Inquiry into teenage pregnancy

CARE for Scotland

Introduction

CARE is a well-established mainstream Christian charity which provides resources and helps to bring Christian insight and experience to matters of public policy and practical caring initiatives. CARE is represented in the UK Parliaments and Assemblies, at the EU in Brussels and the UN in Geneva and New York. CARE for Scotland is a department of CARE and has been working to influence the Scottish Parliament on matters relating to sexual health since 1999. CARE for Scotland has about 3000 supporters drawn from all the major Christian churches in the nation.

CARE has developed a sex and relationship education resource called **Evaluate – Informing Choice**, which seeks to assist young people to value their self-worth and to make healthy choices. It has four levels of presentation at P6/7, S1/2, S3/4 and S4/5. Evaluate is presented by volunteers, and uses multimedia presentations and discussion in a format which is consistent with youth culture. It features positive role models with personalities young people would recognise. It encourages young people to wait until they are in a committed and long-term relationship prior to engaging in sexual intercourse and highlights the benefits of marriage. There is some statistical evidence which shows that this programme has been successful in encouraging young people to change their behaviour and postpone sexual activity and positive feedback has been received from the students. In the sample of schools studied we have seen an overall reduction in the number of sexually active 15/16 year olds where the Evaluate programme has been delivered in a consistent manner.

For many years CAREconfidential was part of CARE and it remains a key partner agency with which we work. It undertakes caring work in the fields of pregnancy counselling and advice on dealing with abortions. Through its extensive contact over 20 years with those affected by abortion, CAREconfidential is one of the major national organisations providing counselling support in this sensitive area with over 150 affiliated pregnancy crisis centres throughout the UK.[1] The aim of

[1] This support is provided by using a specialist 10 week programme called The Journey. The centres offer a range of facilities including free pregnancy testing, counselling relating to unplanned pregnancy, post abortion counselling, miscarriage counselling, befriending services, adoption schemes, accommodation, provision of free clothes and equipment for those on low income, advice on benefits and accommodation and parenting classes. There are 800 trained volunteer counsellors working across the network of 150 centres. The network has approximately 800 trained volunteer counsellors in the UK, as well as a help line and website.[1] The network provides services to over 38,000 clients

the centres is to provide a safe, impartial environment in which women and men can talk through their circumstances of unexpected pregnancy and discover all of the options open to them.

Answers to Questions

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

CARE is of the view that the current direction of policy is fundamentally flawed and has failed to make any significant impact on rates of teenage pregnancy and sexually transmitted infections (STIs). The problem with the dominant approach lies in an over-emphasis on harm reduction at the expense of providing a clear framework of values. Moreover, current policy seems to have mutually contradictory objectives. Teenage pregnancy cannot be viewed as a problem in isolation. The attempt to reduce teenage pregnancy rates by relying mainly on the distribution of oral and long-acting contraceptives is a recipe for an explosion in rates of STIs. The distribution of condoms, although offering protection against STIs, is unlikely to lead to behaviour change which will improve the self-esteem and self-worth of young people. Low self-esteem is a major driver of teenage sexual activity. It is unlikely that condoms will be used on all occasions that a young person has sexual intercourse and oral contraceptives may well be missed or unavailable at the time of the encounter. As a result, and despite the expenditure of millions of pounds since 2000, rates of teenage pregnancy and STIs in Scotland remain stubbornly high.[2] Under 16 teenage pregnancy rates have not fallen and STI diagnosis per year increased by around 10,000 from 1996 until 2009.[3]

The current SNP Government transferred the lead responsibility for tackling teenage pregnancy from health boards to local authorities. It did so despite the unprecedented financial pressures with which local authorities are faced owing to the freeze on the Council Tax that has been in operation since 2007. In contrast, health board expenditure has been relatively protected. Within this context it is unlikely that local authorities are likely to be able to successfully reduce teenage pregnancy when health boards have failed to do so. Reducing teenage pregnancy is not solely a matter of financial resource. Arguably a wide variety of factors come into play. However, the Scottish Government's strategy has been based mainly upon extending the coverage of sexual health services and rolling out comprehensive sexual health education in schools. A large amount of public

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per year and there have been over 10,000 calls to the help line.[1] The website has self help information and access to online advisors plus links to the network of centres throughout the UK and recently won a BT Helpline Association Award for innovative use of web based applications.

[2] See the Information Services Division (ISD) Scotland website at www.isdscotland.org.

[3] See www.isdscotlandarchive.scot.nhs.uk/isd/4907.html.

money has been put into this effort with little success. That being the case, it is unlikely that transferring the lead to cash-strapped local authorities will have much success in reducing teenage pregnancy rates unless it is accompanied by fundamental change in approach.

