Written evidence for Unwanted Pregnancy Inquiry

Response from the Christian Medical Fellowship (CMF)
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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.

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 cross party inquiry into unwanted pregnancy.

1.What is your view on the issue of unwanted pregnancy in the UK?

We recognise the distress of those with unwanted or abnormal pregnancies, and the challenging decisions they will be faced with.

We also recognise that having respect for people's free will and their right to self-determination lies at the heart of many discussions about unwanted pregnancies and abortion.

However we are concerned that the current permissive attitude within society towards abortion as the primary solution to unwanted pregnancies has led to an unprecedented loss of human life, and that abortion also damages society, and carries a risk of harming the women involved. Few people see abortion as a good thing, and for many women abortion brings with it a deep anxiety, grief and sense of loss.

Moreover, it is important to understand that the interest in 'autonomy' is complex, because of the different parties involved. There is the call for each woman to make decisions about what happens to her body – that no one should force her either to carry or to terminate a pregnancy against her will. On the other hand, there is the issue of her baby’s life, which raises the question of whether one person's desire for autonomy should extend to ending another's existence.

Then again there is the doctor who is asked to become part of this process. Should anyone be able to force a member of the medical profession to perform a task that they believe to be unethical or clinically inappropriate?

Currently the assumption in practice (but not upheld by the existing law) is that the woman's need for autonomy overrules all else. The Abortion Act 1967, however, does recognise the doctor's right to conscientious objection, making clear that members of the medical profession can opt out of being involved if they so wish.

At the heart of biblical morality is the idea that the strong should make sacrifices for the weak. We are called to 'bear one another's burdens', as Christians believe Jesus did for us. This means not only providing babies in the womb with the utmost respect, but also helping mothers with an unwanted pregnancy find compassionate and better alternatives to abortion; actions that may involve keeping her baby or giving him or her up for adoption. We believe that the option of adoption is a highly positive option for women experiencing an unplanned pregnancy.

CMF supports the model and work of pregnancy crisis centres such as those run by CARE Confidential as one practical expression of this approach. These provide free pregnancy tests, counselling and on-going support for women making decisions about an unwanted pregnancy.

We also recognise the need to address the causes of unwanted pregnancies, particularly the need to encourage people to make wise and responsible decisions about sex, ideally within the marriage relationship.

2. The evidence is that there are rising abortion rates in some age groups, rising repeat abortions, and high teenage pregnancy rates. What (if any) role is there for the Government in handling the issues?

2.1 High Teenage Pregnancy Rates

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.[1]

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 policies!) Paton says that: '…*unwanted pregnancy has proved remarkably resilient to policy initiatives implemented by different Governments over the past 40 years'*.[2]

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 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

[1] http://sheu.org.uk/content/page/education-and-health-latest-issue
[2] http://sheu.org.uk/content/page/education-and-health-latest-issue

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. [3]

In our response to Q4, we explore the different emphasis that we believe the Government can and should use, to counter these unacceptably high rates.

2.2 High Abortion Rates

As with teenage pregnancy rates, the abortion rates in the UK remain unacceptably high and we are concerned about the high rate of repeat abortions. 34% of the 189,931 women having an abortion last year in England and Wales had had one before and repeat abortions now make up 36% of the total, over a third.[4]

A review of abortion and mental health by the Academy of Medical Royal Colleges,[5] found that there is no evidence that continuing with an unplanned pregnancy poses any greater risk to a mother's mental health than having an abortion. Yet the vast majority of abortions are being carried out in this country each year on mental health grounds.

The Review drew the following conclusions, which we support:

1. Women with unplanned pregnancies need to know that abortion will not reduce their risks of mental health problems relative to giving birth.

2. Those who have a past history of mental health problems, who believe that abortion is wrong, who are being put under pressure by their partners to have an abortion or who are experiencing other stressful life events, need to know that they are at risk of increased rates of post-abortion mental health problems. If this information is withheld from them they will not be able to make fully informed decisions about their pregnancy outcome.

3. The first response to an unplanned pregnancy should therefore not be abortion but, as the Review recommends, an offer of proper support and care for women: '*In the light of these findings, it is important to consider the need for support and care for all women who have an unwanted pregnancy, because the risk of mental health problems increases whatever the pregnancy outcome*.' (p128).

Some women request abortion out of a sense of panic, or obligation, or because they feel that there are no other real options open to them. It is not always a fully informed, rationally made decision and some women can later regret their decision.

It is therefore essential that women to be provided with some information, time and space to think and talk through the alternative options open to them. Women with an unplanned and/or unwanted pregnancy are actually faced with the choice of one of three available options: adoption, abortion or keeping the baby.

