The Morning After:
A Cross Party Inquiry into Unplanned Pregnancy

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Unplanned pregnancy affects the lives of women of all ages from early teens to those in their forties, crossing every socio-economic group while often adversely impacting society as a whole. With approximately 8.7 million women of reproductive age living in England today (NHS Information Centre 2012), the issue of unplanned pregnancy is something that demands our careful consideration and attention.

Given the cost to society and the impact on women, the committee believes that an integrated, cross-departmental strategy to tackle unplanned pregnancies is currently lacking. The rising abortion rates in some age groups and high teenage pregnancy rates suggest that there are still some underlying issues that need to be addressed.

By holding this cross-party inquiry the committee wanted to first understand why there has been an increase in terminations despite the good work established by the Government's Teen Pregnancy Strategy. Secondly, the committee wanted to know what more needs to be done to reduce the number of unplanned pregnancies.

The cross-party inquiry sought to explore these issues and now puts forward a series of recommendations to Government departments on ways to reduce the number of unplanned pregnancies in the UK.

Having taken evidence from a range of key stakeholders, the committee calls on the Government to publish its Sexual Health Strategy without further delay.

Our key recommendation is that a national strategy needs to be implemented that tackles unplanned pregnancy in all age groups.

The recommendations agreed by this inquiry are set out below. They are framed by six key themes arising from the evidence presented to the committee. Of these key themes, Sex and Relationships Education (SRE) and access to contraception were the recurrent, central issues.

Sex and Relationship Education

Recommendations	Action to be taken by
The government should take decisive action and make Sex and Relationship Education (SRE) statutory. This will allow for a more consistent and comprehensive programme to be implemented across the country with clear guidelines for schools to follow. Adopting a holistic approach, SRE should include relationship counselling and education on alcohol and substance misuse. Whilst standardisation is crucial to ensure equality of access, schools should be given flexibility in how they deliver their Personal Social Health and Economic Education (PSHE) curriculum. For example, Relationship Education could be incorporated as part of Citizenship within PSHE, which is already compulsory.	Department of Education
Raising young people's aspirations needs to be a key objective of SRE. Developing self-esteem, values and awareness so that they can make informed choices is important in improving how sexual health is viewed.	Department of Education
Statutory SRE training for teachers should be introduced so that they are more informed about the subject and thus more confident in delivering the subject to pupils.	Department of Education
A system of kite-marking for external agencies should be introduced allowing schools to know which organisations have been assessed and approved as providing appropriate, accurate and evidence-based SRE programmes.	Department of Education

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Access to contraception

Recommendations	Action to be taken by
All women must have equal access to contraceptive services appropriate to age and circumstance. New guidelines should be issued which set out minimum requirements for Clinical Commissioning Groups (CCGs) to meet in terms of including a wider provision of services, such as those made available to the under 25s. This should also include services available in the work place.	National Commissioning Board / Public Health England
All women to have access to a range of Long Acting Reversible Contraception (LARC). This needs to be prioritised.	CCGs National Commissioning Board
NICE guidelines need to include guidance on post-abortion contraceptive services.	NICE
The range of contraceptive services should be tailored to the needs of the local population. Those women with particular cultural and/or religious beliefs need to have local services tailored to their needs.	CCGs National Commissioning Board
A combined strategy involving SRE, nurses and community clinics should be introduced to prevent duplication, gaps in the service and lack of cohesion in service provision.	Department of Health Department of Education
Greater consideration needs to be given on how to support women who experience an unplanned pregnancy whilst also suffering from alcohol and drug addiction. There is a need for a more combined approach to be taken, bringing together sexual health services with drug/alcohol treatment.	Department of Health National Commissioning Board
Appropriate mental health services need to form part of the range of services offered to women so that they can make informed decisions and choices when facing an unplanned pregnancy and cope better with the experience.	CCGs

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Training

Recommendations	Action to be taken by
A robust national training programme needs to be introduced in order to increase the number of healthcare professionals who are trained in giving contraceptive advice and thereby increase access. This could be developed as part of the NHS's National framework to support local workforce strategy development.	Royal Colleges NHS
All women should be given contraceptive advice post delivery as part of the follow up care. This should be incorporated into the care provided by midwives at home for up to ten days after birth and consideration should be given to the training of health visitors.	NICE

Role of public health and commissioning

Recommendations	Action to be taken by
Continue to implement and maximise opportunities and successes achieved through the Teenage Pregnancy Strategy. Elements of the strategy need to be implemented for the over 20s.	Public Health England
The role and involvement of trusted third sector organisations needs to be fostered so that a 'joined-up' approach to service provision can be established, encouraging the sharing of knowledge and experience.	Public Health England
New guidelines need to be published which set out the minimum requirements and expectations of clinical commissioning groups (CCGs).	Public Health England
Public Health England should establish national models for contraceptive pathways that can be tailored by local authorities to the needs of their area. Strong and clear guidelines need to be issued to local authorities so that they can plan services with the appropriate expertise and structures in place after 2013.	Public Health England Local authorities

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Under age sex

Recommendations	Action to be taken by
Increase coordinated efforts to protect young people from sexual exploitation. Local government, healthcare providers, social services, the police and the third sector should work much more closely together and expose and bring to justice cases of sexual grooming and exploitation, including sex with underage girls.	Crown Prosecution Service Police Department of Justice Healthcare providers Social services Third Sector
Boys and girls need to be educated in the importance of consent and the legal implications of this being breached, particularly in terms of violence and coercion.	Department of Education

Role of men

Recommendations	Action to be taken by
Better sex education that breaks the stereotypical view that women should take sole responsibility for thinking about contraception. From an early age men need to better understand their responsibilities in terms of using contraception and their role in sexual relationships.	Department of Education
A programme of combined sex education needs to be piloted and evaluated. Bringing both girls and boys together in order to provide a context where mutual learning and respect between the two sexes can be encouraged. This could help to form a more rounded view of what is involved in a sexual relationship as opposed to just a sexual encounter.	Department of Education
More thought needs to be given to the pervasiveness of pornography and its use amongst young people. This may take the form of a government review.	Department for Culture, Media and Sports
Steps should be taken to improve understanding and availability of vasectomy as a safe and reliable form of male contraception. Cuts in funding in this area should be avoided, thus reflecting the importance and value of this procedure.	Public Health England

2 Background to the Inquiry

Unplanned pregnancy affects the lives of women of all ages from early teens to those in their forties, crossing every socio-economic group while often adversely impacting society as a whole. With approximately 8.7 million women of reproductive age living in England today (NHS Information Centre 2012), the issue of unplanned pregnancy is something that demands our careful consideration and attention.