Research conducted by Prof. David Paton (and others) suggests that a much broader range of factors than sexual health education come into play in determining rates of teenage pregnancy. Not least among these are socio-economic factors and the presence or absence of traditional family structures. In CARE's view, there has been an over-emphasis by the Scottish Government on programmes of sexual health education and on the provision of sexual health services and a failure to consider the wider social, cultural and economic drivers of high rates of teenage pregnancy and adolescent sexual activity.

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?

Health boards have been at the forefront of advancing the Scottish Government's failed approach to tackling teenage pregnancy and wider sexual health. Indeed arguably it was health boards that were the main architects of the Respect and Responsibility strategy. At the local level the emphasis has been placed upon extending the coverage of sexual health services. There has been an emphasis, in particular, on making sexual health services available in or near to schools. This includes the distribution of emergency contraception in some areas despite the fact that the Former First Minister, Jack McConnell MSP, promised that the morning-after-pill would not be distributed in schools. In addition, a major emphasis has been placed by health boards on rolling out 'comprehensive' sexual health education in Scottish schools. This has been done in such a way as to exclude other resources. Moreover, it has been done in a way which runs contrary to important aspects of the Scottish Government's guidance circular (2/2001) for sex and relationship education. Circular 2/2001 states:

"Programmes of sex education should present facts in an objective, balanced and sensitive
manner **within a framework of sound values and an awareness of the law on sexual behaviour**. Pupils should be encouraged to appreciate the value of stable family life, parental responsibility and family relationships in bringing up children and offering them security, stability and happiness. Pupils should also be encouraged **to appreciate the value of commitment in relationships and partnerships including the value placed on marriage by religious groups and others in Scottish society.** At the same time, teachers must respect and avoid causing hurt or offence to those who come from backgrounds that do not reflect this value. **All pupils should be encouraged to understand the importance of self-restraint, dignity, respect for themselves and the views of others. They should be encouraged to recognise the physical,**

emotional and moral implications and risks of certain types of behaviour and to accept that both sexes must behave responsibly."[4]

First, it is notable that the Scottish Government's guidance states that sex and relationship education should be based on foundation of sound values and awareness of the law on sexual behaviour. Yet the approach adopted to sexual health work in schools by health boards has largely ignored this key aspect of the guidance. Rather the 'harm reduction' approach adopted has focused on the distribution of contraceptives to children who are often under the legal age of consent. A cursory emphasis is placed upon the benefits of delaying the onset of sexual activity, but the underlying assumption seems to be that young people are going to have sex and that it is unrealistic to expect otherwise. This leads to a clear message being conveyed to young people that it is okay to disregard the law on sexual behaviour and the age of consent. No questions will be asked and free access to contraceptives will be made available by those who are in positions of authority and who are (often) responsible for delivering the sexual health education programme.

Second the guidance states that children should be taught to appreciate the importance of marriage to religious groups and others in Scottish society. However, marriage has been airbrushed out of the sexual health education programmes which have been developed by health boards. In the Greater Glasgow area, non-denominational primary schools use a sexual health education resource which was developed by Greater Glasgow and Clyde NHS Board. This resource does not mention marriage at any stage with the sole exception of one lesson in primary seven. That lesson is in fact on the subject of the diversity of family life. A number of family scenarios are presented to children. Only one of these scenarios includes a married couple and that relates to an Asian family. The implied message is that marriage is something which is marginal and is practiced, in particular, by religious and cultural minorities. This marginalization of marriage is not only inaccurate but runs contrary to the official guidance.

CARE's sex and relationship education resource, Evaluate -Informing Choice, encourages young people to value the benefits of delaying sexual activity until involved in a committed relationship and, in particular, the value of marriage. Regrettably our experience is that in some local authority areas it has been difficult to persuade schools to use this resource. In part, this difficulty is owing to a lack of financial resources within schools to 'buy-in' outside resources. However, there has also been a policy decision in a few local authority areas to exclude the resource because of the ethos which underpins it. Often the opposition to the resource arises from health board staff, rather than education

[4] Scottish Executive Education Department, Circular 2/2001, Para. 7 - Emphasis added by CARE.

officer and teachers, who object to the emphasis placed upon marriage and the fact that it does not deal with issues of same-sex relationships.

