

Reducing teenage pregnancy

Guidance and self-assessment tool



Contents

1. Introduction	5
1.1 Aim	5
1.2 Focus and background	5
1.3 Audience	6
1.4 Policy and performance drivers in Scotland	7
1.5 Using this resource	11
2. Teenage pregnancy in Scotland	13
2.1 Definition	13
2.2 Teenage pregnancy rates	13
2.3 Effective approaches to reducing teenage pregnancy	14
2.4 Why reducing teenage pregnancy is important	16
3. Overview of key characteristics of successful programmes	19
3.1 Knowledge and awareness	20
3.2 Leadership, co-ordination and performance management	21
3.3 Standards and service provision	22
3.4 Young people	23
4. Self-assessment tool	25
4.1 Overview of the quality indicators	27
4.2 How to use the self-assessment tool	28
4.3 Worked example of a response to a quality indicator	30
4.4 The self-assessment tool	31

5. Appendix: Key risk factors for teenage pregnancy	52
6. Appendix: Resources	57
7. References	59
8. Acknowledgements	63

1. Introduction

1.1 Aim

There are many policy documents, guides and resources providing advice to support the reduction of teenage pregnancy in Scotland. This guidance and self-assessment tool aims to bring together the range of current evidence and advice on the partnerships, strategies and interventions that need to be in place locally if teenage pregnancy rates are to be reduced and the reduction maintained in the long term.

The guidance and self-assessment tool highlights the key characteristics of programmes which are effective in achieving that reduction. It is intended to be flexible enough to take account of local communities' needs and cultural sensitivities. It should support and help build on existing good practice.

1.2 Focus and background

This document focuses on reducing teenage pregnancies. Teenage pregnancy is commonly defined as describing conceptions among young women aged 13–19. For the purposes of this document, this definition is accepted, however, the focus throughout is on the prevention of pregnancy in the under-16 age group.

Additionally, while this document is focused on the prevention of teenage pregnancy, it also recognises the need to ensure appropriate provision for young women who do become pregnant at a young age, and for young fathers, particularly around education, training and employment.

This document is part of the Scottish Government's response to the independent stock-taking review of the national sexual health strategy and action plan *Respect and Responsibility* (2005). A summary of the revised outcomes, *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11*, is available on the NHS Health Scotland website at www.healthscotland.com/documents/2948.aspx.

The recommendations from the review have been considered by stakeholders from across Scotland, and a number of outcomes have been identified as priorities for the next three years. The revised outcomes following the review are outlined in the summary and come under four broad headings:

- Knowledge and awareness
- Leadership, co-ordination and performance management
- Standards and service provision
- Young people.

This guidance is intended to support the implementation of all the outcomes, but places most emphasis on young people. It has been issued to all local authorities and NHS boards to enable them to assess progress in reducing teenage pregnancy.

1.3 Audience

This guidance and self-assessment tool has been designed primarily for use by local multi-agency sexual health strategy groups, but is also for the individuals working within those groups at health board and local authority level, with a responsibility for sexual health/ reducing teenage pregnancy:

- Directors of public health
- Clinical leads for sexual health
- Community Health (Care) Partnership (CH(C)P) leads for children and young people
- Directors for looked after children and young people and care leavers
- Local multi-agency sexual health strategy groups
- Senior health promotion specialists for sexual health
- Local authority directors/commissioners of children's services/education
- Local authority leads for education, sexual health, youth, early years and parenting
- Local and national voluntary organisations
- Youth work leads
- Mental health, alcohol and substance misuse leads
- Skills Development Scotland

- Public health nurses, community midwives and health visitors
- Professionals working in schools and other education settings.

1.4 Policy and performance drivers in Scotland

The overarching purpose of the Scottish Government, as set out in the National Performance Framework, is 'to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. A key theme of the Scottish Government's approach is that all public services should be better aligned to achieve common goals if we are to create a more successful Scotland. The Scottish Government's purpose is supported by five strategic objectives – to make Scotland wealthier and fairer, smarter, healthier, safer and stronger and greener. There is a clear focus on tackling health inequalities in the 'healthier' objective, which is to 'help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care'.

Policy

As indicated above, because of the cross-cutting nature of the actions required to successfully deliver a reduction in teenage pregnancy, it is important that there are strong links with all other relevant policies and strategies being pursued at both national and local levels. At a national level sexual health and reducing teenage pregnancy feeds into a range of key policies and strategies including:

Scottish Executive, *Respect and Responsibility: Strategy and Action for Improving Sexual Health*, 2005

Scottish Government, *Better Health, Better Care: Action Plan*, 2007

Scottish Government, *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11*, 2008

Respect and Responsibility was launched in January 2005 with £15 million of funding over three years. This funding was extended by the Scottish Government within Better Health, Better Care and will continue until 2011.

Scottish Government, *Equally Well – Report of the Ministerial Task Force on Health Inequalities*, 2008

This report of the Ministerial Task Force on health inequalities recognises the need to unite ministerial portfolios to address the underlying causes of health inequalities. There is also recognition that delivering on the Task Force’s recommendations depends on ‘strong joint working between the NHS, local government, the third sector and others within community planning partnerships’. This approach is also required to effectively deliver a reduction in teenage pregnancy.

Scottish Government, *A Guide to Getting It Right for Every Child*, 2008

Getting it right for every child is about the approach, values and principles required to ensure all children and young people are safe, included, responsible, respected, active, nurtured, achieving and healthy. It provides the foundation for all work with children and young people and also affects those working with parents and carers. It threads through all existing policy, practice, strategy and legislation affecting children and young people.

Scottish Government, *Changing Scotland’s Relationship with Alcohol: A Framework for Action*, 2009

Further links are being made to the Alcohol Strategy, including, for example, to explore the scope of brief interventions on alcohol use being delivered in some sexual health services, therefore making clear links across service delivery. Following public consultation in 2008, the *Framework* sets out the Scottish Government’s strategic approach to tackling alcohol misuse and reducing alcohol related harm. The *Framework* highlights the need to better support families and young people to make positive choices in relation to alcohol and provides a commitment to action in a number of areas, including improved substance misuse education in schools, advice for parents and carers, continued youth work and diversionary activities and better identification and assessment of those affected by parental substance misuse.

Learning and Teaching Scotland, *Curriculum for Excellence Health and Wellbeing Experiences and Outcomes 3–18*, 2009

Learning and Teaching Scotland, *Health and Wellbeing: Principles and Practice*, 2009

Scottish Government, Schools (Health Promotion and Nutrition) (Scotland) Act 2007: Health Promotion Guidance for Local Authorities and Schools, 2008

Scottish Government, *Building the Curriculum 3: A Framework for Learning and Teaching*, 2008

There have been major developments in education affecting young people. Taken together, the experiences and outcomes for *Curriculum for Excellence Health and Wellbeing 3–18*, the accompanying paper *Health and Wellbeing: principles and practice*, *Health Promotion Guidance for Local Authorities and Schools* and *Building the Curriculum 3, A Framework For Learning And Teaching* describe the Scottish Government's expectations for promoting the health and wellbeing of children in Scotland. All schools are now expected to treat health and health promotion as 'core' business, alongside literacy and numeracy.

Within Curriculum for Excellence, 'Relationships, sexual health and parenthood' is one of six organisers in the Health and Wellbeing curricular area which identifies experiences and outcomes for children and young people 3–18. The other five organisers also support work in this area, in particular 'mental, emotional, social and physical health' and 'substance misuse'. Links with other curricular areas such as social studies and science are strongly advocated and Health and Wellbeing is premised on partnership working within school and community. Young people's personal and social development is also promoted through the whole school experience described in *Health Promotion Guidance for Local Authorities and Schools*.

Scottish Executive, Looked After Children and Young People: We Can and Must Do Better, 2007

In order to address the needs of looked after children and young people, *We Can and Must Do Better* sets out an action plan to improve outcomes for looked after children and young people, and care leavers, including their health and wellbeing. Relationships and sexual wellbeing are a key part of this policy.

