Health and Sport Committee

5th Report, 2013 (Session 4)

Report on Inquiry into Teenage Pregnancy

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# Health and Sport Committee

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Health and Sport Committee

Remit and membership

Remit:

To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Cities Strategy apart from those covered by the remit of the Economy, Energy and Tourism Committee.

Membership:

Bob Doris (Deputy Convener)
Richard Lyle (from 16 May 2013)
Mark McDonald (until 14 May 2013)
Aileen McLeod
Duncan McNeil (Convener)
Nanette Milne
Gil Paterson
Dr Richard Simpson
Drew Smith
David Torrance

Committee Clerking Team:

Clerk to the Committee
Eugene Windsor

Senior Assistant Clerk
Rodger Evans

Assistant Clerk
Rebecca Lamb

Committee Assistant
Bryan McConachie
FOREWORD

“Birds and blethers fly”, as goes the Scots adage. It could well be applied to much of the previous discussion around teenage pregnancy. Our hope is that this inquiry may take us beyond the controversy, hearsay and prejudice that have become so predictable in defining the subject.

The reasons for Scotland’s high teenage pregnancy rate – being in gradual decline in recent years but stubbornly high in a UK and European context – may be culturally complex but are far from insoluble in social policy terms.

We’ve undertaken to assess the work directed at reducing unplanned teenage pregnancy; and to look at what else can be done to support young people at risk of pregnancy or who have a child very young. The Committee has considered the relationship between teenage pregnancy and poverty, examined the challenges to change in our most deprived communities, asked whether services are being effectively delivered, and tried to highlight those initiatives well regarded but perhaps unsung.

Regarding teenage mums, Anne Houston of Children 1st told us: “Sometimes, they just hope that a baby will love them and that they can love it and…that will fill a bit of a gap”. Clearly happiness, confidence and life opportunities, or the diminishment of some or all of these things, matter a good deal.

There is a view that efforts to prevent teenage pregnancy should begin as early as possible, pre-school even; the most formative years for those children likely to go on to experience what are usually blandly termed “poor outcomes” in their teens and into early adulthood. Such an approach sits well with the premium value that the Chief Medical Officer has placed upon early-years support and positive intervention.

The young mums who spoke to the Committee said sex education was too biologically focused and not enough about relationships. Research shows a correlation between quality sex education and use of contraception, delay of first sexual experience, and having fewer sexual partners. A head teacher told us:
“Evidence points out that discussing sexuality and sexual health does not encourage promiscuity or early adoption of sexual behaviour – quite the opposite.”

Schools, health services and all those who engage with young people have a role here. The Minister for Public Health said he wishes to see more shared ventures between health boards and local authorities in order to tackle teenage pregnancy across Scotland.

The poet Emily Dickinson wrote: “[a] mother is one to whom you hurry when you are troubled”. The trouble with a good deal of the debate concerning teenage mothers – and indeed fathers – has been the hurried tendency to indulge in either moral admonishment or pessimism of the what-can-be-done sort. It needn’t be so.

Duncan McNeil
Convener
Health and Sport Committee
The Committee reports to the Parliament as follows—

INTRODUCTION

1. Scotland has a higher rate of teenage pregnancy than most other western European countries.

Chart 1: Percentage of all live births to mothers under 20 years, Scotland and Western Europe, 2009

*2007 data; ** 2008 data

2. Although, as the report will go on to explore, high levels of teenage pregnancy are associated with deprivation and poverty, Scotland’s high levels do not reflect its levels of poverty in relation to other western European countries.
3. While the Scotland-wide teenage pregnancy rate among the under 18 and under 20 age groups has seen a small but consistent decline in the period 2006-2010, there has been little change in the rate of pregnancy in the under 16 age group.¹

4. The Committee recognises that for some young people, teenage parenthood is a positive experience, whether planned or not. For many however, it can result in the continuation of a lack of family and parental support and a wider cycle of deprivation.

5. The Committee agreed to conduct an inquiry into teenage pregnancy due to concern about the continuing high rates of teenage pregnancy in Scotland. It wished to investigate the statistics within the wider context, taking into account the multiple associations between teenage pregnancy and inequalities.

6. The Committee’s inquiry has been conducted against a backdrop of the Committee scoping out wider work into health inequalities. This work has involved consideration of the reasons why health inequalities remain a significant and long-standing problem in Scotland and why successive Scottish administrations’ strategies and initiatives for reducing health inequalities have not had a significant impact.

7. The Committee has considered the approach taken with this inquiry as an effective model in which to conduct an in-depth examination of a specific health inequality issue and intends to use this approach for other future work on health inequalities.
Evidence

8. The Committee’s call for written evidence on the inquiry was issued on 7 January 2013 and 71 submissions were received.²

9. The Committee also held four evidence sessions with six panels and 27 witnesses. There were visits to Glasgow (Young Parents' Support Base at Smithycroft Secondary School), Dundee (The Corner and Menzieshill High School) and Oldham (Positive Steps). There were also two informal meetings held at the Scottish Parliament, with young parents, facilitated by the Young Mums' Unit based at Wester Hailes Education Centre and by Who Cares? Scotland.

Structure

10. The Committee’s inquiry has focused on two key strands. The first strand has been to assess whether the action being taken in Scotland is sufficient to bring about real and sustained reductions in unplanned teenage pregnancy. The second strand has considered what further action might be required to ensure that those young people at risk of pregnancy at a young age, or who have had a baby when they were very young, are able to gain access to appropriate support and services.³ These strands are explored within the content of the report.

11. The remainder of the report is structured around the following themes—

- Different perspectives on teenage pregnancy
- Teenage pregnancy target
- Factors influencing teenage pregnancy
- High rates of teenage pregnancy and health inequalities
- Policies specifically to address teenage pregnancy
- A New Sexual Health Strategy
- Education
- Contraception
- Support for young parents

² The questions asked in the call for evidence are contained at Annexe A.
³ The Remit for the inquiry is contained at Annexe A.
DIFFERENT PERSPECTIVES ON TEENAGE PREGNANCY

12. At the outset of this report, the Committee wishes to emphasise that not all teenage pregnancies are problematic.

13. The Committee received evidence from a number of witnesses, including Gareth Brown, Head of Blood, Organ Donation and Sexual Health Team, Scottish Government, that it was important to recognise that “a teenage parent is not necessarily a bad parent”. The Committee witnessed the good work of teenage parents first hand during the course of the inquiry. It had the opportunity to meet several inspirational young parents whose children were growing up in loving, nurturing homes.

14. Dr Jonathan Sher of the WAVE (Worldwide Alternatives to ViolenC) Trust called for teenage pregnancy not to be viewed as an inherently bad thing.

15. BMA Scotland stated “the children of adolescent mothers can fare as well in physical and social terms as those born to older women”. BMA Scotland said that biologically there was no reason to suggest that having a baby before the age of 20 was associated with ill health. It suggested that, in fact, it was older women who faced increased risk of complications in pregnancy.

16. Evidence received from teenage mothers consulted by the Fife Gingerbread Project suggested that, in social terms, being a teenage parent was not necessarily a bad thing either. They believed circumstances were more important than age. Some of the older mothers in the group questioned “what was the difference between a 17 year old parent living on benefits and a 30 year old parent living on benefits”.

17. This point was also picked up on by NHS Borders who felt there was a contradiction in society’s attitudes—

“Perhaps we should acknowledge that people enter into parenthood at different ages and stages in their lives. Where a pregnancy is planned within a secure, respectful and loving relationship then the issue of the parent’s ages is likely to be irrelevant—we live in a society where young people are able to marry at 16 yet are labelled if they choose to have a child before they are 20.”

18. Although the Committee heard about a number of positive outcomes from teenage pregnancies, the Committee also heard that there can be significant negative outcomes.

19. The Committee received evidence on the body of research which linked teenage pregnancy with negative outcomes for teenage parents, including—

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6 BMA. Written submission.
7 Fife Gingerbread. Written submission.
8 NHS Borders. Written submission.
• negative short, medium and long-term health and mental health outcomes for young mothers.
• young mothers being less likely to complete their education, pursue positive post-school destinations (in employment or education), or to have qualifications in adulthood.
• teenage mothers being more likely to be in receipt of income-based benefits or in low paid work; so poverty is strongly associated with teenage parenthood; and,
• teenage mothers being more likely to be lone parents, and are more likely to experience family conflict.\(^9\)

20. The negative outcomes which babies and children born to teenage mothers, could face include—

• babies tend to have lower than average birth weight.
• infant mortality rates are higher than for babies of older women.
• lower rates of breastfeeding, which means babies are less likely to benefit from the associated positive health outcomes; and,
• greater risk of living in a lone parent household, with greater risk of poverty, poorer quality housing and poorer nutrition.\(^10\)

21. It is these negative outcomes of teenage pregnancies which the Committee is particularly interested in examining in this report.

TEENAGE PREGNANCY TARGET

22. In policy terms, the main concern has been with reducing pregnancy rates among young women aged under 16 years. Respect and Responsibility: Delivering improvement in sexual health outcomes 2008-2011 set out a national target to reduce by 20 per cent the pregnancy rate (per 1,000 population) in under 16 year olds – from 8.5 in 1995 to 6.8 in 2010. The target was narrowly missed, with the rate of pregnancy in the under 16s in 2010 standing at 7.1 per 1,000 population.\(^11\)

23. There has, however, been a small but consistent decline in teenage pregnancy among the under 18 and under 20 age groups.

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24. In the under-18s the pregnancy rate dropped from 37.3 pregnancies per 1,000 young women in 2007/2009 to 35.9 pregnancies per 1,000 women in 2008/2010. Among the under-20s, it fell from 52.9 pregnancies per 1,000 women in 2009 to 50.2 pregnancies per 1,000 women in 2010.\(^\text{12}\)

25. NHS Western Isles and Comhairle nan Eilean Siar felt it was important to remember that teenage pregnancy rates had seen a consistent decline over the last four years and were at their lowest rates in under 18s since 1994.\(^\text{13}\)

26. BMA Scotland told the Committee that although there had been a steady decline in the number of teenage pregnancies under the age of 20, progress had been slow and the rates of unintended pregnancies amongst the under 16 category had remained largely unchanged.\(^\text{14}\)

27. The Committee explored with the Scottish Government these trends in teenage pregnancy. The Minister for Public Health (hereafter “The Minister”) highlighted the consistent downward direction of teenage pregnancy rates in the under-18s over the past four years and overall pregnancy rates being at their lowest levels since 1994. The Minister told the Committee—

“That is a significant achievement and should not be underestimated. It reflects the hard work of our stakeholders in addressing teenage pregnancy through the use of evidence-informed and effective interventions”.\(^\text{15}\)

28. The Minister did, however, tell the Committee that further work needed to be done—

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\(^{13}\) NHS Western Isles and Comhairle nan Eilean Siar. Written submission.

\(^{14}\) BMA. Written submission.

“… we cannot be complacent. I want Scotland to continue to follow that trend while also achieving larger reductions in our rates of teenage pregnancy, acknowledging the impact that parenthood can have on the parent and the child.”

29. Gareth Brown of the Scottish Government acknowledged that pregnancy rates in the under-16s had not significantly improved but suggested that this needed to be considered within the context of the number of pregnancies in this age group being very small (around 600 cases a year) and that addressing the issue of pregnancy in the under 16s was challenging and complex—

“I am not aware that anyone internationally has cracked the issue of pregnancy in the very young. The issue is difficult to get into. In some ways it relates to … intergenerational issues, deprivation and complex needs.”

30. The Committee welcomes the positive progress made in reducing rates of teenage pregnancy in the under 18s and under 20 age group. Whilst disappointed that the Scottish Government has missed its target for rates of pregnancy in the under 16s, the Committee notes that it has only been missed by a narrow margin. Nevertheless, the Committee notes that, even with the reduction that was achieved, the under 16 figures for Scotland remains higher than those for rest of the UK.

31. The Committee understands that the pregnancy rate in the under 16 age group is particularly challenging to address. The Committee recognises the importance of placing specific emphasis on this age group in the target as it is likely to contain some of the most excluded and vulnerable young women.

FACTORS INFLUENCING TEENAGE PREGNANCY

32. The strong link between inequality and unplanned teenage pregnancy was repeatedly stated during the course of the Committee’s inquiry. Dr Maggie Watts of NHS Ayrshire and Arran called for teenage pregnancy to be considered as a symptom rather than as a condition within the wider socioeconomic context.

“The relationship between high levels of teenage pregnancy and socio-economic inequality is undeniable and extremely obvious.”

“Teenage pregnancy is a highly complex area. It can be considered as a symptom of much larger public health problems.”

“Local, national and international evidence shows a strong link between pregnancy in the teenage years and socio-economic inequality. Such evidence, at times, can be quite overwhelming, particularly in a city like Glasgow, that records such high levels of deprivation.”


\[19\] Fife Gingerbread. Written submission.

\[20\] Sexual Health and Blood Borne Virus Executive Leads Network. Written submission.

\[21\] Glasgow City Council. Written submission.
33. The Committee heard evidence about a number of specific social and economic factors, associated with inequality, which could be contributory factors in a higher rate of teenage pregnancy. These are discussed below.

**Deprivation**

34. One of the most important factors associated with a higher rate of teenage pregnancy is deprivation. The statistical data presented to the Committee showed a clear relationship between deprivation and high rates of teenage pregnancy.

35. For example, the rate of teenage pregnancy among young women aged under 16 living in Scotland’s most deprived areas (13.7 per 1,000) was five times the rate for young women aged under 16 who lived in the least deprived areas (2.7 per 1,000) in the three year period 2008/2010.\(^{22}\)

36. The Committee also received evidence that young women living in the most deprived areas were far more likely to take a pregnancy to delivery, while those young women living in the least deprived areas were far more likely to end a pregnancy through termination.

37. Of the total number of pregnancies among young women aged under 20 in 2010 living in the most deprived areas (a total of 2,949 pregnancies), a much larger proportion of those pregnancies ended in delivery (71 per cent) than in abortion (29 per cent). In contrast, among the young women living in the least

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deprived areas (a total of 680 pregnancies), only 204 (30 per cent) ended in delivery and 476 (70 per cent) ended in termination.  

38. NHS Forth Valley Sexual Health Strategy Group believed that the cultural acceptance of teenage pregnancy was a key driver of health inequalities in Scotland, fuelling intergenerational cycles of disadvantage and deprivation.  

39. The Committee heard evidence from witnesses including Dr Lorna Watson of NHS Fife, that in some communities it was an accepted norm to have children young. The Committee was told that the children of teenage mothers often go on to experience early parenthood themselves.  

Vulnerable groups  

40. A second contributory factor to a higher rate of teenage pregnancy is being a member of a vulnerable group.  

41. The Committee learnt that there were particular groups at greater risk of becoming a teenage parent including—  

- young people in or leaving care;  
- homeless young people;  
- school excludees, truants and young people underperforming at school;  
- children of teenage mothers;  
- young people living in deprived neighbourhoods; and  
- young people suffering abuse.  

42. Some witnesses also argued that, in relation to particularly vulnerable groups, there was a need for a more collaborative approach to target those deemed to be at higher risk.  

43. A particular vulnerable group cited in evidence was looked after children and those excluded from school.  

44. Dr Lorna Watson of NHS Fife described looked-after children as one of the “groups that are at risk”. Young people who have care experiences are one of the poorest socio-economic groups in society and are more likely to have children at a younger age.  

45. Denny Ford of Who Cares? Scotland told the Committee that looked-after children experienced considerable educational disadvantage and poorer outcomes than their peers and that participation in education was a known protective factor.

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24 NHS Forth Valley Sexual Health Strategy Group. Written submission.  
26 NHS Western Isles and Comhairle nan Eilean Siar. Written submission.  
30 Centre for Excellence for Looked After Children in Scotland. Written submission.
in reducing teenage pregnancy rates.$^{31}$ This point was also raised in relation to other young people excluded from school.

46. Another vulnerable group particularly prone to a higher rate of teenage pregnancy was young people who had been subject to abuse. YWCA Scotland highlighted Wood’s 2011 study, which indicated that two thirds of pregnant teenagers had experienced physical violence from a partner.$^{32}$

47. Anne Houston of Children $^{1}$ST told the Committee that young people’s negative expectations of relationships and low self-esteem could result in abusive relationships. This abuse could be either an adult abusing a child or peer-to-peer abuse, with teenage pregnancy being the possible result.$^{33}$

48. Dr Sarah Nelson of University of Edinburgh explained in her written submission that the severe loss of self-esteem and self-respect due to sexual abuse could result in patterns of apparent promiscuity. She stated that—

“… victims think of themselves as only fit for sex, as only fit to be used and abused or who seek love and affection through sex because that is what they have grown up to believe. This in turn greatly heightens the risk of teenage pregnancy.”$^{34}$

**Low self-esteem**

49. A third factor that can be linked to a higher rate of teenage pregnancy is low self-esteem. A commonly expressed view was that the link between deprivation and teenage pregnancy was the result of low aspirations and limited opportunities for young women.

50. It was suggested that a lack of self-esteem could result in ambivalence towards becoming pregnant. Teenage girls having a fatalistic attitude towards pregnancy was raised by Felicity Sung, National Co-ordinator, Sexual Health and HIV, Scottish Government. She told the Committee it was preferable to use the word “unintended” rather than unplanned pregnancy—

“The word “unplanned” indicates a real sense of what a person wants to do and the reasons why. A baby or a pregnancy may not be intended, but it might not be unintended. That links to some of the complexities around fatalism and to issues around aspiration, education and giving young people, including young women, a reason to delay parenthood.”$^{35}$

51. Anne Eriksen of NHS Tayside detailed the findings of research her board had conducted in 2011 on the circumstances of young people becoming mums—


$^{32}$ YWCA Scotland. Written submission.


$^{34}$ Dr Sarah Nelson of University of Edinburgh. Written submission.

“… it was very much about looking for love and affection and looking for someone whom they could love unconditionally and who would love them in return.”36

52. She went on to explain that when young women were faced with low educational attainment and limited job prospects, parenthood offered an option—

“Another reason was to do with gaining recognition and status in their family and the community. Some young women might not see educational attainment or employment as providing that status, so it almost seems that having a baby means being recognised as moving into adulthood.”37

53. Similar views were expressed by Fife Gingerbread—

“Many young girls perceive being a parent as the automatic and obvious transition into adulthood and independence.”38

54. For many, the close association between teenage pregnancy and self-esteem meant that tackling teenage pregnancy involved raising the aspirations of young people and providing opportunities beyond parenthood. Dr Jonathan Sher of the WAVE Trust, for example, told the Committee—

“We also need to prevent a situation in which pregnancy and having a baby seem like the only viable option. That is not just a sexual health issue; it goes much broader than that. One thing that we as a society absolutely need to prevent is the notion that having a baby is the answer to the universal quest to have a meaningful life and a place in the community and to be taken seriously as an adult.”39

55. Children 1ST called for work to be undertaken with young girls to help find ways to raise their self-esteem.40 North Ayrshire Council in its written submission said—

“… there was the need to explore further early intervention and prevention approaches linked to improving positive self-esteem, aspirations for educational outcomes, jobs or further training opportunities to change the culture of low aspiration in some communities.”41

56. Addressing attitudes in some communities where there was a more positive or more enabling attitude towards teenage parenthood was seen as a challenge. Nicky Coia of NHS Greater Glasgow and Clyde told the Committee that there was a job to do to skill up youth workers and other practitioners to frame a different set

38 Fife Gingerbread. Written submission.
40 Children 1ST. Written submission.
41 North Ayrshire Council. Written submission.
of options for young people that did not come across as judgemental, but that sets up the context of wanting better for the young person.\textsuperscript{42}

57. Bryan Kirkaldy of Fife Council saw school education as playing a key prevention role in “raising expectations, aspirations and outcomes” and creating a sense of empowerment in relation to the choices that young people make.\textsuperscript{43}

58. The Scottish Sexual Health Lead Clinicians Group Solutions argued that solutions needed to be found “in partnership with communities, not simply by parachuting in workers and services”. The solutions would, they said, “rarely have or need a label of ‘teenage pregnancy solution’”, but would address the wider context in which teenage pregnancies occur—

“Young people need incentives not to get pregnant by having their horizons broadened and aspirations raised. They need to have the self-belief and self efficacy to realise those aspirations.”\textsuperscript{44}

**Desire for access to social housing**

59. The Committee heard that there was some debate as to whether there was an association between teenage pregnancy and access to social housing. Ann Eriksen of NHS Tayside told the Committee that professionals in Tayside had not felt that access to accommodation was a factor associated with teenage pregnancy. However, NHS Tayside’s findings from research conducted with young mothers found that some young mother’s perception was that they would be able to get their own accommodation and be able to move out of the family home.\textsuperscript{45}

60. The majority of evidence received by the Committee, however, suggested that teenage pregnancy was not seen as a short cut to social housing. The young mothers whom the Committee met at the Young Parents’ Support Base at Smithycroft Secondary School refuted the suggestion of a link. One young mother explained that she had been advised that if she wanted to be allocated a council house she would have to declare herself homeless in the first instance.

