Teenage pregnancy: an update on key characteristics of effective interventions
Introduction

It is now widely recognised that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. It is also increasingly clear that socioeconomic disadvantage can be both a cause and a consequence of teenage parenthood.

The Social Exclusion Unit (SEU) was asked by the Prime Minister in 1999 to study the reasons for teenage pregnancies and to develop a strategy to cut the high rates of teenage parenthood in this country. The SEU’s report, Teenage Pregnancy, provides a comprehensive picture of teenage pregnancy in this country. It includes rates and trends, and what is known about the causes of this country’s high rates of teenage pregnancy. Drawing on available research, it summarises teenagers’ knowledge and experience of sex, their knowledge and use of contraception, what happens to pregnant teenagers and how teenagers cope with parenthood. Case studies are included in the report, chosen for showing promise in sex and relationships education (or PSHE), improving access to contraception, supporting teenage parents and their children, and developing local and national initiatives. Finally, a 30-point Government Action Plan is set out, with two main goals:

• Reducing the rate of teenage conceptions, with the specific aim of halving the rate of conceptions among under 18-year-olds by 2010;
• Getting more teenage parents into education, training or employment to reduce their risk of long-term social exclusion.

The Teenage Pregnancy Unit at the Department of Health was set up a year later to take this strategy forward. The Health Development Agency (HDA), launched in April 2000, has a remit to work in partnership with key organisations and individuals to improve public health and tackle health inequalities. One of its core functions is to establish and maintain evidence of what works in practice and to disseminate practical guidance on public health interventions.

This bulletin, produced by the HDA, brings together current knowledge about the key characteristics of successful interventions and programmes for young people which aim to reduce the rate of teenage pregnancies. It draws on available research evidence, which includes systematic reviews of effectiveness, reviews of good practice, literature reviews, and single research and evaluation studies. It also highlights approaches which appear to be promising from the research so far, and where evaluation is ongoing.

After a short section on the target audience, the discussion about ‘what works’ is divided in terms of community interventions, educational interventions and health service interventions. Promising approaches are then presented. These are approaches which have not yet been conclusively evaluated but, from research published so far, show promise. Finally, some recommendations are made for practice.

This bulletin is substantially based on an earlier review carried out by Jane Meyrick and Catherine Swann for the Health Education Authority.

Young people – who are they?

‘Young people’ are a very diverse social group whose beliefs, values, attitudes, expectations and behaviours differ widely, reflecting individual knowledge and experience and an infinite range of social and cultural influences. Young women and young men behave differently, have different needs and therefore require different intervention approaches, as do young people from different socioeconomic and cultural backgrounds. This diversity represents a challenge for the design of effective health and education interventions.

... and what do they need?

For most of us, sexual relationships are an accepted – indeed expected – dimension of adult life. In making the transition from child to adult, all young people need to learn about:

• the nature of relationships, sex and sexual behaviour;
• sexually transmitted infections (STIs) and safer sex;
• conception and contraception;
• pregnancy, and pregnancy outcomes and options;
• parenting skills and parental responsibility.

In addition, they need to develop the confidence and interpersonal skills to be able to act on this knowledge. Although there remains a belief in some quarters that promoting sexual health and responsibility also promotes sexual activity, there is no research evidence to support this assumed relationship.
Young people need practical information that will enable them to take responsibility for their own health and to share responsibility for other people’s health. All young people, and particularly those identified as being most vulnerable, need support in gaining access to services and other resources and in using these effectively.

The importance of the ‘message’

To be effective, interventions across the different settings must have a clear and consistent value message which is relevant to the local context and is acceptable to young people. The ‘wrong’ message can undermine the credibility and success of the intervention. For example, the message ‘do not have sex’ excludes young people who are, or who have been, sexually active, has a limited life-span and could conflict with other interventions aiming to promote safer sexual behaviours. As yet, there is no evidence to show that abstinence-only programmes delay the onset of intercourse.8,9 Using this example, an inclusive value message which promotes self-determination and respect for others, such as ‘it’s OK to say no’, is likely to be more acceptable and more sustainable into adult life.