Over the past decade there has been a relative increase in the level of unplanned pregnancy. The Department of Health reports that the age-standardised abortion rate was 17.5 per 1,000 resident women aged 15-44, the same as in 2010, but 2.3% higher than in 2001 (17.1) and more than double the rate of 8.0 recorded in 1970 (Department of Heath 2012). Abortion is often the only perceived option of addressing an unplanned pregnancy. The total number of abortions was 189,931 in 2011, 7.7% higher than in 2001 (176, 364) (Department of Health 2012). Whilst unplanned pregnancy in younger women is an important issue, there is strong evidence to demonstrate that not enough attention is being paid to unplanned pregnancy in older women. For example, abortion rates in the over 30s have been rising. During the last three years the abortion rate in the 30–34 age bracket has risen by around ten per cent.

The public perception of unplanned pregnancy is largely shaped by the media, which can have both positive and negative implications. Media stories very often over simplify the situation relating to unplanned pregnancy with the following stereotypes: irresponsible teenagers, career minded women, unemployed women on social welfare, and older mothers who have had children and do not wish to have any more for personal reasons. The overall effect of such stories is to stigmatise women in these situations, which then often leads to feelings of isolation. Underlying factors such as poverty, social chaos and domestic violence are frequently side-lined. But increasingly the link between deprivation, poor education and unplanned pregnancy is being recognised by policy makers and steps are being taken to address this issue.

The term 'unwanted pregnancy' is recognised by some as being too simplistic and does not adequately reflect the complexity of factors and issues which are involved. Unwanted pregnancy can often be confused with teenage parenthood. Terms such as 'unintended' or 'unplanned' are recognised as being more helpful.

Both the absence and incorrect use of contraception has been linked to unplanned pregnancies (Matsuda et al: 2012; Coles et al: 2011; Serrano et al: 2012). The misuse and failure of contraception such as the inconsistent use of the contraceptive pill, condom breakage, and having unplanned sexual intercourse (especially under the influence of alcohol), have been shown, unsurprisingly, to lead to unplanned pregnancy. For older women there may be other issues as well, such as patient choice and access to contraceptive services.

Unplanned pregnancy in teenagers

Over the past decade there has been a great deal of emphasis placed on unplanned pregnancies in teenagers. Evidence submitted by The Royal College of Obstetricians and Gynaecologists (RCOG) and Faculty of Sexual and Reproductive Healthcare (FSRH) reports that unplanned pregnancies that occur during adolescence pose a significant public health issue because of the higher incidence of maternal and neonatal morbidities. The reasons for this may well be complex, but what is important is to ensure that young women who find themselves in these circumstances are cared for and supported in an appropriate manner. Each year in England alone, around 32,000 young women under 18 are still becoming pregnant (Office for National Statistics 2012).

The previous Government implemented the National Teenage Pregnancy Strategy for England, which reduced the under 18 conception rate by around 25 percent (Department for Education 2010). The national reduction hides considerable variation in progress among localities. Some local areas, including those with significant levels of deprivation, achieved reductions of over 40 per cent, illustrating that effective action does bring down rates. Yet despite this progress the UK remains home to the highest teenage pregnancy rates in Western Europe, disrupting the lives of many families up and down the country.

Unplanned pregnancy in older women

Unplanned pregnancy in older women is increasingly an issue, with abortion rates in some age groups markedly increasing over the past few years. As noted above, abortions in the 30–34 group have risen by ten percent over the past three years. This is in stark contrast to other countries like New Zealand, where the rate has decreased by five percent over the same period.

2 Background to the Inquiry

Repeat abortions

Concern has also been expressed over the proportion of repeat abortions over the past decade, rising from 31 percent of all abortions in 2001 to 36 percent in 2011 (Department of Health 2012: 10). This effectively means that one third of women undergoing abortions in 2011 had one or more previous abortions. Nearly one in ten women undergoing abortions had two or more previous terminations. Looking at the under 25 age range, 7 per cent of those under 18 and 19 per cent of 18-19 year olds have had one more previous abortions (Department of Health 2012: 10).

Access

Contraceptive choice is a vitally important issue for women in terms of them taking control and responsibility for their fertility. As the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK has noted, it is a women's fundamental right to be able to access the full range of contraception. However this is often not the reality. Examples include restricted access to oral contraception for women over 25 years old, restricted access to contraception services to UK residents only, and restrictions on access to LARCs through GP referral only (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK 2012: 7). The impact of these restrictions affects a woman's general well-being, their family and their sex life (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK 2012: 12).

Costs

Alongside the physical and psychological impact on women who find themselves in this situation, there is also the significant financial impact of unplanned pregnancy on the NHS. From data submitted by Bayer Healthcare, it has been estimated that the annual cost to the NHS in England of unintended pregnancy stands at £817 million. Consequently, taking steps to reduce the number of unintended pregnancies could deliver significant cost savings to the NHS. Bayer proposes that every £1 invested in contraception saves the NHS £12.50.

Our Response

Given the cost to society and the impact on women, the committee believes that an integrated, cross-departmental strategy to tackle unplanned pregnancies is currently lacking. The rising abortion rates in some age groups and high teenage pregnancy rates suggest that there are still some underlying issues that need to be addressed. This cross-party inquiry sought to explore these issues and now puts forward a series of recommendations to Government departments on ways to reduce the number of unplanned pregnancies in the UK.

Our full report follows.

3 Structure of the Inquiry

Methodology

The inquiry ran during the autumn of 2012 with four oral evidence sessions taking place on 12th September and 16th October. Evidence was taken from a wide range of stakeholders including professional bodies, pregnancy advisory and counselling services, pharmaceutical companies and third sector organisations. A public call for written evidence was also made, framed by the same terms of reference for the oral evidence sessions. Whilst all interviewees were self-selected, every effort was made to ensure a broad cross-section of representation.

An online survey was also conducted which ran for six weeks, from 25th September to 2nd November 2012. It was promoted on the 2020health website as well as tweeted by 2020health, MPs who were involved in the inquiry, Mumsnet, other organisations who were interviewed as part of the research process and other interested parties. It consisted of 22 multiple choice questions. 345 people took part in the survey with the largest number of participants falling within the 25–34 age bracket.

The questions were aimed at women of reproductive age or older. They focused on women's use of contraception; how they had found available services if they had experienced an unplanned pregnancy; their views on ethical and practical issues concerning the morning after pill and sex education in schools.

From reviewing these results and analysing both the oral and written evidence, six key themes were identified. These themes have helped to inform and shape the series of recommendations proposed by the committee with the overarching aim of reducing unplanned pregnancies in all age groups.

List of members of the interview panel

The cross-party inquiry into unplanned pregnancy was conducted by three MPs from different political parties along with health professionals from the think-tank 2020health. The core team included:

- **Amber Rudd,**
  Conservative MP for Hastings and Rye, Chair
- **Sandra Osborne,**
  Labour MP for Ayr Carrick & Cumnock
- **Lorely Burt,**
  Liberal Democrat MP for Solihull
- **Gail Beer,**
  Consultant Director, 2020health
- **Julia Manning,**
  Chief Executive, 2020health
- **Dr Jonathan Shapiro,**
  Senior Lecturer Health Services Research, Birmingham University Medical School and Head of Policy, 2020health.