Scottish Government, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009–11, 2009

In May 2009 the Scottish Government published a new policy and action plan for mental health improvement – *Towards a Mentally Flourishing Scotland* – which set the direction for mental health improvement in Scotland between 2009 and 2011. Mental health improvement refers to activity which promotes good mental wellbeing in the general population, reduces the prevalence of common mental health problems, suicide and self-harm and improves quality of life for those experiencing mental health problems or mental illness. Like the sexual health strategy, it is firmly set within the context of the overarching purpose of government and the national outcomes which cascade from that. It deals with a subject area which is complex and wide ranging, which will require cross cutting actions to deliver, with delivery agents not restricted to the sphere of health, but across a range of areas. The mental health improvement agenda is integral to addressing social inequalities. Poor mental wellbeing and mental health problems can be interlinked with risk behaviours such as sexual health practices, and that action to improve this could have an impact on mental health, and vice versa.

Scottish Executive, *Moving Forward: A Strategy for Improving Young People's Chances through Youth Work*, 2007

This strategy sets out the vision for improving the life chances of all young people through youth work, based on delivering positive outcomes through facilitating their personal, social and educational development.

Scottish Government, *Valuing Young People – Principles and Connections to Support Young People to Achieve their Potential*, 2009

In April this year, in partnership with COSLA, the Scottish Government published this paper, designed to be a helpful tool to ensure connections between, and through, existing services made by delivery partners. It has been shaped by organisations across the public and third sectors as well as young people themselves. It offers a set of common principles for organisations (locally and nationally and across all sectors). The common principles are to deliver services that reflect the reality of young people's lives, to work with local partners to address barriers and gaps, to recognise and promote young people's positive contribution to their communities and to involve young people at an early stage in developing services and opportunities.

These principles should be promoted as the norm and become embedded in day-to-day operations. For national partners, they should underpin policy developments and national delivery. For local partners, particularly those involved in Community Planning Partnerships, they should influence Single Outcome Agreements and provide a reference for local service delivery. And for young people, they should lead to better services which provide better value and improved long-term outcomes.

Scottish Government, *More Choices, More Chances*, 2006

This strategy, introduced by the Scottish Executive in June 2006, aims to reduce for Scotland the proportion of 16–19 year olds not in education, employment or training. Local Authorities and key partners are tasked with the delivery of a local action plan which aims both to tackle disengagement and to increase the proportion of young people in learning post-16 including, specifically, school leavers in positive and sustained destinations (in line with the national performance indicator). The strategy acknowledges links between long-term unemployment and caring responsibilities and identifies teenage parents as one of a number of key sub-groups requiring particular attention.

Scottish Government, *The Early Years Framework*, 2008

Key policy links are being made to the *Early Years Framework* particularly to reduce the number of vulnerable pregnancies in Scotland, such as reducing unintended pregnancies in teenagers and increasing contraceptive provision to women using drug services to

support family planning and timing of future births. Support for young parents to achieve the best outcomes for their children is a key strand of the strategy which will contribute in the long term to better health outcomes for children and young people.

Youth Work in Schools

The Scottish Government has provided funding for a youth work and schools national development officer. The aim of this post is to ensure better communication and links between schools and the youth work sector, so that young people can fulfil their potential under the four Curriculum for Excellence capacities. *Youth Work and Schools: Making it Happen* was launched by Learning and Teaching Scotland in June 2009. It includes best practice examples of youth work and schools working together throughout Scotland and is intended for the use of both teachers and youth workers.

Performance:

The performance management of sexual health outcomes is based upon the following standards and indicators. The Scottish Government undertake an annual visit to each NHS Board and their Sexual Health Strategy Group to consider implementation of the outcomes at a local level. This provides an opportunity to identify barriers to implementation and to share examples of good practice with other areas of Scotland.

NHS Quality Improvement Scotland, *Standards – Sexual Health Services*, 2008

HMIe, *How Good Is Our School? The journey to excellence part 3*, 2007

Sexual Health Key Clinical Indicators annual analysis by NHS Board area

1.5 Using this resource

This resource provides information about teenage pregnancy in Scotland and the key characteristics of programmes successful in achieving a reduction. The appendices provide detailed information on the key risk groups for teenage pregnancy and resources.

This resource also includes a self-assessment tool to enable local areas to focus their priorities and agree actions. Local multi-agency sexual health strategy groups are responsible for co-ordinating efforts to reduce teenage pregnancy, and as such, the self-assessment tool is primarily for use by them. It is intended for annual use as a self-assessment tool and should be used as part of the group's response to locally identified needs.

Sexual health strategy groups should allocate time within annual planning cycles to use this guidance and self-assessment tool. The whole resource should be used by the sexual health strategy group as a detailed assessment of whether the key characteristics of successful programmes are in place in all areas. It is the responsibility of the chair of the group to ensure this happens. Results from using the self-assessment tool will form part of the discussions held at annual meetings with the Scottish Government sexual health and HIV team.

In addition to annual strategic use, individual elements can be used at any time by appropriate partners – for example, education leads may wish to focus on the sex and relationship education (SRE)/relationships and moral education (RME)* characteristics and self-assessment, to ensure progress in this particular area.

*In non-denominational schools, the majority of SRE is delivered as part of Health and Wellbeing programmes. In Roman Catholic schools, the majority of RME is delivered as part of Religious Education programmes. References to SRE throughout this document are made with this distinction in mind.

2. Teenage pregnancy in Scotland

Teenage pregnancies in Scotland are among the highest in Western Europe. Young women in the most deprived areas of Scotland are up to five times more likely to become pregnant than their counterparts in the most affluent parts of the country. A significant proportion of first sex among young people takes place without contraception, and is regretted afterwards.

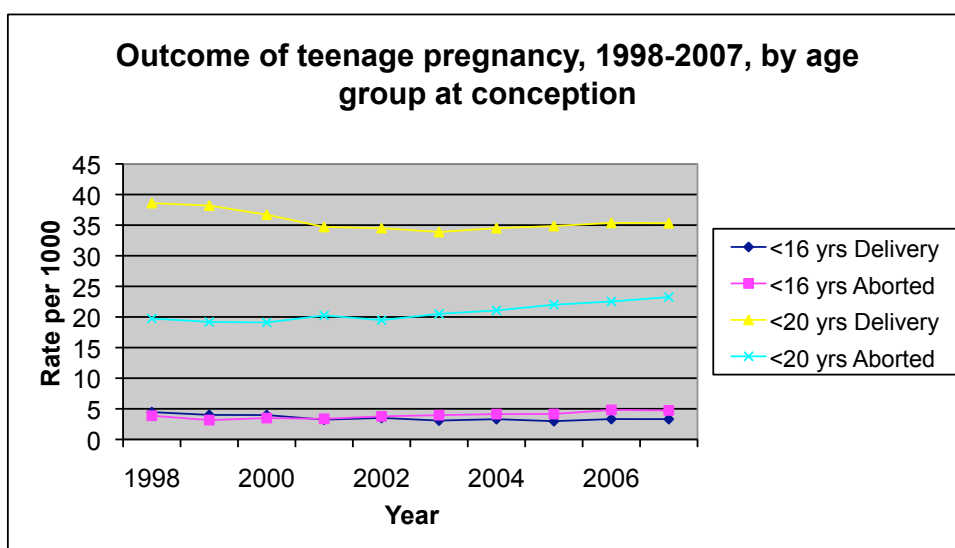
2.1 Definition

For the purposes of this document, teenage pregnancy is defined as conception within the 13–19 age range, however the focus is on the prevention of pregnancy in the under-16 age group.

2.2 Teenage pregnancy rates

Respect and Responsibility includes the target to reduce the under-16 conception rate by 20 % by 2010 (from 8.5 per 1,000 13–15 year olds in 1995, to 6.8 per 1,000). The graph below shows progress made toward that target. It can be seen that rates of teenage pregnancy have remained fairly stable since 1998.

More detailed data for local authorities can be found at the ISD Scotland website at <http://www.isdscotland.org/isd/2071.html>.



