

Summary Review

Teenage Pregnancy and Reproductive Health

Edited by

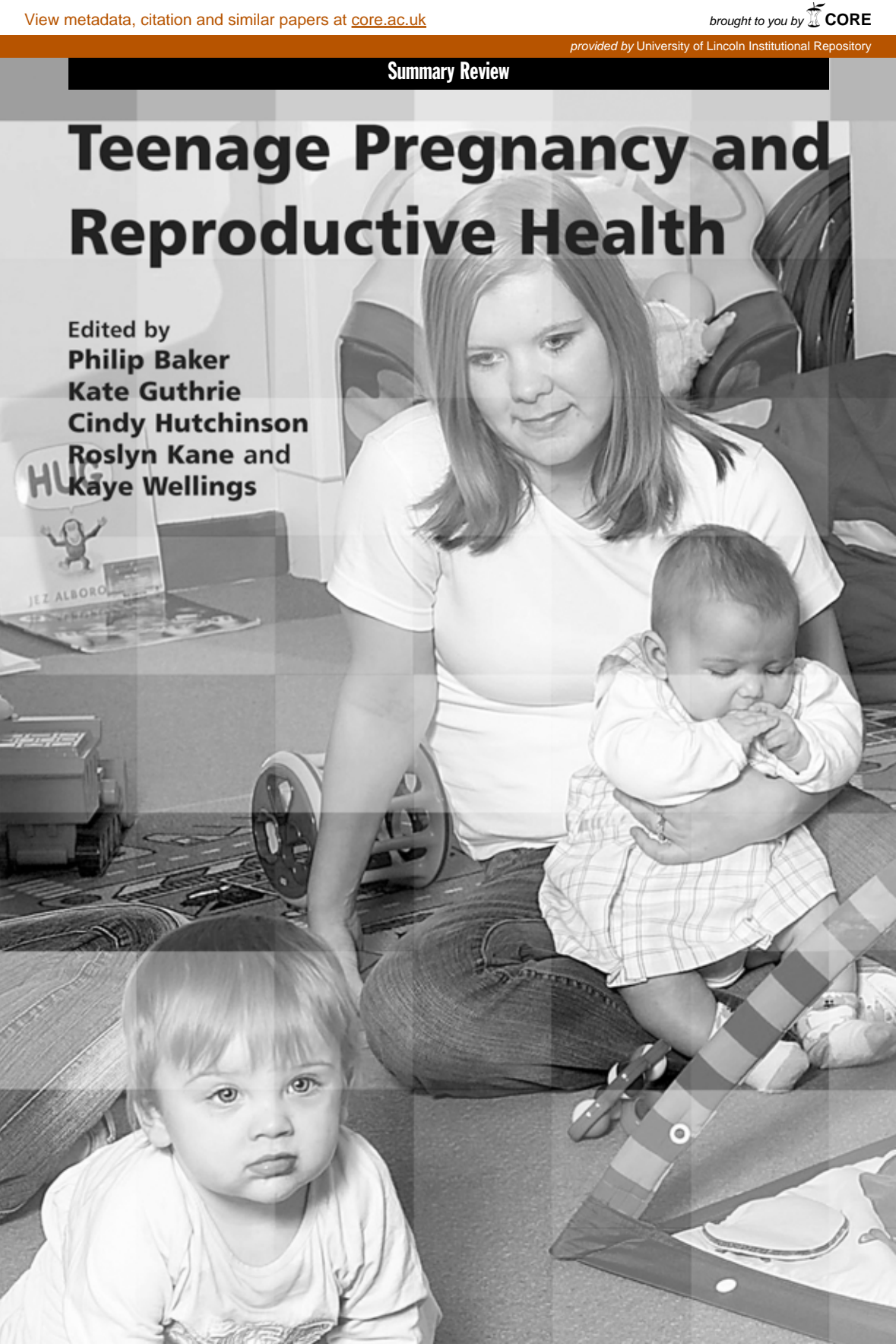
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Foreword

Teenage pregnancy, by and large unplanned, has become one of the major public health issues of our time. Despite the widespread and improved availability of contraception, the problem is unresolved and in some areas is increasing. Both live births and abortions in teenagers in England are among the highest in Europe. The circumstances of teenage pregnancy in the UK, including medical, social and public health implications have been examined by the RCOG Study Group and their findings are given in a comprehensive volume of proceedings, of which this is a summary. Recent headlines point to a teenage sex health crisis fuelled by drink and drugs, as well as confused messages from role models, and the lack of a coordinated national approach. Yet there is some hope of a way forward. The Study Group reveals the factors associated with success, including locally coordinated strategies, comprehensive education programmes, accessible contraceptive services, as well as wider social issues such as workforce training and recognition of vulnerable groups. I recommend this Summary Review to all concerned about this issue, and this must surely include all of us. I want to thank and congratulate the organisers and contributors to the Study Group for a fine piece of work and for sound advice.

