

Teenage Pregnancy: Accelerating the Strategy to 2010



Every Child Matters
Change For Children



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1. Ministerial foreword



1.1 Being a parent is a demanding job. It requires emotional maturity, financial security and the support of partners, family and friends. Teenagers who become parents are less likely to be in this position and consequently are at higher risk of long-term social exclusion. They all too often end up raising their children alone, isolated from the support they need and in poverty. For many – particularly those who leave education when they become pregnant – their lack of qualifications can trap them in poverty for the rest of their lives.

1.2 Children born to teenage mothers generally face disadvantage too: they are more likely to die in infancy; have poor health; and do badly at school. Daughters of teenage mothers are more likely to become teenage mothers themselves, continuing the cycle of early parenthood and social exclusion.

1.3 That's why the teenage pregnancy strategy, which this document extends, is absolutely central to the Government's wider drive to tackle social exclusion and poverty, as set out in our Social Exclusion Action Plan.

1.4 This document has two main messages. The first is that, since its launch in 1999, the teenage pregnancy strategy has been successful in most of the country in securing significant reductions in teenage conception rates. The second is that, if we are to meet our ambitious target to cut teenage pregnancy by half by 2010, we need both a stronger focus on local areas where progress has been poor; and a wider approach to teenage pregnancy which recognises more explicitly the importance of "deeper underlying causes" – poverty, exclusion and poor educational attainment – in driving conception rates in local areas.

1.5 Children and young people's services are being radically reshaped under the Every Child Matters and Youth Matters programmes, bringing a new collective focus on prevention of poor outcomes. This landmark programme of change offers a unique opportunity to target the underlying risk factors that are linked to teenage pregnancy and to give young people the chance to make positive choices and achieve their potential.

1.6 *It is not easy for the Government and local public services to influence young people's decisions about their sexual behaviour. Evidence shows that the attitudes and behaviour of parents have the strongest impact – though peer influences and wider cultural and media influences are also important. But progress to date shows that what public services do does matter. Services can:*

- send clear messages to young people – boys as well as girls – on the negative consequences of having sex at an early age in terms of: the increased risk of unplanned pregnancies and STIs; the poorer health and education outcomes for teenage parents and their children; and the high levels of regret reported by young people themselves;
- provide them with the knowledge, skills and confidence to prevent pregnancy and manage their sexual health;
- improve their access to advice and support on contraception and sexual health;
- help facilitate open discussions between parents and their children on sex and relationships; and
- ensure that advice on contraception is an integral part of the support provided to young women who have had a prior conception (either leading to an abortion or birth), to avoid the risk of second and subsequent conceptions.

1.7 This is the basis of our current strategy to reduce teenage conception rates. There is no evidence that improving young people's access to contraceptive and sexual health advice leads to earlier first sex. Both levels of sexual activity among under-16s and the age at which young people first have sex have not changed since the strategy began. The international evidence from countries with success in reducing teenage pregnancy rates also supports the approach we are taking. And local areas that have implemented these approaches more intensively are the ones that have seen the biggest declines in conception rates.

1.8 Advice on the specific measures needed locally to provide this support to young people and parents, together with detailed analysis of trends in teenage pregnancy and its causes, was set out in delivery guidance issued to Local Authorities and PCTs in July 2006.

1.9 This revised strategy builds on that guidance in two ways. First, we identify the action we will take to intervene in poor performing areas to improve their performance to the standards of the best. Second, we set out what Government must do to address more effectively the underlying risk factors and motivate young people to pursue goals other than early parenthood.

1.10 At the same time, we will continue to support teenage parents and their children, whose life prospects are particularly poor. We will issue detailed guidance on how local areas can best support teenage parents later this year.

1.11 Research shows the vast majority of teenage pregnancy is unplanned. Almost half of under-18 conceptions end in abortion and most young parents wish they had waited. While for the vast majority of young people, there is no evidence that access to housing and benefits acts as an incentive to become pregnant, it remains a concern that some young mothers under 18 can live in social housing without any support. Such mothers often find themselves isolated in unsuitable housing, away from their families and other support networks. That only adds to the risk of poor outcomes for both parents and children.

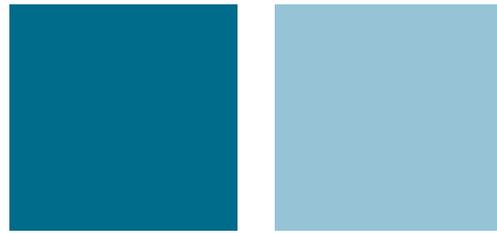
1.12 It is vital that we continue to offer high quality support to teenage parents and their children. But we need fresh thinking about whether we are doing this in the right way. We will therefore be issuing revised guidance to local authorities later in the year on support for teenage parents. As part of this work, I want to look at the way in which teenage parents access appropriate housing, the practical support they receive and the links between the two.

1.13 Our ambition is that all young people should have the skills, confidence and motivation to look after their sexual health and delay parenthood until they are in a better position – emotionally, educationally and economically – to face its challenges.

A handwritten signature in black ink that reads "Beverley Hughes". The signature is written in a cursive, flowing style.

Beverley Hughes
Minister for Children, Young People and Families
Department for Education and Skills

2. Introduction



2.1 When the Teenage Pregnancy Strategy was launched in 1999, it included a challenging target to halve the under-18 conception rate by 2010 – compared to the 1998 baseline year.

2.2 The most recent data (2004) shows steady progress has been made, to the point where both the under-18 and under-16 conception rates are at their lowest levels for 20 years. The reductions achieved so far mean an overall *decline of 15.2%* in the under-16 rate and a *fall of 11.1%* in the under-18 rate.

2.3 Seven years into the strategy, we now know far more than we did in 1999 about the characteristics of young women who become pregnant early, what factors increase the risk of early pregnancy and what action needs to be taken to reduce teenage pregnancy rates.

2.4 The lessons learnt about successful delivery were set out in detailed guidance to Local Authorities and Primary Care Trusts, in July 2006. This highlighted the wide variation in progress between areas – from a reduction of over 40% in one Local Authority, to an increase of over 40% in another. The guidance made clear the ingredients of success – drawn from intensive reviews of action on teenage pregnancy in local areas – and set out the action we expect **all** areas to take to improve performance to the levels of the best.

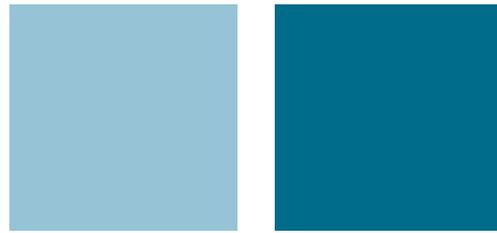
2.5 The guidance also included analysis on the risk factors for early pregnancy, which are summarised in chapter 3 of this document. It identified risks that are addressed directly through local strategies. But it also highlighted *underlying causes* of teenage pregnancy, which reflect the wider circumstances that place young people at high risk of a number of poor outcomes.

