Inquiry into teenage pregnancy

FPA and Brook

About FPA

FPA is one of the UK's leading sexual health charities. Our mission is to help establish a society in which everyone has positive, informed and non-judgmental attitudes to sex and relationships; where everyone can make informed choices about sex and reproduction so that they can enjoy sexual health free from prejudice or harm.

We do this through providing a comprehensive sexual health information service for professionals and the public, running community based sex and relationships education programmes and campaigning to ensure that high quality sexual health information and services are available to all who need them.

About Brook

Brook is the UK's leading provider of sexual health services and advice for young people under 25. The charity has over 45 years of experience working with young people and currently has services in England, Scotland, Northern Ireland and Jersey. Our mission is to ensure young people can enjoy their sexuality without harm.

Brook services provide free and confidential sexual health information, contraception, pregnancy testing, advice and counselling, testing and treatment for sexually transmitted infections and outreach and education work, reaching over 290,000 young people every year.

Introduction

Brook and FPA believe that women and young women have the right to control their fertility and choose if and when they have a family. Unplanned pregnancies can have a huge impact on women's lives, their partners and their families and we want to ensure that women and young women are able to plan their families as much as possible.

From very recently published research by the FPA and Brook, covering the whole of the UK, and released in January 2013, we also know what the cost ramifications of not addressing the cuts and restrictions to sexual health and contraception services that we are seeing today could leave the UK with a cumulative bill of £136.7 billion over the next seven years (by 2020), a significant proportion of which will related to teenage pregnancies. These are both health

and social costs (from education and housing, to support services which ensure wellbeing and social care)[1].

Before giving responses to the Inquiry's questions, we would first like to refer our support to the very-much-related findings of the recent Cross Party Unplanned Pregnancy Inquiry, which produced a series of recommendations on ways to reduce the number of unwanted pregnancies in the UK.

We would also like to draw attention to the submission you will receive from the commissioner for sexual health services in the Highlands, Senior Health Promotion Specialist, Lorraine Mann, which we also support.

Responses to Questions

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

It is clear from the SPICe report provided by the Inquiry, that the teenage pregnancy levels in each age group have slightly declined. However, it is difficult to ascertain as to how much of this is due to the current policy direction and/or actions and how much is due to external factors (for instance the level of social inequality, as highlighted by Question c.).

In any case, the rates of teenage pregnancy do remain high and the Scottish Parliament should indeed be concerned, and continue to invest in teenage pregnancy work, while also ensuring sex and relationship education is statutory.

Furthermore, the Scottish Parliament should be concerned about the impact of unwanted teenage pregnancies on women, their partners and their family's lives. For example, the Academy of Medical Royal Colleges and National Collaborating Centre for Mental Health's systematic review of the mental health outcomes of induced abortion (Dec 2011) concluded that the rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth.

The Scottish Parliament should also be concerned about the economic impact of unplanned pregnancy. Unplanned pregnancies cost the tax payer money as in indicated in the findings of Unprotected Nation[2], yet we know that £1 in contraception saves £12.50[3]. Furthermore, in 2005 NICE calculated that fully implementing its guidance on access to long-acting reversible methods of

[1] Please see Annex A for a summary of Unprotected Nation's findings. The full report can be found here.
[2]Please see Annex A for a summary of Unprotected Nation's findings. The full report can be found here.
[3] Advisory Group on Contraception (AGC). 2012. Submission to the cross-party unwanted pregnancy enquiry.

contraception would save the NHS in England more than £100 million a year[4]. It also estimated that:

- 40.6 per cent of unintended pregnancies end in abortion
- 46.4 per cent of unintended pregnancies result in a live birth
- 13 per cent of pregnancies end in spontaneous abortion/miscarriage.

The guidance also calculates the cost of an abortion as £497, the cost of a miscarriage calculated as £321, and the total maternity cost £2,137.

It is important to point out that not all unintended pregnancies end in abortion. It has been suggested that as many as 30% of pregnancies which end in childbirth are unplanned when they are conceived. (NICE guideline)

b. 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?

