

Inquiry into teenage pregnancy

NHS Greater Glasgow and Clyde

We welcome the committee's inquiry into the issue of teenage pregnancy. Scotland has a very high rate of teenage pregnancy, one of the highest in economically rich countries. Scotland's teenage pregnancy rate remains a clear indicator of social-economic inequality still in place across the nation. It is encouraging that the overall rate in Scotland has been on a downward trajectory since 2007 however Scotland's is still unacceptably high. Therefore this inquiry at a time when wider health inequalities are also being explored is a positive opportunity to take stock of what has been achieved since *Respect and Responsibility* in 2005 and make recommendations for greater focussing of teenage prevention.

a. Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

A reduction in teenage pregnancy is sought as a measure in the *Sexual Health and Blood Borne Virus Framework 2011-2015*. While this is an appropriate aspiration given Scotland's high although decreasing teenage pregnancy rates, we consider its inclusion in a policy that relates to sexual health risks reinforcing a notion that teenage pregnancy is a purely sexual health issue rather than an issue of socio-economic deprivation and inequality. This means that despite the statements in the Framework that local authorities have the lead role for addressing teenage pregnancy, it can be challenging in practice to locate preventing teenage pregnancy beyond the planning and service delivery arenas for sexual health which is perceived as primarily NHS business.

It is clear that there is a strong contribution to be made to the prevention of teenage pregnancy by sexual health interventions and services. The international research evidence base clearly illustrates that a) the provision of sexual health and relationships education to children and young people and b) having appropriate sexual and reproductive health services available can have a positive effect on teenage pregnancy.

However the causes of teenage pregnancy are complex, multi-faceted and are usually the result of much broader sets of issues relating to socio-economic deprivation which all have a much greater role to play.

These issues include but are not limited to growing up with a lack of aspiration and a sense of stake in the future; the experience of poor parenting; disengagement from school; cultural norms among young people in relation to alcohol and sex; growing up in areas where it is a norm to be a teenage parent, as well as the experience of being looked after by the local authority and having experience of the criminal justice system.

Therefore to affect these often linked and entrenched determinants requires a considerable level of joined up partnership working by statutory and voluntary

sector services that are clear about their respective role in affecting teenage pregnancy and guided by committed strategic leadership locally.

While sexual health is therefore a significant partner in this paradigm, it is not a service area that has sufficient influence or status to facilitate the level of change required above. This is especially the case because the workforces that can make the biggest differences in relation to teenage pregnancy, e.g. early years workforce, youth workers etc, may not perceive this as their core business.

There is much that can be learned from the experience of addressing teenage pregnancy in England where there was a teenage pregnancy strategy running for over 10 years with high level government support. Notably this was framed as a social inclusion issue and not a sexual health issue. It is apparent that in areas even with very high rates, change was achievable with the right level of leadership and partnership working.

It would therefore be useful in Scotland to have a clearer policy direction which maintains local authorities in a leadership role, and where performance is measured from a more appropriate policy area.

The current policy makes the issue a key priority in relation to under 16 year olds. While it is true that for under 16 year olds the impact of teenage pregnancy can be particularly profound, the actual number of under 16 year old pregnancies in Scotland is relatively small. In the main teenage pregnancies are found in the 16 to 19 year old age group and the detrimental impacts of teenage pregnancy on this age group can on the whole be every bit as challenging.

The unfortunate effect of focussing on under 16 year olds can lead some partners to minimise the importance of the issue because the actual numbers are so small therefore it can seem difficult to justify such a concentrated response for what can seem like relatively small gain.

Therefore in our view, there is a need to broaden the scope of the current policy framework to address all teenage pregnancies. Some of the promising practice from England suggests that targeting work in neighbourhoods with much higher rates and working to particular neighbourhoods or indeed targeted work with particular vulnerabilities such as looked after children, can yield positive results for all those young people at risk of teenage pregnancy including those under 16.

