Public Health England

Local Government Association

Teenage Pregnancy Prevention Framework

Supporting young people to prevent unplanned pregnancy and develop healthy relationships

Executive summary

Over the last 18 years the under-18 conception rate has fallen by over 60% with all councils achieving reductions, but inequalities remain. There is an seven-fold difference in the rate between local authorities and 60% of councils have at least one ward with a rate significantly higher than England. Sustaining and accelerating progress is integral to improving wider outcomes for children and young people, particularly the most vulnerable, and reducing long term demand on services.

The international evidence is clear. Building the knowledge, skills, resilience and aspirations of young people, and providing easy access to welcoming services, helps them to delay sex until they are ready to enjoy healthy, consensual relationships and to use contraception to prevent unplanned pregnancy. Central to success is translating the evidence into a multi-agency whole system approach.

This Framework is designed to help local areas assess their local programmes to see what's working well, identify any gaps, and maximise the assets of all services to strengthen the prevention pathway for all young people. It is being used in a variety of ways: to review actions across a whole area, to focus on high rate districts or wards or to strengthen a specific aspect of prevention, for example relationships and sex education in advance of statutory status in all schools from September 2020. A self assessment checklist is provided for councils to collate a summary of the current local situation, and identify gaps and actions.

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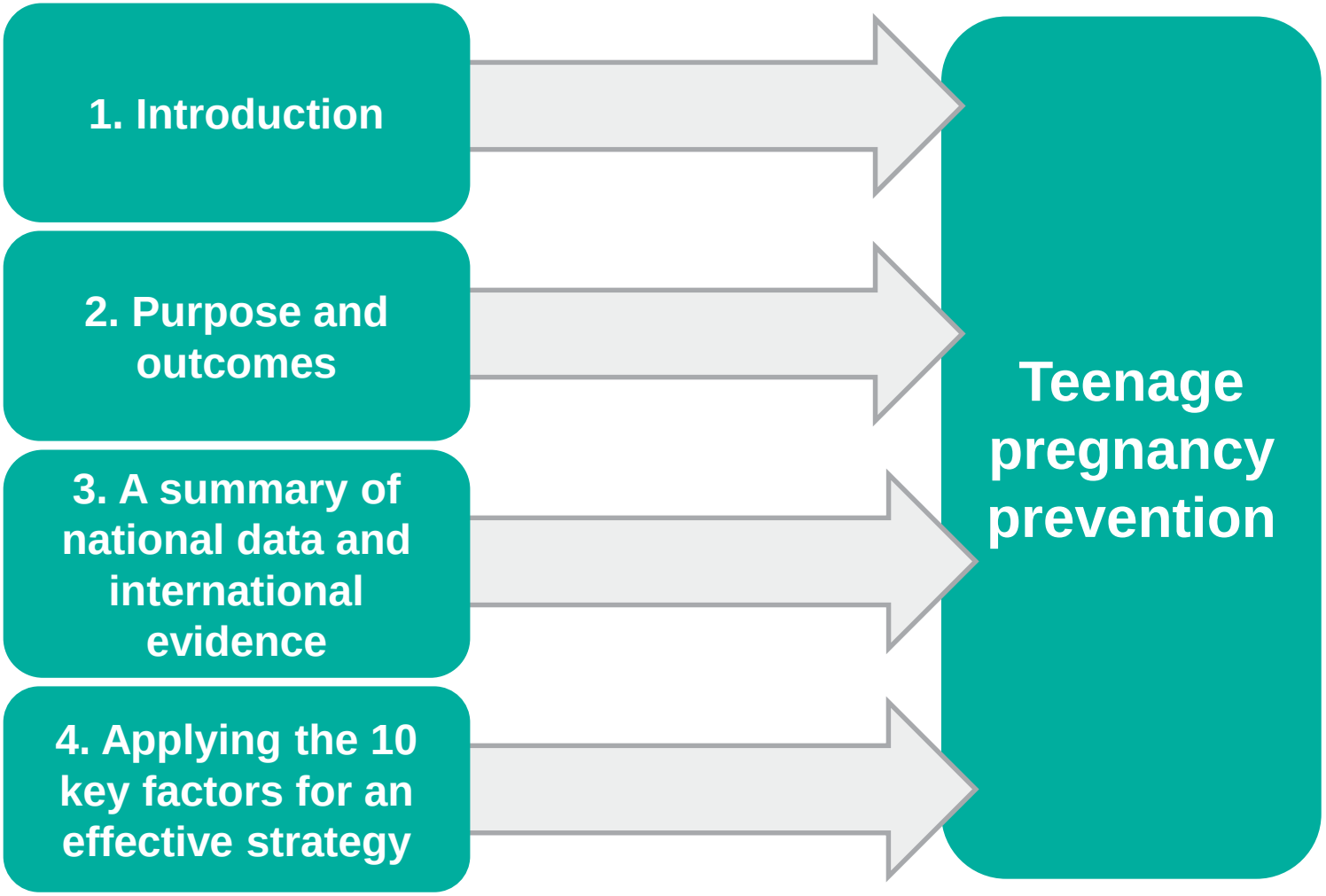
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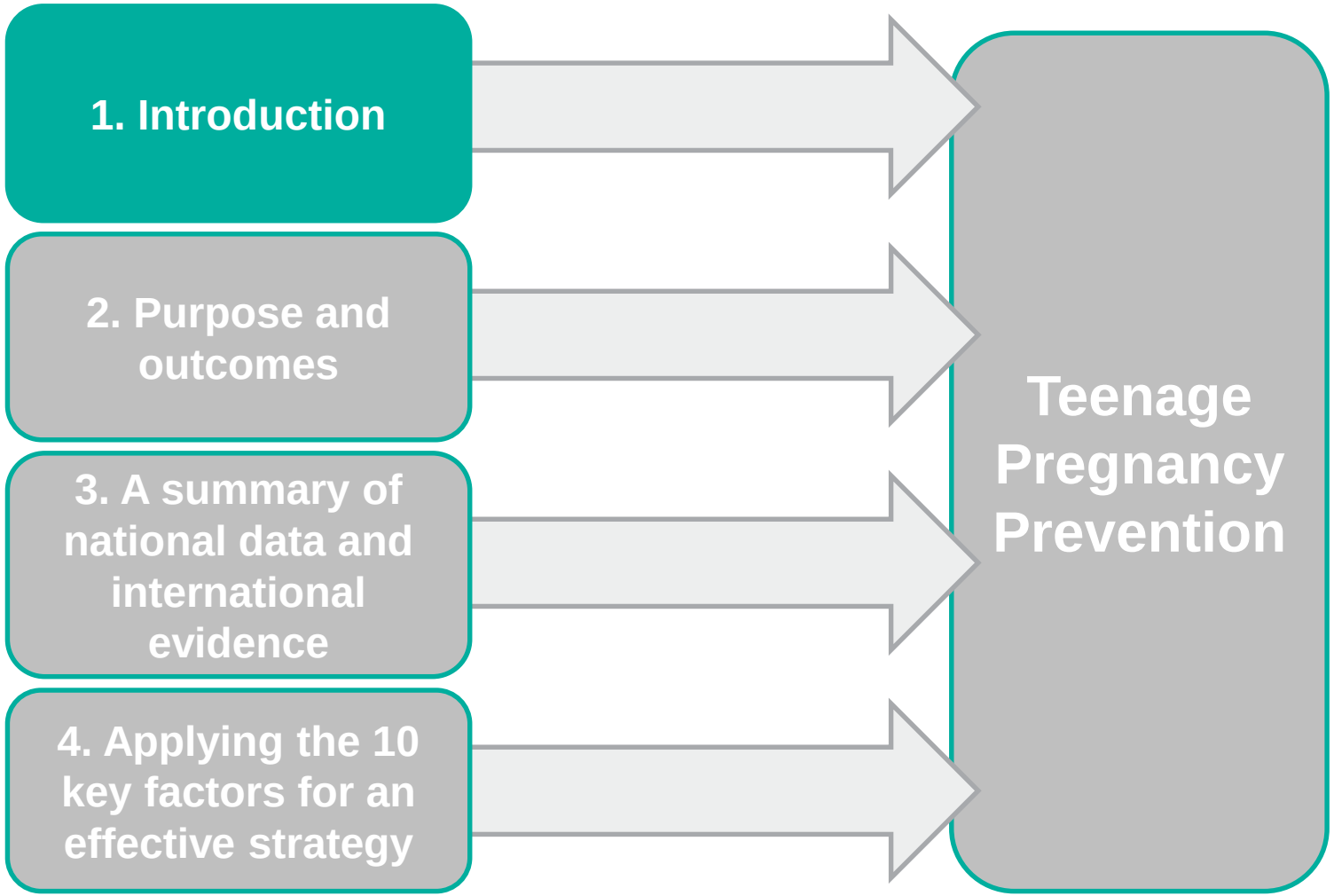
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Introduction: good progress, but more to do…