Source: ISD Scotland

2.3 Effective approaches to reducing teenage pregnancy

Multi-faceted approach

There is good evidence to support a multi-faceted approach to reducing teenage pregnancy, which combines information, education and sexual health services. Education programmes should encourage delay, but recognise that those who are sexually active require clear messages about contraception use and access to confidential and approachable sexual health services.

Linking programmes across primary and secondary sectors may also be effective. Promoting relationships based on respect and equality at an early age may influence the timing of initial sexual activity and reduce homophobic attitudes (Reid Howie Associates, 2001).

Involving staff who deliver sexual health services for young people in school programmes helps bridge the gap between sexual health services and education, leading to improved service uptake. The Healthy Respect Demonstration Project found that drop-in staff assisting in the delivery of SRE reduced barriers for young people accessing sexual health services (NHS Health Scotland, 2008a). Improving access to contraception, provision of quality sex and relationships education and building incentives to avoid early parenthood are the main characteristic of countries with lower rates of teenage pregnancy (UNICEF, 2001). Services should be accessible to young people, confidential and tailored to their needs.

Wider influences

Influencing teenage pregnancy cannot be the result of a single intervention. Combined sexual health services and education, while important components, have not been shown to reduce teenage pregnancy in isolation. While there are strong links between social disadvantage and early sexual activity, subsequent regret, inconsistent use of contraception and teenage pregnancy, self-esteem, motivation, achievement and having a sense of a positive future are all influential in maintaining positive sexual health and wellbeing. Parental, family and media influences also play a part.

Teenage pregnancy is as much a consequence of deprivation as a cause. Failure to address the wider social and cultural influences on teenage pregnancy has contributed to the lack of progress made in reducing it in Scotland in the past (UNICEF, 2001). The most successful programmes therefore are multi-component and address a wide range of determinants of risk.

Promoting positive messages

An approach which combines media campaigns, positive sexual health messages and helps to make sense of the media coverage of sexual health issues appears to be the most successful in influencing attitudes and behaviour. Exploration of media content as part of sex and relationships education can promote better understanding of stereotypical images of gender and diversity issues.

Key components of successful programmes include clear and consistent messages which are reinforced over time, factual and non-judgmental statements, respect for the target audience, use of different formats and targeting specific groups where appropriate.

The Healthy Respect Demonstration Project found that online adverts placed on social networking sites, targeted both by area and age, can be particularly effective at increasing the number of new visits by young people to sexual health websites (NHS Health Scotland, 2008b).

Targeted work

Many groups face barriers to sexual wellbeing. Improving opportunities to access lifelong learning and quality services can reduce these barriers, but for some very hard to reach groups (see section 5), whose sexual health is particularly poor, additional, targeted support is required. Scotland's sexual health strategy, *Respect and Responsibility*, supports a targeted approach to complement mainstream provision.

Involving parents and carers

There is good evidence that providing parents with the skills and knowledge to become active partners in sex and relationships education is effective in preventing teenage pregnancy – young people whose parents are able to discuss issues around sexual health with them are more likely to use contraception at first intercourse (Swann et al, 2003).

A combination of formal and informal SRE may be most effective. In addition, home-based school assignments may help improve parent-child communication and knowledge (Hosie, 2002).

The Healthy Respect Demonstration Project developed home activities resources for use by parents and young people together. The majority of primary school parents found the resource useful because it gave them an opportunity to discuss sex and relationships with their child, or felt it helped their child's learning in SRE (NHS Health Scotland, 2008c).

Raising aspirations, assets and self-esteem through youth work

If young people are supported to develop their strengths and assets, use their time constructively and have positive adult and peer role models, they are less likely to engage in risky behaviours, including early sexual activity and non-use of contraception. They are more likely to feel they have a stake in a positive future. Youth development programmes in the US appear to be effective in reducing teenage pregnancy where they combine some or all of the following: self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports and arts activities, SRE and individual risk counselling (Swann et al, 2003).

Promoting a culture of participation

Young people have the right to participate in key decisions that affect their lives. In line with the UN Convention on the Rights of the Child, successful programmes involve young people at a level that is both meaningful and appropriate, by promoting a culture of participation. This culture of participation includes creating opportunities for young people's individual experiences of education and services around sex and relationships to be heard, and to influence their future direction. Opportunities to involve young people should be considered throughout the development and delivery of work. This will include staff identifying opportunities for participation as part of their objectives, for example, involving young people in the creation of information leaflets and marketing campaigns. Specific participation initiatives can also be developed, where appropriate, to engage young people on a particular issue. This may include short-term research projects, such as a 'mystery shopper' initiative exploring young people's experiences of sexual health services.

2.4 Why reducing teenage pregnancy is important

It is worth noting that for some young women, the desire for pregnancy is present at an early age. The Teenage Pregnancy Unit in England points out that for some young women, 'early parenthood can appear a rational choice, providing a means for marking their transition to adulthood or having someone to love in their lives' (DfES, 2006). However, even 'planned' teenage pregnancies may be cause for concern due to the cycle of deprivation often perpetuated for the young women involved as well as their children; rates of teenage pregnancy are far higher among deprived communities, so the poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next.

There is evidence to show that having children at a young age may be detrimental to young women's physical and mental health and wellbeing. It may also limit their education and career prospects as there are few structures in place to ensure that under-16s will return to school after a birth. Similarly, it is not commonplace for over-16s to receive additional schooling or job training. Teenage motherhood can also reduce the likelihood of obtaining post-secondary education, which is increasingly necessary for the current labour market.

Longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life. Early motherhood is associated with long-term benefit receipt, low income, low occupational status, divorce and large family size. Children born to teenage mothers suffer higher mortality rates, and are more likely to live in poverty, to engage in criminal behaviour and to become teen parents themselves (Social Exclusion Unit, 1999).

Recent UK research of mothers of twins showed that relative to older mothers, young mothers experienced more anxiety and depression. The same study showed that by the time the children were aged five, those who had teenage mothers had experienced more socio-economic deprivation, more mental health difficulties and showed higher rates of illness, accidents and injuries (Moffitt et al, 2002).

Young men who become fathers in their teens and early twenties are twice as likely to live in social housing, to receive benefits and to be unemployed by the age of thirty. They are significantly more likely to have lower educational qualifications, and to earn less. More than one-fifth of teenage fathers have never lived with their child. Of those who have, one in seven have separated from their child within five years, compared to one in ten of older fathers (Berrington, Diamond, Ingham, Stevenson et al, 2005).

These findings and those of other studies show that the difficulties of teenage parenthood have a long reach, which will continue into the next generation (Jaffee et al, 2001).

There are also strong economic arguments for the prevention of teenage pregnancy. Teenage mothers (and their children) are more likely than older mothers to require extensive support, placing a significant burden on local and wider public services, as well as the NHS. It is estimated that the cost to the NHS of pregnancy in the under-18s is over £63 million per annum (*Teenage Pregnancy Unit Annual Report, 2002*).

It is important to note, however, that while teenage mothers are more likely to experience a range of disadvantages in adulthood, this is the result of complex interplay between their early experiences (that is, those that predicted their entry into teenage motherhood) and the additional consequences of being a teenage mother. In other words, teenage motherhood is *one* route through which there is an inter-generational transmission of disadvantage (Berrington, Diamond, Ingham, Stevenson et al, 2005). Prevention of teenage pregnancy, therefore, is but one way to reduce health inequalities, which needs to be complemented by strategies taking account of

education, employment, housing and neighbourhood quality, aspiration, deprivation and support for young mothers and families, among many others.

The challenge for local areas, then, is to provide young people with the means to avoid early pregnancy, but also to tackle the underlying circumstances that motivate young people to want to become parents, or lead them passively to become so at a young age.

3. Overview of key characteristics of successful programmes

This section gives an overview of the key characteristics to aim for in improving the potential for local areas to achieve a reduction in teenage pregnancy rates.

This section is divided into the four main outcome areas described in *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11*:

- Knowledge and awareness
- Leadership, co-ordination and performance management
- Standards and service provision
- Young people.

