

## **Inquiry into teenage pregnancy in Scotland**

### **The Highland Council and NHS Highland**

**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?**

Overall the Highland Council and NHS Highland support the direction taken at national level to reduce rates of Teenage pregnancy in Scotland. It has resulted in a modest long-term reduction in teenage pregnancy rates in Scotland in all three teenage age bandings (<16, <18, <20) between 1994 to 2010 (ISD Scotland).

Whilst biologically the late teens are a good time to have children the negative aspects of lack of experience and maturity and impact upon lifelong family income could be seen to negate this benefit. There are significant problems in relation to the extent of unintended pregnancies and the very strong associations between unintended teenage pregnancy, unintended teenage parenthood and deprivation, both as causes and as consequences.

The efforts over the last ten to fifteen years have been made to improve sexual health outcomes including those for young people are welcomed. Evidence of effective practice has been sought out, nationally and internationally. Good, well-researched policies and strategies have been produced. There has been some modest provision of additional resources and multi-agency groups have been formed at local level. Evidence-based, state-of-the-art Sex and Relationships Education programmes have been developed. Health, including Sexual Health, has been incorporated into the national curriculum for the first time.

NHS Healthcare Improvement Scotland's Quality Standards (NHS Quality Improvement Scotland, 2008) task services with encouraging young people to move towards longer-acting methods of contraception. This has the potential to reduce rates of unintended pregnancy resulting from forgetting to take daily pills.

The National Sexual Health Strategy, Respect and Responsibility, prohibited the provision of Emergency Contraception in schools (The Scottish Executive, 2006). This led to local attempts to introduce GP drop-ins in schools being abandoned, as GPs are independent contractors and neither NHS Boards nor Local Authorities can require them to depart from the practice of prescribing according to medical need, regardless of setting.

Young people place a high value on confidentiality within sexual health services. These services are crucial to reducing teenage pregnancy. NHS Highland and The Highland Council views Child Protection as important in all services which deal with children and young people, including sexual health services. However it is recognised that in some young people who are being abused deliberately exclude themselves from the services which are there to

protect them due to concerns over confidentiality and child protection procedures. Further research could be undertaken to identify to what extent Child Protection procedures within sexual health services acts to protect young people or, as an unintended side-effect, acts to prevent them from accessing services thereby placing them at additional risk and driving sexual abuse further from view.

It is clear that further, significant reductions in rates of unintended teenage pregnancy are achievable. We must strive to maintain the advances in combating unintended teenage pregnancy that have been made over recent years. Things have changed for the better and we need to recognise this and maintain our direction of travel, embedding the gains we have already made and improving on them in future.

### **Sex and relationships education**

NHS Highland works with Highland Council and Argyll and Bute Councils to encourage schools to provide comprehensive sex and relationships education. However nationally there is little requirement to do more than a bare minimum, mostly work around friendships and relationships. Even so, parents may still opt their children out of receiving sex and relationships education.

Primary school sex and relationships education, in particular, is vulnerable to strong complaints from individual parents or small groups of parents. Parental objections appear to focus largely on children being introduced to the correct names for body parts, as specified within Outcome HWB 0-47b/HWB 1-47b of Curriculum for Excellence. Where this happens, there is a natural tendency for schools to back away from dealing with what they see as a difficult subject fearing that they may otherwise end up as the target of media campaigns.

Both state and Independent schools should be required to demonstrate that they provide robust comprehensive sex and relationships education as should parents who home educate their children.

Within Curriculum for Excellence Sexual Health and Relationships education is conflated with Parenthood and the only section where discussion of sexual intercourse is required reads: "I am able to describe how human life begins and how a baby is born," implying that the main function of sexual intercourse is procreative. Sexual intercourse does not usually occur in the context of procreation; it occurs in the context of enjoyment and mechanisms are often used to ensure that procreation does not occur. Young people are likely to be aware of this. Therefore sex and relationships education should be taught in the context of enjoyment and should be decoupled from parenthood.