61. This experience was supported by Brook’s (a leading provider of sexual health services and advice for young people under 25) findings with focus groups of young people on access to social housing. Brook stated that the young people it spoke to “were very clear and spoke passionately about the fact that it is a myth that young parents are handed keys to their own home after giving birth.”\textsuperscript{46}

62. Brook found that it was not uncommon for young people to have spent many months “sofa surfing” or in unsuitable temporary accommodation, with it taking years for someone to be provided with a home of their own. One young person


\textsuperscript{44} Scottish Sexual Health Lead Clinicians Group. Written submission.


\textsuperscript{46} Family Planning Association (FPA) and Brook. Written submission.
told Brook: “I do not know one single person who got pregnant to be housed. I spent time in a hostel (hell).”

Alcohol, drugs and risk taking behaviour

63. The Committee heard that another contributing factor to a high rate of teenage pregnancy was risk taking behaviours, in particular alcohol and drug misuse. Children 1\textsuperscript{st} told the Committee that it knew from its services that teenage pregnancies were more prevalent where there was evidence of alcohol or drug misuse. Many young people in Scotland end up pregnant, according to Children 1\textsuperscript{st}, after having unprotected sex whilst drunk.

64. Marian Flynn of Glasgow City Council told the Committee that alcohol was often involved in young people’s early sexual experiences. She suggested that young people’s behaviour with alcohol was not that much different from adult behaviour. There was a wider cultural issue of people needing “Dutch courage” and using alcohol to excuse behaviours.

65. Robert Naylor of Renfrewshire Council told the Committee—

“Often young women get themselves into situations because of drink and desire to belong to and fit in with a peer group that is leading them into that kind of behaviour. That is partly driven by the modern media and the depiction of women and how they ought to behave. Although there is a broader cultural issue, the behaviour is fuelled and driven to some degree by alcohol and drugs.”

66. In addressing risk taking behaviour associated with teenage pregnancy, particularly alcohol consumption, NHS Highland and Highland Council in its joint submission told the Committee a shift in “culture in relation to alcohol misuse is key to improving young people’s sexual health and reducing teenage pregnancy.” North Ayrshire Council felt there was a need to clearly link national sexual health work with the Alcohol and Drug Partnership agenda at a national level.

Cultural and media influences

67. Many witnesses pointed to the increasing sexualisation of society as contributing to teenage pregnancy. The Committee received evidence of the influence of the media in shaping young people’s sexual behaviour, body image and gender roles.

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47 FPA and Brook. Written submission.
48 Children 1\textsuperscript{st}. Written submission.
51 NHS Highland and Highland Council. Written submission.
52 North Ayrshire Council. Written submission.
68. The Christian Medical Fellowship argued that increasing sexualisation was influencing what young people perceived to be the norm. This view was supported by Marian Flynn of Glasgow City Council—

“It is not uncommon now for primary school children to talk about dieting and to be very conscious of appearance. There is a range of cultural issues underneath what we have been talking about today, which put pressure on young people to engage in sexual activity at an earlier and earlier age.”

69. Rape Crisis Scotland expressed a similar view, pointing to the media and the easy availability of pornography encouraging early and unsafe sexual activity. Dr Lorna Watson of NHS Fife told the Committee that there was “an issue to do with the values that we are transmitting to young people.”

70. Rape Crisis Scotland stated that whilst all young women were affected by gender inequalities, those from less wealthy or less educationally-privileged backgrounds were less likely to have the support and resources to navigate media and peer influences.

71. Suggestions were also made that there was a need for attitudinal changes in relation to tackling wider issues of gender discrimination. YMCA Scotland, for example, stated—

“We would also like to reaffirm the importance of tackling gender discrimination in all support activities, encouraging young people to have healthy, equitable relationships built on active consent to enable fully informed choices on sex, pregnancy and parenthood.”

LINKS BETWEEN HIGH RATES OF TEENAGE PREGNANCY AND HEALTH INEQUALITIES

72. The Committee has discussed above some of the factors which can impact on rates of teenage pregnancy. Each of these factors, in turn, can contribute to increasing a young person’s risk of becoming pregnant. It is possible to adopt an approach which seeks to address each of these individual factors in isolation.

73. However, many of the factors that have been identified in this report as being associated with high rates of teenage pregnancy are also understood and accepted to be factors associated with inequalities more widely. Ultimately, addressing teenage pregnancy requires the wider inequalities within society to be addressed.

74. Denny Ford of Who Cares? Scotland called for the issue to be addressed “at source.” Who Cares? Scotland called for the relationship between socio-

53 Christian Medical Fellowship. Written submission.
55 Rape Crisis Scotland. Written submission.
57 Rape Crisis. Written submission.
58 YMCA Scotland. Written submission.
economic status and levels of teenage pregnancy to be tackled via “a holistic and alternative approach to redressing the causes of poverty and deprivation”.60

75. NHS Forth Valley believed it was vital that action to address teenage pregnancy in Scotland moved away from a focus on sex and sexual behaviour to one on “wider health inequalities, poverty and child health and wellbeing challenge”61.

76. A similar point was made by NHS Highland and Highland Council, that measures to tackle poverty and disadvantage were likely to have more of an impact in reducing teenage pregnancy rates in Scotland than measures which were badged as sexual health.62 Cath King of NHS Highland told the Committee—

“In Highland, our view is that any measures to tackle deprivation will tackle teenage pregnancy—it is as simple as that.”63

77. The Scottish Sexual Health Lead Clinicians Group highlighted the role it saw for the Government in addressing these wider issues—

“… given the proven links between social inequality and incomes inequality, that policy should make explicit the role of central government in preventing teenage pregnancy particularly through management of the economy but also through employment, education and social policy.”64

78. Several witnesses also pointed to the work that could be undertaken in early years as a route to addressing wider socio-economic issues. Scottish Sexual Health Lead Clinicians group believed that research increasingly suggested that successful early childhood intervention was probably the most effective action that could be promoted.65 NHS Highland and Highland Council saw early-years intervention as “establishing a strong foundation for life”.66

79. Ann Eriksen of NHS Tayside argued that wider interventions in the earliest years of childhood, such as the early years collaborative and the family nurse partnership, were ways of building young people’s resilience and aspirations.67

80. In evidence to the Committee, the Minister stated that there were “complex issues” that lay behind teenage pregnancy. The Minister echoed other evidence received by the Committee with regard to a need for teenage pregnancy to be considered within a wider context.68

81. He told the Committee that the prevention of teenage conceptions could not be achieved by health interventions alone and that there was a need to better

60 Who Cares? Scotland. Written submission.
61 NHS Forth Valley. Written submission.
62 NHS Highland and Highland Council. Written submission.
64 Scottish Sexual Health Lead Clinicians Group. Written submission.
65 Scottish Sexual Health Lead Clinicians group. Written submission.
66 NHS Highland and Highland Council. Written submission.
acknowledge the role that deprivation, inequality and lack of aspirations and opportunity can have—

“… the whole issue of dealing with teenage pregnancies is similar to dealing with many of the other factors that drive health inequalities in our society, such as socio-economic inequality, alcohol, poverty, and drugs misuse, all of which can contribute to such issues. That is why we need to look at the issue of teenage pregnancies within that broader policy field, taking into account the role that such factors can play.”

82. The Minister also said that, because of the breadth of the issue and its strong link with socioeconomic disadvantage, many of the resources that are used to tackle inequality impact on teenage pregnancy levels.

83. The Committee recognises that the underlying factors behind teenage pregnancy are complex.

84. The Committee considers that teenage pregnancy needs to be recognised as a symptom rather than a condition within the wider socio-economic context. There is a huge range of social and economic factors associated with inequality that can be contributing factors to higher rates of teenage pregnancy.

85. These factors – which include deprivation, low self-esteem and risk taking behaviour – are also factors that are aspects of health inequalities more widely. The Committee believes, therefore, that addressing these health inequalities will contribute to a reduction in rates of teenage pregnancy.

86. The Committee believes, therefore, that any action taken to reduce teenage pregnancy, for example to address any of the individual contributory factors, also needs to recognise the fundamental structural issues and the need for broader, cross-cutting efforts to address them.

87. The Committee has begun to undertake separate work on health inequalities and will report on this issue in due course.

POLICIES SPECIFICALLY TO ADDRESS TEENAGE PREGNANCY

88. This section of the report considers the current policies to address rates of unplanned teenage pregnancy.

Overall policy context

89. The first sexual health strategy was established in 2005 through the publication, by the Scottish Executive of the time, of Respect and Responsibility:

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90. The Framework is clear that the desired improvements in sexual health will not be achieved by any single agency. Throughout, the document reiterates that improving sexual health and wellbeing is a multi-agency responsibility that cannot be addressed through interventions delivered in specialist sexual health services alone. It further notes that each area has already established a multiagency sexual health strategy group and these groups should continue their role in promoting and delivering partnership working to enable local progress and improvement in sexual health and wellbeing.74

91. There is also a recognition in the Framework, mirrored throughout the evidence taken by the Committee, that poor sexual health and high levels of teenage pregnancies are symptomatic of wider health inequalities. The Framework sets out high level outcomes, firstly of fewer newly acquired blood borne virus and sexually transmitted infections and unintended pregnancies, and secondly, of a reduction in the health inequalities gap in sexual health and blood borne viruses.75

92. Specifically in relation to children and young people, the Framework refers to the Getting it Right for Every Child (GIRFEC) principles, noting that “strong partnership working should be taking place locally across all agencies, at both practitioner and strategic organisational level, to improve outcomes for all children and young people” and adding that this work “should take an early intervention approach and deliver streamlined and co-ordinated help that is appropriate, proportionate and timely”. This section of the Framework argues that this work, combined with the other values, principles and core components of GIRFEC, is key to addressing some of the most entrenched problems in society, including the need for improvement in sexual health and wellbeing. The Framework concludes, therefore, that “improving sexual health and wellbeing should be integrated into wider work streams at local level which aim to address health and social inequalities and risk taking behaviours and which focus on prevention, including building resilience, aspiration and self-esteem”.76

93. On the specific issue of teenage pregnancy, the Framework states—

“Local authorities have the lead role at local level in delivering national strategies which address disadvantage in Scotland and breaking the intergenerational cycle of inequalities. They are, therefore, best placed to assume a leadership role in delivering reduced teenage pregnancies in partnership with NHS, Third Sector and other local partners. Where relevant, local authorities should ensure the inclusion of a teenage pregnancy Single Outcome Agreement indicator.”

94. The Framework also asks local authorities and other statutory and third Sector organisations to work together to implement *Reducing teenage pregnancy – Guidance and self-assessment tool* [Self-assessment tool], published by Learning Teaching Scotland (LTS) in 2010. This brings together the range of current evidence and advice on the partnerships, strategies and interventions that need to be in place locally if teenage pregnancy rates are to be reduced. The Framework argues that, by reviewing this evidence and using the Self-assessment tool annually, local authorities and their partners can build on existing good practice to address teenage pregnancy in the long term. The Framework explicitly states that local authorities should take a “leadership role in addressing teenage pregnancy” and specifically that they should play a key role in implementing the *Reducing teenage pregnancy* self-assessment tool.

**Overall progress resulting from policy changes and strategic direction**

95. Although this report will go on to discuss some areas where improvements can be made, there has already been some positive progress to highlight. Nicky Coia of NHS Greater Glasgow and Clyde, for example, suggested that Scotland had been “on a journey in the past 10 years” with *Respect and Responsibility* enabling progress to be made in the provision of sexual health and relationships education.

96. Glasgow City Council described *Respect and Responsibility* as “a significant landmark” as it was the first sexual health strategy to be published in Scotland and was an attempt to present a holistic model of sexual health and wellbeing that moved away from a previously medical-orientated agenda around sexual activity and contraception.

97. NHS Western Isles and Comhairle nan Eilean Siar, along with other health boards, argued that the “notable decline” since 2007 in teenage pregnancy rates

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79 Learning and Teaching Scotland has since become part of Education Scotland.
82 Glasgow City Council. Written submission.
could be attributed to the impact of *Respect and Responsibility*’s publication in 2005 and the greater commitment to improving sexual health – including teenage pregnancy – across Scotland.\(^{83}\)

**Positive initiatives specifically targeted in area of sexual health and teenage pregnancy**

98. The Committee also heard about a number of positive examples of initiatives and services being delivered by NHS Boards, local authorities and voluntary organisations that were specifically targeted in the area of sexual health and teenage pregnancy.

99. Several NHS boards provided information on a comprehensive range of integrated sexual health services they provided.\(^{84}\) NHS Highland stated that, along with its partner organisations, it currently provided high quality sexual health services to young people through a range of different settings including: GP services; Brook Highland; Highland Sexual Health; community pharmacies; school nurses; and drop-in clinics providing pregnancy testing, Chlamydia testing and condoms.\(^{85}\)

100. NHS Lothian explained that, in many areas of Scotland, young people now had access to general health advice, pregnancy testing and condoms in or within walking distance of schools.\(^{86}\)

101. The Committee also received examples of good practice in relation to the delivery of sexual health and relationships education. This included Dundee’s Speakeasy programme and Glasgow City Council’s ‘Talk 2’ service, which sought to support the Council’s school-based sexual health and relationships education by encouraging parents to talk with their child about growing up, puberty, relationships and sexual health.

102. Marian Flynn of Glasgow City Council told the Committee that, in Glasgow, the Talk 2 service had engaged a range of parents across the city\(^ {87}\), including parents in areas of deprivation and from black and minority ethnic (BME) communities.\(^ {88}\)

103. The Committee also heard positive examples of drop-in centres that aimed to provide an early prevention service for young people. Children 1\(^{ST}\) highlighted the information, counselling and advice service it provided to young people in West Lothian through the Chill Out Zone (“COZ”).\(^ {89}\)

104. Anne Houston of Children 1\(^{ST}\) explained to the Committee that COZ was a service that attracted a lot of young people, who would otherwise have not engaged with some of the more formal settings, for their health and relationships

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\(^{83}\) NHS Western Isles and Comhairle nan Eilean Siar. Written submission.

\(^{84}\) NHS Lothian. Written submission. NHS Western Isles. Written submission.

\(^{85}\) NHS Highland. Written submission.

\(^{86}\) NHS Lothian. Written submission.


\(^{88}\) Glasgow City Council. Written submission.

\(^{89}\) Children 1\(^{ST}\). Written submission.
Young people could talk to a nurse and a counsellor about any sensitive physical, emotional, mental and sexual health matters.

The Committee learnt of a number of good practice examples of services provided to young parents. A key resource highlighted was the provision of the Family Nurse Partnership. A detailed discussion of the FNP is provided later in this report.

The Committee also received information about the Fife Gingerbread project, set up in 2009 to provide support specifically to teenage parents in the Levenmouth area. Levels of engagement in the Teen Parent Project had exceeded expectations and it had now been initiated in two other areas in Fife. Fife Gingerbread told the Committee that, in the past, teen parents had not featured in the focus of local services and that its Teen Parent Project was a “model of delivery that is accessible, cost effective and extremely successful which has resulted in informed and responsible parents which in turn has increased the life chances of them and their children.”

Finally, the Committee received evidence of specific examples targeted at supporting young parents to remain in or to return to education following pregnancy. Dr Lorna Watson of NHS Fife told the Committee that in Fife, there was a young mothers’ initiative with a specific worker who supported those still in education to remain in education and stay engaged. The Committee also met young parents benefitting from the provision of young parents support bases at Smithycroft Secondary School and Wester Hailes Young Mum’s Unit (the provision of these services is discussed further in the section of the report on education provision).

Wider policy initiatives

As discussed earlier in this report, the issue of teenage pregnancy needs to be considered within the wider context of health inequalities.

Tracey Stewart of Dundee City Council told the Committee—

“Some of the interventions that we are working on are not about putting young people into a silo of just sexual health or teenage pregnancy. It is a much bigger picture and it is everyone’s responsibility to address the issue.”

Nicky Coia of NHS Greater Glasgow and Clyde felt that whilst there was a “need to keep the solid foundation” that had been built in sexual health, there was also a “need to do wider work.”

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91 Children 1st. Written submission.
92 Fife Gingerbread. Written submission.
111. The Committee explored with witnesses what was being done at this wider policy level to reduce health inequalities, which could, in turn, lead to reduced rates of teenage pregnancy. Some of the areas discussed are detailed below.

**GIRFEC/Early Years**

112. Cath King of Highland Council emphasised the importance of the GIRFEC approach, which had been adopted by the council as the Highland practice model. Under the model a child had a “named person” throughout their childhood – for example a health visitor, a primary school head teacher or a secondary school guidance teacher, who “should pull together the jigsaw of all aspects of the child’s life”.

113. NHS Highland and Highland Council, along with many other witnesses, emphasised the difference they felt could be made by focusing policies on providing support and guidance in the early years. Cath King told the Committee that there was potential under this approach for changes to be seen in the next generation.

114. The Committee received evidence that, in Fife, within the context of the GIRFEC framework, its multi-agency teams, including the voluntary sector, the police and detached youth workers, intervene in families when there is evidence that a young person is involved or potentially involved in risk-taking behaviour. Bryan Kirkaldy of Fife Council told the Committee that alcohol and substance misuse were “at the top of the risk pyramid” with information that comes to the police or to the NHS being shared with other members of the partnership, including education and community services, to try to tackle the behaviour.

**Looked-after children**

115. The Committee heard evidence of targeted work to reduce health inequalities with some of the groups more vulnerable to teenage pregnancy.

116. In relation to looked-after children Marian Flynn explained that, in Glasgow, attempts had been made to tackle the issue by skilling up the Residential Services, Families for Children and Leaving Care workforce. Glasgow City Council had also sought to provide specific health teams for looked-after and accommodated children, which could provide services to young people, in a holistic way that included discussing sexual health.

117. As mentioned previously, those excluded from school are more vulnerable to teenage pregnancy. Robert Naylor of Renfrewshire Council explained that the Council was looking to change the ethos in school, to develop a culture in which there is a presumption that looked-after children would not be excluded, to try to improve their educational attainment—

“The best that we can do is to quickly organise our extended support teams and our multi-agency frameworks around children whose behaviours are

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leading them to be excluded from school, and to get appropriate supports in place immediately so that they do not end up back in the community where they are likely to be most vulnerable, not least by getting involved in behaviours that could lead to pregnancy.\textsuperscript{101}

**Targeted health inequalities interventions at areas with high rates of teenage pregnancy**

118. Tracey Stewart of Dundee City Council told the Committee that partners were trying collectively, in Dundee, to reduce teenage pregnancy. One initiative in operation within the area was Total Place.\textsuperscript{102}

119. In Dundee Partnership’s Single Outcome Agreement, the Total Place initiative is described as a radical approach that has asked partners to fundamentally reconsider services to make them genuinely focused on the needs and aspirations of families and communities and to move from tackling crisis to offering preventative universal services by identifying ways to release resources from across the partnership. Total Place in Dundee is developing an integrated approach to improving all early-years outcomes in a single ward – Lochee – and is also facing the challenge of helping more young people across the city to reach positive destinations in education, employment or training.\textsuperscript{103}

120. Ann Eriksen of NHS Tayside explained to the Committee that a significant amount of work had been carried out locally on the basis of the national strategy.\textsuperscript{104} The Tayside Teenage pregnancy Healthy Community Collaborative Project, an evaluated and evidence-based community action model, which works with communities and partnership agencies to develop sustainable interventions using both national and local evidence.\textsuperscript{105} NHS Tayside stated that the combination of all these efforts in recent years was contributing to a significant reduction in the five years to December 2012 in teenage conceptions in all age groups, most markedly in the areas of greatest deprivation and was contributing to a narrowing of the inequalities gap.\textsuperscript{106}

**Asset based approach**

121. The Committee also received evidence of new approaches being taken to deliver services. One example of a new approach was the “asset-based” approach being adopted in some areas.

