Response to the

The Scottish Parliament: Call for written views on the inquiry into teenage pregnancy

From The Christian Medical Fellowship

January 2013

Introduction

The Christian Medical Fellowship (CMF) is interdenominational and has as members around 4,000 doctors and 1,000 medical students throughout the United Kingdom and Ireland. In Scotland there are 450 members and over 70 student members.

We regularly make submissions to governmental and other bodies on a whole range of ethical matters (available at http://www.cmf.org.uk/publicpolicy/submissions/), so we welcome this opportunity to input our comments to this Scottish Parliamentary inquiry into teenage pregnancy.

Our response will primarily answer the following Inquiry questions[1]:

a. Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

d. What are the barriers and challenges to making progress in achieving positive change in communities that might lead to reductions in the levels of teenage pregnancy?

g. Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

Inquiry Questions

a. Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

In the past forty years over £250 million has been spent by policy makers on numerous initiatives aimed at cutting teenage pregnancy rates in the UK, yet with almost negligible effect. Economist, Prof David Paton recently published an article in the Education and Health Journal showing (not for the first time) that, despite the vast amounts of money spent, the rate of conceptions to under-16s in England and Wales was almost exactly the same in 2009 as forty years previously.[2]

There have of course been some ups and downs in the rates (between about 7 and 10 per 1,000 per year) but these do not correspond neatly to major Government spending and advertising initiatives to cut teen pregnancy. Despite small recent decreases in the underage conception rate (the most recent decrease in teen pregnancy, from 2008 to the present, has come at a time of spending cuts to

[1] *http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/58033.aspx*
[2] http://sheu.org.uk/content/page/education-and-health-latest-issue

policies!) Paton says that: '…*unwanted pregnancy has proved remarkably resilient to policy initiatives implemented by different Governments over the past 40 years'*.[3]

Perhaps this money has been well spent, by preventing the rates from *worsening* even more.

However a CMF paper in 2008 drew some similar conclusions to those of Paton, that there is considerable evidence that simply increasing the availability of contraception to teenagers without accompanying education on the importance of saving or delaying sex may lead to more sexually transmitted infections and unplanned pregnancies rather than fewer. This is despite a number of research studies which have shown that teenagers often regret the age when they started having intercourse, and over 40% of teenagers in the UK give peer pressure as the reason for first intercourse.[4]

Indeed, we would go so far as to suggest that current government sexual health strategies for tackling teenage pregnancies are primarily based on three false presuppositions: that contraception is safe, that youngsters will actually use it and that abstinence is impossible.

Contraception has a high failure rate among teenagers.[5]. US research suggests that 16% of under 20 year olds will become pregnant in the first 12 months of contraceptive use.[6] Moreover, the increased availability of contraception has not led to a significant reduction in pregnancy rates but has led to increased STI rates.[7] Between 1999-2001 conception rates amongst teens fell by 3.5% but rates of STIs rose by nearly 16%.[8] Paton found that where there was an emergency birth control scheme operating, STI rates for under 16s increased by 12%. Young people aged 16-24 are the most affected group, accounting for 50-65% of all newly-diagnosed STIs in the UK in 2007.[9]

Many youngsters will use contraception (57% of 16-19 year olds in 2008-9[10]) but because easier access to family planning reduces the effective **cost** of sexual activity, by doing so it actually makes it **more likely** (at least for some teenagers) that they will engage in underage sexual activity. This is known as 'risk compensation' and we explore this further in our response to question d) below.

The evidence on abstinence education is more mixed than usually admitted. Some studies have found that abstinence-focused education does have beneficial impacts and youngsters who have experienced the 'abstinence only' approach had significantly later sexual initiation than those in the other programmes. We expand further on this, citing an editorial in the Postgraduate Medical Journal[11], in response to question g) below.

---

[3] http://sheu.org.uk/content/page/education-and-health-latest-issue
[4] 'Teenage Sex', Trevor Stammers, CMF File 37, 2008.
http://www.cmf.org.uk/publications/content.asp?context=article&id=2184
[5] http://www.bmj.com/content/310/6995/1644. Also
http://old.usccb.org/prolife/issues/contraception/contraception-fact-sheet-3-17-11.pdf
[6] http://old.usccb.org/prolife/issues/contraception/contraception-fact-sheet-3-17-11.pdf
[7] http://www.ncbi.nlm.nih.gov/pubmed/21288585
[8] http://www.cwfa.org/images/content/STIRESRevised.pdf
[9] http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1216022460726
[10] http://www.fpa.org.uk/professionals/factsheets/teenagers#fCqi
[11] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743277/

The cost of pursuing current sexual health strategies has been more than the £250 million spent over the past forty or so years. The outcome has not been a drop in conceptions to teenagers but instead a burgeoning epidemic of sexually transmitted disease, unplanned pregnancy and abortion amongst young people. Britain still has the highest rate of teenage pregnancy in Western Europe.

d. What are the barriers and challenges to making progress in achieving positive change in communities that might lead to reductions in the levels of teenage pregnancy?

