Public Health England

Protecting and improving the nation's health

Teenage pregnancy and young parents
Report for Harrow

Purpose

This report brings together key data and information which will help you understand the demand, risk factors, provision and outcomes for services of a particular target population.

This includes:

- appropriate evidence-based information on prevalence;
- incidence and risk factors affecting the provision of healthcare services; and relevant expenditures

PHE offers a range of other resources which will also help you analyse your services. At the end of this report, a section called 'next steps' points you in the direction of some of these.

Introduction

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Despite significant progress over the last 18 years, with a reduction of 64% in the under-18 conception rate, a continued focus is needed. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes (1). Nationally, over 50% of under-18 conceptions and 62% of under-16 conceptions end in abortion and inequalities remain between and within local authorities (2).

Recent data shows that babies born to mothers in England and Wales under 20 years had a 30% higher rate of stillbirth than average, and a 40% higher rate of infant mortality than average (3). Rates of low birthweight in younger mothers were 30% higher than average, and this inequality is increasing (3). Children born to teenage mothers have a 63% higher risk of living in poverty (4). Mothers under 20 have a 30% higher risk of poor mental health two years after giving birth (5). This affects their own wellbeing, and their ability to form a secure attachment with their baby, recognised as a key foundation stone for positive child outcomes (6). Teenage mothers are more likely than other young people to not be in education, employment or training (7); and by the age of 30, are 22% more likely to be living in poverty than mothers giving birth aged 24 or over (8). Young fathers are twice as likely to be unemployed aged 30, even after taking account of deprivation (9). Recent analysis of the Next Steps

data shows that some of these poor outcomes, notably poor mental health, are also experienced by young parents up to the age of 25 (10).

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 66.3% reduction in the under-18 conception rate between 1998 and 2019. The rate of 15.7 per 1,000 is currently at the lowest level since 1969 (11), with the greatest reductions in the most deprived areas, and a doubling in the proportion of young mothers in education, training or employment (12). The success of the strategy's approach has been recognised by the World Health Organization with the lessons being shared internationally with countries seeking to address high rates (13,14).

However, despite the significant progress England's teenage birth rate remains higher than comparable western European countries (15), and inequalities in the under-18 conception rate persist between and within local areas. Over a quarter of local authorities have an under-18 conception rate significantly higher than the England average (11) and 60% have at least one high rate ward (16). Further progress in both reducing the under-18 conception rate and improving the outcomes for young parents is central to improving young people's sexual health and achieving health and educational equity for young parents and their children. Maintaining the downward trend is a priority in the Department of Health Framework for Sexual Health Improvement in England (17) and key to PHE priorities, including reducing health inequalities, ensuring every child gets the best start in life and improving sexual and reproductive health (18). The Public Health Outcomes Framework (PHOF) includes the under-18 conception rate and a number of other indicators disproportionately affecting young parents and their children (19).

The data shown below at local authority level shows the 2019 rates. If more recent annual rates have recently been published, they are available from Office for National Statistics.

Background, demographics and teenage pregnancy in Harrow

As of 2019, Harrow had a population of 4,191 girls aged 15-17 years.

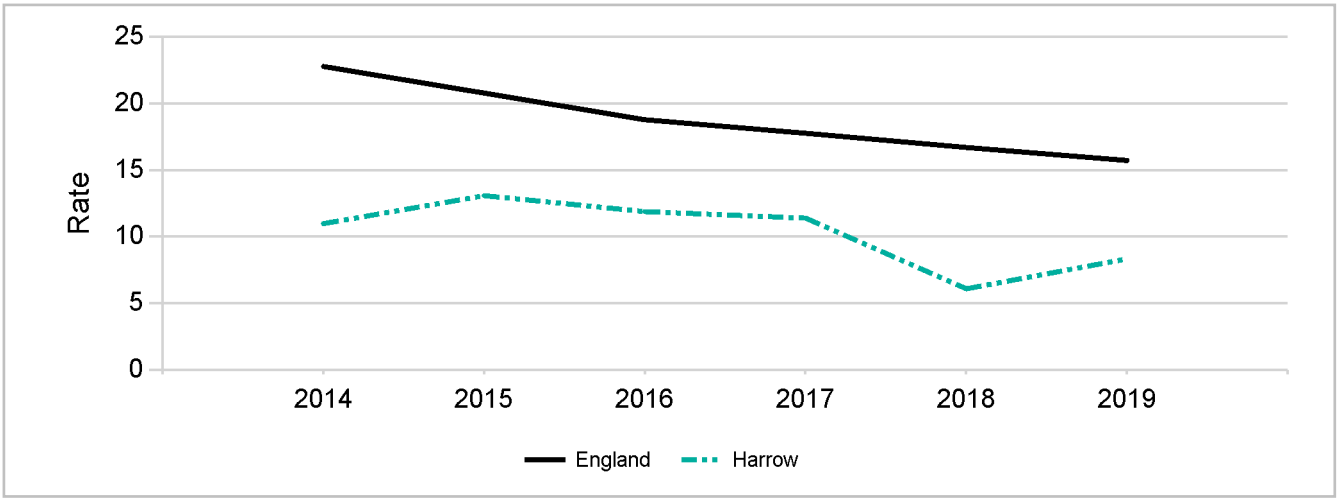
There is a strong relationship between teenage conceptions and deprivation (20). Harrow, with a score of 14.3, is in the second least deprived decile (IMD 2015).