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4 Topics from the Inquiry

a) Sex and Relationships Education

Sex and Relationships Education (SRE) is currently not compulsory in schools. This means individual schools determine how to approach delivery of it, or if they do so at all. Further, according to evidence submitted by the NC Sex Education Forum, current guidance on SRE and Personal Social Health and Economic Education (PSHE) is found to be confusing. SRE focuses on learning about the emotional, social and physical aspects of growing up, relationships, human sexuality, sex and sexual health. Research indicates that high quality and comprehensive SRE programmes have a protective function, as young people who have good SRE are more likely to choose to have sex for the first time later in life (Kirby 2007).

Examining 48 SRE programmes, Kirby (2007) found that 40 percent of these had a significant impact on three aspects of behaviour:

- Delaying the initiation of sex
- Reducing the number of sexual partners
- Increasing condom or contraceptive use

The inquiry found that sadly despite such evidence the provision of SRE in UK was patchy, with a significant variance in terms of its quality. Indeed, Ofsted have repeatedly expressed concern over SRE in terms of provision and teacher training (Ofsted 2007; Ofsted 2010).

There has never been a consistently applied policy on SRE in England, which in turn has meant that children and young people have not received a consistent basic level of education about sex and relationships. Very often staff who are expected to provide SRE receive no training. One research study found that one in ten teachers did not know that chlamydia is a sexually transmitted infection (STI) (Westwood and Mullan 2007). Young people have said that SRE is best when teachers are confident, unembarrassed and able to teach correct biological facts as well as explore relationships issues.

Responses to the inquiry's online survey supported this perspective still further. An overwhelming majority were not fully satisfied with the teaching, for themselves or their children. 41.7 percent of participants felt 'the service was adequate but doesn't cover everything' and another 40 percent felt 'it wasn't effective' at all, with only 1.8 percent responding that 'it seems to be really good, and meets my/my children's needs'.

More often than not SRE programmes focus on the biological aspects of reproduction and place inadequate emphasis on relationships. A Brook survey of over 2,000 young people found that nearly half (47 percent) of secondary pupils said that Sex and Relationships Education does not address the issues they are most concerned with or what they want to know about sex (Brook 2011). Table 1 shows the top ten things young people wanted to learn about in their Sex and Relationships Education lessons.

Table 1 - What young people want from SRE
[Source: Brook 2011: 8]

Rank	Percentage	Issue
1	72	Body confidence
2	71	How to avoid peer pressure to have sex
3	69	How to treat a boyfriend or girlfriend
4	65	Love
5	61	Virginity
6	60	Whether I am feeling the same as others my own age
7	58	Sexual attraction
8	56	How to behave in a relationship
9	54	Whether my experiences are similar to others my own age
10	52	Homosexuality

4 Topics from the Inquiry

The current guidance on SRE (Department of Education and Skills 2000) was also found to be confusing and lacking in clarity. It is compulsory for all maintained schools to teach some part of sex education, such as puberty, reproduction and spread of viruses. HIV and sexually transmitted infections must be taught in secondary schools. These topics are statutory parts of the National Curriculum for science which must be taught to all pupils of primary and secondary age. Issues such as relationships, sexuality, consent, delay, risks after sex and pregnancy choices are provided by PSHE education, which is not a statutory requirement. The broader topic of SRE is currently not compulsory but does fall within non-statutory PSHE and is strongly recommended in Government SRE Guidance (2000). Nevertheless, the evidence is clear that this has not been enough to encourage all schools to deliver more than just the biological understanding, which although a crucial part, is insufficient on its own. As one witness pointed out whilst commenting on her own children's experience of SRE, there seemed to be a lot of attention paid to contraceptive failure rates rather than practical advice, such as how to put on a condom.

The inquiry received repeated calls for SRE to be made mandatory and steps to be taken to prioritise a comprehensive programme that has at its heart a holistic approach, and which runs through primary and secondary education. Evidence from the Royal College of Physicians advocated adopting a holistic approach which incorporated issues such as relationships, gender inequalities, alcohol and substance misuse and contraception. Alongside this, SRE needs to raise young people's aspirations for the future. Developing self-esteem, values and awareness so that they can make informed choices is important in improving how sexual health is viewed.

It was also suggested that this kind of programme should assist young people in being signposted to local services and seek to develop links between school nurses and sexual health services at policy and delivery levels. Countries such as the Netherlands, Denmark and Finland, which have widespread provision of sex education and good access to sexual health services, have seen a marked decrease in teenage pregnancy rates since the 1970s (Teenage Pregnancy Strategy Evaluation Research Team 2005: 57-59).

The matter of age-appropriate education was also raised. SRE is seen to be far more effective if it starts before a young person becomes sexually active for the first time and evolves as that person matures and develops. Calls are therefore made to make SRE start in primary schools and be taught in an age-appropriate manner, beginning with topics such as personal safety and friendship.

Several witnesses commented that the kind of information being presented in SRE programmes did not clearly distinguish between belief, opinion and fact. Whilst belief, opinion and fact are important in providing a balanced and informed programme, evidence indicates that where some SRE presents beliefs or personal opinion as points of fact, it can lead to the inaccurate communication of information and distress among the young people involved. In response to this issue certain interviewees proposed a system of kite-marking for external agencies. This would allow schools to know which organisations have been assessed and approved as providing appropriate, accurate and evidence-based SRE programmes.

Culture and values

Emerging from the gathered evidence, one of the underlying challenges facing any approach to unplanned pregnancy is that of cultural messages. Simon Blake, Director of Brook, has commented that:

"There's no doubt that young people live in a highly sexualised culture and are sexualised by companies wanting them to buy their products. This is one reason why we must talk to them about sex and relationships. We can't protect them by pretending the world isn't sexualised". (Newham Interfaith Sexual Health Forum 2008: 10)

Evidence presented to the inquiry by Straight Talk suggested that some contributing factors to this culture include:

- Risky sexual behaviour amongst young people across the population;
- Alcohol including social binge drinking. There is a strong correlation between alcohol abuse and unplanned pregnancy;
- Peer pressure to conform to expected behaviours. This also refers to peer pressure experienced by those in gangs;
- The increasing secularisation of society and the disappearance of traditional moral codes.

4 Topics from the Inquiry

Sexual imagery and pornography

The use of sexual imagery is used extensively in our culture today in order to attract attention, generate interest and (by businesses) to make money. The Bailey Review (2011) found that parents are particularly unhappy with the increasing sexualisation of culture surrounding their children, which they feel they are largely unable to control. Sexually explicit music videos as well as outdoor adverts that contain sexualised images were cited as examples. These examples lead along a path towards pornographic material, access to which witnesses have suggested has helped to distort people's image of themselves and their bodies.

Perhaps more importantly it also erodes the primacy of relationships whilst promoting a self-centred focus of sex, encouraging young individuals to think about personal gratification, in particular conditioning what men perceive sex to be.

