

Inquiry into teenage pregnancy

NHS Health Scotland

Introduction

Unintended conceptions can result in significant emotional, psychological and educational harm to young girls, with lifelong implications. Unintended teenage pregnancy is often integral with an intergenerational cycle of poverty and disadvantage: it both creates poverty and is created by it. Effectively tackling unintended teenage pregnancy is important, both at an individual level, but also because of its impact on future generations – and needs a multi layered and sustained response.

Definition

Whilst the term teenage pregnancy refers to conceptions in women under 20, the term is often referred to and specifically relates to those less than 16 years. There are issues with this finer definition as the media and other commentators do not always make this distinction, often referring to planned/unplanned pregnancies and thus can inadvertently stigmatise those who have made a positive choice to have a child after age 16. In addition, whilst, Scotland has had a target of 6.8% pregnancy rate per 1000 in the under 16 age group, it has never been clear what is an “acceptable” rate or whether the aim should be to maintain a steady state rather than an increase or indeed whether we should concentrate on reducing the inequality gradient between communities with high and low rates of unintended teenage pregnancy.

Epidemiology

The SPICe briefing on Teenage Pregnancy details the statistics relating to teenage pregnancy in Scotland and how these compare to other countries. While we will not repeat those statistics here, we would highlight that teenage conceptions in Scotland, like the rest of the UK, are strongly associated with social disadvantage. There is still a growing gap between those in the most deprived areas compared to their counterparts in more affluent areas – a female under 16 living in a deprived area is five times more likely to become pregnant compared to a female living in one of the most affluent areas. In the most income-deprived quintile only 28% of teenage pregnancies (<20) end in termination while, in the most affluent quintile, 70% of such pregnancies are terminated. The rate of births to teenage mothers (<20) in the most income-deprived quintile is, therefore, 10.4 times that in the least income-deprived quintile. This represents a significant inequalities gradient which is influenced by a wide range of factors, including personal factors such as low self-esteem, lower educational and occupational aspirations, less use of contraception and sexual health services.

Teenage Pregnancy and Health Inequalities

There are strong links between social disadvantage and early sexual activity, and it is hard to make significant progress without tackling wider social and cultural influences such as poverty and environment. Unintended pregnancy

relies on strategies that take account of education and lifelong learning, employment, housing and neighbourhood quality, deprivation and support for young mothers and families, among many others.

Adolescent mothers (and their babies) often face a range of adverse social and economic consequences during pregnancy and later in life. They are less likely to complete their education thus making it harder to have an adequate income. Compared to their older counterparts, are more likely to be in social housing; be unemployed, or their partner unemployed; be on benefits; and be single by age 30 (if not from the outset) and remain so for a long time. Being a child of a teenage parent is, in itself, a risk factor leading to unintended teenage pregnancy – and this is increased fourfold if that parent has been in care.

Adverse economic, psychosocial, medical and educational outcomes are compounded when repeat adolescent pregnancies occur. Short birth intervals reduce the time devoted to the second child. These associations between teenage pregnancy and adverse outcomes are unlikely to be causal and therefore interventions aimed at reducing social disadvantage may be more effective.

It has been suggested that there are a series of predictors which can identify those who are likely to become a parent at a very early age. These include planning/wanting a first pregnancy, not using long-acting reversible contraception, lack of family support, a history of dropping out of school and low socio-economic status. Equipping staff in educational, social and health settings to use such predictors is one way of actively targeting those most at risk and contributing to long term prevention/reductions in teenage pregnancy.

Effective Approaches to reducing teenage pregnancy and support post delivery

Features of successful programmes

Traditional approaches such as sex and relationships education and better sexual and reproductive health services are not effective on their own – a combination approach is required as recognised by Respect and Responsibility and the current Sexual Health and Bloodborne Virus Framework. Evidence indicates that any work aiming to reduce teenage pregnancy should address:

- social disadvantage and dysfunction
- values and norms about sexual behaviour and childbearing; perceptions of these norms by adolescents
- attachment to parents, groups or institutions that emphasize responsible sexual behaviour

and should be supported by:

- early childhood interventions aimed at promoting cognitive and social development through pre-school education, parent training and social skills training
- clinical services including contraception and obstetric care
- sex education programmes that provide developmentally appropriate, evidence-based curricula
- youth development strategies to enhance life skills, connections to supportive adults, and educational and economic opportunities

Programmes which include multiple interventions (educational, skill building and contraception provision) can reduce rates of unintended pregnancy in adolescents. Both early childhood interventions and youth development programmes can significantly lower teenage pregnancy rates but it should also be noted that some youth development programmes may have no effect on pregnancy rates, or at worst increase them (aka the Young People's Development Programme in England). Bringing together teenage girls at high risk of pregnancy may increase pregnancy rates, possibly as a result of young women being labelled as high risk or by being exposed to peers who reinforce risk-taking behaviour.

