2003 Under 18 Conception Data: Q&As

Q What do the 2003 conception figures show about progress of the Strategy?

A The 2003 England under 18 conception rate is 42.1 per 1000 girls aged 15-17. This represents a 9.8% decline since 1998 – the baseline year for the Teenage Pregnancy Strategy and a 1.2% reduction from 2002-03. Four out of five local authorities show an overall decline in their rates. Eight out of nine regions have reductions ranging from 8-14%. The latest 2002 figures for the under 16 conception rate show an 11.2% reduction. The 2003 under 16 data will be available from ONS in the summer.

Q How can the rate have declined when the numbers of under 18 pregnancies is at its highest?

A To assess change over time, it is important to look at the proportion of 15-17 year olds who become pregnant, not the absolute number as the size of populations change year by year. Between 1998 and 2003 the population of females aged 15-17 increased by 7% which is why the numbers of pregnant teenagers has increased. However, the **proportion** of under 18s becoming pregnant has declined by 9.8%. It is standard statistical practice in all areas of work to measure rates rather than numbers.

Q The percentage of pregnant under 18s having abortions has increased since the start of the Strategy. Is the Government encouraging young people to have abortions?

A No. The aim of our teenage pregnancy strategy is to provide young people with the information, knowledge and skills to make their own informed choices about sex and relationships and pregnancy. Our best practice guidance on effective contraceptive and advice services for young people makes clear that services should provide easy access to early pregnancy testing, non-judgmental advice and referral for NHS abortion services or antenatal care. The decision to have an abortion is one for the young woman, in consultation with her doctor, within the terms of the 1967 Abortion Act.

Q: Isn't the Government likely to miss the 2004 interim reduction target and the 2010 goal?

A. These are very challenging targets to help us focus on a complex and sensitive area of work. Achieving them will require sustained and strengthened implementation of the Strategy at national and local level, involving a wide range of services, professionals, parents and young people. This is why we are asking all areas to redouble their efforts to strengthen their strategies to reach high rate neighbourhoods and teenagers at risk. Fifty percent of under 18 conceptions are in 20% of wards with the highest rates, with the vast majority of authorities having a hotspot ward in their area.

Q: How much money has been invested in the Strategy?

A: £63M was invested in the first three years of the Strategy from 2000-2003. An additional £40M has been invested from 2003-2006.

Q: Hasn't the large investment only achieved limited results?

A: Reducing teenage pregnancy and supporting young parents requires significant changes in service provision, attitudes and behaviour - sometimes deep rooted and spanning several generations - which take time and investment to achieve. The health and social costs of teenage pregnancy are far reaching. Calculations of the cost effectiveness of the Teenage Pregnancy Strategy estimate a saving of around £4 for every £1 spent. This is a very conservative estimate and doesn't take into account additional NHS savings from improved rates of infant mortality, reduced smoking rates, increased breastfeeding rates and the better long term health outcomes that could result from the Strategy.

Q By improving support for young parents won't this encourage more young people to become pregnant?

A This is a simplistic assumption about a complex issue. Pregnancy can be an indicator of many complex issues in a young person's life such as: poverty and social exclusion, family breakdown, violence and sexual abuse, low self-esteem, and low academic achievement. Support for teenage parents challenges inequality by promoting re-engagement in education and training and countering isolation resulting from having a child. Increasing support for vulnerable teenage parents will break the cycle of deprivation and improve life opportunities for them and their children. We need to ensure that we do not become a society that apportions blame on teenage parents for wider problems in society. If support structures were not in place for young parents, we would be failing them and future generations.

Q: What role are parents playing in the Strategy?

A: Research suggests that young people in families where sex and relationships are discussed without embarrassment become sexually active later and are more likely to use contraception. Parents are young people's preferred source of information about sex. However, around half of young people say they have received 'nothing' or 'not a lot' of information sex and relationships from their parents. More than half of young people find it easy to talk to their mother about sex and relationships, but only a quarter say the same about their father. Over a third say they find it very difficult to talk to their father about sex and relationships.

