



# Child Health Information Development



**Developing child health information for  
Tyne and Wear Service Providers**

Report on Exemplar Issue: **Teenage Pregnancy 2001**

## Executive Summary

In Tyne and Wear, there are about 1200 teenage pregnancies (conceptions amongst girls under 18 years) each year. This represents a rate double that across the rest of the country, and at least ten times that in the Netherlands. In some parts of Tyne and Wear, virtually no 15-17 year old girls become pregnant, but in several socially deprived Wards, more than 12% of 15-17 year olds are pregnant each year. In secondary schools in these Wards, one-third of all girls will become pregnant at least once before they leave school.

It has been argued that primary prevention of pregnancy for teenagers is not a major public health priority and that the focus should be on social and educational support for these vulnerable mothers\*. However, pregnancies before the age of 18 are unplanned in at least three-quarters of cases. One third of these conceptions result in therapeutic abortion. For those pregnancies that are completed, the mothers are much more often supported by their parents than by their partners, their education usually ceases, and 40% of them will experience clinical depression in the first year. Furthermore, their babies will suffer even poorer health outcomes than those of older mothers in similarly socially deprived circumstances.

About one-quarter of these pregnancies (250 each year in Tyne and Wear) are amongst girls under the age of 16 years. These are children having abortions or bearing their own children. The scale of morbidity represented by these figures is important, and is now subject to intense central and local public sector activity.

From an information perspective, teenage pregnancy is a positive exemplar. Not only are there accurate and confidential data concerning conceptions, births and abortions, but most Local Education and Health Authorities have invested in regular (albeit unrepresentative) self-completion questionnaire surveys in secondary schools which yield important information on relevant risk factors and attitudes amongst young people. Furthermore, there are standardised data available from the National Teenage Pregnancy Unit on the availability of local contraceptive/family planning services, and their accessibility to young people.

Nevertheless, the conception rate amongst women under 18 years of age has not noticeably fallen, and there are significant information gaps. We have no reliable data source on contraception access and use, and we know almost nothing about the fathers of these pregnancies. Information on services is not clearly linked to an evidence base of what works in avoiding unwanted pregnancy, and we have little systematic data on the local health outcomes of this vulnerable group of teenage mothers and their babies.

\* Lawlor, D., Shaw, M. and Johns, S. (2001) Teenage Pregnancy Is Not a Public Health Problem. *British Medical Journal*, 323, 1428.

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## Teenage pregnancy: why does it matter?

In England, there are nearly 90,000 conceptions a year to teenagers; around 7,700 to girls under 16 and 2,200 to girls aged 14 or under. Although more than two-thirds of under 16s do not have sex and most teenage girls reach their twenties without getting pregnant, the UK has teenage birth rates which are twice those in Germany, three times as high as in France and six times as high as in the Netherlands. In the 1970s, the UK had similar teenage birth rates to other European countries. But while they achieved dramatic falls in the 1980s and 1990s, the rates in the UK remained stuck. Within the UK, rates vary greatly between different countries, local authorities and even wards. This report aim is to draw a HAZ wide profile of the problem, by collating data on teenage conception rates, sex education and teenage use of contraception in Tyne and Wear.

Teenage pregnancy is an issue that has been high on the policy agenda in the UK for some time. A decrease in the rate of teenage pregnancy was a priority in the 1992 Health of the Nation targets. There have been concerns at the number of conceptions to teenagers, the links between teenage conceptions and deprivation and the range of adverse outcomes for both mother and child. Examples of this include an increased likelihood of having a baby with low birthweight,<sup>1</sup> an increased rate of sudden infant death syndrome<sup>2</sup> and an increased risk of death in infancy or early childhood (1-3 year of age).<sup>3</sup> Children of teenage mothers are also less likely to be breastfed<sup>4</sup>, and more likely to be admitted to hospital as a result of an accident, than children of older mothers.<sup>5</sup> The longer-term outcomes also appear to be poorer, with 41% of teenage mothers having an episode of depression within one year of childbirth,<sup>6</sup> an increased likelihood of the child experiencing the divorce or separation of its parents<sup>7</sup> and an increased likelihood of the daughters of teenage mothers becoming teenage mothers themselves.<sup>8</sup> Those who become mothers in their teens are more likely to have no qualification and to be in receipt of non-universal benefit by 33 years of age.<sup>9</sup> They have an increased likelihood to be on substantially lower income,<sup>10</sup> to be divorced or separated<sup>11</sup> and to have large families by age 33.<sup>12</sup>

Biologically, there is no reason why a teenage pregnancy should not have a good outcome if well managed. However, because of their circumstances, teenage mothers tend not to have well managed pregnancies. They usually go to their doctors much later in pregnancy and often miss out on important early pre-conception health measures; they are also most likely of age groups to smoke.<sup>13</sup> For many, family conflicts, a change in care or fostering arrangements, experiences of relationship stress or breakdown, and problems with education, housing and money make any kind of ante-natal planning impossible.<sup>14</sup> It has been argued that these poor outcomes are more the result of poverty rather than teenage parenthood. It is certainly true that whatever the age of the mother, poverty has an impact on a child's prospect. But though infant mortality is higher for the poorest at all ages, a teenage birth worsens the risk for all social classes.<sup>15</sup>

## Teenage parents: scale and trends.

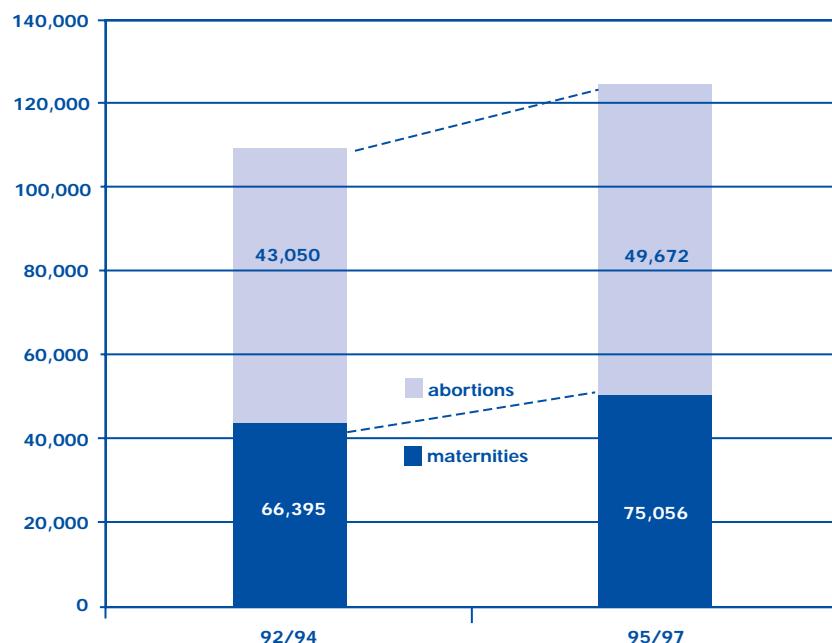
International evidence suggest a striking correlation between countries with high rates of live births to teenagers and high levels of relative deprivation, dropping out of education and family breakdown.

The UK tends to be characterised by high levels of income inequality, poor educational achievement, high percentage of lone parents, low expectations from young people and a history of neglect of the matter.<sup>16</sup> A teenager who has a financially and emotionally secure background and sees a clear future for herself might feel she has something to lose from

Northern Ireland and England have teenage birth rates of around 30 per 1,000 population of women aged between 15 and 17. Wales is higher with a teenage birth rate of 37.7 per 1,000.<sup>19</sup>

Of the 104 health authorities in England and Wales, 26 decreased their teenage pregnancy rate between 92/94 and 95/97 but this was not enough to change the overall increasing national trend. National rates in 95-97 ranged from 22.5 for East Surrey, to 82.7 for Lambeth, Southwark and Lewisham health authority. This brings Tyne and Wear in the top 10% of teenage pregnancy rates in England.<sup>20</sup>

**Figure 1: Conceptions and outcomes for under 18 years of age in England and Wales<sup>21</sup>**



early parenthood. But a teenager who has grown up in poverty, has had difficult family relationships, is in care or under pressure to move out and who sees no prospect of a job might see things differently.