2.6 This analysis of the underlying causes of early pregnancy makes clear that effective delivery of local strategies is critical. But it also recognises that further progress in reducing teenage conception rates will depend on the Government's success in addressing these underlying factors, such as poverty, poor educational attainment and low aspirations. This

document, therefore, focuses on the need to deepen the strategy to tackle these wider issues. Specifically, it:

- Makes clear the negative consequences of early parenthood on both the young mother and child and the costs to the individual, local community and society as a whole;
- Encourages local areas to strengthen local implementation based on the evidence of what works;
- Clarifies which young people are likely to become pregnant to ensure action is focussed on 'hotspot' neighbourhoods and young people most at risk;
- Describes how we will intervene to address poor progress in some areas, starting with the 21 Local Authorities with high and increasing rates (listed at annex 1);
- Sets out how we will build on the Government's existing policies to tackle the underlying causes of teenage pregnancy; and
- Signals further work to improve outcomes for teenage parents and their children that will be set out in full later this year.

3. Why Teenage Pregnancy Matters



3.1 Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young people’s lives such as poor family relationships, low self-esteem and unhappiness at school also put them at greater risk.

3.2 From the perspective of young people in such circumstances, early parenthood can appear a rational choice, providing a means for marking their transition to adulthood or having somebody to love in their lives. There are also some communities in which early parenthood is seen as normal and not a cause for concern.

3.3 But evidence clearly shows that having children at a young age can damage young women’s health and well-being and severely limit their education and career prospects. And while young people can be competent parents, longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves. The facts are stark:

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.ⁱ
- Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth aged 24 or over.ⁱ
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.ⁱ
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth;
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers;

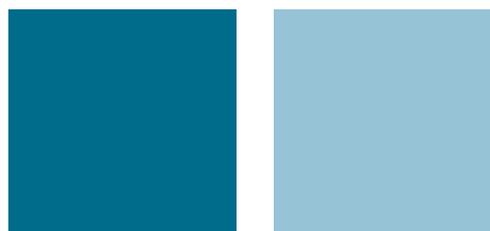
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothersⁱⁱ – both of which have negative health consequences for the child;
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twentiesⁱⁱⁱ, have higher mortality rates under 8^{iv} and are more likely to have accidents and behavioural problems.^v
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.^v

3.4 Rates of teenage pregnancy are far higher among deprived communities, so the negative consequences of teenage pregnancy are disproportionately concentrated among those that are already disadvantaged. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next.

3.5 There is also a strong economic argument for investing in measures to reduce teenage pregnancy as it places significant burdens on the NHS and wider public services. The cost of teenage pregnancy to the NHS alone is estimated to be £63m a year. Teenage mothers will also be more likely than older mothers to require expensive support from a range of local services, for example to help them access supported housing and/or re-engage in education, employment and training.

3.6 The challenge, therefore, 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, or lead them passively to become pregnant at a young age. Reducing teenage pregnancy therefore contributes to a wider strategy to reduce inequalities and social exclusion. For example, work to address the underlying causes of teenage pregnancy contributes to achieving the Government's ambitions for reducing child poverty, infant mortality and the transfer of disadvantage between generations.

4. Identifying those most at risk of teenage pregnancy



4.1 Risk factors for teenage pregnancy are well recognised and provide a compelling case for targeted action on young people who are exposed to these risks.

4.2 Young people experiencing risk factors for teenage pregnancy are highly concentrated within particular areas and among vulnerable groups. To target effectively those most at risk requires both a geographical focus on high rate neighbourhoods and the identification of vulnerable groups at high risk of teenage pregnancy.

Targeting high rate neighbourhoods

4.3 Variations in teenage pregnancy rates are highly correlated with levels of deprivation across England:

- Half of all conceptions under-18 in England occur in the 20% most deprived wards.
- Teenage pregnancy rates among the most deprived 10% of wards are four times higher than in the 10% least deprived wards
- Teenage pregnancy 'hotspots', where more than 6% of girls aged 15-17 become pregnant, are found in virtually every local authority in England.

Identifying high rate neighbourhoods

4.4 Within local authority and PCT areas, neighbourhoods with high teenage pregnancy rates and numbers can be identified using ward level under-18 conception data. These data are disseminated by the Government and provide a geographical picture of where local areas need to focus resources and interventions. Ward level data on educational attainment and deprivation are also available and should be used by local areas to further inform the targeting of resources. We will ensure all areas are both able to, and in practice are, analysing all available data to identify high rate schools and communities within their local areas and targeting their local action in those localities.

Targeting vulnerable groups

4.5 Teenage pregnancy is a complex issue, affected by a wide range of personal, social, economic and environmental factors. However, research evidence has identified the key risk factors which are known to increase the likelihood of teenage pregnancy. These can be broadly grouped into: risky behaviours; education-related factors; and family and social circumstances.

4.6 The risk factors identified in table 1 below are not exhaustive but reflect those factors which local areas may be able to identify among its population of young people. Further details on risk factors for teenage pregnancy can be found in *Teenage Pregnancy Next steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies*, DfES, July 2006.

Table 1: Factors associated with high teenage pregnancy rates

Risk factor	Evidence
Risky Behaviours	
Early onset of sexual activity	<p>Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16.^{vi}</p> <p>Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males and leaving school at 17 or over with qualifications.</p> <p>Early onset of sexual activity is also associated with some ethnic groups (see below).</p>
Poor contraceptive use	<p>Around a quarter of boys and a third of girls who left school at 16 with no qualifications did not use contraception at first sex, compared to only 6% of boys and 8% girls who left school at 17 or over, with qualifications.</p> <p>Survey data demonstrate variations in contraceptive use by ethnicity. Among 16-18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32%), Asian females (25%), Black African females (24%) and Black Caribbean males (23%).^{vii}</p>
Mental health/conduct disorder/involvement in crime	<p>A number of studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17^{viii}.</p> <p>Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police.^{ix}</p>