Over the last 18 years there has been significant progress on teenage pregnancy. The under-18 conception rate has fallen by 62% and the under-16 conception rate by over 65%. Both are now at the lowest level since 1969 [1].

Inequalities have also been reduced. The biggest declines have been in areas with the highest level of deprivation and the proportion of young mothers in education or training has doubled [2].

This has been achieved through a long term evidence based teenage pregnancy strategy, delivered with concerted effort by local government and their health partners, and recognised by WHO as an exemplar for other countries [3]. However, despite this success, a continued focus is needed.

Young people in England still experience higher teenage birth rates than their peers in Western European countries [4], teenagers remain at highest risk of unplanned pregnancy [5], inequalities in rates persist between and within local authorities [6], and outcomes for young parents and their children are still disproportionately poor [7], contributing to inter-generational inequalities.

Sustaining the downward trend and making further progress is one of the key objectives of the Department of Health's Framework for Sexual Health Improvement in England [8]. Preparation for statutory relationships and sex education in all schools in 2020 [9], provides a key opportunity to strengthen support for young people to develop healthy relationships and prevent early unplanned pregnancy.

Introduction

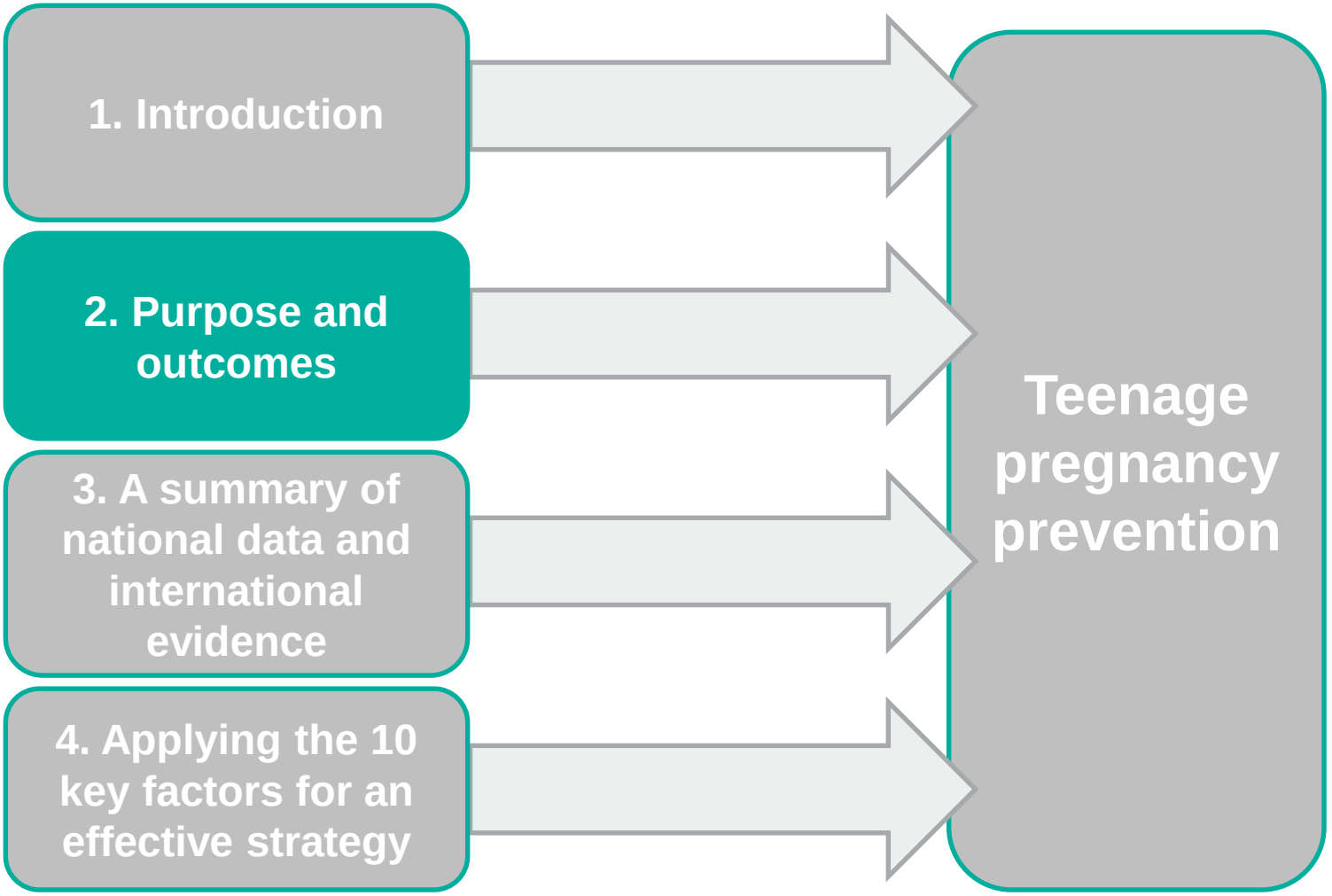
The international evidence for reducing teenage pregnancy is clear [1,2,3]. Building the knowledge, skills, resilience and aspirations of young people and providing easy access to welcoming services, helps them to delay sex until they are ready to enjoy healthy, consensual relationships and to use contraception to prevent unplanned pregnancy. An open culture and ease of parental communication around sexual issues are also associated with lower teenage pregnancy rates [4].

The learning from the last 20 years has shown that partnership working is vital. For effective local delivery, health, education, social care and safeguarding agencies need to understand the relevance of healthy relationships and teenage pregnancy to their own priorities, and how they can contribute to the solution.

In the same way that effective relationships and sex education needs a 'whole school' approach to provide a positive and supportive environment outside the classroom [5], and building young people's resilience needs a family, community and service response [6], prevention of teenage pregnancy also requires a whole system approach. So there is no 'wrong door' for a young person seeking advice. Having a trusted adult to turn to on personal issues is protective for young people on a number of health and emotional outcomes [7,8].

The 10 key factors for an effective strategy, described in this Framework, provide the structure for a collaborative whole system approach.

Translating evidence into a 'whole systems' approach: 10 key factors of effective local strategies [1]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The purpose of the Framework

The Framework is informed by the most up to date international evidence on preventing early pregnancy and the learning from the Teenage Pregnancy Strategy on how to translate the evidence into a whole system approach. Applying the 10 key factors for an effective strategy has been key to reducing rates [1,2] and continues to be relevant in the current commissioning landscape.

The Framework is designed to help local areas review their local programmes to see what's working well, identify any gaps, and help maximise the assets of all services and practitioners to strengthen the prevention pathway for young people. It is a companion document to the multi-agency 'Framework for supporting teenage mothers and young fathers', published by PHE and LGA in 2016 and updated in 2019 [3].

