Scottish Needs Assessment Programme

Teenage Pregnancy in Scotland

SCOTTISH FORUM FOR PUBLIC HEALTH MEDICINE

NOTE

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SUMMARY

1 The rate of conception in all teenagers in Scotland rose steadily from 40.0 to 50.6/1000 teenagers between 1983 and 1991. A reduction in the rate to 48.4 was observed in 1992 and to 45.6 in 1993.

2 The obstetric risks of a teenage pregnancy are slight compared with the social and economic problems and not all teenage pregnancies are unwanted or unplanned.

3 There are differences between younger and older teenagers in the outcome of teenage pregnancy in terms of miscarriage, termination of pregnancy and the birth of a baby.

4 The pattern of teenage pregnancies in Scotland is similar to that in England and Wales. It is not as high as rates in the United States and Eastern European countries, but higher than in the Scandinavian countries and considerably higher than in the Netherlands.

5 Factors known to be associated with teenage conception include sexual behaviour, use of contraception, educational attainment and social background.

6 Recent studies have found a pattern of decreasing age at first intercourse; an increase in the reporting of sexual experience before the age of 16 years and convergence in the behaviour of men and women. It is estimated, therefore, that 43% of Scottish girls and young women aged 13-19 years and over 50% of young men of the same age group are sexually active.

7 At all ages the conception rate increases with deprivation, with a 4-5 fold difference in the rate between those living in deprivation category 1 compared with deprivation category 7. Outcome of pregnancy also varies by area of deprivation, with the highest percentage of births occurring in the most deprived areas.

8 Current contraception provision by general practitioners varies by health board. Services offered in community family planning/well woman clinics also vary.

9 Guidance for schools about education in personal relationships and developing sexuality is given by the Scottish Office Education Department, but implementation is left to the discretion of each head teacher. Evidence from a Scottish study is that young people receive sex education in a piecemeal fashion and not as a subject set firmly in the context of inter-personal relationships.

10 The rate of teenage pregnancy in Scotland is of concern and a number of health boards have introduced various initiatives to address the problem. It must be acknowledged that teenage pregnancy is only one outcome of teenage sexuality and sexual experience and it is believed that initiatives to address the wider issue of teenage sexuality and inter-personal relationships will also lead to a reduction in the rate of unwanted teenage pregnancies.

11 A number of possible initiatives are discussed in this report and costed options that could be introduced by the health service are suggested. It is recommended that Health Boards in conjunction with other agencies develop a teenage sexual health strategy. This should include liaising with other agencies, ensuring the provision of appropriate services and setting targets for the reduction of teenage pregnancies.

RECOMMENDATIONS FOR PURCHASERS

1 At Health Board level a multiagency approach should be adopted in order to develop a teenage sexual health strategy as part of a young person's health strategy. A working group should be established within each Board in partnership with General Practitioners with representation from statutory and voluntary sectors including health, education, social work, the churches and relevant voluntary organisations to plan and implement such a strategy.

2 Health Boards should set local targets for

- the reduction of conception rates in under 16s
- the reduction of unwanted pregnancies in the 16-19 year age group, e.g. as evidenced by the abortion rate

3 Purchasers should ensure the provision of an effective family planning service which is appropriate, accessible and acceptable to young people by providing

- a full range of information about sexuality, sexual health and services
- a full range of contraceptive services and supplies
- an emergency contraceptive service
- an efficient referral system for termination of pregnancy

4 Purchasers in discussion with providers and users should give consideration to the setting up of centres specifically for young people. The siting and remit of these centres should be determined following discussion with young people. A pilot project along the lines of the Nottingham Base 51 initiative would seem a useful way forward.

5 Purchasers and providers should ensure that staff at all levels should receive appropriate training to enable them to respond to the needs of young people.

6 Purchasers and providers should consider how the role of school nurses could be extended to provide help and advice about sexuality and sexual health for young people.

7 Purchasers and providers should ensure that all new initiatives, such as clinics for young people, services for young people by a one door approach are fully evaluated and the information made available to other Health Boards, Trusts General Practitioners and other providers .

1 INTRODUCTION

1.1 The rate of pregnancy in Scottish teenagers during the last decade has risen from 40.0/1000 teenagers in 1983 to 50.6/1000 in 1991. A fall to 48.4/1000 was observed in 1992 and to 45.6/1000 in 1993. The rise was observed in girls under 16 years of age from 6.2/1000 in 1983 to 8.8/1000 in 1991 falling to 8.7/1000 in 1992 and to 8.4/1000 in 1993 and in young women aged 16-19 years from 64.0/1000 in 1983 to 77.9/1000 in 1991 falling to 75.4/1000 in 1992 and to 73.3/1000 in 1993.

1.2 In 1992 in Scotland it is recorded that 10 492 teenagers became pregnant, 764 of whom were under the age of 16 years at the time of conception.

1.3 In their review of teenage pregnancy in Scotland, Rosenberg and McEwan (1991) point out that, although the rate of teenage conceptions did not change between 1975 and 1988, there had been a large increase in births to single mothers. They found that the obstetric risks included -

- a slightly higher rate of preterm delivery;
- a slightly higher rate of low birthweight infants;
- later presentation for antenatal care.

The authors concluded that obstetric risks were more likely to be related to social circumstances than age and that the medical risks were small "compared with the well documented social and economic problems which have long term and indirect effects on health". Other problems associated with having a baby in teenage years include being ostracised by peers and loss of self-esteem.

1.4 Peckham (1992), while acknowledging that teenage pregnancy is perceived as a problem leading to adverse social and medical consequences, questions whether it is a problem by definition when in reality it is merely a descriptive term. Not all teenage pregnancies are unwanted ones. To support his view he points to the substantial differences in pregnancy, abortion and birth rates between younger and older teenage women - for example, the conception rates in older teenagers are much higher than in younger teenagers and of those who become pregnant, the termination of pregnancy rate is lower.