The sexual health actions in the *Sexual Health and BBV Framework* and the previous *Respect and Responsibility* strategy may have contributed to some of the reduction observed in 2007. We recommend the future approach in relation to sexual health should be to maintain and build on the improvements brought about by the current policy. This means continuing to ensure young people have access to confidential and appropriate sexual and reproductive health services where and when they most need them. Additionally the emphasis on offering long lasting contraceptive methods as the first line choice

and the provision of free emergency hormonal contraception through the public health pharmacy contract should be maintained.

In relation to sexual health and relationships education, the evidence strongly illustrates the need for this to be provided in an age appropriate manner throughout primary and secondary schools by a trained and confident workforce and for this learning to be reinforced at home by parents and carers.

Much has been achieved in Scottish schools since *Respect and Responsibility* and the subsequent additional finance released in 2007 to support CPD for teaching staff. All six of the local authorities covered by this health board have developed coherent action plans in partnership with us to ensure high quality curricula are in place, teachers are trained and that there is good information available about key matters to children, young people and parents and carers. These have been achieved with high level support from Education colleagues who have demonstrated a commitment to the issue in every area.

We do have a concern that denominational schools which represents a third of the school estate in this area, may not be providing the same high quality level of SHRE to children, young people and parents. We have no feedback available from denominational schools on what is being taught, what training teaching staff may have had or what involvement parents have had in their children's learning. From our own staff that routinely work with schools, we have an understanding that they can be routinely denied access to denominational schools, or can only do so only if key issues, especially matters to do with sexual health and relationships are not discussed with children and young people.

We are therefore concerned that the national policy direction and especially the outcomes and experiences for children and young people in *Curriculum for Excellence* under the *Relationships, Sexual Health and Parenthood* organiser may not be being fully implemented in denominational schools. Given how strongly school based learning on sexual health and relationships shows up in the research evidence around prevention of teenage pregnancy, this is potentially a considerable gap.

Finally in relation to sexual health and relationships education provided or reinforced at home between parents and carers and their children, we have put in place some locally developed services to provide support and encouragement to parents and carers. It is our view that there is insufficient emphasis in the national framework placed on supporting parents to open up discussion with children and young people on key issues such as preparation for puberty, relationships and sexual health.

There is a wider workforce that work with adults in a variety of settings who could provide similar support for parents, thereby reaching greater numbers and facilitating a speedier culture change than individual services can achieve. There could be great benefit in skilling up this workforce to provide such support interventions.

b. Do you have any views on the action being taken at the local level by health boards, local authorities and other relevant organisations to reduce teenage pregnancy, particularly in the under 16 age group?

Teenage pregnancy is a priority issue for this health board. It is an outcome measure in our planning guidance for our community health (and care) partnerships. We have also through our partnership work with local authorities with whom we have sexual health strategy groups, included measures to address teenage pregnancy within our joint sexual health action plans.

The national direction for NHS Boards in relation to sexual health seem to be the correct actions. We recommend that the continued provision of access to long lasting contraception provided through accessible sexual health services to young people must remain in place. We are currently underway with a review process to ensure our local services for young people are indeed at the right times and in the right locations, and this approach should be encouraged across Scotland.

Our relationships with local authorities are strong in relation to sexual health. Since *Respect and Responsibility* we have prioritised the provision of sexual health and relationships education and targeted work with looked after children and young people in relation to sexual health. In the latter case this has involved training of residential and social care staff and developing staff guidance.

This is an important foundation which needs to be built on to now address some of the wider issues that affect teenage pregnancy that are not in the sexual health sphere of influence.

c. What are your views on the relationship between high levels of teenage pregnancy and socio-economic inequality?

It is well evidenced that teenage pregnancy is a marker for inequality and that measures to tackle inequality can have a positive effect on teenage pregnancy. We have taken the opportunity to map teenage pregnancy locally down to intermediate data zone level and it is clear that our areas with high rates are indeed those facing the greatest levels of socio economic deprivation and that the rates are much lower in our areas of relative affluence. We can make these maps available to you if you would find this useful.

d. What are the barriers and challenges to making progress in achieving positive change in communities that might lead to reductions in the levels of teenage pregnancy?