Sexual Health and Relationships Education tends to be delivered to school classes at a set time in the year. Classes tend to be organised by year group. Young people often reflect that the information and opportunity comes "at the wrong time" for them. There is no easy answer to this, but a clear need to review the how and when of SHARE in schools.

We do, to some extent, recognise that young people make choices around sexual relationships. We talk the language of choice and empowerment but, in reality, our efforts are directed at trying to ensure young people “choose” not to have sex. We are largely unwilling to accept that some young people will take rational decisions to have sex and that others will, like adults, simply make mistakes in the relationships they choose to pursue.

We try to dissuade young people from being involved in sexual relationships by talk of “maturity” and “readiness” for sex. This may be misguided. Many teenagers aspire, above all else, to be considered mature. If we use some concept of “maturity” or “readiness” as a pre-requisite for sex, we create a situation whereby becoming sexually experienced enables young people to demonstrate their maturity.

Much – and, perhaps, an increasing level – of our focus on sex and relationships is on the negative aspects; abusive or exploitative relationships, unintended pregnancy, sexually transmitted infections. Sex and relationships Education should be strengths-based rather than fear-based and should concentrate more on the positives (such as enjoyment and positive relationships) than the negatives (such as unintended pregnancy, STIs and stranger danger). It should cover a wider range of topics including condom use and contraception.

There is a fear that if children know about sex, they will try it out for themselves. We know from a range of well-constructed studies that this is definitely not the case. Knowledge about sex and relationships does not lead to earlier sex or to more sex. A small study carried out in the Highlands examined children’s exposure to sexualised media. Children in Primary 4 and Primary 7 were asked to identify their three favourite TV programmes, computer games, music artists, DVDs/videos/films, magazines, books and websites. These were analysed these for sexual content:

- 17% of Primary 4 girls and 30% of Primary 4 boys listed media with sexualised content as being amongst their favourites.
- By Primary 7 these figures had risen to encompass 57% of girls and 68% of boys.
- Levels of sexualisation varied: many videos featuring favourite artists were, effectively, soft porn while some scenes in video games could be regarded as more extreme (Mann, 2009).

The levels of sexual “knowledge” acquired in this way make it very likely that sexual knowledge is ubiquitous within playground settings and permeates the entire cohort. 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.

**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?**

In terms of services, NHS Highland and its partner organisations currently provide high quality sexual health services to young people through:

- GP services (attendance is not restricted to the GP service with which a young person is registered; it can be delivered by any GP who is willing to provide the service)
- Brook Highland
- Highland Sexual Health
- Community Pharmacies
- School Nurses
- Drop-in clinics providing pregnancy testing, Chlamydia testing and condoms

If we are to reduce rates of unintended teenage pregnancy it is important that these services are maintained, enhanced and extended. In the Highland Council area the NHS contract with Brook's Inverness –based service requires three after-school sessions a week and a 12.00 – 3pm session on Saturdays (timed to coincide with bus timetables), promoting accessibility for almost every young person in North Highland requiring the service. Brook is tasked with increasing rates of attendance by young people in the lower SIMD quintiles and by other marginalized groups, for example, young people with learning disabilities.

However, 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. Demographic issues also result in an inability to secure sufficient appropriately-qualified staff to make service sustainable. Demands on School Nurse time led to difficulties in maintaining some school based services. We must maintain and reinforce our efforts to ensure that accessible services are provided for young people and that young people, particularly those in lower socio-economic groups or living with other marginalising factors, are encouraged to attend.

In Argyll and Bute young people's sexual health services are augmented by drop-in clinics providing pregnancy testing, Chlamydia testing and access to condoms. There has been a recent decline in attendance which is thought to be related to GPs providing more youth-friendly services.

It is important to work towards a position where young people feel that they openly access services to support their sexual health. Again, this will require robust political leadership and significant work with parents, practitioners and others.

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

There are significant problems in relation to the extent of *unintended* pregnancies and the very strong association between unintended teenage pregnancy and deprivation, both as a cause and as a consequence. Therefore measures to tackle poverty and disadvantage are likely to have more impact in reducing teenage pregnancy rates in Scotland than measures which are badged as “sexual health”.