As indicated in section 1.4, it is acknowledged that the sexual health strategy alone cannot deliver a reduction in teenage pregnancies. Therefore, key characteristics of effective programmes drawn from a range of policies and strategies are included within the four outcome areas. Each key characteristic is then linked to a national strategy, where relevant, using the following key:

CfE	Curriculum for Excellence Health and Wellbeing 3–18
CSRWA	Changing Scotland's Relationship with Alcohol: A Framework for Action
EW	Equally well – Report of the Ministerial Task Force on Health Inequalities
MCMC	More Choices, More Chances
R&R	Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11
TAMFS	Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009–11

3.1 Knowledge and awareness: Key characteristics

Communications

A social-marketing approach supports communications activity, which is clearly linked to other risk taking behaviours. The effectiveness of communications activity is assessed.

R&R 1.1, TAMFS P1

Information for young people

Young people, including those most at risk of teenage parenthood, are involved and informed, and have easy access to high-quality information. **TAMFS P6, EW R44**

Media management

There is a strategy for dealing with the media, pro-active media engagement challenging stereotypes and discrimination, and engagement with key groups to achieve more balanced reporting. **R&R 1.2, TAMFS P6**

Parental involvement

Parents and communities are engaged and informed; parenting support programmes include material on sex and relationships; there is general as well as targeted provision.

CWSRA, CfE

3.2 Leadership, co-ordination and performance management: Key characteristics

Engagement of all key partners

There is a clear commitment to reducing teenage pregnancy; it is integrated into planning with links made to drug and alcohol programmes.

Clearly defined roles

Sexual health leads are identified and have clearly defined roles within health boards and local authorities. **R&R 2.2**

Communication between partners

Communication between partners is effective; partners receive appropriate information.

Performance management

Results are measured against local and national outcome measures; issues are raised in a timely and appropriate manner. **R&R 2.3 2.4 2.5 2.7**

Workforce development

Leadership development opportunities are available to those in lead roles. **R&R 2.8**

3.3 Standards and service provision: Key characteristics

Effective use of data

There is a systematic approach to knowing the local population and its needs in relation to teenage pregnancy; data is used to inform local service provision; the National Sexual Health (NaSH) system is implemented. **EW R74–75**

Health improvement interventions

Sexual health interventions include health improvement interventions around preventing teenage pregnancy where appropriate. **R&R 3.1**

Application of standards

Sexual health standards and competencies (being developed) are used in non-clinical interventions; QIS Standards and Key Clinical Indicators in clinical interventions. **R&R 3.2 3.3 3.4**

Workforce development

All local sexual health strategies outline how they will ensure a competent and confident workforce of clinical and non-clinical staff who have access to the capacity building programme supported by special health boards. **R&R 3.5 3.6**

3.4 Young people: Key characteristics

Targeted work

Specific, preventative interventions, involving a range of professionals, target vulnerable groups and take account of the underlying risk factors for teenage pregnancy. **R&R 4.2, TAMFS P1, EW R11–13 R44, CfE, MCMC**

Young people's sexual health services

Well-promoted, accessible sexual health services are tailored for young people and offer a full range of high quality services. **R&R 4.3, EW R44 R51, CfE, MCMC**

Sex and relationships education (SRE)/Relationships and moral education (RME)

There is continuous and progressive SRE/RME in all schools, delivered by trained, committed professionals. **R&R 4.4, EW R11 R44, CfE**

Raising aspirations

Raising aspirations of young people is integral to all other actions; programmes in schools and elsewhere raising awareness and self-esteem reach young people most at risk; there is engagement with both young people and communities. **TAMFS P1 P3 P4–6, CSRWA, CfE, MCMC**

Information

High quality, consistent information is provided to young people in a range of settings. **R&R 4.5, EW R44, CfE**

Youth work

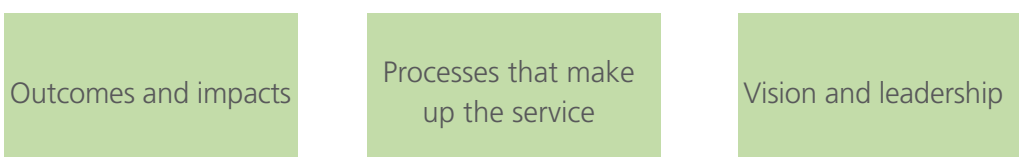
There is a well-resourced youth service with a clear remit to tackle teenage pregnancy; there are well-trained youth workers and provision of advice and contraception/signposting within youth services. **TAMFS P1 P5, Cfe**

Workforce development

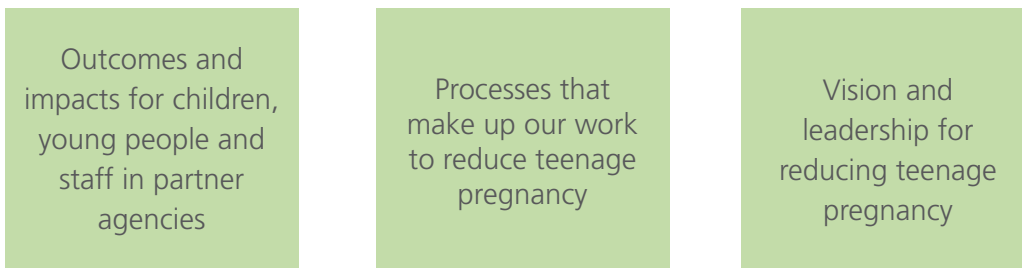
Sex and relationships core training and ongoing CPD is provided to all staff with a key relationship with young people. **R&R 4.6, TAMFS P4**

4. Self-assessment tool

The self-assessment tool uses a format increasingly familiar to many of the professional groups engaged in local sexual health strategy groups. It is adapted from the format of self-evaluation tools developed by HMIE for multi-agency contexts, for example, *How good is our corporate parenting?* (2009) and *How well do we protect children and meet their needs?* (2009), which in turn links with the European Framework for Quality Management (EFQM) excellence model. The EFQM model can provide a comprehensive system for reviewing leadership, key activities and results (HMIE, 1999). The HMIE model consists of three interrelated areas:



The teenage pregnancy self-assessment tool considers three key areas:



Examining these areas give rise to five quality indicators:

1. What key performance outcomes have we achieved in working towards reducing teenage pregnancy?
2. How well do we meet the needs of the stakeholders involved?
3. How good is the delivery of our programmes aimed at reducing teenage pregnancy?
4. How good is our management of the task of reducing teenage pregnancy?
5. How good is our leadership for reducing teenage pregnancy?

These quality indicators are then considered in more detail, giving rise to a number of key questions that encompass the key characteristics of successful programmes described in *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11* and detailed in section 3.

According to HMle, at the heart of the process of self-assessment are three questions:

- How are we doing?
- How do we know?
- What are we going to do now? (HMle, 2007)

These questions therefore head the sections of the tool which will be completed by the local sexual health strategy group or other assessors.

