Teenage pregnancy: huge progress ... but more to do

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In February 2014 data published by the Office for National Statistics (ONS) (2014) showed the under-18 conception rate in England has fallen to an all-time low, with a reduction of 41% between 1998 and 2012 (see Figure 1). This significant decline is the result of the previous government’s 10-year Teenage Pregnancy Strategy and the concerted effort of local government, health organisations, services and frontline practitioners.

However, there is more to do. We have not yet achieved the Strategy’s original 50% reduction goal, England’s rate remains higher than comparable western European countries and progress varies considerably between local authorities. If all areas were doing as well as the top 25%, the national reduction would increase to 52%. Outcomes for young parents and their children, although improving, remain disproportionately poor (Teenage Pregnancy Knowledge Exchange, 2014) (Box 1).

The new policy context

In 2010 the coalition government decided against developing a further teenage pregnancy strategy, but ministers made it clear that teenage pregnancy would remain a priority and that work on prevention and support for young parents should be integrated into relevant policy and programmes.

The under-18 conception rate is one of the 66 indicators in the Public Health Outcomes Framework (Department of Health (DH), 2013) with two other sexual health indicators, diagnosis of chlamydia in 15–24 year olds and late diagnosis of HIV, together with a number of other indicators that disproportionately affect young parents and their children.

Further reducing the under-18 and under-16 conception rate is a priority in the Framework for Sexual Health Improvement (DH, 2013) and a key aim of the school nursing guidance, Developing Strong Relationships and Supporting Positive Sexual Health (DH, 2014). Improving outcomes for young parents and their children and narrowing inequalities is central to the core purpose of children’s centres (Department for Education (DfE), 2013) and the Health Visitor Implementation Plan (DH, 2011).

Local government and clinical commissioning groups are expected, through the statutory health and wellbeing boards, to review progress on teenage pregnancy and the related indicators as part of their joint strategic needs assessments to inform their health and wellbeing strategies and local commissioning decisions. Child health profiles provide a helpful snapshot for each local authority in England against 32 selected indicators, which enables comparison locally, regionally and nationally. You can check how
The evidence on preventing teenage pregnancy

The previous teenage pregnancy strategy and Framework for Sexual Health Improvement are based on the strongest empirical evidence for reducing teenage pregnancy rates and improving sexual health: the provision of high-quality comprehensive sex and relationships education (SRE) in schools and youth settings, complemented by open discussion with parents, combined with easy access to youth-friendly contraception services (DH, 2013).

To equip children and young people with the knowledge and skills to develop healthy and safe relationships, SRE needs to be taught by trained educators and delivered regularly through primary and secondary schools. The Sex Education Forum provides a helpful curriculum design tool on what to include in SRE from the ages of three to 16+ (Sex Education Forum, 2014) and a practical guide for schools on involving parents in SRE – almost 90% of whom want SRE to be taught in all schools (National Association of Head Teachers (NAHT), 2013).

In February 2014, new supplementary advice to the statutory SRE guidance was published by the PSHE Association, Brook and the Sex Education Forum to help schools address some of the new challenges of the 21st century, such as the influence of pornography, ‘sexting’ and social media (PSHE Association et al, 2014).

SRE in secondary schools needs to include information about local young people-friendly contraception and sexual health services. Seventy per cent of young people do not have sex under the age of 16 (Mercer et al, 2013), but for the third who do, and for young people who want to talk through pressure to have early sex and get advice on contraception and sexual health, easy access to a trained and trusted professional is essential.

New public health guidance from the National Institute of Health and Care Excellence (NICE, 2013) includes 12 recommendations for improving young people’s access to and use of effective contraception, including specific advice for school and education-based services and involvement of school nurses. The guidance also reiterates the importance of services being young people friendly and meeting the DH ‘You’re Welcome’ quality criteria.

The new school nursing guidance, Developing Strong Relationships and Supporting Positive Sexual Health (DH, 2014), sets out the policy context and provides some useful tips for school nurses from the Sex Education Forum on strengthening SRE and pupils’ early access to confidential advice (Box 2).