Teenage girls (<20) in the most income-deprived quintile are 4.4 times more likely to become pregnant than teenage girls in the least income-deprived quintile (ISD Scotland). It is important to recognise that, though a significant proportion of these are likely to be unwanted and unplanned, this will not always be the case. The position in relation to young people under the age of sixteen – where pregnancy is unlikely to be planned or wanted – is even more stark. Young women under the age of 16 in the most income-deprived quintile are just over five times more likely to become pregnant than those in the least income-deprived quintile. (ISD Scotland)

Where teenage women (<20) become pregnant those in income-deprived areas are less likely than others to terminate the pregnancy. In the most income-deprived quintile only 28% of teenage pregnancies (<20) end in termination while, in most affluent quintile, 70% of such pregnancies are terminated. (ISD Scotland). The rate of births to teenage mothers (<20) in the most income-deprived quintile is, therefore, 10.4 times that in the least income-deprived quintile. (ISD Scotland) This represents an extraordinarily steep inequalities gradient which is unlikely to be explained by differentials in sex education and access to sexual health services.

There is a view, often expressed in the press, that young women may become intentionally pregnant in order to access welfare benefits and/or housing. We believe this is more likely related to low self-esteem, lack of belief that circumstances can be improved, a search for a role in life and someone to love/be unconditionally loved by. Babies born to teenage mothers are much more likely to be born into poverty.

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

Scottish cultural attitudes towards women and sex are still unhealthy and unacceptable. Over recent years much has been done to address this but much more needs to be done.

There are many ways in which cultural attitudes related to gender manifest themselves including the sexual objectification of women and girls in advertising, the media and popular culture.

The culture around boys and men is also unhelpful, with macho and competitive stereotypes prevailing. In particular, there is little or no reflection of men in nurturing, caring roles and, in practice, few boys and men enter nurturing and caring professions. This may be compounded by In Highland the fact that only a handful of approximately 600 childcare workers are male. Toy advertising in the UK, in contrast to some other European countries, consistently shows girls playing with toys that emulating nurturing roles in play and and boys playing with toys that are traditionally seen as “macho”.

Work to fundamentally change society’s view of gender is a matter of urgency if unintended teenage pregnancy is to be reduced. This should be robustly pursued with clear political leadership.

### **Attitudes to forced, coerced and exploitative sex**

Our culture is still one where high levels of ambivalence in relation to consent and sexual autonomy prevail. Of particular concern were the findings of a 2007 study which illustrated gendered attitudes to forced sexual intercourse amongst 5<sup>th</sup> year school pupils in Scotland:

- 14.7% of boys and 8% of girls agreed (or agreed strongly) that they might force someone to have sex if they were so turned on they couldn’t stop. A further 19.2% of boys and 17.4% of girls were unsure
- 21.5% of boys and 18.4% of girls agreed (or agreed strongly) they might force someone to have sex if they’d both been drinking. A further 27% of boys and 24.4% of girls were unsure.
- 10.6% of boys and 8% of girls agreed (or agreed strongly) they might force someone to have sex if they thought no-one would find out. 20.3% of boys and 18.8% of girls were unsure
- 21.9% of boys and 17.7% of girls agreed (or agreed strongly) they might force someone to have sex if they had had sex before. 22.5% of boys and 21.3% of boys were unsure (Elliott et al, 2010).

Though the level of agreement for girls is lower than that for boys, the extent of cultural acceptance of forced or coerced sex across genders is likely to lead to a position in which victims of sexual abuse do not, themselves, perceive what has happened to them as anything out of the ordinary or in any way unacceptable.

In 2010 the Scottish Government introduced new legislation which provided much greater clarity around issues of consent and sexual autonomy (The Scottish Government, 2010). It is to be hoped that this change will have started a shift in attitudes to sexual violence.

The sexual culture within Scotland must change to a position where forced sex, sexual exploitation and sexual coercion become completely unacceptable and where consent is fully understood and respected. This should be robustly pursued with clear political leadership.