FPA and Brook recommend:

- More moves towards guidance and support for commissioning high quality sexual health services from the Scottish Parliament.
- Clear accountability for local authorities that fail to commission or deliver high quality services for all.
- Relationships and sex education should be made a statutory part of school curriculums.

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

The empirical data would support the need for the provision of targeted sexual health and relationship interventions, such as education in schools and community venues, hostels, looked after children and for vulnerable people. In addition, the investment into multi agency training and interventions would enable improved intelligence sharing to identify the areas of social deprivation and high risk communities.

The evidence in this area is clear, and abundant. For example:

- Early motherhood was associated with higher levels of mental health disorders, lower educational achievement, higher levels of welfare dependence, lower levels of paid employment and lower income[5].

[4] National Institute for Health and Clinical Excellence Clinical Guideline no. 30: Long-Acting Reversible Contraception, 2005.

- Early motherhood is also associated with disproportionate prevalence of early risks that included low birth weight or preterm birth, inadequate prenatal care, teen mother, high lead exposure, low maternal education, child maltreatment, and homelessness[6].
- Almost four out of ten teenage mothers have no qualifications and are at risk of becoming NEET[7].
- Adolescent mothers are at an increased risk of a variety of negative outcomes for themselves, such as maternal depression, and for their children[8].

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

Key barriers and challenges include:

- Access to a choice of contraception. The two most popular methods of contraception are the pill and the condom, which are both user dependent.
- Patchy provision of high quality relationships and sex education.
- Lack of sustained national campaigns on contraception, relationships and pregnancy choices.
- Access to social housing and the prospect of boarding houses as a disincentive for teenage girls to get pregnant.

Contraception

Reproductive health and fertility control are not episodic health issues – they remain throughout women's reproductive years (15-44 years old). They relate to healthy people accessing preventative medicine.

Contraception choice and use are vital. The two most popular methods of contraception are the pill and the condom. We know that when women are happy and confident with their method of contraception they are more likely to use it effectively. Therefore a choice of contraceptive methods with accurate information about them is vital.

FPA Contraceptive Awareness Week in 2009 *Finding the perfect partner* research[9] indicated that:

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[5] Early motherhood and subsequent life outcomes. BODEN, JM,; FERGUSSON, DM; HORWOOD, LJ. Journal of Child Psychology and Psychiatry, vol.49, no.2 (Feb). pp151-160. 2008

[6] Comprehensive challenges for the well being of young children: a population-based study of publicity monitored risks in a large urban centre. FANTUZZO John W; LEBOUEF Whitney; ROUSE Heather L. Child and Youth Care Forum. 40(4), August 2011, pp.281-302. 2011

[7] Life skills. WHITMORE Diana. Every Child Journal. 2(6), 2012, pp.22-27. 2012.

[8] Predictors of parenting and infant outcomes for impoverished adolescent parents. WHITSON Melissa L. Journal of Family Social Work. 14(4), July-September 2011, pp.284-297. 2011.

- There were nearly 2 million women in the UK not happy with the current contraceptive method.
- Almost one in three UK women aged 18-49 typically spends up to just five minutes selecting a suitable contraceptive method to use.
- Almost half of these women (47 per cent) have had a pregnancy scare (thinking they were or could be pregnant when they did not want to be).

In the context of contraception, it is important to remember that no contraceptive method is 100 per cent effective so there will always be unplanned pregnancies and a need for access to safe abortion services if needed.

Sex and Relationships Education (SRE)

Children and young people repeatedly describe the SRE they receive as too little, too late and too biological. In a survey of almost 22,000 children and young people by the UK Youth Parliament, 40 per cent of respondents described their SRE as either poor or very poor, 33 per cent thought it was average and 43 per cent said they had not been taught about personal relationships at school[10].

In 2010 an Ofsted report found that in a quarter of schools a lack of discrete time for PSHE education, particularly in secondary schools, meant that SRE suffered, and in a third of schools pupils had gaps in their knowledge about sex and relationships[11].

