

# **Inquiry into Teenage Pregnancy**

**Professor Roger Ingham**

## **Introduction**

I am Professor of Health and Community Psychology at the University of Southampton, and Director of the multi-disciplinary Centre for Sexual Health Research. The Centre has been carrying out research into aspects of sexual activity and related issues for over 25 years, in the UK and in other developed and developing countries. Funding has been received from a wide range of sources, including the ESRC, DfID, DH, Joseph Rowntree Foundation, the Leverhulme Trust, the European Commission, WHO, the Ford Foundation, and others.

For the duration of the England Teenage Pregnancy Strategy (2000 to 2011), I was the research advisor on the Independent Advisory Group for the Government's Teenage Pregnancy Unit (TPU). As such, it was part of my role to try to ensure that activities and initiatives were, wherever possible, informed by the best and the latest national and international research evidence. I stress 'wherever possible' here for two reasons; first, in areas as complex and challenging as teenage sex and pregnancy, it is extremely difficult to isolate the possible impact of one variable at a time in the way that more traditional sciences can manage, and, second, there is inevitably a balance to be struck between the direction indicated by evidence, on the one hand, and political and resourcing realities, on the other.

The invitation for me to attend and contribute to your discussions on Tuesday 26 February was very kind, but arrived too late for me to be able to rearrange my teaching and other commitments in my post here at Southampton. I regret this, but am grateful for the initial invitation, as well as the opportunity to submit a contribution – albeit briefly – to your deliberations. I would be very happy to expand on anything I have included at a later date.

## **Some general comments on research evidence and its relation with policy**

In the development of policies regarding certain 'sensitive' issues, there is a tendency for views based on faith, personal moralities, political views, and suchlike, to be incorporated into discussions; this is inevitable. However, it can become counter-productive (in terms of arriving at sensible and appropriate policies) when certain policy approaches are afforded greater priority than those indicated by good solid research evidence. I mention this since I wish later to challenge the submission from the Christian Medical Fellowship (TPO12) which relies heavily on claims made by SPUC activist David Paton.

Since I was so closely involved in the work of the English Teenage Pregnancy Strategy, much of what I would say regarding evidence of what works in improving sexual health amongst young people was incorporated in their policies. Ms Alison Hadley OBE, former Head of the Strategy's Teenage

Pregnancy Unit, will be discussing the TPU's approach with you in detail [26 February 2013], and will be able to elaborate on many of these aspects. Amongst other activities, I also carried out a commissioned literature review in 2009 to inform Ministers if any major changes in direction of travel were needed in the light of research evidence since the strategy was developed. I am sure Ms Hadley would make this available to you if you thought this would be helpful to your deliberations.

A further general point that is important to make at the outset is that it is very challenging - in the complex field of sexual health and teenage pregnancy - to isolate the impact of just one or two variables on outcomes, especially if these are based on just one or two studies. This has some important implications for evidence and how it should be used. For example, good sex education programmes will be unlikely to have measurable impacts if there are no supportive and accessible local services, and /or if families are unwilling to engage, and/or if local community norms are strongly in support of early childbearing, and/or if gender attitudes are such that young women have little power over events, and so on.

Similarly, we must move away from the 'injection' approach to health promotion, whereby it is felt that an 'injection' of knowledge, better attitudes, or whatever, will have immediate impact. The general national and international evidence points in the clear direction that coordinated, comprehensive, consistent, open, honest and respectful approaches with young people and their families have positive impact. Some isolated initiatives may be necessary but not sufficient, and may serve as indicative to young people that their needs and rights are being taken seriously by those in authority.

Finally, it is certainly the case that longstanding structural factors (deprivation levels, longstanding community patterns of early childbearing, low educational aspirations, etc.) are closely associated with early conceptions and childbearing. Many of these features will take some time to alter, even where there is a political will to do so. However, this should not be taken as evidence for inaction; the English under-18 conception data have clearly indicated that great reductions can be achieved even in the most deprived and (initially) higher rate areas. For example, some of the Inner London boroughs have shown massive reductions in recent years which provides good testimony to the potential of focused and coordinated approaches. A combination of general and targeted programmes is indicated.

