Waltham Forest Teenage Pregnancy Strategy Evaluation

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1. Introduction

Unintended pregnancy among young people, particularly teenagers, presents an important global public health challenge. Teenage pregnancy is a complex issue and requires a multi-pronged approach to tackle it effectively. Several prevention strategies including sex and relationship education, skills-building and improving access to contraceptive and sexual health services have been tried across the world.

The teenage pregnancy rate in England is currently at its lowest since the publication of the Teenage Pregnancy Strategy in 1999. However, there is significant variation in local area performance. For example, almost half of under 18 conceptions in 2006 occurred in the most deprived 20% of local authority wards. This wide geographical variation in teenage pregnancy rates indicates the need for local approaches.

A number of initiatives have been implemented in Waltham Forest to help reduce teenage pregnancy rates. Even though the teenage pregnancy rate in the borough is generally falling, it is not falling as fast as other areas.

This evaluation was commissioned by the Teenage Pregnancy Executive Board in order to provide an understanding of the impact and effectiveness of the Teenage Pregnancy Strategy in Waltham Forest.

An evaluation assesses the extent to which a service is meeting its objectives. It sets out to:

- Clarify what the service is
- Assess aspects of the service using a systematic evaluation framework
- Assess performance of the service against agreed standards (local, regional, national)

The report gives an overview of national policy relating to teenage pregnancy, then provides a summary of the literature on teenage pregnancy followed by the local picture. The data collected for the evaluation is then presented, followed by a discussion of the data with conclusion and recommendations.

1.1 National policy

The government's ten-year national Teenage Pregnancy Strategy was launched in 1999. The main aims of the strategy were to:

- Reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under-18s, and to set a firmly established downward trend in the rate of conceptions among under-16s, by 2010
- Increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion

Since the publication of the Strategy the Teenage Pregnancy Unit has been co-ordinating initiatives to improve SRE and contraceptive services. Other initiatives have been developed with the aim of improving overall health of young people. The Department of Health launched the Health Demonstration Sites Programme in 2006 to support the development of young people friendly health services. The aim was to provide adolescent

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health information and advice at sites visited regularly by young people such as youth clubs and sports centres.

Another initiative was launched in 2009 to improve sexual health provision for young people. This new media campaign was to raise awareness of the different contraception options, including Long Acting Reversible Contraceptives (LARCs). This initiative would ensure that contraceptive services are made available through a variety of sites, including further education colleges. All the sites providing contraceptive services would be required to meet the ‘You’re Welcome’ quality criteria. These set out criteria for young people friendly services.

The Department of Health (DH) White paper *Choosing Health: making healthy choices easier*, committed to support the implementation of the Teenage Pregnancy Strategy, in particular through action in neighbourhoods with high teenage conception rates and putting in place initiatives to support teenage parents. The DH also issued new guidance on improving access to contraceptive and sexual health advice services as well as increasing choice and continuity of care for teenage mothers through multi-agency working.

Policy efforts in tackling teenage pregnancy have a dual purpose –

*to establish a universal minimum standard in contraception and sexual health services; and target specific interventions and efforts towards recognised teenage pregnancy ‘hotspots’.*

In 2007, the National Institute for Health and Clinical Excellence (NICE) issued guidance on one to one interventions to prevent sexually transmitted infections (STIs) and under 18 conceptions for vulnerable young people based on the best available evidence to date.

More recently the coalition government’s public health outcomes framework indicators for consultation include teenage conception rates. The rational for including teenage conceptions was

“Evidence shows that teenage parenthood leads to poorer health outcomes for both teenage parents and their children - babies born to teenage parents have a 60% higher risk of infant mortality and teenage mothers are three times more likely to suffer from post-natal depression.”

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3 Department of Health Press Release 31 August 2006  
7 Department for Education and Skills and Department of Health (2007) *Improving Access to Sexual Health Services for Young People in Further Education Settings*  
The Equalities Act 2010\textsuperscript{11} identifies pregnancy as a protected characteristic. This places a duty on Public sector bodies to eliminate unlawful discrimination, harassment and victimisation against pregnant women including teenagers.