Many children and young people do not currently receive the SRE they need. We believe this puts their health and wellbeing at risk. Children and young people learn about sex and relationships from a relatively young age from a variety of sources, including family, friends, television and magazines.

SRE plays an important role in correcting the inaccurate and skewed messages they may receive elsewhere. SRE must be statutory to ensure all children and young people receive this vital information.

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[12].

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[9] Further information.
[10] UK Youth Parliament, *SRE: Are You Getting It?* (London: UKYP, 2007).
[11] Ofsted, *Personal Social Health and Economic Education* (London: Ofsted, 2010).
[12] Kirby D, Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases (Washington DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).

SRE can also play a role in keeping children and young people safe. SRE aims to equip children and young people with language and skills to understand appropriate and inappropriate behaviour, be able to resist pressure and to know who to talk to and how to access help and support when they need it.

Currently the quality of SRE is poor; this is partly due to the fact that many teachers who deliver it are not suitably trained to do so. Without training, teachers feel uncomfortable with the subject matter and teaching methods.

Making SRE statutory would send a clear message that the subject is a priority and would require schools not only to ensure that the teachers delivering it were suitably trained but also that it has sufficient time in the curriculum. This would have a positive impact on the quality of information children and young people receive. There is strong support for compulsory SRE from teachers, parents, children and young people.

Brook and FPA also recognise the crucial role that parents play in their children's development. We believe the provision of SRE should be a partnership between parents and schools with lessons in schools supporting the information and messages children and young people receive from their parents.

Access to social housing and the prospect of boarding houses as a disincentive for teenage girls to get pregnant (feedback from Brook young people)

Brook Young People fed directly into the recent Cross Party Unplanned Pregnancy Inquiry on the issues of access to social housing and the prospect of boarding houses as a disincentive for teenage girls to get pregnant. The findings of the young people are pertinent to share here too.

In order to respond to the Cross Party Unplanned Pregnancy Inquiry, Brook facilitated focus groups with young people, some of whom were young parents themselves. These focus groups took place in five different areas in the UK, so that we could obtain a range of responses from different geographic locations. The young people were aged 17 – 24 and included young parents (males and females) with existing children, pregnant mothers and young people who had no dependants. Many of them had experience of homelessness and/or the benefits system.

Brook was also supported by the young mum's organisation, Prymface, who facilitated an online consultation during their weekly Twitter discussion forum #youngmumschat, and created an online survey to collect the views of young women who had experienced teenage pregnancy themselves.

The young people that we 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.

The young people discussed the perception of society, portrayed by the media, that young parents have an easy time with housing allocation and the benefits system. However the reality of the situation is in stark contrast. It was not uncommon for young people to have spent many months “sofa surfing” or in unsuitable temporary accommodation. It can take years for someone to be provided with a home of their own.

Young people who had experienced homelessness talked about the fact that temporary accommodation would usually be provided for quite quickly, but this could be a ‘bed and breakfast’ or hostel, where the quality of housing is usually very poor. Others talked about feeling very vulnerable in temporary accommodation, and it being an unsuitable environment for children as other residents could become aggressive, there were often parties involving risk-taking behaviour and worries about possessions going missing.

They were particularly concerned that a “boarding house” would create a similar unsuitable environment. They reported that it is unheard of for someone to be living in a hostel because they want to get on a housing list, and made it clear that living in a hostel is not a choice and that young people do not become homeless on purpose.

“I have never met anyone who had a child to get benefits/council flat...”
Young mum, via #youngmumschat

“I do not know one single person who got pregnant to be housed. I spent time in a hostel (hell).”
Young mum via Prymface online survey

One young woman shared the example of her step-sister, who spent three years living in a hostel before she was able to be housed by her Local Authority.

A young mother who now has a council flat shared her experience via #youngmumschat: *“I did go on the housing list for a bit when she was 6 months old but they took me off after 3yrs not priority...took losing my parents and the housing association making me homeless before I left my family home.”*

The experiences of the young people we spoke to who were young parents themselves shows that social housing is not that easy to get and they didn’t tend to get a choice in where they were offered.