## **Our cultural view of children and young people**

Times have changed considerably from the Victorian and Edwardian eras where children “should be seen and not heard”. Today’s children have a rights and a voice both of which are underpinned by the UN Convention on the Rights of the Child.

However, there remains a great deal of ambivalence in the way our culture views children. In Scotland children can become almost fully autonomous at the age of sixteen. At this age they can leave home, leave school, have sex, marry or get a job, though it is a further year before they can drive and a further two before they can vote or drink alcohol. Partial autonomy is achieved earlier than this with rights to consent in a variety of settings including medical treatment from the age of twelve. The age at which children in Scotland are considered mature enough to be held criminally responsible for their actions has recently risen from eight to twelve.

Between infancy, when all decisions are made on a child’s behalf by adult carers, and the age of sixteen, when most young people are entitled to make almost all of their own decisions, one of the main tasks of parents, carers, teachers and society at large is to support children to the stage where they are capable of being fully autonomous. This is achieved by building a child’s resilience and self-efficacy and encouraging the child to take increasing levels of responsibility for him/herself.

Work to build resilience, beginning as early as possible in a child’s life, are vital in providing the foundations for developing resilience. If we wish young people to take good decisions as they grow up, including good decisions around their sexual health, it is important to develop their resilience and self-efficacy and to allow age-appropriate exposure to risk. Strategies to develop resilience and self-efficacy should be built into all work with children and young people.

## **Our cultural view of underage sex**

Over many years there has been heated political and cultural debate around adult and teenage sexual orientation, abortion, teenage sexuality, teenage sexual health and teenage pregnancy (intended and unintended). The debate centres around two fundamentally different views:

- On one hand there are those who perceive their view as pragmatic: sexual desire is biologically driven through the action of hormones during and following puberty; a proportion of young people do engage in sexual activity before the age of sixteen and, for most, this is unproblematic; good, comprehensive sex and relationships education which includes discussion of the benefits of sex within relationships, delaying sexual activity and limiting partners, as well as contraceptive/condom use should be provided; sexual health services should be available to young people and so on.

- On the other hand there are those who see their view as primarily moral: having sex before the age of 16 (or, sometimes, outwith marriage) is wrong; young people should be required to abstain (sometimes until marriage); sex education should be restricted to abstinence as the only reliable way of preventing pregnancy and the acquisition of STIs; parental consent should be required for young people accessing sexual health services, abortion should not be permitted (or should be restricted), and so on.

There is a plethora of evidence which would tend to support the first position (Kohler et al 2008, Kirby 2008). The second position, particularly in relation to Sex and Relationships Education and service provision has been used extensively in the United States but has evaluated poorly by comparison to more pragmatic approaches (Kirby 2008, Isley et al 2010, Stranger-Hall & Hall 2011, Yang & Gaydos 2010)

In addition, the first approach is that generally adopted by Western European neighbours where, following implementation of the approach many years ago, teenage pregnancy rates fell significantly and are now much lower than Scottish rates, while the second approach has been extensively adopted in the United States where teenage pregnancy rates are significantly in excess of ours.

In Scotland we have, to some extent, adopted the first approach, while our culture simultaneously clings to strong elements of the second. It is now time to take a clear and unambiguous stand.

Our society's culture around young people, sex and relationships must change to one which is more overtly accepting of the realities of teenage sexuality. This change should be robustly pursued with clear political leadership.

### **Scotland's alcohol culture**

Scotland's unhealthy relationship with alcohol has been clearly demonstrated and the Scottish Government has proposed measures (such as minimum pricing) in an attempt to shift cultural attitudes. Many people in Scotland do not set out merely to have a few drinks, or even to get drunk. A good night is not a good night for some unless they can get completely "wasted".

Alcohol misuse diminishes people's ability to make rational choices and this applies in sexual health as in other areas of life.

There may well be similar issues in relation to both illegal drugs and "legal highs", but, from a sexual health perspective, these are dwarfed by alcohol related sexual health problems.

Shifting culture in relation to alcohol misuse is key to improving young people's sexual health and reducing teenage pregnancy. The Scottish

Government's proposals in its ambition to achieve this are to be welcomed and should be maintained.