2. Literature review

2.1 Factors influencing teenage conceptions

The Teenage Pregnancy Strategy identified a number of risk factors which increase the likelihood of teenage pregnancy. These include risky sexual behaviours; education-related factors, such as low education attainment; and family/background characteristics, such as living in care, being a daughter of a teenage mother and belonging to a particular ethnic group. Whilst current policy aims to lower the risk of social exclusion and health inequalities, interventions designed to reduce these factors need to be formally evaluated.\(^\text{12}\)

The positive association of teenage pregnancy and parenthood with high levels of deprivation and unfavourable health, educational and social outcomes was highlighted in an evidence briefing\(^\text{13}\) in 2003 and reinforced in 2007\(^\text{14}\). Ward level data show that low educational attainment is associated with high teenage pregnancy rates even after accounting for the effects of deprivation.\(^\text{15}\)

Young people from disadvantaged backgrounds experience greater difficulties in accessing contraception and are less likely to use emergency contraception.\(^\text{16}\) The availability of easily accessible sexual health and contraception services also influences teenage conception rates. Areas with high levels of investment in sexual health services through the teenage pregnancy strategy usually had lower rates of conception.\(^\text{17}\)

The choice of contraceptive method influences the chances of a young woman being pregnant. User-dependent methods such as oral contraceptive pills and condoms, which are the most popular contraceptive methods in the UK,\(^\text{18}\) have lower efficacy than LARC.\(^\text{19}\) As young people are more likely to use these user-dependent methods they have a higher risk of contraceptive failure.

Difficulties in negotiating condom use may also influence a young woman's chances of getting pregnant. This may be due to low self-esteem, or being in a relationship with an older partner on whom the young woman is economically dependent.\(^\text{20}\)

Young women from very strong cultural or religious backgrounds (not limited to any particular faith) may have particular difficulties using contraception. They are likely to be living with their parents and would be anxious that the parents do not discover any condoms or contraceptive pills in their possession. It has been reported that children from such backgrounds are usually reluctant to use contraception.\(^\text{19}\)

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\(^\text{12}\)Trivedi D, Bunn F, Graham M, Wentz R (2007) Update on review of reviews on teenage pregnancy and parenthood;
\(^\text{14}\)Trivedi D, Bunn F, Graham M, Wentz R (2007) Update on review of reviews on teenage pregnancy and parenthood;
A young woman’s experience of health professionals while obtaining emergency contraception can influence her chances of seeking emergency contraception in future. Negative encounters will have a negative impact on her likelihood of seeking emergency contraception.

2.2 Effective interventions
International evidence shows that the most effective ways of preventing teenage pregnancies are:

- Effective sex and relationships education (SRE) – which helps young people gain the skills to handle the pressure to have sex as well as equips them with the knowledge and skills to avoid unwanted pregnancies and sexually transmitted infections (STIs)
- Youth development programmes – focusing on personal development including self confidence and self-esteem
- Easy access to young people-oriented contraceptive (found to be cost effective) and sexual health services

However, maintaining a sustained reduction in teenage pregnancy would require actions to address the underlying risk factors such as low educational attainment, low aspirations, lack of engagement in learning post-16 and poverty.

There is evidence from research in England that areas of the country which have achieved the greatest reductions in teenage conception rates in recent years provided accessible sexual health services for young people in addition to good quality school based SRE.

Despite evidence that good quality SRE is effective in reducing teenage pregnancy, a survey by the UK Youth Parliament (UKYP) of over 20,000 young people found that more than 50% had never been taught about teenage pregnancy in school and would not know where to find their local sexual health clinic.

There was no good evidence for the effectiveness of abstinence-based interventions. Programmes that include abstinence messages only seem to be effective if messages about contraceptive services and other practical issues were included.

Evidence shows that the Family Nurse Partnership Programmes improve maternal and child health and social care outcomes. The programme is an intensive, preventive home visiting programme for vulnerable, first time young parents that begins in early pregnancy and ends when the child reaches two. Though the programme only enrols young women who are already pregnant - and therefore would not prevent first pregnancy – the support provided helps prevent subsequent unwanted pregnancies for the young person.

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Economic modelling has demonstrated that one-to-one interventions, including structured discussions or counselling, can be cost-effective. The National Institute for Health and Clinical Excellence (NICE) recommendations combine the identification of high risk groups and the provision of information and advice on prevention of STIs including HIV and under 18 conceptions into mainstream health and other young people’s services.