Allan Templeton

President, Royal College of Obstetricians and Gynaecologists

Introduction

This review reflects evidence-based presentations and discussions of the Royal College of Obstetricians and Gynaecologists 52nd Study Group, entitled *Teenage Pregnancy and Reproductive Health*. The full volume of proceedings is published by RCOG Press. The issues and questions surrounding this complex topic are potentially of interest to all those with concern for the health and welfare of young women and young men.

Mapping teenage pregnancy

Teenage pregnancy in England: an historical perspective

Teenage birth rates persistently reflect the reproductive and sexual behaviour of older women. From the 16th century to the 1950s, teenage births in England tended to be rare. Teenage birth rates rose from the late 1930s because major changes in the determinants of adult sexual behaviour (access to reliable contraception, an increase in income) led to changes in sexual mores, which, in turn, led to increased teenage sexual activity. However, sexual activity was largely confined to marriage until the 1970s, when lack of parental control and increases in income meant that marriage was no longer necessary to attain adult status and privileges.

The timing of the rise in teenage birth rates suggests that few teenage mothers would have been ignorant of the responsibilities associated with rearing a child, and shows that teenage pregnancy rates did not rise in response to improved benefits. Adoption rates are low, even among teenagers from unstable or socially deprived backgrounds, and many choose to keep their baby, reinforcing the important human needs to love and be loved.

A 'class' divide still exists between a lower 'working' class age at marriage and higher fertility, including higher rates of premarital pregnancy and illegitimacy, and a higher 'middle' class age at marriage and lower fertility. Fertility has now fallen to historic lows and middleclass women have become increasingly less likely to become mothers at all.

Variations across countries: an international perspective

Teenage sexual activity and associated outcomes are affected by a combination of biological and cultural factors. In relation to teenage sexual activity and outcomes, there are quite large variations between countries that are relatively similar in terms of economic development. Urgent and challenging issues are associated with the situation in poorer countries, especially with the spread of HIV infection, unsafe motherhood and

abortion. Despite the difficulties involved in explaining cross-national variation in, for example, teenage births, sexual activity and sexually transmitted infections (STIs), there appear to be some clear patterns emerging from studies that have explored such variation in the context of policy change (e.g. income distribution, school education, availability of contraception) and societal attitudes towards young people's sexual activities.

Those countries that have seen the larger declines in teenage conceptions and birth rates have enjoyed relative economic prosperity, increased educational and employment opportunities for young people; they have also faced the challenges posed by changing developmental and marriage patterns, and made changes in the provision of services and education.

In the UK, some positive policy changes appear to have been made, although school-based sex and relationships education is not wholly a compulsory component of youth provision and training for staff involved in young people's sexuality varies considerably. Much can be learned from comparing cultures but the implications need to be carefully thought through and widely applied.

Variations in teenage pregnancy rates in England and Wales

Rates of teenage pregnancy in England and Wales vary considerably, with far higher rates in more deprived areas (56 conceptions/1000 girls aged 15–17 years vs. 25/1000 in least deprived areas, in 2004). However, factors other than deprivation may also have an important role in determining rates of teenage pregnancy, such as socio-economic and service-related factors, educational attainment and ethnicity.

Spatial variations in teenage pregnancy suggest that prevention strategies should adopt both targeted and universal approaches. High-rate neighbourhoods and vulnerable groups should be targeted because half of all under-18 conceptions occur in 20% of ward areas. However, universal interventions are required as low-rate areas still contribute, in absolute terms, a significant proportion of all under-18 conceptions. Targeted approaches to teenage pregnancy prevention should not be constrained to a geographical approach, as spatial distribution of teenage pregnancy is mediated through both personal and area disadvantage. Individual-level risk factors appear to play a significant role, with teenagers experiencing multiple risk factors at greatest risk of pregnancy. Targeted interventions, therefore, need to identify both high rate neighbourhoods and those individuals at greatest risk to succeed in reducing teenage pregnancy.

Understanding teenage pregnancy causes, consequences and experiences

Is teenage pregnancy a health problem?