As was demonstrated in the learning from the *Teenage Pregnancy Strategy* in England, high level leadership and cohesive partnerships of organisations is required to affect change. This “top down” approach is needed to compliment the need to facilitate community ownership for the issues which requires small

neighbourhood grassroots level community development informed approaches.

One of the greatest barriers to achieving progress is getting the issue on the agenda and it being clear that teenage pregnancy is core business. Translating the issues affecting teenage pregnancy into coherent joined up actions owned by Community Planning Partnerships and Children's Service Planning Groups is therefore needed. This means framing the issue as a social inclusion issue rather than a health related issue.

Therefore there needs to be a greater understanding for local authorities of the expectations the government has on preventing teenage pregnancy and their leadership role in the agenda.

On a wider note we wish to raise our concern at the potential impact of the Welfare Reform agenda and the potential for young people at risk of teenage pregnancy to be further marginalised and excluded thereby increasing their vulnerability. This risks a potential increase in teenage pregnancies with the potential costs of this likely to be impacting on public services in future.

e. What are your views on the current support services available to young parents / young mothers, e.g. range of services, focus of services and whether services are being delivered in the most appropriate settings?

Through our partnership with Glasgow City Council, the Young People's Support Base has delivered what we consider the optimal model of support for young parents. The service provided is developed with the needs of young people and their babies at the core of the service and through it's location in education, ensures that educational attainment and future aspirations of young parents can be met while addressing the broader holistic health needs.

While this model works well within a city context we recognise it may be more challenging to replicate this model in a larger and more remote geographic areas however we consider the principles of the service to be replicable.

Securing funding for services like the Young Parents Support Base in other areas will depend on the relative priority of addressing teenage pregnancy perceived by Community Planning Partnerships.

We also acknowledge that the Family Nurse Partnership can make a contribution to preventing second pregnancies and joining these two approaches up may yield additional benefits for young parents and their babies.

f. Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice with regard to

reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?

We are aware of many excellent local initiatives delivered either by single agencies or through partnerships aimed at young people in this health board area. Importantly very few have addressing teenage pregnancy as a stated objective but many are addressing some of the wider determinants of teenage pregnancy such as aspiration or addressing non attendance at school which may have an effect. These range from the peer support and education approach of the Big ShoutER in East Renfrewshire to the MIDAS project in Northwest Glasgow or the Young Women's Project in Glasgow City or Barnardo's Threads service in Paisley.

However, measuring the impact of such diverse services with such varying aims in relation to teenage pregnancy can be challenging, especially when teenage pregnancy may not be their area of concern.

g. Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

The research evidence base points to Youth Development Programmes which is a programme developed in the USA as positively affecting teenage pregnancy as well as partner abuse in relationships. There may be benefits in more detailed investigation of the principles of youth development programmes and exploring their replication within a Scottish context.

The other approach that needs greater emphasis in Scotland is taking neighbourhood approaches to preventing teenage pregnancy. This was a feature in the evaluation of the impact of the teenage pregnancy strategy in England. It is clear that blanket approaches to addressing inequalities rather than targeted approaches can risk increasing health inequalities. Therefore within local authorities with higher rates, the emphasis should be on working in neighbourhoods with the highest rates. As a precursor to this we have recently mapped teenage pregnancy density across the whole health board area and used this to both assess if we have distribution points for our Free Condoms service located in the right areas and to assess where the gaps are in terms of young people's access to sexual health services.

However this mapping could be of greater benefit beyond simply sexual health services. Mapping of rates in high neighbourhoods can enable partnerships to plan addressing the wider determinants of teenage pregnancy and delivering early intervention measures with young people at risk of teenage pregnancy.

h. Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?

It is notable in the learning from the English experience of teenage pregnancy that even in the areas with the highest rates, having committed leadership at a senior level and coordinated partnership approach was able to bring about real reductions. Therefore we would recommend that action to facilitate this leadership and partnership approach is taken with a much greater emphasis on locating the issue as a social inclusion issues. This requires setting out clear guidance on expectations for local authorities and their community planning partners.

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