Moreover, it is important to consider the context in which these programmes have been developed as local Scottish circumstances may not be comparable – the progress Holland and Sweden have made in maintaining low teenage pregnancies is often cited but this has been achieved within a long standing social and cultural environment with a focus on educational aspiration and a positive attitude towards delay of early sexual activity (and the use of effective contraception). This reinforces the need to support long term interventions so that improvements can be realised.

Barriers and challenges

There are wider issues that impact on teenage pregnancy. These include:

- *The Rights of Children and Young People*

Whilst children have rights underpinned by the UN Convention on the Rights of the Child, these are often not recognised in the way we respond to young people. They may not be afforded the right to take decisions for themselves and this can impact on how they use sexual health services. Building resilience is essential from an early age – the Family Nurse Partnership initiative and Early Years Collaborative will be important contributors to this. The recent consultation on the Children and Young People's Bill and the potential for legislative proposals to improve transparency and scrutiny of the actions taken to ensure the progressive realisation of children's rights is welcomed.

- *Sex and relationships education (SRE)*

Evidence clearly advocates the use of comprehensive sex and relationships education in educational settings but there is no obligation to do more than a bare minimum, mostly work around friendships and relationships, as demonstrated in Curriculum for Excellence. For some parents, even this is too much and may withdraw their children from such classroom sessions.

They do not need to demonstrate how they will address their child's needs – this needs review. Nor is there any requirement to use evidence informed resources with the result that inappropriate and/or out of date (and sometimes inaccurate/misleading) materials may be used. Health Scotland's SHARE resource is an example of secondary school resource that has been well evidenced and further developed by those delivering in the classroom. Moreover there is no requirement for teachers and others providing SRE to have undertaken any additional training – something which is not tolerated for any other educational topic. Interestingly, the teenage pregnancy rates started to decrease faster following financial investment to local authorities to support additional teacher training on SRE in 2006/8. The overall effect is that sex and relationships education is patchy and introduced at too late a developmental stage, with schools left to decide for themselves what and how they will deliver and with little feedback from pupils to assess effectiveness. An effective monitoring and assessment process, more than the HMIE cycle, is required – and should cover both local authority and independent schools.

- *Staff attitudes in young people's services*

One of the key tenets of Respect and Responsibility was the provision of safe, confidential and accessible sexual [and reproductive] health services. Significant progress has been made in providing such services for young people but we should increase our efforts to ensure that these are available particularly for those who are most vulnerable, whether that is due to socio-economic circumstances or other risk factors. To facilitate their use, young people must be confident that they will be supported in whatever choices they may make. This requires staff to be non-judgemental and whilst training can help, it may not be sufficient. We need to continue to work towards developing a more positive view of sexual wellbeing across Scotland as a whole.

- *Gender*

Prevailing Scottish cultural attitudes towards women and sex are still often unhealthy and unacceptable whilst macho stereotypes tend to be portrayed for men – media imagery plays a significant part in reinforcing this. In recent years, much has been done to address this but much more needs to be done. The sexualisation of childhood is one such area (and was well documented in the previous research commissioned by the Scottish Parliament's Equal Opportunities Committee).

- *Forced, coerced and exploitative sex*

Evidence suggests that there has been a general ambivalence towards consent and sexual autonomy. The Healthy Respect Demonstration Project found gendered attitudes to forced sexual intercourse amongst 5th year school pupils: girls were more accepting of forced sex, both if already sexually active or if had been drunk compared to their male counterparts and that this had increased over the life of the project (not as a result of the project but more a result of more explicit media imagery). The clarity on consent and sexual autonomy provided by the Sexual Offences Act should lead to an attitudinal shift towards sexual violence.

Cause for Further Optimism?

Evidence from the Healthy Respect Demonstration Project in NHS Lothian and other initiatives indicates that **supportive parenting** (sometimes referred to as family connectedness) – that is, parental supervision of children and open discussion between parents and children – promotes positive wellbeing. The fpa Speakeasy project which provides parents and carers with skills and knowledge to talk to their offspring about sexual health is an example of such an initiative.