In the UK, a significant number of young women conceive more than once in their teens. One in six teenagers who had an abortion in 1997 had already had an abortion or live birth, and 2 percent had both.<sup>17</sup> It is estimated that around 87,000 children in England had a teenage mother in 1999.<sup>18</sup>

The total number of conceptions to teenagers increased from 109,445 in 92/94 to 124,728 in 95/97 in England and Wales (figure 1). These figures do not include miscarriages or illegal abortions (see details on collection methods and data in Teenage Pregnancy Data Issues).

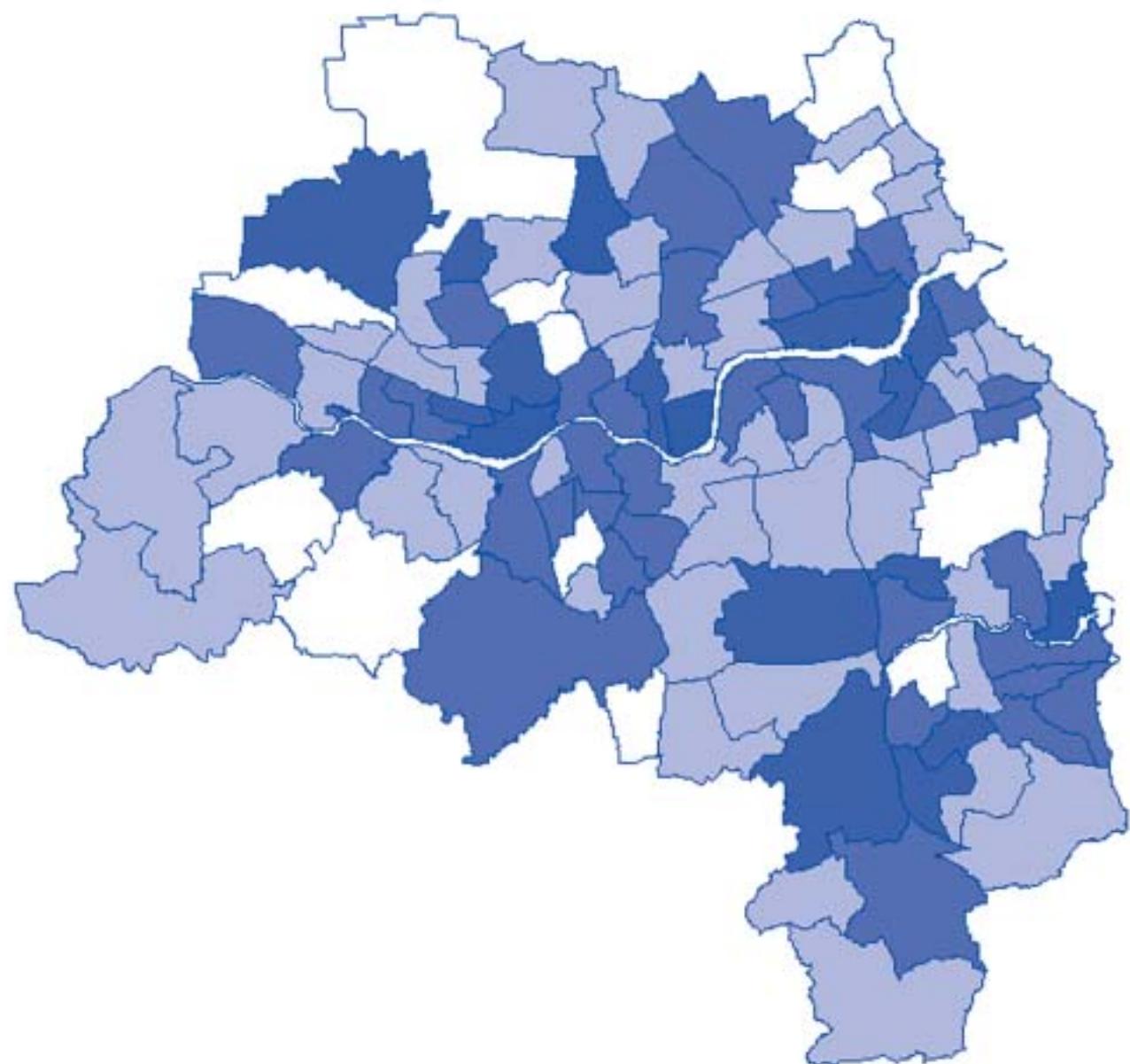
Rates within the UK vary between different countries. Scotland,

Between 1992 and 1997, the northern regions of England had higher under 18 conception rates than Great Britain, in contrast to the South East, South West and East of England regions, which had lower rates. The Northern Regions also had lower percentages of abortions to under 18s than the Great Britain average. Trends were the same at local authority level: those that had high conception rates also tended to have low percentages of conceptions leading to abortion.<sup>22</sup>

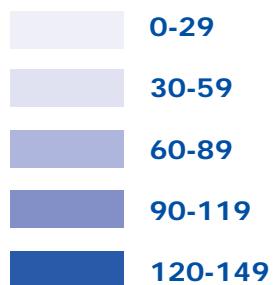
Figure 2 show the under 18 conception rates, expressed per 1000 girls aged 15 to 17 in Tyne and Wear in 1995. This clearly shows how different the situation can be from ward to ward, and how localised action could be in response. It also shows how unrepresentative health or local authority+ wide rates of teenage pregnancies are, as no local authority in Tyne and Wear presents a uniform pattern (see figures 6 and 7).

**Figure 2: Teenage conception rates by Tyne and Wear, expressed per 1000 girls aged 15-17 in 1995**

## Tyne & Wear



**Conceptions per 1000**



## Scale and trends in Tyne and Wear

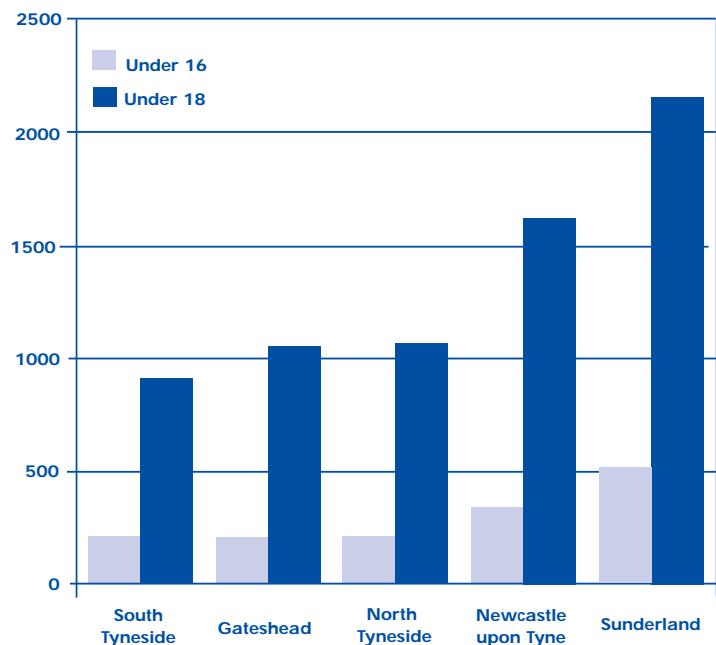
Health in Tyne and Wear is among the worst in England and Wales, with a profound scale of deprivation, which includes pockets of even worse health. The rate of teenage pregnancies is in the top 10% in England, with 800 pregnancies in girls aged 13-15 in 1994-1996.<sup>23</sup> Young teenage pregnancy is often found alongside low educational achievement, socio-economic disadvantage and poor physical and mental health as well as social isolation. Figure 3 shows the number of conceptions by under 16s and under 18s between 1992 and 1997, by local authority in Tyne and Wear. The prevalence for the younger group goes from slightly over 200 in Gateshead,

South Tyneside and North Tyneside, to well over 300 for Newcastle, to over 500 for Sunderland.