1.5 The Department of Health also appears to make the distinction between younger and older teenagers in setting a target. The key target is **to reduce the rate of teenage conceptions among the under 16s by at least 50% by the year 2000** (from 9.5 per 1000 girls aged 13-15 years in 1989 to no more than 4.8). The general objectives set to meet this target are "to reduce the number of unwanted pregnancies and to ensure the provision of effective family planning services for those who want them" (DOH 1993).

1.6 Information is presented in the report about teenage pregnancies, teenage sexuality and services for young people. There are no published cost effectiveness studies of interventions set up to reduce unwanted teenage pregnancies, costings of suggested options are indicated, but all interventions should be evaluated.

2 AIMS AND OBJECTIVES

2.1 The aim of this SNAP report on teenage pregnancy is to provide an overview of the subject in order to assist purchasers in contracting for appropriate services and in building alliances with other agencies such as Education Departments, Social Work Departments and voluntary services at local level.

2.2 The objectives are -

- to review teenage pregnancies with particular emphasis on the Scottish situation;
- to consider the factors known to influence the rate of teenage pregnancy;
- to describe briefly the current services (NHS and other) in Scotland relating to prevention of teenage pregnancy;
- to review initiatives being introduced by Scottish Health Boards and others aimed at reducing the rate of teenage pregnancies;
- to consider costed options, which could be introduced in Scotland with the aim of reducing the rate of teenage pregnancies;
- to make recommendations for consideration by purchasers.

3 RATES OF TEENAGE PREGNANCY

3.1 Composition

The conception rate is extrapolated from the birth rate, the termination of pregnancy rate and the miscarriage rate. As miscarriage data are estimated from hospital discharge data (SMR1 & SMR2) the conception rate will be an underestimate as miscarriages that do not result in hospital admission will not be included. Between 1990 and 1992 of the known teenage conceptions, 58% resulted in a birth, 32% were terminated and 11% resulted in a miscarriage. The teenage miscarriage rate is similar to that of the general population whereas the termination of pregnancy rate is considerably higher.

3.2 The effect of age on the rate of conception and outcome

The conception rate in teenagers in Scotland increases with age from 8.6/1000 aged 13-15 years to 99.7/1000 aged 19 years (Figure 3.1).

Outcome of pregnancies also varies by age group with the percentage of deliveries increasing with age from 49% of all conceptions in the 13-15 age group to 67.9% in the 19 year olds. The miscarriage rate in the 13-15 year olds is much higher at 18% than the older ages as is the termination of pregnancy rate (Figure 3.2).

3.3 Trends over time

During the last decade there has been a steady rise in the teenage conception rate. This has occurred in both the under 16s and in the 16 to 19 year olds although the number of pregnant teenagers has fallen by 1648 because of demographic changes.

Table 3.1
Teenage conceptions in Scotland 1983-1993

	13-15 years		16-19 years		Total	
Year	Number	Rate	Number	Rate	Number	Rate
1983	777	6.2	11 357	64.0	12 134	40.0
1984	811	6.6	11 640	66.2	12 451	41.7
1985	847	7.1	11 817	69.1	12 664	43.7
1986	848	7.5	11 613	69.2	12 461	44.4
1987	803	7.7	11 409	69.3	12 212	45.3
1988	829	8.4	11 413	72.0	12 242	47.6
1989	794	8.4	10 825	71.5	11 619	47.2
1990	750	8.3	10 737	74.7	11 487	48.9
1991	774	8.8	10 520	77.9	11 294	50.6
1992	764	8.7	9728	75.4	10 492	48.4
1993	771	8.4	9038	73.3	9809	45.6

Source: ISD

3.4 Board comparisons

In 1993 the rate of teenage conception between boards varied from 29.4 in the Borders and 54.6 in Tayside. While the more affluent areas tend to have a lower rate, Lanarkshire which has much social deprivation has a rate lower than Grampian. In the under 16 age group it is not appropriate to make Health Board comparisons because of the small numbers involved in each Board. Details by Health Board are given in Appendix 1 (ISD 1994).

3.5 Comparison of teenage conception rates in other countries

a) England and Wales

The rate of conception in girls under the age of 16 years in England and Wales is higher than that in Scotland. This contrasts with the older age group where the rate is higher in Scotland. Between 1990 and 1991 a fall in the rate of conceptions in both age groups occurred in England and Wales (data for 1992 are not yet available). A similar fall was observed in Scotland a year later (Table 3.2).

Table 3.2
Teenage conception rates in Scotland and England and Wales

Age	Year	Scotland	England and Wales
13-15 yrs	1983	6.2	7.3 (1981)
	1990	8.3	10.1
	1991	8.8	9.3
	1992	8.7	-
16-19 yrs	1983	64.0	57.1 (1981)
	1990	74.7	69.0
	1991	77.9	65.1
	1992	75.4	-

Source: ISD and OPCS

b) International comparisons

Before making international comparisons it is important to realise the limitations of international data. While most Western countries record accurate birth data, information about fetal loss either from miscarriage or termination is more difficult to obtain. This may be due to the lack of national information systems or if they do exist, the failure of all hospitals to provide such data. Private hospitals for instance may choose not to take part in a national information system scheme.

3.6 These caveats not withstanding, a review of the international data that do exist reveal that countries which keep reliable statistics, particularly the Scandinavian countries and the Netherlands, all have lower teenage conception rates than Scotland and England and Wales. The converse is true for Eastern European countries and the United States of America which all have considerably higher rates than the United Kingdom (Table 3.3).

