

Inquiry into teenage pregnancy

Alison Hadley - Teenage Pregnancy Knowledge Exchange

Until recently I was Head of the Teenage Pregnancy Unit in the Department of Education, having worked on the Teenage Pregnancy Strategy for England since 2000. Previously I was Director of Policy for Brook, the UK's leading young people's sexual health charity. I am now working at the University of Bedfordshire, as Director of a new Teenage Pregnancy Knowledge Exchange.

This submission briefly sets out the 'journey' of the Teenage Pregnancy Strategy, the lessons on what worked well and some reflections on what might have been done differently. It does not specifically address the situation in Scotland but the learning may be helpful to the inquiry in considering recommendations for further action. The submission provides a summary of these points and is intended as background to the oral evidence session on 26 February when further detail can be discussed.

The journey of the Teenage Pregnancy Strategy

The goals

The Teenage Pregnancy Strategy for England was developed by the Social Exclusion Unit and published in 1999 (1). The ten year Strategy was the first comprehensive approach by Government to reducing England's historically high teenage pregnancy rates and improving outcomes for teenage parents and their children. The Strategy had three goals: a headline target for 2010 to halve the under 18 conception rate from the baseline year of 1998; establish a firm downward trend in the under 16 conception rate; and increase to 60% the proportion of teenage parents in education, training or employment, to reduce the risk of intergenerational poverty and social exclusion.

Based on international evidence of what works, the Strategy set out a 30 point action plan on four themes: joined up action, better prevention – improving sex and relationships education and access to contraception, a national campaign to reach young people and parents, and better support for young parents.

The structures, local targets and funding

A Teenage Pregnancy Unit (TPU) was set up in the Department of Health with cross department funding, and a team of staff combining external experts and civil servants. An inter-departmental Teenage Pregnancy Board was established to reflect the cross cutting nature of the policy challenge. A Teenage Pregnancy Independent Advisory Group (TPIAG) of expert stakeholders was appointed to monitor implementation of the Strategy and advise Ministers. Regional Teenage Pregnancy Coordinators (RTPC) were

appointed in the nine Government Office regions and every local area appointed a Local Teenage Pregnancy Coordinator (LTPC) and Teenage Pregnancy Partnership Board with representation from health, education, social services, youth services, housing and relevant voluntary sector organisations. A national group of relevant voluntary sector organisations was also established to harness additional expertise and involvement in the Strategy.

Local under 18 conception rate reduction targets were agreed with each area: 60% target in high rate areas; 50% in average rate areas; and 40% in low rate areas. Attainment of all local targets would achieve the national reduction target of 50%.

A Local Implementation Grant was provided to each area. The grant allocation was determined by the size of the local 15-17 year old female population and degree of challenge in meeting the reduction target. Allocations ranged from 150K to 600K, with most areas receiving around 300-400K. The grant was ring fenced with conditions for spend which included the appointment of a local TPC and Partnership Board and an annual report on progress of their local strategy. The grant could be used for pump priming new initiatives or extending existing work but was not intended to replace mainstream funding. The total annual grant was around 25M. A further 7M was held centrally by the Teenage Pregnancy Unit to support the national campaign and other strategy activity.

National guidance and support for local strategies

Every local partnership board developed a local teenage pregnancy strategy, led by the LTPC, using guidance published by the TPU. Each strategy was assessed by the RTPCs and TPU. RTPCs facilitated regular network meetings and provided expert support for local teenage pregnancy coordinators and partnership boards. Annual conferences and specific policy focused events were organised by TPU.

To support local implementation of the Strategy, the TPU issued additional guidance on: sex and relationships education in schools (2); young people friendly contraception and sexual health services (3); improving the uptake of contraceptive and sexual health advice by boys and young men (4) and black and minority ethnic young people (5); making general practice young people friendly (6); and setting up school and college based sexual health services (7). Specific guidance was developed for youth support workers and social care practitioners on supporting young people to access contraception and sexual health advice (8,9). The Sure Start Plus pilot programme testing models of support for teenage parents was established and evaluated in 35 areas. (10)

Local areas also received funding for teachers and community nurses to participate in a national PSHE Continuing Professional Development programme aimed at building specialist knowledge and skills and improving the quality of SRE/PSHE provisions. The TPU also provided funding for the Sex Education Forum to develop guidance and support for local areas on SRE and establishing school and college based sexual health services.

A national media campaign – *Ruthinking* – was launched aimed at 13-17 year old girls and boys. Running on radio and in teenage magazines, the campaign focused on resisting peer pressure, accessing advice and using condoms to prevent pregnancy and STIs. Secondary messages about the full range of contraception were delivered through PR activity. A separate campaign – *Time to Talk* -encouraging parents to talk to their children about sex and relationships was funded through Parentline Plus. Campaign materials were made freely available for local areas.

Mid-strategy review (2005-07)

By 2005 there had been a slow but steady decline in the national England rate of 11% for under 18s and 15% for under 16s. However, this masked a very wide variation in progress between local areas. Although the majority were declining, at one end of the spectrum rates had fallen by 42% and at the other end increased by 43%. If all local areas had achieved the reductions of the top 25%, the national reduction would have more than doubled.

This variation in performance prompted two ‘deep dive’ in-depth reviews, the first led by the TPU and the second in partnership with the Prime Minister’s Delivery Unit. The reviews compared three local authorities with declining rates and three statistical neighbour areas - with similar populations and levels of deprivation - where rates were static or increasing. Interviews were conducted with all partner agencies from senior managers through to front line practitioners.