> *“You generally end up living in areas where no-one else wants to live as you are seen as ‘desperate’ for a house so you can be put anywhere. The house would also need decorating and furnishing – so it is a myth that you get a house in a nice area, with a nice garden and all the furnishings you need.”*
> Feedback from Brook Oldham

We asked the young people what they thought about the idea of young, homeless parents being high priority on housing waiting lists. The response was extremely positive, from parents and non-parents alike, and they discussed the importance of vulnerable young people and their children needing appropriate accommodation so that the babies could thrive.

> *"I think it's probably a good idea or you're punishing children for daring to be born. Homeless babies are probably not going to get the best start."*
> Young mum via Prymface online survey

When asked whether the current benefits/housing system encourages young people to become parents, the young people felt strongly that this is not the case:

"Ha! My primark wardrobe says no. As does my empty passport and lack of fondant fancies."
Young mum via Prymface online survey

The young people also felt that there is an extremely negative stereotype of young people which is perpetuated by the media. They felt it was important for young parents to be more accurately represented to de-stigmatise and inform society of the reality of being a young parent.

"I've been on benefits since my child was born, without benefits me and my child would of starved or died from pneumonia."
Young mum via Prymface online survey

When presented with the idea of whether young mums should be housed in boarding houses, the response from the young people was overwhelmingly negative. None of the young people from the focus groups thought that boarding houses would act as a disincentive, because securing housing was not the reasons that young people became pregnant in the first place.

Of all the young people that we consulted with, none of them knew anyone who made a conscious decision to get pregnant solely to get a house or benefits. The reasons around teenage pregnancy are far more complex and diverse. In fact most young people don't make a conscious decision to get pregnant at all and they felt this highlighted the importance of educating young people more around contraception.

Of the 82 young parents who took part in the Prymface online survey, 39% said they became pregnant because of contraceptive failure, 18% got caught up in the moment, 17% weren't thinking and 0% became pregnant because they wanted benefits/housing.

"I don't think it [boarding houses] *would change anything. I don't believe anyone would get pregnant in order to receive accommodation. If the government see teenage pregnancy as wrong they need to stop the pregnancies happening rather than punishing those that fall pregnant regardless of reason."*
Young mum via Prymface online survey

"...Being pregnant isn't a crime. You don't have to build a prison for it. I was made pregnant by abuse."

Young mum via Prymface online survey

All the focus groups felt very strongly that the idea of a 'boarding house' seemed dated and sounded like something from the 1950s and institutional. They also felt that it is widely recognised that children need input from their fathers, and to place just the young mums in boarding houses would not allow for this.

They went on to talk about the importance of children needing security, food, somewhere warm, and stability, and agreed that young parents are vulnerable and need to be provided with suitable accommodation of the safety of them and their baby/child. They were particularly concerned that if 'boarding houses' were designed to act as a disincentive, then they probably wouldn't be pleasant places to live and therefore would not be appropriate to raise a healthy child.

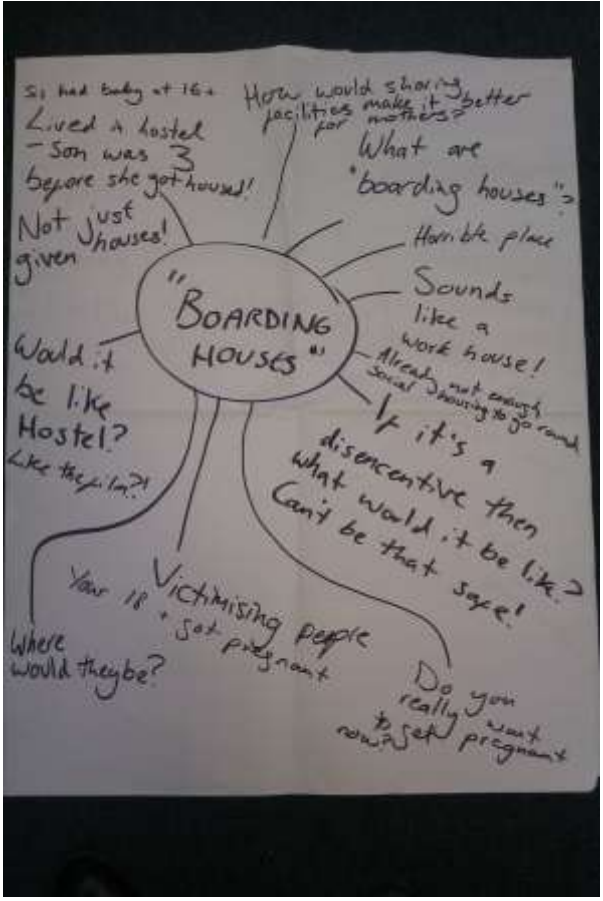
Many of the young people were particularly concerned about the notion of boarding houses, because they felt that at a time when you need support from your friends, family and partner you would be most isolated from them.