122. Conventional approaches to public health typically seek to identify cause-and-effect relationships, with intervention then designed to interrupt or modify these. However, as discussed earlier in this report, the cause and effect pathways leading to issues such as teenage pregnancy are strongly influenced by the adverse social, economic or environmental circumstance in which those affected

\textsuperscript{105} Sexual Health Lead Clinicians. Written submission.
\textsuperscript{106} NHS Tayside. Written submission.
live. Unless these underlying “determinants of health” can be addressed, tackling the direct causes may be difficult or impossible.  

123. An asset based approach seeks to mobilise the assets, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances.

124. Ann Eriksen of NHS Tayside explained how an asset based approach was working in her area. She explained that rather than “doing things to people” there was a need to work alongside communities and particularly young people to identify approaches, share the evidence and develop shared solutions that were more meaningful to people’s lives and communities. She told the Committee this approach had worked well in Tayside.

125. Tracey Stewart told the Committee about Dundee City Council’s Health Buddies programme in which third year pupils deliver aspects of education on relationships, sexual health and parenthood to their peers in S1. The peer education approach involves a joint, strong partnership working, approach that includes community learning and development, the health service and education—

“In the past year, some of the biggest innovations in Dundee have been developed using an assets-based approach and by looking at what we already have in the community. Some social enterprises, some innovative practice and a lot of peer support groups have been established as a result. It is about evaluating what we already have and using it as a strong evidence base for moving forward.”

126. The Committee has set out above some of the progress that has been made on the provision of services specifically targeted in the area of sexual health and teenage pregnancy. The Committee has also highlighted some examples of wider policy and practice approaches which are also contributing to tackling the issue of teenage pregnancy and the support available to young parents. It is clear that, in some areas at least, progress is being made. The Committee did, however, receive evidence which raised some concerns regarding current policy and practice. These are addressed in the next section of the report.

Possible limitation of current policy framework

Too much of a health focus?

127. The Committee heard some concerns regarding the fact that teenage pregnancy was sometimes treated as a purely health issue, rather than being viewed in a wider policy context.

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128. For example, some witnesses questioned the current location of teenage pregnancy policy within the *Sexual Health and Blood Borne Virus Framework 2011-2015*.  

129. Glasgow City Council suggested that “the balance of the debate at national level had tipped back to a very clinical agenda, with its emphasis on disease, epidemiology and medical interventions.”

130. NHS Greater Glasgow and Clyde believed that including teenage pregnancy within a policy that relates to sexual health risks reinforced a notion that teenage pregnancy was purely a sexual health issue rather than one related to socio-economic deprivation and inequality. It argued that this created difficulties in engaging local authorities—

“… despite the statements in the Framework that local authorities have the lead role for addressing teenage pregnancy, it can be challenging in practice to locate preventing teenage pregnancy beyond the planning and service delivery arenas for sexual health which is perceived as primarily NHS business.”

131. Several other witnesses also raised concerns that, whilst local authorities had been given lead responsibility for teenage pregnancy, they continued to view teenage pregnancy as a “health” issue and did not see it within the wider policy context.

132. Lanarkshire Sexual Health Strategy argued that local authorities did not view teenage pregnancy as a wider inequalities issue and this prevented partnership working and limited the impact of work undertaken.

133. Nicky Coia of NHS Greater Glasgow and Clyde cited the Young Parents’ Support Base in Glasgow as an example of the challenge faced in joint working with local authorities. He told the Committee that securing funding outwith the sexual health budget for the Young Person’s Unit was difficult politically, due to local authority perception that it was sexual health business. “Trying to contextualise such a service beyond sexual health to attract funding can be really challenging.”

134. It was also suggested in evidence to the Committee that teenage pregnancy policy issues may not be fully incorporated into the provision of all council services. North Ayrshire Council, for example, stated that there was some concern that “the national policy may not have been fully embedded within all areas of the council and a more strategic approach, with a strategic lead, would be helpful to reduce possible service fragmentation.”

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112 Glasgow City Council. Written submission.  
113 NHS Greater Glasgow and Clyde. Written submission.  
114 Lanarkshire Sexual Health Strategy. Written submission.  
135. Evidence from Jane Hughes of Brook also suggested that the policy shift to local authorities had yet to occur. She told the Committee that in comparison with England, in Scotland Brook engaged more with sexual health services. She said that there was, in Scotland, “more health service provision and slightly less of a link with some of the social care provision”.\footnote{Scottish Parliament Health and Sport Committee. \textit{Official Report}, 26 February 2013, Col 3381.}

136. The Scottish Government acknowledged that there could be challenges for local authorities in recognising their role in relation to teenage pregnancy. Gareth Brown of Scottish Government told the Committee that—

“… a lot of things that could contribute to a reduction in teenage pregnancy are things that local authorities do or should be doing anyway, but if you put a teenage pregnancy badge on it, local authorities get a bit nervous. The issue is about deprivation and aspiration—all the things that local authorities do, and do well. We just need to have that sort of conversation with them at the right level, which can be difficult.”\footnote{Scottish Parliament Health and Sport Committee. \textit{Official Report}, 22 January 2013, Col 3199.}

\textit{Patchy provision}

137. The Committee received some evidence that provision of services was inconsistent across Scotland\footnote{NHS Forth Valley Sexual Health Group. Written submission.} Caledonia Youth stated “While there are many examples of good initiatives being delivered in Scotland to a high standard, we have what can only be described as patchy coverage, at best.”\footnote{Caledonia Youth. Written submission.}

138. The issue of variable provision and lack of monitoring or accountability for work in this policy area tended to be raised in relation to the provision of sex and relationship education\footnote{FPA and Brook. Written submission.} (an aspect explored in much more detail in the education section of the report).

\textit{Resource transfer}

139. One of the possible reasons suggested by local authorities for the variance in provision was that whilst they had been given the lead role on teenage pregnancies under the current framework, this has not been supported by any resource transfer.

140. Glasgow City Council highlighted that no resources had been made available to local authorities as had happened with health boards when the sexual health strategy had first been initiated. The Council suggested that a lack of initial pump-prime funding had prevented a strategic, coherent plan being put into operation and that even at their most basic, change processes required time and money.\footnote{Glasgow City Council. Written submission.} Marian Flynn told the Committee—

\begin{footnotes}
\item[119] NHS Forth Valley Sexual Health Group. Written submission.
\item[120] Caledonia Youth. Written submission.
\item[121] FPA and Brook. Written submission.
\item[122] Glasgow City Council. Written submission.
\end{footnotes}
“I know that such a cry might not be popular in this day and age, but a measure of resource is needed sometimes to pump and prime and start initiatives, which can then become embedded in common practice.”123

141. Robert Naylor echoed this viewpoint—

“In these straitened times, I would have liked consideration of resource transfer, if councils are now driving forward the agenda, albeit with their partners.”124

142. In evidence to the Committee, the Minister echoed the views of other witness as regards the suggestion that the issue of teenage pregnancy had been too health focused—

“The progress that we could have made has, at times, been limited by an overfocus on treating teenage pregnancies as a health issue that can be dealt with through our health service.”125

143. The Minister told the Committee that local authorities had an important part to play in improving rates of teenage pregnancy, particularly in relation to supporting young people to stay connected with education “so that they have aspirations and opportunities for the future.”126

144. The Minister believed that there was a need to take a number of different approaches, because there was no “magic bullet” in dealing with teenage pregnancy, saying: “A multi-agency response is required, with local authorities, the health service and, when necessary, third sector organisations working in partnership.”127

145. The Minister discussed how improvements could be made to the current policy framework.128 He asked the Committee to consider whether there should be a stand-alone strategy that was jointly managed by the local health service and the local authority.

146. He told the Committee that a stand-alone framework might draw together some of the good practice between health services and local authorities and encourage them to work more closely together and share experience more effectively.129 He said that “a strategy that brings the two services together and has shared outcomes might achieve much greater direction at a local level.”130

147. The Minister discussed how the proposed approach would operate, specifically with regard to the transfer of resources. He said that it would give local authorities and health boards an opportunity to pool their resources—

“The issue is not whether we need to give more money to local authorities or to health boards. What we need to get better at is working together more effectively and in a co-ordinated way.”

148. The Committee believes that there has been much positive progress made in the national policies and drivers targeted at tackling teenage pregnancy, despite the missed target mentioned earlier.

149. There are some excellent examples of initiatives and services being delivered by NHS boards, local authorities and voluntary organisations in the area of sexual health and teenage pregnancy. The Committee recognises that good work is also being undertaken which places the issue of teenage pregnancy within the wider context of health inequalities.

150. However, the Committee also heard suggestions that the policy framework could be improved. There still appears to be need for a better understanding that teenage pregnancy needs to be considered as part of wider social and economic policies and not simply as a health issue. Although sexual health services are an essential component of teenage pregnancy policy, there should be a greater acknowledgement of the central role local authorities can play in tackling some of the wider socio-economic factors underpinning teenage pregnancy.

151. The Committee believes that a degree of central government direction is needed to help bring about the cultural change that is needed in local authorities and their partners to encourage them to improve their partnership working and to maximise the impact of work undertaken.

152. The Committee therefore recommends that a new national strategy for teenage pregnancy be developed. This strategy should place issues of sexual health and teenage pregnancy firmly within the context of wider social inequalities and should recognise, in particular, the key roles of health boards, local authorities and voluntary organisations as essential partners in helping to realise a local strategy with shared outcomes.

153. The Committee also recommends that the strategy should include both nationally agreed outcomes, for which central government could be held accountable by the Parliament, and locally agreed outcomes, for which health boards and local authorities should be held jointly accountable by the relevant Scottish Government Minister.

154. In drawing up a strategy, the Scottish Government will wish to draw on current best practice, to consider funding arrangements and to build on pre-existing local partnership structures such as community health and social care partnerships, community planning partnerships and single outcome agreements.

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155. **Furthermore, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) should jointly ensure that any research evidence and examples of best practice are recognised and are spread.**

156. Further consideration of the features of a new national strategy is considered in the next section of the report.

**FEATURES OF THE NEW STRATEGY**

157. The Committee explored with witnesses the question of what the features of a new Strategy on teenage pregnancy should be.

**Targets for reduction of teenage pregnancy**

158. One area considered by the Committee was whether a future strategy on teenage pregnancy should have a more targeted approach to addressing the varying rates of teenage pregnancy across Scotland.

159. The available data on rates of teenage pregnancy suggested to the Committee that deprivation was not the only determining factor, as there were variations in rates of teenage pregnancy between areas with similar levels of deprivation. Dundee, for example, had a rate of teenage pregnancy in under-16s of 14.4 per 1,000 young women, double the rate of 6.9 per 1,000 young women in Greater Glasgow and Clyde.\(^{132}\)

160. Robert Naylor of Renfrewshire Council told the Committee that there needed to be much more targeting towards the areas in which rates were double—or sometimes treble—the rates in other places—

> "We can tackle the problem only by developing much more cogent family-centred approaches from the earliest stage, ensuring that the resource goes into the communities in which we can make the most difference.\(^{133}\)"

161. Nicky Coia of NHS Greater Glasgow and Clyde called for more “focused work” and argued that the issue needed to be looked at below the NHS board and local authority level. Efforts needed to be concentrated at smaller neighbourhoods where the rates were particularly high.\(^{134}\)

162. NHS Greater Glasgow and Clyde explained that it had recently mapped teenage pregnancy density across the whole health board area and used it to assess whether it was targeting its services in the correct areas and whether there were gaps in provision—

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“Mapping of rates in high neighbourhoods can enable partnerships to plan addressing the wider determinants of teenage pregnancy and delivering early intervention measures with young people at risk of teenage pregnancy.”

163. The Committee explored the suggestion that setting specific targets for areas with particularly high levels of teenage pregnancy would incentivise action amongst partner bodies and stimulate progress.

164. NHS Greater Glasgow and Clyde explained that, under the English Teenage Pregnancy Strategy, targeting work in neighbourhoods with much higher rates, working in particular geographical areas or with particular vulnerabilities (such as looked-after children) had yielded positive results for young people at risk of teenage pregnancy including those under 16.

165. The Committee questioned Alison Hadley, Director of the Teenage Pregnancy Knowledge Exchange at the University of Bedfordshire and previous head of the UK Government’s teenage pregnancy Unit, on how the targeted approach to reducing teenage pregnancy rates had worked under the English strategy.

166. She explained that under the English national target to reduce teenage pregnancy by 50 per cent, every local authority area had been given its own specific reduction target. The high-rate areas had a 60 per cent target, the average areas a 50 per cent target and the low-rate areas a 40 per cent target. If the authorities collectively met those targets, the overarching national target would be met.

167. Alison Hadley told the Committee that midway through the strategy, some areas were doing much better than others in reducing their rates, including variation between areas with similar levels of deprivation.

168. She suggested to the Committee that one of the barriers to progress in some areas was that fatalism could creep into the approaches taken. “The attitude of ‘it’s like that round here’ was quite a challenge.” Alison Hadley explained that areas that were not performing well had focused more on improving support for young parents than on prevention, as they felt that high rates were inevitable. Perception in these areas was that teenage pregnancy was part of the local culture and always had been—

“Only when we reflected back to them that similar deprived areas had made big progress on prevention did they start to think that there was something that they could do.”

169. The Committee discussed the issue of a more targeted approach with the Minister, who told the Committee—

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135 NHS Greater Glasgow and Clyde. Written submission.
136 NHS Greater Glasgow and Clyde. Written submission.
“There is merit in considering whether there is a need to have specific targets that are weighted in such a way as to give both health boards and local authorities much more of a focus on the areas where there are particular challenges.”

170. He went on to say—

“If we were to set a target to reduce teenage pregnancies by 5 per cent nationally, which would be tremendously ambitious, my view is that that should be calibrated in a way that focuses on areas where there are higher levels of teenage pregnancy, such as Dundee or parts of Fife. Such a target would have to be shared between local authorities and health boards, given the intrinsically linked nature of their roles in dealing with the issue.”

171. In Scotland there are variations in rates of teenage pregnancy between areas with similar levels of deprivation. The Committee notes evidence on the English Teenage Pregnancy Strategy that the perception that high rates in deprived areas are inevitable can be successfully challenged and this challenge can, in turn, lead to reductions in teenage pregnancy rates.

172. NHS boards, local authorities and other partners need to guard against fatalistic attitudes that, in areas of high deprivation, nothing can be done to prevent teenage pregnancy. As has been demonstrated through the English strategy, progress can be made in any area.

173. There is a need to narrow the difference between the best-performing and the worst-performing areas in terms of addressing rates of teenage pregnancy.

174. The Committee believes that, in order to incentivise progress in areas with higher rates of teenage pregnancy, there is a need to set more focused and specific targets underneath the overarching national target. High rate areas should have higher targets than those of low rate areas. If all areas were to achieve their targets, the overarching national target would also be met.

175. The Committee therefore recommends that the new strategy should provide for specific targets to be introduced which are weighted in such a way as to give both health boards and local authorities much more of a focus on the areas where there is a higher prevalence of teenage pregnancy.

Data

176. Central to ensuring local authorities and health boards deliver a targeted approach is sound information about the areas to target being available earlier than is currently the case. The Committee believes that access to good data and other key information will be essential if the new pregnancy strategy is to be

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effective. The Committee received evidence calling for some improvements to the data currently available, which is considered in the next section.

**Timely and localised data**

177. The most recent national level data on teenage pregnancy available from Information Services Division, NHS National Services Scotland (ISD Scotland) is for conceptions up to the end of 2010. The Committee received evidence which called for this data to be more timely and localised.

178. Bryan Kirkaldy told the Committee that Fife Council would like to know whether the work they have been doing in Fife targeted at specific schools since 2010 was having an impact.\(^{143}\) He stated that the data was “always lagging behind” and that there was a wish to explore whether there was scope for sharing data between local authorities and NHS boards “more frequently and quickly”.\(^{144}\)

179. He went on to explain that the Council and its partners wanted their work to become more “intelligence led” to enable them to assess the impact of the work done in different schools and so identify the areas of work that were making most difference—

“One of the things that the Committee would be well advised to consider is whether we can get a more responsive data-sharing and feedback mechanism, ideally with data disaggregated to community and school levels.”\(^{145}\)

180. The Committee learned that, in Fife, data had been broken down into individual areas by postcodes, which had led four schools in particular being identified. Some of the data was only a year old and had been used to target specific resources into particular areas.\(^{146}\)

181. The Committee also learned during its visit to Oldham that data on numbers of teenage pregnancies was published at council ward and school level. The Committee heard that disaggregating the data to this level had helped engage local head teachers on the issue, as they were able to compare their rates directly with other schools and assess whether the measures they were taking to tackle teenage pregnancy in their school was affecting rates of conception.\(^{147}\)

**Additional data**

182. In addition to suggestions for more timely and localised data, the Committee received evidence calling for other types of data relating to issues regarding teenage pregnancy to be collated.

183. One issue raised during the course of the Committee’s inquiry was data collected on “rapid repeat pregnancy”. Alison Hadley told the Committee that data on repeat conceptions had been collated under the English Teenage Pregnancy

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\(^{147}\) Note of visit to Positive Steps Oldham.
Strategy. The SPICe Briefing highlights that English survey data indicated that many young women who conceive in their teens go on to conceive a second time relatively quickly (usually within 12-24 months).

184. The SPICe Briefing suggests that there is anecdotal information that rapid repeat conception is recognised as an issue affecting some young women in Scotland. The Committee learned, however, that there is no routinely available data on the number of young women in Scotland who have more than one pregnancy in their teens.

185. The Committee noted that, in Oldham, the presentation of data at the level of both school and ward highlighted variations between comparable areas on a raft of measures including pregnancy, repeat pregnancy uptake of long-acting, reversible contraception (LARC). It is understood, however, that the information was only routinely seen by those on the Teenage Pregnancy Partnership (TPP) and decisions about who the data was shared with were a matter for the TPP. Sharing beyond the TPP was rare and only done on a “need to know” basis.

186. The Committee notes that, if similar data systems were to be adopted in Scotland, as the data would be held by a public body, it would be potentially liable to be subject to the provisions of the Freedom of Information (Scotland) Act. However, there is an exemption under FOI which prohibits the release of ‘personal data’ i.e. data that is biographical in nature and potentially identifies an individual.

187. The Committee explored with the Scottish Government data provision on teenage pregnancy. The Minister acknowledged that there could be a 18 month “time lag” for the data. He explained that data collection took place when a termination took place or when the baby was delivered.

188. The Minister suggested that there may be possible issues in the data collected being broken down to a more localised level—

“The challenge is how far we can go down to a localised level with that data without causing difficulties in some communities where only a small amount of information is held on a particular ward, for example, so people can be identified.”

189. The Committee recognises that the availability of robust, timely and localised data on teenage pregnancy is essential for delivering an effective local strategy on teenage pregnancy. Data must be available to ensure that the areas that need to be targeted can be identified, and that an intelligence-led assessment of the effectiveness of approaches being taken in these areas can be made.

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190. The Committee was presented with examples in Fife where data had been disaggregated to community and school levels and the positive impact this had had on the engagement of schools in tackling teenage pregnancy and targeting services appropriately.

191. The Committee therefore calls on the Scottish Government to explore the issues surrounding the provision of data for rates of teenage pregnancy across Scotland disaggregated to a community and school level. The Committee notes the comments made by the Minister regarding the need to ensure individuals cannot be identified by this data. The Committee is also aware of the potential for negative media coverage and publication of unhelpful league tables. The Committee acknowledges these issues and the need for them to be handled sensitively, but notes that they were not a barrier to progress in Oldham and other English local authorities.

192. The Committee believes that collecting data in this way will help ensure a reliable basis for planning and monitoring service delivery across Scotland.

193. The Committee received evidence which suggested that rapid repeat pregnancies can be an issue closely associated with teenage pregnancy. There is currently no routinely available data on the number of repeat teenage pregnancies. It is important that this data be collected so trends in rapid repeat pregnancy can be monitored. The Committee calls on the Scottish Government to consider collecting and collating this statistical data on a routine basis across Scotland.

Clarity on responsibilities

194. The Committee heard from a number of witnesses that, if a strategy on teenage pregnancy is to be successful, it must clearly set out the roles of all the bodies involved and how they should relate to each other.