For teenage girls, there is a lot of pressure on them to have sex, to look sexy and to conform to stereotypes of what the opposite sex sees as attractive, which are often reinforced in outdoor adverts, music videos and pornography. It was perceived there are not enough counter-influences to provide them with alternative ways of feeling good about themselves. As one respondent to the MumsNet online discussion said:

"When I was 16, 20 years ago, my friends and I wanted to be vets, doctors, lawyers; now girls just seem to want to be sexy and famous. How can a young girl feel loved and special? By having sex? By being wanted and needed by someone?"

In response to this evidence there is a growing sense that we need to develop young people's self-esteem, values and awareness so that they can make informed choices. Raising the aspirations of young girls is particularly important in this regard. Taking the example of social housing, the committee learned that there is a belief among some young girls that the allocation of social housing is inherently unfair. Those girls who do not become pregnant are penalised by the system, creating a perverse incentive to become pregnant in order to gain social housing. As one MumsNet respondent commented, building a campaign around the amazing female athletes we now have, following the London 2012 Olympic Games, would be a significant kick start in helping to promote female independence and self-respect. These kinds of role models could act as a step towards the positive incentives that young girls should be surrounded by.

Alcohol & drug misuse

Changes in the way alcohol is perceived and enjoyed is also recognised as having an impact upon sexual activity. Some independent counselling services are witness to the fact that many of the women they see have become pregnant through alcohol related situations. This links to our earlier discussion on the role of SRE and the need for a holistic approach in its delivery, addressing relationships and contraception but also alcohol and substance misuse. Those who suffer from serious drug addiction combined with alcohol problems often require specialist treatment. The committee learned that conception is rarely planned by individuals in these circumstances. Their living conditions and lifestyle cause them to have a low body weight and this combines with the direct effects of opiate misuse to cause amenorrhoea (absence of periods). Consequently many women believe they cannot conceive when in fact this may not be the case (Harding & Ritchie 2003). Those who do conceive and choose to go through with pregnancy clearly express their desire to become parents. This being the case, timing is crucially important in terms of assessment and support because it is very difficult for these women to demonstrate that they can provide a stable home for a child before they have taken control of their drug/alcohol dependency. Evidence from Addictions Clinical Academic Group suggests that dealing with the situation by taking the baby into care undermines recovery from addiction.

Often alcohol and drug misusers will not feel comfortable accessing healthcare resources and services (such as sexual health services or family planning clinics) which are open to the general public. Difficulty in keeping appointments and an inability to wait in a queue can prove problematic, alongside a perceived stigmatisation of themselves as drug users trying to use mainstream services. An audit carried out by the Addictions Clinical Academic Group found that the majority of such women would like to have contraception services available at their drug/alcohol service team base.

Despite the fact that the numbers who fall into this category are small, the emotional, practical and financial impact on the individuals and the community is disproportionately large. The funding of preventive services would potentially save the substantial costs of protecting children who may become at risk of neglect and abuse and who may be at increased risk of having long-term developmental problems during their childhood and adolescence. The committee heard calls to strengthen policy support for reproductive and sexual health services to be provided at the same time and in the same settings as drug/alcohol treatment.

4 Topics from the Inquiry

Recommendations	Action to be taken by
The government should take decisive action and make Sex and Relationship Education (SRE) statutory. This will allow for a more consistent and comprehensive programme to be implemented across the country with clear guidelines for schools to follow. Adopting a holistic approach, SRE should include relationship counselling and education on alcohol and substance misuse. Whilst standardisation is crucial to ensure equality of access, schools should be given flexibility in how they deliver their Personal Social Health and Economic Education (PSHE) curriculum. For example, Relationship Education could be incorporated as part of Citizenship within PSHE, which is already compulsory.	Department of Education
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A system of kite-marking for external agencies should be introduced, allowing schools to know which organisations have been assessed and approved as providing appropriate, accurate and evidence-based SRE programmes.	Department of Education

b) Access to Contraception

A key finding was that access to contraceptive services varies widely across the UK.

- Over 3.2 million women of reproductive age (15–44) are living in areas where fully comprehensive contraceptive services (either through community and/or primary care services) are not provided. This represents almost one third of women in England of reproductive age.

- One in six PCTs confirmed that red or black lists or equivalent formulary arrangements were in place to restrict access to particular contraceptives. These PCTs are responsible for meeting the contraceptive needs of over two million women of reproductive age.

In the case of older women especially, many are reporting problems with access to contraception at GP practices and contraception clinics. Consequently a strong theme emerging from the witness evidence was that access to contraception needs to be widened. Restrictions on community contraception services are making contraception harder as opposed to easier to get hold of. In contrast, the investment in provision of high quality contraception services to young women formed a key part of the Government's Teenage Pregnancy Strategy. The progress achieved has been welcomed by many and demonstrates the need for sustained investment and engagement to maintain long term success.

Despite there being good evidence for the cost-effectiveness of expenditure on contraception, spending remains low with service provision patchy across the country. Data submitted to the inquiry by Bayer states that in England the average annual spend on contraceptive prescriptions is around £8.96 per head of female reproductive age population (15-44 years old). It has been found that PCTs who spend more on contraceptive prescriptions generally experience reduced levels of abortion, and by implication unplanned pregnancy, across all ages.

4 Topics from the Inquiry

Inquiry's online survey

The online survey initiated by the inquiry found that 45.3 percent of all participants who had been pregnant had experienced an unplanned pregnancy, and the majority of these women felt unhappy about it. Strikingly however, just over half of these women were not using secure contraception at the time. 27.9 percent were not using any contraception at all, whilst 9.3 percent were relying on natural family planning and 13.95 percent on the withdrawal method (51.16 percent in total). 23.26 percent had been using condoms. Of those women who had experienced an unplanned pregnancy and had not been using any contraception, 65.2 percent were with a regular partner.

Once women knew they were pregnant, nearly 60 percent felt that professional services helped them through every stage of their pregnancy to a satisfactory level. However, 41 percent felt that the physical aspects of care dominated the emotional side and 28.2 percent felt that there was 'little or no support for how I felt'.

The results showed that awareness and support of the morning after pill was high, with 98.8 percent of participants having heard of it and only 8.4 percent of women agreeing with the statement that 'the morning after pill should not be readily available because it may influence sexual behaviour in a negative way'. Half of participants thought it should be readily available as a useful form of contraception.

Emergency contraception

Advocates argue that the best and most systematic way of ensuring that women have access to emergency contraception is to make it available directly to consumers without a prescription (Boonstra 2002). According to international evidence, emergency contraception is still largely under-used even though it is freely available without prescription in countries such as the UK and USA. More needs to be done in terms of improving understanding of emergency contraception amongst all age groups who have unprotected sex.

International evidence points to how education and changing perceptions may have a positive impact on emergency contraception. In 2002 the French government issued a decree allowing minors to obtain emergency contraceptives from a pharmacy at no charge and without requiring authorisation from a parent. Pharmacists are required to counsel young women and provide them with information about other forms of birth control (Boonstra 2002). In the Netherlands since 2004, women have had access to the Morning After Pill (Norlevo) without a doctor's prescription. The pill may also be sold in outlets other than pharmacies, on condition that a revised package leaflet, providing clearer information for the user on how to use the pill, is supplied with the product (CBG Medicines Evaluation Board 2004). Looking to the future, it appears greater consideration needs to be given to improving education surrounding emergency contraception, with the realisation that our perception of emergency contraception may have to change.