To reduce teenage pregnancy rates by a substantial margin, a prevention strategy needs to reach all young people; however, school nurses and other community nurses may need to provide extra support for young people more at risk. A study in 2013 found that girls most at risk of pregnancy under the age of 18 were eligible for free school meals, persistently absent from school in Year 9 and showed slower than expected academic progress between Years 7 and 9 (Crawford et al, 2013).

Other risk factors include being in care and experiencing sexual abuse or exploitation. With all young people, but particularly those with risk factors, all practitioners need to be vigilant for signs of sexual exploitation and abuse. New guidance, Spotting the Signs, has recently been published by Brook and the British Association of Sexual Health and HIV (BASHH) (Brook, BASHH, 2014) and Brook also has a helpful guide to assessing healthy and harmful sexual behaviours (Brook, 2013).

Supporting young parents

The falling teenage pregnancy rate shows that the vast majority of young people do not want to choose early parenthood; but for those who do, the disproportionately poor outcomes highlight the need for really good support.

Box 1. Disproportionately poor outcomes for young parents and their children

- Babies born to young women under 20 have a:
  - 25% higher risk of a low birth weight
  - 41% higher risk of infant mortality
  - 63% higher risk of experiencing child poverty

- Mothers under 20 are:
  - Three times more likely to smoke throughout pregnancy
  - A third less likely to initiate breastfeeding and half as likely to be breastfeeding at 6–8 weeks
  - At higher risk of postnatal depression and poor mental health for up to three years after the birth
  - At higher risk of missing out on further education, 21% of the estimated number of young women aged 16–18 who are not in education, employment or training are teenage mothers

Box 2. Developing Strong Relationships and Supporting Positive Sexual Health school nurse guidance (Department of Health, 2014)

1. Are school nurses introduced in person to all pupils, for example, by visiting a year-group assembly, tutor-time or sex and relationships education (SRE) lesson?
2. Do pupils know that they can visit the school nurse and other health services ‘uninvited’ and that it is fine to come with a worry or a question – they don’t have to wait until there is a problem?
3. Are younger pupils taught the correct names for sexual parts of the body and about bodily privacy? If not, have you offered to support teachers with suitable vocabulary and resources?
4. Do primary school children learn about puberty before they experience it? Can school nurses provide training for teachers to improve the timing and quality of puberty education?
5. Is the confidentiality offered by school nurses explained to pupils in SRE?
6. Do secondary school pupils have opportunities to practise the skills necessary to use a sexual health service by themselves; for example, role-play conversations between a nurse or receptionist and a client?
7. Does the SRE programme teach sufficient knowledge about sexual health for young people to be able to assess their own need to use a service?
8. Are school nurses documenting common questions and concerns from pupils and feeding this back anonymously to the lead SRE teacher to inform curriculum planning?
9. Do pupils have a way of asking the school nurse a question anonymously; for example, by email or a question box? Is this facility explained in SRE?
10. Are school nurses aware of any external agencies contributing to the school’s SRE and confident about the medical accuracy of what they teach?
11. Are school nurses consulted when the SRE programme is reviewed or the policy updated?
PRACTICE: CPD

Box 3. Case study: Specialist Health Visitor for Teenage Parents, Bristol

Good progress has been made in reducing the under-18 conception rate in Bristol, but less support had been available to support teenage parents and their children, and address inequalities in health outcomes. This developmental post (3 days a week for 2.5 years) was commissioned in 2012 to help improve young parent’s experience of and access to the health visiting service in Bristol, with the aim of improving health outcomes for teenage parents and their children.

Motivation for this post came from the Meriton school for teenage parents, which found that there was a real inequity in the level of service received and that most parents who attended did not have a trusting relationship with their health visitor but often had multiple health needs. The role has developed over time with a focus on three areas:

**Direct service delivery to teenage parents and their children**

Regular clinics at Meriton school, in liaison with the family health visitor; drop-ins at supported young parents housing projects and young parent groups aiming to build up trust and signpost to health visitor services and other support; and involvement in educational outreach and multi-agency antenatal groups.