A review of the effectiveness of primary interventions concluded that:

"combination of educational and contraceptive interventions appears to reduce unintended pregnancies among adolescents"\textsuperscript{28}.

The Department for Children, Schools and Families’ Teenage Pregnancy Self Assessment Toolkit provides guidance on strategies needed in boroughs to reduce teenage conceptions. This guidance includes:

- Strategic accountability and partnership between organisations
- Detailed, accurate and up-to-date data for determining need, planning, commissioning and performance managing appropriately targeted programmes and identifying those most at risk of teenage conceptions
- Effective communication to internal stakeholders, the media, young people and parents with appropriate messages.
- Delivery of high quality SRE/PSHE linked to accessible Contraception and Sexual Health Services (CASH)
- Provision of young people focused contraception and sexual health services (CASH), trusted by teenagers and well known by young people, parents and practitioners working with them
- Workforce development: workforce training on teenage pregnancy and sex and relationship issues in mainstream partner agencies
- Integrated Youth Support Services (IYSS) with a clear remit to tackle teenage pregnancy
- Targeted work with those young people at risk and working on increasing aspirations; and work with parent/carers to prevent teenage conceptions
- Supporting teenage parents through targeted support in the antenatal and postnatal periods to improve health and achieve better outcomes later on in life

\textsuperscript{27} Killoran, A. & McCormic, G. (2010) Towards an integrated approach to sexual health services: The contribution of NICE guidance on on-to-one interventions to prevent STIs and under 18 conceptions. Health Education Journal, 69/3, 297-310

3. Local picture

The Teenage Pregnancy Team, the wider Youth Support Service and other partners were responsible for implementing the Teenage Pregnancy Strategy in Waltham Forest until the end of the strategy in March 2011. The setup is described in section 5.

There was an average of 206 teenage pregnancies a year in Waltham Forest between 1998 and 2009. The highest during this period was 231 conceptions in 2003 and the lowest was 191 in 2004 and 2006.

The teenage pregnancy rate in Waltham Forest remains higher than London and England. Waltham Forest’s teenage pregnancy rate only fell slightly from 56 conceptions per 1000 in 1998 to 49.2 per thousand in the second quarter of 2010. This compares to a reduction from 51.5 to 39.4 per 1,000 in London and 46.6 to 37.2 per 1,000 in England during the same period.

Figure 1 shows trends in teenage conception rates between 1998 and the second quarter of 2010. There was a 2% reduction in teenage pregnancy rates in Waltham Forest between 1998 and 2009 compared to 18% reduction in England and 20% in London. Full year figures for 2010 are not yet available but it is unlikely that the 50% reduction by 2010, set by the national Strategy, will be achieved.

The latest available data show that there were 85 conceptions in Waltham Forest from January to June 2010, compared to 109 during the same period in 2009.

Figure 1: Quarterly under-18 conception rates per 1,000 females aged 15 – 17, 1998 to second Quarter 2010 (Rolling quarterly average)

Due to small numbers, ward level teenage conception rates are generally published by combining three years’ data. The rates for 14 of the 20 wards in Waltham Forest fell in 2006 - 2008 compared to 2005 - 2007, with Leytonstone recording almost 50% reduction during this period. Higham Hill and Lea Bridge continue to have the highest teenage conception rates in the borough.
Four wards in Waltham Forest were among the 20% of wards in England with the highest rates (at least 53.1 conceptions per 1,000 women aged 15-17) in 2006 – 2008. They are Higham Hill, Lea Bridge, Cathall and Leyton.

In 2010/11 Marie Stopes International, the main abortion service provider for Waltham Forest performed 1,793 abortions in total. Eight percent (145) of the women were under 18 years. This compares to 9% in Barking & Dagenham and 13% in Havering.
4. Aims and objectives

4.1 Aim
To assess the impact of the teenage pregnancy strategy in Waltham Forest under the themes:

- Better prevention
- Better support
- Joined-up action
- Sustainability
- Involving young people

4.2 Objectives

- To review the literature to find out what works
- To measure the impact of interventions on young people’s knowledge, attitude and behaviour in relation to teenage pregnancy
- To seek the views of relevant stakeholders on the impact of local interventions
- To assess performance against local Teenage Pregnancy Action Plan
- To compare local Action Plan against a high performing area