### **Judgmental attitudes in young people's services**

Scotland's culture around issues such as gender, sexual orientation, young people, forced and exploitative sex and so on do not simply represent a direct problem in the way they influence young people. We all live in our society and we are all affected by its mores, helpful or otherwise. This applies with equal weight to those who provide services for young people.

While it has long been clear in public policy terms that services for young people should be non-judgemental, it is nevertheless the case that staff working in these services carry with them their own personal package of values and prejudices. We all do.

Most teachers, doctors, social workers, nurses, receptionists and other practitioners have the capacity to differentiate between their personal values and their occupational values. Sometimes these will coincide; sometimes they will differ. But there are still those who cannot make the leap between their cultural and personal values and the non-judgemental nature of the work in which they are engaged.

Training can help, but only up to a point. The only way to move towards services that are truly non-judgemental at every level is to make the shifts in culture required at a population level so that the difference between personal belief and occupational values are diminished or eliminated.

- e. 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?**

### **Teenage parents**

Where parents are still in their teens and, particularly, the earlier in their teens they are, they are more likely than most parents to benefit from additional help and support. There are several reasons for this:

- Being young, they are likely to lack the life experience that comes with age
- Being disproportionately poor they may struggle to make ends meet and face frequent financial crises. This can also have an impact on their mental health and, through this, ability to cope.
- Early pregnancy likely to be indicative of a lack of resilience in some young women.

There is evidence that supportive parenting – particularly parental supervision of children and open discussion between parents and children is protective of health (Wight & Fullerton, 2013). Providing supportive parenting becomes

much more possible if the parent(s) is/are able to cope with their own situation.

The “Getting it Right for Every Child” approach has enhanced partnership working across a range of core services making progress in supporting teenage mothers. This will become targeted through investment in Family Nurse Partnerships in some areas to provide exactly this sort of support to young people in the greatest need. Key features of the programme are:

- A strengths-based approach
- Low caseloads
- Built-in support for staff

In order to reduce their own susceptibility to further teenage pregnancies and, particularly, to reduce their children’s susceptibility to become teenage parents themselves, it is important that effective additional support is provided to young parents. Access to services must be made easier in remote and rural areas as well as urban settings, with appropriate recognition of the additional costs incurred in delivering such intensive, specialist interventions.

- 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?**

A focus on prevention in the early years is essential to tackling many of the issues highlighted earlier in this response. The Highland Council and NHS Highland have long recognised the critical importance of the Early Years in establishing a strong foundation for life. Long term iterative planning and review between partners for children in their early years and their families is essential to ensure that the quality of early years services continues to improve and better value for money is achieved.

**Highland Council’s Early Years Collaborative** sets out to accelerate the conversion of the high level principles set out in the Early Years Framework (The Scottish Government, 2008) into practical action. Plans are ambitious and analyse how the use of total resources will change over time to enable resources to be more readily directed towards meeting the needs of vulnerable children and their families through preventative approaches.

**The Family Nurse Partnership (FNP) programme**, which has been piloted in Lothian, is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old. Key features of the programme are:

- A strengths-based approach
- Low caseloads
- Built-in support for staff

Though the programme is too recent for statistical evidence of its efficacy to be available, those involved, including Family Nurse Practitioners and clients reported a wide range of areas in which FNPs were perceived as having positive impacts in relation to both the sexual health of the teenage mother and the future sexual health of her children, thus breaking the intergenerational cycle of poverty.

FNPs can currently be implemented in urban and semi-urban settings. However, the nature of these programmes is such that they will be difficult to replicated, with sufficient fidelity, to rural settings within the current financial envelope.

Because FNPs require that each nurse works intensively with a lower than normal caseload, this appears, at first sight, as an expensive intervention. However, in weighing up the costs we also need to look at benefits, which have the potential to be very substantial.

- 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?**

These are covered in other sections above

- 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?**

No

**Dr Margaret Somerville,  
Director of Public Health  
NHS Highland  
Bill Alexander  
Director of Health and Social Care  
The Highland Council**

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