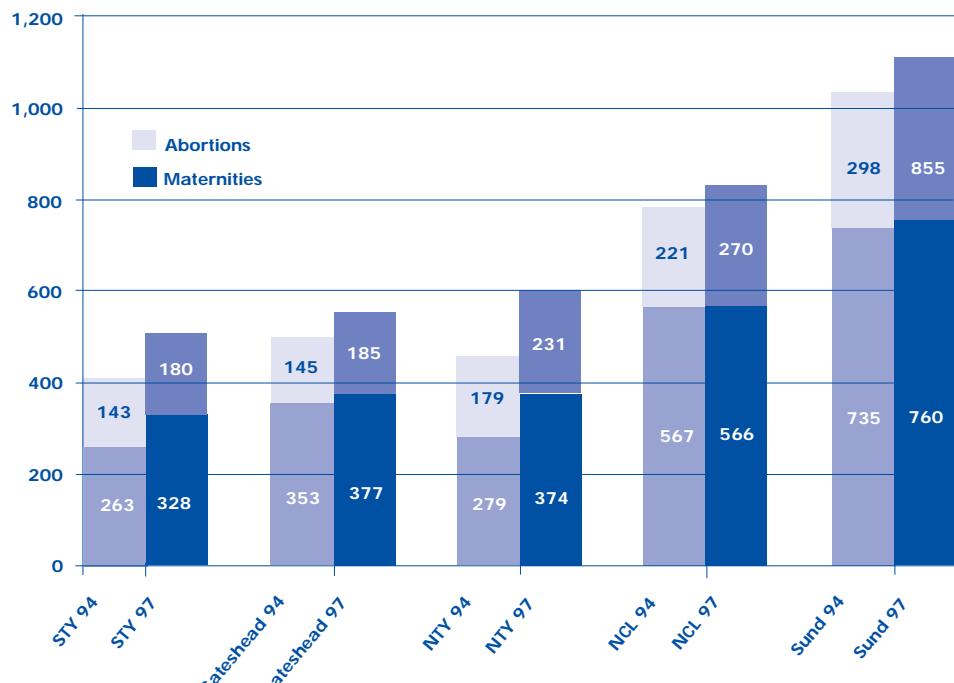
The pattern between authorities is similar for under 18s: with a number of conceptions just over 900, South Tyneside has the lowest number in Tyne and Wear; followed by Gateshead and North Tyneside which present very similar numbers, just over 1000. Newcastle had 1624 conceptions registered, and Sunderland 2148.

Figure 4 shows the number of conceptions by under 18 year olds and by health authorities, between 92/94 and 95/97.

**Figure 3: Number of conceptions by under 16s and under 18s by local authority, between 92 and 97**



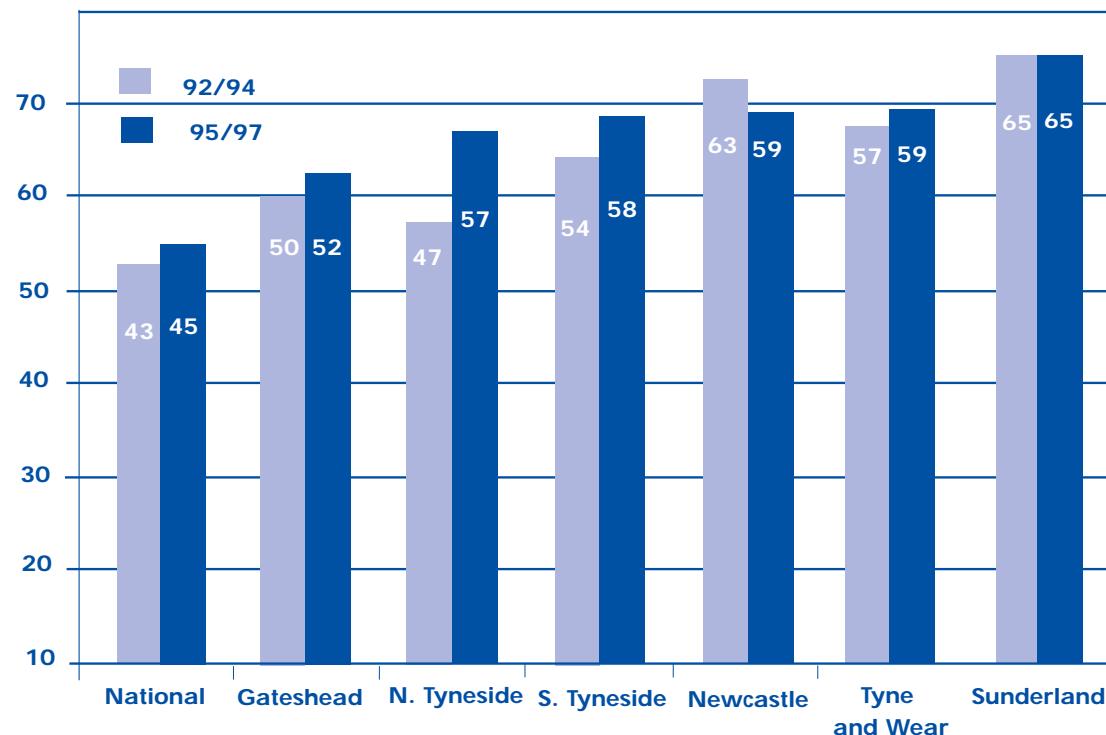
**Figure 4: Number of conceptions and outcomes for under 18 year olds in 92/94 and 95/97.**



The number of conceptions increased in all local authorities between 92/94 and 95/97, leading to both increased abortions and maternity, even if the number of conceptions leading to abortions remained relatively low by national standards.

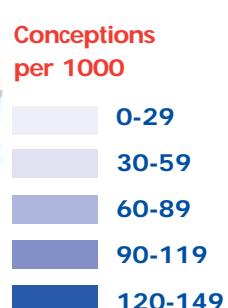
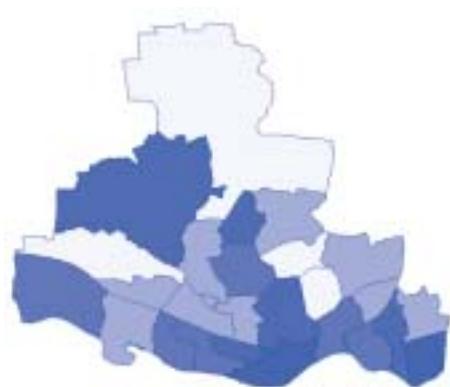
Figure 5 shows the teenage conception rates, per 1000 girls aged 15 to 17 in Tyne and Wear. All local authorities in Tyne and Wear have teenage conception rates higher than the national average, and Sunderland exceeds the rate for Tyne and Wear. While most local authorities have seen their rate increasing between 92/94 and 95/97, Newcastle decreased.

