Inquiry into teenage pregnancy

Ayrshire and Arran Sexual Health Programme Board and Department of Public Health, NHS Ayrshire and Arran

Teenage pregnancy refers to all conceptions, presenting to and recorded by the health service, in young women under the age of 20 years. It is encouraging to note that overall there has been a significant reduction in teenage conceptions over the past decade.

Some young women are well prepared for pregnancy and make a positive choice to become pregnant and have a child. They may be well supported by family, continue to have a good relationship including marriage with the child's father and recognise that they will still be young when their children are older. However it is generally recognised that delaying pregnancy until 20 or more years of age provides better outcomes for mother and baby. Evidence indicates that young mothers are at greater risk of complications during pregnancy with higher risk of premature labour and low birth weight babies. They are more likely to have lower levels of educational attainment and to go on to have lower paid jobs and the educational attainment of children born to young mothers is likely to be less than that of children born to mothers over 20.

The focus of policy concern tends to be on conceptions in girls under 16 years of age, in part because of the legality of sexual intercourse with girls under 16, and also because of the health and wider consequences to both mother and child of such a pregnancy.

a. Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

The view now presented for addressing teenage pregnancy through children and young people's policy area alongside sexual health is welcome. This dual location enables the identification of the leadership role of the local authority and recognises the roles of the health service in supporting prevention and education aspects alongside addressing secondary prevention with contacts only made once pregnancy has been established.

The local authority role is so important since early conceptions are strongly linked to socio-economic deprivation, retention in education and training, employment aspirations and developing positive relationships – all areas where local authorities, and the community planning partnerships they lead, have strong leadership roles.

b. Do you have any views on the action being taken at the local level by health boards, local authorities and other relevant organisations to reduce teenage pregnancy, particularly in the under 16 age group?

In relation to sex education and health advice, sexual health services have developed to provide services across age ranges and are supported by school

nurses with educational inputs and drop in services. Effective contraception is widely available with emergency hormonal contraception available through many community pharmacies. In Ayrshire and Arran, we recognised a gap in training and have developed and deliver sexual health and relationship education (SHARE) for social work, family support and education staff.

However, actions which put the prevention of teenage pregnancy into a wider context of self-esteem, confidence and positive behaviours rely heavily on partner buy in and the sexual health component is not well recognised.

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

The deprivation gradient in both total pregnancies and in the proportion of pregnancies that progress to delivery is well known. However differences in deprivation do not explain all of the difference in pregnancy rates, indicating that other factors such as availability and accessibility of contraception are influences[i].

Negative life circumstances such as poor material circumstances, unhappy childhood, low expectations and aspirations of the future and a dislike of school are more commonly cited in girls who become pregnant compared to their peers[ii]. Such circumstances are not uniquely associated with socio-economic deprivation.

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

A focus on sex education and sexual health services is not sufficient to achieve the desired changes. Working towards positive changes at community level, particularly early childhood interventions and youth development programmes tackling social disadvantage have been shown to impact on teenage pregnancy levels.[iii] This may require a shift in both resources and attitudes, with a recognition of the roles played by all staff groups impacting on children's and young people's care. Embedding of GIRFEC across transitions and into adult age groups will assist in attitudinal shift but is likely to require time.

There are groups of young people who may especially at risk of unprotected sex and teenage pregnancy such as those who are looked after or accommodated, and those who have specific learning difficulties such as fetal alcohol spectrum disorders or autistic spectrum disorders. Particular attention needs to be given to these groups to ensure that they are provided with, and use, the practical advice and support to aid them to make the best choices for themselves.

e. What are your views on the current support services available to young parents / young mothers e.g. range of services, focus of services and whether services are being delivered in the most appropriate settings?

The ability of universal services to address the specific needs of young mothers may be limited due to a range of issues including other service pressures and lack of training. However, vulnerable mothers and babies should be identified prenatally with care planning if required. Specific initiatives such as the Family Nurse Partnership will assist in providing a specific dedicated and tailored service for young mothers, although there are capacity issues with this venture.

The ability to deliver services within the communities where young mothers live is limited by traditional boundaries of services and would benefit from more flexible approaches such as increasing support groups for young mothers.

f. Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice with regard to reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?

Some of the asset based work in communities has the potential to identify and address early conception and pregnancy, although we have not yet progressed to action on that within Ayrshire and Arran.

g. Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

It would be helpful to recognise more explicitly the relationship between sexual behaviours and other risk taking behaviours such as alcohol use. Young women recognise that they may have 'gone further than intended' when under the influence of alcohol and the risk of either early intercourse or teenage pregnancy is higher is girls who began drinking under the age of 16[iv].

The importance of the role of primary care also needs to be considered in more detail. Around 75% of teenagers visit their GP annually and most girls who become pregnant in their teens have consulted the GP for contraception in the preceding year.[v] Primary care staff need to be competent and confident in addressing adolescent health issues and in initiating enquiry into lifestyle choices.

Evidence from young people in Ayrshire[vi] indicates that there are gender differences in approaches to sexual activity, relationships, responsibility for contraception and for deciding pregnancy outcomes which could influence how approaches and programmes are constituted.

We know that evidence indicates population based approaches are effective in addressing alcohol harm and suggest that consideration be given to whole population approaches be used to address teenage pregnancy as another behaviour associated with risk taking.

h. Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?

The area of teenage conception is relatively poorly researched in Scotland and investment in research on effective practice, including using community and asset based approaches would be welcome.

Dr Maggie Watts
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[i] McLeod A. Changing patterns of teenage pregnancy: population based study of small areas. British Medical Journal 2001; 323: 199-203

[ii] Harden A. Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies. British Medical Journal 2009; 339: b4254

[iii] Harden A. Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies. British Medical Journal 2009; 339: b4254

[iv] Royal College of Physicians. Alcohol and sex: a cocktail for poor sexual health. Report of the Alcohol and Sexual Health Working Party. London:RCP,2011

[v] McLeod A. Changing patterns of teenage pregnancy: population based study of small areas. British Medical Journal 2001; 323: 199-203

[vi] Hooke A, Capewell S, Whyte M. Gender differences in Ayrshire teenagers' attitudes to sexual relationships, responsibility and unintended pregnancies. Journal of Adolescence 2000, 23, 477-486