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[3] 'Teenage Sex', Trevor Stammers, *CMF File* 37, 2008.
http://www.cmf.org.uk/publications/content.asp?context=article&id=2184

[4] http://www.bbc.co.uk/news/health-18249026

[5] '*Induced Abortion and Mental Health: A Systematic Review Of The Mental Health Outcomes Of Induced Abortion, Including Their Prevalence And Associated Factors*.' December 2011. http://aomrc.org.uk/publications/reports-a-guidance.html.This review was funded by the Department of Health.

Information on the alternatives to abortion – including support for mothers and information about adoption – should be an important part of the decision-making for women with an unplanned or unwanted pregnancy.

DH guidance states that: '*GMC and BMA guidance encourages doctors to explain to patients the importance of knowing the options open to them while respecting a person's wish not to know, and states that basic information should always be provided about what the treatment aims to achieve and what it will involve.*'[6]

One of the RCOG recommendations is that: '*Women should have access to objective information and, if required, counselling and decision-making support about their pregnancy options*.'[7]

As well as accurate information on abortion, including its risks, and the alternatives to abortion, Government should also make the provision of fully **independent counselling** for all women with an unplanned pregnancy a key priority, in order that women can have access to support and counselling that is not linked to abortion provision.

Many countries offer counselling as standard to women with an unwanted pregnancy. However several countries require mandatory counselling to be provided for women, including Australia, France, Netherlands, Belgium, Croatia, Cuba, Czech republic, Germany, Guyana, Hungary, Poland and Singapore.

We do not suggest that mandatory counselling be introduced here, nevertheless we do strongly believe that women should be offered counselling that is independent of an abortion provider before they make a final decision about their pregnancy. Ideally this counselling should be free, in order for it to be accessible to all women, regardeless of personal and economic circumstances.

3. What lessons can be learnt from previous attempts to tackle unwanted pregnancies?

See our answer to Q4 following.

4. Are there any measures the Government should be implementing to reduce unwanted pregnancies?

Please refer to our response to Q1 and Q2 above for suggestions to reduce high rates of abortion.

Following we review policy and options to reduce teenage pregnancy rates.

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

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[6] Department of Health. *Reference Guide to Consent for examination or treatment. 2nd edition.* London: Department of Health; 2009. P13. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643

[7] 'The care of women requesting induced abortion: Evidence-based Clinical Guideline Number 7'. 2011. RCOG. pp 7. http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

Yet recent 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.[8]

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 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.[9]

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.

This is known as 'risk compensation'. This is a phenomenon where applying a prevention measure results in an increase in the very thing it is trying to prevent. 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.

What could have a better effect on teen pregnancy rates?

[8] http://www.ncbi.nlm.nih.gov/pubmed/21288585

[9] 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.

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.[10]

Because of the problem of risk compensation however, we concur with Paton's recommendations, advocating 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*.'[11]

Paton also advocates more involvement of parents in the sexual health education of their teenagers.

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

1.Reducing the level of underage sexual activity.

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.

Some studies have found that abstinence-focused education may have beneficial impacts. Jemmot et al (201025) 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.

Even the mention of abstinence education is frequently met with a negative response. However it does seem 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

[10] http://www.telegraph.co.uk/health/healthnews/9497270/Sex-education-doesnt-cut-teen-pregnancy-rate-claims-academic.html
[11] http://sheu.org.uk/content/page/education-and-health-latest-issue

While Government does of course have a legitimate interest in reducing teenage pregnancy and the spread of sexually transmitted diseases, parents in the UK have been increasingly sidelined in the delivery of sex education.

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.[12]

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.[13] Further, young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse.[14]

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.

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[15]) have failed to find a significant impact on underage conception rates, although there is some evidence of an impact on births relative to abortions.

[12] http://admin.cmf.org.uk/pdf/publicpolicy/PSHE_Response_Form_v2_CMF_Response.pdf
[13] BMRB International (2001). Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of benchmark wave. January 2001. www.teenagepregnancyunit.gov.uk
[14] 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
[15] Paton, D. 'The Economics and Abortion, Family Planning and Underage Conceptions', *Journal of Health Economics.* 2002. 21. pp.27-45.

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

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*.'[16]

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.

Sadly, 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[17] 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.

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'.[18]

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

[16] http://www.newish.org.uk/836 Report Pages (4).pdf
[17] 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
[18] Triple Helix, 2002. http://www.cmf.org.uk/publications/content.asp?context=article&id=1183