**Service development**

Identifying gaps in service and training needs for health visitor teams. Supporting health visitors as a specialist resource. Participation surveys of teenage mothers’ views on health visiting, and health visitors’ views on working with teenage parents. Identified training needs led to updates on contraception and sexual health. Funding also provided in response to the survey outcomes for creative training on communication and engagement with teenage parents.

**Multi-agency working**

Providing a direct link to health visitors and wide range of agencies. This post has allowed time to work with and engage with other agencies supporting young parents, and raise awareness of the role of health visiting. Feedback from agencies has been extremely positive with an appreciation of the specialist health role a health visitor can provide.

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The programme with the strongest evidence for improved outcomes for young parents is the Family Nurse Partnership (FNP). FNP, developed in the US, is an intensive, strengths-based programme delivered by trained family nurses to first-time young mothers under 20, from no later than 28 weeks of pregnancy until the child is aged two. FNP is now running in many areas with an expansion to 16,000 places by 2015. A randomised, controlled trial comparing many areas with an expansion to 16,000 places by 2015 found that those who received FNP with those who haven’t will report later this year (FNP, 2014).

Despite its success, FNP is a voluntary programme for first-time young mothers only, and even with the expansion is unlikely to reach all young parents. Therefore, it is vital that mainstream services of midwifery, health visiting and children’s centres meet young parents’ needs. The components of a protective care pathway have been identified from the Sure Start Plus pilot, local service evaluations (Department for Children, Schools and Families, 2007) and recommendations from Olsted’s analysis of serious case reviews involving the children of young parents (Olsted, 2011). After ensuring the young woman has had access to unbiased advice on pregnancy options the pathway needs to ensure:

- Swift referral to antenatal booking and information to support healthy early pregnancy with folic acid and Healthy Start vitamins starting as early as possible
- Careful pre-birth assessment in maternity services to identify any problems; for example, poor mental health, alcohol or drug misuse or domestic violence, and bring in early specialist support
- Tailored antenatal care and preparation for parenthood for teenage mothers and young fathers, in a youth-friendly environment, including discussion about postnatal contraception and sexual health advice. It is estimated that 20% of births conceived to under-18s are to teenage mothers and all sexually active 15–24 year olds should have a chlamydia test annually or on change of partner
- Clear referral arrangements between maternity services and ongoing support services (health visitors, children’s centres and GPs) to make sure young parents don’t slip through the gap between services

- A nominated lead professional for young parents, co-ordinating support on health, education, housing, benefits and parenting, and providing a contact point for other practitioners
- The development of personal development plans for both parents, building aspirations and helping them return to education to gain skills and qualifications.

The Raising the Participation Age (RPA) legislation now requires all young people aged 16 years old to stay in education, training or work-based learning until the end of the academic year in which they turn 17 and in 2015 until their 18th birthday. RPA also applies to young parents, with the guidance stating that local authorities should develop an individual plan for all young parents to support their re-engagement (DfE, 2013).

Every local authority will have an RPA lead who will be able to provide information and advice on education, training and work-based learning opportunities in the area. All young parents who begin a course under 19 are entitled to child care funding from the Care to Learn programme (DfE, 2013).

**Including young fathers**

The importance of supporting young fathers to become good parents is highlighted in the Ofsted report on serious case reviews and there is clear evidence of the benefits to the child of positive involvement of the father, even if they are no longer in a relationship with the mother (Fatherhood Institute, 2012). However, young fathers often report feeling excluded from services, so more effort is needed to make them welcome and involved. Practitioners have reported that when invitation letters for development checks or immunisation are addressed to both the mother and the father, many more fathers attend.