Teenage pregnancy is associated with a number of adverse medical and psychosocial outcomes for mother and child, including maternal depression, preterm delivery,

perinatal/infant mortality and, in the long-term, adverse general and mental health and offspring neurocognitive development. However, association between teenage pregnancy and adverse outcomes does not equal causation (i.e. adverse outcomes 'caused by' young age). Indeed, the body of evidence suggests that having a baby or becoming pregnant below the age of 20 years *per se* is unlikely to be causal in these associations.

There is compelling evidence that the outcomes of a teenage pregnancy are influenced by the context and culture in which the pregnant women lives; the cumulative effect of social and economic exclusion is detrimental to the health of mothers and their babies, whatever their age. Thus, age-related policies aimed at teenage pregnancy may result in less public health gain than policies that are aimed at reducing socio-economic inequalities across the whole population and providing social support, as well as good medical care, for all mothers and their children. One important caveat is that little is known about the health outcomes for pregnancy at a very young age because pregnancy under the age of 15 years is rare. While its scarcity means that it is not a major determinant of population health, understanding the best way of supporting these very young pregnant women is important.

Currently, most activity focuses on reducing teenage pregnancy rates rather than reducing the risk to teenage parents of social exclusion. However, the fact that maternal age is unlikely to be causally related to many of the adverse health outcomes with which it has been associated should not be used to remove interventions that have been developed in many UK obstetric units and strategic health authorities to improve outcomes for pregnant teenagers. Interventions aimed at reducing social exclusion need to be formally evaluated and those shown to be effective implemented across the country.

Is teenage pregnancy an obstetric problem?

Analysis of data on obstetric outcomes of teenage pregnancy is commonly hampered by failing to control for various biological and socio-demographic factors. Furthermore, the clinical implications of adverse outcomes, such as low birth weight and prematurity, are debatable, as reports frequently do not enable objective estimates of their clinical impact. Knowledge of health, psychosocial and behavioural risks by obstetricians and midwives and improvements in health and social services to pregnant teenagers, including adequate maternity care, is fundamental for improved outcomes of teenagers who are pregnant and who continue their pregnancy.

A comprehensive package of health care, self- and direct referral from all agencies dealing with pregnant teenagers, is essential. Early access to dedicated medical and midwifery care should ensure choice in pregnancy options, better lifestyle choices and health education for the teenage parents, good antenatal care and improvement in the ability of the teenage mother to care for her baby. In the long term, return to education, training and employment may be facilitated. Initiated in the antenatal period, programmes for teenage maternity care should extend beyond childbirth to direct attention toward parenting education and family planning, which may produce

favourable outcomes (such as mother–infant interaction) and reduce repeated unplanned pregnancies.

Causes and consequences of teenage pregnancy

There is unequivocal evidence that young women from disadvantaged backgrounds are more likely to be mothers early in life, and that women who become mothers early in life are more likely to be disadvantaged in adult life than those who do not. The extent to which these are independent of each other is less clear. Research suggests that pre-existing disadvantages (spatial and individual) are compounded by having a child early in life and, regardless of background, having a child early in life potentially confers additional risk in terms of hardship, over and above that ‘socially inherited’, especially with regard to lack of support, instability and isolation. Moreover, adverse material and psychosocial aspects of women’s childhood experiences are repeated in their adult lives. These effects (with the possible exception of relationship breakdown) are not a function of simply conceiving at an early age but of actually having a child, and this seems to be particularly so for factors relating to family and relationships.

Interventions that are effective in preventing early motherhood and in mitigating the psychosocial consequences of having a child early in life have the potential to break the cycle of deprivation. However, a more thorough knowledge is required of the factors that can alleviate the effects of socio-economic adversity, social isolation and lack of support, and the processes and pathways in the transfer of disadvantages from one generation to the next.

Effect of maternal growth and nutritional status on obstetric outcome

Teenagers are reported to have a high risk of pregnancy complications, particularly preterm labour, intrauterine growth restriction (IUGR) and pre-eclampsia. These result in high rates of neonatal morbidity and mortality (such as low birth weight and poor cognitive development), childhood problems (such as neglect and behavioural problems) and long-life disability (such as coronary heart disease and diabetes). Pregnancy-related complications may be complicated by gynaecological immaturity and hormonal insufficiencies/imbbalances. Smoking is also known also to be associated with fetal and neonatal problems, including decreases in birth weight and gestational age at birth, placental abruption and neonatal withdrawal syndrome.