4.1 Overview of the quality indicators

	Quality indicators	Detailed quality indicators	Key characteristics ¹
Outcomes	1. What key performance outcomes have we achieved in working to reduce teenage pregnancy?	1.1 Improvements in performance	<ul style="list-style-type: none"> • Young people (local performance indicators)
	2. How well do we meet the needs of our stakeholders?	2.1 Impact on children and young people 2.2 Impact on parents/carers 2.2 Impact on staff in partner agencies	<ul style="list-style-type: none"> • Parental involvement • Workforce development • Targeted work
	3. How good is provision of our programmes aimed at reducing pregnancy?	3.1 Information for young people 3.2 SRE/RME 3.3 Sexual health services 3.4 Health improvement interventions 3.5 Raising aspirations	<ul style="list-style-type: none"> • Information for young people • Health improvement • Young people's sexual health services • SRE/RME • Raising aspirations • Youth work
Processes	4. How good is our management of the task of reducing teenage pregnancy?	4.1 Partnerships between key agencies 4.2 Policy development and planning	<ul style="list-style-type: none"> • Communications and information strategy • Engagement of key partners • Clearly defined roles • Application of standards
	Vision	5. How good is our vision and leadership for reducing teenage pregnancy?	5.1 Leadership and direction 5.2 Monitoring and evaluating performance outcomes

¹ *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008–11*

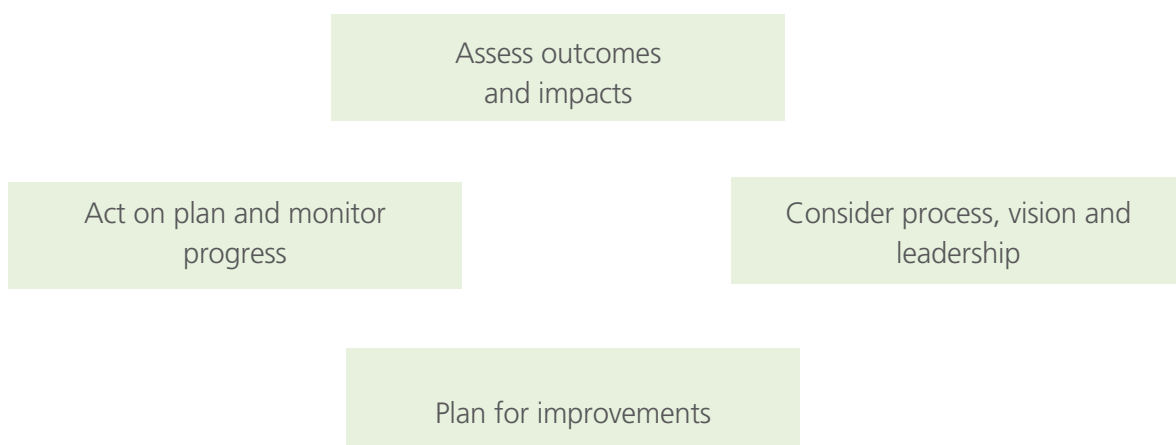
4.2 How to use the self-assessment tool

The starting point in the self-assessment process is the annual review by the local sexual health strategy group (or other assessors) of the outcome indicators which provides quantitative data on progress towards reducing pregnancy. A list of potential outcome indicators is provided under the first quality indicator. The second quality indicator then considers the impact on stakeholders, ie, their experience of the sexual health services and training provided.

The review of outcomes and impacts provides an essential guide to performance, and should therefore come before considering the processes. For example, a local area may provide what appears to be an excellent health service (process) but this may not be yet trusted by the young people who are most at risk (impact) and this lack of trust will affect the numbers of young people at risk who use the service (outcome).

By then considering each of the following quality indicators, the sexual health strategy group can identify strengths. Each quality indicator has detailed questions which help assess progress. The progress made and evidence of that progress should be noted in the second column. This evidence will support local groups through the auditing phase.

As well as identifying strengths, the process of asking the key questions will uncover areas for improvement. The self-assessment tool is therefore not only an assessment tool, but a guide for planning. In the third column, necessary action should be noted, with a note of the lead agency and the timescale for undertaking the action. Although the review is an annual exercise, assessors may find it helpful to plan to focus on the detail of a particular quality indicator during the year, especially where underperformance in this area is identified at the annual review.



For each quality indicator, local sexual health strategy groups or other assessors should evaluate local performance using the six levels of performance used by HMIe:

6	Excellent	Excellent or outstanding
5	Very good	Major strengths
4	Good	Important strengths with some areas for improvement
3	Adequate	Strengths just outweigh weaknesses
2	Weak	Important weaknesses
1	Unsatisfactory	Major weaknesses

4.3 Worked example of a response to a quality indicator

MEETING THE NEEDS OF OUR STAKEHOLDERS		
		Scale (1–6) 4
<p>Q2.1 Impact on children and young people</p> <p>Themes</p> <ul style="list-style-type: none"> • The extent to which young people are engaged • The extent to which young people participate in the design of programmes and approaches • The extent to which young people report that they have the sexual health information that meets their needs 		
<p>Key questions</p> <ul style="list-style-type: none"> • How well do we consult young people, including those most at risk, about the delivery of programmes and sexual health services? • How well do we ensure that young people's views influence improvement, eg, through mystery shopping, training of professionals and peer education? • How well do young people trust the sexual health services we provide? • To what extent do young people use the sexual health services provided? 	<p>Evidence (How are we doing? How do we know?)</p> <p>Electronic consultation and focus groups carried out in 5/7 secondaries. Results used to inform the setting up of new young people's sexual health services. Consultation report produced. Vulnerable groups not yet consulted.</p> <p>Customer satisfaction electronic survey set up at sexual health service venue. Too soon to analyse results.</p> <p>Thirteen clients and 22 visits in first three months of new sexual health service. Only three of these from areas of deprivation. However, number of return visits suggests clients make good use of the service once over the door. Sexual health service statistics.</p>	<p>Planned action(s) (What are we going to do now? Timescales and lead agency)</p> <p>Consultation with vulnerable young people by December 2009. Youth Workers and LAC Nurse.</p> <p>Insert on engaging with young people in next round of multi-agency training November 2009. Health Improvement.</p> <p>Strengthen marketing campaign through use of local radio and through new opportunities in the two secondary schools in the area by December 2009. Health Improvement and Education.</p>

4.4 The self-assessment tool

QUALITY INDICATOR 1: KEY PERFORMANCE OUTCOMES								
Detailed quality indicator 1.1: Improvement in performance								
Themes	<ul style="list-style-type: none"> • Targeting groups most at risk • Sex and relationship education • Sexual health services • Raising aspirations 	<ul style="list-style-type: none"> • Sexual health information • Youth work • Workforce development 	Year 1	Year 2	Year 3			
<p>Performance data should be reviewed annually. Examples of performance data measures should be selected to suit local context and may include:</p> <p>Targeting groups most at risk:</p> <ul style="list-style-type: none"> • Percentages of professionals in alternative education settings and special schools trained to deliver SRE • Percentages of social workers and family support workers trained in sexual health issues and interventions • Numbers of vulnerable young people accessing sexual health services, particularly in deprived areas • Numbers of looked after young people receiving sexual health information through LAC nurse, or specialist sexual health services • Numbers of BME young people receiving sexual health interventions <p>Performance in sex and relationships education:</p> <ul style="list-style-type: none"> • Percentage of schools with staff trained to deliver SRE • Percentage of schools involving external health professionals in SRE delivery • Percentage of schools involving parents/carers in SRE • Numbers of young people reporting they receive information on sex and relationships from their parents • Percentage of schools that have received support around the delivery of Curriculum for Excellence Health and Wellbeing outcomes for relationships, sexual health and parenthood 								

<p>Performance in young people's sexual health services:</p> <ul style="list-style-type: none"> • Numbers of young people's drop-in sexual health services • Percentage of these either in or within walking distance of secondary schools or young people's centres • Numbers of young people accessing sexual health services 			
<p>Performance in raising aspirations:</p> <ul style="list-style-type: none"> • Percentage of schools providing targeted approaches to young women most at risk • Numbers of young parents accessing support around education, training or employment • Proportion of post-16 young people in education, training or employment • School exclusion rate • Numbers of young people accessing extra-curricular, voluntary or community-based activities 			
<p>Performance in providing sexual health information:</p> <ul style="list-style-type: none"> • Percentage of schools, libraries, youth projects and health centres providing access to accurate, up-to-date information to young people • Percentage of secondary schools providing access to sexual health information websites • Number of visits to websites where appropriate 			
<p>Performance in youth work:</p> <ul style="list-style-type: none"> • Numbers of youth workers who have received training around sexual health/teenage pregnancy • Number of youth workers involved in sexual health service delivery to young people • Number of specific sexual health/teenage pregnancy information sessions/events delivered by youth service 			
<p>Workforce training:</p> <ul style="list-style-type: none"> • Numbers of professionals working with young people outwith mainstream schools trained to deliver sexual health interventions • Number of training participants on sexual health training courses delivered by health promotion/improvement services 			