For those young people who are early parents, they may not have the life experience or financial capacity to successfully cope with the responsibilities of parenthood and thus may benefit from additional support. This includes the **Family Nurse Partnership (FNP)** programme which aims to improve outcomes for young first time mothers and their children through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old. One of the key features of this programme is to increase the gap between the first and subsequent pregnancies. Although still early days, there is evidence that FNPs have the potential to support young mothers to develop skills as competent, confident parents; access contraception when they might not otherwise have pursued this; feel better supported in relation to their own mental and emotional health and wellbeing; and resolve/manage relationship conflicts. By working with young women at a very early stage, it is also hoped that their babies, having hopefully had a more secure attachment than their mothers may have experienced, will consequently approach motherhood and parenting very differently.

Some of these impacts would tend to suggest the potential for positive outcomes in relation to their own sexual health. However many of the impacts are likely to improve sexual health outcomes for the children of parents who are supported in this intensive way and it has the capacity to be a tool for breaking the intergenerational cycle of poverty.

The asset based approach, the intensity of visiting, the level of expertise of the FNP nurses and the therapeutic relationship that develops between the young women and the FNP nurse are crucial. Some commentators have suggested that the FNP programme is an expensive programme but early evidence suggests the benefits would appear to outweigh the costs, particularly in terms of addressing the needs of very vulnerable young women and their babies. The learning from this work needs to be actively shared, and more evaluative studies are due soon from Health Scotland.

Early Years Collaborative

The critical importance of the Early Years in establishing a strong foundation for life has long been recognised but will now be given higher focus with the establishment of the Early Years Collaborative, which utilises improvement methodology approach within CPP areas, as a contribution towards making the Early Years Framework a reality. The continued development of Integrated Children's Services Plans (ICSP) by Community Planning Partnerships will be a vital component of directing resources towards meeting

the needs of vulnerable children and their families through preventive approaches. Reinforcing family connectedness (as previously mentioned) should contribute to the continued reduction of unintended pregnancies in the longer term.

National Parenting Strategy

If followed through, the implementation of this strategy should prepare teenagers and young people to be better parents of the future and support expectant parents and current parents to develop better attachments with their children. The opportunity to influence the direction this takes and the contribution this could make towards a more positive parenting culture in Scotland should be maximised.

Refocus of Community Planning Partnerships

Teenage pregnancy and other sexual health issues cannot be viewed in isolation but need to be seen alongside other issues such as using alcohol, experimenting with drugs, domestic violence and intensive supports for teenage parents and their families. Collaborative partnerships and joint action across these areas can be, and are in some areas, being actively pursued but more could be done. Clearer guidance and direction about what tackling teenage pregnancy means for Community Planning Partnerships and Children's Services planning structures would help make this consistent across Scotland. This does not mean applying the same model in all areas but rather providing strong leadership and investment in tackling deprivation and aspiration which will in the long term impact on teenage pregnancy. The learning from the English Teenage Pregnancy Strategy on pooling resources and jointly funded posts could be usefully applied more widely in Scotland as would sharing the learning from the work on developing a Teenage Pregnancy Pathway across Lothian.

Conclusion

Reducing the rate of teenage pregnancies and improving the outcomes for young women and their babies should continue to be a focus for Scottish Government. Most teenage pregnancies in Scotland are unintended, so helping to prevent these has been, and will continue to be, a key focus of NHS Health Scotland's work to support the Scottish Government's policy on sexual health and wellbeing. This includes developing sex and relationships education resources for schools and parents/carers and developing evidence on what works. There is no one single intervention: we know that a combination of information, education and sexual health services can help to reduce teenage pregnancy and this needs to be in conjunction with all key stakeholders. The challenge is to provide young people with the means, desire, and attractive alternative lifestyle options to avoid early pregnancy and recognise the value of delaying early sexual activity, but also to tackle the circumstances that make young people want to become parents, or lead them to become so at an early age. Self esteem, motivation, achievement and having a sense of a positive future are all influential in maintaining positive sexual health and wellbeing.

Health Scotland will continue to support such efforts, in particular through:

- active involvement in the Early Years Collaborative and the Family Nurse Partnership programme
- Continued support to local Community Planning Partnerships to address the wider determinants that influence teenage pregnancy.
- Working with Education Scotland to ensure that Curriculum for Excellence meets the needs of children and young people

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