Table 3.3
Teenage conception rates/1000 women 15-19 years by country by year

Country	Rate
USA	95.0 (1985)
Norway	39.7 (1985)
Hungary	78.7 (1984)
Canada	37.4 (1985)
Czechoslovakia	69.5 (1984)
Finland	32.8 (1983)
England	69.0 (1990)
Sweden	29.1 (1985)
Scotland	65.4 (1990)
Netherlands	9.2 (1990)

Source: World Health Organisation

3.7 International comparisons of teenage live birth rates

Because of the difficulty some countries have in providing total conception data, comparisons of live birth rates by country is a useful proxy. It can be seen from Table 3.4 below that in 1990 the lowest live birth rates are in Italy, Belgium, Denmark, France, Netherlands and Switzerland. Scotland had the third highest birth rate of the countries reviewed in 1990 and had a smaller percentage reduction than 12 of the countries.

Table 3.4
International comparisons of teenage live birth/fertility rates

	Rate per 1000 women aged 15-19 years			
Country (ranked by 1990)	**1970**	**1980**	**1990***	**% reduction of birth 1970-1990**
USA	68.2	53.0	53.6	21.4
England and Wales	49.6	30.4	33.3	32.9
Scotland	47.6	32.0	31.9	33.0
Northern Ireland	42.9**	29.2	29.3	31.3
Portugal	29.8	41.0	24.6	17.4
Greece	36.9	52.6	21.8	40.9
Austria	58.2	34.5	21.3	63.4
Norway	43.7	25.2	17.1	60.9
Republic of Ireland	16.3	23.0	16.2	0.6
Sweden	34.0	15.8	14.1	58.5
Spain	13.8	25.3	13.4	2.9
Finland	32.2	18.9	12.4	61.5
West Germany	35.8	15.2	11.6	67.6
Italy	27.1	20.6	9.8	63.8
Belgium	23.2	14.9	9.3	59.9
Denmark	32.4	16.8	9.1	71.9
France	27.0	17.8	8.8	67.4
Netherlands	17.0	6.8	6.4	62.3
Switzerland	16.0	7.2	4.6	71.2

Source: Babb 1993

***** 1990 or latest available year.
****** 1971

4 FACTORS ASSOCIATED WITH TEENAGE CONCEPTION

4.1 In Scotland in 1991 there were 214 980 girls and young women aged 13-19 years (inclusive) of whom 4.9% became pregnant during that year.

4.2 It is known that many important factors influence reproductive behaviour including -

- ethical standards based on culture and religion;
- attitudes to sexuality in the home during childhood, at school and in the community as a whole;
- the status of woman in her role as worker and at home;
- the availability and effectiveness of methods of controlling fertility (RCOG 1991).

4.3 Attitudes to sexuality

In a report of a Working Group of the Royal College of Obstetricians and Gynaecologists reviewing Unplanned Pregnancy (1991), the importance of being brought up in a caring environment and receiving information and education about sexuality and sexual relations both from home and at school is stressed. The report also highlights the confused messages that young people in our society receive.

"Attitudes to sexual behaviour in Britain are confused, complex and contradictory. Sexual images and situations are used frequently for commercial reasons but there are negative public attitudes towards education about sexuality and contraception. Some people in public life who influence policies on sex education deplore the number of unplanned pregnancies and abortions but are also reluctant to accept that broadly based school courses and educational television programmes would help young people to understand and regulate this aspect of life. This ambivalent public attitude is partly due to a lack of knowledge and partly to a desire not to offend a vocal but small minority who oppose effective sex education".

4.4 The factors that are known to be associated with teenage conception include sexual behaviour, use of contraception, educational attainment and social background.

4.5 Sexual behaviour

Information about sexual behaviour is notoriously difficult to collect. Much of the data presented below come from the recently published national survey - Sexual Attitudes and Lifestyles (Johnson et al 1994). This survey provides information from nearly 19 000 people selected at random and resident throughout the United Kingdom aged between 15 and 59 years. The response rate of eligible people was 72% which compares favourably with other studies of this kind.

4.6 Age at first intercourse

Information is available about the age of first intercourse. The findings of the survey were that there is -

- a pattern of decreasing age at occurrence;
- an increase in the reporting of experience before the age of 16 years;
- some convergence in the behaviour of men and women over time.

4.7 Decreasing age at occurrence of first intercourse

In the past four decades the median age at first heterosexual intercourse has fallen from 21 to 17 years for women and from 20 to 17 years for men, while the proportion reporting its occurrence before the age of 16 years has increased from fewer than 1% of women aged 55 to 59 years at the time of interview compared with nearly one in five of those interviewed aged 16 to 19 years. Thus in the 971 women who took part in the survey aged 16-19 years, 18.7% reported that their first heterosexual intercourse occurred before the age of 16 years. In the 827 men of the same age who took part in the survey, 27.6% reported that their first heterosexual intercourse occurred before the age of 16 years. In the study population whose current age is 16-24 years 75% of women reported having had their heterosexual intercourse before the age of 20 years - that is, 19% of those under 16 years; 41% of those aged 16 and 17 years and 15% of those aged 18 and 19 years.

4.8 Regional differences in the age at first intercourse

The authors comment that as the information on regions related to the current residence of respondent it cannot be assumed that in a mobile population this is the region where first intercourse occurred. They state that "according to popular stereotypes, it might be expected that first intercourse would take place earlier on average in the 'permissive' south than in the 'puritanical' north". They found that although for women the median age of first intercourse was one year later in East Anglia and Scotland there was no clear pattern for men. Neither was there a clear urban/rural difference observed.

4.9 Estimated number of sexually active teenagers in Scotland

Extrapolating from the findings in the Sexual Attitudes and Lifestyles Survey to the Scottish experience, it is estimated that 93 778 girls and young women aged 13-19 years are sexually active (Table 4.1). This might be a slight overestimate in that a recent study in the West of Scotland found that 7% of women aged 18 years experienced intercourse before the age of 16 years (West 1994). The percentage is greater for boys with 28% being sexually active by the age of 16 years.