**Figure 5: Conception rates by 1000 girls aged 15-17 in Tyne and Wear, by local authority**



**Figure 6: Teenage conception rates by ward in Newcastle and North Tyneside Local Authorities**

**Newcastle**



**North Tyneside**

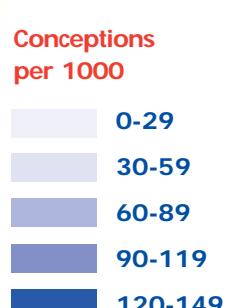
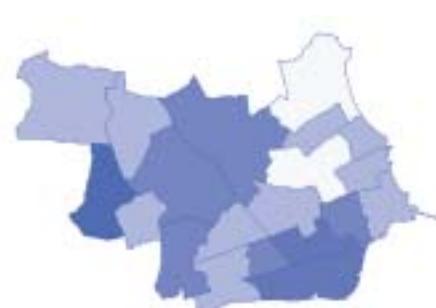
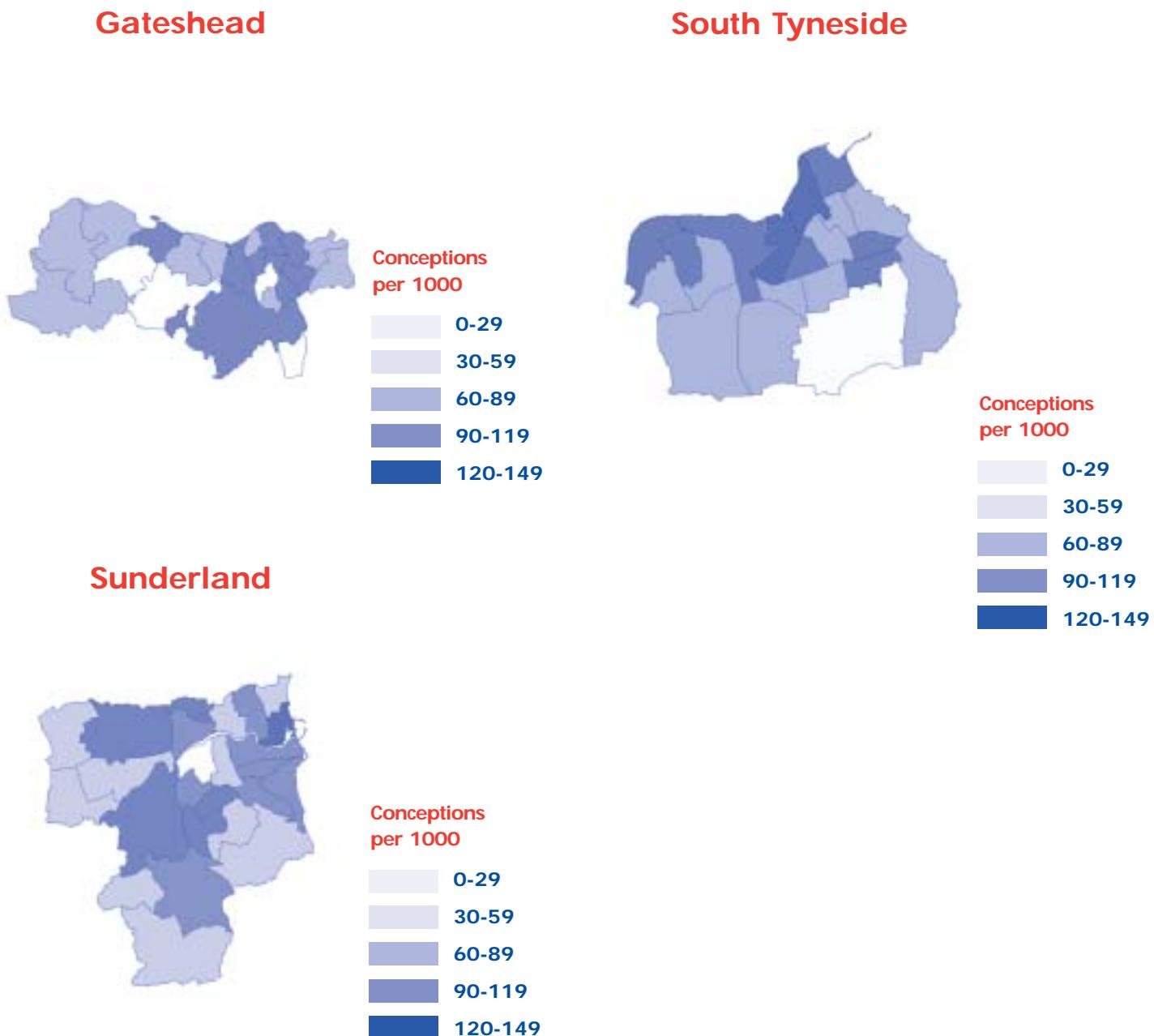


Figure 6 shows teenage conception rates by ward in Tyne and Wear Local Authorities, expressed per 1000 girls aged 15-17 in 1995 (population figures by ward estimated from the 1991 census data). Although rates are generally given either by Local or Health authority, it is obvious from these maps that rates vary greatly from ward to ward.

Newcastle and North Tyneside health authorities both present great diversity in their rates of teenage pregnancy, although a greater number of blue areas (90 to 119 and 120 to 149 teenage conceptions per 1000 girls aged 15 – 17) illustrates why the global prevalence is higher in Newcastle.

Figure 7 shows the teenage conception rates in Gateshead, South Tyneside and Sunderland. The maximum teenage conception rate found in Gateshead local authority was between 60 and 89 conceptions per 1000 girls aged 15 to 17 in 1995. South Tyneside, with two wards presenting rates between 90 and 119, has only one sparsely populated ward in the lowest rate band.

**Figure 7: Teenage conception rates by ward in South Tyneside, Sunderland and Gateshead Local Authorities, expressed by 1000 girls aged 15 to 17 years old in 1995.**



Sunderland has high rates across many wards and is the local authority presenting the highest overall teenage conception rates.

## A social exclusion phenomenon

Teenage pregnancy is often a cause and a consequence of social exclusion. Poverty has been shown to be a key factor: research has shown that the risk of becoming a teenage mother is almost ten times higher for a girl whose family is in social class V (unskilled manual), than those in social class I (professional).<sup>24</sup> Children in care have repeatedly been shown to be at higher risk of teenage pregnancy.<sup>25</sup> In addition, there is evidence of a strong link between teenage parenthood and not being in education or low educational achievement,<sup>26</sup> for 16 and 17 year old women. Several studies have shown an association between abuse in childhood and teenage pregnancy,<sup>27</sup> and there is also a link between police contacts and teenage parenthood.<sup>28</sup>

Many young people share several of these risk factors and have a very high chance of becoming a teenage parent. There are no comprehensive statistics on either live births or abortions by ethnic group because the mother's ethnic group is not recorded at birth registration or abortion. However, a few surveys show that three ethnic minorities in particular are at substantially greater risk of teenage parenthood than the national average: Bangladeshi, African Caribbeans and Pakistanis.<sup>29</sup>

Multiple risk factors also lead to a geographical concentration of teenage pregnancy. The poorest areas in England have teenage conception and birth rates up to six times higher than the most affluent areas.<sup>30</sup> When the ONS classification of local authorities<sup>31,32</sup> is used as an indicator of the socio-demographic characteristics of areas, the pattern of under 18 conceptions varies substantially between areas. The Coalfields, Manufacturing Centres, Established Service Centres and Ports and Industry groups have high under 18 conception rates and low percentages leading to abortion.<sup>33</sup> The characteristics of these areas include high unemployment, a large proportion of the population in Social Class IV and V and a high proportion of terraced housing and social housing. Tyne and Wear is classed as part of the Port and Industry category.

## Teenagers' experience of sex

*"You think everybody is doing it and they ain't. It's only afterwards you think 'what do you mean you haven't?' I wish I hadn't. I thought you had"*

*"They told us what the bits were called and my teacher was a nervous wreck"*

While children have always aspired to reach adulthood as quickly as possible, the process seems to have accelerated in recent years, and the earlier onset of sexual activity among teenagers (17 years of age on average, versus 20 forty years ago<sup>34</sup>) might be in part due to this accelerated process of growing up. Some of the fall in age of first intercourse may also reflect falling ages of sexual maturity, thanks to the improvements in general health and diet. There is no consensus on exactly what the average age of puberty now is for young women, but it is thought to be of 12 years and 7 months on average.<sup>35</sup> Additionally, there are pressures on young people to have sex by their peers and by a belief that it is expected from them. For many boys, having sex is an achievement of manhood, whereas many girls associate sex with romance, love and affection.<sup>36</sup> Sex among teenagers is often opportunistic, unplanned, affected by alcohol and takes place outside of any long-term commitment. Young people themselves give a variety of reasons for starting sex, including curiosity, opportunity, peer pressure, the wish not to be left behind, fear of losing a boy or girl friend, the need to feel in love and the belief that sex equals love.<sup>37</sup>

However, young people's access to information about sexual health and contraception has not caught up with their increasingly early exposure to sex. Research shows that ignorance about sex is a risk factor for teenage pregnancy<sup>38</sup> and that good education helps to delay rather than accelerate when young people start sex. The limited information that young people do have access to comes from four different sources:

**Parents.** They are the ones young people would most like to tell them about sex, but they often feel ill equipped to fulfil this role and are given little help for it.