"I feel these houses could be dangerous to their mental health. I know if it had been me I would have gone and jumped off the nearest bridge."
Young mum via Prymface online survey

"For me this would have been horrendous, I was already under immense pressure and stress and being judged and thrown into a unit after such a traumatic time would have been really bad for my already suffering mental health."
Young mum via Prymface online survey

"It [boarding houses] *won't address the issues as to why YP get pregnant so would be a waste of public funds. Spend the money where it's needed not on some new oppressive and discriminatory hair brained scheme."*

Young mum via Prymface online survey



Flip-chart record of discussion with young people at Brook London

Many of the young people felt that supported housing for homeless young parents could be positive, as long as the staff were adequately trained and experienced in the complex needs of young parents. They felt supported housing could be beneficial if it is run by a specialist organisation who are able to give tailored support to young parents who have additional needs. However they also expressed the view that entering supported housing should always be a choice, as it may not be suitable for everyone, and some young people report experiencing institutionalisation, stigma, feeling separated from their family and friends and being exposed to negative environmental factors.

"It should be a means of support rather than as a disincentive."

Young mum via Prymface online survey

All the young people involved reflected that there is a negative stereotype of young, single parents on benefits.

f. 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 like to highlight the service at Brook Highland which is specifically targeted at young people. The success of this service will be further verified and outlined in the response to the Inquiry that will be provided by the commissioner

for sexual health services in the Highlands, Senior Health Promotion Specialist, Lorraine Mann.

As a rural, and often remote place, providing accessible services to young people in the Highlands does of course present logistical issues. However, the service has been able to address this by encouraging access to Long Acting Reversible Contraception (LARC). As such the service has seen a markedly high increase in the uptake of LARC (particularly implants) in the past year, due to increased funding to support training staff in delivering clinics.

The service is also particularly proud of its Education Project which will run for 2 years. Under this Project, Brook Highland will deliver a programme to support vulnerable young people in Highland to be better equipped to protect themselves from bullying, coercion, and sexual and emotional ill health; this will be developed in the context of the needs of Scottish young people, Scottish culture and the health and education agenda.

The programme builds on materials designed and evaluated by Brook Wirral. This includes '*All Different, All Beautiful*', which is a five day programme based on research that shows that young people who have low expectations about their self-worth, and their likely future prospects, are more likely to engage in negative risk taking, experience poor sexual health and may face unplanned and early parenthood.

Participants are encouraged to take responsibility for their choices and actions and develop personal goals and aspirations. Delivery is targeted at young people identified by either Brook or partner agencies as being a priority for additional support.

The programme will also include '*Bite Size Brook*', which is a one day interactive information giving event with a focus on sexual health and risk taking behavior. Bite Size Brook can work with up to 100 young people at a time at secondary schools and colleges, or can be used more flexibly with smaller groups to address specific issues.

Participants benefit from accurate knowledge and information, blended with activities to increase confidence and personal awareness, enabling them to make positive choices, and equipping them with the skills to put these into action.

The project will also build on existing relationships and partnerships that Brook Highland has with statutory and voluntary sector agencies working with vulnerable young people. Through these links, and our own direct work with young people, we will identify individuals who would benefit most from this initiative, and engage with them. We will also seek to work with schools with catchment areas where significant numbers are disadvantaged as defined by Scottish Index of Multiple Deprivation postcode data.