QUALITY INDICATOR 2: MEETING THE NEEDS OF OUR STAKEHOLDERS	
Detailed quality indicator 2.1: Impact on children and young people	Scale (1–6)
<p>Themes</p> <ul style="list-style-type: none"> • The extent to which young people are engaged • The extent to which young people participate in the design of programmes and approaches • The extent to which young people report that they have the sexual health information that meets their needs 	
<p>Key questions</p> <ul style="list-style-type: none"> • How well do we consult young people, including those most at risk, about the delivery of programmes and services? • How well do we ensure that young people's views influence improvement, eg, through mystery shopping, training of professionals and peer education? • How well do young people trust the sexual health services we provide? • To what extent do young people use the sexual health services provided? 	
Evidence	Planned action(s)

QUALITY INDICATOR 2: MEETING THE NEEDS OF OUR STAKEHOLDERS		
Detailed quality indicator 2.2: Impact on parents/carers	Scale (1–6)	
<p>Themes</p> <ul style="list-style-type: none"> The involvement of parents as partners in their child's SRE and other programmes Support for parents of children at risk 		
<p>Key questions</p> <ul style="list-style-type: none"> How good are our schools at consulting parents/carers on the school's SRE policy and programmes, and involving them as partners in their child's SRE? How effective are our parenting support programmes in delivering SRE by trained professionals? How good are we at involving parents and carers in developing programmes and messages? How clear, accurate, culturally appropriate and accessible is our information for parents/carers? To what extent is the wider workforce aware of parents/carers as a source of support, and how well do they engage with them? How effective are we at providing targeted support for the parents/carers of young people most at risk? How good are we at ensuring the rights of young people are uppermost when parents are not supportive? 	<p>Evidence</p>	<p>Planned action(s)</p>

QUALITY INDICATOR 2: MEETING THE NEEDS OF OUR STAKEHOLDERS		
Detailed quality indicator 2.3: Impact on staff in partner agencies	Scale (1–6)	
<p>Themes</p> <ul style="list-style-type: none"> • Staff training around SRE • Staff training around supporting young people, issues of sexual health, pregnancy and parenthood 		
<p>Key questions</p> <ul style="list-style-type: none"> • How competent and confident are our staff to deliver SRE? • How competent and confident are our staff to deliver interventions and signposting around the reduction of teenage pregnancy? • How well do we assess staff training needs and local health needs and use this information to inform planning? • How good are we at encouraging and supporting staff to engage with the capacity building programme offered by the special health boards? • Do we ensure our training opportunities include both clinical and non-clinical staff? • How well do we target training and support to staff who work in areas with high conception rates? • To what extent do we provide mandatory training for those professionals who work with high-risk groups – social work managers, family support workers, carers and relevant social workers and careers advisers? 	<p>Evidence</p>	<p>Planned action(s)</p>

- Do we include youth workers in training, recognising their key role in relations to social issues affecting young people, including sexual health, alcohol and substance misuse?
- How widely offered are our multi-agency SRE training opportunities and how widely are they taken up, eg, by youth and social workers, foster carers, school nurses, teachers, learning support workers, residential care officers, education welfare officers, careers advisors and others with key relationships with young people, particularly those most at risk?
- To what extent are our staff working with young people aware of and adhering to guidance/policies on confidentiality, child protection, legal issues, referral procedures and the benefits of delaying sexual activity?
- To what extent do our staff's annual personal development plans/professional review and development address their training needs around sexual health?
- To what extent do staff promote positive sexual health messages including delay, and for the sexually active, safer sex?

QUALITY INDICATOR 3: PROVISION OF PROGRAMMES	
Detailed quality indicator 3.1: Information for young people	Scale (1–6)
<p>Themes</p> <ul style="list-style-type: none"> • Range of information provided • Accessibility of information provided • Quality of information provided 	
<p>Key questions</p> <ul style="list-style-type: none"> • How proactively do we publicise local services to young people most at risk? • How good are we at providing up-to-date information on all aspects of sexual health including relationships advice, preventing pregnancy and sexually transmitted infections? • How good are we at ensuring that sexual health information is available in a wide range of settings, including schools, libraries, youth work settings and health centres and that firewall systems do not block access to health promoting websites? • How clear and consistent are our messages to young people, and how well are they reinforced over time? • How varied are the formats used to convey information to young people? 	
Evidence	Planned action(s)

- How well do we target specific groups for information where appropriate?
- How good are we at providing information that is factual and non-judgemental?
- How good are we at ensuring our information is respectful of the target audience?
- How good are we at including our audience in the design and delivery of information?
- How well do we recognise the importance of information from the Internet, particularly in remote areas?
- How involved are our youth workers in delivering information about sexual health to young people?

QUALITY INDICATOR 3: PROVISION OF PROGRAMMES		Scale (1–6)
Detailed quality indicator 3.2: SRE/RME		
Themes	<ul style="list-style-type: none"> • Partnership working between schools and other agencies • Quality and integration of programmes provided • Inclusion and diversity • Provision in both mainstream and alternative settings 	
Key questions	Evidence	Planned action(s)
<ul style="list-style-type: none"> • To what extent are our SRE/RME programmes led by trained, committed teachers with support from other key staff such as school nurses, drug and alcohol education workers, sexual health specialists and other voluntary and statutory sector workers? • How integrated is SRE/RME as part of a holistic approach to health and wellbeing and health promotion in our schools? • To what extent are our SRE/RME programmes planned, assessed and evaluated against Curriculum for Excellence: Health and Wellbeing, both in mainstream and alternative education settings? • How well designed is our SRE/RME for different age groups, and how good are the links made across primary and secondary programmes to ensure continuity and progression? 		

		<ul style="list-style-type: none"> • How inclusive are our SRE/RME programmes and how sensitive to the diverse backgrounds and needs of all children and young people, including boys and young men, BME communities and LGBT young people? • To what extent are our SRE/RME programmes based on Kirby's 17 characteristics of effective curriculum based programmes (eg, SHARE)? • How well do our SRE/RME programmes raise awareness of equalities issues, such as gender roles, sexual stereotypes and ethnicity? • How well do our programmes emphasise healthy relationships, building assertiveness, self-esteem and self-confidence? • Is training and support targeted at schools with high conception rates and at non-mainstream educational settings? • How knowledgeable about sexual health services are staff working in schools and other educational settings and how well equipped are they to signpost appropriately? • To what extent do young people in special schools and non-mainstream education settings receive appropriate sex and relationship education from trained professionals? • How well do we prioritise at-risk groups² for the provision of sex and relationships education and one-to-one support by services engaging with these groups?

² Young people who are the following groups: not at school or in post-16 learning, offenders, looked after and accommodated, leaving care, teenage parents, migrants, asylum seekers and those with limited provision in English

QUALITY INDICATOR 3: PROVISION OF PROGRAMMES		Scale (1–6)
Detailed quality indicator 3.3: Sexual health services		
Themes		
<ul style="list-style-type: none"> • Range and quality of sexual health services provided • Accessibility of sexual health services provided 		
Key questions	Evidence	Planned action(s)
<ul style="list-style-type: none"> • How good is the mainstream funding provision for our young people's sexual health services? • How good are we at providing sexual health services which are welcoming, inclusive, friendly and non-judgemental, with the rights and responsibilities of young people clearly communicated? • How well are services promoted with visible marketing and signposting (including those within schools)? • How available are our services? Are they open at appropriate times and for a minimum of two hours a week? • Is there a mix of skilled staff available, eg, youth work and school nurse? • How well do we adhere to child protection and confidentiality procedures and policies? • How accessible are our sexual health services, eg, are they within walking distance of secondary schools/youth work settings? 		