Table 4.1
Estimated number of sexually active teenage girls in Scotland in 1991

Age	Number	% Sexually Active	Number Sexually Active
13-15 yrs	88 006	19%	16 721
16-17 yrs	64 487	60%	38 692
18-19 yrs	64 487	75%	48 365
Total	**216 980**	**43%**	**93 778**

4.10 Use of contraception

Research studies suggest that sexually active teenagers are now more likely to use contraception than 20 years ago. The findings of the Sexual Attitudes and Lifestyle survey are that contraceptive use at first intercourse varies with age. When intercourse occurred before the age of 16 years, no method of contraception was used by nearly half the young women and more than half the young men. By 16 years and over, 68% of women and 64% of men reported using some form of contraception at first intercourse, the condom being the most popular method. Many teenagers delayed using contraception for many months. This may not be surprising given that intercourse tends to be unplanned and infrequent. What is worrying, however, is the finding of an American study reported by Bury (1984) that 22% of all premarital pregnancies occurred during the first month of sexual activity and 50% occurred during the first six months.

4.11 Research findings

Two studies undertaken in Grampian (Warham, personal communication) provide information about the use of contraception in 100 young women who subsequently had a termination of pregnancy and 100 teenagers who were interviewed after the birth of their baby. In the termination group 61% used a method of contraception when they first had intercourse and 49% used a method around the time the index pregnancy was conceived (withdrawal was not included as a method). In the second group, 56% said they had used a method of contraception when they first became sexually active and 22% had around the time the index pregnancy was conceived. Thirty-four of these young women (34%) had either planned to conceive or did not mind if they became pregnant. Another study in Dundee (Waugh personal communication) found that women presenting for abortion did not use contraception for the following reasons:

- dislike/afraid of contraception 39%
- didn't think it would happen to you 21%
- unplanned intercourse 21%
- afraid parents would find out 19%
- afraid to ask doctor 19%
- don't understand them 16%
- father did not want to or not discussed 16%
- other 17%

4.12 Educational attainment

The median age at first intercourse increases with educational level and the effect is particularly marked for graduates. Non-graduate men are more than three times as likely to have sex before their 16th birthday compared with graduate men and non-graduate women more than one and a half times as likely as graduate women.

4.13 Effect of deprivation

All Scottish postcodes have been assigned a deprivation score depending on a number of characteristics (Carstairs and Morris 1991). Girls and young women who live in areas of deprivation have much higher conception rates than those living in more affluent areas (Figure 4.1).

4.14 The greatest number of teenage conceptions by age occur in young women aged 19 years. By deprivation category the greatest number occur in deprivation category 4.

4.15 The outcome of pregnancy also varies by area of deprivation. Young women living in the most affluent areas have the lowest percentage of births and the highest percentage of terminations whereas the young women living in the most deprived areas have the highest percentage of births and the lowest percentage of terminations (Figure 4.2). These differences may be due to accessibility of services, parental pressure, or young women obtaining the outcome they want.

4.16 When age and deprivation category are considered together, it can be seen from figure 5 that at all ages the conception rate increases with increasing deprivation. There is a 4-5 fold difference in each age group in the rate of pregnancy between those living in deprivation category 1 and deprivation category 7.

5 OTHER DISEASES ASSOCIATED WITH SEXUAL ACTIVITY

5.1 Certain diseases are associated with teenage sexual activity. These include sexually transmitted disease, including infection with the human immuno-deficiency virus (HIV) and cervical cancer.

5.2 Sexually transmitted diseases

During 1991 there were 7698 women treated for sexually transmitted diseases at genito-urinary clinics in Scotland and 9316 men. In the under 16 age group there were 22 girls and 3 boys and in the 15-19 year age group there were 1797 young women and 722 young men.

5.3 The rate for all sexually transmitted diseases in females aged 15-19 years has risen from 639/100 000 in 1970 to 770/100 000 in 1980 to 1082/100 000 in 1990. In contrast in recent years there has been a reduction in the rate of sexually transmitted disease in males aged 15-19 years from 571/100 000 in 1970 to 606/100 000 in 1980 to 418/100 000 in 1991.

5.4 HIV infection in teenagers

To June 1994, there have been 189 young people in the 15-19 year age group known to be infected with the HIV virus - 68 young women and 121 young men.

5.5 Cervical precancer

There were 4854 cervical smears reported in 1993 in Glasgow for young women under the age of 20 years; 83% were classified as negative, 4% unsatisfactory, 9% borderline and 4% (215) abnormal.

5.6 The conditions outlined above provide further information about the sexual activity of young people. It is obvious therefore that they require information not only about preventing unwanted pregnancies but also about sexual health.

6 CURRENT SERVICES

6.1 NHS provision of family planning services

General Practitioners

Contraceptive services have been freely available to all residents of the United Kingdom since 1974 regardless of age or marital status. Services are provided both by general practitioners and community family planning clinics. General practitioners providing the primary health care services for the family are in many ways the most appropriate people to provide information, advice and services relating to the sexual health of young people. This is certainly true of couples in long-standing relationships. Much evidence exists, however, to support the view that others, particularly young people, prefer attending a service where they are not previously known because of their concern about confidentiality. A recent paper comparing family planning provision between GPs and family planning clinics found that currently "more family planning clinic professionals than GPs offer the full range of specialist family planning services". The conclusion of the paper was that the roles of GPs and family planning clinics were complementary (Cooper et al 1994).

Since 1975 the majority of general practitioners have provided contraceptive services for which they receive an item for service payment.