The review clearly identified that high performing areas were implementing all aspects of the strategy effectively and that progress was determined by the actions taken not the amount of funding received.

The key factors evident in these areas were:

A strong senior champion who was accountable for and took the lead in driving the local strategy;

Active engagement of all of the key mainstream delivery partners who have a role in

reducing teenage pregnancies – Health, Education, Social Services and Youth Support Services – and the voluntary sector;

The availability of a well publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake preventive work, as well as delivering reactive services;

A high priority given to SRE and PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools;

A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;

The availability (and consistent take-up) of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, Youth Workers and Social Workers) working with the most vulnerable young people; and

A well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

In addition to the deep dive reviews, TPU carried out further data analysis to help areas provide more targeted support in their strategies. This included:

- Identifying high rate wards within each area. Analysis had shown that fifty percent of under 18 conceptions in England occur in 20% of wards and almost all areas, even those with low overall rates, had at least one very high rate ward;
- Highlighting the contribution of repeat conceptions. At a national level, it was estimated that 20% of births to under 18s are to young women who are already mothers and 11% of abortions to under 19s are repeat abortions. However there was significant variation in the proportion of repeat abortions locally, ranging from 5% to 39%;
- Drawing on evidence to clarify the characteristics of young people most at risk of pregnancy who would require more intensive support. Annex A provides a table of risk factors.

To support a more targeted approach, TPU also reviewed the national campaign. *RUthinking* continued to provide universal messages for younger teenagers and a new campaign, *Want Respect: Use a Condom* was developed for older teenagers and those most at risk. Campaign materials were again free for local areas to use in relevant settings.

New more prescriptive guidance and self assessment toolkit

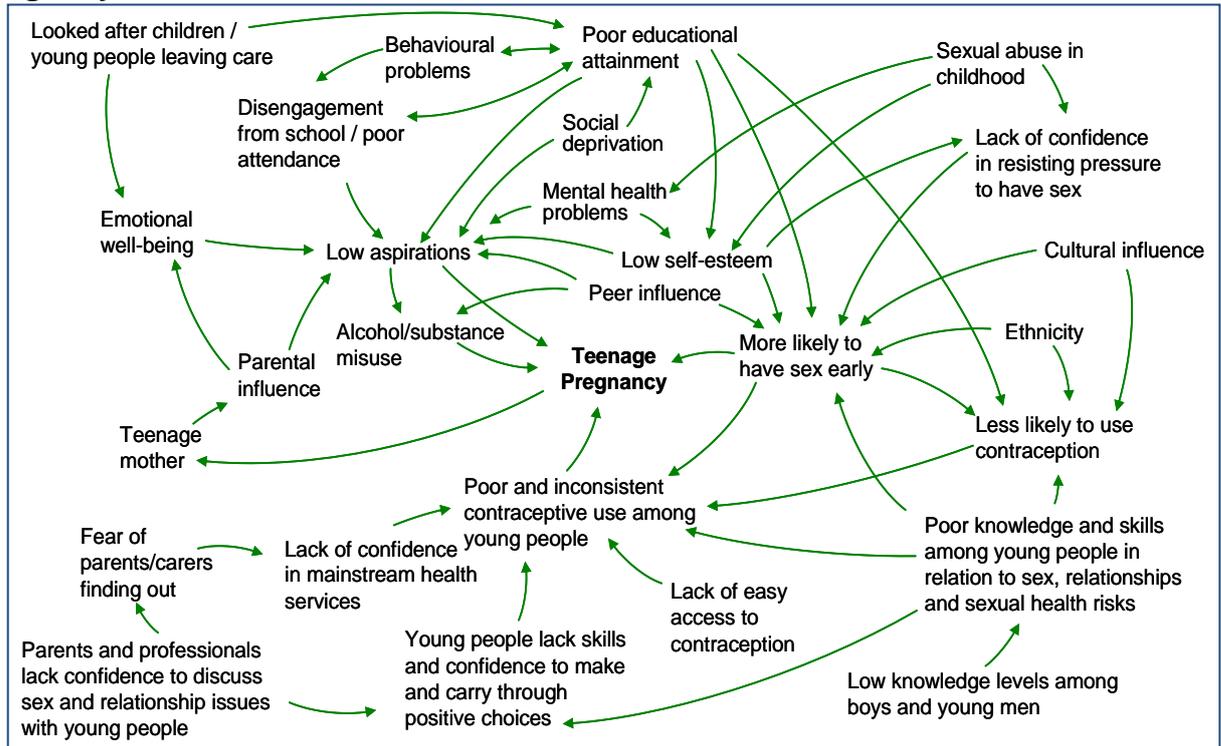
The mid-strategy review highlighted two key issues. Firstly the contrasting progress of very similar areas made it very clear that high rates were not inevitable. With leadership and the right actions rates could be reduced, even in deprived areas. This was an important message for areas where some senior leaders believed the high rates of teenage parenthood were an intractable part of the local culture. Secondly it confirmed the underlining principle of the Strategy that the complex issue of teenage pregnancy and sexual health has to be addressed through a whole systems approach. The benefits of high quality sexual health services would only be seen if other agencies and practitioners in touch with young people's daily lives contribute to prevention and provide swift and easy referral pathways. To reflect this, Ministers published new and more prescriptive guidance for local areas, setting out more clearly the practical actions for all relevant partner organisations. (11)

The two diagrams below were used to illustrate how to translate the complex issue of teenage pregnancy into a whole systems approach with every agency understanding their contribution, and senior leadership at the centre providing accountability.