<ul style="list-style-type: none"> • How good are we at providing access to condoms, contraception, pregnancy and Chlamydia testing, emergency contraception through pharmacies and long-acting reversible contraception for vulnerable young women? • How strong are the links between young people's sexual health services and other local services, eg, pharmacies, family planning, GUM, abortion and general practice? • How good are our referral systems to other services, eg, drug and alcohol support service, smoking cessation and youth services? • To what extent do sexual health service providers contribute to sexual health promotion work in schools and other educational settings? • How well do our sexual health services meet the needs of boys and young men? • How strong is our focus on contraceptive advice following pregnancy to avoid subsequent birth or repeat termination? • How involved are youth workers in condom distribution schemes and the delivery of sexual health services to young people? • How clear are the arrangements for referral from youth workers to specialist services? 		
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QUALITY INDICATOR 3: PROVISION OF PROGRAMMES		
Detailed quality indicator 3.4: Health improvement interventions		Scale (1–6)
Themes <ul style="list-style-type: none"> • Range and quality of interventions • Targeted nature of interventions 		
Key questions <ul style="list-style-type: none"> • How comprehensive are our sexual health consultations? Do they include health improvement interventions, especially for those most at risk? • How comprehensive are our interventions with young women who are already mothers? Do they include information about returning to education, training or employment? • How well are family centre staff and health visitors trained to play a role in interventions with young women who are already mothers? • Do we provide a range of complementary interventions involving a range of professions and tailored to suit specific needs? • How well do we prioritise at-risk groups³ for the provision of SRE and one-to-one support by services engaging with these groups? 	Evidence	Planned action(s)

³Young people who are: not at school or in post-16 learning, offenders, looked after and accommodated, leaving care, teenage parents, migrants, asylum seekers and those with limited provision in English.

- How well do we invest in targeted programmes that address risk taking behaviour, eg, alcohol and drug abuse?
- What progress are we making with having health assessments in place for all looked after children and young people (required by April 2010)?
- How involved are our youth workers in engaging young people in discussions on sex and relationships, including challenging negative sexual health attitudes among boys and young men?
- How well do we provide a range of complementary interventions involving a range of professions and tailored to suit specific needs?

QUALITY INDICATOR 3: PROVISION OF PROGRAMMES		
Detailed quality indicator 3.5: Raising aspirations		Scale (1–6)
Themes <ul style="list-style-type: none"> • Range and quality of activities • Targeted nature of activities • Transitions 		
Key questions <ul style="list-style-type: none"> • How wide is the range of positive activities available locally for young people, eg, arts, sports, faith groups, community and voluntary work? How good are we at encouraging participation? • To what extent are behaviour, attainment and attendance at school seen as central to reducing teenage parenthood? How comprehensive are our interventions to support young people who present difficulties in these areas? • To what extent do we support young people to resist peer pressure, become media literate and help deal positively with insecurity and lack of self-confidence? • How much use is made of alternative education provision for young women identified as most at risk of teenage pregnancy? 	Evidence	Planned action(s)

- How good are we at raising the aspiration of vulnerable young men and addressing their attitudes to sex, relationships and fatherhood?
- How good are we at providing strong transition arrangements to ensure support for young people at risk of being disengaged from learning, including the post-16 stage?
- How well do we target young parents for support, reintegration to education, training or employment?
- How inclusive are our schools and education settings for young people, even those with challenging behaviour?
- How good are we at providing arenas for young people and their communities to discuss challenging issues like teenage pregnancy?
- What actions are we taking to provide positive male and female models for young people?

QUALITY INDICATOR 4: MANAGEMENT		Scale (1–6)
Detailed quality indicator 4.1: Partnerships between key agencies		
Themes <ul style="list-style-type: none"> • Engagement of key partners • Roles and remits • Communication across agencies and disciplines 		
Key questions	Evidence	Planned action(s)
<ul style="list-style-type: none"> • How consistent are partners in demonstrating a clear commitment and accountability to the reduction of teenage pregnancy and how regularly do they meet? • Do those in lead roles in the partnership hold senior strategic positions within their agency? • How clear are all partners about their agency's accountability in reducing teenage pregnancy? • Is there a champion for reducing teenage pregnancy at a high level within the health board, the local authority and the multi-agency sexual health strategy group? • Are there clearly defined roles for leads within the health board, the local authority, clinicians, nurses, primary care and health promotion? • Is there a partnership agreement that clearly sets out expectations, roles and protocols? • How effective is the communication of information that facilitates partnership working? 		

QUALITY INDICATOR 4: MANAGEMENT		Scale (1–6)
Detailed quality indicator 4.2: Policy development and planning		
Themes <ul style="list-style-type: none"> • Local sexual health strategy • Communication strategy • Media management 		
Key questions	Evidence	Planned action(s)
<ul style="list-style-type: none"> • How integrated is the reduction of teenage pregnancy into other relevant strategies, plans and programmes, particularly those relating to mental health? • How effective is our local communication strategy? Have we identified a local lead for communication? • How well linked is the communication programme to other risk-taking behaviours? • Are our communications materials culturally appropriate and inclusive of particular at risk groups? • Do we have protocols in place to promote the local strategy and ensure consistent responses? 		

QUALITY INDICATOR 5: VISION AND LEADERSHIP	
Detailed quality indicator 5.1: Leadership and direction	Scale (1–6)
<p>Themes</p> <ul style="list-style-type: none"> • Shared leadership of the drive to reduce teenage pregnancy • Strategic planning and communication 	
<p>Key questions</p> <ul style="list-style-type: none"> • How available are leadership development opportunities to sexual health lead staff, in particular, lead clinicians, lead nurses, sexual health promotion specialists, and local authority and voluntary sector staff where appropriate? • How well do local authorities take a lead in delivering training around comprehensive SRE programmes? • How effective is our use of the national communications programme and how well is it linked to other risk-aking strategies? • How clear is our local strategy group about its role in supporting national communications and social marketing programmes? • Do we regularly assess the effectiveness of media and communication programmes? • How well do we engage with the media and key groups in challenging stereotypes, reducing stigma and discrimination and achieving more balanced reporting? 	<p>Evidence</p>
	<p>Planned action(s)</p>

QUALITY INDICATOR 5: VISION AND LEADERSHIP	
Detailed quality indicator 5.2: Monitoring and evaluating performance outcomes	Scale (1–6)
<p>Themes</p> <ul style="list-style-type: none"> • Performance data and measures showing trends over time • Overall quality of information and services provided by partners • Performance against national standards 	
<p>Key questions</p> <ul style="list-style-type: none"> • How committed is our local authority single outcome agreement to reducing teenage pregnancy? Does it include an indicator for a reduction in teenage pregnancy? • To what extent does our local sexual health strategy group monitor an agreed set of local performance indicators and review actions against agreed outcomes? • How systematic is our approach to knowing the local population and its needs in relation to teenage pregnancy? • How well do our planning bodies prioritise the collection, analysis and use of data and agree how to share it across sectors? • How effectively do we use information at the local level (local health profiles, school attendance, deprivation, ethnicity, and looked after and accommodated children) to target interventions? 	
Evidence	Planned action(s)

<ul style="list-style-type: none">• How well do we monitor and evaluate progress to increase our understanding of which programmes are most/least successful, and how to adapt them?• How ethical are we in our use of data and performance information with respect to confidentiality and the avoidance of stigma?• To what extent are we applying sexual health standards and competencies for non-clinical interventions?• To what extent are we applying NHS QIS standards in primary care interventions?• To what extent have we implemented the National Sexual Health (NaSH) system?• To what extent are we reporting on Key Clinical Indicators where appropriate?		
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5. Appendix: Key risk factors for teenage pregnancy

This section provides some information about the risk factors for teenage pregnancy, those groups most at risk, and why reducing teenage pregnancy is a priority for the Scottish Government.

The risk factors identified in this section are not exhaustive but indicate factors that local areas will be able to identify among their populations of young people.

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Where young people experience multiple risk factors their likelihood of teenage parenthood increases significantly. Young women experiencing five risk factors – daughter of a teenage mother, deprivation (father's social class IV & V), social housing at age 10, conduct disorder and poor reading ability at age 10 – have a 31% probability of becoming a mother under 20, compared with a 1% probability for someone experiencing none of these risk factors (Berrington, Diamond, Ingham, Stevenson, et al, 2005). Similarly, young men experiencing the same five risk factors had a 23% probability of becoming a young father (under age 23), compared to 2% for those not experiencing any of these risk factors.