The Framework can be used flexibly according to each local area's need. This might be a review of the whole local authority programme, or of the prevention work in smaller geographical areas with high rates. It can also be used to explore one or more of the 10 key factors. For example, targeted support for young people at risk, or RSE in preparation for statutory status in 2020.

The Framework provides a short summary of each of the 10 factors, key questions to be considered, and links to relevant policies and helpful resources.

A self assessment checklist has been produced to collate a summary of the current situation, identified gaps and SMART actions. As the Framework requires a whole system multi-agency approach, completion of the self assessment will require input from different partners in the council. This might be done through a dedicated workshop with relevant leads.

The self assessment checklist is available for download.

The contribution of teenage pregnancy prevention to wider outcomes

Supporting young people to develop safe, healthy relationships and prevent unplanned pregnancy is key to enabling them to fulfil their aspirations and potential.

At a strategic level, getting prevention right:

- is integral to safeguarding, emotional health and wellbeing and early help
- integrates with Chlamydia screening and STI prevention
- maximises cost effectiveness of sexual and reproductive health services
- is key to giving every child the best start in life
- breaks inequalities
- helps address young people's alcohol and substance misuse
- reduces future demand on health and social services
- contributes to Public Health and NHS Outcomes

Laying the foundations of prevention for children and young people will also contribute to reducing later unplanned pregnancy and its associated poorer outcomes. Teenagers are the group at highest risk of unplanned pregnancy but the greatest number occur in women aged 20 to 34 [1].

How progress on prevention of teenage pregnancy contributes to Public Health and NHS outcomes

Under-18 conception rate
Reduction in first and subsequent pregnancies contributes to improving outcomes.

Stillbirth
30% higher rate for children born to women under 20.

Incidence of low birth weight of term babies
30% higher rate for babies born to women under 20.

Infant mortality rate
60% higher rate for babies born to women under 20.

Smoking status at time of delivery
Mothers under 20 are 3 times more likely to smoke throughout pregnancy.

Breastfeeding prevalence at 6 to 8 weeks
Mothers under 20 are half as likely to be breastfeeding at 6 to 8 weeks.

Maternal mental health
Mothers under 20 have higher rates of poor mental health for up to 3 years after birth.

Child development at 2 to 2½ years
Parental depression is the most prevalent risk factor for negative impact on poor child development outcomes; children of teenage mothers are more likely to have developmental delays.

Rates of adolescents not in education, employment or training (NEET)
An estimated 12% of 16-17 year old females recorded as NEET was a teenage parent

Public Health England

Addressing teenage pregnancy saves money: £1 spent saves £4 [1]. For every £1 spent on contraception, £9 is saved [2]

Safeguarding

For every child prevented from going into care, social services would save on average £65k per year
Every domestic violence incident prevented saves police, local authorities, the Criminal Justice System and the NHS £2,700

School readiness

Every child who is 'school ready' who would not otherwise be - saves schools £1,000 per year

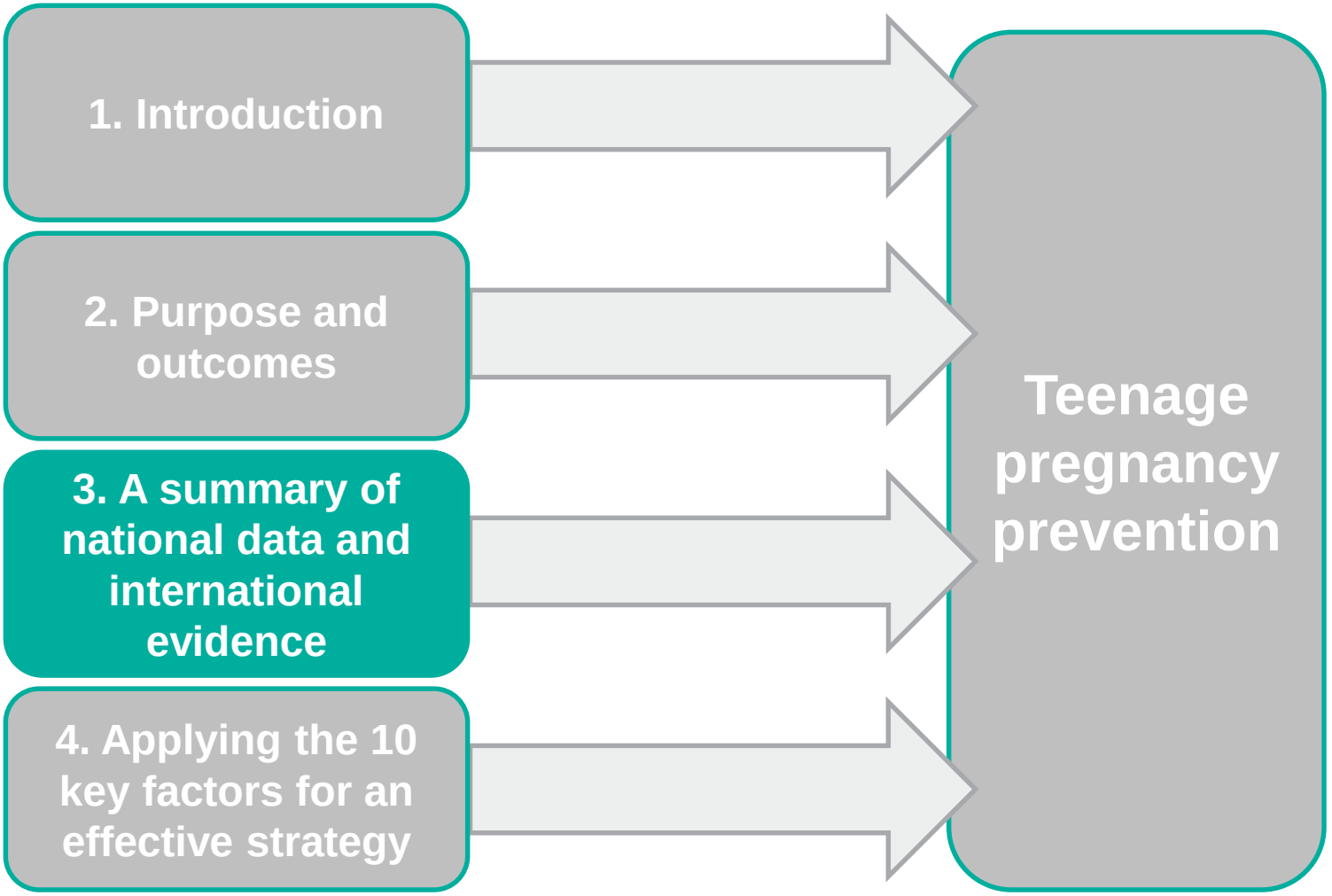
EET

Every teen mum who gets back in to Education, Employment and Training (EET) saves agencies £4,500 per year

Mental health

For every individual who does not develop a mental health issue saves a local authority £2,000 per year

