



## DEBATE PACK

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# Regional variations in the rate of teenage pregnancy

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## Summary

This pack has been produced ahead of the debate to be held in Westminster Hall on Tuesday 19 April 2016 at 4.30pm on regional variations in the rate of teenage pregnancy. The Member in charge is Lucy Allan.

Significant progress has been made in reducing the number of teenage pregnancies and rates have fallen considerably in recent years. However, substantial regional variations persist in teenage pregnancy rates.

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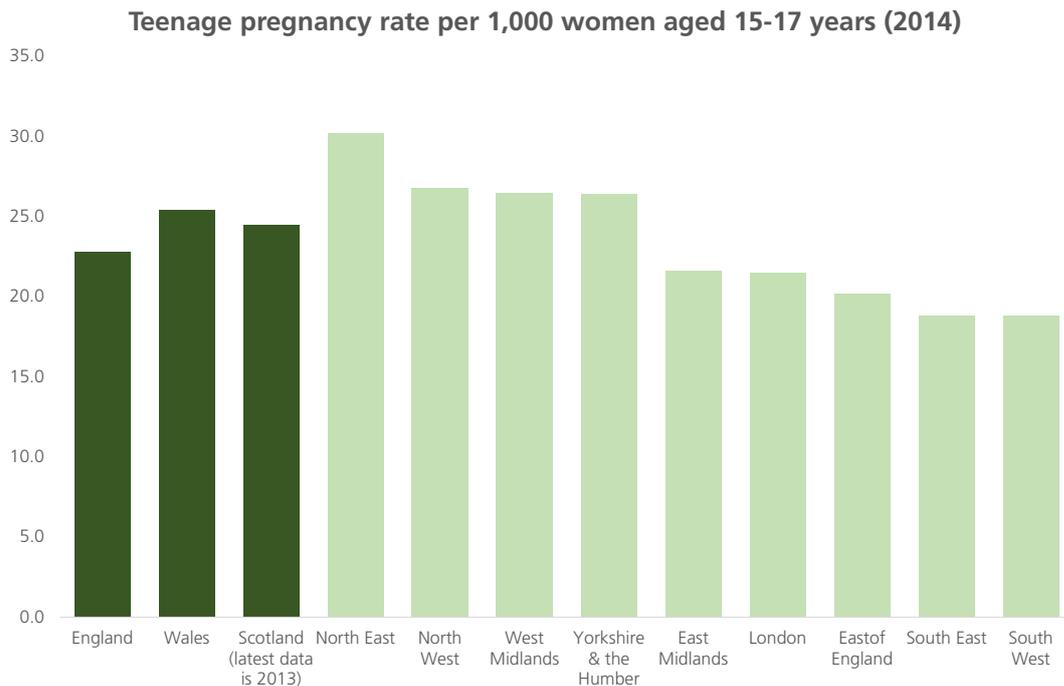
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# 1. Statistics

Significant progress has been made in reducing the number of teenage pregnancies and rates have fallen considerably in recent years. However, substantial regional variations persist in teenage pregnancy rates.

Current rates for England are lower than Scotland and Wales and within England much higher levels of teenage pregnancy are observed in the North East, North West, West Midlands and Yorkshire and the Humber. (Figures for Northern Ireland are not available)



Sources: [ONS Conceptions data](#) and [ISD Scotland Teenage Pregnancy Data](#)

Comparisons at local authority level reveal even larger discrepancies. In England, the 2014 rates ranged from 5.2 per 1,000 in Hart to 43.0 per 1,000 in Nuneaton and Bedworth. In Wales the lowest rate was observed in Monmouthshire -14.2 per 1,000 – compared with 32.1 per 1,000 in Bridgend.

The ONS [Interactive Teenage Conceptions map](#) allows you to examine trends between 1998 and 2014 at local authority level in England and Wales, providing a comparison with the national average

Similar variation in teenage pregnancy rates at local authority level is found in Scotland. The 2013 figures ranged from 11.4 per 1,000 in East Renfrewshire to 43.9 per 1,000 in Dundee.

## 2. Policy on teenage pregnancy

### 2.1 Sex and relationship education in schools

#### **What must be taught and the parental right to withdraw their children**

Local authority maintained schools in England are obliged to teach sex and relationships education (SRE) from age 11 upwards, and must have regard to the Government's [SRE guidance](#). Academies and free schools do not have to follow the National Curriculum and so are not under this obligation. If they do decide to teach SRE, they also must have regard to the guidance.

Parents are free to withdraw their children from SRE if they wish to do so. The only exceptions to this are the biological aspects of human growth and reproduction that are essential elements of National Curriculum Science.

#### **Reviews and proposals for change**

The position of SRE on the curriculum was considered within the then Government's 2011 internal review of personal, social, health and economic education (PSHE). It was decided that PSHE would remain a non-statutory subject, and the position of SRE remained unchanged.

During the 2010 Parliament concerns were frequently raised about the content, status and quality of SRE. A 2013 Ofsted report found that SRE "required improvement in over a third of schools."

Private Member's Bills have been tabled during both the 2010 and 2015 Parliaments to introduce compulsory SRE (sometimes within proposed statutory PSHE), from Labour and Green MPs. The shadow Education Secretary, Lucy Powell, recently [announced](#) that statutory PSHE would be one of the first measures implemented by a Labour Government.

There were also calls from across parties for the Government's SRE guidance, which has been in place since 2000, to be updated. The Coalition Government argued that supplementary advice for schools published by the PSHE Association, the Sex Education Forum and Brook, "[Sex and relationships education \(SRE\) for the 21st century](#)", performed this function.