**Sex and Relationship Education (SRE)** in schools. Teachers with little, if any, special training are expected to teach sex education in large and mixed gender groups, often causing embarrassment on both sides. In addition to being squeezed for time and under developed, SRE is patchy and rarely integrated with local strategies that tackle teenage pregnancy. They often focus on the biological aspect of sex, and omit to discuss contraception or emotional, relational or behavioural aspects. Generally, young people feel they are told too little and too late. A recent survey has shown that school pupils thought sex education to be unsuccessful as it only addressed the mechanics of sex, rather than self confidence and esteem and how to talk about feelings.<sup>39,40</sup>

**Friends.** A 1997 survey found that, for children of 14 and 15, friends were as influential a source of information about sex as was school.<sup>41</sup> Peer networks can be very strong indeed and information passed through them perceived as highly credible, although relaying of misinformation is relatively common.<sup>42</sup>

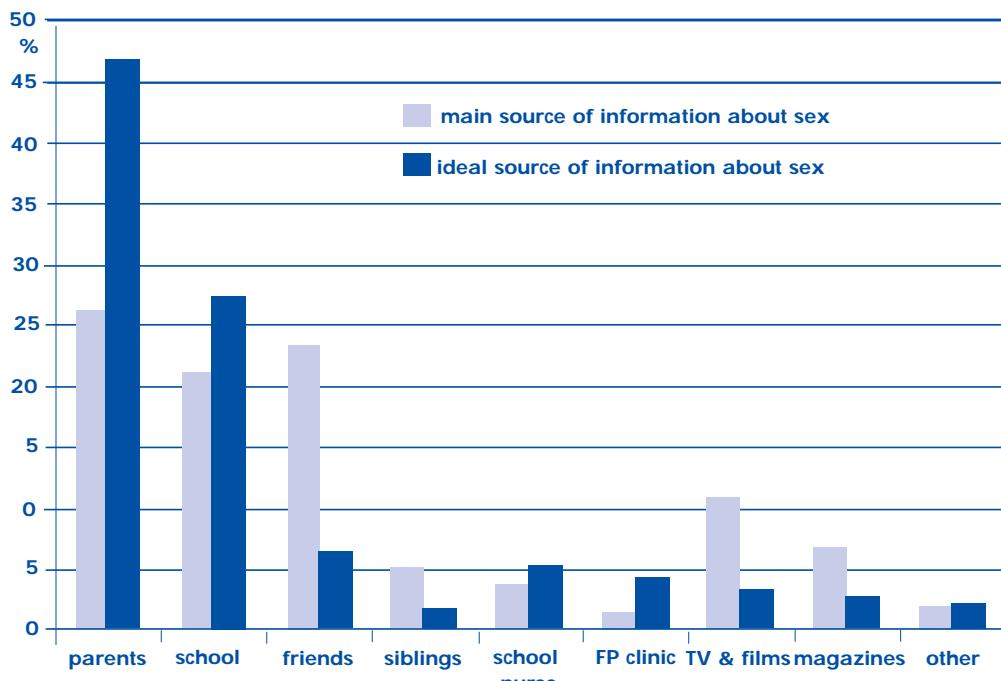
**The Media.** Teen magazines are an important and trusted source of information, particularly for girls. However, they are also perceived by parents to encourage sex and to foster frustration among young readers by setting unachievable standards of beauty and sexual attractiveness.<sup>43</sup>

## Sex education and teenagers' experience of sex in Tyne and Wear

### 1. South Tyneside and Gateshead

As shown in figure 5, the teenage conception rate in South Tyneside increased from 54 conceptions per 1000 girls aged 15

**Figure 8: Main and ideal source source of sex education in South Tyneside, 2000**



to 17 in 1992/94 to 58/1000 in 1995/97. Over the same period of time the same trend occurred in Gateshead, where the rate went from 50 to 52.

A health related behaviour survey was conducted in 2000 across South Tyneside and 1582 pupils aged 11 to 16 participated. 46% of the participants had visited their GP in the preceding 3 months and 20% of them had felt quite or very uneasy at this occasion. 24% of them had a boyfriend or girlfriend at the time of the survey. 40% of them said they were worried about puberty and growing up, and 80% of the pupils found school sessions on this subject of some use. 59% did not know whether there was a family planning clinic for young people locally, and 63% of them did not know where to get condoms free of charge. 68% of the girls had started menstruating (33% had started before or at the age of 11) and 32% of them had felt frightened at the first occurrence.

Figure 8 shows what pupils described as their actual main source of information about sex, and what they thought should be their main source of information about sex. Parents were the most frequent source of information, followed by friends and school. Pupils strongly felt that parents should be their main source of information, followed by school. Only 6% of them thought that their friends should tell them about sex matters. TV, films and magazines were a source of information about sex in nearly 20% of the cases.

14% of the children were not sure whether they would take care not to get infected by the HIV virus in the future and 46% of them could not remember any school session about HIV or AIDS.

When a previous HRBQ survey was conducted in South Tyneside in 1995, 3386 pupils were asked what they would like to do after leaving school (question not asked in the 2000 questionnaire). 50% said they would like to continue in full time education and 33% declared wanting to start a family (the proportion being higher among female and younger pupils). 18% of them thought that it might be difficult for them to get a job they would like after school because of becoming a parent

## 2. Sunderland

In Sunderland, the rate of teenage conceptions stayed at 65 per 1000 15 to 17 year olds between 92/94 and 95/97. Teenage attitudes surveys were conducted in some secondary schools in Sunderland in 1994 (1477 pupils), 1996 (1777 pupils), 1998 (1426 pupils) and 2000 (1459 pupils).

In 2000, 29% of the participating pupils had a boyfriend or girlfriend at the time of the survey and 48% said they worried about puberty and growing up. 72% of the girls had started menstruating (34% had started at or before the age of 11, 56% said they were surprised and 34% they were frightened when it first happened). 13% of the pupils could not remember any school lesson about puberty and growing up, and less than half