Acknowledgement: Family Nurse Partnership National Unit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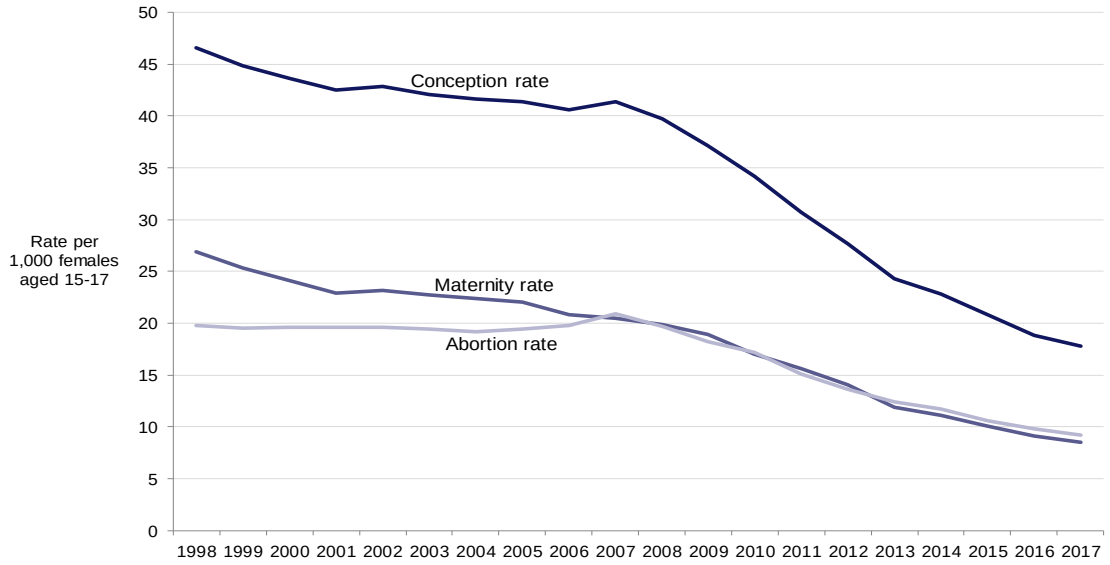
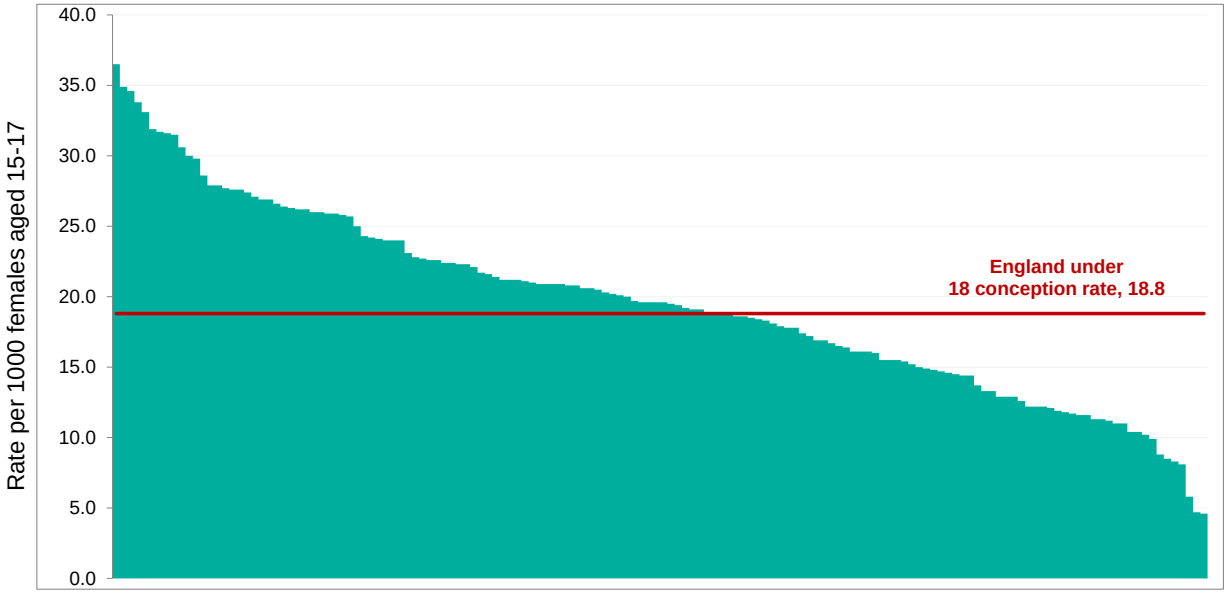
A 61.8% national decline since 1998, but significant local variation



In England the under-18 conception rate has reduced by 61.8% between 1998 to 2017.

There remains significant variation in under-18 conception rates between local authorities in England: each bar represents one local authority's data in 2017.



The range of under-18 conception rates (2017) across 150 local authorities in England

The international evidence for reducing teenage pregnancy

High quality relationships and sex education sex, reflecting the key effectiveness factors [1,2]:

- a comprehensive, inclusive programme with timetabled slots on the curriculum every year and age appropriate content
- trained educators
- medically and factually accurate information
- promoting core values: equality, consent, mutual respect
- participatory and small group work
- partnerships with parents and carers

Combined with the use of effective contraception, provided through accessible, youth friendly services [3].

86% of the decline in the US teenage pregnancy rate is attributed to improved contraceptive use [4].

The wider protection of effective relationships and sex education [1,2]

Young people who report receiving RSE are more likely:

- to delay first sex
- to experience first sex which is consensual and to have a smaller age gap with their partner - a large age gap is associated with intimate partner violence
- to be aware of, or report sexual abuse
- to protect first sex with contraception and condoms

Young women and men who cite school as their main source of RSE are:

- less likely to contract a sexually transmitted infection
- young women are less likely to be pregnant by 18 and to experience an unplanned pregnancy in later life

The ingredients of young people friendly services*[1,2]

1. Involving young people in their care and in the design, delivery and review of services
2. Explaining confidentiality and consent
3. Making young people welcome
4. Providing high quality health services
5. Improving staff skills and training
6. Linking with other services
7. Supporting young people's changing needs

* These 7 proposed You're Welcome standards have been developed with young people and piloted in a range of services, as part of a project supported by PHE, NHS England and the Department of Health.

Proportionate universalism: the importance of universal and targeted support

All young people need comprehensive RSE and easy access to services to develop healthy, consensual relationships, prevent unplanned pregnancy and protect their sexual health.

Two thirds of young people don't have sex before 16 but by age 20, 85% of young people will have experienced vaginal intercourse [1].

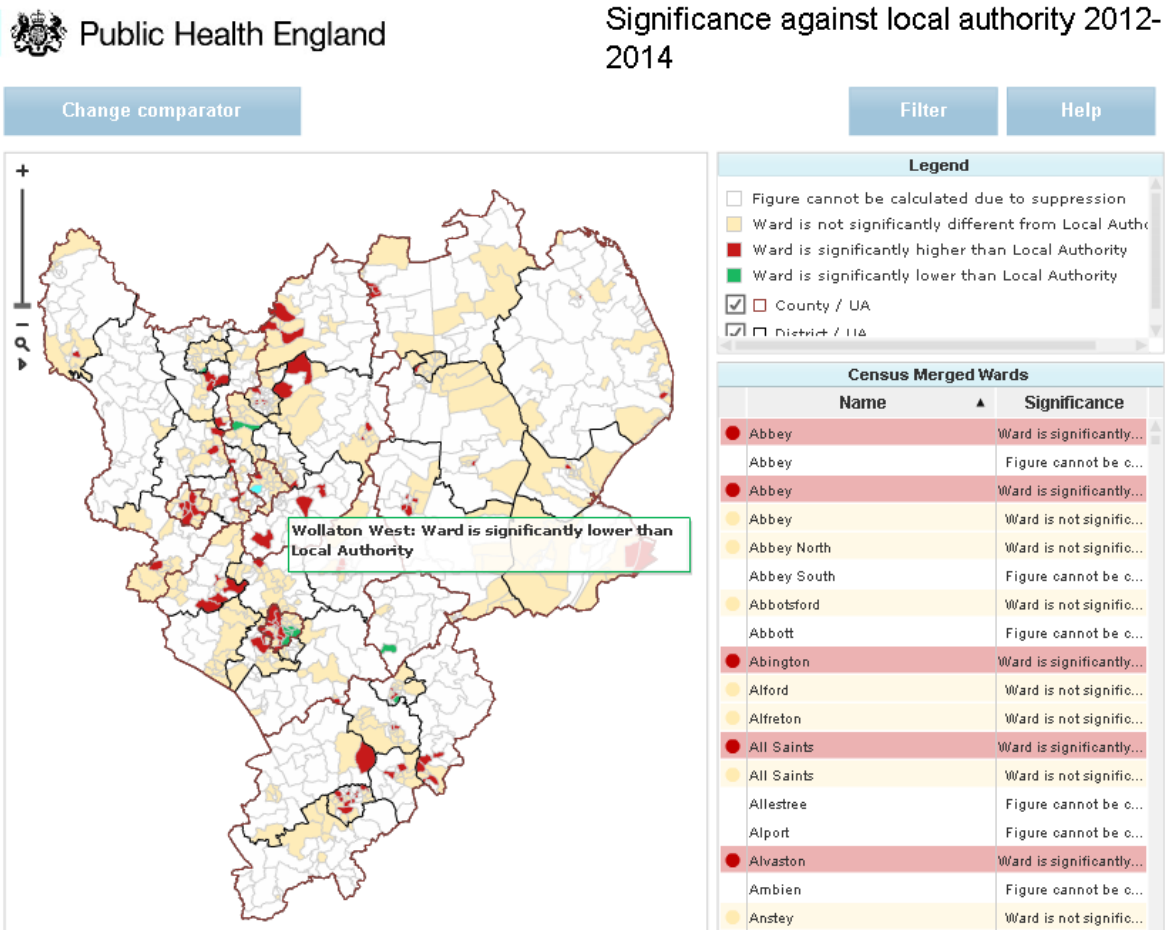
A teenage pregnancy prevention strategy that seeks to reduce conception rates by a substantial margin cannot concentrate on high risk groups alone [2].