Information about general practitioner contraceptive services is included in Scottish Health Statistics, but is unfortunately not broken down by age. The rate of women registered for the ordinary contraceptive service and fitting of the intrauterine contraceptive device is given in Table 6.1. There does not appear to be a direct association between rate of the use of the community family planning service and the use of GP services.

Table 6.1
General practitioner contraceptive services by Health Board 1991

	Ordinary rate/1000 women	IUD fitting rate/1000 women
Scotland	268	7.2
Argyll & Clyde	242	8.2
Ayrshire & Arran	277	13.9
Borders	277	15.0
Dumfries & Galloway	298	9.3
Fife	279	7.5
Forth Valley	258	6.7
Grampian	299	8.1
Greater Glasgow	252	5.3
Highland	289	3.1
Lanarkshire	237	6.2
Lothian	291	4.8
Orkney	321	12.4
Shetland	231	13.0
Tayside	264	7.8
Western Isles	227	7.2

Source: Scottish Health Statistics 1992

6.2 In 1991 in Scotland 99 953 women attended the family planning service provided by Health Boards (Scottish Health Statistics 1992). Of those attending 15 726 were under the age of 20 years giving a rate of 95/1000 teenagers. There was a large variation in the rate of teenagers attending by Health Board (Table 6.2).

Table 6.2
Attendance rate/1000 at family planning clinics by Health Board 1991

	<20 years	20-34
Scotland	95	108
Argyll & Clyde	74	108
Ayrshire & Arran	82	65
Borders	22	52
Dumfries & Galloway	28	71
Fife	--	--
Forth Valley	77	92
Grampian	79	68
Greater Glasgow	162	191
Highland	19	24
Lanarkshire	87	110
Lothian	160	146
Orkney	--	19
Shetland	--	--
Tayside	73	87
Western Isles	3	39

Source: Scottish Health Statistics 1992

6.3 The highest rates are found in Glasgow and Lothian, both Health Boards with a large and comprehensive family planning service.

6.4 Family planning clinics in Scotland

A recent review of Family Planning/Well Women Services in Scotland (Reid 1993) found that all but Shetland provided community family planning clinics as well as general practitioner contraceptive services. The number of clinic sessions varied by Board. In just over half of the designated clinic sessions, a combined family planning and well woman service was offered, 25% offered family planning only, 8% well woman services only and 9% of the sessions were designated specialist sessions. These included psycho-sexual counselling, menopause treatment and counselling, colposcopy, vasectomy and natural family planning. Seven Health Boards offered some of these specialist services. Eleven Boards (excluding Orkney, the Western Isles and the Borders) were considering or had already started a young persons service. Of those attending the community clinics, 96% were women and 4% were men.

6.5 Services for young people

Although services at all family planning clinics are made available to young people, it is only in recent times that Health Boards have considered establishing special services. A number of researchers have questioned whether young people would use traditional family planning clinics if separate sessions were run (Allen 1991, Bury 1984, Simms and Smith 1985) as research has shown that young people prefer advisory services in premises designed to meet young peoples needs and separate from other services.

6.6 Confidentiality is the issue which concerns young people, making them often reluctant to visit their GP. Confusion over the legal aspects among the under 16s is an added problem.

6.7 Comparisons with other countries

As seen in Table 3.3 the teenage conception rates in Sweden and Holland are exceedingly low. In both these countries the contraceptive services are targeted at young people. In Holland, although the clinic system is less extensive than it is in Scotland, it is targeted at meeting the needs of young people and in Sweden there are parallel clinic systems for the general population and for the school age population (Peckham 1992).

6.8 Other agencies providing contraceptive advice and services

a) Brook Advisory Clinics: The Brook Advisory Service was established in 1964 to provide a service for unmarried young people under the age of 25 years. The only clinic in Scotland, in Edinburgh, was opened in 1966. As well as providing a contraceptive service the focus is on education and counselling. In 1993, there were 3000 new attenders, 400 of whom were under the age of 16 years. There were in total 10 671 clinic attendances (1500 male and 9171 female).

b) Community pharmacists: There are 1140 community pharmacists throughout Scotland who provide contraceptive devices and advice. In recent years pharmacists have displayed contraceptives in a readily accessible place making it much easier for people to obtain them.

6.9 Groups with special needs

Within the teenage group there are smaller subgroups with special needs, including those with learning difficulties, those with sensory impairment, the physically disabled, those from black and minority ethnic groups and travellers. In providing contraceptive services, the needs of these groups must be considered.

6.10 Views of consumers

A series of focus groups including teenagers in Wessex identified a number of areas where the existing services fail to meet their needs. The recommendations made by these groups would be worthy of consideration by the Health Boards in Scotland.

They included -

- effective marketing of Family Planning Services;
- increased formal training of GPs;
- extension of the role of the nurse in FP provision;
- continuation of flexible provision through existing alternative outlets;
- easy and well publicised access at all times for emergency contraception;

- the issues of confidentiality, improved information, convenient clinic opening times, and the option to see a female doctor to be included in the contract.

Users of the services should be involved in the ongoing evaluation of the service as well as any new initiatives.

A needs assessment undertaken by a member of the Health Education Department in Dundee obtained the same views. Over 250 young people from 35 different groups including schools, voluntary groups and those run by the community education department took part (Redman 1994).

6.11 NHS Services for pregnancy and abortion

Services will always be required for pregnant teenagers. For those wishing to continue with the pregnancy, maternity care is required. Others who choose to have the pregnancy terminated will require abortion services. Pregnant school girls who go on to have their babies require support from education and social work departments as well as Health Boards. A community unit has been established for some years by Lothian Health Board at Wester Hailes for pregnant teenagers. Girls within the unit attend Wester Hailes Community School and are encouraged to follow a career programme (SPRIG 1993).