Involving parents in prevention is an important strand of our teenage pregnancy strategy. We regularly consult with parents through a Parents Panel organised by the National Family and Parenting Institute (NFPI). We

also support the Time to Talk media initiative, run by Parentline Plus, aimed at helping parents talk to their children about sex and relationships. This is supported by the Parentline Plus freephone helpline. Local teenage pregnancy strategies are developing ways of supporting parents, through schools, community groups and voluntary organisations.

Q: Do parents support the Strategy?

A: There is strong evidence from our national tracking survey that parents fully support the values and principles of the Strategy. For example, 84% believe there would be fewer teenage pregnancies if parents talked to their children about SRE issues and 86% think SRE helps young people be more responsible.

Q: The US reports a 28% reduction in pregnancies to 15-19 year olds from 1990 to 2000. If this is due to abstinence only education, why doesn't the Government adopt the same approach?

A: Analysis by researchers at the US Alan Guttmacher Institute calculate that the vast majority of the reduction in pregnancies is due to more effective contraceptive practice, with a minority attributable to reduced sexual activity.

There is no strong evidence that abstinence only education is effective. A recent review applied strict methodological criteria to assess the available evidence for the effectiveness of teenage pregnancy prevention interventions and concluded that there is some evidence that abstinence approaches may actually *increase* rates of pregnancy and sexually transmitted infections. Specifically this effect was seen in the partners of male participants in the interventions.

In contrast there is strong evidence concerning the effectiveness of comprehensive sex and relationship education, linked to accessible services, which encourages young people to delay sexual activity but also encourages them to use contraception if they do have sex. This is the approach of our strategy. In addition, research does not suggest that providing young people with sex and relationships education and contraceptive advice increases sexual activity.

Q Why doesn't the Strategy encourage young people not to have sex?

A Helping young people resist peer pressure to have early sex has always been one of the central themes of the Strategy. Teenagers having sex before 16 are significantly more likely to report regret; to not use contraception; and to get pregnant before 18. The UK has a significantly higher percentage of sexually active under 16s compared to European neighbours such as France, the Netherlands and Sweden. This message is promoted through our Sex and Relationship Education Guidance issued to schools in 2000 and the national media campaign in teenage magazines and

local radio. New messages on delay for the teen media are being developed with young people.

Q Can under 16s get contraception and emergency contraception without their parents knowing?

A Health professionals can provide contraception including emergency contraception to young people under 16 provided that they are satisfied that:

*the young person understands the advice provided and its implications;
* her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.

This is set out in guidance to health professionals issued by the Department of Health in July 2004. The guidance also makes clear that when an under 16 year old requests contraception, health professionals should establish rapport and give the young person support and time to make an informed choice by discussing:

*the emotional and physical implications of sexual activity, including the risks of pregnancy and STIs;
* whether the relationship is mutually agreed and whether there may be coercion or abuse;
* the benefits of informing their GP and involving a parent or carer
* any additional counselling or support needs

Young people have the same right to confidentiality as adults. However if the health professional has serious concerns about their safety or welfare they would follow locally agreed child protection policies. The younger the age, the greater the concern is likely to be about abuse or exploitation.

Q Can a girl aged under-16 have an abortion without her parents' knowledge?

A Yes, but this is unusual. We recognise that these are very difficult cases which should be handled sensitively. However, the priority must be for young women faced with a pregnancy to get the support they need to make an informed choice as early as possible Guidance published by the Department of Health in July 2004 states that health professionals can provide contraception, sexual and reproductive health advice and treatment to under 16s, without parental consent, provided the young person:

* understands the advice provided and its implications
* his/her physical or mental health would otherwise be likely to suffer so provision of advice or treatment is in their best interest.

In reality, it is unusual for a young person, aged under 16, to undergo an abortion and not involve a parent. The guidance makes clear that health professionals should always encourage the young person to involve a parent.

If the young person is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.

Q Is there a lower age limit for consent or confidentiality?