Emergency contraception is strongly supported for use amongst adolescents who have unprotected sex and to prevent repeat pregnancies. Emergency contraception is available in most NHS clinics, however problems over access in the UK seem to relate to perception, patient confidentiality and professional unease over prescribing to teenagers (Fallon 2009). Calls have been made for SRE, nurses and community clinics to help address these misconceptions over the use of emergency contraception. Evidence submitted by HRA Pharma suggested that there may be an opportunity to commission a National Enhanced Service for Emergency Contraception through the NHS Commissioning Board, thus helping to minimise or even removing the chance of geographic inequalities in terms of access.

Long Acting Reversible Contraception

A strong case is being built for using long acting reversible contraception (LARC) such as IUDs, implants and injectables in order to prevent unintended and unplanned pregnancies. This is instead of using methods such as oral contraceptives and condoms. The benefits of LARC are found in the fact that they do not have to be taken daily like the pill. Despite these benefits, take up is low due to a number of reasons, including restricted access to LARC through GP referral only and a lack of awareness about efficacy and benefits (All-Party Parliamentary Group on Sexual & Reproductive Health in the UK 2012: 7): around 8 percent of women aged 16–49 in 2003–04, compared with 25 percent for the oral contraceptive pill and 23 percent for male condoms (NICE 2006). The committee learned that this lack of awareness may also be due in part to the attention paid to teenage pregnancies. Women of other groups are relatively disadvantaged in terms of access to emergency contraception, routine contraception and LARC.

4 Topics from the Inquiry

Coupled with this is recognition of the need to implement a strategy for training more health professionals in this area and ensuring robust and affordable accreditation processes for nurses. This would help to ensure that service provision is mapped effectively so as to avoid disparities on the basis of geography.

The report Sex, lives and Commissioning, published by Advisory Group on Contraception (AGC) in April 2012, found that two thirds of PCTs (67 percent) were unable to provide any information at all about the number of practitioners trained to fit subdermal and intrauterine contraceptives. Of the remaining 33 percent, 16 percent of PCTs were unclear in their response to the question, whilst 17 percent were able to provide information (AGC 2012: 27). Furthermore, it was found that nine PCTs have chosen not to put an enhanced service in place for fitting LARC.

It was acknowledged that pharmacies have been developed as a valuable resource in terms of emergency contraception and condom provision, but they also need to be promoted as a resource for better provision of regular and longer term contraceptive methods. As an example, larger pharmacies could provide facilities for fitting IUDs by appropriately qualified staff.

Post abortion contraception services

Consideration needs to be given to post-abortion contraception services in order to integrate contraception into abortion care. It seems illogical for a woman to access abortion services but then be required to arrange to see her GP or other healthcare professional in order to obtain contraception. The abortion pathway therefore needs to incorporate contraception services, with abortion services being commissioned with advice and contraception as key components, not only after the abortion but prior to it as well.

Concerns

In 2011 BPAS carried out a survey of women of reproductive age (15–44) and their knowledge and use of LARC. It found that while a minority did not know about LARC, the main reasons women did not want to use them centred on concerns about fitting/removal (i.e. the reliance on a healthcare professional to both insert and remove it) and side effects. This points to the importance of ensuring that women are provided with the right advice and support in making decisions about contraception. By providing the necessary resources for an informed choice to be made on the basis of risks and benefits, women can determine their priorities and choose a method that best suits their needs. It needs to be recognised that, even with this information, some women may well find the side effects associated with LARCs (such as irregular bleeding, pain and weight gain) are not tolerable and so will not pursue it further.

Full contraceptive advice needs to ensure that the greatest number of women continue using contraception that best suits them and that they have had the freedom to be able to make a well informed choice from a variety of contraceptive methods. The notion that there is an objective 'perfect' contraceptive does not make sense; a contraceptive may only be perfect from the subjective point of view of the individual concerned.

Contraception success rates

Several pieces of evidence made reference to the fact that those within the policy community, as well as the general public, all too often have little understanding of the massive range of failure rates of contraceptive methods. Instead they hold to a more general view that contraception rarely fails. It is felt that whilst sexual health professionals have become increasingly aware of the differences between failure rates in a research context and 'real life', those who may influence government policy and health service strategy appear to not have grasped this fact.

Focusing attention on the older woman

Moreover, whilst the predominant focus in the media and policy development regarding unplanned pregnancy has been on women under the age of 25, there remains a profound need to ensure women over this age continue to have access to contraception. The committee learnt that older women may experience different challenges in accessing contraception or emergency contraception because of work commitments or childcare issues. Services are not designed with these women in mind and they can find themselves being excluded from local services on the basis of age (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK 2012: 13).

The issue of investment was picked up by a number of witnesses who gave evidence to the inquiry. Investment in primary care services and providing GPs with the capacity and training to continue to play a vital role in this area was seen to be essential in helping to shape the future. Paying greater attention, time and energy to integrating services was thought to be a move in the right direction. Integrating primary care and specialist services between NHS and local authorities would yield many benefits.

4 Topics from the Inquiry

Lifestyle changes in women and postponing motherhood

Women in the UK are increasingly choosing to delay childbearing in order to follow careers, and so avoid pregnancy during their most fertile years. Having sex while trying to avoid pregnancy for a longer period of time in their more-fertile twenties, women are putting themselves at a higher risk of having an unplanned pregnancy. Coupled with this is the fact that new relationships after divorce and separation mean that some women in later life may be less familiar with the contraceptive options and health services that are available to them.

With one of the highest female employment rates in world, the increasing expectation in the UK is that women will go out to work. The ability of women to control their fertility is therefore crucial in enabling them to attain educational and professional development and play a full role in public life. Such empowerment and expectation have been significant in the shift towards later motherhood. In the UK the average age for first-time mothers is 27.8 (Office for National Statistics 2010). Evidence submitted by BPAS suggests the fact that couples are now tending to choose to start their families in their thirties rather than their twenties is a key factor in explaining why the abortion rate remains static, rather than going down as access to contraception has improved. With the changing nature of the labour market comes a new set of pressures for women, which in turn requires appropriate recognition and response. For example some women may not be able to accommodate the unexpected and heavy bleeding which can be one of the side effects of LARC, should facilities at their workplace be inadequate.

At 36 percent, the proportion of women undergoing abortion who report a previous procedure has increased slightly since 2010 (34 percent) but remains comparable with rates in France (35 percent) and lower than those in Sweden (40 percent) and the US (50 percent) (Cohen 2006). Women have reproductive lifetimes of 30 years and may well be exposed during that period to unplanned pregnancy on more than one occasion, particularly as more women postpone motherhood. It is not surprising that the proportion of women reporting previous abortion is highest in the older age groups, who may have been exposed to unplanned pregnancy in their teens or early twenties and again after they have completed their families.