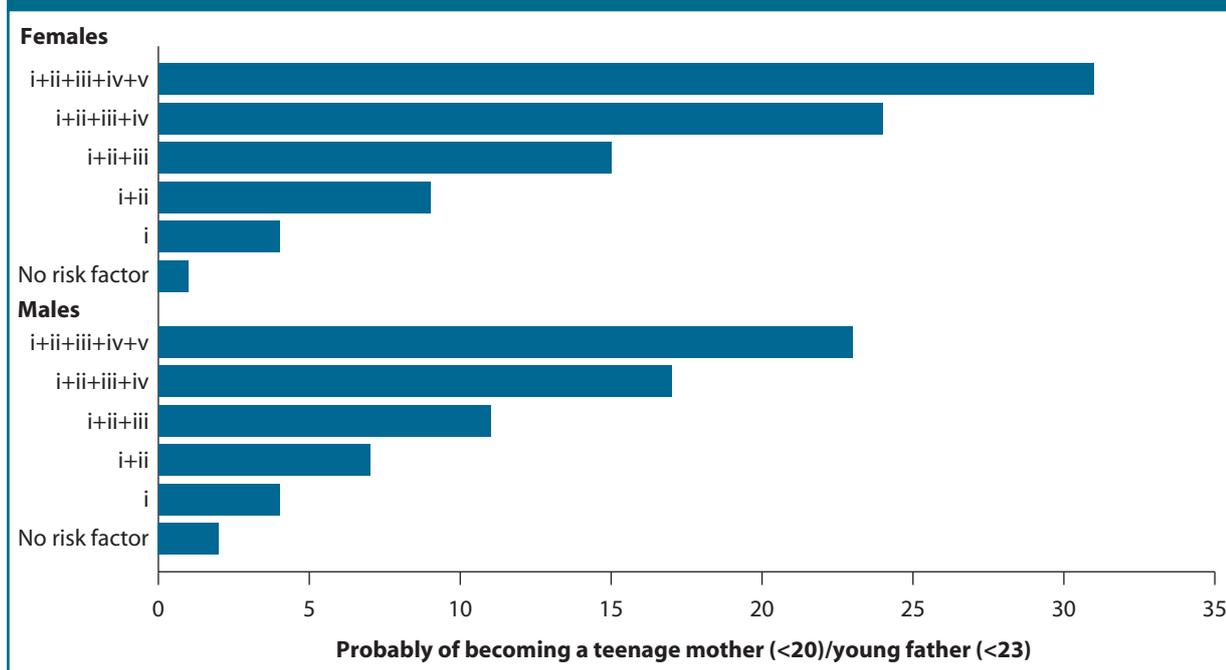
Risk factor	Evidence
Risky Behaviours	
Alcohol and substance misuse	Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for both young men and women. A study in Rochdale showed that 20% of white young women report going further sexually than intended because they were drunk ^x . Other studies have found teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience. ^{xi}
Teenage motherhood	A significant proportion of teenage mothers have more than one child when still a teenager. Around 20% of births conceived under-18 are second or subsequent births.
Repeat abortions	Around 7.5% of abortions under-18 follow either a previous abortion or pregnancy. Within London this proportion increases to around 12% of under-18 abortions.
Education-related factors	
Low educational attainment	The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment (80 per 1000 girls aged 15-17 compared with 40 per 1000).
Disengagement from school	<p>A survey of teenage mothers showed that disengagement from education often occurred prior to pregnancy, with less than half attending school regularly at the point of conception. Dislike of school was also shown to have a strong independent effect on the risk of teenage pregnancy.^{xii}</p> <p>Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with more than 8% of half days missed had, on average, an under-18 conception rate 30% higher than areas where less than 8% of half days were missed.</p>
Leaving school at 16 with no qualifications	<p>Overall, nearly 40% of teenage mothers leave school with no qualifications.^{xiii}</p> <p>Among girls leaving school at 16 with no qualification, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over.</p> <p>Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex (see below).</p>

Risk factor	Evidence
Family/Background factors	
Living in Care	<p>Research has shown that by the age of 20 a quarter of children who had been in care were young parents, and 40% were mothers^{xiv}.</p> <p>The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.</p>
Daughter of a teenage mother	<p>Research findings from the 1970 British Birth Cohort dataset showed being the daughter of a teenage mother was the strongest predictor of teenage motherhood.</p>
Ethnicity	<p>Data on mothers giving birth under age 19, identified from the 2001 Census, show rates of teenage motherhood are significantly higher among mothers of 'Mixed White and Black Caribbean', 'Other Black' and 'Black Caribbean' ethnicity. 'White British' mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented.</p> <p>A survey of adolescents in East London^{xv} showed the proportion having first sex under-16 was far higher among Black Caribbean men (56%), compared with 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, 30% of both White and Black Caribbean groups had sex under-16, compared with 12% for Black African, and less than 3% for Indian and Pakistani women.</p> <p>Poor contraceptive use has also been reported for some ethnic groups (see below).</p>
Parental aspirations	<p>Research shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage motherhood.^v</p>

4.7 Where young people experience multiple risk factors, their likelihood of teenage parenthood increases significantly. Figure 1 below shows that young women experiencing five risk factors (daughter of a teenage mother; father's social class IV & V; conduct disorder; social housing at 10 and poor reading ability at 10) have a **31%** probability of becoming a mother under 20, compared with a **1%** probability for someone experiencing none of these risk factors.^{xiv}

4.8 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.^{xiv}

Figure 1: Predicted probabilities of becoming a teenage mother (<20 yrs) and young father (<23 yrs) according to risk factors



Source: Analysis of 1970 British Cohort Study data in Berrington A, et al (2005)^{xiv}

Identifying vulnerable groups

4.9 Identifying those most at risk of teenage pregnancy is of critical importance.

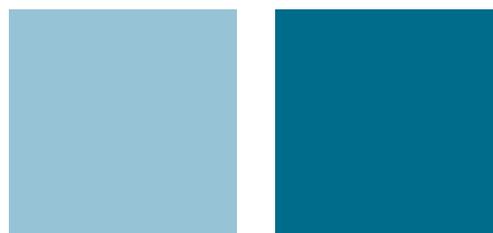
However, a review of local teenage pregnancy strategies found that many local areas had difficulty identifying vulnerable groups.

4.10 To ensure those at greatest risk of teenage pregnancy are identified the key factors in table 1 need to be incorporated into all risk assessments undertaken by agencies and professionals working with children and young people. Local data collection systems also need to capture those factors associated with high teenage pregnancy rates and other negative outcomes.

4.11 To support local areas with identifying vulnerable groups, the Teenage Pregnancy Unit will:

- Provide analysis identifying schools that may have high numbers of pupils at risk of teenage pregnancy by overlaying ward under-18 conception data with school catchment data;
- Develop a checklist on making the best use of locally available data, including advice on how best to assess the incidence of second pregnancies;
- Develop a checklist on best practice for working with different BME communities;
- Share best practice of those areas where they have successfully identified those at greatest risk of teenage pregnancy.

5. Accelerating Progress



Driving up local performance to the level of the best

5.1 All Local Authorities and PCTs have under 18 conception rate targets which they are expected to reach by 2010 to meet the national PSA reduction of 50%. Some are making excellent progress, while others are performing badly. Intensive reviews of statistically similar areas with contrasting rates of progress, carried out in 2005, identified the key factors in successful areas:

- *Active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies – Health, Education, Social Services and Youth Support Services – and the voluntary sector;*
- *A strong senior champion who was accountable for and took the lead in driving the local strategy;*
- *The availability of a well publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services;*
- *A high priority given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools;*
- *A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;*
- *The availability (and consistent take-up) of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, Youth Workers and Social Workers) working with the most vulnerable young people; and*
- *A well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.*

5.2 Our Delivery Guidance makes clear that all areas should have these factors in place to perform at the level of the best – if all areas were achieving the reductions of the top 25%, the national reduction would be 23% – more than twice the 11.1% reduction that has been achieved.