Implementation of the new guidance was supported by wider Government initiatives to promote a more joined up and holistic approach to improving the outcomes for children and young people. Notably, *Every Child Matters*, a new Targeted Youth Support programme to reach vulnerable young people, a strengthened Healthy Schools programme which reinforced the links between SRE and contraception/sexual health services and the *You're Welcome* quality criteria for young people friendly services. (12) To reflect the cross cutting nature of the Strategy and the importance of joining up with other children and young people programmes, TPU had also been moved from the Department of Health to a new Children, Young People and Families Directorate in the Department of Education and Skills, but continued to work closely with the Sexual Health Division in DH who were responsible for implementing the National Strategy for Sexual Health and HIV (published in 2001) and led on contraception, abortion and STI policy for all ages.

To help areas assess their progress, TPU provided detailed data analysis sheets for each local area showing trends on conceptions broken down by births and abortions, other relevant data on education attainment and comparisons with statistical neighbour areas. To strengthen local performance management, a self assessment toolkit was published to enable areas to monitor the implementation of their strategy actions more closely and identify and address gaps. (13)

Translating the complex issue of teenage pregnancy with a range of risk factors into a whole systems approach with clear actions for each agency



The ten key factors for effective local strategies



New ministerial focus on poorly performing areas

Recognising that the national reduction would have doubled if all areas were performing as well as the top 25%, DH and DCSF ministers decided to have a specific focus on the 21 local areas with high and increasing rates. (14) Chief executives of the Primary Care Trust and Local Authority were requested to submit a 6 monthly report of progress which received joint ministerial feedback. They were also invited, with an elected councillor, the Director of Public Health and the local TPC, to attend an annual ministerial meeting to discuss and share effective practice. The 21 areas were provided with additional support from the RTPCs. In-depth reviews, with recommendations, were also provided by a newly appointed Teenage Pregnancy National Support Team in DH which worked closely with TPU and the RTPCs.

2008-2010: a strengthened focus on SRE and effective contraception

In addition to a focus on improving local performance, further thought was given to what national action would help accelerate progress. An updated international research review (15) confirmed the original evidence base for the Strategy that the provision of high quality comprehensive sex and relationships education, (16) and improved use of contraception (17) are the areas where strongest empirical evidence exists on reducing teenage pregnancy rates.

From the start of the Strategy there had been a sustained call to Government from the Teenage Pregnancy Independent Advisory Group, the Sex Education Forum and other stakeholders, to make PSHE and SRE a statutory part of the curriculum. Statutory status was considered essential to address the inconsistent provision and unacceptable lottery for young people of whether or not they received good SRE. Following a powerful survey of 20,000 young people from the UK Youth Parliament which showed that 40% rated their SRE poor or inadequate, and a campaign – *Beyond Biology* – from the Sex Education Forum, Government commissioned a review of SRE and PSHE and in 2008 accepted the review recommendations to make PSHE statutory (18). The Bill failed to get passed in the final legislative wash up in April 2010, which was a very significant blow to the much needed progress in improving SRE. However, during the preparation for the Bill there was some important progress made through public polls, consultations and publicity on both improving the understanding of what good SRE looks like – and dispelling myths about ‘sex lessons for 5 year olds’ - and developing a clear consensus between young people and parents of the importance of SRE in schools. The expectation of statutory status also prompted some local areas to raise the priority of SRE and develop programmes and training to prepare schools.

The importance of on improving young people's access to and effective use of contraception was highlighted by the Santelli research (17) showing that 86% of the recent US decline in teenage pregnancy rates was attributable to better contraceptive use. In addition, while the overall under 18 (and under 16) conception rates were declining, conceptions leading to birth were declining more steeply than conceptions ending in abortion which suggested young people needed further support on choosing and using contraception effectively. To support local areas in improving access to effective contraception, DH secured 33M additional funding from the Spending Review settlement for 2008-11. The primary aim was to increase access to all types of contraception and particularly to ensure that Long Acting Reversible Contraception was easily available in all areas as a choice to all women, including young women. Funds were distributed through Strategic Health Authorities which were asked to ensure investment was made on activities which would be sustainable beyond the three year lifetime of the fund. DH provided additional support to promote good practice and learning. To continue the important promotion of condoms to protect against STIs, Brook, the UK's leading young people's sexual health charity, was funded to develop guidance for local areas on condom distribution schemes. (19) TPU also funded Brook to develop guidance on sexual health outreach to help local areas take services to young people who may find it difficult to access other settings. (20)

As part of the drive to improve awareness and uptake of contraception, there was a further review of the national campaign and the role of communications in reducing teenage pregnancy and improving sexual health (21). The review identified that the greatest impact of a communications campaign would be to help change the culture around sexual health advice and show conversations about contraception and sexual health as a normal part of everyday life. Under an umbrella campaign, *Sex. Worth Talking About*, TV, cinema and radio ads showed conversations about contraception and Chlamydia between young people, with parents and with professionals. For the first time, ads about the range of contraceptive choices were brought into the living room, before the 9pm watershed. The notable lack of complaints was a further reflection of the growing consensus around the importance of good sexual health information.

The final 2010 data

Because of the time lag in receiving conception data from the Office of National Statistics, the final 2010 data was published in February 2012. This showed a 24.3% reduction in the under 18 conception rate from 46.6 in 1998 to 35.4 in 2010 - the lowest level since 1969. The under 16 rate had dropped by 20% from 8.8 to 7.0. From 2008 both abortion and maternity rates for

under 18s were declining but within the 23.4% overall reduction over the ten years, there was a steeper 35% reduction in conceptions leading to birth.