The abortion rate in Scotland varies by Health Board. Many factors, such as medical, social, religious and economic considerations, will influence this but Health Boards must ensure that the service relating to termination of pregnancy is accessible to young women. This means that information about the service must be readily available. Women should be seen as early in pregnancy as possible so direct access clinics are an advantage; all acceptable methods of termination of pregnancy should be available, including medical termination. Counselling services should also be on hand. The rate of abortions in women aged 15-44 years is provided in Table 6.3. Teenage abortion rates are not provided by Health Boards because the numbers in most Boards are not large enough to make meaningful comparisons on a one year basis. The actual numbers for young women aged 16-19 years are also provided in Table 6.3.

Table 6.3
Abortion rates and numbers by Health Board, Scotland 1992

	Abortion rate	Number of abortions	
	15-44 years	<16 years	16-19 years
Argyll & Clyde	6.3	10	130
Ayrshire & Arran	8.4	25	169
Borders	8.7	3	51
Dumfries & Galloway	8.5	10	71
Fife	10.0	25	155
Forth Valley	8.8	12	130
Grampian	11.1	34	293
Greater Glasgow	9.5	32	400
Highland	10.2	12	110
Islands	7.4	3	20
Lanarkshire	7.2	23	212
Lothian	11.5	29	372
Tayside	13.0	28	244
Scotland	9.6	247	2366

Source: Scottish Health Statistics 1993

7 EDUCATION ABOUT PERSONAL RELATIONSHIPS AND DEVELOPING SEXUALITY

7.1 In the report of the RCOG Working Party On Unplanned Pregnancy (1991) the importance of educating children of both sexes in personal relationships and their sexuality (sometimes referred inappropriately as sex education) is stressed. It states that "if the caring adults are able to answer questions about sex accurately and with unembarrassed confidence, the children will acquire an informed and positive attitude to sexuality and will minimise their chance of adverse or injurious sexual activity. Sex education in school should both complement and supplement that received at home".

7.2 Sex education in schools

Guidance for sex education in schools is given by the Scottish Office Education Department, but implementation is left to the discretion of each head teacher. Sex education may, therefore, be introduced at a primary level, at secondary level or not at all.

7.3 Most recent research suggests that the provision of sex education in schools is inadequate. Young people in Scotland aged 15 years reported that they "had no discussion at school, or at home or with their friends about subjects as wide ranging as pregnancy, contraception, AIDS and relationships. There is evidence that many young people receive sex education in a piecemeal fashion and not as a subject set firmly in the context of inter-personal relationships". The authors conclude that "experience of steady relationships and sexual activities is commonplace among Scottish school children by the age of 15/16". Consequently it is necessary to provide young people with adequate and appropriate information and opportunities for discussion about personal relationships and sexual matters from an early age, possibly when they are still at primary school.

7.4 There is concern in some quarters that the provision of sex education and family planning programmes for teenagers are part of the problem rather than the solution - that is, they result in increased sexual activity, pregnancies and abortion. Research has shown that if sex education includes information about birth control methods it helps teenagers avoid pregnancy through use of contraceptives at first intercourse and thereafter (Zelmir & Kim 1982). In the Netherlands, despite the age of consent being 12 years and society having a very liberal attitude, the age at first intercourse is later than in Scotland.

7.5 Legal aspects

Information about sex, under 16s and the law provided by the Central Legal Office is given in Appendix 2. In summary it appears that while professionals must be aware of the law and its application, nevertheless it should be appreciated that the law is designed to protect both the child **and** the professional. Although young people in question will be committing criminal offences, it is acknowledged that those giving advice in order to prevent the risks of disease and pregnancy will not be guilty of encouraging criminal behaviour. Also young people who understand the choices they are making are legally competent to give a valid consent and it is quite proper for professionals to maintain confidentiality to young people, unless required to make a disclosure in Court. There is no requirement for parents or guardians to be informed although this would obviously be preferable.

7.6 Comparison with Sweden and Holland

Sweden and Holland have low teenage conception rates, 19.1/1000 and 2/1000 respectively. In 1975 the abortion law in Sweden was liberalised, causing concern this would precipitate a dramatic increase in abortion rates and a decrease in the use of effective contraception. The government's response was to introduce the first compulsory programme of sex education in schools (Leslie-Harwit, Meheus 1989). Currently, Sweden has very low rates of births to teenagers although it does have a relatively high teenage abortion rate (Jones 1988).

7.7 Holland

In Holland, sex education in schools is not compulsory although required levels of knowledge are set in subjects relating to sexuality such as biology and health education. There is a widespread belief among the general public that unwanted teenage pregnancy, and not teenage sexual activity itself, is the target problem. Thus, freely available services and information for young people are regarded as normal and necessary.

7.8 Sex education in Holland is co-ordinated by the Rutgers Foundation. This organisation originally provided both education and clinical services but, like the FPA in this country, devolved responsibility for the provision of family planning services to other agencies and now concentrates on education. The Foundation is funded to the tune of £2-3 million per annum by the Ministry of Health and it receives £1-2 million of income from its clients. It has an important role in the training of teachers, in particular providing a three-day national training course in sexuality education for biology teachers. Education experts from the Foundation visit individual schools, helping them to recognise their areas of need and create their own policies and protocols for sex education. Each school establishes a set of guidelines for the management of potential problems such as suspected cases of sexual abuse.

7.9 The Foundation is also involved in the provision of sex education outwith the school (in youth clubs and child-care centres, for example) and specifically designed material is used in these settings. The Foundation also works closely with the confidential doctor service. This system was introduced when the extent of child abuse became apparent. The doctors above all agree to protect the confidentiality of their patients and it was hoped this would enable young people suffering abuse to come forward. The system has subsequently expanded its remit to include advice and information on all aspects of sexuality. The system is widely publicised and knowledge of its existence is almost universal among young people.