Continuing maternal growth is thought to establish competition between the mother and fetus for critical nutrient supply. There is a preferred partitioning of nutrients to the mother and away from the developing fetus. The susceptibility of teenagers to IUGR is related to the inability of the adolescent body to adapt to pregnancy metabolically, resulting in under-nourishment of the fetal–placental unit. Maternal nutritional status is also known to have significant effects on placental growth and physiology, consistent with the detrimental effect of generalised maternal under-nourishment on pregnancy

outcome. Additionally, the impact of dietary restriction/deficiency on pregnancy outcome is dependent on maternal energy reserves at the start of pregnancy and on the timing of food restriction.

The About Teenage Eating study aims to further elucidate the impact of maternal growth and nutritional status on pregnancy outcome in teenagers from deprived areas, and, in turn, to improve maternal health and pregnancy outcome.

Tackling teenage pregnancy

Primary prevention: interventions and strategies

The Teenage Pregnancy Strategy (England)

The Teenage Pregnancy Strategy was launched in 1999, following an extensive review of the issue by the Social Exclusion Unit, as a result of teenage birth rates in England remaining significantly higher than in other Western European countries. The 10-year strategy has two specific goals:

- to reduce the under-18 conception rate by 50% by 2010
- to reduce the long-term risk of social exclusion of teenage parents by increasing the proportion of 16- to 19-year-old mothers in education, training and employment to 60%.

The action plan was developed from an international evidence base of what works in reducing teenage pregnancy rates. In summary, beneficial actions are:

- clear messages to young people about early sex and its associated risks, contraception, STIs and availability of advice
- sex and relationships education to enable development of positive and safe personal and sexual relationships
- confidential contraceptive services
- discussion between young people and their parents about sex and relations.

Contrary to reports that teenage pregnancy rates are increasing, there was a national reduction of 11.8% in the under-18 conception rate from 1998 (baseline) to 2005. However, there is significant variation in progress between areas. A 'deep-dive' review of three areas with increasing rates and three with decreasing rates has revealed six clear success factors, which hinge around early implementation of a local strategy, comprehensive education programmes, easily accessible contraceptive services, workforce training on sex and relationships education, targeted work with vulnerable groups and a well-resourced youth service. Delivery of local strategies and widening of the Teenage Pregnancy Strategy to tackle the deeper underlying causes of early pregnancy are required to make a lasting and positive impact on teenage pregnancy rates.

Sex and relationships education, healthy schools and school-based health services

Current guidance on sex and relationships education aims to help young people through their physical, emotional and moral development and to develop the skills and understanding to make responsible and informed decisions to live healthy and independent lives. Every state school has to produce a policy for sex and relationships education, describing what is to be taught beyond the National Curriculum for Science. However, there is no legal requirement to teach a curriculum that meets pupils' needs and little perception that sex and relationships education might effect their educational attainment. Another major hurdle is the professional development of teachers, who are often not experienced or interested in sex and relationships education.

The way forward is through the National Healthy Schools Programme, which reflects practice proven to be effective in four inextricably linked themes: Personal, social and health education (PSHE), healthy eating, physical activity and emotional health and wellbeing. The advent of schools with extended services should increase school-based health services, with swift and easy referral to specialised support services. Moreover, once the concept of school-based sexual health services has been introduced into a critical mass of schools, more will be prepared to follow. What will be important is the continuing requirement to ensure services meet pupils' needs.

Encouraging abstinence and delay as approaches to sexual ill-health

Concern is expressed that the median age of first intercourse has been declining for a number of years in many countries, while the reported number of sexual partners before marriage has been increasing. The most effective way to reverse these trends in young people's sexual activity is by abstinence and information on sex and relationships. However, a distinction needs to be made between making support available for young people who wish to resist the pressures of engaging in sex and imposing an 'only desired option' approach.

Abstinence-only approaches are ineffective; they may be dangerous for public health, constitute a denial of young people's rights to information and support and encourage intolerance of diversity. Approaches that emphasise delay are included in UK comprehensive sex and relationships education programmes but lack of evaluation makes it difficult to assess their efficacy and there are reservations about their implementation and reception by young people. There are also issues around 'the right time' and risks of encouraging a sex-negative attitude (such as guilt and shame) among those who do not feel that they have delayed for sufficient time. The UK-based delay approach must be selectively applied and resist making choices on behalf of young people, rather than supporting them to decide for themselves. Moreover, any approach that does not take into account the sexual desires and developments among young people, especially young women, is at risk of missing the target.

Approaches in the Netherlands have had a positive impact; they stress the rights, respect and responsibility of youths, recognise that sex can be pleasurable and are

supported by service provision and complete and early information. As such, the median age of first intercourse, teenage pregnancy rates, STIs and reported regret following sexual intercourse is considerably lower than in many other countries.