Third the guidance states clearly that not only should young people be encouraged to understand the importance of self-restraint, dignity and respect, but also to recognise the **physical, emotional** and **moral** implications of certain types of behaviour. CARE doubts that current programmes of sexual health education are frank about the physical risks of certain behaviours. For example, we doubt that the factual evidence pointing to the high levels of inherent risk of an active homosexual lifestyle is given the prominence that it would merit based on the statistical evidence. A harm reduction approach is adopted which whilst highlighting the dangers of certain behaviour (sex without the use of a condom) is unlikely to emphasise that the safest (and therefore the recommended) context for sexual activity is within a life-long stable relationship and preferably marriage between a man and a woman. It is unlikely also that one of the primary purposes of the institution of marriage (the procreation of children) features highly in sex and relationship education. Moreover, the emotional and moral consequences of certain behaviours (e.g. abortion) are unlikely be emphasised or perhaps even mentioned. This would appear to run contrary to the guidance.

In essence, an approach based on an ideology of sexual liberation has been adopted by the health boards. This ideology has failed to deliver with regard to reducing rates of teenage pregnancy and STIs. Despite this failure, the health boards continue to extend and advance their fundamentally flawed approach. Having failed to do reduce teenage pregnancy and STI rates, the lead responsibility for tackling teenage pregnancy has now been passed to local authorities. Yet local authorities have little freedom or discretion to adopt an alternative approach. The Scottish Government's public health section and the health boards continue to determine the ideological approach which is to be adopted by local authorities. It is an approach which will continue to fail as it is based upon an ideology which is fundamentally flawed.

What are your views on the relationship between high levels of teenage pregnancy and socio-economic inequality?

There is no doubt a correlation between high rates of teenage pregnancy and socio-economic deprivation. The extent to which the latter can be claimed to be a direct causal factor of the former is unclear. However, it is likely that those with poor life opportunities, limited career expectations and lower educational attainment may well be more likely to view teenage pregnancy in a positive manner, particularly if having a child increases the likelihood of obtaining a council house.

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

It should be noted that other factors than socio-economic inequality are likely to be very important contributors to high teenage pregnancy rates. Alcohol and drug consumption will certainly play a major role. Similarly poor parenting, absent fathers, relationship breakdown and a family history of teenage pregnancy are significant factors to consider. Within this context, even the most extensive programmes of sexual health education or access to sexual health services are likely to be of limited effect in changing behaviour, particularly if they are based upon the harm reduction approach. Rather we suggest that an approach based upon providing good role models and active mentoring for young people, combined with economic development, vocational training and flexible and affordable childcare are could have a significant role to play in improving sexual health and reducing teenage pregnancy. Churches are well placed to facilitate such programmes through the activities of youth workers and volunteers, by running mothers and toddler groups and through the use of premises to host vocational training.

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?

There is a danger that public authorities seek to provide all services in-house. However, creative partnerships with the voluntary sector, and in particular the churches, could provide a much more effective community-based support system for young parents/mothers.

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?

We would draw the committee's attention to the Romance Academy programme which to date has been mainly run south of the border. We would also mention the fact that Positive Steps had a very effective sex and relationship education programme, but that this organisation ceased to operate after Glasgow City Council decided to provide all its sexual health education in-house (in partnership with the health board) and after the Scottish Government stopped its funding.

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?

An abstinence-based approach has never been tried properly in Scotland. At the time that Respect and Responsibility was drafted, CARE proposed to the Scottish Executive a pilot abstinence-based programme should be funded. The Executive considered this, but decided not to progress with such an initiative. A major emphasis needs to be placed on encouraging young people to delay engaging in sexual activity. This approach should be accompanied by the provision of good role models for young people in the form of youth workers who "practice what they preach" and who develop strong relationships with the young people involved. A mentoring programme which lasts more than just a few weeks would be crucial. In addition, more support (including financial resources) should be made available for independent pregnancy crisis counseling in order to allow women to facilitate proper informed choice around the issue of termination of pregnancy, to support women who choose to continue with the pregnancy and to provide assistance to those who suffer from post-abortion emotional trauma and/or regret.

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?

We suggest that the ABC (abstinence, be faithful and proper condom use) approach should be adopted with the priority in that order. In Uganda this approach has been successful at tackling high rates of HIV infection and it is an approach recommended by UNICEF. It is important to note that in Uganda the use of condoms was emphasised for those who were actively engaged in risky behaviour (e.g. sex workers) rather than being proposed as a blanket policy for the whole of society. In Scotland, we have more of a CSD (condom use, stable relationships and delay) approach which is rolled out and applied to the general population, with delay being very much a low priority. It is unsurprising that this approach has failed to address the problems of teenage pregnancy and high levels of STIs.

CARE recommends to the Health & Sport Committee the evidence submitted by the Christian Medical Fellowship which explores in greater detail (including statistical evidence) many of the points highlighted in our submission. We will be happy to give oral evidence should the commit so wish.

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