5.3 Implementation of the Guidance recommendations will be monitored in all areas through the improvement cycle. Local areas will be provided with a self assessment diagnostic tool to review their strategies against the deep dive factors and identify areas for improvement.

Tackling neighbourhoods and Local Authorities with high and increasing rates

5.4 The progress of *all* authorities towards their reduction targets will be monitored each February when the annual under 18 conception rates are published. We will alert the media and public to the individual performance of all areas each year when data is published.

5.5 High performing areas have demonstrated that if the strategy is implemented effectively and with strong commitment, teenage conception rates can fall very substantially. It is therefore neither inevitable nor acceptable that rates should be static or rising in other areas. Therefore, we are proposing specific actions in poor performing areas to drive performance to the level of the best.

5.6 We will potentially intervene in areas with high and increasing rates, in line with the Government's drive to improve delivery in local authorities, and the forthcoming Local Government White Paper. The aim is for local areas to get better value from existing resources by learning from successful areas and commissioning what works. A key principle of Children's Trusts is to bring funding streams together to fund jointly commissioned Children and Young People Plans. Areas with declining rates have achieved this and we do not believe that local authorities will need to spend more. We will continue to work with key stakeholders, including local government and keep costs under review. The Government remains committed to ensuring that unfunded new burdens are not placed on local authorities. This will involve:

- a Ministerial meeting in the autumn with senior officials from local areas with high and increasing rates, to establish a network for ongoing support and challenge;
- using the self assessment tool to identify weak delivery and agree necessary action with GO Children's Services Advisers in Priorities Meetings;
- Support from the Department of Health's National Support Team for areas identified by GOs as facing the biggest challenges to meeting their target;
- 'Twinning' high performing areas with poor performing areas to provide peer support and challenge.
- Termly progress reports to Ministers from high and increasing rate areas.

Deepening the Strategy to tackle broader risk factors

5.7 The analysis of risk factors in Chapter 3, makes clear the links between teenage pregnancy and risky behaviour, family and parental influences; poor educational attainment and school attendance, and low aspirations. Targeted youth support will help to ensure services work together to address the factors that put young people at risk of a range of serious problems and restrict their opportunities. Addressing these underlying risk factors is critical if we are to further reduce teenage pregnancy rates.

5.8 We have a wide range of programmes in place which are making significant progress. The recent cross-Government Social Exclusion Action Plan signals our commitment to accelerating the impact of these programmes and narrowing the gap in life chances between young people who are achieving well and those most at risk.

Tackling risky behaviour

Improving PSHE

5.9 Schools are now inspected against the Every Child Matters framework and need to ensure that – through the curriculum – young people are gaining the skills and confidence to help them achieve the 5 ECM outcomes. There are currently a number of subjects through which young people acquire this knowledge and skills, including PSHE, Citizenship and programmes such as Social, Emotional & Behavioural Skills (SEBS) and Social and Emotional Aspects of Learning (SEAL), as well as through cross-curricular project work.

5.10 We have set out in our delivery guidance what we believe the key features of a good SRE programme within PSHE should include. In summary, we want all young people – both boys and girls – to have access to high quality information about sex and relationships and support to develop the skills, confidence and appropriate values framework they need to make and carry through positive choices, including a strong focus on the benefits of delaying early sex.

5.11 Evidence from practice suggests that strong PSHE, active citizenship and pastoral care can improve engagement with learning through building self esteem, emotional development, reducing bullying and improving behaviour – as well as helping to tackle key health issues such as teenage pregnancy and substance misuse.

5.12 We have signalled the importance of PSHE through its inclusion in the mandatory requirements of the Healthy Schools Programme, the development of QCA Key Stage assessment statements, the funding of a CPD programme for teachers and nurses, and the establishment of a new PSHE Subject Association.

5.13 However, to accelerate progress in poor performing areas, we will explore – through the Healthy Schools programme and Local Area Agreements – how to incentivise schools

in high and increasing rate authorities to improve PSHE. All schools will either be a healthy school or working towards Healthy School Status by 2009. The importance of good quality PSHE will also be reinforced in new curriculum guidance for all PRUs later this year.

5.14 Schools affected will be expected to have a specialist trained PSHE teacher who is undertaking, or already meets the criteria of our PSHE continuing professional development programme. To monitor provision, we will ask OFSTED to focus their next PSHE subject report on these schools, and include feedback from pupils on whether the programme met their needs.

5.15 We will also ensure that the impact that good quality PSHE has on reducing England’s high teenage pregnancy rates is fully taken into account by QCA in its development of the curriculum.

5.16 Many local areas have said that they lack information on the range of SRE resources available. In response, we will develop a menu of programmes that areas might want to invest in. Details of SRE programmes will be developed (presented in a common format to help comparisons) and sent to those responsible for commissioning such resources. An initial summary of programmes is included in the table below to illustrate the broad range of approaches. This will be expanded into a web-based resource to allow it to be easily updated as new resources come on stream. While not endorsing individual SRE resources, the ‘menu’ will allow local areas to investigate what is available and select resources that best meet the needs and circumstances of young people in their local communities.

Table 2: a non-exhaustive list of SRE programmes			
Name of programme	Key features	Evaluation	Contact details
L8r	An interactive SRE programme aimed at 12-18 year olds, involving 8 short dramas on different aspects of SRE, a linked website, and practitioners’ resources. Participants can ‘vote’ on moral dilemmas posed at the end of each episode and take part in live chat and online forums mediated by trained peer mentors.	Post course evaluation questionnaires of over 800 participants show L8r is well regarded and highly effective at engaging young people. The ability to access the L8r site anonymously to discuss personal issues that they didn’t feel comfortable discussing in the classroom/group, was found to be particularly useful.	Maria Annecca Tel: 020 7538 8075 E-mail: info@l8r.uk.net Or visit: www.l8r.uk.net

Table 2: a non-exhaustive list of SRE programmes (continued)

Name of programme	Key features	Evaluation	Contact details
RIPPLE	Peer-led programme delivered by 16-17 year olds to young people in Year 9. Focus on skill-based activities on topics such as relationships, contraception and STIs	Participant feedback rated RIPPLE more highly than teacher-led programmes. By age 16, significantly fewer young women reported having had sex than in comparison programmes and fewer unintended pregnancies.	Ann Oakley Tel: 020 7612 6397 E-mail: ssru@ioe.ac.uk
APAUSE	A comprehensive and modular programme covering Key Stage 3 and 4. Peer-led programme complements the adult facilitated modules. Structured opportunities for health professional participation. Ready-to-go classroom materials supplied with all elements. An integrated evaluation reports on process, impact and outcomes.	Highly valued by 88% of participating schools. Positive effects on knowledge, attitudes and beliefs. Analysis of questionnaires completed in Year 11 shows APAUSE students less likely to be sexually active than young people in comparison schools	John Tripp Tel: 01392 403146 E-mail: apause@exeter.ac.uk
SEXPRESSION	SRE programme delivered by medical students in the role of 'quasi-peer' educators. Aims to promote self-esteem and empowerment and informed decision making. Strong focus on giving young people the confidence to access mainstream contraceptive and sexual health advice services	93% of young people interviewed thought medical student involvement in SRE delivery was a good idea and 70% said they would talk more openly with a medical student.	Matt Prior E-mail: sexpression@medsin.org