There is a great deal of evidence from research that ‘cultural openness’, where sex is discussed in an open and accepting manner rather than being ambivalent, or the way in which young people’s sexuality and sexual behaviour is socially represented and communicated, has a considerable impact on the effectiveness of local and national interventions.10

Gender

Research highlights the different social meanings that sex and contraception may have for young men and young women, and the influence of these social meanings on behaviour.8,9,10 This may also vary between social classes. When designing interventions for young women or young men, or both, these issues, together with a local needs assessment, must be taken into account so that the intervention is appropriate for the target audience. For example, some research suggests that young men should be targeted with separate clinic provision.

Vulnerable groups

Research evidence suggests11 that interventions that are tightly focused, targeting one particular vulnerable social group, are likely to be effective. In most locales, vulnerable young people – those most exposed to risk and/or most susceptible to adverse outcomes – will include:

- young people living in deprived areas;
- young people who do not attend school;
- young people who are looked after by, or who are leaving, local authority care services;
- young people who are homeless;
- young people who are the children of teenage parents;
- young offenders.

Little is known about the needs, attitudes and access to services of young people from some minority ethnic groups, particularly those who also fit into the categories above. The most vulnerable young people are also likely to be the most difficult for service providers to reach; collaborative, multi-agency interventions are likely to be most effective.11 A first step must be to assess the local needs of these vulnerable groups.

A ‘stepwise’ approach to prevention goals has been recommended:12 intervening before the onset of sexual activity; preventing unintended conception, supporting decision-making relating to conception; preventing adverse outcomes of pregnancy and adverse outcomes of early pregnancy.

What works? Research findings and implications for practice

‘What works’ in preventing teenage pregnancy can be grouped in a number of ways. Given the wide variety of programmes, differing in intensity, duration, components, approaches, age and situation of the target population, it is not always possible to draw firm conclusions, but it is possible to outline the characteristics or common components of effective programmes and to identify promising approaches.4

Some aspects of young people’s behaviour can be successfully addressed through risk-reduction interventions. Patterns of behaviour that arise from wider ‘structural’ forces, such as socioeconomic disadvantage and social exclusion, may be more difficult to address in a service setting, although these factors are likely to be key in effecting long-term change. However, interventions to improve the quality and responsiveness of services with the aim of preventing adverse outcomes demonstrate effectiveness. General anti-poverty strategies are likely to have a longer term influence on conception rates,13,14 but teenage pregnancy and parenthood is a highly complex area and recent evidence15,16 indicates that programmes to address it need to be multi-faceted, addressing the individual, social and economic factors involved.

Wider community interventions

Evidence from other European countries (notably Norway, the Netherlands and Greece) shows that where efforts by different agencies in different sectors work in unison (for example co-ordinated improvements in contraceptive service provision, sex education in schools, and policy and law reforms) there have been major improvements in teenage conception rates in recent decades.6 Collaborative, multi-agency programmes involving schools, community groups and family planning clinics are being established, and show promise.14

The methodology to evaluate community-wide interventions is still being developed.11 It is difficult, for example, to isolate which components may have had the greatest effect. However, it has been found in the USA that it is common for effective programmes to use multiple approaches (for example skills development, community outreach, contraceptive access, contraceptive education, life-option enhancement, self-esteem and sexuality/STI/HIV/AIDS education) and to use several methods of delivery, including group discussions, lectures, role playing, videos, peers as educators and involvement of parents.5

It is important for multi-component programmes to deliver a consistent message through school, the media and health services.

Knowledge and skills

Some aspects of young people’s behaviour can be successfully addressed by risk-reduction interventions which seek to improve knowledge, and to provide support to develop the skills that are needed to use this knowledge within relationships and in social situations.

Designing educational interventions

Most parents and young people expect to receive information about sexuality through schools. A review of reviews carried out by the Medical Research Council shows that school-based sex education can be effective in reducing teenage pregnancy, especially when linked to access to contraceptive services.1 It can reach most young people under the age of 16 and can be associated with delay in first intercourse and increased condom and other contraceptive use.13,17 A review of the most reliable evidence shows that school-based sex education does not increase sexual activity or pregnancy rates.6

A review of effective sex education programmes in the USA showed that they shared nine important characteristics. They:

1. Focus clearly on reducing one or more sexual behaviours that lead to unintended pregnancy or STI/HIV/AIDS infection;
2. Incorporate behavioural goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of students;
3. Are based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviours;
4. Allow sufficient time for presentation of information;
5. Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse;
6. Use a variety of teaching methods designed to involve the participants and help them personalise the information;
7. Include activities that address social pressures related to sex;
8. Provide models of, and practice in, communication, negotiation and refusal skills;
9. Select teachers or peers who believe in the programme and then provide them with training, which includes practice sessions.

