commitment to equal treatment for women with respect to wages and salaries, as called for by the European Commission.

**Reference:**

[www.bmfsfj.de/Kategorien/Service/newletter-abo.html](http://www.bmfsfj.de/Kategorien/Service/newletter-abo.html)

## STUDIES

### Study of 'Abstinence only programmes' in America

The 'abstinence only programmes' which are run in state schools in America and are designed to promote abstinence from sexual activity before marriage generally replace any form of sex education and explanation of how to use contraception and have been the subject of frequent criticism in Germany. The programmes are now coming under pressure from a long-term study conducted by the Mathematica Policy Research Institute, which found no evidence to support the assertion that teaching abstinence delays the start of sexual activity. Moreover, the number of teenage pregnancies was on the decrease as early as 1991, before the introduction of these programmes. However, it is precisely in Texas, where the abstinence programme has been implemented to a particularly high extent, that the lowest decrease in pregnancy rates is found, as assessments of government statistics demonstrate.

A summary of the results can be found on the Institute's homepage.

**Contact:**

[www.mathematica-mpr.com/publications/PDF.s/impactabstinenceEs.pdf](http://www.mathematica-mpr.com/publications/PDF.s/impactabstinenceEs.pdf)

## TRAINING

### Integrative in-service further training in sex education and family planning

Session 5 of the integrative in-service further training course in 'Sexualpädagogik und Familienplanung' [*'Sex education and family planning'*] starts at Merseburg college in October 2007. The college offers a Germany-wide one-off theoretical and practical course of studies in the field of application-oriented sexology. Professors from the college and proven external experts are available to the students to deal with any fundamental, current key areas and issues arising from their interests.

The study provides a qualification for working in pregnancy information centres in accordance with the pregnancy conflict law and for work in many different areas and is suitable for people employed in social education, psychology, education, education science, medicine, nursing, etc. For masters studies there are special entrance requirements (university degree – see the conditions of study for further details). It provides a qualification for higher service and for promotion.

The course, which is subject to charges, begins on 19.10.07.

**Contact:**

Silke Ait-Kaki  
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[silke.ait-kaki@hs-merseburg.de](mailto:silke.ait-kaki@hs-merseburg.de)  
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[www.sexpaed.de](http://www.sexpaed.de)  
[www.hs-merseburg.de](http://www.hs-merseburg.de)

### MA course in gender studies in Bielefeld

The 2007/08 winter semester sees the start of the four-semester masters course 'Gender Studies – Interdisziplinäre Forschung und Anwendung' [*'Gender studies - interdisciplinary research and application'*] at the University of Bielefeld. With key areas of 'Socialisation, education and interculturality', 'Work and organisation', 'Body and health' and 'Transnationalisation and democratisation' the course combines and links the varied activities in the area of gender studies at the University of Bielefeld.

The course prepares the graduates for taking up additional scientific positions at colleges and research institutions and enables them to apply for positions in public and political institutions, in private enterprise, non-governmental organisations and associations. Gaining the ability to analyse and reflect on gender ratios in professional contexts qualifies the graduates for many and varied fields of activity, including the education and further education sectors, politics and management, media and culture, public health, social work and sport.

**Information:**

<http://www.uni-bielefeld.de/genderstudies/>

### Focus on sex education – supervision for those involved in sex education

Sex education is a comparatively new area within the field of pregnancy counselling which has increasingly gained in importance in recent years. Many counsellors now offer projects for school classes, groups of girls, etc. on the subjects of sexuality, contraception and relationships. The requirements profile differs in many ways from that of counselling work. In addition to specialist know-how in terms of youth sexuality, contraception and fertility, the requirements also include group educational and methodical knowledge and the ability to evaluate one's own role in contact with young people.

In addition to directly supervisory matters, elements of specialist counselling and sharing of experiences between colleagues are also included. In a small group (8 to 10 persons as a maximum) quite specific issue-related and personal matters can be discussed.

The event takes place in Dortmund on 10–11 October. The cost, including board and lodgings, will be between 60 and 120 euro.

**Information:**

Sozialdienst katholischer Frauen  
– Zentrale e. V. –  
Referat Frauen und Familien  
Gisela Pinggen-Rainer  
Agnes-Neuhaus-Straße 5  
Telephone +49 (0)2 31 55 70 26-34  
Fax +49 (0)2 31 55 70 26-60

**CONFERENCES**

**Baby simulators in educational practice**

For some years, educational practice has resorted to computer-aided baby simulators to demonstrate motherhood or parenthood as a concept of life in school and in out-of-school contexts. Findings relating to educational work with baby simulators in Germany are now available in the form of the independent evaluation study 'Lebensplanung mit dem Babysimulator – Konzepte, Umsetzungen und Reichweite eines sexualpädagogischen Präventionskonzeptes (für Mädchen)' [*Life planning with the baby simulator – concepts, implementation and scope of a sex educational prevention concept (for girls)*]. The results of the study will be presented by Anke Spies, the author of the study, at a conference at the Carl von Ossietzky University, Oldenburg, on 12 September 2007.