Clear leadership

195. The Committee received evidence which suggested that clear leadership at a national and local level was critical to ensuring the successful delivery of a strategy on teenage pregnancy.

196. NHS Greater Glasgow and Clyde referred to the Teenage Pregnancy Strategy in England as demonstrating that “high level leadership and cohesive partnerships of organisations is required to effect change”. NHS Greater Glasgow and Clyde called for a “top down” approach alongside efforts to facilitate community ownership of the issue—

“… there needs to be a greater understanding for local authorities of the expectations the government has on preventing teenage pregnancy and their leadership role in the agenda.”153

153 NHS Greater Glasgow and Clyde. Written submission.
197. Alison Hadley told the Committee that national performance management had been “quite critical” in getting local leadership to take charge of the English Teenage Pregnancy Strategy.  

198. She explained in detail the leadership structure, at both a central government and local government level, which had been put in place in England to support its strategy. This had included a Teenage Pregnancy Unit within the Department of Health, supported by an inter-departmental Teenage Pregnancy Board to reflect the cross cutting nature of the policy. At a local level, it had included a Local Teenage Pregnancy Coordinator and Teenage Pregnancy Board with representation from health, education, social services, youth services, housing and relevant voluntary sector organisations.

199. During the course of the Committee’s inquiry, a Committee Reporter visited Oldham to meet with representatives who had been responsible for implementing the English national strategy at a local level. The Committee received evidence that central government had been instrumental in ensuring the English Teenage Pregnancy Strategy was delivered in Oldham.

200. The Committee learned that, in Oldham, rates of teenage pregnancy had not been declining in the early 2000s. In 2006, Oldham’s Director of Children’s Services was formally invited to meet with representatives from Government Office for the North West over concerns regarding the borough having a RAG rating of Red for teenage pregnancy. Oldham was placed in the equivalent of “special measures” to address the issue.

201. Emphasis was placed on the fact that central government involvement in Oldham’s delivery on the teenage pregnancy strategy had encouraged Oldham to make real progress on the issues. Data up to 2010 indicated that Oldham had seen the 10th highest reduction in teenage pregnancy conceptions in England.

202. In addition to the evidence the Committee received on the importance of clear leadership between central government, local authorities and health boards, the Committee also received evidence which stressed the importance of having clear leadership within local authorities.

203. In relation to delivery of the English Teenage Pregnancy Strategy in Oldham the Committee heard that clear leadership and strategic buy-in at chief executive level, alongside close monitoring and directives on what needed to be put in place, was critical alongside political buy-in to the strategy from Oldham’s councillors.

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155 Alison Hadley. Written submission.
156 Note of visit to Positive Steps Oldham.
157 RAG rating for issues, based on the Red, Amber, and Green colours used in a traffic light rating system.
158 Special measures is a status applied by Ofsted, the schools inspection agencies, to schools in England, respectively, when it considers that they fail to supply an acceptable level of education and appear to lack the leadership capacity necessary to secure improvements.
159 Note of visit to Positive Steps Oldham.
160 Note of visit to Positive Steps Oldham.
204. Ann Eriksen of NHS Tayside also highlighted the importance of senior management engagement at a local authority level—

“Getting the buy-in and strategic leadership at the right level is pretty crucial. Having the ear of the chief executive, the director of education and the director of social work is vital, because they are the people who can make some of this happen locally.”

Co-ordinated partnership working

205. The Committee received evidence that partnership working was central to ensuring the successful delivery of a strategy on teenage pregnancy. NHS Forth Valley stated that “Influencing teenage pregnancy cannot be the result of a single agency or intervention”. Alison Hadley believed that the issue needed “to be everybody’s business” and there was a need for a “whole systems approach”.

206. Ann Ericsken of NHS Tayside told the Committee that it was important that policy development in this area be viewed as a partnership of local authorities, health boards the voluntary sector and communities “working to tackle the issue with evidence-based approaches”.

207. Caledonia Youth called for greater acknowledgement of the voluntary sector in partnership working—

“While there are encouraging examples of partnerships working, we believe the value and contribution that the third sector can provide is yet to be realised to its true potential.”

208. Caledonia Youth argued that the voluntary sector had particular skills and experience in working with challenging and often hard to reach groups and developing partnership approaches would enhance the opportunity to make further impact on teenage pregnancy.

209. Several witnesses considered community planning partnerships as vital to ensuring the issue of teenage pregnancy was considered within the wider remit of social and economic inequalities.

210. Robert Naylor of Renfrewshire Council told the Committee that a community planning approach was required, with all the agencies working much more closely together to target approaches in communities where there were generational cycles of teenage pregnancies, single-parent families and unemployment.

211. NHS Greater Glasgow and Clyde raised a similar point—

162 NHS Forth Valley Sexual Health Strategy. Written submission.
166 Caledonia Youth. Written submission.
167 Caledonia Youth. Written submission.
“One of the greatest barriers to achieving progress is getting the issue on the agenda and it being clear that teenage pregnancy is core business. Translating the issues affecting teenage pregnancy into coherent joined up actions owned by Community Planning Partnerships and Children’s Service Planning Groups is therefore needed. This means framing the issue as a social inclusion issue rather than a health related issue.”\textsuperscript{169}

212. The Committee saw first-hand, with Positive Steps in Oldham, the effectiveness of adopting a partnership approach to tackling the issue of teenage pregnancy. Within Oldham, overall responsibility for the strategy had been led by a multi-agency partnership board, which included local authority, NHS primary care trust and the voluntary sector. There was also representation from housing, social care and youth services.\textsuperscript{170}

213. Jane Hughes of Brook believed that what had made the Oldham project successful was a commitment to partnership working at both a strategic and operation level.\textsuperscript{171}

214. The Committee also received evidence that, to ensure clear leadership, partnership working and delivery at an operation level, clear guidance from the centre to support strategic direction was needed. Nicky Coia of NHS Greater Glasgow and Clyde told the Committee—

“The Committee has heard what a complex issue teenage pregnancy is, so making sense of it and turning it into practical, tangible action is challenging. I therefore think that there is a place for clearer guidance for local authorities and particularly for community planning partnerships on their respective contributions to the agenda.”\textsuperscript{172}

215. The Committee concludes that, if a strategy on teenage pregnancy is to be successful, it must clearly set out the roles of all the bodies involved and how they should relate to each other. The strategy should also place emphasis on the importance of partnership working.

216. There is a clear balance to be struck between the need to provide clear and strategic leadership from the centre and to allow the flexibility for local partners to develop their local strategy, taking account of local circumstances and resources. In issuing any guidance to local authorities and health boards, the Scottish Government needs to have regard to the need for this balance.

217. The Committee therefore takes the view that the national strategy should be supported by clear guidance, based on best practice, not only in Scotland, but from across the UK and beyond. Implicit in this guidance should be an expectation that local strategies will be developed by local authorities and boards through community planning partnerships, but, in line with current outcome-based approaches to issues, national guidance

\textsuperscript{169} NHS Greater Glasgow and Clyde. Written submission.
\textsuperscript{170} Note of visit to Positive Steps Oldham.
\textsuperscript{172} Scottish Parliament Health and Sport Committee. \emph{Official Report}, 22 January 2013, Col 3196.
should not be over-prescriptive and should allow sufficient flexibility for appropriate local solutions and strategies to be fully developed.

218. The Committee noted that, in a number of local authorities in England, significant progress had been made after provision of detailed localised data, combined with integrated de-stigmatised services and local leadership held to account by national inspection. The Committee therefore believes that the NHS and local authorities should explore ways of promoting and sharing best practice across Scotland, and that there should be a clear role for the Joint Improvement Team in delivering in this area. Details of how best practice has been promoted and shared across Scotland should be reported on as part of the annual progress report laid before the Scottish Parliament by the Minister.

EDUCATION AND OTHER LOCAL AUTHORITY SERVICES

219. This section of the report considers the role of education services in helping to reduce the incidence of unplanned teenage pregnancies and in supporting young women who become pregnant, and subsequently become parents, during their education.

220. The Committee is aware that, in addition to education services provided in schools, local authorities are also key providers of other relevant services such as youth work and community learning and development, which, in some councils, may not be structurally located within the education service. However, for the purposes of this section, these services are considered as education services, regardless of where they are located within particular councils.

221. As previously noted, delegations from the Committee visited the Young Parents’ Support Base at Smithycroft Secondary School in Glasgow, the Corner (health, information and peer-led services for young people) in Dundee, and Menzieshill High School, also in Dundee. Findings from those visits are also incorporated into this section.

What role do education services play?

222. The roles that can be played by local authorities and their partners in relation to teenage pregnancy are potentially complex and varied. They would, however, be expected to include the following—

- sexual health and relationship education (SHRE);
- the responsibilities of all teaching staff in relation to supporting health and wellbeing across the curriculum;
- the responsibilities of schools in relation to the Getting it Right for Every Child approach;
- specialised units within schools to support young parents in continuing their education;
- school nursing services; and,
- youth work and information services – for example drop-in centres, detached youth work and specific sexual health projects, which might
typically be organised or funded through a council’s community learning and development service (or social work or other service) in partnership with a health board or voluntary organisation.

**Sexual Health and Relationships Education (SHRE) – policy context**

**SHRE within Curriculum for Excellence**

223. The educational experience that most young people are likely to encounter during their education is sexual health and relationships education. The label used for this varies between different schools and local authorities. In some schools, the term Personal and Social Education (PSE) is used. In Roman Catholic (RC) schools, areas related to sexual health and relationships are covered under Religious and Moral Education (RME), although it is understood that in Catholic schools the term ‘religious education’ is used in preference to ‘religious and moral education’. Some of the written evidence received by the Committee also referred to “relationships, sexual health and parenthood education” (RSHP). Throughout this report, SHRE has been used to refer generically to all types of sexual health and relationships education in schools.

224. Curriculum for Excellence (CfE) came into operation in August 2010, and is intended to provide a coherent, flexible and enriched curriculum from ages three to 18. CfE is intended to help children become successful learners, confident individuals, responsible citizens and effective contributors. CfE covers not only curriculum areas and subjects, but should also provide opportunities for interdisciplinary learning, develop the ethos and life of the school and provide opportunities for personal achievement. This last includes “opportunities for achievements both in the classroom and beyond, giving them a sense of satisfaction and building motivation, resilience and confidence.”

225. The Education Scotland website explains that the curriculum is “structured around all the experiences that are planned as part of learning and teaching”. By recognising and planning learning around different contexts and experiences, it goes on to say, “the curriculum aims to make better connections across learning”.

226. Under CfE, health and well-being and religious and moral education are two of eight “curricular areas”. Under each curricular area, there are “experiences and outcomes” that are expected to form part of each pupil’s learning under that curricular area. These apply to learning from pre-school through to the end of S3, after which pupils will study for qualifications in the ‘senior phase.’ Some aspects of ‘Health and Wellbeing’, including learning about relationships, are the responsibility of teachers across the whole curriculum. However, children will experience other aspects of health and wellbeing through focused programmes such as personal and social education programmes.

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227. The “relationships, sexual health and parenthood” section of the health and well-being curricular experiences and outcomes set out a broad, overarching outcome—

“Learners develop an understanding of how to maintain positive relationships with a variety of people and are aware of how thoughts, feelings, attitudes, values and beliefs can influence decisions about relationships, and sexual health. They develop their understanding of the complex roles and responsibilities of being a parent or carer.”\textsuperscript{175}

228. It then sets out a wide range of learning outcomes and experiences, which contribute towards that outcome, appropriate to the age of the child concerned. Examples of these would range from “I am aware of how friendships are formed and that likes, dislikes, special qualities and needs can influence relationships”, at the early end of the three-to-18 continuum, to “through investigation I can explain the support available for parents and carers looking after babies and bringing up children” at and beyond the later stages. Amongst these experiences are a number that would encompass what was traditionally understood as “sex education” – for example, at the early and first stages, “I am learning about where living things come from and about how they grow, develop and are nurtured” and at the second stage, “I am able to describe how human life begins and how a baby is born”.

229. In respect of Roman Catholic (RC) schools, the Religious and Moral Education experiences and outcomes state that there are “meaningful links between religious education and all other areas of the curriculum”. In particular, they state—

“… some aspects of health and wellbeing provide opportunities for learning about some moral dimensions of life – for example, relationships education. Other moral and ethical issues are frequently raised through topics in other curriculum areas.”\textsuperscript{176}

Inspection
230. Inspection of the quality of teaching and learning in all schools is the statutory responsibility of Her Majesty’s Inspectors. Formerly a single-purpose Scottish Government agency, in April 2011 Education Scotland was formed from Learning and Teaching Scotland and HMIe to provide both curriculum support and inspection.

231. Secondary school inspections are carried out against the quality indicators (QIs) set out in How good is your school: the journey to excellence.\textsuperscript{177} Under the

\textsuperscript{175} Education Scotland Website. Available at:

\textsuperscript{176} Education Scotland Curriculum for excellence: Religious education in Roman Catholic schools, principles and practice. Available at:

\textsuperscript{177} HMIE (2007) How good is our school? Available at:
broad heading of “delivery of education” (one of nine broad headings) inspectors assess schools’ performance against nine quality indicators, of which QI 5.8 (Care, welfare and development) is most relevant to SHRE. Assessed under QI 5.8 are—

- arrangements for ensuring care, welfare and child protection;
- approaches to and provision for meeting the emotional, physical and social needs of children and young people; and,
- curricular and vocational guidance.

232. A new approach to inspections (set out in August 2011) states that “there will be a particular focus on learning, teaching, literacy, numeracy and health and wellbeing within the context of a broad general education”.178

SHRE in practice – general points

233. This section of the report sets out general points that emerged from the Committee’s evidence on SHRE. At the end of the section the report makes a number of general recommendations to the Scottish Government. The report will then go on to examine a number of specific issues related to SHRE, making further recommendations in each section.

234. A number of witnesses who gave oral evidence to the Committee during its roundtables highlighted good work that was being developed within schools and in youth work settings around the country. Marian Flynn of Glasgow City Council, for example, told the Committee that Glasgow placed great emphasis on involving parents. It had conducted a consultation with parents asking them what they thought of education on sexual health and relationships received by themselves and what they wanted for their children. They had then used that information to create a dedicated service that aimed to encourage parents to talk to their children from a very early stage about growing up, puberty and sexual health matters.179 Other local authorities who were involved in the roundtable, including Fife Council and Renfrewshire Council, also reported positive examples of work going on in their areas in SHRE, both universally and with pupils at particular risk, such as looked-after children.180

235. However, there was also some criticism of SHRE. Jane Hughes of Brook told the Committee—

“Young people consistently tell us that the sex and relationships education that they receive is too little, too late and too biological. What they ask for is education support that equips them with the language and skills to manage their relationships effectively, understand appropriate and inappropriate

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behaviour, and enable them to resist peer pressure. They tell us that they often do not receive that type of education, although it is what they need. 181

236. The written evidence received by the Committee painted a fairly mixed picture of SHRE. Although there was wide acknowledgement that Curriculum for Excellence would, if delivered as intended, “empower young people to develop health self-esteem, make informed choices and be resilient” 182, there was also comment that there was “inconsistent provision across Scotland”. The BMA stated that school based programmes for sexual health promotion, “although a part of Curriculum for Excellence”, were “not implemented uniformly across Scotland”. 183 The BMA also welcomed the Learning and Teaching Scotland Self-assessment tool as a “useful resource” but argued that its implementation of this was “patchy across the country”. 184

237. Caledonia Youth noted that while there were “many examples of good initiatives being delivered in Scotland to a high standard”, there was only “patchy coverage, at best”. 185

238. NHS Forth Valley noted that Curriculum for Excellence was designed to facilitate better links in SRE programmes to potential ‘real-life’ situations and the impact of alcohol use on the sexual behaviours and sexual risk taking of young people, but suggested that it was likely that schools would “need support/training/resources to make it happen”. 186

239. NHS Health Scotland was particularly critical of SHRE in schools. It argued that although evidence clearly advocated the use of comprehensive sex and relationships education in educational settings, there was no obligation to “do more than a bare minimum, mostly work around friendships and relationships, as demonstrated in Curriculum for Excellence”. 187 It also argued that there was no requirement to use evidence-informed resources with the result that inappropriate or out of date and sometimes inaccurate or misleading materials could be used in schools. It suggested that there was no requirement for teachers and others providing SRE to have undertaken any additional training. The overall effect, NHS Health Scotland concluded, was that sex and relationships education was “patchy and introduced at too late a developmental stage, with schools left to decide for themselves what and how they will deliver and with little feedback from pupils to assess effectiveness”. 188

240. This theme of patchiness, inconsistency and too much being left to the discretion of individual schools and their head teachers was carried through in much of the written evidence. Scottish Sexual Health Lead Clinicians Group, for example, argued that although SHRE was a key policy intervention, there was “no monitoring and accountability, nor sanctions in place for non-compliant schools”

182 Scottish Sexual Health Lead Clinicians Group. Written submission.
183 BMA. Written submission.
184 BMA. Written submission.
185 Caledonia Youth. Written submission.
186 NHS Forth Valley. Written submission.
187 NHS Health Scotland. Written submission.
188 NHS Health Scotland. Written submission.
and schools were “free to determine content”.\(^\text{189}\) Similarly, Scottish Sexual Health Promotion Specialists Group argued that “schools need to be more accountable for what they are delivering as currently this is not known”.\(^\text{190}\) Also expressing similar views was NHS Forth Valley Sexual Health Strategy Group, which argued that “more accountability for schools to report on what is being delivered in SRE would be useful as there is inconsistency in the quality and content of programmes in schools despite training and curriculum development support being available”.\(^\text{191}\)

241. Concerns were also expressed in some of the written evidence received by the Committee that the inspection regime in schools was not sufficiently robust in regard to SHRE. Fife Health and Wellbeing Alliance, for example, argued that “there should be a stronger role for HMie to inspect RSHP specifically within health and wellbeing outcomes in the same way they would inspect subject areas”.\(^\text{192}\)

242. The Minister for Public Health acknowledged that the variation in experience of SHRE across the country, noting that in his discussions with young people, he had heard “mixed reports about the nature of the relationships and sex education that is provided in schools”.\(^\text{193}\) He told the Committee that the Scottish Government would “reflect on that”.\(^\text{194}\) He also indicated interest in innovative approaches that have been taken in Fife, where a number of schools had engaged closely with young people to identify what they thought might be the best approach to dealing with issues related to relationships and sexual health. These approaches had also considered whether it would be appropriate to move to single-sex classes to discuss particular topics, and whether this might be more effective in allowing young people to discuss issues openly.\(^\text{195}\)

243. The Minister also told the Committee that he was open to the idea of considering whether the approach to relationships and sexual health education in schools should involve an audit of young people’s views.\(^\text{196}\)

244. The Committee concludes that although there has been undoubted progress over the last decade in the quality of SHRE provision in schools, the progress has not been consistent. While there are many examples of good and innovative practice in Scottish schools, it is clear from the evidence received by the Committee that much of what is provided in schools is left largely to the discretion of the head teacher. Moreover, although Curriculum for Excellence lays significant emphasis on health and well-being, in practice the time and other resources available for SHRE are often limited.

\(^\text{189}\) Scottish Sexual Health Lead Clinicians Group. Written submission.
\(^\text{190}\) Scottish Sexual Health Promotion Specialists Group. Written submission.
\(^\text{191}\) NHS Forth Valley Sexual Health Strategy Group. Written submission.
\(^\text{192}\) Fife Health and Wellbeing Alliance. Written submission.
245. There are also questions about the level of training available for teachers involved in SHRE and the extent to which the subject, as one that does not, in itself, lead to any qualification, receives any degree of priority in schools, or, indeed, in school inspections.

246. Elsewhere in this report, the Committee calls for a new Scottish Government strategy on teenage pregnancy. The Committee calls on the Scottish Government, as part of the development of that strategy, to carry out a full review of the provision of SHRE in schools. It should be a wide-ranging review that includes consideration of skills, resources, partnership with other agencies, the potential for further development of peer education approaches, the extent to which there should be central direction, initial teacher education and the inspection regime. The Committee believes that the effectiveness of delivery of SHRE within schools in any new strategy should be assessed within the existing Education Scotland inspection process.