#### **Education Committee report and letter from committee Chairs**

In February 2015 the Commons Education Select Committee recommended that, alongside PSHE, age-appropriate SRE should become a statutory subject in primary and secondary schools, albeit with parents retaining their right to withdraw children. The Government response published in July 2015 did not take forward this recommendation, although it stated that it would be giving further consideration to the Committee's arguments in 2015.

In February 2016 the Education Secretary [confirmed](#) that PSHE would not be made statutory.

#### **Teaching about same-sex marriage**

During and following the passage of the *Marriage (Same Sex Couples) Act 2013* there was considerable debate about the implications of the legislation for teachers whose religious beliefs led them to oppose the measure. The then Equalities Minister stated that teachers would be able to describe their belief that marriage is between a man and a woman,

while acknowledging that same-sex marriage will be available within the law. Reforms for schools to 'actively promote' British values have provoked further debate in this area.

For more information see Library Briefing Paper 06103: [Sex and Relationship Education in Schools \(England\)](#).

## 2.2 Government's sexual health strategy

The extract below is from [A Framework for Sexual Health Improvement in England](#) (March 2013) and sets out Government policy aimed at reducing the incidence of teenage pregnancy. The Government's ambition is to:

Continuing to reduce under-18 pregnancies is a high priority, as highlighted by the inclusion of this as an indicator in the Public Health Outcomes Framework. This is because:

- of all young people not in education, training or employment, 15% are teenage mothers or pregnant teenagers;
- teenage parents are 20% more likely to have no qualifications at age 30;
- teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner; and
- teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth.

Outcomes are also worse for children:

- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60% higher.
- Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child.

While teenage conception may result from a number of causes or factors, the strongest empirical evidence for ways to prevent teenage conceptions is:

- high-quality education about relationships and sex<sup>33</sup>; and
- access to and correct use of effective contraception.

Over the past ten years, local areas have developed structures for translating this evidence into local delivery, with all partner agencies understanding their contribution. It is for local authorities, working with health and other partners, to continue to take the lead in reducing teenage pregnancies. Local areas have been given the freedoms and flexibilities to do what fits to reduce teenage pregnancies in their area – by providing appropriate support to ensure that young people have ambitions and stay engaged with and reach high levels of educational attainment, so that all young people can have the best start in life. Some local areas have undertaken successful early-intervention

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schemes to identify young people at risk of teenage pregnancy at an early age and provide them with more intensive support to address multiple risks and raise self-esteem. There is a great deal of learning about what works on the Department for Education's website. Having clear and realistic goals around reductions in under-18 conceptions is vital, and the importance of local leadership and partnership working in translating evidence into local actions cannot be underestimated in delivering real improvements in outcomes for young people. Use of good local data to inform commissioning and interventions is essential. The Children's Improvement Board data profile should also be used to help local areas to review their own progress on children and young people's outcomes, and to provide support and challenge to local areas to further improve through sector-led improvements and peer support.

### 2.3 Local authorities' duties

As outlined in the previous section, efforts to tackle teenage pregnancy are led by local authorities. Authorities make decisions about whether a teenage pregnancy coordinator (TCO) is needed in their local areas.

There is no requirement for authorities to report centrally on whether they have a coordinator [[HC Deb 6 May 2014 c156-7W](#)]. For those areas that have a TCO, funding may come from local authorities' core DCLG funding, DH public health funding, the Business Rates Retention Scheme, or from other grants.

[Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities](#) (2013) is designed to help local authorities to commission high quality sexual health services for their local area.

The [Local Authorities \(Public Health Functions and Entry to Premises by Local Healthwatch Representatives\) Regulations 2013 \(SI 2013/351\)](#) require local authorities to arrange for the provision of certain services, including open access sexual health services, for everyone in their area; including free contraception, and reasonable access to all methods of contraception. The requirements are broadly the same as the requirements which the NHS previously had to fulfil.

### 3. Press articles and publications

**BBC News, 11 March 2016**

[Why are teen pregnancy rates in the West Midlands so high?](#)

**Guardian, 9 March 2016**

[Halving of teenage pregnancy rate since 1998 'extraordinary'](#)

Conception rates among under-18s in England and Wales at lowest level since records began after falling 6.8% in one year

**FT, March 9 2016**

[UK teenage pregnancies fall to record low](#)

**Local Government Association, January 2016**

[Good progress but more to do: Teenage pregnancy and young parents](#)

**National Child and Maternal Health Intelligence Network**

Has a [regional snapshot tool](#) showing area profiles of teenage pregnancies which was updated in January 2016.

**BBC:** [Teen Pregnancy Rate continues to fall](#), 9 March 2016

## 4. Recent PQs

To ask Her Majesty's Government whether they carried out an equality impact assessment before deciding on the recent in-year budget cut to public health funding.

**The Parliamentary Under-Secretary of State, Department of Health (Lord Prior of Brampton) (Con):** My Lords, we pay close attention to equalities considerations when deciding how to distribute the public health grant between local authorities. The Department of Health is about to consult on how to implement the savings and we will address our equalities duties in full when announcing our final decisions.

**Baroness Walmsley (LD):** My Lords, I thank the Minister for his reply, but given that these cuts will impact on teenage pregnancy programmes for the young, domestic violence programmes for women, HIV prevention programmes for gay men and some members of the BME community and TB prevention programmes for the poor and homeless, will he say where the equality is in that?

**Lord Prior of Brampton:** The noble Baroness will know that decisions on these matters are left to local authorities, and we wish to give them as much discretion as we can.

[HL Deb 9 July 2015 c237](#)

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