4.3 Methods

The Donabedian framework was used to structure the evaluation. This examines:

- Structure: resources (financial, capital, human)
- Process: what the service does
- Output/Outcome: what the service delivers

4.4 Data collection

Data was collected from a variety of sources using different methods:

- Teenage pregnancy data from ONS/TPU
- Workshop with the teenage pregnancy team
- Survey of school children and teenage mothers to assess their knowledge, attitude and views
- Semi structured interviews with service providers delivering services for young people in relation to sexual health, contraception and pregnancy. The following services provided information:
  - ONEL CS (providers of young people’s sexual health clinics)
  - Family Nurse Partnership
  - School Nursing
  - Change for Children Team (providers of SRE support to schools)
  - Children’s centres
- Documentary analyses – covering relevant strategies and plans

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4.5 Data analysis

Qualitative data from semi-structured interviews were analysed by identifying recurrent themes. Quantitative data collected from the questionnaires completed in the student survey were summarised into percentages; and teenage pregnancy data was analysed through Excel to produce graphs.
5. Results

5.1 The Teenage Pregnancy Team

5.1.1 Structure

When the National Teenage Pregnancy Strategy was launched in 1999, a ‘virtual’ teenage pregnancy team was formed in Waltham Forest to work with partners to implement the strategy. This was made up of workers from different directorates of the Local Authority identified with responsibility for teenage pregnancy. These workers more or less worked as individuals without shared aims and objectives. As a result it was difficult to engage other agencies towards a shared vision for teenage pregnancy. The ‘virtual team’ had no systems in place for record keeping.

Strategically, teenage pregnancy work in Waltham Forest was initially led by the PCT. Prior to 2008 there was a large management group consisting of both strategic and operational staff. This group was transformed into the current Teenage Pregnancy Executive Board, which is jointly chaired by the Director of Public Health and Deputy Director, Children and Young People’s Services and the Teenage Pregnancy Strategic and Implementation Group.

The current team, based at Leyton Youth Centre, was only formed in 2008 - almost ten years after the publication of the national strategy. Responsibility for teenage pregnancy then moved from Children’s Social Care to the Youth Support Service. In 2010 the team added a young fathers’ worker. The team is made up of the following staff (Box 1):

Box 1: The Teenage Pregnancy Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Full-Time Equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strategic Lead</td>
<td>1 (WTE)</td>
</tr>
<tr>
<td>1 Teenage Pregnancy Co-ordinator</td>
<td>1 (WTE)</td>
</tr>
<tr>
<td>1 Teenage Pregnancy Reintegration Officer</td>
<td>1 (WTE)</td>
</tr>
<tr>
<td>1 Sexual Health Link Worker</td>
<td>1(WTE)*</td>
</tr>
<tr>
<td>2 Connexions Personal Advisors – includes young fathers’ worker</td>
<td>2 x 0.6 WTE</td>
</tr>
<tr>
<td>1 Social Worker</td>
<td>0.5 WTE</td>
</tr>
<tr>
<td>1 Careers Adviser – includes young fathers’ worker</td>
<td>0.4 WTE</td>
</tr>
<tr>
<td>1 Administrator</td>
<td>1 WTE</td>
</tr>
</tbody>
</table>

*Not based at Leyton Youth Centre

The Teenage Pregnancy Team has been dissolved following the cessation of the teenage pregnancy grant in March 2011. It has been replaced by generic Opportunity and Development Workers who will have teenage pregnancy work within their remit.

5.1.2 Process

The team has clear aims and objectives.

The aims are two pronged - prevention and support.

- To reduce teenage pregnancy rates in Waltham Forest
- To provide support to teenage parents and pregnant teenagers and their partners

The objectives are

- To reduce the rates of sexually transmitted infections and unwanted pregnancies
- To provide appropriate information and support to facilitate easy access to contraception and sexual health services
To increase the proportion of teenage parents in education, training or employment

All the team members are clear about the aims and objectives and how their individual activities contribute to achieving them. The team members vary in the proportion of their time devoted to prevention of teenage pregnancy and support to pregnant teenagers and teenage parents (this includes preventing further unwanted pregnancies), as shown in table 1 for those who provided this information.