Table 2: a non-exhaustive list of SRE programmes (continued)

Name of programme	Key features	Evaluation	Contact details
NOT JUST A BUMP	Aimed at 12-19 year olds, the programme involves 5 x 3-hour group sessions, prior to looking after a virtual baby for a night to understand the demands and responsibilities of parenthood, followed by opportunity to reflect on experiences consider attitudes to parenthood.	Positive feedback from participants, in particular on the experiential learning involved in the programme which was judged to have the greatest impact on attitudes to early parenthood. Post-course questionnaires indicate greater inclination to delay pregnancy/use contraception.	Lee Turnbull Tel: 0161 745 9771 E-mail: lee.turnbull@btconnect.com
STRAIGHT TALKING	Young parents trained to deliver sessions on the realities of young parenthood. Focus on exploding myths about access to 'nice' housing/'generous' benefits, and encouraging young people to delay parenthood until they are older.	Positive feedback from participants, in particular, due to the credibility of the message coming direct from those with experience of young parenthood. High level of recall of key messages by participants. Positive spin-off is the increase in confidence and esteem of the young mothers who facilitate the sessions.	Hilary Pannack Tel: 020 8605 0900 E-mail: straight.talking@virgin.net

5.17 The National Institute for Clinical and Health Excellence (NICE) will publish guidance later this year on effective one to one interventions to reduce under-18 conceptions and STIs.

Preventing repeat pregnancies

5.18 Around 20% of births to under-18s are to young women who are already teenage mothers. We have made clear in the Children's Centres' Practice Guidance and Maternity Standard of the National Service Framework, the critical importance of supporting teenage parents to access a method of contraception they are confident to use. We will also be:

- disseminating information to Children’s Centres, maternity units and GPs, so they can alert teenage parents to the risks of pregnancy following childbirth;
- identifying and sharing effective practice on prevention through the ECM website and the NSF emerging practice database;
- liaising with relevant professional bodies for midwives and health visitors, including the Royal Colleges, to build contraception training into pre-registration and CPD programmes;
- ensuring the health visitors involved in the intervention programme detailed in the Social Exclusion Action Plan, have the skills and competences to ensure young parents access and use contraception effectively.

5.19 We also need to tackle the problem of young people facing repeat abortions – around 7.5% of abortions under-18 follow either a previous abortion or pregnancy. We will:

- include the need to provide comprehensive abortion care packages (including contraception and counselling) in forthcoming DH commissioning guidance to PCTs on contraception/reproductive health services
- test different models of supporting young people who have had an abortion, and teenage parents, in their use of contraception – in the four DH Teenage Health Demonstration pilots.

Extending the media campaign to tackle risky behaviour

5.20 We have made significant strides in our media campaign to give young people clear and consistent messages about resisting pressure to have early sex, the risks of unprotected sex and the importance of using condoms. Both the *RUthinking* campaign (targeted at under-16s) and the new *Want Respect?* use a *condom* campaign (focused on older, sexually active teenagers) have had a real impact on raising awareness. Tracking surveys have highlighted that young people who are aware of the campaign are: less likely to think that the majority of under-16s have had sex, more likely to talk to a health professional about contraception and more likely to say they intend to use a condom if they do have sex.

5.21 We will extend and target the campaign further by:

- making the *RUthinking* materials available to schools, with additional focus through the Healthy Schools Programme to schools in areas with high and increasing rates and to schools in all areas serving ‘hotspot’ wards;
- continue to develop messages to help young people see the benefits of delaying early sex and resisting pressure to have sex they do not want. This will include further work to develop a ‘delay’ message which has a resonance and credibility amongst boys and young men;

- an increased focus on media channels targeting boys and potential partnerships with national sports organisations and popular commercial outlets;
- a new focus on reaching 16 and 17 year olds in FE colleges – providing Want Respect materials to Student Support Services;
- work with independent retailers to promote ‘Want Respect’ messages to older teenagers at high risk of early pregnancy, and increase their access to free or low cost condoms. This will include nail bars, hair salons, barbers, independent record stores and ‘street wear’ shops’;
- continue to commission research to better understand the sexual attitudes and behaviours of the most at risk target audiences in order to inform future communications activity.

Improving Emotional Health & Well-being

5.22 As the analysis in chapter 3 indicates, mental health problems are associated with higher risk of teenage pregnancy. The Government’s aim – set out in Standard 9 of the National Service Framework for Children, Young People and Maternity Services – is to provide all children and young people who need it with access to timely, integrated, high-quality mental health services. Additional resources have been provided to ensure that a comprehensive CAMHS service is provided in all local areas by December 2006, including provision of services for all 16 and 17 year olds, appropriate to their age and level of maturity.

5.23 Bullying and dislike of school are often cited by young mothers as the reasons for their disengagement from learning, which in turn was one of the contributory factors to their becoming pregnant. Work in schools on improving young people’s emotional health and well being – which is recognised as a strong protective factor against a range of negative outcomes – has become a much higher priority over recent years. The new Healthy Schools standard requires schools to have measures in place to support young people’s emotional development in order to achieve Healthy School Status.

5.24 The development of children and young people’s social, emotional and behavioural skills is key to promoting positive behaviour and effective learning. In June 2005, the Social and Emotional Aspects of Learning (SEAL) curriculum programme was made available to all primary schools and it contains a whole-curriculum approach to developing these skills. Some of these skills are particularly relevant to reducing the risk of teenage pregnancy and include developing self-awareness, self-esteem and confidence, along with improved social skills and a sense of responsibility for others. A pilot to explore which approaches to this work are appropriate in secondary schools is currently underway.

Education-related factors

Improving attainment, behaviour and attendance

5.25 It is clear that teenage pregnancy is strongly associated with low educational attainment. On average, deprived wards where less than 40% of girls achieve 5 GCSEs, have under 18 conception rates twice as high as similarly deprived wards with more than 60% of girls gaining 5 GCSEs.

5.26 The analysis also shows the strong association between leaving school at 16 without qualifications and earlier first sex, poor contraceptive use, and the consequent greater likelihood of conceiving under-18.

5.27 While steady progress is being made on improving educational attainment across the board, we need to ensure these improvements reduce the gap between the average and those who currently achieve least at school.