In Harrow in 2019, 35 young women aged under 18 years conceived, which is a rate of 8.4 per 1,000 population: 14% of these were to girls aged under 16 years. The national rate of under 18 conceptions was 15.7. In 2019, 5 girls became pregnant under 16 years, a rate of 1.1 per 1,000 population; the national rate was 2.5. Of under 18 conceptions in Harrow in 2019, 57.1% led to abortion, compared with the national average of 54.7%.

The charts and tables below show trends in under 18 and under 16 conceptions and abortions. The abortion rate (number of abortions per 1,000 population) is also displayed in the chart showing under-18 conceptions. The tables below the chart show the data for the conception rate, abortion rate and the percentage of conceptions leading to abortion.

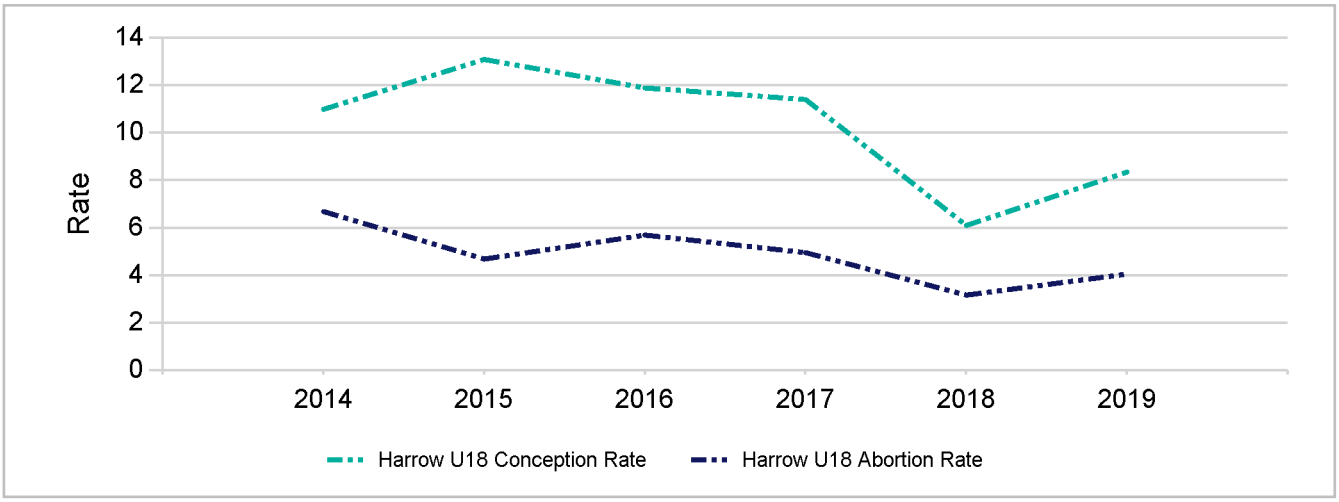
Recent conception statistics have been taken from the Office for National Statistics. Older statistics can be found on the NHS IC Indicator Portal.