(Effective Programs and Research Task Force of the National Campaign to Prevent Teen Pregnancy)3

The best available evidence11,16 also suggests that successful approaches to school-based risk-reduction interventions are:

- timely – initiated early, before patterns of behaviour are established (one large-scale survey in this country found that two-thirds of the population thought they should have been better informed about sex before they started being sexually active);2 In July 2000 the DfEE issued guidance to all schools, including primary

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schools, recommending that they should have an age-appropriate sex and relationships education programme which is rooted in the PSHE framework;16

• positive – about young people, about sex and sexuality, and about young people’s relationships;

• integrated – education about sexual and reproductive health issues is planned and delivered as a comprehensive and cohesive programme, with strong links between services and ‘joined-up’ service planning and provision. Effectiveness has been clearly demonstrated when school sex education is linked with local contraceptive services;

• practical – up-to-date information about local contraceptive and sexual health services is included (what is available, when and where, who can use the service, how to get there);

• set in a social context – activities are designed to address gender issues, social and cultural stereotypes and power inequalities;

• needs-led – content, approach and direction are determined by what young people say they need.

Two ongoing sex education projects in Britain are currently being evaluated: SHARE (Sexual Health and Relationships: Safe Happy and Responsible) is a teacher-led approach which involves extensive training of teachers, draws on educational theories and practices, and incorporates existing expertise and skills alongside research into young people’s behaviour.20

RIFFE involves young people as educators and is being implemented in secondary schools in Central Southern England.21

Health service interventions

A review of reviews has established that increasing the availability of contraceptive clinic services for young people is associated with reduced pregnancy rates.22 Research shows that availability of youth-based contraceptive services in a locality is associated with lower conception rates.11

The best available evidence suggests that successful service interventions will be those which improve the quality of provision in the following areas:1,15,59

• awareness – promotional materials should accurately describe the services available and must be needs-based, that is specifically designed for and effectively disseminated to local young people;

• acceptance – policies, practices and staff attitudes should be non-judgemental, friendly and supportive of young people’s choices;

• flexibility – young people should be able to attend with friends and should be able to access a wide range of services without having to make an appointment;

• ‘time to talk’ – access to a trained counsellor or health advisor should be routinely available for young people who wish to discuss any health and relationship issues;

• targeted for boys and young men – to increase uptake.

The Teenage Pregnancy Unit has provided guidance on the provision of effective contraception and advice services for young people built up from the available research evidence and what is known of best practice.21

Bridging the gap – aiming for a seamless service

Building links between specialist services and improving access to them (for example, by reviewing opening hours to make them more accessible to young people) is also a key recommendation of many current research reports. Wider links (for example, through the provision of information) to services, or ‘joined-up’ services for young people that address social exclusion, may also be beneficial, and may help to tackle the wider causes and consequences of unwanted and unintended conceptions.

Research evidence21 suggests that ‘joined-up’ services, offering a variety of services between them, are more likely to meet the needs of young people, and so are more likely to be effective than isolated service specialisms. Taking practical steps to close the gap between education and health has also been shown to be effective in reducing the risk of a young pregnancy. Successful initiatives have included:

• involving health service staff in the delivery of sex education programmes and activities to familiarise young people with clinic staff and processes;

• making arrangements so that school nurses or other members of staff can book appointments with a local service provider for young people who need emergency contraception;

• providing a clinic on school premises to promote access to information, advice and methods;

• organising school group visits to local clinics to improve accessibility and boost confidence.