The ten year decline in the under 18 conception rate contrasted with increasing conception rates in older age groups. In 2010, conception rates in England increased among all age groups with the exception of the under 20s. It is estimated that if the under 18 conception rate had remained at the same level as 1998, there would have been 60,000 additional conceptions.

At a local level, 93% of areas had declining rates but there continued to be considerable variation in progress. Reductions ranged from over 40%, including in areas with high levels of poverty and deprivation, to much lower declines of 10-20%. It was notable however that the areas under ministerial focus and strong local performance management had started to see reductions. Annex B provides a full data note on the 2010 statistics, the breakdown of births and abortions and the variation in progress between areas.

Lessons learned

The collective efforts of all those involved in the Teenage Pregnancy Strategy have made significant progress in reducing England's teenage pregnancy rate. But the job is not yet done. At a national level we are only half way to the original ambition to halve the rate to levels experienced by young people in other Western European countries. And while some areas have very effectively brought down rates to almost reach their original target, two thirds have declines of less than 25% and 7% have yet to see an overall reduction.

Although the Coalition Government has decided not to have a further standalone teenage pregnancy strategy, Ministers have made clear they want local areas to continue their efforts to reduce rates as part of the drive to narrow inequalities and reduce child poverty. The importance of further progress is reflected in the Government's new Public Health Outcomes Framework which includes the under 18 conception rate as one of the three sexual health indicators and around twenty other indicators to which progress on teenage pregnancy will directly contribute. A continued focus on teenage pregnancy is expected to be included in the forthcoming sexual health strategy document from DH.

Embedding and building on the learning of the Strategy will be key to further progress in England but may also be of interest to the inquiry. In summary, the key lessons from the Strategy which have been outlined in this briefing are:

High teenage pregnancy rates are not inevitable. Concerted effort makes a difference even in deprived areas with historically high rates of teenage parenthood. With leadership and the right actions rates can be reduced.

Follow the evidence. The international evidence consistently shows that high quality comprehensive sex and relationships education, both in and outside of school, combined with easily accessible young people friendly contraception services are the key factors in reducing rates. Good SRE and access to services needs to be universal and targeted. All young people need high quality SRE and access to contraception and sexual health services to enable them to make positive and well informed choices, but those most at risk require targeted more intensive support, combined with programmes to build aspiration.

Teenage pregnancy needs to be everybody's business. For effective local strategies, high level evidence needs to be translated into a whole system approach. All agencies and practitioners in touch with young people need to understand why teenage pregnancy matters and be clear what their role is in supporting young people.

Good data and local intelligence is essential for effective strategies. Analysis of local data and trends, combined with soft intelligence from service providers and an understanding of where and how young people 'live their lives' are all critical for getting needs assessments right and ensuring that services and support are commissioned in relevant locations and settings.

Senior leadership is key at national and local level. Senior leadership, strong performance management and accountability are key to maintaining the priority of teenage pregnancy, highlighting the links to improving other outcomes for children and young people and ensuring all agencies contribute to the local solution.

Good structures can support delivery. Having a national Teenage Pregnancy Unit with a clear line of communication through the RTPCs to the local TPCs and Partnership Boards helped deliver clear information and consistent messages about Strategy implementation and enabled barriers to be quickly identified and addressed. The RTPCs also played an essential role in providing expert support to local areas and joining up with other relevant policy leads in regional Government to help strengthen engagement from all relevant agencies. The Teenage Pregnancy Independent Advisory Board provided expert support and challenge to Ministers, the TPU and local areas, published a range of teenage pregnancy briefings with key professional organisations and contributed well informed opinion to media debates. Central funding of the voluntary sector to provide resources and support harnessed

their specific expertise and helped build capacity in the delivery of the Strategy.

There is clear consensus on the importance of SRE and contraception/sexual health services. There is strong consensus between young people, parents and professionals about the key elements of the Strategy. Data from polls and surveys taken during the Strategy showed that: young people (95%) and parents (82%) support SRE being a statutory part of the national curriculum; 86% of parents believe there would be fewer teenage pregnancies if parents talked more to their children about sex and relationships; and over 80% of parents agree young people should have access to confidential contraceptive services, even if they are under 16. However, the consensus needs to be visible – nationally and locally – in order for local areas, schools and practitioners to feel confident in providing SRE and sexual health services which meet local need.

What could we have done differently?

Reflection on the lessons learned has also highlighted some gaps and weaknesses in the Strategy which, if addressed, might have led to faster progress. With the exception of the first point about statutory SRE/PSHE, there is no tested evidence that they would have made a significant difference, but are included in this briefing in case they are helpful for the inquiry's consideration.

Making SRE/PSHE a statutory part of the national curriculum from the start of the Strategy Given that high quality comprehensive SRE is one of the two planks of evidence for reducing teenage pregnancy rates, having no statutory lever to raise the priority in schools was a major barrier. While many schools with dedicated teachers and PSHE advisers made huge improvements, it remains a lottery for young people whether or not they receive the SRE they need to make safe and informed choices. Statutory provision does not automatically lead to improved quality but it signals the importance of SRE/PSHE and sets in train the building blocks towards quality – notably teacher training, clear learning outcomes and inclusion in school inspections. Although the benefits of statutory status would have taken time to reach all pupils, by the end of the 10 year strategy we would undoubtedly have had a more consistent offer to all children and young people and, as a result, a greater reduction in unintended pregnancies.