A The duty of care and confidentiality applies to all under 16s. Whether a young person is competent to consent to treatment or is in any serious danger is judged by the health professional on the circumstances of each individual case, not solely on the age of the patient. However, the younger the patient the greater the concern that they may be being abused or exploited. The DH Guidance makes clear that health professionals must make time to explore whether there may be coercion or abuse. Cases of grave concern would be referred through local child protection procedures.

Q. Doesn't the new Sexual Offences Act mean that all sexual activity under 16 is an offence?

A. In England and Wales, the law on Sexual Offences has been updated. Under the law, the legal age for young people to consent to have sex is still 16, whether they are straight, gay or bisexual.

The aim of the law is to protect the safety and rights of young people and make it easier to prosecute people who pressure or force others into having sex they don't want.

Although the age of consent remains at 16, it is not intended that the law should be used to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation.

Under the Sexual Offences Act young people under 16 still have the right to confidential advice on contraception, condoms, pregnancy and abortion.

Q Doesn't the Sexual Offences Act mean the provision of contraception to under 16s is illegal?

A No. The Act states that anyone providing contraception, sexual health or reproductive advice or treatment to someone under 16 is not committing an offence providing they are acting to:

* protect a child from pregnancy or sexually transmitted infection
* protect the physical safety of a child
* promote a child's emotional well being by the giving of advice.

This exception in the Act covers not only health professionals but anyone who acts to protect a young person, for example teachers, Connexions PAs, youth workers and social care practitioners.

Q What is being done about increasing rate of sexually transmitted infections among young people?

A : The National Strategy for Sexual Health and HIV (linking closely to our Teenage Pregnancy Strategy) and the new Public Health White Paper, Choosing Health, identify young people as a priority group for action. Our media campaigns are raising awareness among young people of STIs, and how to avoid them. Awareness of chlamydia has increased from 32% to 64% among 13-17s since 2000. We are also tackling the most common STI through our national chlamydia screening programme, which already covers a quarter (84) of Primary Care Trusts in England. Access to confidential contraceptive and sexual health advice services is an essential part of both strategies. This is particularly important for under 16s who are the least likely to use contraception and condoms.

General Q&As about the Strategy

Q: What is the Teenage Pregnancy Strategy?

A: It is the first cross Government Strategy to tackle our unacceptably high rates of teenage pregnancy. The UK's teenage birth rates are more than twice as high as Germany, three times as high as France and five times higher than the Netherlands.

The Strategy was launched by the Prime Minister in 1999 and has two key goals: to halve the under 18 conception rate and establish a firm downward trend in the under 16 conception rate by 2010; and to increase to 60% the proportion of 16-19 year old mothers in education, training and employment by 2010, to reduce their long term risk of social exclusion. The reduction goal is a joint Public Service Agreement between DfES and DH, central to our Change for Children Programme and Public Health White Paper.

The Strategy draws on the best available international research evidence. This has resulted in a multi-faceted approach which includes helping young people resist pressure to have early sex through improved sex and relationship education and supporting parents in talking to their children about these issues; increasing uptake of contraceptive advice by sexually active teenagers; and supporting young parents to improve the health and social outcomes for them and their children.

Q: How is the strategy implemented at local level?

A: Each top tier local authority area has its own 10 year Teenage Pregnancy Strategy to reach locally agreed under 18 conception reduction targets. The local strategies are led by a Teenage Pregnancy Co-ordinator working with a Teenage Pregnancy Partnership Board. This has representation from local Primary Care Trusts (PCTs), social services, education and housing/Supporting People teams, Connexions service and

other relevant local stakeholders. Local teenage pregnancy strategies are supported and monitored by nine Regional Teenage Pregnancy Co-ordinators, located in each Government Office in England. They work closely with relevant regional leads in Government Offices for example for education, children's and youth services to ensure that teenage pregnancy and its underlying causes are taken fully into account in wider children and young people's initiatives.

Details of implementation of the Strategy's 30 point action plan can be found in the Strategy Progress Report, on the Teenage Pregnancy Unit website

Teenage Pregnancy Unit
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