Inquiry into teenage pregnancy

BMA Scotland Submission

Introduction

Respect and Responsibility, the national sexual health strategy published in 2005, set national targets to reduce for teenage pregnancy in Scotland "by 20% of the pregnancy rate (per 1000 population) in under 16 year olds from 8.5 in 1995 to 6.8 in 2010". Although there has been a steady decline in the number of teen pregnancies under the age of 20, progress has been slow and the rates of unintended pregnancies amongst the under 16 category remains largely unchanged.

Adolescents and teen pregnancy

There is no biological reason to suggest that having a baby before the age of 20 is associated with ill health. In fact it is older women who face increased risk of complications in pregnancy. The children of adolescent mothers can fare as well in physical and social terms as those born to older women. Early childbearing can protect women from breast cancer, and their children from diabetes[1]. Many teenage pregnancies are, however, unplanned. Being an adolescent parent can lead to an increase in relative poverty, unemployment, poorer educational achievements and poor health of the child born[2].

Although teenage pregnancy is not necessarily a public health problem, the cumulative effect of social and economic exclusion on the health of the mothers and their babies, whatever their age, is. Teenage motherhood often interferes with the adolescent's education. High teenage pregnancy rates are linked to high levels of social exclusion and poor knowledge of contraception; they partly reflect poor sexual health practice[2].

Which adolescents/teenagers experience pregnancy?

Analysis of the Labour Force Survey in 2001 indicated that teenage motherhood is more common among Caribbean, Pakistani and Bangladeshi women, than among white women.

Across the UK, rates of teenage pregnancy are considerably higher in areas of greater socio-economic deprivation[3]. The highest levels of teenage pregnancy in Great Britain tend to be in urban and industrial areas; the lowest rates tend to be in rural and prosperous areas. The association between teenage childbearing and residence in more deprived areas seems to be largely due to personal disadvantage rather than to area characteristics[4]. Research in Scotland revealed that the variations in teenage pregnancy rates between more affluent and more deprived areas widened between the 1980s

[1] Arai L (2001) Early childbearing is sometimes rational. *BMJ* 323:1428
[2] Taylor A (2001) Teenage pregnancy is a public health problem. *BMJ* 323:1428
[3] McLeod A (2001) Changing patterns of teenage pregnancy: population based study of small areas. *BMJ* 323: 199-203
[4] McCulloch A (2001) Teenage childbearing in Great Britain and the spatial concentration of pverty households. *Journal of Epidemiol Community Health* 55: 16-23

and 1990s[3]. In general, higher percentages of adolescent conceptions lead to abortion in more prosperous areas, and to maternity in less prosperous ones. These findings are borne out in the most recent statistics on teenage pregnancy and abortion statistics (ISD, National Service Statistics, 2012)

Research has shown that the risk of unintentionally becoming a teenage mother is 10 times higher among girls from manual unskilled social backgrounds than among those from professional backgrounds[5].

Early sexual initiation is an important factor in teenage pregnancy. NATSAL (National Survey of Sexual Attitudes and Lifestyle) published in 2000 found that early age at first intercourse was significantly associated with pregnancy, motherhood and abortion under 18 years.

The association between early sexual initiation, pregnancy and sexually transmitted infections may be explained partly by sexual incompetence. Among adolescents, there are wide variations by age in sexual competence (Defined by measurements of regret, willingness, autonomy and contraception). However, there is an association between age at intercourse and competence. According to analysis of NATSAL, 91% of girls and 67% of boys aged 13 to 14 at first intercourse were not sexually competent[6].

Educational level is significantly associated with sexual competence and use of contraception for both men and women; low attainment is also associated with early motherhood. The data collected by NATSAL clearly identifies a group of women vulnerable to teenage pregnancy; 29% of sexually active young women in this study who left school at 16 with no qualifications had a child at age 17 or younger[6].

Source of information about sex is also significantly associated with sexual competence and use of contraception. Among men, discussion with parents about sexual matters is associated with use of contraception[6]. NATSAL found that the prevalence of reporting STIs was higher among those whose main source of information about sex was friends and others. In 1999, a survey of adolescents attitudes towards sexual activity found that adolescents who were well informed on sexual health matters were significantly less likely to be influence by peer pressure or to be sexually active[7].

The Social Exclusion Unit's report of teenage pregnancy attributed the UK's high rates to three factors: low expectations, ignorance and mixed messages[8].