Use of decision analysis in contraceptive choice

Research suggests that young people make independent decisions on their contraceptive method. They report less condom use with their main partner than with casual partners, in longer relationships and when the risk of STIs is low. As STI risk decreases, pregnancy prevention becomes the main driver and more effective methods of contraception are chosen.

Decision analysis essentially breaks down complex problems into manageable components and then combines them logically to show the best course of action; it takes into account a range of outcomes with their probabilities and the weight that the individual puts on each outcome. Benefits of this approach include increased knowledge, communication and individual values, which potentially result in increased adherence and satisfaction, and improved outcomes and service use.

Use of effective contraceptive methods has been shown to result in substantial financial and health gains. The costs associated with pill and condom use are higher among younger people because of the efficacy in preventing pregnancy is lower in this group and the often unfounded fears about harmful adverse effects associated with contraceptive use. Since the benefits appear to outweigh the risks, there is a need to develop interventions that provide young people with the skills and tools to make contraceptive decisions.

What is the right configuration of services?

Young people lack confidence in the traditional health services that address sexual and reproductive health issues and, therefore, many do not seek advice. Barriers to using services are notably accessibility and fears surrounding confidentiality and feelings of exposure. Other factors, such as the degree of information about available services, challenges within their communities and lack of attention to their sexual and reproductive health needs by general practices also affect young people's use of services. Overcoming these barriers, access to health specialists and GPs with interest in teenage problems and concerns and modification of GP services will be beneficial. However, well-implemented 'one-stop shop' clinics provide for the needs of a large number of young people and currently these are most desired by young people, who are increasingly seeking anonymous service provision because it is totally confidential. Since the start of the Teenage Pregnancy Strategy, there has been an increase in a wide range of services appropriate for adolescents. Those implementing the Teenage Pregnancy Unit's guidance have benefited from greater teenager satisfaction and trust from those accessing the service and more effective communication between staff and clients.

Working with under-16s

The majority of young people (70%) do not have sexual intercourse until after their 16th birthday and, consequently, under-16 conception rates are lower than those among older teenagers. Since the introduction of the Teenage Pregnancy Strategy, there has been a sustained downward trend in teenage pregnancies, with the greatest reductions among the under-16s; in 2004 the rate was 7.6/1000 among 13- to 15-year-olds, representing 7613 conceptions and an overall reduction of 15.2% from 1998. Attendance at contraceptive services aimed at young people has also increased but there is still a gap between the numbers of teenagers having sex before the age of 16 years and those accessing these services.

Contraception and sexual health clinics aimed at young people must offer a confidential, accessible and non-judgemental service; without these, young people will not attend. Simultaneously, health professionals need to be aware of the vulnerability of very young sexually active teenagers and be alert for evidence of sexual exploitation. The government's Working Together guidelines recommend that professionals perform routine risk assessments on all sexually active under-18s, concentrating on any power imbalances between the young person and their sexual partner, and share information with appropriate agencies (social services and the police) when serious concerns arise. Skills training is required for professionals performing these assessments to increase confidence about when and how to share information. Contraception and sexual health services also need to create good links with local schools, colleges and youth services, so that younger people can be informed about sexual health services in sex and relationships education. Teenage pregnancy rates have been reduced where work has been proactive.

Provision of contraception to teenagers

The Department of Health's You're Welcome quality criteria are aimed at making health services young people-friendly. Drawing on the experience of Hull, UK, where implementation of the criteria is active, these guidelines should be easy to implement by all services. However, implementation needs high-level leadership and commissioning commitment because financial rewards dictating service focus are not linked to health promotion but to clinical activity. In addition, alternative and innovative ways to engage, empower, educate and provide young-people-focused services should be sought, such as non-governmental organisations and peer-delivered community-based services, and web-based education, assessment and service delivery.

Local experience shows that with an unlimited budget or provision there can be a reasonable uptake of long-acting reversible contraceptive methods across all age groups, including teens. Budgeting for clinical resources, health promotion and marketing are key issues which must be addressed in commissioning if advances are to be made in tackling unplanned teenage pregnancy.

Young women's experiences of repeat childbearing

Data suggest that, although the majority of second conceptions among teenagers are unplanned, this is not always so, and that repeat pregnancies seem more likely to be planned than first pregnancies. This should not be overlooked in the care of these young women and their babies. Where a second pregnancy is intended, discussions of alternative life goals, such as education or employment rather than birth control, is more likely to encourage delay, but adequate service support must be provided. Teenage mothers who wish to delay a second pregnancy may benefit from targeted strategies of birth control, as conscious effort to avoid pregnancy is not consistent. A more proactive approach to discussions on contraception during the postnatal period may be effective for teenage mothers wanting to postpone further pregnancy, as shown by long-acting methods of contraception being chosen following the birth of the second child. Appropriate midwifery care is fundamental to assist young mothers in the prevention of unplanned second pregnancies and support those who choose to have further children in their teenage years.