### **Some brief comments on the CMF submission**

The CMF submission rests heavily on the claims made by Paton, an industrial economist at Nottingham University Business School, and an active member of, and contributor to, the Society for the Protection of Unborn Children (although this is not reported in the CMF submission, nor in Paton's published articles). Of course, attempts to impose personal moralities on policy decisions are to be expected, but the potential for confusion between solid

research data and such personal views needs to be borne in mind. I have provided a few examples.

1 It is claimed on page 1 that over £250m has been spent in the UK on policies to reduce teenage pregnancy rates over the past *forty years*. It is difficult to see how this figure was derived, given the wide range of local and national initiatives. Further, Paton has argued elsewhere that this is the cost of the TP Strategy over the past *ten years*. (In fact, according to the Ministerial response to a parliamentary question from Tim Loughton in 2007, the total budgeted spend on the Strategy between 1999 and 2010/11 was £340m). This paragraph goes on to say that 'despite the vast amounts of money spent' the rate of conceptions to under 16s is the same as it was forty years ago. I have a number of concerns about this comment.

First, the England strategy targeted under 18 conceptions, not under 16 conceptions. Although failing to meet the initial (and highly unrealistic) target of halving rates, the actual reduction of around one quarter was highly impressive indeed. Further, the increase in abortion proportions meant that the actual reduction in birth rates in this age group was 35 per cent. Given the year on year lowering of numbers of births, and the changes in population size in this age group (15 to 17 year old women), it is possible to calculate a cumulative total of reduction in under-18 conceptions as well as babies born to women who conceived under the age of 18. Different assumptions lead to different figures, but a conservative estimate would be that there has been a 'saving' of around 60,000 conceptions and (given an abortion proportion of around 50 per cent) 30,000 births. Given the cost of the TP strategy was around £340m, then this represents a cost of £11,000 per birth avoided. Given the cost of the Care to Learn allowance in London, this saving would be recouped in 62 weeks. Of course, not all these reductions in births can necessarily be attributed to the Strategy, but the rough figures do indicate that the investment was indeed worthwhile.

Second, the denominator for calculating rates of births – when comparing across forty years – needs to be questioned. Traditionally, rates are based on the total population of women in specific age categories - so, for under 18 rates, the population base is women aged between 15 and 17 years, whereas for under-16 rates, the population is women aged between 13 and 15 years. Now, comparisons across time scales may be legitimate if the base population remains the same. However, there is a very strong case for saying that the true denominator should be *per thousand sexually active* women in those age groups rather than *all* women in those age groups. It is highly likely that the proportion of women in those age groups who have experienced sexual activity has increased over the past forty years, so conception rates per 1000 sexually active women will actually have shown a steep decline. This must be regarded as a success of health promotion and service provision, even if increasing levels of sexual activity at younger ages is not to be welcomed (and will certainly require different emphases to address).

2 At the top of page 2, it is claimed that a CMF paper in 2008 reached similar conclusions to those in a paper by Paton. This is not altogether surprising since the CMF article was based very much on Paton's claims!

3 The CMF/Paton arguments on risk compensation (more risky sex as a result of greater service provision) is very dubious indeed. There is no direct evidence at all that this occurs in the field of sexual activity; this whole argument is based on theoretical possibility, and dubious inferences from low level data. Indeed, a recent article published by Peipert et al. in the leading international journal *Obstetrics and Gynaecology* (vol 120 (6) 1291-1297) reports that providing no-cost contraception in St Louis was associated with a teenage birth rate of one-fifth that of the US average rate (6.3 per 1000 as compared with the national rate of 34.3 per 1000), as well as considerably lower abortion rates (between 4.4 and 75 per 1000 compared with the national figure of 19.6 per 1000). No data were published from this study on STI rates.