Some young people will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration – providing the means and the motivation to prevent early pregnancy [3].

Reaching young people in need of greater support involves looking at ward data, raising awareness of associated individual risk factors for early pregnancy and prioritising prevention in schools, colleges, alternative education provision and services looking after young people most at risk.

Looking at the under-18 conception ward data

60% of LAs have at least one ward with a rate significantly higher than the England average; 45% of LAs have at two or more [1]



Illustrative example only

Individual risk factors associated with young women experiencing pregnancy before 18

Free school meals eligibility: a poverty indicator.

Persistent school absence by year 9 (aged 14).

Slower than expected academic progress: between ages 11-14 [1].

First sex before 16: associated with higher levels of regret and no contraceptive use [2].

Looked after children and care leavers: approximately 3 times rate of motherhood<18 [3].

Experience of sexual abuse and exploitation [4].

Lesbian or bisexual experience: young lesbian or bisexual women are at increased risk of unplanned pregnancy [5].

Alcohol: associated with under 18 conception and STIs, independent of deprivation [6]. One in 12 young women under 20 accessing drug and alcohol services are either pregnant or a teenage mother [7].

Experience of a previous pregnancy: 12% of births to under 20s are to young women who are already mothers; 10% abortions to under 19s are to young women who have had one or more previous abortions [8].

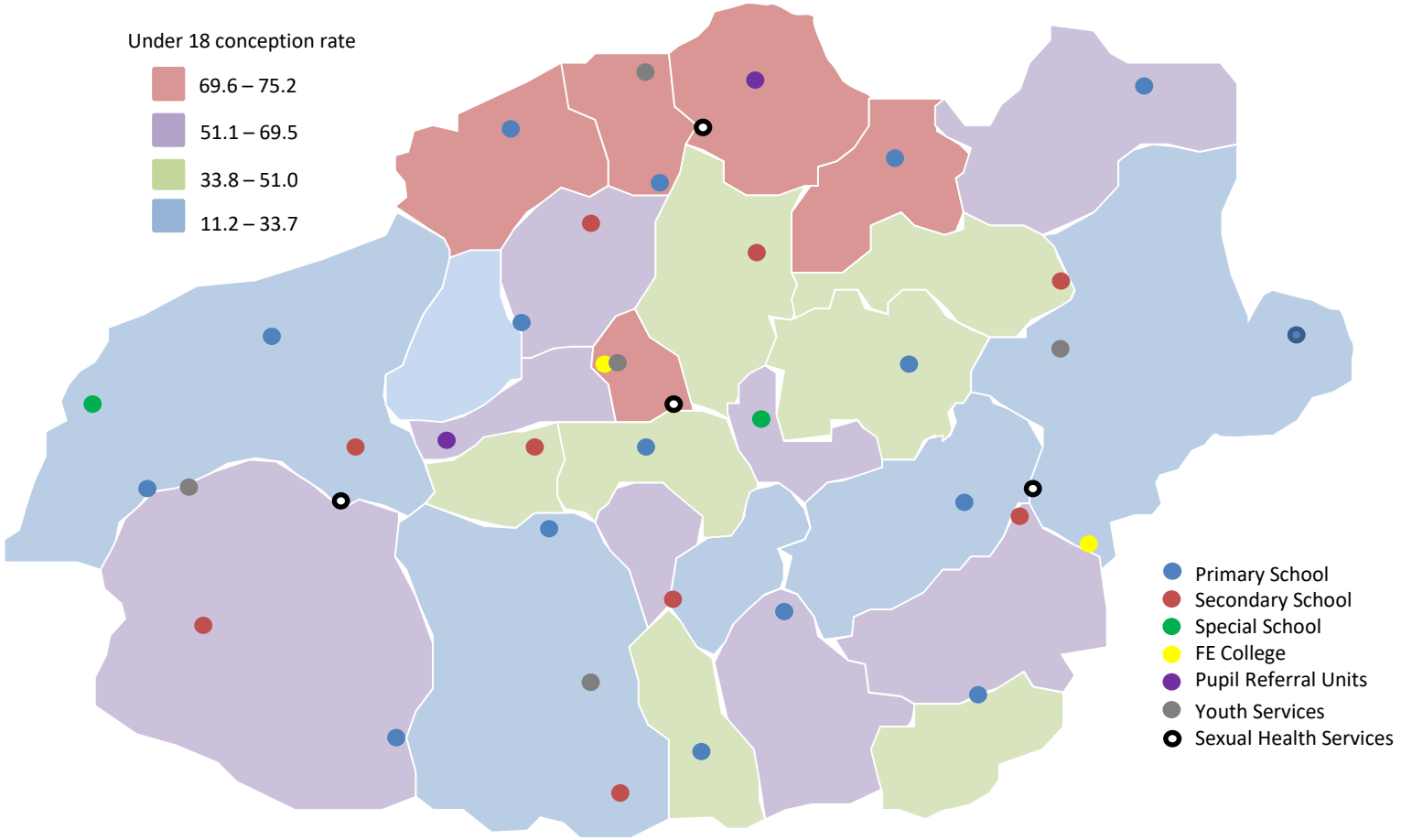
As with **Adverse Childhood Experience** analysis, young people who have experienced a number of these factors will be at significantly greater risk [9].