Table 1: Proportion of time allocated to prevention and support

<table>
<thead>
<tr>
<th>Team member</th>
<th>% prevention</th>
<th>% support</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5</td>
<td>95</td>
</tr>
<tr>
<td>B</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>C</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>D</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>E</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>Average</td>
<td>34</td>
<td>66</td>
</tr>
</tbody>
</table>

This suggests that on average the team spends almost twice as much time supporting teenagers who are already pregnant, and teenage mothers (to prevent secondary pregnancies), than primary prevention work to prevent unwanted pregnancies in the first place. The secondary prevention work also aims to prevent the social exclusion of pregnant teenagers and teenage parents.

The balance between ‘prevention’ and ‘support’ was dictated originally by the posts such as reintegration officer. However, the reintegration officer job description was modified to include more prevention work, linking with the dedicated teenage pregnancy nurse, Connexions and youth workers on ‘drop down’ days and Christopher Winter SRE Project in schools.

Primary prevention work is carried out in collaboration with:
- Schools through PSHE, school nurses and the Extended Schools Team
- Early years through Children’s Centres
- Youth Support Service (YSS) via the youth bus, centre based and targeted outreach activities
- Young people’s substance misuse services
- Third sector organisations

The Teenage Pregnancy Team referred to and received referrals from other services, for example sexual health services, FNP, young people’s substance misuse services and youth clubs. The team had a system in place which ensured that midwives within the borough referred all pregnant young women under 19 years.

Work with young people involves one to one and group work providing information, advice (on STIs and different types of contraception) and guidance, signposting to appropriate health and social care services, and direct referrals to the sexual health and contraception service. The aim is to empower young people to enable them make informed choices, with an emphasis on the use of Long Acting Reversible Contraception (LARC).

Both prevention and support functions include outreach work, visiting young people at home where appropriate.
5.1.3 Outputs/outcomes
The team has set up the following projects through which young people are supported:

- Condom distribution scheme
- Young people’s sexual health drop-in
- Young mums group
- Young fathers group
- Courses for pregnant teenagers and teenage mothers

Through the links with midwives, the team is able to identify pregnant teenagers and provide appropriate support. This has enabled some young mothers to go on to complete college and university. In terms of outcomes, all the teenage mothers who took part in the telephone interviews as part of this evaluation were aware of different types of contraception, and only one is currently not using any contraception.

The Teenage Pregnancy Strategic and Implementation Group is ultimately responsible for delivering the National Teenage Pregnancy Strategy target of halving the rate of teenage pregnancies by 2010 compared to the 1998 baseline.

5.2 Interviews with service providers
Semi structured interviews were conducted with providers of young people’s sexual and reproductive health services to find out how their services help young people in terms of the stated aims of the evaluation:

- Better prevention
- Better support
- Joined-up action
- Sustainability
- Involving young people

See appendix for the interview guide. Table 2 summarises the services provided by those interviewed. The Young people’s Substance Misuse Service (722) provides some sexual health services such as condom distribution. Unfortunately this service could not be interviewed but references have been made to the service in the report.
<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Service description</th>
</tr>
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<tbody>
<tr>
<td>ONEL Community Services</td>
<td>Established for over 12 years providing community sexual health and gynaecology services, including contraception, and clinics for young people. The service employs a Teenage Pregnancy Outreach Link Nurse who provides school and non school based activities raising awareness and providing support to young people. This nurse provides contraceptive advice and supports young people in making an informed decision whether or not to terminate pregnancy. The role also includes administering contraception, including some Long Acting Reversible Contraceptives (LARC).</td>
</tr>
<tr>
<td>Family Nurse Partnership (FNP)</td>
<td>The FNP programme works with young families from early pregnancy up until the child is two. It has been established in Waltham Forest since 2009 and the staff provide intensive weekly, fortnightly or monthly home visits depending on need. The service helps improve antenatal health and parents’ economic self-sufficiency. This may include preventing subsequent unwanted pregnancy but it is not set up to prevent pregnancies in the first place as it only enrolls young women who are already pregnant.</td>
</tr>
<tr>
<td>Change for Children (CFC) Team</td>
<td>The CFC Team has been working in Waltham Forest for over 10 years in supporting schools in different areas including substance misuse and SRE. In the past the team provided more frontline work, providing services directly to young people. However, for some time the work has been more focused on training teachers and other staff to work with students, with very little direct contact with young people. The CFC Team provides support for schools in developing policies and programmes in line with national guidance. They also broker links between schools and sexual health services including the teenage pregnancy team, facilitating professionals to give talks in schools.</td>
</tr>
<tr>
<td>Youth Support Service (YSS)</td>
<td>The YSS established an after school youth provision which included preventative work at a secondary school as a result of an increase in under 16 pregnancies, training teachers to deliver SRE via the Christopher Winter Project, school drop down days, Children in Care group, work with the Pupil Referral Units (PRUs) and new arrivals. They also run stalls at all the local festivals which include condom distribution. In addition, the YSS also does preventative work with young people in gangs which is linked to work with substance misuse services. Some YSS staff have received intensive training as part of the Christopher Winter SRE project to work alongside and peer train teachers on preventative work around relationships in selected schools including two special</td>
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30 Young people’s clinics not operating any more due to service restructure
schools. The special schools were targeted as a Tell Us survey indicated the young people were getting poor SRE input.