Providing more prescriptive guidance for local areas to follow and stronger performance management from the start of the Strategy While the original guidance for the development of local strategies development set out a clear framework for what needed to be in place, the 'must do' actions required of

each agency and relevant senior leaders were not sufficiently clear. This resulted in inconsistent local implementation and presented a challenge in monitoring progress across the breadth of the strategy actions. The more prescriptive guidance issued after the deep dive reviews and the self assessment toolkit helped local areas identify and address gaps in their strategies and strengthened performance management by both local leaders and the RTPCs.

More collaboration with general practice There was some proactive work done with general practice in the first phase of the Strategy, notably the *Getting it Right for Young People* guidance for GPs and the *Confidentiality Toolkit*, and there was GP representation on the Teenage Pregnancy Independent Advisory Group. However there wasn't a sufficiently strategic approach to maximise the contribution general practice could make to engaging young people and supporting them to prevent early pregnancy and look after their sexual health. Given that general practice is a universal service, close to where people live and open all week, there is huge untapped potential to increase young people's early uptake of contraceptive advice from GPs and practice nurses – and for general practice to make links with local schools, colleges and youth services.

A stronger focus on contraception in the national campaign. Until the *Sex. Worth Talking About* campaign, the headline message of the previous national campaigns *RUthinking* and *Want Respect*, had focused on increasing the use of condoms. Information about the choice of more effective contraceptive methods was delivered in secondary messages through PR activity. While the rationale for focusing on condoms was clear – to convey an integrated message on prevention of pregnancy and STIs, to young men as well as young women – progress was slow in improving young people's knowledge about the range of effective contraception available. It was notable that the steepest annual decline in the under 18 conception rate of 6% occurred from 2009-10, coinciding with the new campaign and the increased access to a wider range of methods through the additional DH funding. However, there remains a challenge, still to be resolved, in how to effectively convey strong messages about contraception and condoms in one campaign.

A national strategic approach to young people scrutiny from the start of the Strategy. There were several pieces of work to encourage young people involvement throughout the course of the Strategy: guidance on participation for local areas, service evaluation by young people as part of the DH *You're Welcome* Quality Criteria for young people friendly services, and an SRE audit tool for pupils to help schools evaluate and improve their SRE provision. From 2005 young people were also represented on the Independent Advisory Group. Although some local areas did some excellent scrutiny work, at a

national level there was no strategic, systematic way of monitoring how well the Strategy was reaching young people. Some data was collected through the tracking survey of the National Campaign, but not published. An annual national survey of young people to monitor improvements in SRE, access to contraception and ease in asking for advice might have provided some helpful proxy indicators of progress. The same survey could have been made available for local areas.

A more realistic target. Having a target was clearly helpful at national and local level to set an ambition and prioritise action. The rationale for the target was clear. A 50% reduction would bring the rate down to levels experienced by young people in comparable Western European countries. However, the ten year timescale for the necessary shift in culture to tackle historically high rates may have been too ambitious. At a local level, in some very high rate areas, the challenge of halving rates seemed impossible and either demoralised or de-motivated leaders and practitioners. Having a ten year target of 35% and a 50% target for 15 years may have been more realistic.

More proactive work with the media to lead a calm debate. Although the vast majority of parents and young people support SRE and young people's access to contraception, the consensus is often hidden under 'shocking' media headlines and polemic debate. This often misinforms and alarms the public – for example depicting SRE as 'sex lessons for five year olds', or school based clinics as 'condoms for 11 year olds'; makes schools, services and frontline practitioners nervous about the SRE or support they are providing; and gives young people very confusing messages about whether they should or should not be talking about sex and relationships and asking for advice. A national media strategy to highlight the consensus and lead a well informed discussion might have helped counter some unhelpful and misinformed media reports and promote the more open culture which, international evidence suggests, is fundamental to helping young people to discuss issues that concern them and ask for advice without stigma or embarrassment.

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Annex A

Factors associated with high teenage pregnancy rates

Early onset of sexual activity	Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16. ⁱ Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males and leaving school at 17 or over with qualifications. Early onset of sexual activity is also associated with some ethnic groups (see below)
Poor contraceptive use	Around a quarter of boys and a third of girls who left school at 16 with no qualifications did not use contraception at first sex, compared to only 6% of boys and 8% girls who left school at 17 or over, with qualifications. Survey data demonstrate variations in contraceptive use by ethnicity. Among 16-18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32%), Asian females (25%), Black African females (24%) and Black Caribbean males (23%). ⁱⁱ
Mental health/conduct disorder/involvement in crime	A number of studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17 ⁱⁱⁱ . Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police. ^{iv}
Alcohol and substance misuse	Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for both young men and women. A study in Rochdale showed that 20% of white young women report going further sexually than intended because they were drunk ^v . Other studies have found teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience. ^{vi}
Teenage motherhood	A significant proportion of teenage mothers have more than one child when still a teenager. Around 20% of births conceived under-18 are second or subsequent births
Repeat abortions	Around 7.5% of abortions under-18 follow either a previous abortion or pregnancy. Within London this proportion increases to around 12% of under-18 abortions
Education-related factors	
Low educational attainment	The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment. (80 per 1000 girls aged 15-17 compared