Research in the UK has associated teenage pregnancy with certain groups thought to be most likely to become pregnant. These have included young people:

[5] Tabberer S (2002) Teenage pregnancy and teenage motherhood. In Bradshaw, J (ed) (2002) *The well-being of children.* London: University of York & Save the Children
[6] Wellings K, Nanchahal K & Macdowal W et al (2001) Sexual behaviour in Britain: early heterosexual experience. *The Lancet* 358: 1843-50
[7] Burack R (1999) Teenage sexual behaviour: attitudes towards and declared sexual activity. *The British Journal of Family Planning* 24:145-8
[8] Social Exclusion Unit (1999) *Teenage Pregnancy*. Great Britain: The Stationary Office

- Living in deprived areas
- Who do not attend school
- Who are looked after by a local authority
- Who are homeless
- Who are themselves the children of young parents, particularly teenage mothers[5]

Interventions in adolescent sexual health

Education

Scotland has a poor record of sex education in schools in comparison to some other European countries. However, school-based lessons are now the main source of information about sexual matters for adolescents. School based physical, health and social education can encourage behaviour modification in adolescents to help prevent unwanted pregnancy and the transmission of STIs. Education can focus on increasing awareness of birth control and can also develop social skills such as negotiating in relationships and accessing and using sexual health services[9].

Evaluative studies of educational strategies show that school-based sex education can be effective in reducing teen pregnancy, especially when linked to access to contraceptive services. School based skills building, combined with factual information and programmes encouraging vocational development, may also help to reduce rates of unwanted teenage pregnancy. The most reliable evidence shows that sex education does not increase sexual activity or pregnancy rates[10].

The timing of educational interventions appears to be important: young people who are already sexually active at the commencement of interventions are less likely to change their contraceptive behaviour[10]. The BMA therefore supports the introduction of sex and relationship education into the primary school curriculum.

Although school education reaches a large proportion of the adolescent population, its impact as an agent of change is affective by variable political and social constraints. It is important to remember that school based programmes for sexual health promotion, although a part of Curriculum for Excellence, are not implemented uniformly across Scotland. Work done by Learning Teaching Scotland and Health Scotland to provide a useful resource is welcome but the implementation of this is again patchy across the country.

Access to services

Confidentiality

In the UK, adolescents under the age of 16 can, with some exceptions, be provided with contraceptive care even if unwilling to inform their parents.

[9] British Medical Association (2002) *Sexually Transmitted Infections*. London. BMA

[10] NHS Centre for Reviews and Dissemination (1997) Preventing and reducing the adverse effects of unintended teenage pregnancies. *Effective Health Care* 3: 1-12

Nonetheless, many adolescents express doubts about confidentiality in these circumstances as well as fear of being judged[11]. It is important that adolescents understand professional confidentiality and are reassured that their consultation will remain private. A doctor's duty of confidence to a child is the same as that for any other person. An explicit request by a child that information should not be disclosed to parents or guardians, or indeed to any third party, must be respected, save in the most exceptional circumstances, for example where it puts the child at risk of significant harm, in which case the disclosure may take place in the public interest without consent. Where a health professional decides to disclose information to a third party against a child's wishes, the child should generally be told before the information is disclosed[12].

Contraception

Respect and Responsibility stated that the full range of contraceptive methods should be available to all patients. It is generally accepted that the use of Long Acting Reversible methods of contraception (LARCs) are effective in reducing unintended pregnancy.

Within primary care, the provision of this service can be provided by a GP practice under the terms of a Local Enhanced Service. The use of this type of arrangement can be particularly useful in remote and rural areas where family planning services are not available and access to a local GP is more convenient for the patient. This form of contraception is offered to those young women considered at risk of unintended pregnancy.

Targeted interventions

It has been suggested that as adolescents are not homogenous, programmes should be tailored to the groups they serve[10]. The frequent clustering of risk among adolescents makes the identification of high risk groups a sensible strategy in intervention.

The strong association between low educational attainment and early motherhood supports the government's current strategy to involve education and social services in a bid to reduce teenage pregnancy. General anti-poverty strategies such as 'Equally Well' could also influence rates of teenage pregnancy and reduce adverse outcomes.

Helping adolescent parents

The health and development of teenage mothers and their children has been shown to benefit from programmes promoting access to antenatal care, including the family nurse partnerships, targeted support by health visitors, social workers and provision of social support, educational opportunities and

[11] Garside R, Ayres R & Owen M R et al (2000) General practitioners' attitudes to sexual activity in under-sixteens. *Journal of the Royal Society of Medicine*93: 563-4

[12] British Medical Association (2012) *Medical Ethics Today: The BMA's handbook of ethics and law*. (London) BMA.

pre-school education. Specific interventions including the provision of supplementary nutrition, social support, educational opportunities and pre-school education are likely to be effective in reducing the adverse outcomes of teenage pregnancies. Improving the housing conditions of some teenage parents and their children may also be important[10].

Conclusion

It is clear that the problems of unintended teenage pregnancy in Scotland are not straightforward or easy to resolve. While the 2005 strategy was funded in its early years, this funding has not continued beyond 2010 and the strategy has now been incorporated into the Sexual Health and Blood Borne Virus Framework. Progress to reduce unintended teen pregnancy has been slow and it is vital that resources are directed towards the achievement of the outcomes set out in the framework to: (1) reduce unintended pregnancies; (2) reduce the inequalities gap in sexual health; and (3) ensure sexual relationships are free from coercion and harm.

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