Mental health

As Rowlands (2007) has stated, seeking to increase access to contraceptive information and services in order that people simply use contraception more effectively is too simplistic. As the committee learned, there are many inter-related factors beyond the need for improved contraceptive services that impact upon unplanned pregnancies. These include an unconscious desire for pregnancy, risk-taking behaviour, coerced sex, substance excess or abuse, mental health problems, peer pressure, or deferment of child bearing. There is a need for further work to be carried out into the interrelationship of these factors.

Whilst the committee planned to look into women's mental health in relation to unplanned pregnancies from the outset of this inquiry, it was further brought to their attention (as recent research has found) that having an unplanned pregnancy is associated with an increased risk of mental health problems. However, the Academy of Medical Royal Colleges and National Collaborating Centre for Mental Health's systematic review of the mental health outcomes of an induced abortion concluded that 'the rates of mental health problems for women with an unplanned pregnancy were the same whether they had an abortion or gave birth' (Academy of Medical Royal Colleges 2011). This would indicate that it is not whether a woman has an abortion or gives birth to a baby that affects their mental health, rather it is the unplanned aspect of the pregnancy which can often have negative effects. There is a need, therefore, to see that the appropriate mental health services form part of the range of services offered to women so that they can make informed decisions and choices when facing an unplanned pregnancy.

4 Topics from the Inquiry

Recommendations	Action to be taken by
All women must have equal access to contraceptive services appropriate to age and circumstance. New guidelines should be issued which set out minimum requirements for Clinical Commissioning Groups to meet in terms of including a wider provision of services, such as those made available to the under 25s. This should also include services available in the work place.	National Commissioning Board / Public Health England
All women to have access to a range of Long Acting Reversible Contraception (LARC). This needs to be prioritised.	Clinical Commissioning Groups National Commissioning Board
NICE guidelines need to include guidance on post-abortion contraceptive services.	NICE
The range of contraceptive services should be tailored to the needs of the local population. Those women with particular cultural and/or religious beliefs need to have local services tailored to their needs.	Clinical Commissioning Groups National Commissioning Board
A combined strategy involving SRE, nurses and community clinics should be introduced to prevent duplication, gaps in the service and lack of cohesion in service provision.	Department of Health Department of Education
Greater consideration needs to be given on how to support women who experience an unplanned pregnancy whilst also suffering from alcohol and drug addiction. There is a need for a more combined approach to be taken, bringing together sexual health services with drug/alcohol treatment.	Department of Health National Commissioning Board
Appropriate mental health services need to form part of the range of services offered to women so that they can make informed decisions and choices when facing an unplanned pregnancy and cope better with the experience.	National Commissioning Board

4 Topics from the Inquiry

c) Training

Given the number of contraceptive options potentially available to women there is a need for healthcare professionals to be suitably trained in order that they can deliver the most effective and comprehensive service. On this basis, women can be empowered to make an informed choice. A skilled sexual health workforce, with national oversight giving direction in terms of training and ongoing development, would be an invaluable asset in helping to address unplanned pregnancy.

At present, training of healthcare professionals is inadequate as the number of doctors and nurses able to fit LARCs is low. The AGC report Sex, Lives and Commissioning found that less than one fifth of PCTs (17 percent) who responded to the audit could supply information about the number of professionals in general practice who were trained to fit subdermal and intra-uterine contraceptive methods (AGC 2012: 4). As there is currently no audit or register of the number of health professionals qualified to fit each type of LARC, commissioners do not have the necessary information to ensure local needs can be met. Improving training and introducing an appropriate form of accreditation for training of nurses in this area could help improve take-up.

One proposal made to the committee by the AGC was that Public Health England or the NHS Commissioning Board should work with appropriate professional bodies to establish national standards of competence for healthcare professionals delivering contraceptive services. These standards should take note of local training provision and tailor services according to the needs of each locality. The fact that the opportunity to train and receive certification in contraceptive care has reduced in recent years was also highlighted. It does not help the situation that there is no standardisation or regulation of university courses for nurses in sexual health. Whilst some nurses may possess a qualification in sexual health, it does not necessarily follow that they are competent in contraceptive care. The current shortage of trained professionals acts as a barrier to women from being able to access LARC.

Post-delivery care

Data submitted by BPAS from a survey of 1,000 women who had given birth in the last three years revealed that:

- The majority did not discuss postnatal contraception with a healthcare professional whilst they were pregnant, while more than half did not discuss it until their postnatal check at around six weeks or later, both of which are contrary to the expert guidance issued by the National Institute for Health and Clinical Excellence (NICE) and the Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists.

- More than half (55 percent) of women who chose to use breastfeeding as a method of contraception said that no healthcare professional discussed with them what form of contraception they would use if they stopped or reduced feeds.

The survey suggests that new mothers may not be given the full range of contraceptive options. Only a fifth reported discussing the implant and just one percent the contraceptive patch and ring. Findings such as these point to the importance of creating opportunities in the ante-natal period for women who want contraceptive advice.

Recommendations	Action to be taken by
A robust national training programme needs to be introduced in order to increase the number of healthcare professionals who are trained in giving contraceptive advice and thereby increase access. This could be developed as part of the NHS's National framework to support local workforce strategy development.	Royal Colleges NHS
All women should be given contraceptive advice post delivery as part of the follow up care. This should be incorporated into the care provided by midwives at home for up to ten days after birth and consideration should be given to the training of health visitors.	NICE

4 Topics from the Inquiry

d) Role of public health and commissioning

Data on UK teenage pregnancy in February 2012 showed that the under-18 conception rate is now at its lowest level since 1969, at 35.5 conceptions per thousand women aged 15–17 (Office for National Statistics 2012). Whilst there is still much to do in this area, progress to date has been widely attributed to Government initiatives since 1999. These have included:

Teenage Pregnancy Strategy (1999)
The Government strategy set a clear target to reduce the rate of under-18 conceptions by 50 percent by 2010. One of the five key pillars of the strategy was to increase investment in high quality contraceptive services and access to sexual health services. Rates of under 18 conception were reduced by 24.3 percent from 46.6 in 1998, the baseline year for the Strategy, to 35.4 percent in 2010 (Department of Education 2010).

Investment in General Practice HCP training to provide LARC services (accelerated through 2008–2010)
This funding was disseminated both via strategic health authorities and directly to PCTs. The most successful programmes seemed to feature stronger co-ordination by the SHA (e.g. South-West Region, East Midlands, East of England)

Local Enhanced Service (LES) schemes (largely introduced from 2008–2009)
These were designed to encourage the co-ordination of local contraceptive services, including the fitting of LARC within a primary care setting.

Department of Health 'Sex, Worth Talking About' campaign (2009–2010)
This campaign took a novel approach to communicating the importance of good sexual health, including use of contraception.

The collective impact of these measures has been positive and demonstrates what can be achieved through a combined strategy. It is likely that a continued level of focus and commitment will be necessary in order to make further progress.