Figure 1: Under 18 conceptions in Harrow (rate per 1,000 population)



Source for Figure 1: Office for National Statistics

Figure 2: Under 18 conceptions and abortions in Harrow (rate per 1,000 population)



Source for Figure 2: Office for National Statistics

Table 1: Under 18 conceptions, rate per 1,000 population

	2014	2015	2016	2017	2018	2019
England	22.8	20.8	18.8	17.8	16.7	15.7
Harrow	11.0	13.1	11.9	11.4	6.1	8.4

Source for Table 1: Office for National Statistics
-1 may be shown where small numbers have been suppressed

Table 2: Under 16 conceptions, rate per 1,000 population

	2014	2015	2016	2017	2018	2019
England	4.4	3.7	3.0	2.7	2.5	2.5
Harrow	1.5	1.2	-1.0	1.7	0.7	1.1

Source for Table 2: Office for National Statistics
-1 may be shown where small numbers have been suppressed

Table 3: Under 18 abortions, rate per 1,000 population

	2014	2015	2016	2017	2018	2019	2020
England	11.1	9.9	8.9	8.4	8.1	8.0	6.7
Harrow	6.7	4.7	5.7	5.0	3.2	4.1	3.5

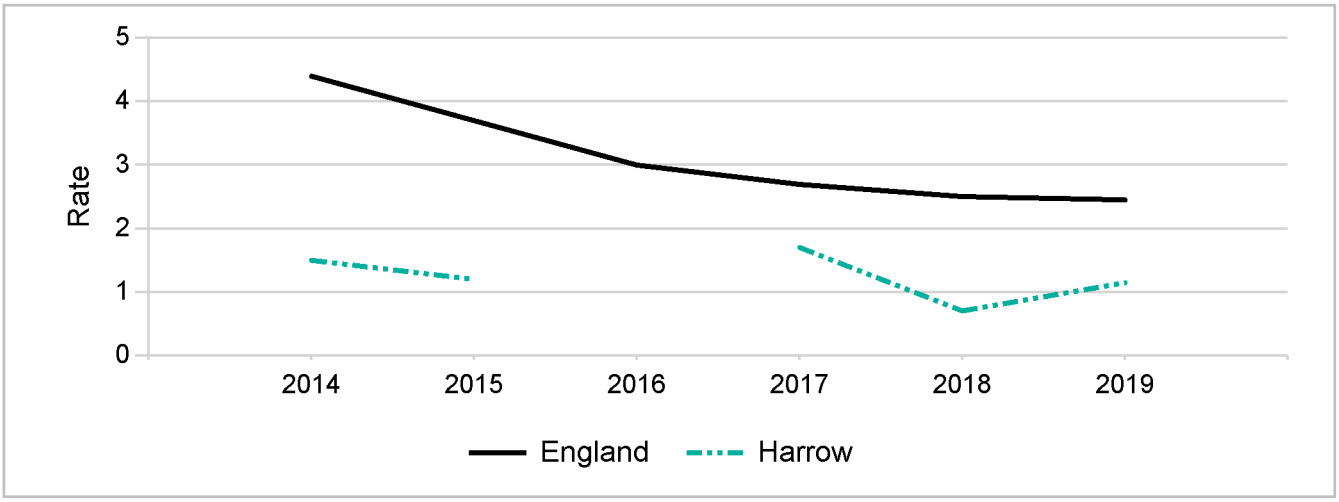
Source for Table 3: Office for National Statistics
-1 may be shown where small numbers have been suppressed`

Table 4: Percentage of under 18 conceptions leading to an abortion

	2014	2015	2016	2017	2018	2019
England	51.1	51.2	51.8	52.0	53.0	54.7
Harrow	59.6	45.5	55.1	54.3	52.0	57.1