	with 40 per 1000)
Disengagement from school	<p>A survey of teenage mothers showed that disengagement from education often occurred prior to pregnancy, with less than half attending school regularly at the point of conception. Dislike of school was also shown to have a strong independent effect on the risk of teenage pregnancy.^{vii}</p> <p>Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with more than 8% of half days missed had, on average, an under-18 conception rate 30% higher than areas where less than 8% of half days were missed.</p>
Leaving school at 16 with no qualifications	<p>Overall, nearly 40% of teenage mothers leave school with no qualifications.^{viii}</p> <p>Among girls leaving school at 16 with no qualifications, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over.ⁱ</p> <p>Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex (see below).</p>
Family/Background factors	
Living in Care	<p>Research has shown that by the age of 20 a quarter of children who had been in care were young parents, and 40% were mothers^{ix}.</p> <p>The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.</p>
Daughter of a teenage mother	<p>Research findings from the 1970 British Birth Cohort dataset showed being the daughter of a teenage mother was the strongest predictor of teenage motherhood.</p>
Ethnicity	<p>Data on mothers giving birth under age 19, identified from the 2001 Census, show rates of teenage motherhood are significantly higher among mothers of 'Mixed White and Black Caribbean', 'Other Black' and 'Black Caribbean' ethnicity. 'White British' mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented</p> <p>A survey of adolescents in East London^x showed the proportion having first sex under-16 was far higher among Black Caribbean men (56%), compared with 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, 30% of both White and Black Caribbean groups had sex under-16, compared with 12% for Black African, and less than 3% for Indian and Pakistani women</p> <p>Poor contraceptive use has also been reported for some ethnic groups (see below)</p>
Parental aspirations	<p>Research shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage motherhood.ⁱ</p>

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- ^x Viner R, Roberts H (2004) *Starting sex in East London: protective and risk factors for early sexual activity and contraception use amongst Black and Minority Ethnicity adolescents in East London* University College London, City University and Queen Mary, University of London

Annex B

Conception statistics 2010: key findings

Under-18 conceptions

England and Wales

- Figures for England and Wales show that the 2010 under-18 conception rate (35.5 conceptions per 1,000) is the lowest estimated rate since 1969. The 7.3% decline in the under-18 conception rate 2009 to 2010 represents the greatest single year decrease in the under-18 conception rate since 1975/76.
- Data for England and Wales show that conception numbers and rates fell at all ages under-18 (see Table 3 in Annex 1). Younger age groups (especially those under 15) continue to account for a very small proportion of teenage conceptions. In 2010 5% of under-18 conceptions in England and Wales were to under 15s.

England

- In 2010, the under-18 conception rate for England was 35.4 conceptions per 1,000 girls aged 15-17. This represents a decline of 7.3% since 2009 (38.2 conceptions per 1,000) and continues the overall downward trend observed since 1998. The under-18 conception rate has fallen by 24% since 1998, down from 46.6 conceptions per 1,000 (see Table 1 in Annex 1).
- The total number of under-18 conceptions in England has declined by 10.5% since 2009, down from 35,966 to 32,552.

- The proportion of conceptions leading to abortions for under-18s was 50.3%, up slightly from 2009 (49.1%).
- Both maternity and abortion rates for under-18s are declining. However, the rate of under-18 conceptions leading to births continues to fall at a faster rate than overall conceptions. In 2010, the rate of under-18 conceptions leading to births was 17.6 per 1,000. This is 10% lower than in 2009 (19.5 per 1,000) and 35% lower than in 1998 (26.9 per 1,000) (see Figure 1 in Annex 1)

Regions

- The under-18 conception rate decreased in all regions 2009-10. London experienced the biggest decline with an 8.8% decrease from 40.7 conceptions per 1,000 in 2009 to 37.1 in 2010. The North East continues to have the highest under-18 conception rate at 44.3 per 1,000 in 2010 whilst the South East has the lowest rate at 28.3 conceptions per 1,000 (See Table 4 in Annex 1.)

Local authorities

- There continues to be considerable variation in performance across local authorities. In 2010 the under 18 conception rate ranged from a low of 13.1 per 1,000 in Wokingham to a high of 64.7 per 1,000 in Haringey.^x
- Comparing 2010 with 2009 the majority of top tier local authorities (112 out of 150)^x saw reductions in their under-18 conception rates, with 61 local authorities seeing reductions of more than 10%. However, around a quarter of areas saw increases in their under-18 conception rates 2009 to 2010.
- It is important to bear in mind that, given the small numbers involved, local authority rates can be subject to large year on year fluctuations. Comparing the three year aggregate conception rate 2008-2010 against the three year aggregate rate 1998-2000 gives a more robust picture of LAs overall performance smoothing out the effect of any random year on year fluctuations. Nearly all top-tier local authorities (140 out of 150) have seen a reduction in their average under-18 conception rate over this period. (see Figure 3 in Annex 1)
- Annex 2 gives further details of the conception rates in selected local authorities.

Under-16 conceptions

- There were 6,256 under-16 conceptions in England in 2010. This equates to an under-18 conception rate of 7.0 conceptions per 1,000 girls aged 13-15.
- The under-16 conception rate is 6.7% lower than in 2009 (7.5 conceptions per 1,000) and 20% lower than in 1998 (8.8 conceptions per 1,000) (see Table 2 in Annex 1).
- The proportion of under-16 conceptions leading to abortion was 62.8%, up from 60.2% in 2009. In 2010 the rate of under-16 conceptions leading to births was 2.6 per 1,000 (see Figure 2 in Annex 1).