Young mothers appear not to anticipate life with two children being harder than with one. While it is generally believed that family support to young women during a first pregnancy is likely to deter a second pregnancy, the converse may also be true, as the full demands of parenting are masked and help is not always welcome. Family members should be encouraged to share their parenting skills, enabling teenagers to appreciate their responsibilities as parents and reduce their ambivalent attitude to future pregnancy. Generally, young mothers would not recommend their actions to their peers and sharing these experiences may be beneficial to peer education.

Secondary prevention: reducing social exclusion rates among teenage parents and their children

Supporting pregnant teenagers and teenage mothers: the Sure Start Plus initiative

Sure Start Plus is a government scheme aimed at reducing the risk of long-term social exclusion associated with teenage pregnancy through coordinated support, including housing, health and child care, parenting skills and education, to pregnant under-18 year-old teenagers or teenage parents. The targeted holistic package, involving a personal advisor who gives support and implements individual development plans for young women, has been successful in providing crisis support on emotional and practical levels, mediating family relationships and in laying the foundations necessary to improve the futures of young women and their children. Crisis work has enabled targeting the most vulnerable.

Evidence suggests that holistic support programmes may have a positive effect on teenage mothers' emotional wellbeing and repeat pregnancies and that intensive holistic interventions in pregnancy and the early years, targeted at those most vulnerable, can also be highly cost effective in the long term. It is therefore important

that health, education and social services link up with Children's NHS trusts to provide holistic and targeted support to pregnant teenagers and teenage parents, offering crisis management support as a priority to reduce social exclusion.

Ensuring education and child care for young mothers

It is generally recognised that teenage motherhood impacts on the young woman's chances to engage in education, with heavy costs to her and her child's future life chances and to society. While all teenage mothers have a right to appropriate education and child care, the current policy and practice can make this difficult to achieve. Indeed, disincentives from within the benefits system and from learning providers can dissuade teenage mothers and pregnant teenagers from remaining in education. Consequently, despite the wide range of initiatives designed to improve their life chances, only limited progress is being made. Much of the focus in policy and practice has been around educational re-engagement of school-aged mothers, rather than preventing disengagement in the first instance. The drive to ensure that teenage mothers engage in education fails to consider the fact that they are a disengaged community whose opportunities are limited – not only by motherhood but also by societal prejudice and discrimination as well as policies and practice that fail to meet their needs. The education of teenage mothers is prioritised in the Teenage Pregnancy Strategy, with policies and practices to reduce the risk of poor outcomes for them and their children.

Housing difficulties for teenage parents and their children

The aim of the East Midlands study (2004/05) was to understand the barriers to supported housing for lone teenage parents and their children. The findings show that young parents have a range of problems in relation to their housing and support needs. They have problems accessing social housing, such as needing a guarantor, having to leave the family home or having to be 'evicted' to be classed as 'homeless'. Many sleep at the houses of friends, adding to the 'hidden homelessness' where they are not included in housing statistics or in local authority planning processes. Others are placed far away from their families and support networks. There were also problems identified with the supported housing units themselves, in particular, rules preventing fathers and male family members from visiting or staying overnight, evictions after young women had broken the rules and a lack of 'move-on' accommodation preventing young mothers from getting independent tenancies. They experience judgemental attitudes and poor information and treatment from housing support workers (not supported housing unit staff). These issues need to be addressed if any policy on supported housing is to be successful.

Listening to learn: evidence from young people on the services required

To evaluate progress towards reducing the risk of social exclusion among teenage mothers and their children, young parents were interviewed as part of the evaluation of the National Teenage Pregnancy Strategy about their experiences since becoming pregnant. The assumption that the high proportion of young women leaving school before 16 years was because of their pregnancy is not necessarily true. Some fell pregnant after leaving school. Despite sex and relationships education guidance, there is still evidence of inflexible attitudes among teachers and that some young women are asked to leave school because of their pregnancy, yet the view that pregnant teenagers have a negative impact on their peers is unfounded. Moreover, pregnant schoolgirls often receive a hostile reaction from their peers. The majority of these young women report an increased willingness to engage in education following childbirth, especially if offered appropriate nonjudgemental support.