247. The Committee further notes that the Minister was open to the idea of considering whether the approach to relationships and sexual health education in schools should involve an audit of young people’s views. Although the Committee has not taken any evidence on this specific proposal, much of the evidence received pointed at general dissatisfaction with the quality of SHRE and the need to listen to the views of young people. The Committee therefore takes the view that such an audit would, indeed, be helpful, and urges the Scottish Government to bring forward plans to conduct one as part of its review of SHRE.

248. The Committee further proposes that, whatever approach to SHRE is adopted, the views of young people on the education provided should be regularly ascertained and the value of the approach measured against the outcomes of the data set.

SHRE – specific issues

Targeting of vulnerable young people

249. A number of the written submissions and comments in oral evidence suggested that although all children and young people should receive SHRE, there was also a need both to target those considered as most vulnerable and to ensure that appropriate opportunities were made available outside schools, as some of the most vulnerable are those who attend schools least.

250. NSPCC Scotland, in its written evidence, argued that a key limitation of sex education delivered in schools was its inability to reach those outside of school, such as transient families, persistent truants or looked-after children not in receipt of formal education. These groups, it was suggested, may be at an increased risk of exposure to particularly risky sexual behaviour. NSPCC also argued that looked-after children were exposed to greater risk factors for teenage pregnancy than many other groups and that young people in care were recognised as being
one of the principal groups to experience social isolation, a key determinant of teenage pregnancy.\(^{197}\)

251. Caledonia Youth, acknowledging and supporting the significant resources that had been invested in SHRE in schools, argued that it should also be acknowledged that for many of Scotland’s most vulnerable young people – those most at risk of unplanned pregnancy – a standardised package was simply insufficient for a number of reasons, including issues relating to literacy skills, learning styles, and non-attendance or poor attendance at school. Looked-after young people, Caledonia Youth argued, were two and a half times more likely to become pregnant as teenagers yet were less able to access good quality, consistent sources of sex and relationship education and advice than many other children and young people.\(^{198}\)

252. The Scottish Sexual Health Lead Clinicians Group suggested that local authorities needed to be made more accountable for their responsibilities regarding sexual health in areas such as looked-after and accommodated children.\(^{199}\) The Centre for Excellence for Looked After Children in Scotland (CELCIS) noted that looked-after young people and care leavers might have less access to SHRE as a result lower attendance rates in mainstream schools and higher rates of exclusions and were also more likely to be educated in alternative education settings, such as residential schools, and also to have disrupted education. CELCIS went to suggest that disabled looked-after young people may be further excluded and that sexual health information and support should be communicated appropriately to meet their needs.\(^{200}\)

253. The Committee noted the preliminary findings of a Scottish study (reported by CELCIS in its written evidence) of the sexual health of young people in care, which had found that looked-after children had higher rates of sexual activity (62.9 per cent) compared to non-looked-after children (39.9 per cent) and 58.8 per cent had their first sexual experience under the age of 13 compared to 21.3 per cent of non-looked-after children.\(^{201}\)

254. The Committee heard, in one of its oral evidence roundtables, of the specific interventions and efforts that were being made in Renfrewshire Council, Glasgow City Council and Fife Council, in relation to the specific sexual health needs of looked-after and accommodated children in these local authority areas, particularly in relation to training and “up-skilling” of foster carers.\(^{202}\)

255. While much of the written evidence highlighted examples of successful and innovative youth work and community learning that had been carried out around the country in non-school settings – for example the Chill Out Zone (COS) provide by Children 1\(^{st}\) in West Lothian and the Corner in Dundee, which was visited by some member during the inquiry – some concerns were expressed that this type of work was particularly vulnerable to local authority budget cuts in the current

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\(^{197}\) NSPCC Scotland. Written submission.

\(^{198}\) Caledonia Youth. Written submission.

\(^{199}\) Scottish Sexual Health Lead Clinicians Group. Written submission.

\(^{200}\) The Centre for Excellence for Looked After Children in Scotland. Written submission.

\(^{201}\) The Centre for Excellence for Looked After Children in Scotland. Written submission.

economic climate. The STUC, for example reported that its affiliated trade unions had raised concerns about the impact of public spending cuts in local authority budgets, which has seen a reduction in services and projects aimed at young people and a reduction in numbers of community centres and safe places to go.\textsuperscript{203} NHS Grampian argued that good quality youth work and community education had been shown, in the English teenage pregnancy strategy, to be effective in reducing teenage pregnancy, yet these were “frequently areas targeted for cuts, and certainly not for expansion”.\textsuperscript{204}

256. The Committee is particularly interested in this area, given its deliberate linkage in this inquiry to its related work on health inequalities.

257. The Committee also accepts that looked-after and accommodated young people face increased risks of becoming involved in sexual activity earlier and are likely to receive reduced exposure to SHRE as a result of being more likely than other children to be poor attenders at school.

258. The Committee notes that much of the innovative and ground-breaking work that does take place with the most vulnerable young people is away from the mainstream education sector and is, potentially, a target for budget reductions, particularly by local authorities, in the current economic climate.

259. The Committee therefore calls on the Scottish Government, alongside the review of SHRE in schools, to examine the specific needs of looked-after and accommodated children and other vulnerable young people, with a view to the emerging teenage pregnancy strategy having particular regard to addressing the specific needs of the young people most at risk, including the looked-after and accommodated population.

\textit{Content of SHRE}

260. As noted in the general introduction to this section of the report, many witnesses were critical of current SHRE in Scottish schools, citing a number of issues including timing, a lack of central direction with too much left to the discretion of individual schools and head teachers, insufficient training for teachers and an overemphasis on the biological and reproductive aspects of sex.

261. Much of the written and oral evidence received by the Committee laid a heavy emphasis on the need for SHRE to concentrate more on raising confidence, aspirations and self-esteem and on learning how to develop and sustain relationships, with correspondingly less emphasis on the biological aspects. NHS Forth Valley Sexual Health Strategy Group, for example, in its written submission argued—

\textquote{Raising aspirations for all children and young people are key to any programmes, inputs or resources when tackling TP. It is essential to raise awareness, confidence and self-esteem especially of those who are vulnerable or at risk.}\textsuperscript{205}

\begin{flushright}
\textsuperscript{203} STUC. Written submission.
\textsuperscript{204} NHS Grampian. Written submission.
\textsuperscript{205} NHS Forth Valley Sexual Health Strategy Group. Written submission.
\end{flushright}
262. Similarly, NHS Tayside argued that there was emerging international evidence that pointed to the importance of interventions in the earliest years of life and youth development work, in particular work that fosters “self-esteem, self-efficacy, and aspiration for the future through opportunities such as volunteering, which can have a significant impact on reducing teenage pregnancy”. 206

263. Fife Health and Wellbeing Alliance argued that the focus “ought also to be earlier and more on building resilience, confidence and aspirations in children, as this is far more effective than any contraceptive in reducing teenage pregnancy”. 207

264. YWCA Scotland was concerned that—

“... sex education and teen pregnancy reduction initiatives often fail to recognise that many young women lack agency with regard to managing their intimate relationships. This means initiatives based primarily on providing “biological” information about sex or encouraging use of condoms could be largely ineffective.” 208

265. Another strand of evidence received by the Committee, related to the promotion of “abstinence” as a way of discouraging sexual activity at a young age. The written submission from the Christian Medical Fellowship’s (CMF) argued—

“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.” 209

266. In oral evidence, Dr Alastair Noble, an education consultant for CARE Scotland, told the Committee that it was “better to talk about encouraging young people to delay sexual activity until they are in a stable relationship, which we would say would preferably be marriage”. He went on to say that there were “mixed research messages around abstinence that include some positive messages.” He concluded—

“We need a higher profile for the message that there is value in delaying sexual activity, valuing relationships and anticipating relationships for the future. It is a mix, but I am simply saying that I think that the balance has tipped too far in the direction of harm reduction and assuming that teenagers will be involved in sex, which perhaps inadvertently encourages the very thing that we are trying to prevent.” 210

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206 NHS Tayside. Written submission.
207 Fife Health and Wellbeing Alliance. Written submission.
208 YWCA Scotland. Written submission.
209 Christian Medical Fellowship. Written submission.
267. However, these views, and those of the views of the Christian Medical Fellowship in particular, were heavily critiqued by Professor Roger Ingham, Professor of Health and Community Psychology at the University of Southampton and Director of the multidisciplinary centre for Sexual Health Research. Professor Ingham suggested that the CMF arguments on risk compensation (that young people would be likely to engage in more risky sex as a result of greater service provision) was “very dubious indeed” and based on “theoretical possibility, and dubious inferences from low level data” with “no direct evidence at all that this occurs in the field of sexual activity”.

268. Professor Ingham concluded that most commentators in the field “propose that sex and relationships education that enables and empowers young people to make informed and responsible choices is more likely to lead to delayed sexual activity, and more careful sexual activity when it does occur”. Noting that “some or much early sexual activity in the UK is coerced, or based on reputations, or other ‘dubious’ reasons”, there was “general agreement that delay amongst some young people is to be encouraged”. While in that sense, there was “accord with certain aspects of the CMF submission” there was a “fundamental disagreement between the CMF and the vast majority of researchers and practitioners in the field on the means by which such outcomes can best be achieved; the evidence is very clear in pointing to the need for comprehensive SRE as a major component of a comprehensive package of measures”.

269. The Committee notes the views of the CMF and Care Scotland and accepts that such views are genuinely held and may be supported by some parents. However, the Committee believes that it is important that children and young people have the opportunity to experience high quality SHRE throughout their education, at a level appropriate to their age.

270. The Committee also notes the evidence received that the quality of SHRE can be variable.

271. The Committee has also noted the increasing sexualisation of young people and their exposure to sexual images and information through the media and popular culture and through the easy availability of internet pornography. As much of the written evidence received by the Committee pointed out, many of these cultural influences reinforce negative gender role stereotypes and may create in young people unhealthy and negative expectations of sexual relationships. Yet the Committee heard the suggestion that the focus of SHRE remains too much on the biological and reproductive aspects of sex.

272. There is obviously a need for young people to receive factually accurate information about the biological and reproductive aspects of sex and practical information about methods of contraception. However, the Committee believes it is vital that SHRE, whether provided in schools or in other educational settings, concentrates on relationships, respect and tolerance and on developing the skills and behaviours needed to develop

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211 Professor Roger Ingham. Written submission.
212 Professor Roger Ingham. Written submission.
and sustain relationships with others, and to develop the maturity, confidence and self-esteem to enable them to make the decisions and choices on whether these become sexual relationships or not. The Committee’s evidence showed that, in some schools and educational programmes, progress has been made towards such a shift of emphasis, but there was also evidence that progress had been variable and patchy.

273. Bringing about such a change will clearly require resources and leadership, not least in ensuring that SHRE is given sufficient priority in schools and elsewhere, but also in ensuring that teachers and other staff are sufficiently skilled to deliver. The Committee therefore calls on the Scottish Government, as part of the review of SHRE called for earlier in this section, to consider what further measures are needed to ensure that children and young people receive high quality SHRE that emphasises relationships and respect over biology.

SHRE at different ages

274. Some of the written evidence received by the Committee referred to the need for SHRE to begin at as early an age as possible, in line with current thinking that social problems are best addressed at as early a stage as possible, with resources dedicated to what has become known as “preventative spending”. BMA Scotland argued in its submission that—

“… the timing of educational interventions appears to be important: young people who are already sexually active at the commencement of interventions are less likely to change their contraceptive behaviour. The BMA therefore supports the introduction of sex and relationship education into the primary school curriculum.”

275. Scotland’s Commissioner for Children and Young People (SCYYP), while supporting the continuing development of SHRE in schools, also argued that the focus should now move to early and structural interventions that “shape young women's life chances”. Work should, therefore, be focused on “prevention and addressing the wider influences of poverty and a lack of aspiration amongst our young people”. SCYYP also argued for a focus on “structured youth development programmes and harnessing the interests of those most disengaged and disadvantaged”.

276. The submission from the Scottish Sexual Health Promotion Specialists Group went further—

“SHRE needs to be embedded from nursery, through primary and secondary schools, and parents and carers should be involved and supported to continue this work at home. There is merit in considering making delivery of SHRE compulsory in all formal educational settings (denominational, non-denominational and independent schools).”

213 BMA. Written submission.
214 Scotland’s Commissioner for Children and Young People. Written submission.
215 Scotland’s Commissioner for Children and Young People. Written submission.
216 Scottish Sexual Health Promotion Specialists Group. Written submission.
277. NHS Highland and Highland Council, in their joint submission, made the point that levels of sexual “knowledge” acquired through exposure to electronic media (music videos, games consoles etc) made it very likely that sexual knowledge was “ubiquitous within playground settings” and permeated “the entire cohort” The submission went on—

“However Curriculum for Excellence does not require children to learn about sexual intercourse until the end of Primary 7. Therefore the sexual component of sex and relationships education should be introduced earlier, in line with children’s pre-existing level of media and playground-gained knowledge.”

278. Other evidence received by the Committee suggested that good quality SHRE would be likely to encourage young people to delay, rather than encourage, sexual activity. Fife Health and Wellbeing Alliance, for example, argued that “it needs to be reinforced that the evidence that good SRE delays rather than encourages early sex, and that parents are generally supportive of relationship, sexual health and parenthood education (RSHP)”.

The FPA and Brook submission elaborated on this, saying—

“High quality SRE does not encourage young people to become sexually active. In fact, international research has shown that school based SRE, especially when linked to confidential advice services, can have a positive impact on children and young people’s knowledge and lead to them delaying sexual activity as well as making them more likely to use contraception.”

279. FPA and Brook’s comments on parental support were also backed up by the Scottish Sexual Health Lead Clinicians Group, Noting that parents were “quite naive of the fact that young people are sexually active so young, have so much opportunity and pressure to do it, and that alcohol has a significant role in children’s sexual behaviour” added that parents “often express anxiety about talking to their young people about puberty, relationships and sexual matters and want schools and want support with this as well as being grateful when other agencies take this role on.” NHS Forth Valley Sexual Health Strategy Group echoed this, noting that “parents talking to their children about sex, relationship and contraception may support the reduction of teenage pregnancy, but much work is required as many feel ill equipped to do so”.

280. The Committee recognises that provision of SHRE at younger ages and at earlier stages of a child’s education has the potential to be controversial. There is potential for parents to withdraw their children and for sensational tabloid media headlines along the lines of the sex lessons for five year olds that have occasionally been seen in the past.

281. Nevertheless, the Committee accepts the majority of the evidence presented to it that SHRE needs to begin earlier and that the majority of

217 NHS Highland and Highland Council. Written submission.
218 Fife Health and Wellbeing Alliance. Written submission.
219 FPA and Brook. Written submission.
220 Scottish Sexual Health Lead Clinicians Group. Written submission.
221 NHS Forth Valley Sexual Health Strategy Group. Written submission.
parents, many of whom feel ill-equipped to discuss sexual matters with their children, would welcome and support quality SHRE provision from an early age.

282. A number of witnesses have commented to the Committee that, in Scotland, we are not very good about talking about sex. The Committee takes the view that it is probably never too early for children to start talking about relationships and learning how to relate to and respect others, which in turn will lead to discussion, in due course, about sex as an aspect of relationships. Clearly, it is important that the content of such learning is appropriate to the age and maturity of the children and young people concerned, but it is also essential that steps be taken that will support the earlier development in children and young people of the knowledge, skills and competences to help them understand and sustain relationships and make the appropriate choices when options present themselves to them.

283. The Committee therefore calls on the Scottish Government, in carrying out the review of SHRE called for earlier, to consider what measures might need to be taken to ensure that the appropriate level of SHRE is consistently available to children and young people from as early an age as possible.

Methods of delivery of SHRE

284. A delegation from the Committee visited Menzieshill High School in Dundee, where members were able to join a first-year SHRE class, in which trained third-year pupil peer educators were working with small groups of first-years on a planned programme, under the leadership of guidance teachers. Staff at Menzieshill told the members that the peer education project had provided significant benefits both for those delivering and for the recipient. Teachers reported that the initial SHRE activities delivered by the peer-educators were better received by pupils when provided by people nearer to their own age, than when delivered by teachers. There was also less initial giggling and embarrassment, and when teachers took over in later stages, the first-year pupils were better prepared than they might otherwise have been. Pupils who had been through the peer education project wanted to be peer educators themselves, and there was stiff competition for places. Those who were successful found that being involved boosted their confidence and self-esteem.

285. NHS Forth Valley Sexual Health Strategy Group set out the advantages it saw in the peer education approach in its written submission to the Committee—

“Research on peer education suggests that young people are more likely to hear and personalise messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures. Peer education can support young people in developing positive group norms and in making healthy decisions. Peer education draws on the credibility that young people have with their peers, leverages the power of role modelling, and provides flexibility in meeting the diverse needs of young people.”

222 NHS Forth Valley Sexual Health Strategy Group. Written submission.
286. Peer education approaches have also been used effectively outside the formal education setting, and these may be particularly important in the case of young people who are irregular or poor attenders at school, who may be engaged by youth workers and community learning and development workers. YWCA Scotland’s submission argued that it was necessary to “ensure there are mechanisms for young people themselves to be involved in shaping policies and planning, delivering and evaluating services both to ensure that they are relevant and to their needs, to encourage self-advocacy and support opportunities for peer learning and peer support on sexual health, relationships, pregnancy and parenting”.223

287. Written evidence received from the Scottish Sexual Health Lead Clinicians Group also noted successful examples of peer education projects in Dumfries and Galloway Council and City of Edinburgh Council areas.224

288. The Committee recognises that SHRE can be delivered in different ways and using a range of resources and skills, including those of professional teachers and other staff, as is appropriate. Nevertheless, the Committee has been impressed both by the peer education projects it observed during its visits and by the evidence it received in written submissions on the benefits of peer education. There appears to be a consensus that these projects have real benefits both in terms of acceptance of the health messages by those in receipt of peer education and in the self-esteem, confidence and level of aspirations of those involved in delivering them.

289. Although the Committee acknowledges that there are other relevant approaches and that it is a matter for local partners to determine the appropriate mix for their areas, the Committee believes that the benefits of the peer education approach, where it has been able to be used, have been amply demonstrated.

290. The Committee therefore calls on the Scottish Government, local authorities and the NHS to work in partnership to ensure that there are adequate resources to support training and networks in local areas where area partners believe such an approach would be beneficial.

Denominational schools

291. Earlier in this section of the report, the Committee noted a general concern that much of what was provided by way of SHRE in schools was left largely to the discretion of the head teacher. More specific concerns were, however, raised in evidence over the provision of SHRE in RC schools.

292. NHS Greater Glasgow and Clyde (NHSGG&C), in its written submission to the Committee, was particularly critical of the denominational schools in its local authority areas—

“We do have a concern that denominational schools which represents a third of the school estate in this area, may not be providing the same high quality

223 YWCA Scotland. Written submission.
224 Scottish Sexual Health Lead Clinicians Group. Written submission.
level of SHRE to children, young people and parents. We have no feedback available from denominational schools on what is being taught, what training teaching staff may have had or what involvement parents have had in their children’s learning. From our own staff that routinely work with schools, we have an understanding that they can be routinely denied access to denominational schools, or can only do so only if key issues, especially matters to do with sexual health and relationships are not discussed with children and young people."

293. NHSGG&C went on to say that, because of the experience described in the quote above, it was “concerned that the national policy direction and especially the outcomes and experiences for children and young people in Curriculum for Excellence under the Relationships, Sexual Health and Parenthood organiser may not be being fully implemented in denominational schools”. The submission concludes that, given how strongly school based learning on sexual health and relationships shows up in the research evidence around prevention of teenage pregnancy, “this is potentially a considerable gap.”

294. The submission from NHSGG&C drew a sharp response from the Scottish Catholic Education Service (SCES). In a letter to NHSGG&C (copied to the Committee), Michael McGrath, SCES’s education director, expressed the “gravest concerns” over what he described as the “very serious allegations” contained in NHS Greater Glasgow and Clyde submission. Noting that the submission had “caused considerable consternation among parents, teachers and head teachers in Catholic schools”, Mr McGrath’s letter invited NHSGG&C to “apologise for this upset” and to investigate the circumstances “that led to a public body making unfounded claims to the Scottish Parliament”.