Individual risk factors associated with young men experiencing fatherhood

Young fathers are more likely than older fathers and than other young men to [1]:

- have been subjected to violent forms of punishment at home and are twice as likely to have been sexually abused
- have pre-existing serious anxiety, depression and conduct disorder
- have poor health and nutrition
- drink, smoke and misuse other substances [2] : 1:6 young men under 25 accessing drug and alcohol services are young fathers [3]

Mapping the prevention pathway around where young people most at risk live their lives



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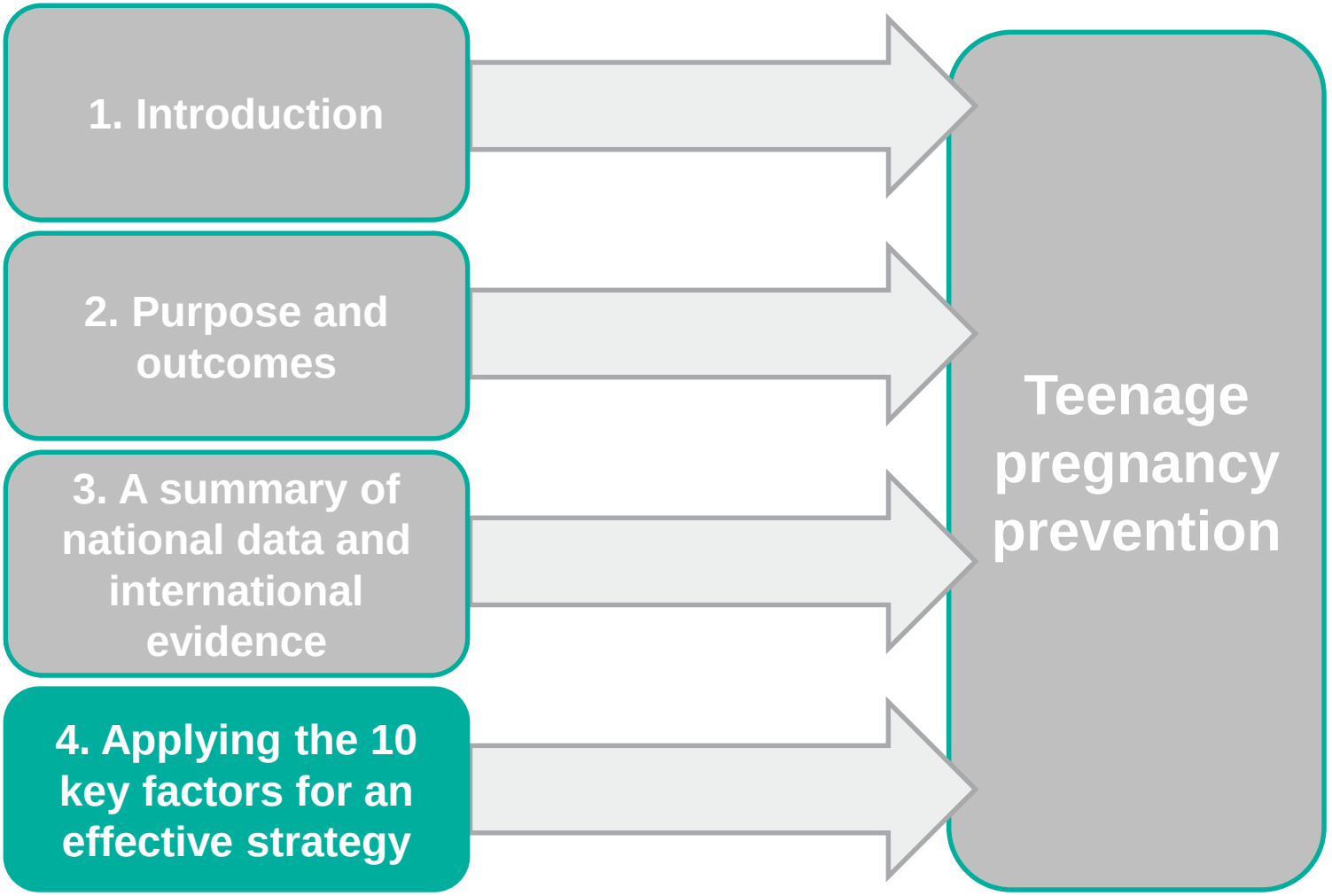
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Translating evidence into a 'whole systems' approach: 10 key factors of effective local strategies [1]

Reviewing the 10 key factors

It is clear that system-wide multi agency approaches are required to tackle teenage pregnancy and there are a range of opportunities to maintain and strengthen local delivery.

The following slides* provide a short summary of each of the 10 factors, key questions to be considered, and links to relevant policies and helpful resources. These can be used flexibly according to each local area's need. This might be a review of the whole local authority programme or the prevention work in smaller geographical areas with high rates. They can also be used to explore one or more of the 10 key factors. For example, targeted support for young people at risk, or RSE in preparation for statutory status in 2019.

To support local engagement a self-assessment checklist (based on the 10 key factors for addressing teenage pregnancy) has been produced to be used alongside the framework. The self-assessment checklist is designed to enable local areas to identify current good practice, address gaps in the response to reducing under-18 conceptions, and support a local coordinated approach. As the Framework requires a whole system multi-agency approach, completion of the self assessment will require input from different partners in the council. This might be done through a dedicated workshop with relevant leads.

The self assessment checklist is available for download.

Further information can be found on PHE Fingertips that provides local authority teenage pregnancy reports, data and information and the Teenage Pregnancy Knowledge Exchange that provides a national source of expert knowledge and advice on all aspects of teenage pregnancy.

***** References for the content of the following slides can be found in the introductory section.

1. Strategic leadership and accountability

Summary

Strategic leadership and accountability have been central to success in those areas with the highest reduction in under 18 conception rates.

A successful decrease in local under 18 conception rates can result in lowering the priority to focus on prevention, and risks rates increasing. Strategic leadership and accountability is required to maintain reduced rates and provide challenge for further reductions.

Failure to see a significant decrease in under 18 conceptions can lead to a perceived inevitability of high rates. Strategic leadership and accountability should continue to ‘make the case’ for prevention and challenge acceptance of high under 18 conception rates.

Teenage pregnancy is more than a health issue. Partnership contributions are essential to achieve whole system approach, and this requires strategic leadership and accountability to coordinate a range of stakeholders.

Helpful resources

Good progress but more to do - Teenage pregnancy and young parents
Tackling Chlamydia - LGA
Improving young people’s health and wellbeing: a framework for public health - Public Health England
A public health approach to promoting young people’s resilience - Association for Young People’s Health
Healthy child programme 0 to 19: Health visitor and school nurse commissioning
Best start in life: promoting good emotional wellbeing and mental health for children and young people

Strategic leadership and accountability: key actions to consider

Agree the governance arrangements and senior accountable board for monitoring implementation and impact of agreed actions.

Identify a senior official or elected member to be a ‘teenage pregnancy champion’ to provide visible leadership on the ambition and implementation of the local strategy, including with the local media.

Identify a teenage pregnancy lead in the council, with sufficient seniority to engage partner agencies, and report directly to the senior accountable board.

Provide briefings for elected officials and all key partners on the importance of teenage pregnancy, the relevance to wider council priorities and the required contribution of their agency.

Agree named senior teenage pregnancy champions and accountable leads in each partner agency for commissioning and monitoring their agreed contribution.

Integrate teenage pregnancy actions with commissioning of relevant programmes for maternity, early years, children and young people and sexual health services.

Agree arrangements with partner agencies for a regular review of data and performance, with overall progress regularly reported to the senior accountable board.

2. Strong use of data for commissioning and monitoring of progress

Summary

Strong use of data is essential for assessing need, planning, commissioning and monitoring; and can enable proactive and targeted approaches.

Data should be reviewed at all relevant levels (local authority, ward, LSOA etc) to establish variations and expose inequalities that may be masked by presentation of data at higher levels.

Benchmarking appropriately (national, regional and statistical) enables relative progress to be monitored.

Proxy data and indicators from local abortion and maternity providers can provide more timely monitoring of progress in addition to annual/quarterly ONS data.

Data should be combined with local intelligence, and appropriately shared with local stakeholders, to inform commissioning decisions. For example, a school located in a high rate area may not be attended by young people from that community - targeted work with a neighbouring school attended by the majority of pupils from the high rate area would have greater impact.

Collection of service data should be used to evaluate impact of commissioned programmes.

Helpful resources

Local Authority teenage pregnancy reports
ONS Quarterly conceptions to women aged under 18, England and Wales.
Sexual and Reproductive Health Profiles
Child Health, Young People and School-age Children Fingertips Profiles
AYPH - Key Data on Young People 2017
Supporting evaluation in Sexual Health, Reproductive Health & HIV. PHE 2018.

Strong use of data for commissioning and monitoring of progress: key actions to consider

Identify a named lead in the council with responsibility for collation and analysis of teenage pregnancy data and local service uptake statistics.