There is strong justification for addressing the loss of educational opportunities to those women returning to education and training and of younger girls in danger of leaving school prematurely because of pregnancy. Opportunities to return to education are likely to capitalise on the strong motivation to succeed prompted by having a child. However, a consequence of early motherhood, which seems to be at least equally problematic as lost life chances, is social isolation and depression. This was a more typical problem among mothers who were not supported in a relationship or by their families and where childcare problems of accessibility and cost existed. Interventions such as Care to Learn are likely to be as important in attenuating social isolation in young mothers as they are in facilitating a return to education and training.

Findings also suggest that prevention of a second child to those whose first child was conceived before the age of 18 years may not always be appropriate, particularly where the inclination was to have another child to complete their family before training for a job.

Involving young men

Most young men first have heterosexual intercourse between the ages of 14 and 17 years, with around 30% of young men reporting first sex before 16 years. Contraceptive use has risen in recent years and about 80% of young men having first sex at 16 years reports using a condom. Condom use declines in favour of other methods as the relationship progresses. STIs have increased considerably; other concerns are linked to anxieties around what is considered 'normal' and 'performance'. Poor use of services and ambivalent attitudes to sex and relationships education are influenced by their perceptions of masculinity (robustness, self-reliance). Boys' poor response to sex and relationships education stems from a failure to address their needs and concerns in an appropriate environment.

Progress has been made in including young men and young fathers in policies regarding teenage pregnancy and sexual health. Sex and relationships education and services must acknowledge men's needs to overcome the view that they preferentially

offer protection to women. The case still needs to be made that working with them is as vital as working with young women. Targeted work with young men can be used to develop understanding, confidence and skills but these may be lost if mainstream approaches fail to take into account issues that are important to them and methods that help them engage. For example, ‘delay’ may work with young women and meet their needs but may reinforce men’s feelings of exclusion from sexual health promotion and sex and relationships education. In the long term, to involve young men, there is a need to alert them to risk but also to acknowledge their desire to enjoy sexual relationships.

Teenage pregnancy and parenthood: effects of ethnicity on attitudes and experiences

Poorer reproductive and sexual health outcomes occur among young people from some minority ethnic communities in the UK. There are wide variations among different ethnic groups in sexual behaviour and in the proportion of young people who become teenage parents, although there are very few births before 16 years among all ethnic groups. There are also differences in social, cultural and religious influences on young people, and the perceived and actual consequences of pregnancy or parenthood at an early age or outside of marriage; these are far greater for women than for men.

Although teenage pregnancy and parenthood in some communities (particularly Bangladeshi, Indian and Pakistani groups) is not common outside marriage, in cases where it does happen additional support may be required to address cultural and religious taboos. For many women, teenage pregnancy is a very positive outcome and is culturally acceptable. Education and socio-economic status is likely to contribute to the differences in pregnancy rates and there is indication that when educational and career aspirations increase among some ethnic groups, teenage births decrease.

Local strategies, rather than nationally applied ones, based on the requirements of the local population are needed. Culturally and faith-sensitive sex and relationships education and sexual and reproductive health services also need to be developed in response to local assessment, while recognising diversity across and within minority ethnic groups.

What works? Evidence of effectiveness

Teenage strategy: what works?

The Teenage Pregnancy Unit’s ‘deep-dive’ review on three local authority areas performing well (decreasing under-18 conception rates) and three performing poorly (increasing rates) to Teenage Pregnancy Strategy initiatives, highlighted seven key factors for success:

- partnership working, to plan, implement and ‘own’ the Teenage Pregnancy Strategy

- a strong Teenage Pregnancy Strategy leader/champion, accountable to driving the local strategy forward
- accessible, well-publicised, young people's contraceptive and sexual health services
- personal, social and health education with high priority and delivered in schools supported by the local authority
- strong, targeted interventions with vulnerable young people
- multidisciplinary personal, social and health education/sex and relationships education training
- well-resourced youth services, providing activities and addressing emotional and social issues.

School-based sex education: teacher-delivered and peer-delivered programmes

Given the health and social burdens of unwanted sexual outcomes and the uncertain value of resource investments in sex education, evaluation of sexual health interventions is of global importance. The UK Medical Research Council funded two large, randomised trials of school-based sex education: SHARE evaluated the most widely practiced approach of teacher-delivered sex education and RIPPLE evaluated peer-delivered sex education that is widely believed to be more appropriate. Both trials suggest that improved school sex education, whether teacher- or peer-delivered, is unlikely to have a greater impact on sexual behaviour than that already achieved by current health promotion initiatives. The broader social factors shaping behaviour seem too influential and even peer-education, intended to act on peer influence, has only modest effects.