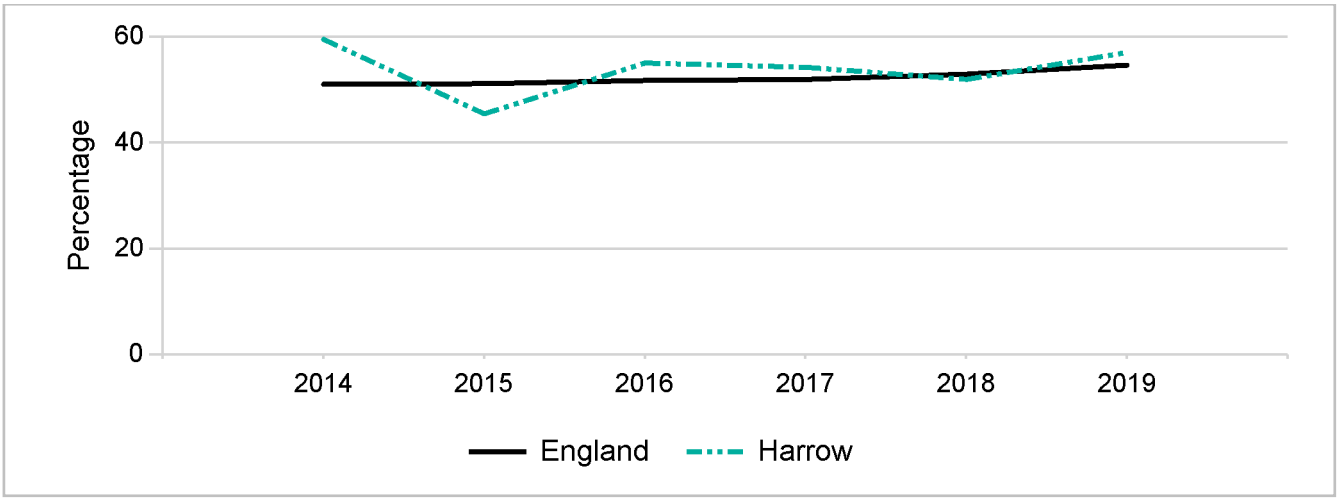
Source for Table 4: Office for National Statistics
-1 may be shown where small numbers have been suppressed

Figure 3: Under 16 conceptions in Harrow (rate per 1,000 population)



Source for Figure 3: Office for National Statistics

Figure 4: Percentage of under 18 conceptions leading to an abortion



Source for Figure 4: Office for National Statistics

What can be done to reduce teenage conceptions, and to improve outcomes for teenage parents and their children

Supporting young people to prevent early pregnancy

International evidence identifies the provision of high quality, comprehensive sex and relationships education (SRE) linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates (21,22,23). SRE also has wider safeguarding and health benefits but to have impact, provision needs to reflect the internationally recognised effectiveness factors(24,25). From September 2020, new legislation requires all primary schools to provide relationships education, all secondary schools to provide relationships and sex education and both primary and secondary to provide health education. Final statutory guidance for schools setting out the subject content was published by the Department for Education in Summer 2019 (26). This includes specific reference to ensuring all secondary school pupils know about local services providing confidential SRH advice and care. Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice, with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects, and support young people to choose and use their preferred method (27,28). An open and honest culture around sex and relationships is also associated with lower teenage pregnancy rates. Countries with more open approaches to young people's sexual health, as assessed by better RSE, more parental communication and more accessible contraceptive services, have lower conception rates (29).

Measures to reduce teenage pregnancy need to be delivered through proportionate universalism. Although two thirds of young people don't have sex before 16, by the age of 20, 85% will have experienced vaginal intercourse (30) so all young people need good RSE and access to services to prevent early pregnancy and look after their sexual health. Universal prevention programmes are also essential to reduce rates by a substantial margin (31). Some young people, however, will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration – providing *the means and the motivation* to prevent early pregnancy (29). Reaching young people most in need involves looking at area and individual level associated risk factors.

Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates (32). In , young people aged 11 to 15 years in every 100 lived in low income families in . This compares to per 100 regionally and nationally. In Harrow 2.6% of young people aged 16 to 18 years were not in employment, education or training in 2020. This compares to 5.5% regionally, and 5.5% nationally.

At an individual level, the strongest associated risk factors for pregnancy before 18 are free school meals eligibility, persistent school absence by age 14, poorer than expected academic progress between ages 11-14 (31), and being looked after or a care leaver (33). Other associated risk factors include first sex before 16 (34), experience of sexual abuse or exploitation (35), alcohol (36), and experience of a previous pregnancy (37). Young women with lesbian or bisexual experience are also at increased risk of unplanned pregnancy (38). As with Adverse Childhood Experiences, young people who have experienced a number of these factors will be at significantly higher risk (39).

Supporting pregnant teenagers

Teenagers are more likely to present late for abortion and to book late for antenatal care (40,41). The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services (42). Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays (43). Young people who have experienced pregnancy are also at higher risk of

subsequent unplanned conceptions (44). An estimated 12% of births conceived to under- 20s are to young women who are already teenage mothers. Ten per cent of under-19s having an abortion have had one or more previous abortions but this percentage varies significantly between local areas (45). Advice on contraception during abortion or antenatal care and access to the chosen method immediately post pregnancy helps reduce unplanned conceptions (46).