There is widespread support for the Government's Sexual Health Strategy, which is expected to play an important role in setting the agenda for sexual health and contraceptive services for all ages and how these are to be delivered within the new NHS framework. Nevertheless, concern was expressed over delays to the launch of this strategy. Witnesses to the committee called on the Government to publish it without delay.

Commissioning
Under the new arrangements, commissioning of contraceptive services will be divided between the public health service and the NHS, so clarification is all the more important. As the Directors of Public Health take up their roles with newly established responsibilities for commissioning sexual health and contraceptive services, it is paramount that they understand the current necessity to improve service provision and respond to local need.

The future of these services currently looks uncertain and so guidance from the government is required. From witness evidence it was apparent that there is anxiety over the future of commissioning of sexual and reproductive healthcare, where responsibility for sexual health (but not abortion care) moves to the remit of local authorities. The common view is that local authorities do not have the structures and expertise to commission specialist clinical services, nor are they aware of what is involved in providing open access services. Consequently this could lead to specialist contraception services being undervalued and the further fragmentation of reproductive choice/abortion care services.

Evidence presented by The Royal College of Obstetricians and Gynaecologists and Faculty of Sexual & Reproductive Healthcare suggested that the NHS Commissioning Board takes full control over clinical sexual and reproductive health services such as contraceptive care, STI prevention and treatment. Should the decision be taken that clinical commissioning groups (CCGs) or local authorities commission abortion care services then the process for this must be carefully monitored so as to meet national specifications that do not restrict access. Guidelines that set out the minimum requirements for CCGs need to be published.

4 Topics from the Inquiry

Whole life course approach

The committee learnt that there was support for a 'whole life' approach to sexual and reproductive health, recognising that contraceptive needs change throughout a woman's life. Advice on, choice of and access to contraception does not cease when you are no longer a teenager. As many witnesses pointed out, women should have the choice of contraception that is most suitable for their lifestyle.

Integration and partnership

Three key themes emerged regarding the organisation and provision of services to women. First, closer links need to be made between alcohol awareness and health education so as to ensure that there is a consistent and joined-up message being communicated regarding prevention of pregnancy. Second, a cohesive response then needs to be coordinated by public health so that all agencies are working synergistically towards a common goal. Contraception services need to be better joined with adolescent services and chronic disease areas where unintended pregnancies present additional risks to women and pregnancy.

Thirdly, post-natal services need to be incorporated into the whole more effectively. Through such a move the intention would be to gain greater understanding of how and when women make contraceptive decisions in these periods and whether targeted or generic approaches to contraception are preferable. Clarity should therefore be given as to the role of commissioners in relation to contraception, the outcomes delivered and how bodies should work together to achieve an integrated service.

The role of the third sector

The committee recognised that the input and role of trusted not-for-profit organisations needs to be incorporated far more. Such organisations have a wealth of experience in practically delivering patient-centred advice about sexual health services. It was noted that Teen Pregnancy Partnership Boards did help to link different professionals and voluntary services together so that a 'one stop' service was easily accessible, with reports of awareness about the need for contraception and STI protection increasing in areas such as Hampshire. Nevertheless, from a local perspective, within the various forums the participation and input of voluntary organisation was not really encouraged.

In general there seems to have been an unwillingness to take seriously the voluntary organisations' skills and knowledge of the local community – even though such organisations might have a wealth of experience from supporting the local community over a number of years. Simply assisting the coordination of services, so to ensure that women get the right support when they need it, may have a positive impact on reducing conception rates and multiple abortions generally. As the Government looks to reduce costs and increase the effectiveness of social policy, it would be wise to achieve more joined-up partnerships with the third sector and local government/NHS.

Investment

In order to see much of this integration come about, financial investment needs to be in place. Previous cuts in budgets by PCTs for contraception care and service provision have in turn led to inconsistent levels of service across the country. Far from helping to make lasting savings, cutting these services can lead to increased levels of expenditure in terms of abortion services. The committee heard calls to ring fence funding for sexual and reproductive healthcare. The cost of unplanned pregnancy is high and money could be saved by supporting improved services.

Evidence presented by Bayer suggested to the committee that the budgets for contraception, abortion, miscarriage and pregnancy should be brought together. Such a move would facilitate joined-up working across sexual health services as well as help to provide clarity in terms of where spending on preventative action in one area of sexual health can deliver savings elsewhere.

4 Topics from the Inquiry

Recommendations	Action to be taken by
Continue to implement and maximise opportunities and successes achieved through the Teenage Pregnancy Strategy. Elements of the strategy need to be implemented for the over-20s.	Public Health England
The role and involvement of trusted third sector organisations needs to be fostered so that a 'joined-up' approach to service provision can be established, encouraging the sharing of knowledge and experience.	Public Health England
New guidelines need to be published which set out the minimum requirements and expectations of clinical commissioning groups (CCGs).	Public Health England
Public Health England should establish national models for contraceptive pathways which can be tailored by local authorities to the needs of their areas. Strong and clear guidelines need to be issued to local authorities so that they can plan services with the appropriate expertise and structures in place after 2013.	Public Health England Local authorities

4 Topics from the Inquiry

e) Under age sex

Despite the relative success of the National Teenage Pregnancy Strategy, set up in 1999, the United Kingdom remains home to the highest teenage birth and abortion rates in Western Europe. Teenage birth rates are roughly five times greater than those in the Netherlands and around double those in France and Germany (Family Planning Association 2010).

Whilst it is recognised that the underlying conditions for unplanned pregnancies are complex, there are some common factors borne out through international evidence. These include age (Adhikari et al 2009; Goicolea et al 2010) and early sexual debut (Goicolea et al 2009; Lion et al 2009). As discussed in the following section (Role of Men), schools, care workers or police are currently often aware of minors having sex with men over the age of 21. Yet the situation frequently continues because no action can be taken unless the child puts in a complaint.

Witness evidence from the Respond Academy (a community organisation that supports young people) indicates that if some high profile prosecutions for underage sex were to take place in the public arena, this would contribute to a reduction in the sexual abuse of young girls. There is a pressing need for government action on this issue: first, in terms of enforcing the law when it comes to the penalty for engaging in under age sex; second, in terms of local government, NHS, the police and the third sector working much more closely together in order to expose and bring to justice cases of sexual grooming and exploitation.

Also crucial to this issue is the need to educate both boys and girls on the importance of consent in sexual relationships. The legal implications of consent being violated need to be clearly understood so that women and young girls are not pressured into sexual relationships, especially through violence and coercion.

Recommendations	Action to be taken by
Increase coordinated efforts to protect young people from sexual exploitation. Local government, healthcare providers, social services, the police and the third sector should work much more closely together and expose and bring to justice cases of sexual grooming and exploitation, including sex with underage girls.	Crown Prosecution Service Police Department of Justice Healthcare providers Social services Third Sector
Boys and girls need to be educated in the importance of consent and the legal implications of this being breached, particularly in terms of violence and coercion.	Department of Education

4 Topics from the Inquiry

f) Role of men

There is a critical need to change the culture surrounding sexual health and contraception so that men are brought into the debate as responsible actors. Historically, the emphasis of responsibility has been placed on the woman to ensure that adequate precautions are taken and contraception is used appropriately. The result is that all too often the woman alone is blamed for the consequences of unplanned pregnancy and criticised for wanting a termination. It is likely that encouraging greater levels of responsibility on the part of the man would help reduce the rate of unplanned pregnancy. Government action in this area could help to address this unhelpful stereotype.