4 Any inferences made in the basis of changes in rates of STIs find it very difficult to account for possible changes in testing access and availability – since a very high proportion of cases of the most common STIs are asymptomatic. Apparent increases or higher rates may simply reflect more publicity and opportunities for testing. Areas that invest more in contraceptive services may also invest more in testing (with a seeming rise in rates), thereby giving rise to false assumptions regarding causal links.

5 The claim on page 2 (para 4) that areas that invested more in emergency birth control (EBC, but normally called emergency (hormonal) contraception) led to a 12 per cent increase in STIs among young people aged under 16 needs to be closely examined. First, it is immensely difficult to get accurate measure of EBC provision in an area, since provision starts and stops according to pharmacy policy, local funding arrangements, etc. Any measure thus derived is likely to be very crude; a claim which is strongly supported by staff working in the field (for example, the average number of pharmacies per local authority offering EBC per 1000 15 to 19 year olds is reported as being 0.0006 (see Table A1 of Girma and Paton), a proportion that makes simple errors highly likely indeed). Second, the incidence of STIs is very low indeed, so a 12 per cent apparent increase may sound large, but represents very small absolute numbers. The same table in the Girma and Paton paper shows that the rate of GUM diagnosed under 16 STIs is 1.39 per 10,000 young women. A 12 per cent increase therefore changes this average rate to 1.56 per 10,000. Thus, in a city like Southampton (population c250k, with a female population aged between 13 and 15 year olds of, say, 5000) there will be an increase in diagnosed STIs from 0.70 to 0.78 – an increase of one case each eight years. This is hardly enough to argue against the provision of emergency contraception for those who need it.

6 On the topic of abstinence based sex education, the CMF paper cites one recent article from Jemmott et al. from 2010 (albeit misspelled in the CMG submission). Although this study did reveal a slight (self-reported) delay in sexual debut amongst young (mean age 12.2 years) black school pupils, the effects were not large and it is not clear how well the results would transfer to

less vulnerable young people. What the CMF submission does not refer to is the extensive work of the late Douglas Kirby, who has spent the past 25 years exploring the impact of different types of sex education programmes. Although individual programmes on their own may suffer from methodological challenges, by reviewing large numbers of studies together it is possible to observe trends in the results. Kirby concludes that comprehensive programmes, as well as wider youth support activities out of school, are associated with reduced sexual activity and conception rates, age for age. He reports no support whatsoever for abstinence-only sex education. Others (for example, John Santelli in Columbia University, New York) have questioned abstinence-only education from the point of view of denial of human rights (as enshrined in the UN Convention on the Rights of the Child, for example), alongside the lack of supportive evidence.

7 What most commentators in the field propose is 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; this is the approach adopted in the Netherlands, for example. Given that some or much early sexual activity in the UK is coerced, or based on reputations, or other 'dubious' reasons, then there is general agreement that delay amongst some young people is to be encouraged; in this sense, there is accord with certain aspects of the CMF submission. However, there is 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.

8 Similarly, the CMF paper implies that parents are actively excluded by school-based SRE and confidential service provision. This is simply not the case; the Teenage Pregnancy Strategy, in line with the vast majority of SRE programmes, placed parents at the centre of initiatives. The evidence is clear that schools and parents working in concert, with mutual support for each other, will lead to better outcomes. One problem is that the public pronouncements of organisations like the CMF, and the coverage of certain academic claims in popular media, possibly serve to make parents reluctant to get involved and to show interest in the area, with the consequent appearance of lack of interest and involvement. The possibility of confidential services is necessary for those very few young people who are genuinely put at risk should they be known to be sexually involved, or even just seeking advice .

9 Finally, there is widespread agreement on the fact that massive changes are occurring in young people's culture, access to potentially harmful online material, and other recent developments. Child sexual abuse is certainly more widely reported, and may be increasing in prevalence. These threats to the safe and healthy development of young people need to be actively addressed, not made invisible by denying the education, services, openness and support that research has shown to be protective. Knowledge and confidence enable young people to exercise their choices – as

determined by their faith, culture, or whatever - from a position of strength rather than from a position of weakness.

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