Other age groups

- The decline in the under-18 conception rate contrasts with increasing conception rates in older age groups over the past 10 years. In 2010, conception rates in England increased among all age groups with the exception of the under 20s.
- The rate of under-20 conceptions was lower in 2010 compared with 2009, falling from 57.1 per 1,000 girls aged 15-19 in 2009 to 54.5 per 1,000 in 2010, a decrease of 4.8%. This continues the overall downward trend in conceptions for this age group over the last decade.

Annex 1

Table 1: Under-18 Conceptions for England: 1998-2010

Year	Under 18 conceptions	Under 18 conception rate*	Percent leading to legal abortion
1998	41,089	46.6	42.4
1999	39,247	44.8	43.5
2000	38,699	43.6	44.8
2001	38,461	42.5	46.1
2002	39,350	42.7	45.8
2003	39,553	42.1	46.1
2004	39,593	41.6	46.0
2005	39,804	41.3	46.8
2006	39,170	40.6	48.8
2007	40,366	41.8	50.6
2008	38,750	40.5	49.7
2009	35,966	38.2	49.1
2010	32,552	35.4	50.3

Source: Office for National Statistics and DfE, 2012

*per thousand females aged 15-17

Table 2: Under 16 Conceptions for England: 1998-2010

Year	Under 16 conceptions	Under 16 conception rate*	Percent leading to legal abortion
1998	7,855	8.8	52.9
1999	7,408	8.2	53.0
2000	7,620	8.3	54.5
2001	7,407	8.0	56.0
2002	7,395	7.9	55.7
2003	7,558	7.9	57.6
2004	7,181	7.5	57.6
2005	7,473	7.8	57.5
2006	7,330	7.7	60.2
2007	7,718	8.3	62.0
2008	7,123	7.8	61.8
2009	6,756	7.5	60.2
2010	6,256	7.0	62.8

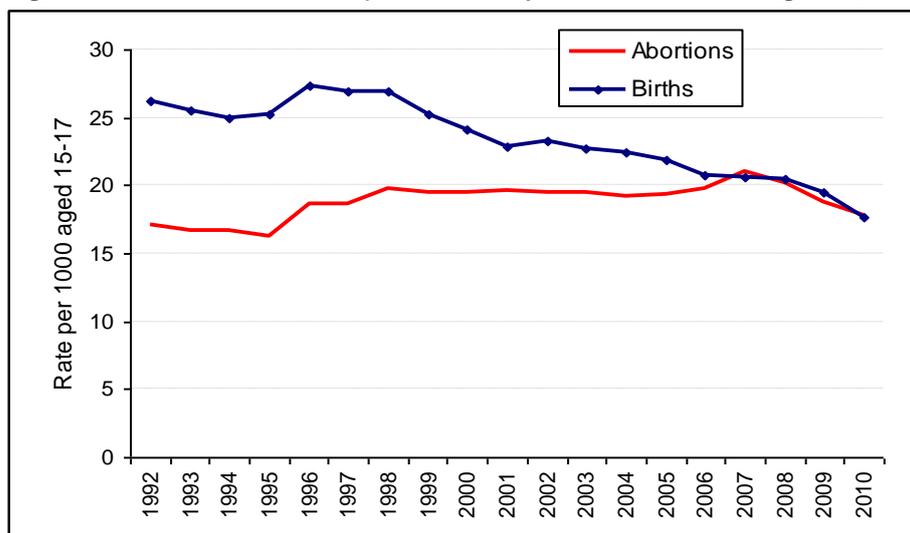
Sources: Office for National Statistics, 2012
 *per thousand females aged 13-15

Table 3: Conceptions by single year age group: **England and Wales**

Age	All conceptions (base numbers)		% leading to legal abortion		Conception rates per 1,000	
	2009	2010	2009	2010	2009	2010
Under 14	316	305	57.9	68.2	1.0	1.0
14	1,697	1,552	64.9	68.8	5.4	4.9
15	5,145	4,817	58.2	60.2	15.9	15.2
Under-16	7,158	6,674	59.8	62.5	7.5	7.0
16	11,896	10,629	49.7	49.7	36.0	32.6
17	19,205	17,330	44.2	45.2	55.9	52.2
Under-18	38,259	34,633	48.8	49.9	38.3	35.5

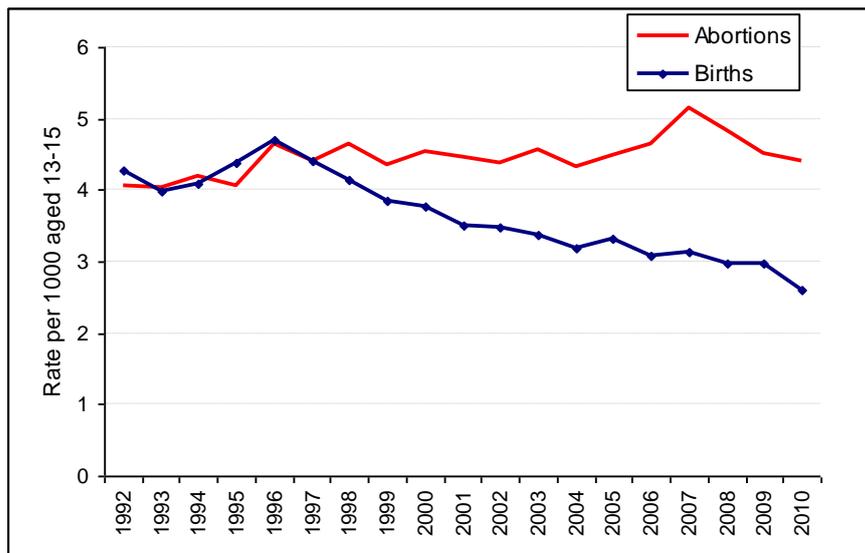
Source: Office for National Statistics and DfE, 2012
 Note: Figures are for England and Wales not England only