**Information:**

<http://www.uni-oldenburg.de/babysimulatoren/>

**It's all or nothing now!**

A women's congress will be held by the North Rhine-Westphalia Women and Girls Network [*FrauenMädchenNetz NRW*] and the Friedrich Ebert Foundation [*Friedrich Ebert Stiftung*] on 20 October 2007 in Bonn.

What affects women and girls? What do they desire? What concerns them? The congress will provide a forum for taking stock and will offer attractive prospects for developing projects aimed at women and girls.

The topics discussed in the specialist forums will be: 'Women in the balance – the law and justice', 'Abundance rather than lack – the future of educa-

tion and work for women', 'If we do not dream ... Power is the opportunity to act', 'Always on the move – faster, more beautiful, completely healthy?'

The organisers of the congress are inviting educationalists, female experts and those interested who work with girls to take part in the congress. The congress will also provide an opportunity to establish a connection between work with women and girls.

**For further information:**

[www.frauenmaedchennetz-nrw.de](http://www.frauenmaedchennetz-nrw.de) or  
[www.maedchenarbeit-nrw.de](http://www.maedchenarbeit-nrw.de)

**Women's issues – Conference aimed at women with disabilities**

The Federal Association for the Physically Disabled and Those Suffering From Multiple Disabilities [*Bundesverband für Körper- und Mehrfachbehinderte e.V.*] is holding a women's conference from 9–11 November 2007 in Rheinsberg as the introduction to a new project aimed at disabled women and men and entitled 'Women are different and so are men'. The aim of this project is to develop and test gender-specific concepts for working with disabled women and men. On 30 November and 1 December, the Association will hold the follow-up event in this series in Kassel, which will be aimed at men: 'Men need new concepts!'

**Contacts and Information:**

Bundesverband für Körper- und Mehrfachbehinderte e.V.  
Brehmstraße 5–7  
40239 Düsseldorf  
Women's project  
Anne Ott  
[Anne.ott@bvkm.de](mailto:Anne.ott@bvkm.de)  
Men's project  
Fabian Schwarz  
[Fabian-schwarz@bvkm.de](mailto:Fabian-schwarz@bvkm.de)  
Telephone +49 (0)2 11 6 40 04-21  
[www.bvkm.de](http://www.bvkm.de)

**INTERNET**

**FORUM online**

A new online version of the FORUM Sex Education and Family Planning provides an overview of the media, projects and activities involved in sex education and family planning. The results of current scientific investigations and evaluations are presented.

Every issue of the FORUM journal since 1996 can be found here: In all, over 1,000 articles are available in full text. It goes without saying that FORUM online also offers a keyword search function, numerous links which, amongst other things, simplify ordering, and an author database with addresses and short biographies.

**Contact:**

<http://www.forum.sexualaufklaerung.de>



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Infotheque

**FORUM** *Sexualaufklärung und Familienplanung*  
A series of publications from the Federal Centre for Health Education (BZgA),  
Department of Sex Education, Contraception and Family Planning  
Ostmerheimer Straße 220  
51109 Köln

[www.sexualaufklaerung.de](http://www.sexualaufklaerung.de)

Bibliographic information published by Deutsche Bibliothek:  
Forum Sexualaufklärung: Informationsdienst der Bundeszentrale für gesundheitliche Aufklärung/BZgA  
Bundeszentrale für gesundheitliche Aufklärung, Abteilung Sexualaufklärung, Verhütung und Familienplanung – Köln: BZgA  
Published three times a year  
Included after 1996,1  
ISSN 1431-4282

Conceptual design:  
Department of Sex Education, Contraception and Family Planning  
Manager:  
Monika Hünert  
Text and editing:  
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Translation from the German:  
ECLIPSE Translation LTD,  
Northumberland, United Kingdom  
Layout und typesetting:  
Dietmar Burger, Berlin  
Druck: Media Cologne, Hürth  
Auflage: 1./3./9.07

FORUM Sex Education and Family Planning 2–2007 is available free of charge from:  
BZgA, 51101 Köln, Germany  
Order No. 13 32 92 67  
[order@bzga.de](mailto:order@bzga.de)

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