Government policy for the past forty or so years has primarily focused on **school sex education** and on providing **easy access to contraception**.

We note that the SPICe briefing on teenage pregnancy,[12] which was 'written to inform' this Inquiry, cites 'The Learning and Teaching Scotland (2010) resource: Reducing Teenage Pregnancy: Guidance and self-assessment tool' which '*highlights a number of measures that assist in reducing teenage pregnancy',* for example:

- *'Involving staff that deliver sexual health clinical services for young people in mainstream school programmes in order to help bridge the gap between sexual health services and education and so lead to improved service uptake.*
- *Improving access to contraception, provision of quality sex and relationships education and building incentives to avoid early parenthood are recognised as centrally important. These activities have been found to be important in countries with lower rates of teenage pregnancy.'*[13]

Yet the research by Prof David Paton, published in the *Journal of Health Economics*, on the effect of promoting emergency contraception found that widely promoting it to youngsters did *not* lead to any reduction in pregnancy or abortion rates. Unfortunately however, it *did* increase STI rates amongst teenagers.[14]

Not only has easy access to contraception been ineffective (at best), Paton claims that the impact of sex education on pregnancy rates is also weak. He points out that an evaluation of the *Teenage Pregnancy Strategy* in 1996 was unable to find a correlation between local authorities judged to have the best SRE provision and those with the biggest decreases in teenage pregnancy rates.

Why have these strategies had so little effect and why have rates not dropped?
Clearly many factors impact on teen pregnancy rates – poverty, education, family stability, media messaging etc – and small improvements in these may be at the root of small reductions in underage births since 1996.

It is widely acknowledged that poverty and education are linked to teenage pregnancy, however there is less consideration of the impact that **family structure** can have on teen pregnancy, and we encourage the Inquiry to consider this as part of their research.

Teenage sexual activity is more widespread among children of divorced, broken and single parent homes, as this can create an environment in which positive parenting is much more challenging. Those least likely to have experienced a loving, intact home

[12] SPICe Briefing Teenage Pregnancy 22 January 2013
http://scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-03.pdf
[13] SPICe Briefing Teenage Pregnancy 22 January 2013, p14.
[14] http://www.ncbi.nlm.nih.gov/pubmed/21288585

are least likely to be able to have open and constructive communication with their parents about relationships and sex, and are more likely to continue the cycle of poor parenting.[15]

Government policies directly aimed at reducing unwanted pregnancy rates also have a significant impact. The focus of government policy on school sex education and on providing easy access to contraception is based on the two assumptions that it will, on one hand, reduce pregnancy rates for those already having sex, while at the same time it will not cause others to begin sexual activity.

However the two are closely linked. Easier access to family planning reduces the effective cost of sexual activity and makes it *more* likely (at least for some teenagers) that they will engage in underage sexual activity.

Many youngsters will use it (57% of 16-19 year olds in 2008-9)[16] but because easier access to family planning reduces the effective **cost** of sexual activity, by doing so it actually makes it **more likely** (at least for some teenagers) that they will engage in underage sexual activity.

This is known as 'risk compensation',[17] a phenomenon where applying a prevention measure results in an increase in the very thing it is trying to prevent. Some teenagers will take risks they would not otherwise take, because contraception and abortion are promoted as risk reduction measures. So if a girl is on the pill then her sexual behavior will seem to her to be less risky or costly and so she will continue with it or even increase it, in the false belief that she will not suffer harm.