5.28 Personalised learning, with a stronger focus on ensuring that every child is secure in English and maths, is key to driving up standards further, and tackling the persistent achievement gaps between social and ethnic groups.

5.29 Exciting and engaging whole-class teaching will remain the cornerstone of a good education, but in order to ensure that all children are stretched and engaged it must be supported by:

- earlier interventions to prevent children falling behind their peers – tackling potential problems before they have a long-term impact on a child’s education;
- extra small group or one-to-one tuition for those pupils who have fallen behind their peers in English and maths, particularly at Key Stage 3, where some children do not consolidate their success at primary school.

5.30 We have also introduced more targeted approaches to tackle under-performance among particular groups of young people who are at greater risk of teenage pregnancy, in particular policies and programmes designed to raise achievement of black and minority ethnic groups and looked after children.

5.31 In 2003, we launched a national strategy *Aiming High: Raising the Achievement of Minority Ethnic Pupils*, designed to raise the performance of BME pupils. Since 2003 we have seen year on year improvements at each Key Stage for BME pupils.

5.32 Poor attainment is often a consequence of poor attendance and behaviour. The Government has made improving behaviour and attendance a key priority over recent years. This has led to improvements in the levels of attendance in many schools.

5.33 However, persistent absence among a small core of young people remains a problem. The introduction of school partnerships – clusters of local schools pooling resources and sharing successful approaches to tackle common problems – is designed to harness innovation and creativity in tackling these difficult problems. By September 2007 all secondary schools should be working together in partnerships to improve behaviour and tackle persistent truancy.

5.34 To maximise the impact of schools' attainment, behaviour and attendance strategies on teenage pregnancy rates, we will publish a short briefing for Local Authorities to send to all schools, making clear the strong association with low attainment and poor attendance, and highlighting additional risk factors for teenage pregnancy such as being emotionally withdrawn or showing poor social engagement.

5.35 This will enable them to strengthen support to young people who may not currently be the focus of these programmes and ensure that they make speedy referrals to additional pastoral support. Schools may also want to consider the provision of intensive PSHE or personal development programmes to ensure a robust package of support for young people most at risk.

Raising aspiration

5.36 We know that teenage pregnancy rates are higher in more socially deprived wards and that young people who live in those wards are more likely to go ahead with the pregnancy rather than have an abortion.

5.37 The Neighbourhood Renewal Strategy aims to improve health, education, employment, housing and the local environment and reduce crime in the poorest areas – factors that can have a significant impact on vulnerable young people and the choices that they make.

5.38 The Neighbourhood Renewal Fund has been used in many deprived areas to support teenage pregnancy related projects and mainstream programmes. Some Local Strategic Partnerships have also developed targets that aim to narrow the gap in teenage conceptions between the areas with the highest and lowest rates.

5.39 More specifically, the New Deal for Communities (NDC) neighbourhood renewal programme has been heavily involved in activities to reduce teenage pregnancy in deprived areas. Activities range from improving access to contraception and sexual health advice services to raising aspirations, peer education and changing attitudes to teenage pregnancy.

5.40 In addition there are an increasing number of personal development opportunities (both as part of alternative Key Stage 4 learning packages and through extra-curricular activities) that seek to raise aspirations among those at greatest risk. For example, the Young People Development Pilots (YPDP) pilots aimed at helping young people avoid risk-taking behaviour/negative outcomes.

Case Study: Teens and Toddlers programme

What it is and what it does:

Teens and Toddlers integrates learning with hands on experience. Participants (male and female deemed 'at-risk') receive approximately 40 hours of contact with nursery children and 20 hours of curriculum input over the course of the programme. The teaching and learning sessions focus on personal experiences of time with toddlers and theoretical considerations of topics associated with understanding the impact of unplanned pregnancy and personal development.

How it contributes to reducing teenage pregnancy:

'Teens and Toddlers' attempts to interrupt expected life trajectories of 'at-risk' teenagers by giving participants the experience of the hard work involved in child care, whilst helping them to develop alternative goals to being pregnant. The programme enlists the help of teachers in order to identify 'at-risk' young people. By enlisting the help of professionals with educated insight into student circumstances and placing the programme within boroughs and wards with above average teenage pregnancy rates, the scheme is successful in identifying young people most in need.

Evaluation:

Current research suggests that 97.5% of participants who completed the course did not become pregnant, and nearly 99% do not become parents under the age of 18.

In addition, the 'Teens and Toddlers' approach is very effective in influencing young people's attitudes towards pregnancy. 85% of participants reported that the programme increased the age that they wanted to have children with 73% believing that the ideal age to become a parent was over 22. Furthermore, 75% reported that it influenced their decision to practice safe sex and 85% believed it had made a positive difference in their lives. 90% believed that the programme would be useful to their peers.

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5.41 The *Youth Matters* green paper, published in 2005 set out the vision that by April 2008 every young person with additional needs and who requires integrated support should have access to a lead professional who can broker a support package that draws on mainstream and specialist services of sufficient quality and quantity.

5.42 Targeted youth support (as demonstrated through the Young People's Development Programme) will help to build a cohesive response to many of the key risk factors associated with teenage pregnancy, such as poor attendance at school, low aspirations or poor parental support. An early, comprehensive identification of young people's needs through the common assessment framework, tailored packages of support co-ordinated by the lead professional and improved access to expert workers will all help to tackle the factors linked to increased risk of teenage pregnancy.

Case Study: Young People's Development Programme

This project in Great Yarmouth targets 13-15 year old girls identified by school or other agencies as having significant educational and social needs.

"It gives me something to do... otherwise I'd be hanging around on the streets and stuff." said one participant; *"I was always in trouble with the Police for fighting and stuff before I came here"* added another. Most of the girls have a poor school record – either not attending, sometimes because of bullying, and others are at risk of exclusion. Three of the group were on anger management programmes in school.

The project uses volunteer mentors (usually young mothers themselves) to offer support and encouragement and the girls undertake a range of activities – many of which lead to accredited outcomes such as Getting Connected, Community Sports Leader Awards and the new Youth Arts Award. The group recently took and passed their Food Hygiene certificates so that they could make and serve healthy snacks to the young children in the GFS nursery provision.

All aspects of health feature strongly on the curriculum, including addressing substance misuse issues and risky sexual behaviour. This takes place both in group sessions and in one to one discussions with the mentors. Some of the mentors have completed the "delaying early sex" training and the girls are encouraged to think carefully about their relationships. *"It's helped me cope... and (staff member) and (mentor) help you when you need it."*

The participants are also working with a local arts group to research, prepare and film a documentary about the impact of contraception on women's lives over the last hundred years. Three of the young women will be trained to go into schools once they are 16 to act as sexual health peer educators.

The project is valued by the young people. All the young people speak of having increased confidence. *“I am proud of how far I have come in behaviour and confidence and listening to people – and I got certificates now.”*

Family/Background factors

Supporting parents and carers to reduce the risk of early pregnancy

Case Study: Speakeasy

What it is and what it does

Speakeasy offers a non-threatening group based opportunity for parents to learn together and acquire the confidence and skills they need to talk to their children about sex and sexuality.

