DH Department of Health

Effective Public Health Practice

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Circulation List	
Description	This document contains examples of effective local practice identified by the Teenage Pregnancy National Support Team. The examples reflect the range of essential factors that have been shown to have reduced teenage pregnancy rates, as part of work to improve a range of outcomes for young people. This is offered as a useful resource: its use is not mandatory
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Contact Details	Kate Quail Public Health National Support Teams Wellington House 13-155 Waterloo Road London SE1 8UG 0207 972 3377
For Recipient's Use	

Introduction to Public Health National Support Teams

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Health Inequalities, Teenage Pregnancy, Tobacco Control, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People's Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in a range of Knowledge Management and Evaluation reports.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The NST's approach, based on principles of change management, has been about performance development, rather than performance management, with an ethos of 'high challenge, high support'.

The Teenage Pregnancy NST

The Teenage Pregnancy NST worked with Local Authorities, Primary Care Trusts, health organisations, Children and Young People's Partnerships and other statutory and voluntary partners, providing consultancy-style, tailored support on reducing under-18 conceptions.

This document includes a number of examples of effective local practice from across the country which have been identified by the Teenage Pregnancy National Support Team (TP NST). The examples reflect the range of essential factors that need to be in place to reduce teenage pregnancy rates, as part of work to improve a range of outcomes for young people. The examples have been assessed as 'effective' using 'Maxwell's Six Criteria' which define health care quality and effectiveness and are often used for assessing evidence based practice.

Department of Health

TEENAGE PREGNANCY NATIONAL SUPPORT TEAM
EFFECTIVE PUBLIC HEALTH PRACTICE

Introduction

WHY TEENAGE PREGNANCY MATTERS

The majority of teenage pregnancies are unplanned and around a half end in abortion [1]. As well as the emotional cost to individuals and families, abortions represent an avoidable cost to the NHS. Where teenage pregnancies result in a birth, evidence shows that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. And while young people can be competent parents, longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves.

WHAT WORKS?

International evidence, as well as the lessons from areas where teenage pregnancy rates have fallen fastest, show that all young people need effective sex and relationships education (SRE) – which helps young people to deal with pressure to have sex, as well as equipping them with the knowledge and skills to avoid unplanned pregnancies and STIs – alongside easy access to young people-centred contraceptive and sexual health (CASH) services, when they need them.

But it is also clear that as well as giving all young people the means to avoid early pregnancy, sustained reductions in teenage pregnancy rates will only be possible if action is taken to address the underlying factors that increase the risk of teenage pregnancy, such as poverty, educational underachievement, low aspirations and lack of engagement in learning post-16.

HOW INVESTMENT IN TEENAGE PREGNANCY PREVENTION AND IMPROVING OUTCOMES FOR TEENAGE PARENTS AND THEIR CHILDREN CAN SUPPORT WIDER LOCAL STRATEGIES

Tackling Teenage Pregnancy is a vital part of local initiatives to address:

- Child Poverty and Worklessness
- Safeguarding
- Infant Mortality
- Health Inequalities
- Poor sexual health
- Poor emotional wellbeing and mental health

[1] Social Exclusion Unit (1999) *Teenage Pregnancy.* London: HMSO), (National Statistics (2010) *England under-18 conception statistics*, 2008)

Child Poverty and Worklessness[2]

Teenage pregnancy is both a contributory factor and an outcome of child poverty. Teenage parent families have at least one parent under the age of 18 with responsibility for a dependent child aged under five. These families are at increased risk of the biggest causes of poverty (worklessness and low pay); while under-fives make up 44 per cent of all children in poverty[3]. As a result:

- children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties[4]

- at age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed.

Poverty, like teenage pregnancy, follows intergenerational cycles with children born into poverty at increased risk of teenage pregnancy, especially for young women living in workless households when aged 11-15[5]. The majority of teenage parents and their children live in deprived areas and often experience multiple risk factors for poverty, experiencing poor health, social and economic outcomes and inter-generational patterns of deprivation. Teenagers who become pregnant are more likely to drop out of school, missing a key phase of their education, leading to low educational attainment and no or low-paying, insecure jobs without training.

Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth aged 24 or over. Young mothers are also more likely to be lone parents with their children raised in a home with one income and often living in sub-standard housing or temporary accommodation. Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.

Safeguarding

Many young women experience a high level of violence and abuse in their relationships and many of the young women vulnerable to teenage pregnancy may have much older male partners. International research findings demonstrate connections between sexual abuse, coercion, intimate partner violence and teenage conception rates. Recent research in the UK has shown clear links between teenage pregnancy and non-consensual sex [6]

Girls who have been sexually abused are more likely to become sexually active at a young age and be at specific risk of teenage pregnancy. The NHS Taskforce on Violence against Women and Children refers to teenage pregnancy as one of many impacts of abuse. Alcohol is often cited by young people as one of the factors that contribute to sexual activity they have subsequently regretted.

Infant Mortality

The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers; children born to teenage mothers have higher mortality rates under 8 years and are more likely to have accidents and behavioural problems. A reduction in teenage pregnancy makes a significant contribution to reducing Infant Mortality.