Male sex education

The relative ease of access to pornography has also tended to shape and distort people's image of themselves and their bodies and in particular the primacy of relationships. It would also appear that young men often receive the majority of their sex 'education' from pornography (Family Planning Association 2011; Campbell 2009). Clearly pornography does not involve advice on contraception and does not tend to promote the use of condoms. Consequently if this for many young males is their main source of sex 'education', it is likely to make it harder for young girls to insist that condoms be used.

Whilst there is value in adopting a single-sex approach to delivering SRE, in light of the stereotypically 'male' view of sex which is promoted through, and dominant in, popular culture and pornography, there could equally be a case for a combined sex education programme. The aim of this would be to provide a context where mutual learning and respect between the two sexes can be encouraged, thereby forming a more rounded view of what is involved in a sexual relationship as opposed to just a sexual encounter.

Domestic violence and rape

In some cases, coercion by a male partner to fall pregnant, contraception sabotage or being a victim of domestic violence is a major factor behind unplanned pregnancy. In fact, many sexual experiences that young girls describe to people who seek to help and support them, could be construed as rape according to evidence presented by Respond Academy. One girl expressed it like this, 'If you don't let them, they just do it anyway, you might as well give in otherwise it's a punch in the head'. Distressingly, the committee was informed that other girls would agree with this view.

In terms of government action, protecting young people from sexual exploitation must be an ongoing priority. There is the need for local government, NHS, the police and the third sector to work much more closely together in order to expose and bring to justice cases of sexual grooming and exploitation. Moreover, wider societal questions need to be asked about why girls are finding themselves in this position in the first place and why parental support is apparently lacking.

Male contraception

Seeking to improve men's involvement in using contraception was also recognised a key for the future. Vasectomy is safe and reliable and allows men to take an active part in contraception. The committee learnt that a number of PCTs are attempting to save money by reducing the funding available for vasectomy services. The number of vasectomies carried out has fallen by over 50 percent over the last decade, figures from the NHS Information Centre show (2010-11). Reasons for this could be due to improvements in LARC methods of contraception, and the rise in divorce rates and 'second families', but the fact that some PCTs are restricting vasectomy funding should not be overlooked.

Funding contraception for men as well as women should be a priority for CCGs and local authorities and sufficient to allow couples and families access to all methods of contraception. Not only is this a pragmatic decision but it also promises significant financial savings in the longer term as well.

4 Topics from the Inquiry

Recommendations	Action to be taken by
Better sex education which breaks the stereotypical view that women should take sole responsibility for thinking about contraception. From an early age men need to understand their responsibilities in terms of using contraception and their role in sexual relationships.	Department of Education
A programme of combined sex education needs to be piloted and evaluated. Bringing both girls and boys together in order to provide a context where mutual learning and respect between the two sexes can be encouraged. This could help to form a more rounded view of what is involved in a sexual relationship as opposed to just a sexual encounter.	Department of Education
More thought needs to be given to the pervasiveness of pornography and its use amongst young people. This may take the form of a government review.	Department for Culture, Media and Sports
Steps should be taken to improve understanding and availability of vasectomy as a safe and reliable form of male contraception. Cuts in funding in this area should be avoided, thus reflecting the importance and value of this procedure.	Public Health England

5 Appendices

Appendix I: Terms of reference

1) What is your view on the issue of unplanned pregnancy in the UK?

2) The evidence is that there are rising rates of abortion in some age groups, rising rates of repeat abortions, and high teenage pregnancy rates.

   a. Are there any underlying reasons for these, and if so, what are they?

   b. How (if at all) would you and your organisation respond to these?

   c. What (if any) role is there for Government in handling the issues?

3) What lessons may be learned from previous efforts to address these problems?

Appendix II: Full list of witnesses

Whilst all interviewees were self-selected, every effort was made to ensure a broad cross-section of representation.

Oral Evidence Session 1

- **Ann Furedi,** Chief Executive of BPAS
- **Dr Paula Franklin,** Medical Director of Marie Stopes
- **Clare Laxton,** Policy and Parliamentary Manager of the FPA
- **Dr Kate Gutherie,** Spokesman for RCOG
- **Professor Clare Gerada,** Chair of RCGP

Oral Evidence Session 2

- **Rowan Davies,** Mumsnet Campaigns & Policy Director
- **Dr Geetha Nagasubramnian,** Faculty of Sexual & Reproductive Healthcare

Oral Evidence Session 3

- **Alison Hadley,** Previous Head of the Teenage Pregnancy Unit, Department for Education
- **Baroness Gould**

Oral Evidence Session 4

- **Simon Blake,** Chief Executive of Brook
- **Hilary Pannack,** Chief Executive at Straight Talking Peer Education
- **JC Mcfee,** Project Manager at Respond Academy
- **Professor David Paton,** Nottingham University

Appendix III: Full list of written submissions

Written Evidence was received from:

- Abortion Rights
- Addictions Clinical Academic Group
- Advisory Group on Contraception (AGC)
- Bayer HealthCare
- British Pregnancy Advisory Service (BPAS)
- Brook
- Care Confidential
- Christian Medical Fellowship
- Department for Education
- Family Planning Association
- HRA Pharma
- Julia Hines
- Judith Monk
- Robert Mucci
- Marie Stopes International
- MSD
- Mumsnet
- NC Sex Education Forum
- Professor David Paton
- Royal College of Physicians
- Royal College of General Practitioners
- Royal College of Obstetricians and Gynaecologists and Faculty of Sexual & Reproductive Healthcare
- Respond Academy
- Sex Education Forum
- South London and Maudsley
- Straight Talking

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Creating a healthy society

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2020health research and activity includes the following workstreams

Fit-for-school:
To create a holistic picture of wellbeing and what children need in order to thrive at school, and identify ways of enabling more children to flourish and break the cycle of failure.

Fit-for-work:
To continue looking at the importance of work for health and health for work, and ensure that those who experience illness receive timely and appropriate support, understanding that worklessness impacts on economies and society as a whole.

Fit-for-later life:
To look from active retirement, to increasing dependency and end-of-life care and consider new models of provision, raise the status of caring, embed respect for ageing and ensure inclusion.

Forgotten conditions:
To ensure that people with rare or unusual health conditions have their needs met by the NHS.

Integration:
To promote integrated care that uses technology to empower people and enable management of their healthcare and wellbeing.

International:
To ensure that we continue to share our knowledge of healthcare and learn from those countries that care for people better than we do.

Innovation:
To ensure that people have access to innovation in all its forms and keep the UK at the forefront of R&D.

Social Care:
To find sustainable solutions to ensure people's vulnerable or final years are the best they can be.

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