School Nursing Team

The school nursing service has been around historically as part of the Local Authority education provision. They provide generic health related services to schools such as immunisations, screening (vision, hearing, etc), Child Measurement Programme and health promotion and advice, which include sexual health. The school nurses are also responsible for the care of children with special needs requiring medication and provide training to teachers, for example on how to respond to emergencies. The school nurses are therefore not directly involved in reducing teenage pregnancy. The TPT attempted to undertake joint preventative work in schools with the school nurses but other priorities took precedence.

Children’s Centres

Children’s Centres support young people once they are pregnant, targeting families with children under 5. They provide welfare and employment support and advice. The support that Children’s Centres provide may help prevent subsequent unwanted pregnancies but they are not set up to work with young people to prevent pregnancies in the first place.

As shown in table 2 above, the Teenage Pregnancy Team (TPT), ONEL CS, Change for Children (through SRE) and the YSS see their work as involving primary prevention i.e. directly preventing teenage pregnancies in the first place. The other services, for example the FNP and Children’s Centres, may help prevent subsequent unwanted pregnancies but do not help prevent first pregnancies as they only work with young people after they become pregnant. The school nurses may have a limited impact on prevention of pregnancies through their health promotion work but this does not seem to be an intended aim of the service.

ONEL CS undertakes prevention activities through provision of contraception and advice to young people who attend clinics. The teenage pregnancy outreach link nurse specifically provides contraception advice and products to young people and also does outreach work in schools, Pupil Referral Units (PRUs) and other young people’s centres targeting high risk girls. However, the service acknowledges that the outreach work is not as effective as it could be. For instance, links with other services such as young people’s substance misuse services and Looked After Children could be strengthened.

In addition, the teenage pregnancy outreach nurse used to be partly based with the TPT as part of the team, which facilitated prompt referrals and joint discussion of caseloads. However, this arrangement ceased prior to March 2011, which created a gap in terms of the TPT having easy access to the outreach link nurse; and a communication gap in terms of follow up of referrals.

As described earlier in table 1, the TPT staff members spend more of their time in supporting young people who are already pregnant, than prevention activities targeting the larger
teenage population to prevent pregnancies in the first place. The FNP and Children’s Centres also provide support to pregnant young women to prevent social exclusion.

All the services have some systems in place to involve young people in improving their services. The TPT ran the ‘Young Mums’ group, which provided a space for teenage parents to discuss issues of concern. This group planned and reviewed the support provided for young people. This group ceased even before the TPT was wound up due to a range of factors including lack of funding, some of the very active young mothers going back to college and young people being more empowered and needing less support. Young people were also involved in peer education through facilitating health promotion sessions with support from the team.

The TPT attempted to run formal consultations with young people through focus groups but feedback from team members suggests that this was not very successful. There were attempts to include young people on the Teenage Pregnancy Strategic and Implementation Group. There was regular representation from young mothers on this group. The young mothers presented at two staff conferences, worked with young advisors and helped the service obtain the QISS Quality Standard. They were also involved in interviewing for FNP and Reintegration Officer posts. This could not be sustained due to lack of funding to pay the young mothers for the input.