**The vital ingredient**

As with prevention services, the vital ingredient throughout the pathway is for practitioners to establish a trusted relationship with young parents. The quotes from young parents that follow illustrate how easily they can feel judged and unwelcome, but how positively they respond to feeling valued and understood.

What hinders: ‘I had a lot of problems with breastfeeding, which was upsetting because I really wanted to do it. The hospital treated me as if I was
stupid and assumed I wouldn't cope.'
What helps: 'The midwife was lovely. She said
"Oh well done!" and gave me confidence.'

What hinders: 'I went to the antenatal
appointments but no one spoke to me. It felt
like they were looking down their noses at us'
(Young father)
What helps: 'The midwife was really helpful and
always brought my boyfriend in.'

What hinders: 'It was our first baby and we didn’t
have a clue what to do ... tell us if we’re not doing
it right, but do it a bit nicer.'
What helps: 'I could tell that she had been
specially trained to deal with teenagers. She is
lovely, she left me her number.'

Conclusion
As the data show, we have made huge progress
on teenage pregnancy. The evidence is clear
that, with the right services in place, high rates
are no longer inevitable and the poor outcomes
for young parents can be addressed. The
challenge now is how to sustain and build on
that progress in a time of limited resources. Key
challenge now is how to sustain and build on
pathways on both prevention and support; and
for frontline services and practitioners to work
closely together so that there is ‘no wrong door’
for a young person seeking advice.

References
Guide to Identifying Sexual Behaviours. Available from:
www.brook.org.uk/index.php/traffic-light-tool-0-
to-5 [Accessed April 2014].
Brook, British Association for Sexual Health and
proforma for identifying risk of child sexual exploitation
in sexual health services. London: Brook/BASHH.
in England, Centre for Analysis of Single Transitions
Department for Children Schools and Families
(DCSF), (2007) Teenage Parents Next Steps: Guidance
for Local Authorities and Primary Care Trusts. London:
DCSF
Department for Education (DfE). (2013) Sure Start
children's centres statutory guidance. London: DfE.
DfE. (2013) Statutory Guidance on the Participation of
Young People in Education, Employment or Training.
London: DfE.
London: DfE.
London: DH.
2016. London: DH.
London: DH.
DH. (2013) Family Nurse Partnership (FNP) Implementation Plan
DH. (2014) Developing Strong Relationships and
Supporting Positive Sexual Health, London: DH.

PRACTICE: CPD

CPD questions (please visit www.communitypractitioner.com/CPD to submit your answers)

1. The teenage conception rate reduced by what percentage between
1998 and 2012?
A. 22%
B. 36%
C. 41%
D. 56%

2. How many indicators are there in the Department of Health Public
Health Outcomes Framework?
A. 17
B. 28
C. 57
D. 66

3. Mothers under the age of 20 are how many times more likely to smoke
throughout pregnancy?
A. Once
B. Twice
C. Three times
D. Four times

4. Which of the following are risk factors for girls under 18 becoming
pregnant?
A. Those receiving free school meals
B. Those persistently absent from school in Year 9
C. Those with slower than expected academic progress in Years 7–9
D. All of the above

5. Babies born to women under 20 have what risk of a low birth weight?
A. 25%
B. 35%
C. 45%
D. 55%

6. The Family Nurse Partnership (FNP) is a programme delivered by
trained family nurses to whom?
A. Pregnant women from deprived backgrounds of any age
B. First-time young mothers under 20
C. New mothers from ethnic minority backgrounds
D. Mothers aged over 35

7. It is planned that the FNP will be expanded by how many places
in 2015?
A. 10,000
B. 12,000
C. 13,000
D. 16,000

8. What percentage of births are estimated to be conceived to under 18s?
A. 5%
B. 10%
C. 15%
D. 20%

9. When invitation letters for development checks or immunisation are
addressed to both the mother and the father, many more fathers
attend. True or false?
A. True
B. False

10. It is recommended that all sexually active 15–24 year olds should have
a chlamydia test how often?
A. Every three weeks
B. Every month
C. Every six months
D. Annually

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