295. The Committee was also copied into the reply from NHSGG&C’s Director of Corporate Planning and Policy, Catriona Renfrew. The board’s letter stood by the original submission. It noted that in all six local authorities covered by the board, “considerable progress” had been made in working both strategically and at school level to improve the taught curriculum delivered by teachers, confidence and skills of teachers to deliver SHRE, policy guidance for staff in delivering SHRE, communication between schools and parents and carers, and information provided to children and young people on sexual health and relationships. The letter went on to note, however, that in all six local authority areas, this work had only covered the non-denominational school sector and that in all areas there had been “expressed tensions about the national guidance in relation to the best practice in teaching and information about SHRE and the approach in denominational schools”. The letter also said that there were “issues about equalities legislation and how this can appear to be at odds with the guidance which Roman Catholic schools are provided by the Scottish Catholic Education

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225 NHS Greater Glasgow and Clyde. Written submission.
226 NHS Greater Glasgow and Clyde. Written submission.
227 Correspondence between Scottish Catholic Education Service and NHS Greater Glasgow and Clyde Health Board. Written submission.
228 Correspondence Between Scottish Catholic Education Service and NHS Greater Glasgow and Clyde Health Board.
Service on behalf of the Bishops of Scotland”. In addition, it claimed that a survey of health improvement and school nursing staff to assess their relative experience of working in denominational and non-denominational schools had highlighted in “a range of significant ways that differential practice is required within denominational schools” which, in NHSGG&C’s view, “degrades the services” it can offer to young people in those schools. Finally it also clarified that it had been unable to agree the provision of basic information about its sexual health services within denominational schools, which “again disadvantages young people in those schools in terms of access to the NHS services they might need”.

296. The Committee understands and fully accepts that the position of religious education in denominational schools is set out in statute and that the Catholic Education Commission has responsibility for the faith content of the curriculum in Catholic schools, on behalf of the Bishops’ Conference of Scotland. The Committee also understands that the Scottish Government is working in partnership with the Catholic Education Commission in the development of guidance for Catholic schools in keeping with the values, purposes and principles of Curriculum for Excellence.

297. Nevertheless, the comments by NHS Greater Glasgow and Clyde on being denied access to RC schools and its concerns over the lack of feedback on what SHRE is being provided in RC schools and difficulties in providing information on the board’s sexual health services for young people are worrying.

298. The Committee notes the argument between NHSGG&C and the Scottish Catholic Education Service, draws the attention of the Scottish Government to it and asks that it consider these matters during the review of SHRE that the Committee has called for. It would also be helpful for the Scottish Government to engage directly with SCEC and NHSGG&C in order to help find a way forward from the current impasse between the two bodies.

299. Finally, the Committee understands that the Scottish Government intends to review the content of Education Circular 2/2001, which governs the conduct of sexual education in schools, following the passage of the same-sex marriage bill. This review would present an opportunity to consider, together with the RC authorities, whether any changes are required in relation to SHRE provision in RC schools.

Education for young parents

300. Alongside the Committee’s inquiry investigations on what can be done to reduce numbers of unplanned teenage pregnancies, it was also interested in looking at how teenage parents were supported through the pregnancy and following the birth of the child. Clearly, education services, although not the only agency with an important role to play, are very significant, particularly for those mothers who were attending school before they became pregnant.

229 Correspondence between Scottish Catholic Education Service and NHS Greater Glasgow and Clyde Health Board. Written submission.
301. Although most of the written evidence received by the Committee focused on other issues, the submissions from City of Edinburgh Council and Glasgow City Council were particularly strong on this aspect of the inquiry, reflecting the priority and degree of effort that has been devoted to supporting young people facing pregnancy and childbirth in the two cities.230

302. Glasgow City Council took the view that the outcomes for the baby and its mother would be enhanced if the mother continued her secondary education during pregnancy and after the baby had been born, rather than dropping out of school. Its submission231 noted that “research evidence indicates that not only does this approach improve the life circumstances of the parent but that the parent will engage more positively around the child’s learning once they engage with the formal education process”. The council had, therefore, “put considerable emphasis into ensuring that all young women remain engaged with or re-engage with learning during their pregnancy and after the birth of the baby” as part of its wider efforts to provide young parents with “age appropriate, integrated and accessible services”.232

303. The Committee was able to see for itself the excellent support for young parents provided at the Young Parents’ Support Base (YPSB) at Smithycroft Secondary School during its visit. It was clear to the Committee that a lot of effort and resources had been devoted to supporting the young women to remain engaged with learning. More details of the visit are contained in the note annexed to the report, but it was clear that multiple measures had been taken, including flexibility in timetabling, toilet passes and early lunches. There was also a well-equipped and staffed nursery. During the visit, members had an opportunity to talk to some of the young mothers, and it was clear that the support provided had been enormously beneficial, not only in itself, but in the support that it enabled the young women to give each other. Some of the young women reported that becoming pregnant had motivated and incentivised them to do better at school, with the thought that they would be responsible for a young child and would need to do as well as they could in the employment market in order to support that child. A number of examples were given of young women who were applying for FE college or university places, having been able to remain at school during pregnancy and after the birth of the baby.

304. City of Edinburgh Council, noting that “pregnancy during teenage years, presents real challenges for both the young mum and her family” argued that it “should not mean the end of education and a girl’s aspirations for the future”. The council’s submission went on to say that was “critical that she gets the support she needs to ensure the best chance of a positive start to her child’s life as well as maximising her own potential through education”. The alternative, it said was “all too often a lifetime on benefits, poverty and little or no aspirations for both the mum and her baby”.233

231 Glasgow City Council. Written submission.
232 Glasgow City Council. Written submission.
233 City of Edinburgh Council. Written submission.
305. The Council stressed, in its submission, its guidance to its Children and Families staff to assist them "to recognise the needs of school-age pregnant women and young mothers, enabling them to maintain their education, reach their full potential and remain as fully integrated in the education community as possible". The Council's guidance is clear, therefore, that teenage mums have the right to stay at their own school. Edinburgh does, however, like Glasgow, also have specialised provision for young parents, at the Young Mums Unit (YMU) at Wester Hailes Education Centre (WHEC). This unit was established in 1983.\textsuperscript{234}

306. The Committee was grateful for the opportunity to meet a group of young women who had benefited from the support of the YMU, in a meeting at the Parliament during the inquiry. In a similar way to the young women the Committee had met in Glasgow, many of those present spoke of how the YMU had re-engaged them with education. One of them was, at the time, going through the process of applying for university.

307. The Committee also visited Dundee, where it learned about the impressive partnership work going on between NHS Tayside and Dundee City Council and other partners. Dundee, like Edinburgh and Glasgow, had a specialised unit, located at Menzieshill High School. The Committee was able to see the excellent facilities there, to take part in one of the Health Buddies peer-education sessions and to talk to some of the young parents who were supported. Once again, the enthusiasm and confidence of the young women was clear, as was the value of the support they gained not only from the services provided at Menzieshill – including excellent nursery provision – but from each other.

308. The Committee commends the quality provision it was able to observe during these visits, as well as the much wider support that was being made available to young parents through partnership working across a range of services and organisations. There is no doubt that huge progress has been made in the level and quality of support available to young women who become pregnant during their teenage years.

309. The Committee is also fully supportive of policies that support young women to continue their engagement with education during their pregnancy and after the birth of their baby, even on a limited basis if necessary. The evidence that this is likely to lead to the best outcomes, both in terms of the economic prospects of mother and baby and the likelihood of the child itself being able to engage with education, appears convincing.

310. The Committee did not find much evidence of the specialised unit type of support outside the major cities. This may, of course, be linked to the cities having the highest levels of deprivation and the highest number of teenage pregnancies. However, the Committee wondered whether young parents, perhaps living in deprived areas outside the major cities, would experience the same level of support to enable them to remain in education. Aside from the units themselves, it was clear that a great deal of work had been done in Glasgow, Edinburgh and Dundee to develop cross-cutting, strategic policies to improve and promote sexual health amongst young

\textsuperscript{234} City of Edinburgh Council. Written submission.
people in those cities and it is likely that the units themselves, as well as being products of these policies, probably contributed significantly to their continuing development. Council areas that lack such specialised facilities are, arguably, at a disadvantage in developing such comprehensive policies and services.

311. Clearly, it would not be necessary or appropriate for every local authority in Scotland to have its own specialist support unit and, of course, there is much that can be done to support young women who become pregnant to continue their education within their own school. Nevertheless, the absence of these units in deprived areas outside the major cities would, on the face of it, appear to disadvantage young parents living in these areas.

312. While the Committee is not calling for a mass expansion of this type of service across the country (which is likely, in any case, to be unaffordable at the present time) the Committee wonders whether there is scope for collaboration between local authorities to develop joint, specialist provision across areas where it might be most needed.

313. The Committee acknowledges that strategic planning of education provision is a matter principally for local authorities. However, the Committee calls on the Scottish Government, as part of the development of a national strategy, to work with COSLA to encourage its members to consider whether there is scope for collaboration between local authorities to develop such joint provision.

**Fathers**

314. The focus of teenage pregnancy discussions invariably fall upon the mother. However, the Committee has been careful not to overlook the importance of fathers in this issue.

315. There were a number of comments in the written evidence about fathers. NHS Borders reporting that it was adopting a new antenatal parent education programme that would strengthen support for young parents, including fathers, it remarked that there was “little support and few interventions aimed at teenage fathers”.\(^{235}\) Not only did this reinforce the gender stereotype that women are responsible for childcare, NHS Borders said, but it assumes that young fathers are not involved in the life of their child. It concluded that young fathers may need support to engage with housing, health, employment and social services and if this were not offered “the health inequality gap could potentially be widened”.\(^{236}\)

316. Children 1\(^{ST}\) also made the point that teenage pregnancy should not be seen simply as an issue for girls. “It takes two to make a pregnancy and it is vital that services, support and education are directed also at boys and young men” it said in its written submission. Noting that there was peer pressure on young men to not use condoms, Children 1\(^{ST}\) suggested that boys “need to understand their responsibilities, how to resist the pressure from their peers and how to maintain

\(^{235}\) NHS Borders. Written submission.
\(^{236}\) NHS Borders. Written submission.
Research carried out in 2010 by Children 1ST and Glasgow School of Social Work showed that many young fathers felt that the pregnancy was a turning point in their life and steered them away from a negative lifestyle such as alcohol use and criminal activity. However, the research also showed that these young fathers felt marginalised and ignored by maternity services, and that there is a lack of support specifically for them. Children 1ST believed that “any policies relating to teenage pregnancies must take the fathers into account and all services dealing with parents and giving support to mothers during pregnancy should give equal recognition to men as parents”. Including men throughout the pregnancy process, Children 1ST concluded, would be “more likely to help establish some form of co-parenting and produce more positive family relationships.”

Similar points were made by the WAVE Trust, which noted that there was a problem “at both ends of the spectrum”. On the one hand, many of the men involved in the creation of a teenage pregnancy were allowed or enabled to escape responsibility for either their ineffective contraception or the consequences of pregnancy for their partner and child. On the other hand men who were keen to play an active, positive role in the pregnancy and life of their child, whether or not they remained the partner of the mother, were “too often marginalised or discouraged”. The WAVE Trust urged the Committee to “take full account of the challenges and opportunities of fathers becoming, and remaining, part of the solution” concluding that “children benefit from the presence of loving, competent fathers in their lives”.

These points were also echoed by Scotland’s Commissioner for Children and Young People (SCCYP). Citing the research carried out by Children 1ST mentioned above, the Commissioner notes that it found that young men were often ignored or portrayed negatively in public discourse and in interactions with support services. He supported a “more nuanced approach which includes portrayals of the more positive end of the spectrum, where young men are highly participative and committed as partners and or parents”.

These points were generally echoed during the Committee’s oral evidence sessions. Cath King of Highland Council told the Committee that young men had been slightly sidelined. She argued that more work was needed, “nationally and locally, to encourage young men to take nurturing roles; to a great extent, that is currently absent.”

City of Edinburgh Council, noting that its policies and guidance to schools was overwhelmingly focused on the needs of young women who become pregnant, also recognised that schools could offer similar types of support to young men who come to fatherhood at an early age. Most young men would not have planned the pregnancy, and, like the young women, would “have a range of responses and mixed emotions about their potential new role and responsibilities”.

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237 Children 1ST. Written submission.
238 Children 1ST. Written submission.
239 WAVE Trust. Written submission.
240 WAVE Trust. Written submission.
241 Scotland’s Commissioner for Children and Young People. Written submission.
which would be “more emphasised depending on if they have an on-going relationship with the young woman and if they attend the same school”. The Council suggested that authorising agreed absences to allow the young man to attend medical appointments and to be present at the birth were examples of how schools could provide support.\textsuperscript{243}

321. Marian Flynn of Glasgow City Council told the Committee—

“The committee has visited the young parents support base in Glasgow. The emphasis in the work there is on ensuring that we talk about the issue in terms of not young mothers but young parents, and we try to engage fathers from an early stage. More could definitely be done to encourage fathers to be involved, but we have found that, when they are there—as in the majority of cases that we work with at the support base—they want to be involved, although they are sometimes sidelined by a series of professionals and the emphasis is very much on the mother.”\textsuperscript{244}

322. The Committee’s visits to the Young Parents’ Support Base in Glasgow, to The Corner and Menzieshill High School in Dundee and the two informal sessions organised at the Parliament by City of Edinburgh Council and Who Cares? Scotland (which included a young father) gave a strong indication that the various partners involved in these “on the ground” services shared a pragmatic view that, where possible, it was important that fathers be given the opportunity to be as actively involved in the pregnancy and beyond, but that practical consideration meant that there were often challenges in doing so. While specialised services like those visited made efforts to engage the fathers, the traditional mainstream antenatal and maternity services sometimes found it difficult to do so in an appropriate way.

323. Carolyn Wilson, operational policy manager in the child and maternal health division of the Scottish Government, told the Committee—

“… there is a lot of evidence that the father is not involved in visits to maternity services and even in health visiting in the early days after birth. On some occasions, he is almost actively excluded from any discussions on the child’s wellbeing or, indeed, the pregnancy as it progresses....We know that fathers want to be involved, to be part of their children’s lives and to understand what they need to do to help to shape the children’s outcomes, but they lack information or support to understand the information that they are given.”\textsuperscript{245}

324. Alison Hadley, director of the teenage pregnancy knowledge exchange at the University of Bedfordshire and previously head of the UK Government teenage pregnancy unit, put it more bluntly—

“We know that midwives just do not get it right with young parents. There is something about the environment into which they receive them, and they

\textsuperscript{243} City of Edinburgh Council. Written submission.  
seem to portray a slightly judgmental approach, even though they might not want to do so. The same can be said for health visitors. They might not offer a chair to the young father, for example. There are some basic things that we need to get right in universal mainstream services that could make quite a difference. Targeted interventions for very vulnerable young people need to be overlaid on top of that.

“The danger sometimes is that we forget that we do not have in place the main building blocks for all young people in the universal system on prevention or support. We must not forget that that is the big question, so that everyone gets what they need. The targeted work is done on top of that. Otherwise, we are in danger of chasing the thing that will make the difference in the end, which I am not sure that we will ever find.”

325. The key themes in regard to fathers that emerge from the written and oral evidence and from the Committee’s visits were acknowledged by the Minister—

“There are two parts to this. There is still more work to be done on young men understanding and recognising their responsibilities around the use of contraception. At times, a lot of the focus is on young women. More work can be done to ensure that young men recognise their responsibilities in that area.

“More can also be done on working with young fathers and engaging them. There will always be challenges. For example, the support base in Glasgow takes in young mums from different parts of Glasgow. Some of them have to travel a fair distance to make use of that service—that challenge is there for young fathers as well.”

326. The Minister concluded that there was “an opportunity to consider how to improve the engagement of young fathers”. Praising FNP, which he said provided “good examples of how young fathers can be helped to engage much more effectively with their parenting roles and their responsibilities” he suggested that there was a need to build on that work that with regard to education to look at what can be done to support young fathers in retaining and maintaining their education.

327. The Committee fully accepts the evidence that teenage pregnancy is not an issue only for young women and that young men need to be helped to learn how to manage relationships appropriately and to take more responsibility for contraception and become more involved in the lives of children of whom they are the father.

328. While much of the stereotypical behaviour of young men (and, indeed all men and women) has its roots in wider, structural issues that may be difficult for health, education and other services to address, there is much that can be done through SHRE in schools and in informal and detached

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youth work to help change the attitudes of young men and raise their awareness over time. The Committee asks that the Scottish Government consider this specifically in the review of SHRE that it has asked for elsewhere in this report.

329. The Committee commends the efforts that have been made in Edinburgh, Glasgow, Dundee and elsewhere, by local authorities, NHS boards and voluntary sector partners to support young fathers and to help them maintain an involvement with their children.

330. However, the Committee found some evidence that mainstream antenatal and maternity services could be variable and were sometimes unwelcoming to young fathers, leaving them potentially vulnerable to being marginalised. Although in some areas, there may be scope for developing services specifically tailored to young people, in many parts of Scotland the numbers will not be sufficient to justify this investment, so it is essential that mainstream services are capable of providing appropriate services that are sensitive to the specific needs of young people, including fathers, and that staff involved have the necessary skills to engage in an appropriate manner. The Committee calls on the Scottish Government to consider this matter as part of the development of the national strategy. It would also be helpful if the Scottish Government would set out the general issues, in relation to the specific needs of young people, that NHS boards and their local partners should, at a minimum, take into account in planning and developing their antenatal, maternity and other services.

CONTRACEPTION AND PROVISION OF SEXUAL HEALTH SERVICES

331. Under the current policy framework, issues relating to access and provision of contraception and sexual health services are covered in the Learning and Teaching Scotland resource: reducing teenage pregnancy guidance and self-assessment tool [the Self-assessment tool]. The Self-assessment tool encourages a multi-faceted approach that combines information, education and sexual health services.

332. The Self-assessment tool promotes education programmes which focus on encouraging the delay of sexual activity, while also recognising that those who are sexually active require clear messages about contraception and access to confidential and approachable sexual health services. The Self-assessment tool suggests a number of activities to achieve this, including improving access to contraception. The Self-assessment tool also recommends involving staff who deliver sexual 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.

Views on provision of contraception
333. During the course of the Committee’s inquiry, the provision of contraception and sexual health services was discussed by many witnesses.
334. The Committee heard opposing views on whether the promotion of access to contraception should be considered a preventative measure in relation to teenage pregnancy.

335. Some witnesses claimed that access to contraception was a factor in encouraging sexual activity. Dr Alastair Noble of CARE Scotland told the Committee—

“I think the balance has tipped too far in the direction of harm reduction and assuming that teenagers will be involved in sex, which perhaps inadvertently encourages the very thing that we are trying to prevent.”  

336. CARE Scotland raised concerns that reducing teenage pregnancy rates by relying mainly on the distribution of oral and long-acting contraceptives was “a recipe for an explosion in rates of STIs”.

337. The Christian Medical Fellowship held a similar view, arguing that increasing the availability of contraception without accompanying education on the importance of saving or delaying sex might lead to more sexually transmitted infections and unplanned pregnancies rather than fewer. The Christian Medical Fellowship suggested that current government sexual health strategies for tackling teenage pregnancy were “primarily based on three false presuppositions: that contraception is safe, that youngsters will actually use it and that abstinence is impossible.”

338. In contrast Ann Eriksen stated: “Undoubtedly, more effective contraception has had an impact on reducing teenage pregnancy”.

339. Alison Hadley held a similar view and pointed to the need for a combination of good SHRE and access to contraception—

“The international evidence consistently shows that high quality comprehensive sex and relationships education, both in and outside of school, combined with easily accessible young people friendly contraception services are the key factors in reducing rates.”

340. FPA and Brook believed that a “choice of contraceptive methods with accurate information about them is vital” with women who are happy and confident with their method of contraception more likely to use it effectively.

Access to contraception in schools
341. Some of the evidence received on the provision of contraception and sexual health services during the course of the inquiry centred on which services should be provided and where they should be delivered.