Young people’s views were sought in other ways including feedback forms for all sessions ran by team members. In addition the TPT collaborated with other services including the Change for Children Team and ONEL Community Services to organise the annual Teen Voices conference. It was a consultation event with representation from local schools. The conferences were highly rated by schools. This annual event came to an end due to lack of funding.

Other services had their own in-house consultations with young people. For example, ONEL Community Services organised user surveys and focus groups to elicit young people’s views. The service was also visited by the Young Advisors as mystery shoppers to record their experiences of using the service. The report from these visits was very insightful.

The Change for Children Team, working with young people and other agencies, developed a DVD to help improve young people’s access to sexual health services. Young people were involved throughout the development of the film.

There was concern that in the past young people had been consulted regarding the location of a young people’s sexual health clinic in the north of the borough. The response from young people indicated that they did not like the clinic’s location and suggested a different location. However, this was not acted upon by the service provider and there was no feedback to the young people. Cases like this undermine young people’s confidence in taking part in consultations.

The TPT publicised its services in a number of ways including:

• work with schools – sending out information to schools and participating in assemblies
• participating in community and young people specific events
• sending out referral forms to other agencies working with young people

However, the fact that uptake of the condom distribution scheme for example, which provides free condoms to young people, was poor suggests that this particular project was
not publicised well enough. Some comments regarding publicity of young people’s services were:

“When I speak to young people they don’t know that they can get free condoms”

“There is no publicity of EHC pharmacies”

“I’d like to see more publicity”

“Young people especially boys are not aware”

There were attempts to launch a website but this had a number of issues causing very long delays. It was a wider Local Authority website for young people which was meant to include teenage pregnancy, as Council policy is not to allow stand alone websites.

Young girls in the borough who become pregnant are referred to the Teenage Pregnancy Team through schools, midwives, health visitors or professionals from the Contraception and Sexual Health Services. Schools often proactively identify at-risk young people and ask the team for some input to help prevent unwanted pregnancies.

However, the team members acknowledged that there is a gap in early identification of young people at risk due to the Common Assessment Framework (CAF) not being used by all young people’s services in Waltham Forest. A multi agency CAF panel group has recently been set up to ensure implementation of CAF across all young people’s services.

There were specific comments about young people’s sexual health clinics including:

“All the young people’s clinics are closed now leaving only Oliver Road”

“Oliver Road young people’s clinic is run alongside adults’ clinic. Young people think it is not confidential”

“Young people want the sexual health clinics back, especially Tom Hood. It is next to a school so very convenient”

Some groups were identified as particularly difficult to engage, and more effort is required to ensure that these groups are able to access appropriate services. These include:

- Young people not in education, employment or training, who are more likely to get pregnant
- Looked After Children
- Young offenders
- Young fathers
- Travellers

The Teenage Pregnancy Team works with other services but there is recognition that more needs to be done to provide support to Looked After Children in private homes and children excluded from school. There were some concerns that the Department of Sexual Health at Whipps Cross University Hospital does not have a young people’s GUM clinic. This might affect young people’s access to the clinic.

Some barriers to improving young people’s access to services and/or reducing teenage conceptions were identified as follows:

- Lack of long term strategy and commitment
• Lack of coherence in short and long term objectives
• Lack of ongoing evaluation and learning from experience within some services
• Limited/restricted access to young people’s clinics due to closures
• Lack of accurate information about young people’s sexual health services - for example changes in clinic locations and times not communicated to partners
• Changes in Youth Support Service not always communicated to partners in a timely manner
• Lack of outreach peripatetic LARC service for young people
• Lack of robust data on outreach work performed by some team members
• Teenage pregnancy data is about 18 months late so it is difficult to establish reasons for increase or decrease and target interventions accordingly

However, there was acknowledgement of some of the successes of the teenage pregnancy team. These include:
• The team is able to identify most teenage parents and provide support
• Young people are better informed about sexual health and services since the team was set up
• Some young mothers supported by the teenage pregnancy team have since completed college and/or university
• Young people have been engaged in challenging misconceptions around teenage pregnancies

5.3 Survey of young people

Part of the evaluation was to run focus groups with young people to elicit their knowledge and attitudes to contraception; awareness of services and their views on the quality of SRE in schools. Due to logistic reasons focus groups could not be conducted. However, questionnaires were sent out to students in years 9, 10 and 11 in different parts of the borough with the support of Change for Children Team. See appendix. There are variations in their completeness across the different types of school. It was not always possible to identify which questionnaires were from which part of the borough.