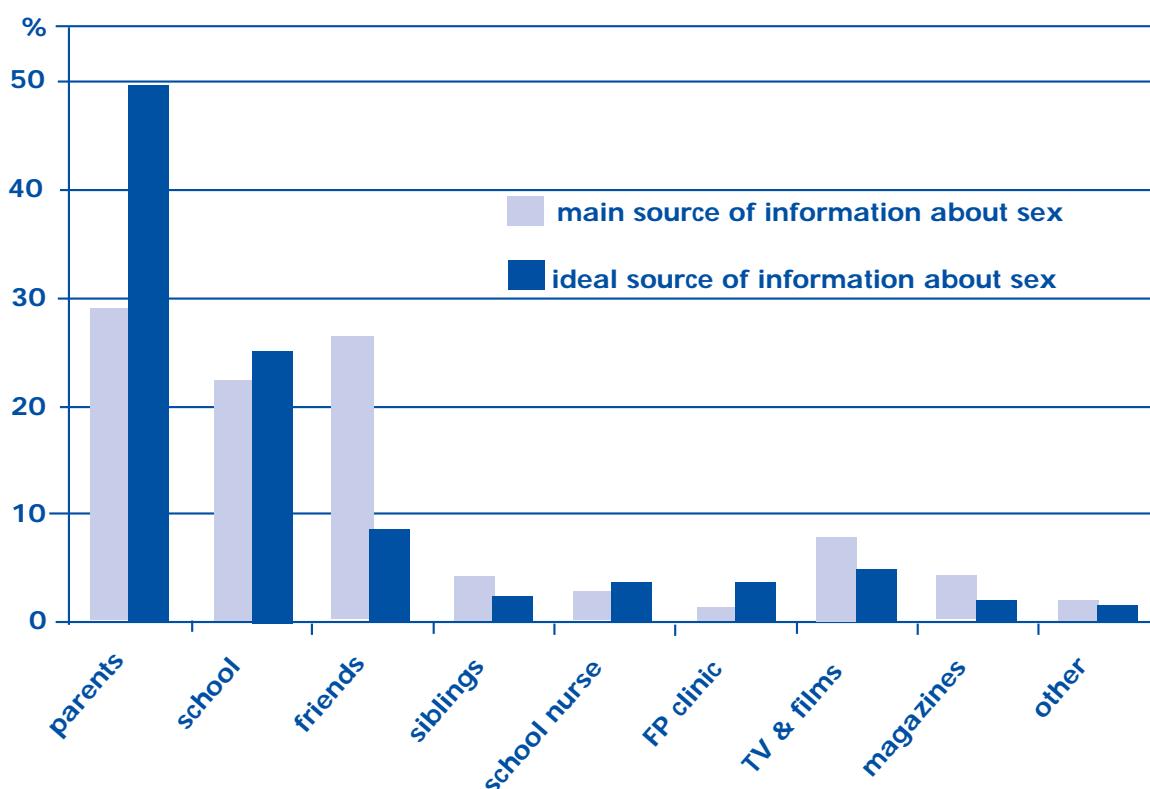
(48%) of those who could remember found them quite useful or very useful. Girls were more likely than boys to remember school sex education sessions and to find them useful.

Figure 9 shows the main and ideal source of information about sex among the 2000-survey participants.

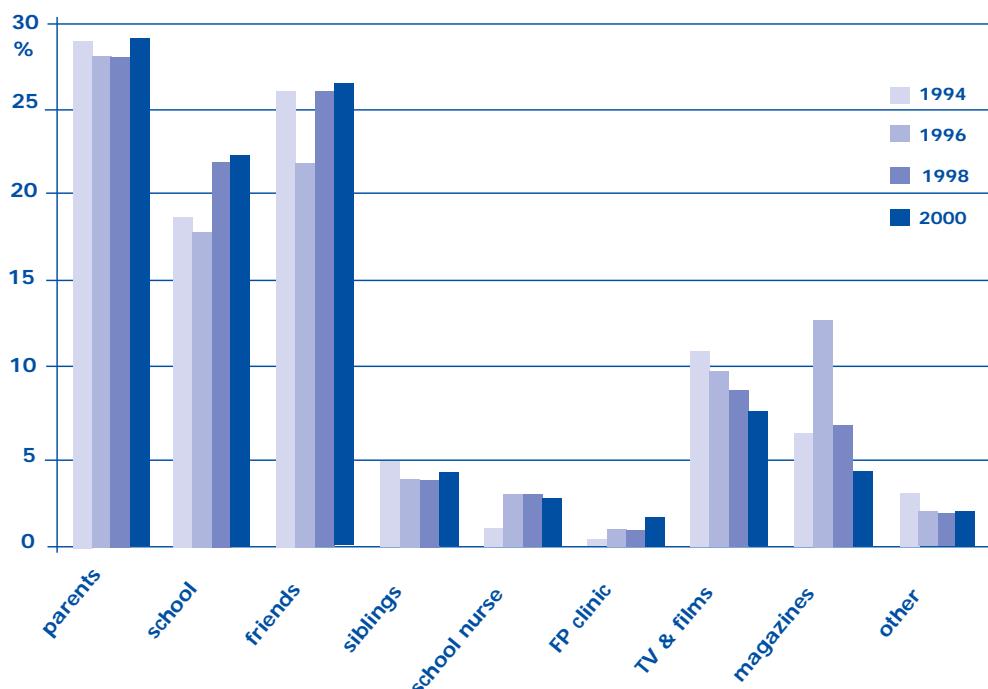
50% of the pupils thought parents should be their main source of information about sex, followed by their school, their friends and various other sources. In reality, parents were still the most frequent source of information but to a much lesser extent, and closely followed by friends. While the discrepancy between main and ideal source of sex education for parents and friends was noticeable, schools sex education accounted for just over 20% of the pupils knowledge, but they did not seem to expect much more from it.

Figure 10 shows the main source of information about sex for Sunderland pupils over the four HRBQ surveys. Over the four surveys, pupils actual source of information about sex changed little: for just under 30% of the pupils, parents were the most important source of sex education. Friends remained the second most important source, although if 1994 and 2000 data are compared, the influence of school seems to have been increasing, consequently reducing the gap between the two sources. The influence of the media seems to have been decreasing, while family planning clinics seem to have slightly increased their influence.

**Figure 9: Main and ideal source of information about sex, Sunderland 2000**



**Figure 10: Main source of information about sex in Sunderland over the 4 HRBQ surveys**



### 3. Newcastle

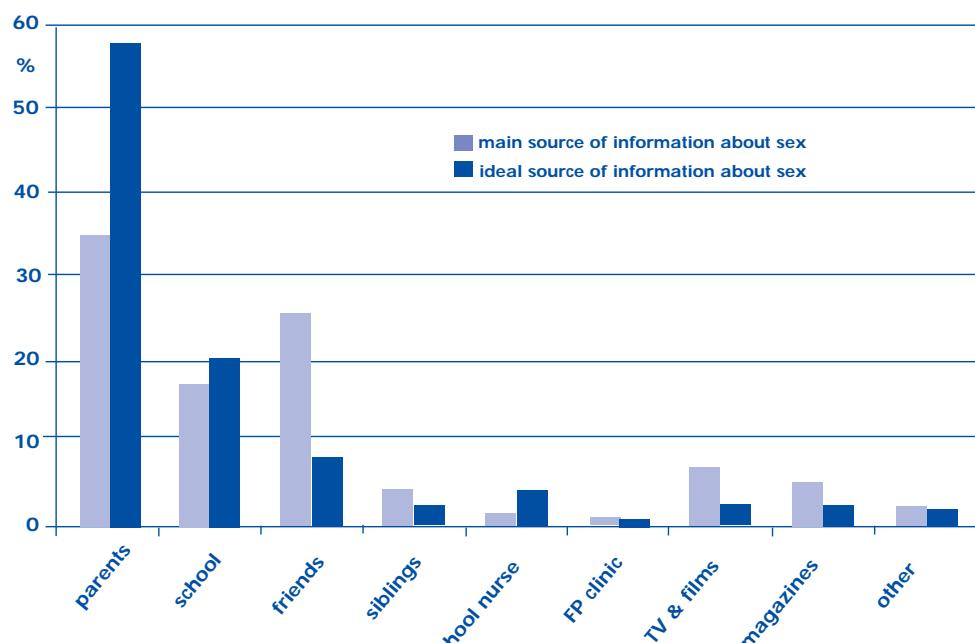
In Newcastle, the rate of teenage conceptions decreased from 63 per 1000 girls aged 15 – 17 in 92/94 to 59 per 1000 in 95/97. A Teenage Attitudes Survey was conducted in some secondary schools in Newcastle in 1997, and 1245 pupils aged 11 to 16 were included. 31% of them had a boyfriend or girlfriend, but 71% of boys and 54% of girls did not know where they could get free condoms. 71% were not sure whether they could find a family planning clinic for young people in their locality.

When asked what they would like to do on leaving school, 47% of the pupils said they would like to continue in full

time education, 33% said they would like to start a family (43% of the boys and 24% of the girls), and 19% thought becoming a parent would reduce the chance of them getting a job they would like on leaving school.