Teenage pregnancy is probably the outcome least influenced by school sex and relationships education, as rates are shaped by social exclusion, educational aspirations and local views towards childbearing. Policy is therefore increasingly focused on raising aspirations that conflict with early parenthood (such as educational prowess). Since aspirations are heavily influenced by socio-economic, parental and cultural factors and are apparent from an early age, successful intervention is likely to require support from parents and schools at an early stage. However, school sex education is also important for other aspects of sexual experience, such as emotional wellbeing and STIs. Conventional sex education and sexual health promotion already achieves high levels of condom and contraceptive use; the teacher-delivered programme further improved practical sexual health knowledge and reduced regret, while the peer-delivered programme increased knowledge and raised young women's reported age of first sexual intercourse. Both programmes were rated as more satisfactory than conventional sex education by the pupils receiving them.

Preventing teenage pregnancy: evidence from systematic reviews

On behalf of National Institute for Health and Clinical Excellence, an update (2001–2006) was carried out of a review evaluating the interventions and outcome measures aimed at reducing teenage pregnancy and supporting teenage parents. Interventions identified by the review as potentially effective included:

- early childhood interventions for pre- and primary school children and their parents, and youth development programmes promoting social and academic skills
- personal and academic support, parental involvement and conflict resolution skills
- education and career development programmes providing tailored support for childcare and bonuses to encourage young parents back into education, training and employment
- implementation of wider measures to tackle social disadvantage and poverty among young people to lower teenage pregnancy rates and promote long-term social inclusion
- services to ensure that young people are well informed about sexual matters, including contraceptive availability.
- Many interventions have been evaluated and evidence-based strategies implemented but gaps in the evidence base remain. This is particularly true of the UK, where many interventions have not been rigorously evaluated. Further development and evaluation of programmes is required to facilitate development of models of good practice, while research agendas should be responsive to issues and needs identified by programme providers.

Teenage pregnancy in the Netherlands

Preventative behaviour in the Dutch population regarding contraception and STIs has been among the most effective in the world; teenagers in the Netherlands are at least four times less likely to have an unwanted pregnancy than teenagers in the USA or the UK. Factors thought to explain this success include:

- the quality of sex education in the formal (school) and informal (family, social) educational curriculum
- the degree of openness within society and the media regarding sexuality
- the quality of public prevention campaigns
- the communication skills of teenagers
- accessibility of contraceptive methods and services.
- However, there are still groups within Dutch society that are more at risk of unwanted pregnancy and STIs: teenagers with little education, immigrants and people in their 30s who recently ended a relationship. To optimise overall sexual health, preventive strategies need to be tailored to the target groups, which requires knowledge of their determinants of preventative behaviour.

Consensus views of the study group members on teenage pregnancy and reproductive health

Research

Regarding young men and women's sexual health, research should be aimed at:

- comparative, up-to-date, age-specific, descriptive data, disaggregated by ethnicity, socio-economic status, and marital/cohabitation status
- aspects to aid improvement, including insight into attitudes, understanding of perceived risks of contraceptive methods, male aspirations, impact on GPs and young people of public health strategies seeking to encourage delay of onset of sexual activity, and cultural/faith sensitive sexual health services/programmes
- supporting teenage parents
- determining the specific effects of maternal age on health outcomes for mother and child.

Policies

Regarding policies aimed at preventing unplanned teenage pregnancies, the Government should continue to prioritise teenage pregnancy by:

- ensuring progress of the Teenage Pregnancy Strategy to 2010
- developing and implementing policies and interventions aimed at reducing unwanted teenage pregnancy and supporting teenage parents and their children
- incorporating research findings and factors contributing to the success in reducing teenage pregnancy in some areas
- training those working with young people in policies and strategies
- making personal, social and health education a statutory foundation subject in all schools.

Provision for prevention

In practice, prevention of teenage pregnancy requires provision of:

- single and mixed gender sex and relationships education work in schools and community settings
- personal development programmes for those at most risk
- confidentiality
- youth-friendly contraceptive services
- services in keeping with lifestyle
- on-site contraceptive and sexual health advice in all education establishments.

Provision for support

In practice, support for teenage parents and their children requires provision of:

- a maternity healthcare package and childcare provision
- specially trained midwives and healthcare professionals in maternity services
- advice on and access to contraception
- access to a dedicated personal adviser providing an individualised support package
- continued education and training
- advice on and contact with housing support services.

Source

Baker P, Guthrie K, Hutchinson C, Kane R, Wellings K, editors. *Teenage Pregnancy and Reproductive Health*. London: RCOG Press; June 2007.

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