Agree with senior officials in partner agencies, a set of lead indicators for monitoring the implementation and impact of strategy actions, and invest time to establish consistent data sets.

Establish data sharing agreements between partner agencies and service providers.

Agree arrangements for regular review of the agreed data set, with a RAG or other rating system to identify trends and identify early warning signs, with reporting up to the senior accountable board.

3. Relationships and sex education (RSE) in schools and colleges

Summary

RSE should form an integral part of Personal Social and Health Education (PSHE) and be embedded as a whole school approach.

From September 2020 relationships education in primary schools, RSE in secondary schools, and health education in both primary and secondary will be statutory in all schools. This including academies, free schools, faith schools and the independent sector. Statutory guidance was published in 2019. To prepare for statutory status, schools should continue to make improvements to the quality and delivery of RSE using evidence based resources.

School is cited by young people as the preferred source of RSE, followed by parents and health professionals. Media and internet are not the most preferred sources.[1]

RSE should be an age appropriate entitlement for all children and young people, including young people with special needs, disabilities or learning difficulties, through comprehensive delivery in schools, special schools, colleges and alternative provision.

RSE contributes to health, emotional wellbeing and safeguarding. Providing information, skills and values to have safe, fulfilling and enjoyable relationships; alongside resilience and protective benefits concerning issues such as Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) and mental health.

Helpful resources

Relationships and Sex Education briefing for Councillors. LGA, PHE, RSE Hub & Sex Education Forum. 2018
Sex Education Forum PHSE Association Rise Above for schools
SRE for the 21st century (Brook, Sex Education Forum and PSHE Association)
A public health approach to promoting young people's resilience (AYPH)
The Schools and Students Health Education Unit

Relationships and sex education in schools and colleges: key actions to consider

Appoint a dedicated lead for RSE/PSHE in the local authority and in individual schools or colleges, and provide training and support for teachers to deliver RSE and support for schools in engagement with parents and faith communities.

Integrate RSE with a whole school approach promoting healthy and respectful relationships with clear links to relevant policies on anti-bullying, alcohol and drugs, emotional health, CSE and safeguarding. Include questions on RSE in the annual schools safeguarding Section 11 quality assurance audit.

Establish clear pathways between RSE and 1 to 1 confidential advice within school and college or local services, maximising the contribution of school nursing, with the details of how to access 1 to 1 advice well publicised to students. The statutory RSE guidance requires all secondary schools to provide pupils with information about local sexual and reproductive health services.

Agree arrangements to audit and monitor improvements in RSE delivery across the local area, for example the proportion of schools with a policy and trained teacher, and in individual school through assessment of learning outcomes and regular audit of student views.

Provide briefings for senior leaders and school heads which: dispel myths and address common concerns; explain the content of RSE by age; and how RSE, delivered within PSHE and a whole school approach, contributes to attainment, achievement and school ethos, by equipping pupils to stay safe, develop healthy relationships and positive self-esteem, and to look after their sexual health.

4. Support for parents to discuss relationships and sexual health

Summary

Children and young people who can talk openly to their parents or carers about relationships and sexual health are more likely to have first sex later and to use contraception.

After school, young people identify parents as their second most preferred source of information about relationships and sexual health. However, parents ranked low among the current sources of information – particularly for boys who would like more information from their fathers [1].

Barriers to parental communication include embarrassment, concern that discussion may encourage early sexual activity, and uncertainty about how to answer questions appropriately.

All parents and carers should be reassured about the protective benefits of open communication and supported to talk to their children about relationships and sex, including parents and carers of children with special needs, disabilities or learning difficulties.

The vast majority of parents support RSE at primary and secondary level. Effective RSE is a partnership between parents and schools. School-home communication about RSE should start early so that parents can anticipate topics covered at school and make their own timely input or follow up at home.

Helpful resources

Add DfE parents guide

Family Lives. How to talk to your child about sex.
NHS Choices - How to talk to your child about sex

Support for parents to discuss relationships and sexual health: key actions to consider

A local accountable lead to coordinate and commission work supporting parents and carers.

Information and advice on talking to children at different ages about relationships and sexual health displayed and offered to all parents and carers in universal locations. For example, via schools as part of RSE, and in general practice, pharmacies, and appropriate community settings identified by local consultation with parents.

Specific programmes to provide parents and carers with more detailed information and opportunities to discuss and develop their confidence, prioritising parents in areas with high conception rates.

Consultation with faith communities to identify any specific concerns and the most appropriate settings for providing information and support.

Arrangements to sustain the programme by training practitioners in agencies most in contact with parents to become facilitators.

Including information in other programmes supporting parents and carers, particularly those which are addressing underlying risk factors for teenage pregnancy. For example, school attendance and attainment, aspiration and emotional wellbeing.

5. Youth friendly contraceptive/sexual health services and condom schemes

Summary

Improved use of effective contraception has the biggest impact on reducing teenage pregnancy.

All young people should have knowledge, awareness and access to the full range of contraceptive methods, including the most effective long acting reversible contraception options.

You're Welcome provides standards for making health services young people friendly and sets out principles that help health services to 'get it right' for young people.

Clarity about confidentiality is essential to encourage early uptake of advice. Young people, including those aged under 16 years, have a right to confidentiality. Confidentiality may only be broken in exceptional situations where the health, safety or welfare of the individual, or others, would otherwise be at grave risk.

The limits of confidentiality should be clearly communicated to young people, while maintaining their trust in the service.

General practices that are young people friendly can help encourage uptake of early advice about a range of health issues, including sexual health. On average, young women aged 15 to 19 visit their GP 4.5 times a year; young men visit twice a year [1].

Helpful resources

NICE [PH51] Contraceptive services for under 25s
NICE Condom distribution [NG68]
You're Welcome
C-Card condom distribution schemes
GP Champions for Youth Health
NICE Contraception Quality Standard [QS129]
Condom distribution schemes in England
Brook confidentiality statement
Establishing Local Healthwatch
RCGP Confidentiality and Young People Toolkit Getting it Right for Young People in Your Practice
Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV

Youth friendly contraceptive or sexual health services and condom schemes: key actions to consider

Identify an accountable local lead for the commissioning of young people's contraception and sexual health services.

As part of the commissioning process, undertake a needs assessment to match service capacity to the estimated number of sexually active young people in the local population, using available national survey data.

Agree a set of service indicators to monitor attendance and method uptake by the local population.

Develop process maps with young people to identify the potential points of access, and barriers, to ensure the service network provides all young people in the area with easy access to the full range of contraception and sexual health screening, complemented by condom distribution schemes.

Commission services using the World Health Organization endorsed You're Welcome standards.

Agree arrangements for regular evaluation of service by young people, including through 'mystery shopper' initiatives, and explore links to Healthwatch.

6. Targeted prevention for young people at risk

Summary

All young people should receive high quality RSE and be able to easily access reproductive and sexual health services, as most under 18 conceptions are not to young women with specific risk factors.

Young people identified at risk should receive additional targeted prevention. The strongest associated risk factors for pregnancy before 18 are free school meals eligibility, persistent school absence by Year 9 and slower than expected progress between key stages 2 and 3.

Young women who are looked after are 3 times more likely to be a parent by 18.

Teenage pregnancy risk can be associated with a range of individual vulnerabilities and prevalence is often concentrated geographically in more deprived areas. Local data analysis and intelligence should be used to identify where risk groups are located and target interventions.

NICE guidance PH51 recommends targeted work in tailoring services to reach socially disadvantaged young people.

Outreach is a key component to engage young people at risk who may be unable or unwilling to access services.

Adverse Childhood Experiences impact on childhood development and future mental and physical health. Experiencing 4 or more ACEs can result in being 5 times more likely to have had sex under 16[1] and 16 times more likely to have been pregnant (or got someone accidently pregnant) under 18[2].