Aims

Speakeasy has 4 broad aims:

- To increase parents’ factual knowledge around sex and sexual health;
- To increase parents’ confidence and communication skills with their children;
- To provide a step towards further learning and personal development for excluded groups of parents;
- To enable health and educational professionals to give higher priority to work with parents and carers, with the backing of accredited Speakeasy training so that large numbers of parents throughout England will have access to a Speakeasy course.

How it works

Recruitment takes place through established parent centres in partnership with local staff who will often help facilitate on the courses. The reach of Speakeasy has been greatly increased as a result of the accredited training offered to parenting professionals. This enables the work to become embedded in local Teenage Pregnancy strategies, Sure Start Children’s Centres, Healthy Schools and Extended Schools and other health promotion work.

Backed up by fpa’s training resources and expertise, the course offers a flexible and relaxed way for parents and carers to gain greater confidence in an area that can cause embarrassment and awkwardness for them. The emphasis is on making the courses as accessible as possible for those who will benefit.

Following initial training from **fpa**, groups of Speakeasy 'competent' staff continue to deliver courses for parents and to train more staff from a variety of backgrounds, with the aim of delivering the programme through a wide range of local community and school based parenting support initiatives, including Sure Start.

Evaluation

The project was externally evaluated in September 2004 and June 2006. The evaluation found that the Speakeasy programme has enabled large numbers of parents and carers to talk with more confidence about sex and relationships with their children. It is estimated that there have been 12,000 direct (parents and children) and 20,000 wider beneficiaries such as extended family members (including children) and other social contacts the direct beneficiaries have in the community.

The positive outcomes include increased knowledge on topics such as contraception, STIs and puberty changes. These have been sustained for 2 years and more following the course. **fpa** has cascaded the model by training staff from health and community backgrounds to deliver the programme in parent settings. Trained parenting professionals report a greater priority being given to sex and relationships education in their work settings. Parent peer educators and Parent facilitators have furthered the work through local networks.

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5.43 Research shows that a positive parenting style has a strong and positive impact on children's outcomes and can act as a protective factor against teenage pregnancy.

5.44 Most parents do provide effective support to their children. However many parents welcome help and advice at some point and some need additional support. We are driving this work forward by:

- developing a commissioners' toolkit to support local areas in identifying the most suitable parenting programmes. This will include supporting parents to discuss sex and relationships more confidently with their children.
- asking local authorities to identify a single commissioner of parenting support, with responsibility for assessing need for parenting support, identifying gaps in services, and ensuring that parenting support is reflected in local planning.

- providing a range of services for parents, including information on parenting and childcare, access to parenting groups and more specialised support for parents who want and would benefit from it, through the Extended Schools parenting support core offer
- piloting 'Transition Information Sessions' in around 500 schools across 10 local authorities, which will offer parents of children starting primary and secondary school an opportunity to discuss parenting issues and concerns.
- piloting a new school-based outreach role – Parent Support Advisers – who will help provide early intervention to families where there are signs of problems
- establishing the 'National Parenting Academy' to provide a stronger focus on training for frontline and specialist staff to help them identify and work effectively with parents who are struggling, before problems escalate.
- piloting Parenting Early Intervention Pathfinders. These will increase the delivery of parenting programmes in 15 Local Authority areas, aimed at parents of children aged 8-13 considered at risk of anti social behaviour;
- piloting and evaluating the Parentline Plus 'Time to Talk' community programme in 5 areas. This will target parents with children at highest risk of teenage pregnancy, to improve their skills and confidence in discussing sex and relationships.

Reducing the risk for looked after children and care leavers

5.45 We know that the negative life experiences of young people in care make them particularly vulnerable to a range of poor outcomes, including early pregnancy. We will shortly be publishing a Green Paper on Children and Young People in Care which will set out our ambition to significantly improve their life chances. The broad range of proposals will help to reduce the risk of teenage pregnancy by improving protective factors such as strong support at home, attainment at school and engagement in positive activities.

5.46 But it is clear from our intensive reviews of teenage pregnancy in local areas, that targeted work on sex and relationships education with children and young people in care is a key success factor in areas with declining under-18 conception rates.

5.47 In our delivery guidance, we signalled our expectation that all areas should develop this targeted work and have included case studies of good practice. To help make this a priority we will:

- include specialist training modules on sex and relationships in the new training and qualifications framework for foster and residential carers, making clear children and young people in care's heightened risk of early sex and teenage pregnancy;

- provide resources to help schools, carers and social workers establish a shared approach to SRE for children and young people in care, to make sure they receive consistent messages and support, in and out of school;
- provide SRE training modules for Local Authorities to offer leaving care teams – in early 2007;
- provide, in early 2007, an easy to use SRE toolkit for carers and designated teachers for children and young people in care, to help them discuss sex and relationships issues – with a focus on helping young people develop the confidence to delay early sex and access early contraceptive advice when they do become sexually active.

Case Study: Targeted SRE work with children and young people in care using the 'L8r' SRE resource

What it is and what it does

'L8R' is an interactive resource consisting of short drama episodes on DVD, a website and a practitioner's pack. Young people use the website to: vote on dilemmas that arise at the end of each episode; affect how the story proceeds; chat with the characters; debate issues; and access information. Themes include sex & relationships, friendships and loyalties, STI's, teenage parenthood, self esteem, peer pressure and related issues like drugs and alcohol. L8R also trains online peer educators aged 16-25, who moderate the site forums and host live chat sessions. Practitioners can set up bespoke live chat sessions with the peer educators for their young people.

Work with Looked After Children and Care Leavers

L8R has recently been used in 9 residential children's homes in Southwark, Wandsworth and Lambeth and a linked Care Leavers group in Camden. A Health Promotion worker attended L8R inset sessions set up as part the project's partnership with Southwark Teenage Pregnancy team, and then disseminated the resource to local homes, where the video episodes were first used as part of a successful series of separate '*nights in*' for girls and boys.

Evaluation

A 2005 Evaluation report from the University of the West of England said: *"The resource works well...by providing a fictional context in which to consider sensitive issues... It is notable that young men got involved in thinking and talking about teenage pregnancy."*

The practitioner leading work with Looked After Children said *"It is really a very good resource... excellent, because there are so many relevant issues, [Episode 4] raised interesting issues for them ...about their own situations...of being looked after. We have now mainstreamed L8R, it's going to be an ongoing part of our work on emotional health and well being."*

Contact Details

The L8R team can provide partnership packages including INSET tailored to your needs. L8R is produced by Hi8us, a registered charity that specialises in participatory arts & digital media projects with young people. Contact Hi8us (South) about L8R on 020 7538 8075, or go to the website www.l8r.uk.net

Ethnicity

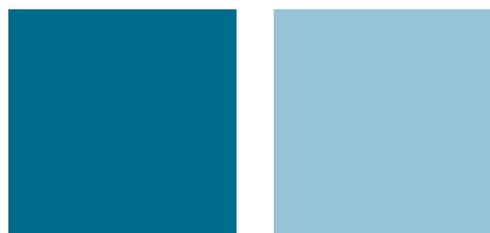
5.48 There is evidence that young people from some ethnic groups are much more or less likely to experience teenage pregnancy than others, – even after taking account of the effects of deprivation. For example, teenage pregnancy rates vary dramatically between London boroughs with a similar level of deprivation, but a different ethnic composition. In some instances, a Borough's rate is double that of a similarly deprived Borough with a different ethnic make-up.