Health Inequalities

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[2] DfE Brieifng (2010)

[3] DWP (2008) 'Ending child poverty: everybody's business.

[4] Mayhew E and Bradshaw J (2005) '*Mothers, babies and the risks of poverty*' Poverty, No.121 p13-16.

[5] Ermisch, J., Francesconi, M and Pevalin, D. J. 2001) '*The outcomes for poverty of children' DWP Research Report 15.*

[6] A MISSING LINK?: AN EXPLORATORY STUDY OF THE CONNECTIONS BETWEEN NON-CONSENSUAL SEX AND TEENAGE PREGNANCY Executive Summary July 2010 Maddy Coy, Kerry Lee, Liz Kelly and Colleen Roach Child and Woman Abuse Studies Unit London Metropolitan University

[7] Health Protection Agency: Health Protection Report, Volume 4 Number 34 Published 27 August 2010

Teenage pregnancy does not affect young people equally and higher rates are found in areas that experience generally poor health. Teenage pregnancy also increases health inequalities and leads to poor long-term outcomes for young parents and their children.

Poor Sexual Health Outcomes - Abortion and Sexually transmitted infections

They key actions needed to reduce teenage pregnancy rates – effective SRE and improved access to CASH services – will also impact on the likelihood of young people suffering poor sexual health. Health Protection Agency figures on sexually transmitted infections (STIs) in 2009 show an upward trend in the levels of infection in young people. Left untreated, sexually transmitted infections can lead to infertility as well as a range of other health problems[7].

Addressing teenage pregnancy alongside work to reduce sexually transmitted infections is a government public health concern. Access to Contraceptive and Sexual Health Services, advice and clear messages about using both a condom and the most appropriate effective contraception is necessary to achieve both outcomes.

Poor emotional wellbeing and mental health

Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth. A lack of self-esteem can affect a young woman's ability to resist peer pressure, abusive relationships, unwanted sexual activity and to negotiate the use of contraception.

EFFECTIVE LOCAL APPROACHES TO REDUCING TEENAGE PREGNANCY

The factors influencing teenage pregnancy are complex and there is no single intervention which is effective in reducing teenage pregnancy. A strong partnership approach is needed to drive and deliver a range of local interventions. The examples below have been identified by the Teenage Pregnancy National Support Team (TP NST), which provided expertise and intensive support to areas facing the greatest challenges in reducing their teenage pregnancy rate. The examples reflect the range of essential factors that need to be in place to reduce teenage pregnancy rates as part of work to improve a range of outcomes for young people. The examples have been assessed as 'effective' using 'Maxwell's Six Criteria' which define health care quality and effectiveness and are often used for assessing evidence based practice.

MAXWELL'S SIX CRITERIA

Appropriateness (targets unmet community needs, is relevant to the local population)
Accessibility (convenience of location, time, barriers and levers, levels of breakdown in supply and delivery chains, waiting times)
Acceptability (service design, user friendly levels, culturally and linguistically acceptable, a humane and considerate service, getting the right setting, user involvement, consumer led)
Equity (targeted to where there is most unmet need)
Effectiveness (timely intervention for individuals concerned, correct and working equipment, professionals and staff well trained, overall results and successful outcomes achieved, quality of service delivery)
Efficiency (workload and unit cost in comparison to another model, or maximum output for minimum amounts of input)

[8]

[8] Maxwell RJ. Quality assessment in health. *BMJ* 1984; 288: 14702)

List of examples

Common themes and priorities for improvement	Case study	Accessibility	Appropriateness	Acceptability	Effectiveness	Efficiency	Equity
Strategic leadership, Performance Management and Governance of the Teenage Pregnancy Strategy	Brighton and Hove	x	x	x	x	x	x
Effective use of data to support commissioning	Salford - Teenage Pregnancy and Sexual Health Dashboard	x	x	x	x	x	x
Young people friendly contraceptive services	Bradford - TicTac services in schools	x	x	x	x	x	x
	Bristol - Young Peoples Sexual Health Outreach Services	x	x	x	x	x	x
	Nottinghamshire - County-wide scheme for condom distribution	x	x	x	x	x	x
	Berkshire West PCT - Youth Outreach Nurse Specialist – Contraceptive Services	x	x	x	x	x	x
Workforce development	Hampshire - Multi-agency Tiered Training Programme	x	x	x	x	x	x
	Warwickshire - Workforce Development in Relations and Sex Education and Supporting Teenage Parents	x	x	x	x	x	x
Sex & Relationships Education	North Lincolnshire - Sex & Relationship Education Database	x	x	x	x	x	x
Targeted prevention work with young people at risk	Stoke on Trent - Early Identification of (and Intervention with) Young People at Risk	x	x	x	x	x	x
	Teens and Toddlers Programme - London Borough of Brent	x	x	x	x	x	x

Sources of Further Information
www.education.gov.uk www.dh.gov.uk www.ncb.org.uk www.chimat.org.uk

Written and collated by TP NST: Kate Quail, Joanna Nichols, Roger Street, Anne Graney.

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