Promising approaches

Integrated campaigns

Evidence from Europe and America suggests that campaigns that are designed to address AIDS/HIV and other STI prevention are effective in increasing condom use, and can delay the initiation and reduce the frequency of sex,11 and therefore can enhance efforts to reduce unintended pregnancy. In general, there is no evidence that making condoms available as one part of a campaign either hastens or increases sexual activity.6,10

The role of parents

Recent research has shown that communication with parents is associated with a delay in the age of first intercourse, and can improve the acceptability and use of contraception. It has been shown too that the way sexual issues are discussed with children is as important as what is said, for example discussing issues rather than dictating behaviour. If parents are able to discuss sexual matters with their children in a skilled and comfortable manner, it may help their children to discuss sex with their peers.15,16 There is scope for providing support for parents to equip them with the knowledge and skills to discuss sexual health issues with their children. This could be done in a number of ways (leaflets, videos, parenting classes, etc.) but especially in conjunction with school sex education programmes.21

Youth development programmes and life options

The aim of these programmes is to tackle the education and life options of young people (school performance, belief in the future and general risk-taking behaviour) and they can, for example, equip young women in particular with the communication skills to negotiate about sexual intercourse and contraception, and with motivation to delay early intercourse and childbirth. At the family and community level, they address ‘nonsexual risk factors’ – poverty, social disorganisation and isolation. These have been effective in reducing actual rates of teenage pregnancy and childbirth.15,18 There is still more to be learnt about the ways in which they have an impact, and the long-term impact on different ethnic groups. However, results from research studies so far are promising.1,14

Interventions to improve life chances through improving the learning skills and confidence of children as young as those of pre-school age have been shown to reduce the chance of those children becoming teenage parents over a decade later,19 as has day care for pre-school children in the USA.27

Peer education

Peer education is a popular method of working with young people, especially those more vulnerable or socially excluded and where a topic might be ‘sensitive’. In simple terms, peer education is young people imparting information to others of a similar age. It is not a new approach and there is considerable variation in the way it is used (such as one-off sessions, theatre presentations and conferences).

Peer education has been used in school settings. One example is the A PAUSE programme which combines input from teachers, peers and health professionals. Initial results indicate that the programme delayed the age of first intercourse and increased knowledge about sex, contraception and STIs.11 However, the effectiveness of peer sex education has not been extensively researched, so the results of the A PAUSE and RIPPLE evaluations will be a valuable contribution.

One review found some evidence to support the effectiveness of delivered health promotion for young people.20 Peer education can be an effective strand in a multi-component programme.5

The review points to some common characteristics of effective peer health education. The peer educators received specialist training which took place over some time and which covered knowledge acquisition, skills development and some teaching/classroom management skills. Successful projects appear to be fairly small and focused on clear outcomes with clearly stated aims and objectives.

Emergency contraception

Increased availability of emergency contraception ‘over the counter’ has potential to reduce unintended teenage conception. Pilot schemes being carried out in two Health Action Zones (in Manchester and London) are being evaluated. It should be possible to see the long-term impact on teenage conception rates.
Recommendations

The provision of sex education should be linked to access to contraceptive services; for example, health service staff could lead sex education sessions given in schools to provide a ‘bridge’ into services. All interventions on sex education, including school-based programmes, should aim to empower young people, promoting sexual self-acceptance and a positive and open view of sex and sexuality with young people and service staff working with them (taking cultural differences into account).

Sustained programmes should:

• when focusing on a single aspect of sex education, such as information about contraception, provide links to relevant support services (for example family planning services);
• be clearly thought through, based on theory (for example social learning theory used in peer education), evidence of effectiveness and local needs assessment;
• improve mainstream provision, as well as identify and target local vulnerable groups, such as school non-attendees or teenagers in low-income families;
• know and use the local context to inform work;
• include active learning techniques, such as group work, discussion and role play;
• address the social and media issues about sex, contraception and pregnancy;
• be in place before young adolescents become sexually active;
• reinforce value messages such as ‘permission to say no’.

Service provision could be improved within traditional settings (including better access to emergency contraception) and expanded to include dedicated young people’s services meeting local needs. Agencies working with young people could work towards integrating services, and ensure that links with a variety of service areas (for example STIs, HIV/contraception, general health) and support are in place.

As well as providing accurate and targeted information, programmes could include discussion of the positive aspects of young people’s relationships and sexualities. Again, cultural sensitivity is important.

Programme and service staff, including front-line staff, should have adequate training, and be recruited for their dedication and enthusiasm for working with young people, and their ability to deliver services without personal judgement.

References


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