So easier access to family planning reduces the effective cost of sexual activity and makes it more likely (at least for some teenagers) that they will engage in underage sexual activity.

g. Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

Brook and other family planning groups advocate more of the same: more information for teenagers, more sex education, easier and free access to contraceptives, confidentiality for under 16s.[18]

Because of the problem of 'risk compensation' however, we advocate instead:

'…*a shift in focus from policies aimed at reducing the **risks** associated with underage sexual activity to those which are aimed more directly at reducing the **level** of underage sexual activity*.'[19] (our emphasis)

The SPICe briefing acknowledges the need for a much broader approach than simply focussing on risk reduction. However we suggest this must be given more

[15] Family breakdown as risk factor and consequence of teenage parenthood is referred to extensively in SEU, 1999, Social Exclusion Unit Report on Teenage Pregnancy Cm 4342, HMSO.
[16] http://www.fpa.org.uk/professionals/factsheets/teenagers#fCqi
[17] http://en.wikipedia.org/wiki/Risk_compensation
[18] http://www.telegraph.co.uk/health/healthnews/9497270/Sex-education-doesnt-cut-teen-pregnancy-rate-claims-academic.html
[19] http://sheu.org.uk/content/page/education-and-health-latest-issue

prominence and significantly greater priority in strategies to reduce teenage pregnancy rates:

*'The tool [*The Learning and Teaching Scotland (2010) resource*] also highlights that, while important, combining sexual health services and education does not, alone, affect real change. Action is also needed that focuses on improving self-esteem, motivation and achievement. Having a sense of a positive future is argued to play a critical part in achieving positive sexual health and well-being.* ***Parental, family and media influences are also important****. Failure to tackle the wider social and cultural influences that interact with teenage pregnancy is thought to limit the progress that can be made in this area*.'[20](our emphasis)

What could have a better effect on teen pregnancy rates?

1.Reducing the level of underage sexual activity.

Sadly, even the mention of abstinence education is generally met with a derogatory response.

In fact the evidence on abstinence is more mixed than usually admitted. Some studies have found that abstinence-focused education does have beneficial impacts and youngsters who have experienced the 'abstinence only' approach had significantly later sexual initiation than those in the other programmes. An editorial in the Postgraduate Medical Journal states that: **'***66% of the decrease in teenage pregnancies among unmarried girls from 1991 to 1995 [in the US] is attributed to an increase in abstinence, and 53% of the decline in overall teenage pregnancies between 1991 to 2001 is attributed to changes in sexual behaviour including, but not limited to, abstinence. As yet, the UK government continues to turn a blind eye to such striking evidence*.'[21]

Some studies have found that abstinence-focused education may have beneficial impacts. Jemmot et al (2010) compare an 'abstinence only' intervention with both 'abstinence-plus' and 'contraception-based' interventions. They found that youngsters who experienced the 'abstinence only' approach had significantly later sexual initiation than those in the other programmes.

CMF's view on teaching about relationships to teenagers is that we cannot deal effectively with teenage sex and its legacy of sexually transmitted disease, illegitimacy and abortion without challenging the widely promoted idea that teenage relationships are incomplete without sex. Teenagers need help and support in crossing the border between childhood and adulthood; affirmation from peers, family and friends, accurate information about sex and its consequences and assurance that virginity is good and that saying 'No' is OK

Policy makers need to be careful in drawing firm policy conclusions from the results of studies on abstinence education. The evidence relating to conception rates is still limited and more research is needed. Without doubt there are good and not so good abstinence education programmes.

---

[20] SPICe Briefing Teenage Pregnancy 22 January 2013.
http://scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-03.pdf

[21] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743277/

It does seem somewhat ironic to us that an approach that is based on encouraging young people to exercise self-control attracts so little support, and indeed sometimes outright opposition, from official sources.

Rather than dismissing all such approaches, better would be to try to find out which ones are more effective.

2. Involvement of parents

The state has a legitimate interest in reducing teenage pregnancy and the spread of sexually transmitted diseases, but parents in the UK have been increasingly sidelined in the delivery of sex education.

Parents can usually better determine the physical, mental and emotional stages of development of their child and, accordingly, can deliver the required education within a moral, ethical and spiritual framework – unlike the present value-free teaching in schools and wider society.

A report by Ofsted in July 2010 found that too many schools are failing to consult parents in this important area of education. It also seems that many parents are confused by sex and relationships education in primary schools. Both these concerns need rectifying by increased communication with parents.