Figure 11 shows young people's actual main source of information about sex, and what they think should be their main source of information about sex. As in the other health authorities, the difference of main and ideal source of information for parents and friends was noticeable, whereas pupils did not seem to expect much more from school than what they had already.

**Figure 11: Main and ideal source of information about sex, Newcastle 1997**



## Teenagers and contraception

*"I'd go to my GP. I wouldn't. I couldn't do that.  
I know the nurses."*

In a study comparing the views of key informants in four countries about family planning services,<sup>44</sup> the 1985 Gillick ruling<sup>45</sup> was described and given as source for confusion and embarrassment among both general practitioners and teenagers about confidential care for young people in the UK. The training of general practitioners in the provision of family planning services was viewed as inadequate, and generally family planning was not perceived as a prestigious work. On the other hand, teenagers (particularly those under 16) were reported confused as to whether they had any right to seek confidential advice. A study conducted by Southampton University<sup>46</sup> reinforced this idea by highlighting that young people under the age of 16 find obtaining contraception particularly difficult. With an increasing proportion of young people becoming sexually active under the age of 16, this is a heightening problem. In the 1990/91 National Study of Sexual Attitudes and Lifestyles, 16% of women and 25% of men aged 16 to 24 years interviewed were sexually active before the age of 16, compared to only 2% of women and 10% of men of a cohort aged 54-59 at the time of interview. More recent estimates suggest that the numbers sexually active before age 16 are as high as one in three.<sup>47</sup> In 1994, it was estimated that between a third and half of sexually active teenagers do not use contraception at first intercourse; a higher proportion than in any other European country.<sup>48</sup> However, a more recent study suggests that most teenagers who become pregnant do access general practice in the year before their pregnancy, and that teenagers who become pregnant have higher consultation rates than their aged matched peers, most of the difference owing to consultation for contraception.<sup>49</sup>

Research in 1999 showed that 13% of 16-24 year olds have used emergency contraception.<sup>50</sup> But there are still many barriers to access, especially if unprotected sex takes place at weekends when it is more difficult to visit a GP or a family planning clinic. However, a 1996 Scottish study found that teenagers were well informed about the existence of emergency contraception though many did not know when and how to access it.<sup>51</sup> Since the 1st January 2001, emergency contraception has been made available over the counter for teenagers over 16. Knowledge of this

might improve in the near future. In 1999-2000, 48% of the post-coital contraceptives prescribed at family planning clinics in the UK were prescribed to women under 19 years of age.<sup>52</sup>

The Teenage Pregnancy Unit released guidelines on Best Practice on the Provision of Effective Contraception and Advice Services for Young People in November 2000. According to this, a trusted and accessible service would involve an age specific focus, non-judgemental staff, accessible location and opening hours, a friendly atmosphere and advertisement in places where young people generally meet. Services should encourage attendance by younger teenagers and have an explicit confidentiality policy. They should offer young people the time and support to make informed choices about their relationships and sexual health. The Teenage pregnancy Unit has launched an internet site dedicated to young people and linked to a help line ("Sexwise"): [www.ruthinking.co.uk](http://www.ruthinking.co.uk). On this website, teenagers can search for a range of services related to sexual health (Abortion reference services, contraceptives, counselling, emergency contraception, pregnancy testing...) in their area. Such a search has been run for Newcastle, North Tyneside, South Tyneside, Gateshead and Sunderland, and table 1 summarises the result of this search, together with other area characteristics.

	Gateshead	N Tyneside	S Tyneside	Newcastle	Sunderland
Pop. 15 to 17 year olds (1995)*	6,895	6,959	5,555	8,698	11,300
Contraception rate in 1997**	52.4	56.8	58.4	58.9	65.5
Number of clinics***	6	14	6	11	8
Number of clinics for young people****	2	6	4	4	2
No opening hours/ week*****	19hr	58hr	24hr	46hr	32hr
No opening hours/ after 4pm/week	7hr(1.0)*****	16hr(2.3)	13hr(2.3)	33hr(3.8)	13hr(1.2)
No of services opened on week ends	1	0	1	2	1

\*Female population estimated from the 1991 census.

\*\*Conceptions per 1000 girls aged 15-17.

\*\*\*Total number of places providing contraception services and advice, as given by 'ruthinking' website.

\*\*\*\*Number of clinics dedicated to young people, included in the total number of clinics.

\*\*\*\*\*Total number of hours per week when family planning services are available in the area.

\*\*\*\*\*Hrs per week per 1000 15-17 yr olds.

It is estimated that in 1999 – 2000 over 7% of resident females aged 13-15 and 23% of women aged 16-19 in the UK attended family planning clinics.<sup>53</sup> The primary methods of birth control chosen were the male condom / sheath and oral contraception for the attendees under 16. Oral contraception was primary method for about 55% of women aged 16-19. In Northern and Yorkshire, it is estimated that 6% of under 15s, 18% of 15 year olds and 23% of people aged 16-19 attended a family planning clinic for the first time in 1999-2000.

Although adoption was a common choice in the 70s, it is now only rarely chosen as the answer. There is considerable variation between health authorities in access to NHS abortions, but the greater influence seems to lie in a young woman's perception of her future prospects; those who have higher education aspirations are more likely to have abortions than their peers.<sup>54</sup> Young people from more deprived areas seem to disapprove strongly of abortion, to think it would only be considered by people who had something to lose, or to think that they may be stigmatised by others if having an abortion.

## How do teenagers cope with parenthood?

**"I've just found out I'm pregnant. My mum gave me three days to decide on an abortion. When I told her I wanted to keep it, she threw me out.**

**But I want to go back home. I miss her."**

For the 75% of teenagers who did not plan their pregnancy, the news that they are pregnant will be traumatic. Although decisions often have to be made at a time of great strain, there is little provision for co-ordinated help that could enable teenagers to make informed choices about the future. While they are likely to experience difficulties with education or employment and quite possibly relationships, they have to decide between abortion, adoption or pregnancy and motherhood.

Attention to ensuring a pregnant teenager continues to receive education is often patchy and there are innumerable examples of pregnant girls pushed out of school on grounds of pregnancy or "health and safety". For many teenagers this is the beginning of a permanent detachment from education. In addition, they get little support to get into a job, to obtain proper housing or to be a good parent and are too often given state support that isolates them from what they need most.

**"If you could just keep that maternal 'I've got something to love' kind of thing, but it's not like that, it's like a really long day when you are shut indoors watching Teletubbies"**

**"I tried to go back to school. I wanted to go back, but the school didn't want to know."**

During its consultation the Social Exclusion Unit<sup>55</sup> often heard from teenage parents who, although they loved their child and were glad they had given birth to them, had no idea how hard being a parent would prove to be. Nationally 90% of teenage mothers receive Income Support, and teenage mothers are likely to rely on benefits alone and remain on them for longer than other lone mothers (see in Annex 1 the benefits available to teenage parents). However, the benefit system does not encourage teenage mothers back to work or education and the lack of childcare and necessary qualifications hinders those who try.

Seven out of ten 15 and 16 year old mothers, and around half of 17 and 18 year olds stay at home,<sup>56</sup> but the rest tend to live in care or social housing. In one study, teenage parents were six times as likely as other households to live in areas dominated by local authority housing.<sup>57</sup> Moreover, for many, a lack of parental support is compounded by relationship breakdown. Four out of ten teenage mothers suffer from depression within a year of giving birth – almost double the rate for single women of the same age living at home.<sup>58</sup>

## Strategies

### The Government's action

The Government's action to tackle teenage pregnancy can be summarised in three broad categories: 1) A national campaign to mobilise every section of the community. 2) Better prevention of teenage pregnancy through better sex and relationship education, clearer messages about contraception and special attention to at-risk groups. 3) Better support for pregnant teenagers and teenage parents, to make sure they finish education and are not housed in isolated independent tenancies.