Figure 1: Under-18 conception rate by outcome* for England, 1992-2010



* Rate of abortions/births resulting from under-18 conceptions Source: Office for National Statistics and DfE, 2012

Figure 2: Under-16 conception rate by outcome* for England, 1992-2010

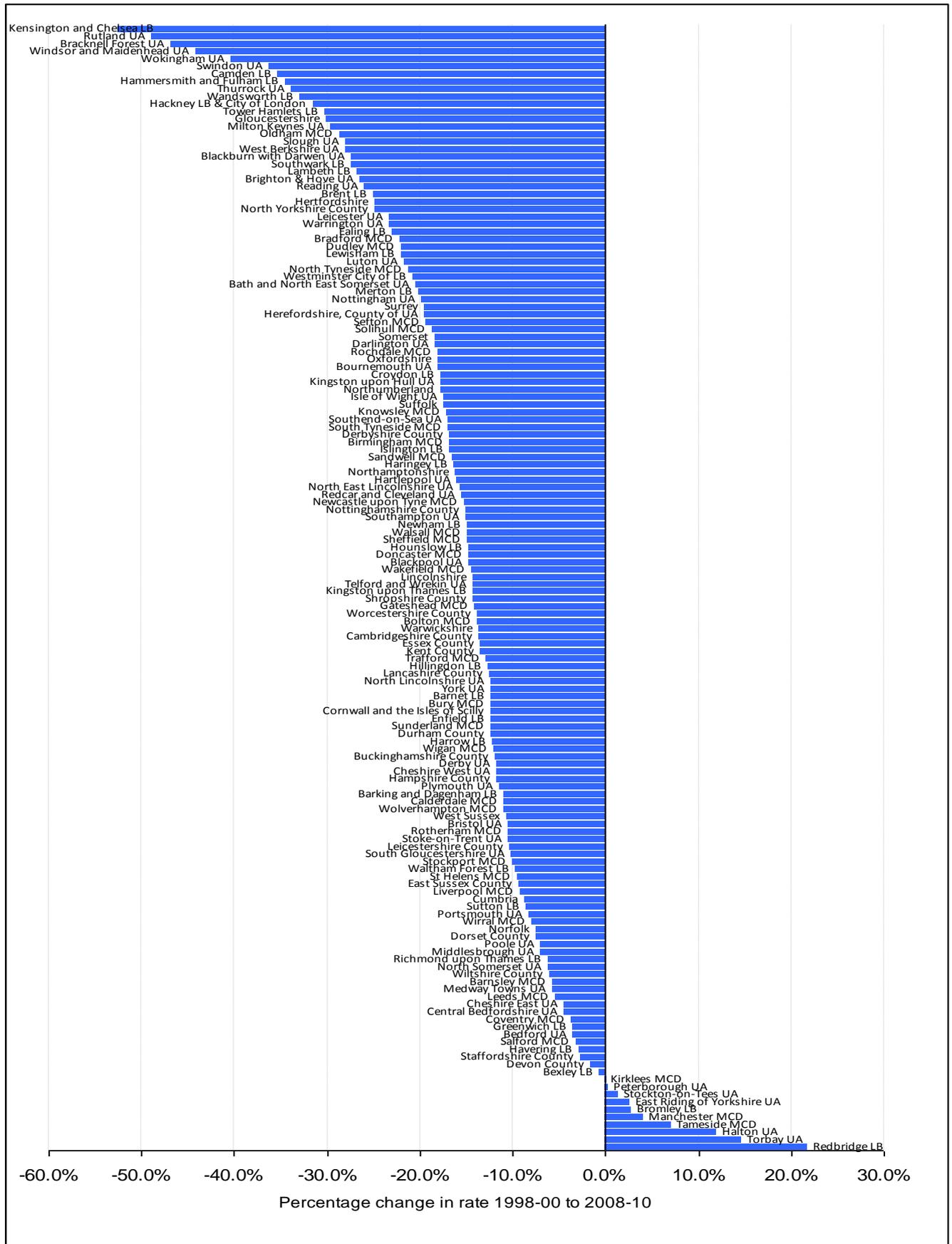


* Rate of abortions/births resulting from under-16 conceptions Source: Office for National Statistics and DfE, 2012

Table 4: Change in under-18 conception rates by region, 1998-2010

Region	Conception rate per 1,000 15-17 year olds			% change	
	1998	2009	2010	2009-2010	1998-2010
England	46.6	38.2	35.4	-7.3%	-24.0%
North East	56.5	46.9	44.3	-5.5%	-21.6%
North West	50.3	43.7	40.7	-6.9%	-19.1%
Yorkshire & Humber	53.1	44.1	40.5	-8.2%	-23.7%
East Midlands	48.8	37.7	34.5	-8.5%	-29.3%
West Midlands	51.7	43.9	40.5	-7.7%	-21.7%
East England	37.9	31.3	29.8	-4.8%	-21.4%
London	51.1	40.7	37.1	-8.8%	-27.4%
South East	37.8	30.1	28.3	-6.0%	-25.1%
South West	39.4	32.4	29.9	-7.7%	-24.1%

Figure 3: Change in under-18 conception rate by LA in England, 1998-2000 to 2008-2010



Source: Office for National Statistics and DfE, 2012