7.10 Holland is also unique in that the legal age of consent is set at only 12 years of age. This means that young people seeking services or information are protected from the fear that they are participating in an illegal activity and are therefore encouraged to seek help (Doortje Bracken personal communication).

8 ADDRESSING TEENAGE PREGNANCY - INITIATIVES IN SCOTLAND

8.1 Is teenage pregnancy a problem in Scotland?

While the rate of teenage pregnancy may not be as high as it was 20 years ago, it is considerably higher than in many other countries and within different sections of society in Scotland. The variation in the rate of termination by area of residence related to deprivation requires further elucidation. Is the difference due to young women in the more affluent areas finding services more accessible or are they being pressurised by their parents or peers to have a termination because a baby would interfere with their career plans? Or are those living in deprived areas more likely to want to keep their baby because it is wanted and their employment prospects are poor?

8.2 The fact, however, that so many pregnancies end in termination infers that these pregnancies at least and perhaps others were unwanted, which is the real problem. Factors (or their lack) contributing to the problem include attitudes of the society in which the young people are living including religious beliefs, the accessibility and availability of appropriate services as well as their own education, knowledge and confidence. Many Health Boards in Scotland have acknowledged that there is a problem and are undertaking a number of initiatives to address it in their area.

8.3 Health Board initiatives

Following inquiries to Consultants in Public Health Medicine in each Health Board information was provided about a number of initiatives that are already being undertaken by different Health Boards. It appears that only Argyll & Clyde has developed an inter-agency strategy.

8.4 Initiatives within the health services include -

- improved advertising of services;
- ensuring the provision of and information about post-coital contraception;
- providing appropriate training about sexuality and sexual health for staff who come into contact with teenagers as well as carrying out pilot projects;
- seconding a health visitor to a school to promote sexual health and to provide help and guidance in relation to contraception;
- establishing a young person's health clinic within a school. In one case this service was provided by a general practitioner who also did family planning sessions.

8.5 Health Education Board for Scotland

The following initiatives are ongoing or are being planned -

- publication of 'The Issue' a magazine for teenagers promoting positive health;
- the production of a booklet for parents to help them to communicate with their teenagers about HIV and sexual issues;
- a background ethnographic research project about young people's self defined health needs is being commissioned. (Millburn personal communication).

8.6 Education initiatives

Guidance has been developed for teachers in Scotland on teaching personal relationships and developing sexuality and will be available for Scottish schools in November 1994. Three aspects for development are covered - general guidelines, staff development activities and a framework for teachers. This work has been developed by Strathclyde University Faculty of Education in conjunction with teachers and supported by the Scottish Office Education Department.

8.7 Multi-agency initiatives

a) Dundee Young People's Health and Information Project

This multi-agency funded project is being established in Dundee. It is a facility aimed at mid-teens. It is to be a drop-in centre, providing a youth information point, clinical services on a sessional basis, with youth workers and health promotion officers. An outreach team will work in areas of priority treatment. Leased premises are currently being sought and the revenue budget is £250 000 per annum (Redman personal communication). The project is being evaluated by HEBS.

b) Nottingham - Base 51

A multi-agency funded service has been established in Nottingham amid much publicity. The service is a drop-in centre (Base 51) for young people aged 12-25 years. It is modelled on 'The Door', a revolutionary Young Centre in New York's West Side and is situated in a converted factory space in central Nottingham. This drop-in service was established because a young person's family planning clinic was not meeting the needs of those living in the most deprived areas. The centre provides the opportunity for music, dance, or meeting and talking (there is a cafe and a crèche) as well as offering health and contraceptive advice. Very many young people use the services available including contraception and over 400 young people who do not have a general practitioner are registered for total health care with a general practitioner who attends Base 51 on a sessional basis.

8.8 Research

Grampian Health Board funded a study - Health Advice and Information Centres for Young People: an investigation of existing alternatives which was undertaken by the Department of Education, University of Aberdeen during 1992/93. The aim of the project was to produce a review and evaluation of existing services, particularly in Scotland and focusing on issues of sexual health. The researchers obtained information about five different types of services -

- treatment type services - including family planning, counselling and other specialist services;
- generalised advice services;
- community action and outreach services;
- media initiatives;
- agencies using a mix of methods.

They report that "even where statutory authorities have been operating family planning services specifically targeted at young people there appears to have been little collaboration with other projects working with young people in the area or with personnel with other professional backgrounds than strictly medical ones". the establishment of effective networks is obviously very important.

The researchers also make the point that presenting options within the report "fossilises the arguments about a young people's service at one point of time", and that agencies must be prepared to respond to changes by changing themselves.

The five options (not costed) they do present for discussion are -

- a teenage clinic focusing only on contraception and sexual health;
- a youth enquiry service offering a range of medical, and non-medical services for young people;
- a health shop offering a general range of health information and clinical services;
- an outreach service using paid sessional workers in schools and community settings;
- a multi-site service, consisting of health shops in Aberdeen and a small number of outlying centres, each with an outreach area of their own (Shucksmith et al 1994)

9 CONCLUSIONS

9.1 Although teenage pregnancy was the initial focus of this report, it became apparent that it would be inappropriate to omit consideration of the wider aspect of teenage sexuality and sexual activity. It has to be acknowledged that young people are maturing at a younger age and that the age of first intercourse is decreasing with many young people becoming sexually active before the age of 16 years. Evidence from international studies suggest that lower teenage pregnancy rates are associated with openness about sexuality and the availability of sex education in schools. Conversely rates of teenage pregnancy are high in the United States where there is a strong anti-contraception and anti-abortion movement. It is unlikely that the rate of teenage pregnancy will be reduced by changes in the provision of health services alone. What is required at Health Board level is that a multiagency approach should be adopted.

10 COSTED OPTIONS

10.1 Increase the role of school nurses

There are 408 secondary schools in Scotland, with an average roll of 763 pupils.