Behavioural factors

Early sexual activity

Young women having sexual intercourse under the age of 16 are three times more likely to become pregnant than those who have first sex over 16 (Wellings et al, 2001).

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Poor contraceptive use

The barriers to using contraception and using it correctly for those aged under 16 may be greater than for those who are older; and the effort required to surmount them may be perceived as too great (Buston, Williamson and Hart, 2007).

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Social, emotional and behavioural difficulties

A number of studies have suggested a link between mental health problems and teenage pregnancy. One study of young women with behavioural difficulties showed a third became pregnant before the age of 17 (Maskey, 1991).

Alcohol and substance misuse

Some studies have found that teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience (Alcohol Concern, 2002). Young women experiencing pregnancy were found, in one study, to be more likely to regularly smoke cigarettes and have more than half of their friends who smoke (Buston, Williamson and Hart, 2007).

Educational factors

Low educational attainment

Young people scoring below average on measures of educational achievement at ages 7 and 16 have been found to be at significantly higher risk of teenage parenthood (Kiernan, 1995).

Unhappy at school

Young women who have experienced teen pregnancy are significantly more likely to report feeling disengaged from school (Buston, Williamson and Hart, 2007).

Leaving school at 16 with no qualifications

Around one in three sexually active young women leaving school at 16 without any qualifications had a child before the age of 18, compared with 1 in 6 who left at 16 with qualifications, and 1% of those who left at age 17 or over (Macdowall et al, 2002).

Low self-esteem

The risk of teenage pregnancy is raised among teenage girls with lower self-esteem than their peers. This is probably linked with an increased likelihood of unprotected intercourse (Emler, 2001).

Family/background factors

Socio-economic deprivation

Young women aged under 20 are up to five times more likely to be teenage mothers if they live in a deprived area (ISD Scotland, 2003). Delaying motherhood is less likely for all women living in deprived areas compared with the most affluent areas – the latter tend to have children around 12 years later.

Family 'connectedness' and parental monitoring

Young people who report more emotionally available parents are more likely to have intimacy-oriented attitudes towards sexual relationships as opposed to power-based attitudes. This is linked to delayed sexual debut and higher levels of discussion of and use of contraception (Ingham, 2002). Those reporting learning about sex from school or parents were less likely to report early sexual intercourse and more likely to report condom use, particularly for initial contact (Macdowall et al, 2002). Parents feel strongly that there would be fewer teenage pregnancies if more parents talked to their children about sex, relationships and contraception. However, many feel ill-equipped to undertake this role (Walker, 2004). Young women experiencing pregnancy were significantly less likely in one study to live with both parents or to have a high level of parental monitoring (Buston, Williamson and Hart, 2007).

Low aspirations

If there appear to be no future possibilities for a young woman that are worth attaining, motherhood may seem a viable alternative, even at a young age (Blum and Goldhagen, 1981). Young women who are restricted in life choices (due to family circumstances, low income and educational levels for example) may see parenthood as something to aspire to (Daguerre and Nativel, 2006). Also, lack of family aspiration, particularly a mother's aspiration for her daughter (as measured at age 10), can be seen as an early risk factor for teenage pregnancy (Wellings, Nanchahal, Macdowall et al, 2001).

Daughter of a teenage mother

A daughter whose mother was teenage mother is twice as likely to have a teen birth as one born to an older mother (Ermisch and Pevalin, 2003).

Particular groups

This list is not exhaustive. There are other groups about whose sexual health needs very little is known, but which are likely face barriers to sexual wellbeing and may be more vulnerable to teenage pregnancy. A research scoping review with a series of technical reports on the sexual health evidence on vulnerable populations will be published by Health Scotland in collaboration with the Medical Research Council in Summer 2009. Groups focused on include refugees and asylum seekers, gypsy/traveller communities and women subjected to gender-based violence.

Looked after young people

Up to a quarter of young women who have been looked after have a child by age 16 and nearly half become mothers within 18–24 months of leaving care (Corylon and McGuire, 1997).

Young offenders

Estimates suggest that in England around 39% of women under the age of 21 in prison are mothers, and one in four young men are fathers (HM Chief Inspector of Prisons, 2004). The picture is similar in Scotland. In one study, teenage boys and girls who had been in trouble with the police were twice as likely to become teenage parents compared to those who had no contact with the police (Hobcraft, 1998).

Teenage mothers

Figures available for the US and UK show that around 20% of births conceived under the age of 18 are second or subsequent births (DfES, 2006). In Scotland this figure is somewhat lower. Many young women in this group may not perceive early motherhood as problematic (Raneri and Wiemann, 2007).

Black and minority ethnic communities

Caribbean, Pakistani and Bangladeshi women have higher teenage birth rates than young white women. Cultural and religious attitudes to sexuality and marriage can pose difficulties, particularly for those young women who face dissonance between the dominant social norms of wider society and those of their family or faith group. This can lead to problems in acquiring sexual health knowledge and accessing services (Low, 2002).

Little is known about the sexual health needs of Polish and other Eastern European migrants to Scotland; research is required to ascertain their needs in relation to reducing teenage pregnancy.

Young people with learning disabilities

The sexual health experiences of young people with learning disabilities are varied and complex. Their sexuality is often ignored, stereotyped or distorted which may lead to the development of low expectations about sexual relationships and impact on their self-esteem (Douglas-Scott, 2003).

LGBT young people

Lesbian, gay, bisexual and transgender teens are at higher risk of early sexual activity and teenage pregnancy than heterosexual teens due to stigma, discrimination, sexual abuse and harassment at school. Creating safer, more supportive schools is cited as being a key step required to improve teenage pregnancy rates in all young people, but in LGBT teens in particular (Saewyc et al, 2008).

6. Appendix: Resources

The following links may be useful when looking for resources to support actions, particularly around work with young people:

www.healthscotland.com/topics/health/sexual-health/index.aspx

This area of the NHS Health Scotland website provides information on their Wellbeing in Sexual Health programme and network, including training opportunities, resources, research, publications and related links.

www.LTScotland.org.uk/sexandrelationshipseducation/index.asp

This area within the Learning and Teaching Scotland website provides information on SRE programmes, training, national guidance, policy examples and involving parents.

www.healthyrespect.co.uk/downloads-and-campaigns.htm

Evidence and reports, media campaigns and resources for parents, professionals and young people from the former National Health Demonstration Project, Healthy Respect.

www.LTScotland.org.uk/curriculumforexcellence/healthandwellbeing/index.asp

Information about Health and Wellbeing, including experiences and outcomes, from Curriculum for Excellence.

www.scotland.gov.uk/Topics

The sections in this area of the Scottish Government's website on Education & Training, Health & Community Care and People & Society include useful information and resources on a range of issues relevant to reducing teenage pregnancy.

www.nice.org.uk/Guidance/PH3

National Institute for Health and Clinical Excellence, *One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups, 2007.*

www.youngscot.org/channels/feelinggood

This part of the Young Scot website includes information for young people on a range of health topics including sexual health.

www.lgbtyouth.org.uk/home.htm

LGBT Youth Scotland is a national youth organisation working towards the inclusion of lesbian, gay, bisexual and transgender young people in the life of Scotland. It provides a range of services and opportunities for young people, families and professionals in order to proactively assist with increasing awareness and confidence, in turn reducing isolation and intolerance.

www.edlaw.org.uk/guidance/sexed.pdf

Circular 2/2001: Standards in Scotland's Schools etc Act 2000: Conduct of Sex Education in Scottish Schools

www.scotland.gov.uk/Topics/Health/health/sexualhealth

The purpose of this site is to provide key information about the programme of action to influence and encourage the nation to develop a culture of self respect, respect for others and strong relationships.

www.walk-the-talk.org.uk

A national initiative led by NHS Health Scotland designed to help health professionals make health services more youth-friendly.

www.healthscotland.com/documents/2502.aspx

This guidance was developed by Fair for All Age to help NHS Scotland understand aspects of age equality and achieve outcomes and improvements in the way services and functions are delivered in relation to age.

7. References

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