There is some evidence from the US showing that States that have introduced parental involvement laws have seen decreases in abortion rates *and* teenage STIs. We have cited some such studies in a separate submission to the Dept for Education in 2011.[22]

In the UK research has found that parents feel strongly that there would be fewer teenage pregnancies if more parents were involved in talking to their child(ren) about relationships, sex and contraception. Among the first wave of the BMRB tracking survey sample of 600 parents of 10–17 year olds, 86% agreed with this statement. Moreover, just over three-quarters (78%) of parents surveyed felt it was easy to talk to their child about sex and relationships. There is research evidence that including teenagers' parents in information and prevention programmes is effective.[23] Further, young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse.[24]

Despite this, the Teenage Pregnancy Unit has consistently emphasised that confidentiality is crucial when providing family planning and abortion services to young people, especially those below the age of consent. The rationale behind this is that if parents do not have to be informed then uptake of services by young people will increase and this will in turn contribute to lower underage conception rates.
However, this disempowers parents and makes it difficult for parents who object to this approach, or who are ambivalent to it, and whose children attend state schools. They have had to face situations where school-based clinics have been set up with the ability to provide contraception and emergency birth control to young people under the age of consent with no requirement that parents be informed.

---

[22] http://admin.cmf.org.uk/pdf/publicpolicy/PSHE_Response_Form_v2_CMF_Response.pdf
[23] BMRB International (2001). Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of benchmark wave. January 2001. www.teenagepregnancyunit.gov.uk
[24] Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003). Teenage pregnancy a review of reviews. Evidence briefing. London: Health Development Agency. www.hda.nhs.uk/evidence

If research shows that access to such services does not reduce conception rates, then the case for guaranteeing confidentiality is weakened. In fact, there is very little evidence to support many of the measures that have been put in place with the intention of cutting teenage pregnancy rates. Very few studies have actually examined the impact of removing (or enforcing) confidentiality for contraception on pregnancy rates (rather than just on the uptake of services). Those that have (eg. Paton, 2002[25]) have failed to find a significant impact on underage conception rates, although there is some evidence of an impact on births relative to abortions.

Overall, the evidence base for this policy is mixed. We suggest that government should actively encourage the involvement of parents in their children's decision-making.

3. Challenge and change wider cultural messages

We also suggest that the Inquiry fully considers the effect of the messaging of the media and broader cultural values on teenagers.

There are some areas of agreement with family planning and sexual health charities. For example, the director of *Brook,* Simon Blake, has highlighted one of the biggest challenges facing any approach, which is that:

'*Young people live in a highly sexualised culture and are sexualised by companies wanting them to buy their products*.'[26]

Shadow health minister Diane Abbott has also recently warned that British culture is 'increasingly pornified' and is damaging young people: '*She called for better sex education in schools and urged parents to "talk about these matters" with children and teach them how to say "No"…**British culture is "increasingly pornified" and is damaging young people.***'[27]

Sexual imagery plays a very strong part in our culture today and sexual images are used in nearly all areas of advertising and the media, in fashion and dress, in order to generate interest and make money.

Yet all too often teenagers are the ones who are blamed as being solely responsible for embarking on sexual relationships and for becoming pregnant. This happens regardless of the fact that it is adults who have exposed children of all ages to a society which is obsessed by sex, thus putting them under enormous pressure to conform. Adults must take greater responsibility for the problem.

The Bailey Review[28] found that parents are particularly unhappy with the increasingly sexualised culture surrounding their children, which they feel they have no control over. They singled out sexually explicit music videos, outdoor adverts that contain sexualised images, and the amount of sexual content in family programmes on TV. **The Bailey Review findings should therefore be considered as part of this exercise, along with the recommendation to make parents' voices heard**.

---

[25] Paton, D. 'The Economics and Abortion, Family Planning and Underage Conceptions', *Journal of Health Economics.* 2002. 21. pp.27-45.
[26] http://www.newish.org.uk/836 Report Pages (4).pdf
[27] http://www.bbc.co.uk/news/uk-politics-21127073
[28] Bailey Review of the Commercialisation and Sexualisation of Childhood, 2011. http://www.education.gov.uk/inthenews/inthenews/a0077662/bailey-review-of-the-commercialisation-and-sexualisation-of-childhood-final-report-published

As Christians, we at CMF consider that the commodification of sex outside of permanent relationship is a much-distorted view of sex, and that many sexual images in popular culture are negative or manipulative, usually self-centred and focused upon 'what I can get out of it'.[29]

As a society we should be developing the self-esteem, values, life skills and knowledge of youngsters, so that they are able to consider media messages and the impact of actions and choices on themselves and others.

Public Policy Department
The Christian Medical Fellowship
February 2013

[29] Triple Helix,2002. http://www.cmf.org.uk/publications/content.asp?context=article&id=1183