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

FPA and Brook concur with the deep dive work undertaken by the national Teenage Pregnancy Strategy Team that teenage pregnancy rate can be reduced as a result of:

- Dedicated national strategy
- National accountability (Independent Advisory Group)
- Improved provision of sex and relationships education
- Investment in contraception and information services
- Local services working together

We are not saying that this exact method has to be followed but investment coupled with incentives and national accountability would go far in improving rates of unplanned pregnancy.

h. 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 would like to draw your attention to the best practice that has been taking place at the Brook service in Oldham, which lead to significant reductions in the local teenage pregnancy rate. Formal reviews and reports were undertaken by Oldham's Teenage Pregnancy Coordinator together with a team from the Teenage Pregnancy Unit, which verify the success of the service. Furthermore, the 'Deep Dive Reviews' that took place nationally highlighted Oldham for its best practice and the approach was promoted to areas struggling to reduce the teenage conception rates. We would be happy to make available to the Inquiry by request any of these evaluations.

The contributing factors which were deemed to be effective in reducing the teenage pregnancy rate included:

- Overall responsibility for the strategy led by a multi-agency Partnership Board which included Local Authority, PCT, Hospitals NHS Trust and the voluntary sector. There was also representation from housing, social care and youth services.

- Below the strategic Partnership Board were two sub-groups; one focused on prevention and included Sex and Relationship Education work, and other preventative services; and the second which led on support for teenage parents.

These groups consisted of staff at a more operational level within the services who pushed forward genuine partnership working and helped to ensure that young people did not fall through gaps in service provision.

In particular, resources were invested in:

- Improved access to contraceptive and sexual health services (Brook opened seven days a week) including targeted provision. For example, this was delivered for Looked After Children through peripatetic services provided by Brook's nurse and the Looked After Children nurse in schools.

- Improved Sex and Relationship Education provision through partnership working between Brook, schools, colleges and the Healthy Schools Team.

  Locally a Lead for Personal Health and Social Education (PSHE) was established to support schools in establishing an effective PHSE curriculum which included input from external agencies such as Brook. Much of this work included sessions aimed at building self-esteem and supporting young people to make informed choices. Targeted single sex sessions were also delivered to boys/young men and girls/young women.

- Improved promotion of local services. This was most effectively delivered by Brook outreach teams promoting services through schools, colleges and youth centres.

  Anecdotally, the clinic team at Brook was always able to identify which schools the education team had been in during the past week, as the uptake of the clinical services would increase significantly from students from those schools.

- A multi-agency project was established and led by Brook which consisted of a teenage parent's Health Visitor (based in a Surestart Centre in the local ward with the highest teenage conceptions) working closely with the Teenage Pregnancy Midwife at the local hospital.

  A three pronged approach with Brook ensured that under 18s were referred to the Teenage Pregnancy Midwife, then in turn the Teenage Pregnancy Health Visitor and back to Brook for on-going contraception following their pregnancy or termination of pregnancy.

  As a consequence, the number of repeat conceptions in under eighteens reduced significantly. A dedicated Connexions Personal Advisor also worked with the young parents.

- The establishment of Brook's '*Realities*' programme which was delivered by teenage parents trained as Peer Educators who visited schools, youth centres, and other places where young people could be engaged.

  This approach involves young people talking about the realities of being a teenage parent. They are supported by a Brook Education Worker who would also deliver an education session around effectively managing and negotiating relationships, contraception and access to services.

  The Peer Educators also attained accredited learning as a consequence of their training as peer educators. Almost all subsequently moved on to further education, training or employment.

- Targeted one-to-one support was offered to young people identified as vulnerable and at increased risk of teenage pregnancy. Referrals were made by a range of professionals into the Brook service where support and peer mentoring was offered by the education team and young peer mentors.

- Multi disciplinary and multi-agency training was delivered by Brook targeted at professionals working with young people. This included teachers, pastoral care staff, careers advisors, youth support workers, staff from Youth Offending Teams, training providers, and housing support staff. The training was offered at levels 1, 2 and 3 with the option for accreditation and focused on supporting professionals to talk to young people about sex.