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250 CARE Scotland. Written submission.
251 Christian Medical Fellowship. Written submission.
253 Alison Hadley. Written submission.
254 FPA and Brook. Written submission.
342. Several witnesses called for better access to contraception. CAIR Scotland stated in its written submission that there should be improved access, including in schools, to the C (condom) Card scheme, which makes condoms available at a range of venues to 13-24 year olds at no cost. The Royal Pharmaceutical Society also called for such schemes to be expanded where there were gaps in provision.255

343. Derek Allan, Head Teacher of Kirkcaldy High School, told the Committee that one aspect of the Kirkcaldy High School project had been the distribution of condoms to pupils. Out of a school population of approximately 1,100 pupils, 373 condoms had been distributed to females and 252 to males. He explained that condom distribution had been done appropriately without a great deal of fuss in the school.256 Whilst evidence was anecdotal, Mr Allan said that he had seen a reduction in the number of teenage pregnancies at the school in recent years.257

344. A possible barrier highlighted to the Committee regarding the provision of contraception services in school settings was the potential negative media coverage that provision could attract. Whilst Alison Hadley suggested that coverage of the issue of teenage pregnancy in the press over the last 10 years had improved, she told the Committee that if media coverage was inflammatory it could impact on the services delivered—

“Scandalous headlines affect local delivery. If a school is starting to deliver some really good sex education programmes or is setting up a school-based clinic, one bad headline like “Condoms for 11-year-olds” makes everyone very nervous, and it stops the delivery of good practice.”258

345. As well as discussion regarding the provision of condoms in schools, the Committee also received evidence calling for schools to consider delivering other forms of contraception.

346. The Scottish Sexual Health Lead Clinicians Group questioned why emergency contraception was not provided in schools, and suggested there was “timidity” on the part of government and local authorities on the issue—

“The Scottish Government is prepared to make a stand on controversial subjects like gay marriage, why does it run scared of its critics on the subject of making emergency contraception available in schools?”259

347. The Scottish Sexual Health Lead Clinicians Group called for the Scottish Government to give consideration to the availability of certain interventions in schools, particularly in rural areas and areas with higher teenage pregnancies, including the availability of emergency hormonal contraception in schools.260

255 The Royal Pharmaceutical Society. Written submission.
259 The Scottish Sexual Health Lead Clinicians Group. Written submission.
260 The Scottish Sexual Health Lead Clinicians Group. Written submission.
348. The issue of provision of emergency contraception in schools was explored with other witnesses. Marian Flynn of Glasgow City Council questioned whether young people would feel that school was the most appropriate place to access the service, with concerns regarding whether they would feel it would be confidential enough and give them the required level of anonymity.\(^\text{261}\)

349. She explained that, in Glasgow, provision involved community based health services, so that young people could have access to emergency contraception in their own area, whether through a dedicated sexual health service or pharmacy provision—

“There is a difficulty in putting all the eggs in one basket and saying that school nurses alone will deliver the service. There must be a range of forms of delivery so that young people feel comfortable approaching services.”\(^\text{262}\)

350. Sally Egan of NHS Lothian also suggested that there was a need for contraception provision and sexual health advice to be provided in other settings—

“… many children do not want to do these things in school; they would rather go somewhere else, as long as it is easily accessible.”\(^\text{263}\)

351. Robert Naylor of Renfrewshire Council raised the point that, in addition to general questions about whether pupils would want emergency contraception provided in schools, particular consideration would need to be given to the proposal in relation to denominational schools. He also argued that there would be a need for a significant reconsideration of the allocation of health resources to provide the school nurse service that would be needed to deliver such a service in schools.\(^\text{264}\)

352. Cath King of Highland Council questioned whether distribution of emergency contraception sat within the school nurse’s role or whether their role was signposting services and giving confidential advice to young people.\(^\text{265}\)

School nurse

353. Discussion of the role of the school nurse also took place in the wider context of school nurses’ role in the provision of sexual health services and whether there was scope for that role to be further enhanced.

354. The RCN stated that the role of the school nurse was “key to reducing the rate of teenage pregnancy by enabling teenagers to make positive and informed decisions about their lives.”\(^\text{266}\)

355. The Committee learned that school nurses had played a central role in the Kirkcaldy High School project. Derek Allan told the Committee that “having an


\(^{266}\) RCN. Written submission.
effective school nurse service working in partnership with the education people is key to tackling the issue.\textsuperscript{267} The school nurses had been “very proactive” in supporting teaching staff in delivering SRE and had also provided a health drop-in service with assistance to access specialist services where needed.\textsuperscript{268}

356. The Committee heard that there may be limited capacity for school nurses to take on additional roles in relation to sexual health and contraception provision.

357. Cath King of Highland Council told the Committee that school nurses were under competing demands—

“The tension is between their health improvement role, their immunisation role and child protection – there are a whole raft of things there, and an increasing number of things to consider.”\textsuperscript{269}

358. Sally Egan of NHS Lothian noted that school nurses were taking on increased responsibility in providing child immunisation programmes in schools, concluding that it would “therefore be difficult for our school nurses to take on much more.”\textsuperscript{270}

359. Robert Naylor of Renfrewshire Council also stated that school nurses were charged with a great many activities, only one of which related to teenage pregnancy. He suggested that in relation to school nurses the “resource is limited”.\textsuperscript{271}

360. The Committee also received evidence that school nurses were not always available on site and the structure of provision of school nurses across the country varied. Whilst practice in NHS Fife and NHS Highland and Highland Council was to have a school nurse assigned to every secondary school in their areas.\textsuperscript{272} Sally Egan explained that, in NHS Lothian, school nurses tended to be based in drop-in centres because they covered more than one school.\textsuperscript{273}

Sexual health service provision out with school – drop-in centres and sexual health clinics

361. A recurring theme during the course of the Committee’s consideration of access to contraception and the provision of sexual health services was the need for choice with regard to where and how services were provided and ensuring that all services were tailored to the needs of young people.

362. Jane Hughes of Brook told the Committee—

\begin{footnotes}
\item[268] Fife Health and Wellbeing Alliance. Written submission.
\end{footnotes}
“... young people have different views, so what they need is choice. Therefore, as well as services that are provided in schools and colleges, there is a need for services out in the community.”

363. She went on to emphasise the importance of ensuring these services were well-publicised and appropriate for young people to feel comfortable to access. Jane Hughes explained that, to ensure the services Brook provided were tailored to young people, they consulted them for their views when a new service was set up. She told the Committee “it is really important that the young people are given a voice”.

364. Professor Lawrie Elliot of Edinburgh Napier University also felt it was important that sexual health services were “more youth friendly”.

365. Bryan Kirkaldy of Fife Council explained that, in its targeted schools in Fife, the drop-in services were provided near the school, in a community centre. He emphasised that engagement with young people along with their parents in the provision of these services had been key—

“We listen to what young people say about what they would find accessible, and we listen to what staff and parents say about what they would find acceptable. That means that we have a range of sources of advice and support.”

366. Dr Lorna Watson of NHS Fife told the Committee that accessible drop-in services for young people were important. The advice offered was often not solely about sexual health but about a range of advice services for young people. She explained that great efforts were made to make services “accessible” and “confidential” and, as far as possible, the services tried to ensure that young people could visit them without feeling any “stigma”.

367. The issue of stigma in relation to accessing sexual health services was also raised by Alison Hadley. She told the Committee people found it difficult to go to a sexual health clinic—

“There is a particular issue around sex in Britain. We do not find it easy to talk about things. Young people still say that it feels stigmatising to go and ask for sexual health advice and that they are not sure whether they should do that. Sometimes, they say that they do not go to services because they are not sure whether they will be judged for doing that.”

368. The Committee received evidence of services that sought to address concerns regarding stigma. One such drop-in service visited by the Committee was the Corner. It was established by Dundee City Council in response to

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research that showed that young people in Dundee wanted a drop-in, city-centre facility where they could get confidential information and advice.

369. The Committee also saw a good practice example in Oldham, at the Positive Steps Centre. The Centre provided a number of services co-located at the hub, which acts as a central point for careers advice, health advice and social work support in Oldham town centre for people under the age of 21. As the centre is a hub for various services, visiting the building does not hold any stigma for a young person wishing to access sexual health services.

370. Another issue raised in relation access to services was ensuring access in rural areas. NHS Highland and Highland Council stated—

“... for many young people – particularly those living in rural areas – service provision is patchy. There are particular access difficulties for young people who are bussed to school.”

371. NHS Highland and Highland Council explained that they had sought to mitigate this issue through the NHS contract with Brook’s Inverness based service, which provides three after-school sessions a week and a 12-3pm session on Saturdays, timed to coincide with bus timetables. This service promoted accessibility for almost every young person in north Highland who required the service.

372. NHS Highland and Highland Council also raised the importance of seeking to ensure their services were accessible, in particular, to those young people in lower socio-economic groups. Brook had been tasked with increasing rates of attendance by young people in the lower SIMD quintiles and other marginalised groups, for example, young people with learning disabilities.

373. In evidence to the Committee, the Minister for Public Health explained that a key part of the Scottish Government’s work had been to look at how it could provide advice services outwith schools that could be utilised by school-age pupils—

“Part of the challenge will be to ensure that, when a young person needs advice and information, it is provided in the way that is most appropriate to them.”

374. He told the Committee that because most school nurses were not in school all the time, it was important to ensure that young people had access to advice from a school nurse even if the school nurse was not in the school. He also mentioned education provision, physical service provision and related support services.

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280 NHS Highland and Highland Council. Written submission.
281 NHS Highland and Highland Council. Written submission.
282 NHS Highland and Highland Council. Written submission.
375. He explained that a number of health boards had taken forward this work in partnership with local authorities and had developed drop-in facilities. He made specific reference to the approach taken in Fife and said that there had been improved uptake and access to the services in this area.\textsuperscript{285}

376. The Committee believes that access to contraception has an important part to play in preventing teenage pregnancies. The Committee recognises that the complexity of the issue of teenage pregnancy means that provision of contraception is not, in itself, the whole solution. However, high quality, comprehensive sexual health and relationships education (SHRE) combined with easily accessible young people-friendly contraception services are key elements in the drive to reduce rates of teenage pregnancy.

377. The Committee believes that it is essential that young people be consulted and their views be taken into account in planning and developing contraception services, and indeed all sexual health services, that are primarily aimed at young people.

378. The Committee believes that schemes such as the C Card Scheme, which makes condoms available at a range of venues to 13-24 year olds at no cost, make an important contribution to ensuring contraception is easily accessible to young people.

379. As mentioned earlier in the report, the Committee recognises that responsibility for determining the nature of the provision of these services in schools lies with the local authority and head teacher. The Committee notes other approaches being taken in the school setting, such as the Kirkcaldy High School project, which includes distribution of condoms to young people in school. There is potential for other schools to adopt similar schemes to the Kirkcaldy one, should it be appropriate in the local circumstances.

380. The Committee notes that one of the potential barriers for schools to provide new and enhanced sexual health services and contraception provision is concern about a potentially negative response in the community and in media coverage. In order to avoid this as far as possible, it is essential to ensure that, where new services are provided, communication with pupils, parents and the wider community about the reasons for the development of the provision is carefully and sensitively managed.

381. Elsewhere in the report, the Committee indicates that it would be helpful for the Scottish Government to issue guidance to local authorities and other local partners in relation to the development of a local strategy, drawing on existing good practice. Clearly, it would be useful for such guidance to examine the issues surrounding the provision of contraception and sexual advice services in schools.

382. The Committee notes the call by the Scottish Sexual Health Lead Clinicians Group for consideration to be given to the provision of emergency hormonal contraception in schools, particularly in rural areas where it may be difficult to access other sexual health services, and in areas with higher teenage pregnancy rates.

383. The Committee believes however that there are several potential problems with this suggestion. First, the Committee recognises that there are concerns that young people may not feel school is the most appropriate place to receive emergency contraception due to concerns regarding confidentiality and anonymity. Second, although the Committee acknowledges that school nurses can play a key role in giving advice and support to young people about sexual health matters, but in relation to the provision of emergency contraception it believes that school nurses are unlikely to have the capacity to take on this additional role. There would probably need to be a significant reconsideration of the allocation of health resources, at least in some areas, to provide the school nurse service that would be needed to deliver it. At present, the provision of sexual health advice is just one aspect of a school nurse’s role and many are not always available on site due to being based in drop-in centres covering more than one school. Third, there are likely to be insurmountable issues that would prevent such services being made available in RC schools. Finally, the potential for parental unease and negative media coverage is extremely high.

384. The Committee therefore does not, at present, support the call for schools to provide emergency hormonal contraception.

385. The Committee believes that focus should primarily be placed on improving access to emergency contraception through specialised drop-in youth services.

386. The Committee heard of a number of positive examples of such services including The Corner in Dundee. The Committee also saw the positive benefits of the co-location of resources at Positive Steps in Oldham. The strength of these services is that they are tailored to young people and are delivering services where and when they are required. Co-locating such resources with a range of other services removes the stigma that might be created were they to be provided in school.

Community pharmacists

387. In addition to consideration of the possibility of contraception and sexual health services in schools and drop in centres, the Committee also received evidence which emphasised the role of community pharmacists.

388. The Royal Pharmaceutical Society said in its written submission that the ease of access and wide availability of pharmacy services meant that pharmacists
and community pharmacies played an essential role in providing access to sexual health services and contraception.\textsuperscript{286}

389. The National Pharmacy Association stated—

“Community pharmacy services have contributed to the consistent decline in teenage pregnancies and may have had an impact on the reducing abortion figures in Scotland.”\textsuperscript{287}

390. A call was made by Community Pharmacy Scotland, Royal Pharmaceutical Society and the National Pharmacy Association for an enhanced role for community pharmacists in the provision of contraception.

391. The Royal Pharmaceutical Society believed—

“… it is now time to consider the expansion of pharmacist prescribing in this area, building on some of the successful local initiatives addressing particular local needs in collaboration with local sexual health clinics”.\textsuperscript{288}

392. Community Pharmacy Scotland argued that an enhanced role would lead to improved integration of community pharmacy in the wider sexual health primary care team and would support current policy direction.\textsuperscript{289}

393. The Royal Pharmaceutical Society stated that widening access to oral and long-acting reversible forms of contraception via community pharmacies could have a significant impact on teenage pregnancy, abortion and repeated use of Emergency Hormonal Contraception.\textsuperscript{290}

394. The National Pharmacy Association explained that of all the primary care health professional sites, pharmacies most closely matched the distribution of deprivation—

“Pharmacists are the most accessible healthcare professionals with the clinical skills and existing service experience to facilitate targeting the relationship between teenage pregnancy and socio-economic inequality.”\textsuperscript{291}

395. Community Pharmacy Scotland proposed three key areas of possible service development for community pharmacies—

- adoption of Ulipristal as first line emergency contraceptive of choice;
- introduction of a short term supply of oral contraception from local community pharmacies to facilitate formal signposting of patients into contraceptive services; and,
- introduction of the availability of long term contraception from community pharmacies.\textsuperscript{292}

\textsuperscript{286} Royal Pharmaceutical Society. Written submission.
\textsuperscript{287} The National Pharmacy Association. Written submission.
\textsuperscript{288} Royal Pharmaceutical Society. Written submission.
\textsuperscript{289} Community Pharmacy Scotland. Written submission.
\textsuperscript{290} The Royal Pharmaceutical Society. Written submission.
\textsuperscript{291} The National Pharmacy Association. Written submission.
396. In relation to the specific call for the introduction of a short term supply of oral contraception, Community Pharmacy Scotland argued that patients who present for emergency contraception should be offered suitable support beyond signposting—

“This service if adopted across Scotland supports moving the current service provision into a more proactive service and will reduce the need for patients to return to community pharmacy to receive further supplies of emergency contraception.”

397. The Minister for Public Health told the Committee that he had “not yet come to a fixed position on community pharmacies and the provision of contraception over the counter.”

398. He explained to the Committee that it was not a case of saying that pharmacies did not have a role, but of recognising the wider issues that apply to a young person who is considering using oral contraception. He suggested that, in some cases, there may be an argument that a general practitioner or a doctor in a sexual health clinic should discuss those issues with the young person—

“We would have to be careful about changing how that type of service is delivered, given the other possible consequences of young people being sexually active. We need to address all the issues rather than just a specific aspect.”

399. With regard to the adoption of Ulipristal as the first line emergency contraceptive of choice, the Royal Pharmaceutical Society Scotland explained that it was a new form of emergency hormonal contraceptive that was effective for a longer period of time following unprotected sex than emergency contraception in current use. It could be taken up to 120 hours after intercourse and “could be added to the Patient Group Direction for emergency contraception to provide even better protection for high risk teenagers.”

400. In response to this call, the Minister explained that Ulipristal was currently only available on prescription as there were regulatory restrictions placed on its use.

401. Following the Committee meeting, correspondence between HRA Pharma and the Scottish Government explained that the Black Triangle Status of Ulipristral acetate (ellaOne) had been lifted in November 2012.

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292 Community Pharmacy Scotland. Written submission.
293 Community Pharmacy Scotland. Written submission.
296 The Royal Pharmaceutical Society Scotland. Written submission.
298 This indicates that a medication is new to the market and highlights the need for any Adverse Drug Reactions to be reported.
402. In correspondence from the Scottish Government to HRA Pharma on 18 April 2013, the Scottish Government stated that it was currently considering the use of Ulipristral with officials and appropriate stakeholders.\textsuperscript{299}

403. The ease of access and wide availability of pharmacy service means that they make a key contribution to the provision of sexual health services and contraception.

404. The Committee recognises that, with over twice as many pharmacies being in the most deprived areas, they are physically well placed to target the relationship between teenage pregnancy and socio-economic inequality.

405. The Committee notes the calls made by pharmacy representative bodies for an enhanced role in the provision of contraception.

406. The Committee believes that making contraception more widely available and accessible is an important element in tackling teenage pregnancy. However, there is a balance to be struck between improving access to contraception and providing the appropriate advice and information to young people who are considering embarking on a sexual relationship. In such cases, there may be choices to be made about the most appropriate form of contraception and it might be arguable that these choices might be best be explored by consulting a GP or sexual health specialist doctor.

407. The Committee therefore calls on the Scottish Government, as part of the emerging strategy that the Committee has called for, to examine the possibility of extending the role of community pharmacies in the provision of contraception, with a view to striking an appropriate balance between maximising ease of access to contraception and the provision of the required information and advice to enable young people to make the most appropriate choices for them. The Committee notes that a review of community pharmacy provision is due shortly; this may provide an opportunity to explore such possibilities in detail.

408. The Committee notes that emergency contraception that is effective for longer could have a potential impact on reducing unwanted pregnancies if it was more widely available and accessible. The Committee therefore requests an update from the Scottish Government on its consideration of the use of Ulipristral, and, in particular, what it can do to improve access to emergency contraception that is effective for a longer period than most of that currently in use in Scotland.

\textit{Long-acting reversible contraception}

409. The Committee received several submissions calling for the further promotion of LARC services. Felicity Sung of the Scottish Government told the

\textsuperscript{299} HRA Pharma. Written submission.
Committee that it was a method of contraception that could be effective in reducing unintended pregnancy.\(^{300}\)

410. The Committee learnt from Sally Egan of NHS Lothian that its maternity in-patient service at the Simpson hospital had just introduced the opportunity for its most vulnerable mothers who have delivered to have long-acting reversible contraception before they leave hospital.\(^{301}\)

411. BMA Scotland pointed out that health boards could contract with GPs to provide long-acting, reversible contraception services. The BMA considered that this could be particularly valuable in rural areas, where family planning services were not available.\(^{302}\)

412. The Committee notes NHS Lothian’s initiative to offer LARC to the most vulnerable young people who have delivered babies in its hospitals. Given the high risk that has been identified of young women who have babies at an early age having a second conception within a short period of time, this appears to potentially be an important initiative. The Committee asks the Scottish Government to monitor the impact of this initiative.

413. The Committee also asks the Scottish Government to consider whether more can be done to promote more widespread use of LARC, particularly amongst more vulnerable young people and those with chaotic lifestyles, after their first unplanned pregnancy, who would, on the face of it, appear to be most vulnerable to user error in relation to other, conventional contraception.

FAMILY NURSE PARTNERSHIPS

414. The Family Nurse Partnership (FNP) is a voluntary programme for young, first time mothers. It offers intensive and structured home visiting delivered by specially trained nurses (family nurses) from early pregnancy (before 28 weeks) until the child is two. The FNP aims to improve pregnancy outcomes, child health and development and the mother’s economic self-sufficiency.

415. The FNP is a licensed programme developed in the USA over thirty years ago. It has been tested in England since 2007.

416. In Scotland, the FNP programme is currently being delivered in six NHS Board areas – Lothian, Tayside, Fife, Greater Glasgow and Clyde, Ayrshire and Arran and Highland. NHS Lanarkshire is due to begin implementing the programme during the course of 2013.\(^{303}\) National roll-out is due to be completed in 2015.\(^{304}\)


\(^{302}\) BMA Scotland. Written submission.