Helpful resources

NICE Public health guideline [PH51] Contraceptive services for under 25s
Institute of Fiscal Studies: Teenage Pregnancy in England (2013) PHE CSE Evidence Summary
Healthy futures: supporting and promoting the health needs of looked after children

Targeted prevention for young people at risk: key actions to consider

Collaborate with local accountable lead for early help and intervention, to identify young people most at risk of early pregnancy and needing additional support.

Regularly review local data and intelligence to inform targeted work.

Consult with young people, inclusive of gender and sexuality, to identify need and barriers to service access.

Consider the location of targeted prevention to engage young people at risk who may be unable or unwilling to access services. For example, those in alternative education provision or attending Youth Offending Services.

Commission targeted support services which take a youth work approach, delivered in non-clinical, young people friendly settings and supporting young people on a range of issues relating to sexual health and relationship.

Publicise the targeted support services to young people and encourage practitioners working with vulnerable groups to proactively promote the services.

Agree the indicators and process for monitoring young people's use of the service and evaluation of impact.

7. Training on relationships and sexual health for health and non-health professionals

Summary

Workforce training helps move prevention upstream, maximising the contribution of local assets.

Improving individual professional's confidence enables them to take an appropriate and proactive approach to relationships and sexual health.

A well trained workforce increases opportunities for young people to discuss healthy relationships, raise concerns and gain accurate information, and provides swift referral to early contraceptive advice.

Training non-health professionals, who have a trusted relationship with young people at risk particularly supports young people who may be unable or unwilling to access health services.

Training can be tiered to ensure relevance across the workforce and linked with training on risk and resilience, safeguarding and child sexual exploitation and wider issues of sexuality and sexual health.

Helpful resources

Brook free e-learning: consent, pleasure, relationships, contraception, abortion, CSE, sexual behaviours, delivering RSE
RCGP e-learning course on contraception
Royal College of Paediatrics and Child Health: e-learning on adolescent health and teenage pregnancy
Making Every Contact Count

Training on relationships and sexual health for health and non-health professionals: key actions to consider

Identify agencies and practitioners in touch with young people and assess training needs on relationships and sexual health, including safeguarding.

Provide training programme on relationships and sexual health, prioritised for agencies and practitioners working in areas with high conception rates and those working with vulnerable young people.

Embed the training programme in service commissioning, including induction and updating of staff, and ensure this is monitored as part of the contract management.

Make clear the expectation of providing support for young people in relationships and sexual health by inclusion in practitioner job descriptions.

Agree a senior lead in all relevant agencies to prioritise and monitor uptake of training by practitioners.

Agree indicators and process for monitoring impact on practitioner knowledge and confidence.

8. Advice and access to contraception in non-health, education and youth settings

Summary

Advice and access to contraception in non-health settings can provide universal support and targeted intervention. For example, provision in an FE college has the potential to reach large numbers of 16-17 year olds, the age when sexual activity increases; outreach in a supported housing or drug and alcohol service will provide support to small numbers but some of the most vulnerable young people.

Using non-health, education and youth settings settings makes advice easily available and removes many of the potential barriers to access.

Advice and access to contraception can range from training non-health, education and youth setting staff to initiate sexual health discussions and signposting, through to those staff providing condoms and direct referrals to sexual health services.

Sexual health practitioners can also operate from non-health, education and youth settings to improve access to services, particularly for those who otherwise may not access clinical services.

The settings identified should be relevant to the local context, but school and education based contraceptive services are a recommendation of the NICE guidance PH51.

Consulting with young people is essential to identify non-health, education and youth settings accessed by young people and at which they would like to receive advice and access to contraception.

Helpful resources

NICE Public health guideline [PH51] Contraceptive services for under 25s
NICE Sexually transmitted infections: condom distribution [NG68]

Advice and access to contraception in non-health, education and youth settings: key actions to consider

Review contraceptive clinic attendance by young people in high rate and deprived wards.

Identify education and other non-health settings used and trusted by young people.

Consult with young people, staff and in education settings, parents, to explore the benefits and challenges of providing 1 to 1 sexual health advice and support.

Pilot the initiative to gauge the views of young people and staff before further development, or roll out to other services.

Agree a joint confidentiality policy and protocol and inform young people and staff.

Establish referral pathways with other relevant services, and to clinical services offering the full range of contraception and sexual health screening if required.

Agree arrangements for monitoring young people's use of the service and evaluation of impact.

Ensure senior leaders and service managers are well briefed and accurate information about the service is provided to the media before the service opens.

9. Consistent messages to young people, parents and practitioners

Summary

Openness about sexual issues is associated with lower teenage pregnancy rates and helps reduce stigma and embarrassment about seeking early advice.

Communication is key to maintain or enhance teenage pregnancy prevention. Young people want clear, concise, consistent and credible information.

Systematic publicity of services helps ensure all young people know where to go for advice ahead of need, and helps convey a clear message that seeking early help is the right thing to do.

Messages and service publicity can also be integrated with communications and campaigns aimed at raising aspirations or other underlying issues affecting unplanned pregnancy, including alcohol and substance use.

Parents/carers should be encouraged to talk to their children about relationships and sexual health.

Practitioners need to be kept up to date with prevention initiatives and local service information/ developments.

Clear messages from councillors and senior local leaders help convey the importance of supporting young people to prevent unplanned pregnancy and develop healthy relationships.

Helpful resources

Sexwise FPA
Brook
NHS Choices

Consistent messages to young people, parents and practitioners: key actions to consider

Agree a local accountable lead to coordinate local communications on teenage pregnancy.

Provide regular briefings or newsletter to keep elected councillors and practitioners informed and updated on strategy activities and progress.

Agree a media strategy to promote well informed reporting and normalise discussion about relationships and sexual health, with an agreed protocol for quick responses to negative stories.

Provide clear, accurate and consistent messages about relationships and sexual health and service publicity to reach all young people in the local area through a mix of digital and other communication channels.

Provide parents with information, advice and sources of support.

Agree the arrangements for a coordinated and updated database of local services to inform practitioners and strengthen partnership working.

10. Support for pregnant teenagers and young parents, including prevention of subsequent pregnancies

Summary

An estimated 12% of births conceived to women under the age of 20 are to young women who are already teenage mothers. 10% of under-19s having an abortion have had one or more previous abortions, but this varies significantly between CCGs from 1% to over 20% 1.

Teenagers are more likely to present late for abortion and antenatal care 2. Early pregnancy testing, unbiased information and advice on pregnancy options and swift referral to maternity or abortion services helps improve early access.

Advice on contraception during abortion or antenatal care, and access to the chosen method immediately post pregnancy helps reduce unplanned conceptions.

Improving outcomes for teenage parents reduces intergenerational risk factors for early pregnancy in the children of teenage parents.

Helpful resources

A framework for supporting teenage mothers and young fathers
NICE Contraception Quality Standard [QS129]
NICE Public health guideline [PH51] Contraceptive services for under 25s
fpa Contraceptive choices after you've had a baby
FSRH guidance on contraception after pregnancy

Support for pregnant teenagers and young parents, including prevention of subsequent pregnancies: key actions to consider

Agree arrangements for free and well publicised pregnancy testing available in easily accessible locations.

Provide and publicise unbiased pregnancy options advice. Inform young people if other organisations offering free pregnancy testing and advice are opposed to abortion.

Provide access to counselling if required, with referral pathways to maternity services or abortion care.

Ensure abortion care provision is accessible to all young people, including those relying on public transport. Check whether the proportion of under-18 and under-16 conceptions ending in abortion is line with the regional and national average. A low proportion may indicate barriers to accessing abortion care.

Provide information about post-pregnancy contraception during the abortion care pathway or antenatal period, with provision of chosen method at time of abortion or immediately postnatally.

Agree arrangements for post-pregnancy contraception follow up support.

Monitor subsequent pregnancy data to measure impact of contraception commissioning arrangements.

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