- Training and support was also provided to parents to help them talk to their children about sex and relationships.

- Introduction of a C-card Scheme across the Borough.

- Opening the area's first targeted youth support centre (at Positive Steps Oldham) which provided teenage parents the chance to meet others, in addition to receiving support from health professionals including contraceptive services, and ante-natal care services.

Much of the success outlined above occurred as multi-agency professionals established effective relationships built on trust, which ensured effective support and referral for the young people and prevented even the most vulnerable from falling through gaps between the services.

Harry Walker
Policy and Parliamentary Manager
Family Planning Association

7 February 2013

Annex A: Key Messages from Unprotected Nation- The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services, January 2013

- If the cuts and restrictions to sexual health and contraception services that we are seeing today continue unabated across the UK, **the consequences could leave the country with a cumulative bill of £136.7 billion over the next seven years** (by 2020). These costs include both health and social costs (from education and housing, to support services which ensure wellbeing and social care).

- This report is the **most comprehensive and complete look at the impact of cuts to contraception and other sexual health services.**

- We conducted it to **help decision makers review the short term nature of the restrictions and cuts being put in place today.** These very real restrictions were highlighted by the cross party Advisory Group on Contraception.

- The report was commissioned by Brook, FPA and Durex and conducted by an **independent third party** company specialising in economic research and whose recent clients include DCLG and DWP. The report used **robust, publicly available data** from places like ONS and the WHO to predict what will happen if the cuts that we are currently seeing to sexual health and contraceptive services continue.

- Increasing cuts and restrictions means **less access to services,** which will lead to **increases in unintended pregnancies and the associated social and health care consequences, as well as increases in sexually transmitted infections. And this is against a backdrop of the UK already having some of the worst sexual health records in Europe.**

- These cuts have a **very real and dramatic impact on people's lives**, health and well-being, as our Unprotected Nation report shows.

- The conclusions drawn from the Unprotected Nation report demonstrate the short-sighted nature of restrictions and cuts. Some of the key findings are:
    - **£298.6 million in additional NHS health costs** will be required between 2013 and 2020 to care for women with unintended pregnancies through increased birth rates, increased miscarriages and increases in the number of abortions sought
    - Over **22,000 women will seek NHS abortions per year** by 2020, because of unintended pregnancies

- **Social costs** such as housing, education and social welfare will increase and **could total £124.7 billion** by 2020 – to put this in context, this is the **equivalent to 10% of the UK's anticipated total welfare spending** in the same period

- Of course, this isn't just about the consequences of unintended pregnancies, it's about the **wider sexual health of the UK.**

- The increasing fragmentation of services and reductions in the effectiveness of education and awareness raising programmes highlights that we are going to **turn back the clock on progress** made in this area.

- The Unprotected Nation report predicts that the restriction of sexual health services **could lead to an extra 91,620 STIs per year by 2020 -** of these, 76,840 cases are expected to be Chlamydia.

- The increase in STI rates alone could place an **additional cumulative costs of £314 million on the NHS by 2020.**

- Our modeling shows incidences of **Chlamydia could account for 40%** of NHS treatment costs for STIs between 2013-2020.

- Of course, in many cases Chlamydia is treatable but if left untested and unfound then it can lead to infertility, a sad and easily preventable outcome.

- Our report shows that with a relatively small amount of investment the economic impact of **improving access** to contraception and sexual health services could - when compared to the continued cuts scenario outlined in Unprotected Nation:
  - **Reduce the cumulative total of NHS costs** associated with unintended pregnancies by 4% (£196m) by 2020
  - **Reduce cumulative wider social expenditure** costs by 14.4% (£3bn) by 2020
  - **Cut £4.4bn cumulatively from public health** spending by 2020

- In response to reports of restrictions to contraception across the UK, Brook and FPA joined forces earlier this year to launch *XES – We Can't Go Backwards*, a major awareness campaign.

- This report demonstrates the need to take urgent action now.