\(^{303}\) Scottish Government.(March 2013) *Family Nurse Partnership Programme*. Available at: [http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership](http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership) [Accessed 1 May 2013]

Benefits of FNP

417. The Committee received evidence that the FNP delivered a positive difference for young parents and their children.

418. Alison Hadley explained that over 30 years of rigorous research in the USA had shown that there were significant benefits of the FNP programme for vulnerable young families in the short, medium and long term across a range of outcomes. Benefits included:

- improved early language development, school readiness and academic achievement;
- improvements in antenatal health;
- reductions in children’s injuries, neglect and abuse;
- improved parenting practices and behaviour;
- fewer subsequent pregnancies and greater intervals between births;
- increased maternal employment and reduced welfare use;
- increases in fathers’ involvement; and,
- reduced arrests and criminal behaviour for both children and mothers.

419. Carolyn Wilson of the Scottish Government told the Committee that it was expected that similar outcomes would be achieved in Scotland, as the FNP model had been implemented according to the requirements of the programme across the Scottish sites. She believed that it would probably be two to three years before the programme could be assessed to determine whether it was delivering the same outcomes as it had in America, but the initial findings from the NHS Lothian pilot had been positive.

420. Sally Egan of NHS Lothian explained that there were some small signs the programme was having an impact on increasing rates of breastfeeding in young mums and ensuring young people were maintaining tenancies that they might not have been able to maintain previously, as a result of receiving better support through the FNP.

421. NHS Tayside believed that the introduction of the FNP in its area had “dramatically improved the support for young parents”.

422. Sir Harry Burns, Chief Medical Officer, told the Committee that the FNP was a resource to be valued and spoke of the support provided by family nurses leading to mothers carrying on with their education and moving on to employment—

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305 Alison Hadley. Written submission.
309 NHS Tayside. Written submission.
“... there is no doubt in my mind that supporting pregnant teenage girls through their pregnancy and the first year or two of the baby’s life transforms the lives of both the baby and the mother.”

423. This view was supported by evidence from a young mum from the Young Mums’ Unit based at Wester Hailes Education Centre, who spoke very highly of her experience of being supported by a family nurse. She told members that the support she had received from her family nurse had made a real difference to ensuring the father of her child had remained involved in their daughter’s life.

424. The Minister also emphasised to the Committee the positive role of FNP in providing practical advice and information to make immediate differences to young mothers and their children. The Minister told the Committee that the FNP could address some of the long-term issues that could arise from young parenthood. He suggested that the programme had an important role to play in tackling wider health inequalities issues—

“There is evidence that, if a family nurse partnership supports a young mum in their parenting role and in preparing the child for education, which is part of the partnership’s role, that can have a long-term benefit for both the parent and the child. That long-term future health benefit relates the approach that we need to take to deal with some of the long-standing health inequalities that we face.”

Possible limitations of FNP

Targeted support

425. While witnesses spoke highly of the support those in the FNP received, some witnesses suggested there were limitations to the programme. Fife Gingerbread stated the FNP was “prescriptive, costly and has a restricted access window”.

426. The Committee received some evidence noting the programme had limitations when it came to targeting support at particular individuals. Marian Flynn of Glasgow City Council told the Committee—

“... the FNP is not a targeted resource. It does not identify the young people with the greatest need but is just open to young parents.”

427. Carolyn Wilson of the Scottish Government, however, felt that the FNP had the potential to reach the most vulnerable people as at least 75 per cent of teenage mothers were in the first two deprivation quintiles.

Uptake

428. Carolyn Wilson told the Committee that there was a 75 per cent uptake in Tayside and 80 per cent in Lothian of those women who were eligible who chose


\[312\] Fife Gingerbread. Written submission.


to engage in the programme.\textsuperscript{315} She explained that for those not engaging in the programme, FNP had good links with universal services, such as maternity and health visiting services, so young women could continue to be supported in an effective way.\textsuperscript{316}

429. The Committee sought assurances from the Scottish Government that those choosing to use the service were the ones who needed it the most. Carolyn Wilson told the Committee that the women were self-selecting—

“Those who are in most need and appear most vulnerable on paper are those who are most likely to engage in the programme and will benefit most from it. The ones who are least likely to engage in the programme could well have a wider support network available, as they come from more affluent families, although they themselves are unlikely to have a high level of income, in common with most teenage parents.”\textsuperscript{317}

430. Whilst the Committee received evidence that the majority of the women on the FNP lived within a low income base, Sally Egan of NHS Lothian suggested that deprivation was not the only factor which placed young people as being the most in need of the FNP.\textsuperscript{318}

431. She told the Committee that providing a service open to young women, regardless of their level of deprivation, meant that young people who were high risk for other reasons could be reached—

“I know of two girls in the FNP who came from very affluent backgrounds, but whose vulnerabilities were probably tenfold those of most of the kids on the programme. That is why we should not make assumptions. We should not assume that everything in the garden is rosy because somebody lives in a nice neighbourhood and their parents drive two cars. The person has still had an unplanned pregnancy and still perhaps needs support, and there may be other factors around them.”\textsuperscript{319}

Accessibility of service

432. Dr Maggie Watts of NHS Ayrshire and Arran told the Committee that under 16s were much more likely to conceal a pregnancy and present late.\textsuperscript{320} The Committee explored with officials from the Scottish Government concern that this could result in the most vulnerable women not being selected for the programme, as they presented after 28 weeks’ gestation, which is the deadline for participation.

433. Carolyn Wilson of the Scottish Government told the Committee that the Scottish Government did not have the ability to change this criterion under the licence for the programme. In addition she commented that evidence showed that

engagement needed to take place by 28 weeks’ gestation for participants to benefit from the programme.\textsuperscript{321}

434. Alison Hadley highlighted that another criterion for qualification for access to the FNP was that it was for first-time mums only.\textsuperscript{322} As discussed earlier in the report, there is evidence that many young women who conceive in their teens go on to conceive a second time relatively quickly. There were some concerns, therefore, that the FNP criteria may potentially excluding a group who may be in need of the service, but not eligible.

435. The Committee also received some evidence that some young women who were eligible for the FNP were not necessarily in receipt of it. The service was not yet available across all of Scotland and, where available, finite resources limited access. Marian Flynn of Glasgow City Council told the Committee that “the programme is limited because it works on a quota basis” with a finite number of nurses being able to carry only a certain case load.\textsuperscript{323}

436. The Minister told the Committee that, by the end of 2013, around a third of young people eligible for the programme would have access. He also stated that national roll-out should be completed in 2015.\textsuperscript{324}

\textbf{Costs and resources}

437. Issues were also raised regarding the costs and resources involved in the FNP.

438. The cost of the FNP per client, per year is around £3,000.\textsuperscript{325} Carolyn Wilson explained that whether this was considered expensive depended on how other potential cost savings were viewed—

“The costs of a special care unit for a baby who is delivered early, of care if a child is given up for adoption and of a range of health and education services all mount up and can be balanced and offset against the FNP’s cost.”\textsuperscript{326}

439. She told the Committee that if the FNP were to be offered to every eligible woman in Scotland, approximately 360 nurses would be needed. Slightly more than 50 per cent of the nurses came from generic case-holding health visitor backgrounds.\textsuperscript{327}

440. She explained that the Scottish Government was working closely with its nursing directorate and workforce planning officials to consider how the workforce

could be sustained and developed without having a significant impact on universal services.\textsuperscript{328}—

“...the evidence so far in the areas in which we have implemented the FNP is that it has not had an impact on the universal health visiting service. Either posts have been replaced or services have been reshaped to take account of the reduction in the number of generic health visitors. As I said, we will take cognisance of the impact. We will not move forward with a programme that is going to have a very detrimental effect on the wider health visiting services.\textsuperscript{329}

441. Sally Egan explained that NHS Lothian would shortly be recruiting a second team of nurses for the FNP. She told the Committee that if the successful candidates were to come from health visiting, it would have an impact, as the “public health nursing workforce is very vulnerable”. She felt this would need to be carefully managed.\textsuperscript{330}

442. When asked whether these concerns were a workforce management issue or a resource issues she responded “it is a resource issue at the moment because the people need to be trained”, explaining that health visitors require further qualifications compared to those training to become a family nurse.\textsuperscript{331}

443. Sally Egan added—

“As important as workforce planning is, the fact is that Scotland might not have the human resources to fill all the posts that become vacant.”\textsuperscript{332}

444. In addition to concerns about the potential impact of the provision of the FNP on the delivery of statutory services, it was also suggested that FNP may be having an impact on the provision of non-statutory services. Action for Sick Children Scotland told the Committee—

“We have found that since the implementation of the FNP some young mothers’ groups such as Baby Bumps and Young Mums To Be, which had been previously available to support young mothers no longer meet in Tayside. There is a view that young mothers who are under the care of the FNP find it difficult to commit to any more groups even though these would have positive benefits in terms of peer support, reducing isolation experienced by young parents.”\textsuperscript{333}

445. The Committee notes the evidence that the Family Nurse Partnership (FNP) has the potential to be a highly valuable resource. The outcome-focused, evidence based approach has been shown to be able to transform the lives of young parents and their children. The Committee is encouraged by the positive indicators already seen in the Scottish pilots that the

\textsuperscript{333} Action for Sick Children Scotland. Written submission.
programme has the potential to address some of the underlying issues which link teenage pregnancy with poorer outcomes for both parent(s) and child. The Committee supports the Scottish Government’s commitment to roll the programme out nationwide by 2015 and looks forward to an evaluation of the impact of the programme in due course.

446. Not all teenage mums access the FNP. This can be because they choose not to take it up, do not qualify because they present after 28 weeks gestation, already have a child or because the programme has not yet been rolled out in their area. There is, therefore, the potential for some of the most vulnerable young people not to have the opportunity to benefit from engagement with FNP for a number of reasons.

447. It is vitally important that in the case of young people who do not receive this intensive support through FNP, other options should exist to enable them to receive the support most appropriate to their needs. The Committee therefore calls on the Scottish Government, as the roll-out of FNP progresses, to assess the impact of the programme on an ongoing basis, but at the same time to monitor the take-up of FNP and the support received by those who are not eligible.

448. The Committee notes the evidence it received that there was a workforce planning issue, with the recruitment of family nurses potentially having a detrimental impact on health visitor provision. The Committee believes that it is important that, as far as possible, FNP does not affect the provision of universal services, though it is recognised that movements and trends are inevitable with large workforces and, to some extent, have to be managed in the best way possible at the time. The Committee acknowledged the work that is going on with the nursing directorate and workforce planning but also calls on the Scottish Government to explain, in its response to this report, what steps it will take to minimise any wider workforce impacts brought about by the roll-out of FNP on universal services.

449. The Committee notes the view that there may also be a possible risk that provision of FNP may have an impact on voluntary sector provision of services which support young mums. The voluntary sector provides vital support services which can often reach individuals who choose not to engage in other forms of statutory provision. The Committee seeks assurance from the Scottish Government that the FNP will recognise the complementary role for the voluntary sector in supporting young people and monitor the impact of FNP on these services.
ANNEXE A: REMIT AND QUESTIONS ASKED IN THE CALL FOR EVIDENCE

The remit of the Committee’s inquiry sought to address the following two key strands—

- to assess whether the action being taken in Scotland is sufficient to bring about real and sustained reductions in unplanned teenage pregnancy.
- to explore with witnesses what further action may be required to ensure that those young people at risk of pregnancy at a young age, or who have a baby when they are very young, are able to gain access to appropriate support and services

The questions asked in the call for evidence were—

- Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?
- Do you have any views on the action being taken at the local level by health boards, local authorities and other relevant organisations to reduce teenage pregnancy, particularly in the under 16 age group?
- What are your views on the relationship between high levels of teenage pregnancy and socio-economic inequality?
- 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?
- What are your views on the current support services available to young parents / young mothers, e.g. range of services, focus of services and whether services are being delivered in the most appropriate settings?
- Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice with regard to reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?
- 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?
- Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?
ANNEXE B: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE

35th Meeting, 2012 (Session 4)
Tuesday 18 December 2012

1. **Decision on taking business in private**: The Committee agreed to consider items 4 and 5 in private.

4. **Approach to inquiry into teenage pregnancy**: The Committee considered and agreed its approach to the inquiry.

2nd Meeting, 2013 (Session 4)
Tuesday 22 January 2013

**Inquiry into teenage pregnancy**: The Committee took evidence from—

Ann Eriksen, Executive Lead – Sexual Health and Blood Borne Virus, NHS Tayside;

Nicky Coia, Principal Health Improvement Officer (Sexual Health), NHS Greater Glasgow and Clyde;

Gareth Brown, Head of Blood, Organ Donation and Sexual Health Team, and Felicity Sung, National Co-ordinator: Sexual Health and HIV, Scottish Government;

Dr Maggie Watts, Consultant in Public Health Medicine, NHS Ayrshire and Arran;

Dr Lorna Watson, Consultant in Public Health Medicine, NHS Fife.

**Inquiry into teenage pregnancy - witness expenses**: The Committee agreed to delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses in the inquiry.

5th Meeting, 2013 (Session 4)
Tuesday 19 February 2013

**Inquiry into teenage pregnancy**: The Committee took evidence from—

Tracey Stewart, Quality Improvement Officer – Education Department, Dundee City Council;

Robert Naylor, Director of Education and Leisure Services, Renfrewshire Council;
Marian Flynn, Strategic Manager – Young People’s Sexual Health, Social Work Services, Glasgow City Council;

Bryan Kirkaldy, Head of Service, and Derek Allan, Headteacher, Kirkcaldy High School, Fife Council Education and Learning Service;

Cath King, Health Improvement Policy Manager, Highland Council;

and then from—

Sally Egan, Associate Director – Child Health Commissioner, NHS Lothian;

Carolyn Wilson, Operational Policy Manager, Child and Maternal Health Division, Scottish Government.

6th Meeting, 2013 (Session 4)

Tuesday 26 February 2013

Inquiry into teenage pregnancy evidence session The Committee took evidence from—

Denny Ford, Corporate Parenting Officer, Who Cares? Scotland;

Anne Houston, Chief Executive, CHILDREN 1st;

Lucy Morton, Service Manager, NSPCC Scotland;

Terri Ryland, Practice Development Director, Family Planning Association;

Jane Hughes, Deputy Chief Executive, Brook;

Dr Jonathan Sher, Scotland Director, WAVE Trust;

Dr Alastair Noble, Education Officer, CARE for Scotland;

Joanne Milligan, Support Team Leader, Fife Gingerbread;

Alison Hadley, Director, Teenage Pregnancy Knowledge Exchange, University of Bedfordshire. Previously Head of the UK Government Teenage Pregnancy Unit;

Paul Bradshaw, Senior Research Director, ScotCen Social Research;

Professor Lawrie Elliott, Research Professor, Edinburgh Napier University.
7th Meeting, 2013 (Session 4)
Tuesday 5 March 2013

Inquiry into teenage pregnancy: The Committee took evidence from—
Michael Matheson, Minister for Public Health, Scottish Government.

15th Meeting, 2013 (Session 4)
Tuesday 14 May 2013

Inquiry into teenage pregnancy (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its next meeting.

18th Meeting, 2013 (Session 4)
Tuesday 4 June 2013

Inquiry into teenage pregnancy (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its next meeting.

19th Meeting, 2013 (Session 4)
Tuesday 11 June 2013

Inquiry into teenage pregnancy (in private): The Committee considered and agreed a draft report on its inquiry into teenage pregnancy.
ANNEXE C: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

2nd Meeting, 2013 (Session 4) Tuesday 22 January 2013

Written Evidence

NHS Tayside
NHS Greater Glasgow and Clyde
NHS Ayrshire and Arran

Oral Evidence

NHS Tayside
NHS Greater Glasgow and Clyde
Scottish Government
NHS Ayrshire and Arran
NHS Fife

5th Meeting, 2013 (Session 4) Tuesday 19 February 2013

Written Evidence

Glasgow City Council
Highland Council
NHS Lothian
Fife Health and Wellbeing Alliance

Oral Evidence

Dundee City Council
Renfrewshire Council
Glasgow City Council
Fife Council Education and Learning Service
Highland Council
NHS Lothian
Scottish Government

6th Meeting, 2013 (Session 4) Tuesday 26 February 2013

Written Evidence

Who Cares? Scotland
CHILDREN 1st
NSPCC Scotland
Family Planning Association
Brook
WAVE Trust
CARE for Scotland
Fife Gingerbread
Fife Gingerbread - Teens Response
Fife Gingerbread - Gallatow Teens Response
Teenage Pregnancy Knowledge Exchange, University of Bedfordshire;
ScotCen Social Research;
Edinburgh Napier University.

Oral Evidence
Who Cares? Scotland
CHILDREN 1st
NSPCC Scotland
Family Planning Association
Brook
WAVE Trust
CARE for Scotland
Fife Gingerbread
Teenage Pregnancy Knowledge Exchange, University of Bedfordshire
ScotCen Social Research
Edinburgh Napier University

Supplementary Written Evidence

Teenage Pregnancy Knowledge Exchange
Teenage Pregnancy Knowledge Exchange

7th Meeting, 2013 (Session 4) Tuesday 5 March 2013

Written Evidence

Oral Evidence
Scottish Government
ANNEXE D: LIST OF OTHER WRITTEN EVIDENCE

Mary Ainsworth (Individual)  
Alison M Gardner (Individual)  
Highland Children's Forum  
Consilient Health  
The Scottish Sexual Health Lead Clinicians Group  
Donald Coid Consultants  
Lisa Milner-Smith (Individual)  
North Ayrshire Council - Focus Groups for Teenage Pregnancy  
Rape Crisis Scotland  
Christian Medical Fellowship  
BMA Scotland  
CAIR Scotland Ltd  
NHS Borders  
Caledonia Youth  
NHS Forth Valley  
West Lothian Community Health and Care Partnership  
Action for Sick Children Scotland  
S W Shaw (Individual)  
Western Isles NHS & Local Authority (CNES)  
Action for Children  
Community Pharmacy Scotland  
Centre for Excellence for Looked after Children in Scotland  
South Lanarkshire Council  
University of Edinburgh  
Scotland's Commissioner for Children and Young People  
National Pharmacy Association  
Lanarkshire Sexual Health Strategy Group  
Angus Council  
Royal College of Nursing  
Sex Education Forum  
YWCA Scotland  
Scottish Sexual Health Promotion Specialists Group  
Sexual Health and Blood Borne Virus Executive Leads Network  
NHS Grampian  
Royal Pharmaceutical Society in Scotland  
Healthy Respect Lothian  
Zero Tolerance  
HRA Pharma Submission 1  
HRA Pharma Submission 2  
HRA Pharma Submission 3  
Young Mums Group, Citadel Youth Centre  
SPUC Scotland  
Royal College of Midwives Scotland  
Scottish Trades Union Congress  
Glasgow Pregnancy Crisis Centre  
City of Edinburgh Council  
NHS Dumfries and Galloway - Dumfries and Galloway Council  
HIV Scotland and Hepatitis Scotland
Action for Sick Children Scotland
Health Scotland
One Parent Families Scotland
One Parent Families Scotland - Teen Parent Peer Mentoring Service
One Parent Families Scotland - Peer Mentoring Service
Desmond Ryan (Individual)
Children in Scotland
Comhairle nan Eilean Siar and NHS Western Isles
Professor Roger Ingham
Correspondence Between Scottish Catholic Education Service and NHS Greater Glasgow and Clyde Health Board
ANNEXE E: NOTE OF VISITS TO THE CORNER AND MENZIESHILL HIGH SCHOOL, DUNDEE; YOUNG PARENTS' SUPPORT BASE SMITHYCROFT SECONDARY SCHOOL, GLASGOW, AND POSITIVE STEPS, OLDHAM

The note of the visit to Smithycroft Secondary School, Glasgow can be found on the Scottish Parliament website at the following webpage:
http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/Note_of_a_visit_to_Smithycroft_Secondary_School_Glasgow.pdf

The note of the visit to the Corner and Menzieshill High School, Dundee can be found on the Scottish Parliament website at the following webpage:
http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/Note_of_a_visit_to_The_Corner_and_Menzieshill_High_School_Dundee.pdf

The note of the visit to Positive Steps, Oldham can be found on the Scottish Parliament website at the following webpage:
http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Inquiries/Note_of_a_visit_to_Positive_Steps_Oldham.pdf
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