### Better prevention: sex and relationship education

In July 2000, the Department for Education and Employment issued guidance for Sex and Relationship Education in schools, recognising that there is still "much uncertainty about what sex and relationship education is and how it should be taught". This was the first time that schools had a national framework to support work in this area. The report provides guidance on policy development for sex and relationship education, ways to develop teaching strategies and the setting up of partnerships with parents and the wider community.

### Newcastle and North Tyneside

Co-ordination locally focuses on the establishment of a local profile of teenage parenthood; an audit of local services, including preventative services, as well as availability of suitable child care provision, housing, education, training and employment opportunities; the consultation and involvement of local communities; and the link to other local plans and initiatives.

In Newcastle and North Tyneside the target for reducing teenage pregnancy is 55% by 2010, with a decrease of 15% by 2004. The views, needs and expectations of young people were assessed for the writing up of a ten year strategy<sup>59</sup> which revolves around sex and relationships education in schools, access to contraception and sexual health services, support for young parents, and media campaigns. In each of these areas, a number of gaps have been identified, and action is planned within and in collaboration with schools, communities and professional teams.

## Conclusion

Data on teenage pregnancy, contraception and attitudes to sex in teenagers have not been found to be common place, particularly when only Tyne and Wear (as opposed to the whole nation) was looked at, and were often of qualitative interest only. If programmes are to be developed and implemented and progress monitored, teenage conception rates will have to be established systematically, and as locally as possible if action is to be targeted geographically. As a holistic approach is taken in tackling the problem, qualitative and / or quantitative data will also be needed in a variety of other areas such as contraception use by young people and their views about services provision, their accessibility and their quality. Further information about school sex education and young people's attitudes-towards and understanding-of relationships, peer pressure and, for example, alcohol as well as the care of teenage parents and their children would help the monitoring exercise if collected regularly, centrally and disseminated appropriately. An important and neglected indicator is the proportion of completed teenage pregnancies that are unplanned and those that are regretted/unwanted. Equally, we should not ignore the father's of these pregnancies. Some young people in loving relationships may both be traumatised. In other cases there may have been duress or other perhaps illegal circumstances.

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# **Child Health Information Development Project**

## **Terms of Reference**

To collate information across sectors concerning the health and health outcomes of local children and assess its fitness for the purposes of users

To develop and map a set of exemplar indicators of child health and health outcomes from public services for children across Tyne and Wear

To pilot and evaluate option(s) for improved creation and dissemination of inter-sectoral child health information.

## **Programme of Work**

A series of representative indicators of children's health across the Health Action Zone will be explored in some depth, in particular, for their social differentiation and relationships to indicators of social exclusion.

The exemplar issues chosen are:

- 1 Teenage pregnancy
- 2 Birthweight
- 3 Smoking
- 4 Incidence of serious injury
- 5 Prevalence and severity of handicap in children with cerebral palsy
- 6 Quality Protects

A consultation exercise with a sample of users will examine the fitness-for-purpose and priorities for development across the full range of actual and potential indicators of child health outcomes. An option appraisal exercise will be conducted on potential methods of access to and enhancement of such information sources within and without the Authorities and bearing in mind the requirements of the NHS Information Strategy. Following this exercise the recommended options will be piloted and evaluated using quality indicators, pre-specified by users.

The work is led by Dr Philip Lowe, a senior research associate employed by the University of Newcastle and supervised by Professor Jarvis and Dr Cresswell, former Director of Public Health, Newcastle and North Tyneside. Close links will be developed with the Health Authorities, Local Authorities and Community Paediatricians.

## **Timetable**

**Stage 1:** Collation of data: in-depth studies of 6 exemplar issues with reports.

**Stage 2:** Sample survey of users: Option development, appraisal and reports.

**Stage 3:** Option pilot(s) and evaluation. Reports and recommendations.

For further information please contact Dr Philip Lowe, Tel: 0191 477 6000, Fax: 0191 477 0370 or e-mail: [p.j.lowe@ncl.ac.uk](mailto:p.j.lowe@ncl.ac.uk)

# Teenage Pregnancy Data Issues

## Objective

To enhance existing information relating to teenage pregnancy to enable all interested parties to deliver better services and to focus on those issues that appear to be most relevant locally.

## Method

Contact local teenage pregnancy co-ordinators to obtain data on teenage conception rates, abortions and births  
Consult widely with actual and potential data users to design and pilot an improved information system

## Source(s) of Data

The most important national source of qualitative data is the Social Exclusion Unit's report 'Teenage Pregnancy' published in 1999. An article in Population Trends<sup>33</sup> provided data on conception rates and the proportion leading to abortion in the different countries, regions and local authorities within Great Britain. The Office of National Statistics analysis of abortion and birth statistics (see below) provided further data by Health and Local authorities, as well as by ward in Tyne and Wear. Data collected by the School Health Education Unit in Exeter with the Health Related Behaviour Questionnaire has been mostly used to document teenagers' experience of sex and sex education. Contact has been made with the local teenage pregnancy co-ordinators about local targets and strategies.

## Conceptions Under 18 in 1992-94 and 1995-97 and Under 16 in 1992-97 for each ward in England and Wales - ONS Data

These data cover conceptions which led to maternities or to abortions under the 1967 Act. They do not include conceptions resulting in spontaneous miscarriages during the first 23 weeks of gestation (the incomplete data for these are not collected centrally) nor any illegal abortions.

The date of conception is not collected explicitly. It has been estimated using recorded gestation for stillbirths and abortions and assuming 38 weeks gestations for livebirths.

The woman's age at conception has been calculating by subtracting the date of her birth from the estimated date of conception. In the small number of cases where the woman did not provide her date of birth, a date was imputed from a comparable record.

The figures by local authority relate to the ward of a woman's place of usual residence when the maternity or abortion takes

place, although there is a possibility in the case of some abortions that the informant has supplied a temporary address. No information is available for ward of usual residence at time of conception. The ward boundaries used are those which existed at April 1999.

The number of conceptions for an age group will not match the equivalent number of births and abortions. This is mainly due to the time-lag between conception and birth or abortion. Eg a woman may conceive at age 17 but give birth at age 18 – she will be included in under 18 conceptions but not in under 18 births.

Confidentiality and suppression of small numbers:

To protect the confidentiality of individuals, no separate statistics can be provided about maternities and abortions and suppression of small numbers of conceptions has been necessary where:

- ◆ the count for under 16s or under 18s was 0, 1 or 2;
- ◆ the count for 16 and 17 year olds (calculated by subtraction of under 16s from under 18s) is 0, 1 or 2. For wards where this is the case, the count for under 16 has been suppressed;
- ◆ Suppressed figures can be calculated by subtraction from totals for local or health authorities. In the few local authorities where this is possible, figures for additional wards have been suppressed.

## Data problems

Data on teenage sexual behaviour, use of contraception and pregnancy are scarce, or collected within different institutions (hospitals, family planning clinics, surveys), having various reporting systems and different catchment areas. This made it all the more difficult to draw a comprehensive picture. Socio-economic status and knowledge and attitudes about contraception are rarely collected within medical settings.

*This report has been prepared by Monique Lhussier, research associate in Health Promotion*

## **Annexe 1**

### **Benefits for Teenage Parents**

- ◆ A mother under 16 cannot claim benefit in her own right. However, if her parents are getting Income Support they can claim extra for any grandchildren living with them. Grandparents can also claim Child Benefit.
- ◆ A mother aged 16 or 17 who is living with her parents can claim Income Support of £65.05 a week for herself and her child (figures below are all for mother and child)
- ◆ A mother aged 16 or 17 living on her own can claim Income Support of £74.80 a week.
- ◆ A mother aged 18 and over can claim Income Support of £85.50 a week.
- ◆ A couple both over 18 can claim Income Support of £114.75 a week.
- ◆ Child Benefit is not paid on top of Income Support.
- ◆ Those getting Income Support will get help for their rent and council tax.