Supporting young parents

Evaluation of the Sure Start Plus programme identified that the key ingredient for improving outcomes for young parents and their children is having a dedicated adviser for young parents, who coordinates additional support to meet individual need (47). Reintegration officers based in local authorities have a positive impact on school-age mothers continuing their education (48). Care to Learn childcare funding is shown to facilitate young parents return to learning (49).

The Family Nurse Partnership (FNP) is a licensed programme, developed in the USA. Over 35 years of rigorous research has shown significant benefits for vulnerable young families in the short-, medium- and long-term across a wide range of outcomes. A randomised controlled trial on the impact of FNP in England was commissioned by the Department of Health and published in 2015 (50).

The trial looked at four primary outcomes in mothers receiving FNP: maternal smoking, birth weight, timing of second pregnancy and children's attendance at Accident and Emergency. The study found no significant difference in the primary outcomes between the mothers receiving FNP and the control group receiving normal care.

However the study showed promising early indications of improvement in some of the secondary outcomes such as those relating to child development, safeguarding and mothers' self-efficacy. In addition the research found that the programme is popular with the young parents and has succeeded in engaging with a group who are sometimes reluctant to access services and to trust professionals. The family nurses were able to develop respectful and trusting relationships with their clients and uptake of the visits was good.

The results of the trial have been used to improve and develop the support provided to vulnerable young parents and their children. Areas for focus include improving support to stop smoking, to address neglect and intimate partner violence, and greater personalisation of the programme, including dosage to reflect client needs, and targeting and eligibility criteria. Building Blocks 2-6, a follow up to the original trial, is evaluating the long term effectiveness of FNP. The results are due to be published in 2020-2021 (51).

Support for young parents should always address the needs of young fathers. Many young fathers have vulnerabilities and face challenges in fulfilling both their parenting and educational opportunities (52). However they often remain invisible to services and fail to get the support they need (53).

A whole system approach

Implementation of the previous Teenage Pregnancy Strategy identified ten key factors for an effective local approach to translating evidence into practice and developing a whole systems approach (see figure below). Guidance on how to review and strengthen local actions on both prevention and support, and examples of effective practice can be found in the 'next steps' section.

The ten factors for effective local action

Next steps

To help local authorities make further progress and narrow inequalities, PHE has published evidence-based guidance on the prevention of early pregnancy and support for young parents, with clear actions for reviewing and strengthening local commissioning. Both pieces of guidance have been developed at the request of, and in collaboration with local authorities, and are co-badged by the Local Government Association.

The Teenage Pregnancy Prevention Framework (first published in January 2018) is designed to help local areas assess their local programmes to see what's working well, identify any gaps, and maximise the assets of all services to strengthen the prevention pathway for all young people. It can be used flexibly to review actions across a whole area, to focus on high rate districts or wards or to strengthen a specific aspect of prevention, for example relationships and sex education to prepare for statutory status of RHSE in September 2020. A self-assessment checklist is provided for councils to collate a summary of the current local situation, and identify gaps and actions. Local areas are using the Framework in a variety of ways, as illustrated by these examples from Croydon, Havering, Oxfordshire, Buckinghamshire, Barnsley, Middlesbrough and Warwickshire.

The Framework for supporting teenage mothers and young fathers is designed to help commissioners and service providers review current support arrangements for young parents and the role of all relevant agencies. It can be used flexibly to focus on the commissioning of dedicated support, the contribution of specific services – for example maternity services and post-16 education, or on the whole care pathway for young parents. Key actions are set out for each service to help identify and address gaps.

Other useful resources include:

- Teenage Pregnancy and Young Parents: good progress, more to do is a useful briefing for councillors and includes local case studies illustrating effective practice on both prevention and support.
- Supporting young parents to fulfil their potential is a briefing for councilors which highlights the importance of dedicated, coordinated support for young parents to achieve health and education equity for them and their children. Local case studies illustrate different models of support arrangements.
- Relationships and sex education briefing for councillors provides a summary of the evidence, the factors necessary for effective delivery and examples of how councils can support improvements in RSE in preparation for statutory status in 2019.
- Visit the PHE fingertips tool to see your local authority's data on teenage pregnancy, sexual health and vulnerable young people
- Visit the local health tool to see ward and MSOA level data on deliveries to teenage mothers (find it within the section on behavioural risk factors and child health)
- Data on teenage pregnancy is published quarterly by the Office for National Statistics; this report only covers the most recent full year.

Contact your PHE Sexual Health Facilitator, or email your local knowledge and intelligence service for further advice and support:

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