5.49 Establishing the precise impact of ethnicity is difficult because: ethnicity is not recorded at birth registration; BME groups are over-represented in deprived areas where high rates would be expected; and sexual behaviour, knowledge and attitudes may vary considerably *within* BME groups. Nevertheless, the available evidence does indicate that girls and young women from some ethnic groups are more likely to become pregnant under-18.

5.50 Differences in sexual behaviour and risk of teenage pregnancy between ethnic groups demonstrate the need for local strategies to develop culturally appropriate approaches to reducing teenage pregnancy rates – especially in areas with large BME populations. In particular, in local areas where ethnicity is a factor, local strategies should work closely with BME community groups and BME parents to ensure services are tailored to address their specific needs and circumstances.

5.51 To support local areas, we will – through the Young London Matters initiative – fund a project to identify good practice and share effective interventions on working with BME communities to reduce teenage pregnancy and improve young people's sexual health.

6. Support for teenage parents



6.1 As our Strategy makes clear, our priority is to reduce rates of under 18 conception by giving young people the means and motivation to delay parenthood until they are in a better position – emotionally, educationally and economically to face its challenges. However, for those who become young parents, we are also committed to reducing the risk of poor outcomes for them and their children, with a target to increase to 60% the participation of mothers aged 16-19 in education, training or employment by 2010.

6.2 The evaluation of our Sure Start Plus pilot programme, identified the key benefits of a dedicated personal adviser for teenage parents – notably the increased participation in education of school age mothers and significantly higher levels of involvement in post 16 education when the advisers were based in education settings.

6.3 We have set out our expectations that all areas should provide the successful ingredients of Sure Start Plus through Children’s Centres and the targeted support in Children and Young People’s Plans. We will be issuing further guidance on supporting teenage parents later this year.

6.4 But there is an important issue which we want to raise now: ensuring that we offer high quality support to all parents under 18, who cannot live with their own parents. We are concerned that some young mothers under 18 can live in social housing without any support. Such mothers often find themselves very isolated, at a distance from their families and other support networks. This only adds to their risk of social exclusion. We think that all teenage parents, who cannot live at home, should be placed in either a dedicated housing project, or have an intensive floating support package, co-ordinated by a lead professional. Such a package would:

- develop strong and confident parenting skills;
- address any emotional or mental health problems;
- prevent further unplanned pregnancies;

- mediate positive relationships with their family and, where appropriate, the father of the child;
- continue or re-engage with education and training;
- develop financial management skills;
- develop the knowledge and skills to look after their own and their children's health;

6.5 The content and length of the package would be tailored to the individual needs of the young parent.

6.6 We also need to do further work to assess what support is needed by young fathers, so that they can play a positive role in their child's upbringing, whether or not they continue to be in a relationship with the mother. While data on the fathers of children born to teenage mothers is limited, qualitative studies suggest that these fathers are more likely than fathers of children born to older mothers to:

- not be engaged in education, employment or training;
- live in deprived areas;
- have poor levels of educational attainment; and
- have been in trouble with the police.

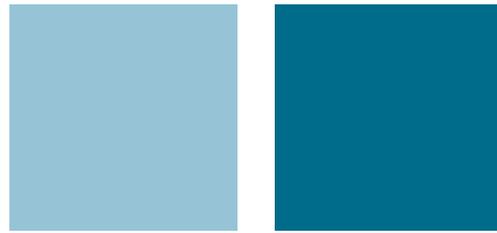
6.7 In order that more young fathers can contribute positively to their children's lives, including providing financial support, further work will explore:

- how maternity services and Children's Centres can be better tailored so that they encourage young fathers' involvement – research indicates that many young fathers feel excluded due to the negative attitudes of some professionals and the overtly female-centred environment in ante-natal and maternity services;
- how young fathers can be supported to re-engage in education, employment and training; and
- how to support young fathers to take greater responsibility for contraception – research suggests that men have a strong influence over their partner's choice of contraception – to help reduce second and subsequent unplanned pregnancies.

6.8 We will issue good practice guidance on engaging and supporting young fathers in the autumn.

6.9 All of these issues will be addressed in delivery guidance to local authorities and PCTs on support for teenage parents to be published in early 2007.

7. Endnotes

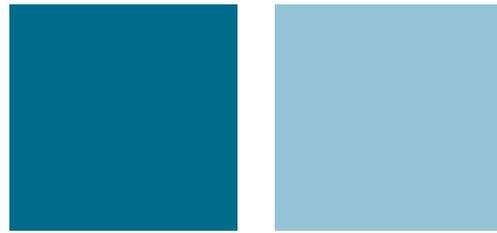


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Annex 1

Local Authorities with high and increasing* under-18 conception rates, 1998-2004



LA Name	1998 rate	2004 rate	% change 98-04	2004 Traffic light
Lambeth LB	85.3	84.0	-1.5	Red
Blackpool UA	64.8	72.3	11.6	Red
Barking and Dagenham LB	54.6	71.8	31.5	Red
Haringey LB	62.3	68.6	10.0	Red
Stoke-on-Trent UA	68.5	67.4	-1.6	Red
Manchester MCD	61.3	65.2	6.3	Red
Greenwich LB	62.6	64.7	3.3	Red
Redcar and Cleveland UA	58.3	58.3	0.1	Red
Newcastle upon Tyne MCD	52.8	57.4	8.6	Red
Swindon UA	53.5	56.4	5.5	Red
Sheffield MCD	50.5	54.4	7.6	Red
Tameside MCD	53.6	53.9	0.6	Red
Brent LB	47.8	53.4	11.7	Red
Bolton MCD	50.3	53.2	5.8	Red
Hounslow LB	49.6	52.2	5.3	Red
Enfield LB	46.4	51.1	10.2	Red
Torbay UA	44.2	49.9	13.0	Red
Stockton-on-Tees UA	48.3	49.0	1.5	Red
Hillingdon LB	43.9	46.4	5.7	Red
Luton UA	43.1	44.7	3.8	Red
Solihull MCD	40.3	43.2	7.2	Red

*Includes LAs with high rates and less than 2% reduction between 1998 and 2004

Note: Table shows the position in February 2006. Under-18 conception statistics for 2005 will be released in February 2007

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