Assuming that a district nurse is employed for one session per week to provide advice and support for young people at each school then the resulting number of WTE district nurses required would be 40.8.

The cost of these nurses, assuming they are paid at the midpoint on their salary scale and including on costs is £903 965.

Additionally there would be a requirement for training for these nurses. Depending on the number of midwives requiring to be trained the cost would vary between £50 000 and £100 000.

Thus, the estimated total cost in Scotland of having a school nurse trained in sexuality counselling and advice in each secondary school is £944 965.

10.2 Provide young people clinics in each Health Board

Assuming that the clinic is held once a week in each Health Board area, there is a requirement for 15 clinic sessions per week. If the clinic is staffed by a receptionist, a grade E and a clinical medical officer, then the staff cost per clinic per annum, using midpoints on scales and including on costs, is £6220.

The total cost for all 15 Health Boards is, therefore, £93 300.

10.3 Pilot a model drop-in centre along the lines of the Nottingham Base 51 initiative

The cost of this is uncertain but, based on the work in Dundee and depending on what was being provided, a budget of between £170 000 and £250 000 would seem reasonable.

11 POTENTIAL SAVINGS

11.1 The cost of teenage pregnancies

It is not known whether a reduction in teenage pregnancies would occur if a programme of personal relationships and developing sexuality were developed in schools and NHS services were targeted for teenagers. Additional factors, such as improvement in employment opportunities will also have an effect. A crude estimate has been made considering the effect if the rate of teenage pregnancies were the same in all deprivation categories and if the rate of those in category 5,6 and 7 fell to the rate in deprivation category 4.

11.2 Illustrative costs are estimated from a variety of sources. The cost of antenatal, intrapartum and postnatal care is taken from the Policy Review Document (1993), which gave an average cost per delivery of £1919 in 1991/92 excluding the cost of health visitors and SCBU. The average fundholding charges for termination are taken from the 5 Glasgow acute units, which gives an average charge for a daycase of £231. For miscarriages the average length of stay in Glasgow hospitals is one day and thus, an estimated cost of £233 has been included.

Table 11.1

Total conceptions, deliveries, miscarriages and legal abortions by age at conception

Age	13-15	16	17	18	19	All
conceptions	2254	4480	6928	9014	10 1875	32 875
deliveries	1102	2673	4387	5930	6919	21 011
miscarriages	390	530	771	959	1010	3660
abortions	762	1277	1770	2125	2247	8181

11.3 Using these estimates the cost of teenage pregnancy in the 3 year period was approximately £43 million, or £13.4 million per annum. The following tables show the effect of reducing the rate in all age groups, firstly to the rates of depcat 1 and secondly, to the rate of depcat 4 for those in depcat 5 to 7.

Table 11.2
Predicted numbers of conceptions, deliveries, miscarriages and legal abortions if all depcat groups have the same rates as depcat 1

Age	13-15	16	17	18	19	All
conceptions	728	1572	2317	3143	3782	11 542
deliveries	254	428	731	1151	1687	4251
miscarriages	177	168	320	522	426	1613
abortions	297	976	1266	1470	1669	5678

11.4 Applying the same costs as above, the predicted cost of teenage pregnancies has fallen to £9.8 million, or £3.3 million per annum. The potential savings are therefore in the region of £10 million pounds, or £469 per conception prevented. This would need to be offset against the cost of reducing the rate to that of depcat 1.

Table 11.3
Predicted numbers of conceptions, deliveries, miscarriages and legal abortions if all depcat groups greater than 4 have the same rates as depcat 4

Age	13-15	16	17	18	19	All
conceptions	1966	3761	5884	7796	8939	28 346
deliveries	882	2043	3565	4873	5856	17219
miscarriages	376	420	566	751	892	3005
abortions	708	1298	1753	2172	2191	8122

11.5 Using the same approach as before, the total predicted cost of teenage pregnancies in a three year period would be approximately £35.6 million, or £11.8 million per annum. The predicted number of conceptions has fallen by 4506 (14%), giving a resulting predicted saving per conception averted of £1642.

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INFORMATION ABOUT SEX, UNDER 16S AND THE LAW

The law has evolved to protect both the young person under 16 and the professional whose duty it is to advise the young person.

The legal protection of young girls arises from statute law.

The Sexual Offences (Scotland) Act 1976, S4, makes it an offence for a male to have sexual intercourse with a girl over 13 but under 16 years of age, unless (a) he had reasonable cause to believe that the girl was his wife or (b) that the male was under the age of 24 at the time of the offence, and that he has not been charged with a similar offence before, and that he had reasonable cause to believe that the girl was over 16 at the time of the offence.

The Act applies to males only.

The same Act, S3, makes it a very serious offence if the male has sexual intercourse with a girl under 13. There is no defence available as defined in Section 6. The essential consideration for health professionals is to ensure that they do not actively promote the commission of these offences. Advice should be given on the basis that it is in the best interests of the health and welfare of the girl.

The Age of Legal Capacity (Scotland) Act 1991 sets out the criteria which are to be applied by the medical practitioner to ensure that the girl is capable of giving a valid consent to the provision of care and treatment. In essence, the consent of a girl under 16 is effective if the medical practitioner believes her to be capable of understanding the nature and possible consequences of the treatment. The Act does not however change the rights of the parents or those with parental responsibility to treatment proposed for their children or to be brought into consultations with doctors. If the young person refuses to allow a parent to be told the doctor must decide in her best medical interests whether or not to offer advice or treatment. Professional confidentiality should be maintained wherever possible.

The Government (Hansard HL Deb Vol 531 - 635/6) advised that in issuing guidance to doctors in Scotland the importance of seeking to persuade a child under 16 to involve her parents and to obtain parental consent to treatment wherever possible should be stressed.