All the 76 questionnaires were completed from different types of school, as shown in table 3 below:

<table>
<thead>
<tr>
<th>Type of school</th>
<th>Number of questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream schools</td>
<td>50</td>
</tr>
<tr>
<td>Alternative Provision</td>
<td>19</td>
</tr>
<tr>
<td>Special schools</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
</tr>
</tbody>
</table>

Of the fifty questionnaires from mainstream schools seven were from year 9, twenty-six from year 10 and seventeen from year 11. Generally there was good knowledge of contraception and most of the respondents indicated that they obtained the knowledge from school/college. Participants also gave other sources of sexual health and contraception information including sexual health clinics, GP and TV/media. Some specific local services were also mentioned as sources of information – Face-to-Face, 722, 4YP.

More than 98% of the young people think contraception is useful and the main reason given was that it prevents pregnancy. About 10% indicated that it prevents STIs as well.
Young people obtain sexual health and contraception advice from a number of sources such as school/college, GP, sexual health clinic, hospital, media/TV, and some specific local services as mentioned above. The most popular sources were school/college, sexual health clinic and GP.

A number of factors influence young people’s views about contraception. The young people who took part in this survey indicated that their views were influenced by family and friends, information from college and the media (approximately 30% each). A minority mentioned young people becoming pregnant as the main factor that influenced their views on contraception.

There was generally very good knowledge of different types of contraception, particularly condom and the pill. Almost all the years 10 and 11 students mentioned Emergency Hormonal Contraception (EHC) as well; however, none of the students from special schools mentioned EHC. In addition, about 80% of respondents knew how to use a condom. Most of them learnt this from school/college and had a positive attitude towards its use.

Many students did not answer the question asking for their views on getting pregnant under 18 years old. For those who answered this question, their views were mainly negative but one respondent stated

“It depends on the relationship”.

The vast majority of the students knew about SRE from school/college and mentioned contraception and relationships as the main issues that were taught. Most found the sessions useful. However, about 10% of respondents did not find the sessions useful. Some comments were:

“I think it’s good because it is getting us ready and showing us the consequences so like it’s our choice to make it right” – Year 9 male

“The SRE that we learn in school only make you aware of the consequences of sex and relationships so is not that good.” – Year 10 male

“It was not good because they didn’t explain a lot of information” – Year 9 male

“Don’t receive enough” – Year 9 female

“Was very helpful, there are difference between sex and relationship” – Alternative Provision

5.4 Interviews with young mothers

Telephone interviews were conducted with a selection of teenage mothers on the Teenage Pregnancy Team’s caseload to elicit their awareness and views on services. Eight teenage mothers took part and only one reported not using contraception. The rest reported using implant and knew about other forms of contraception. All the teenage mothers thought it is important to use contraception and the reasons given were “it stops pregnancy” and “it prevents pregnancy”.

20
The teenage mothers generally obtain contraception advice and products from Oliver Road; some specifically mentioned the sexual health nurse/teenage pregnancy nurse. The internet was also mentioned as a source of advice. Five young mothers reported they had received SRE lessons at school and generally thought they were good and should have been more frequent. However, one commented:

“They were biological, need more realistic information. Could have prepared us better”.

Most of the young mothers were aware of services in schools/colleges that help raise awareness of how young people can avoid unwanted pregnancy – the Teenage Pregnancy Team and youth workers were mentioned. Half of them were not aware of health promotion initiatives that help raise awareness of how young people can avoid unwanted pregnancy in the borough. Of those who were aware of such initiatives some of their responses were:

“There is good work around second pregnancy, TPT, FNP”
“Leaflets in GP surgery”
“TPT was at some summer events doing stalls with information/advice”

The young mothers rated local services that help young people avoid unwanted pregnancies from poor to very good. Some comments were:

“TPT very good and friendly, they do not judge you”
“It’s private and explains choices”
“More work around awareness needed”
“Not enough preventative work around preventing first pregnancy”
“You can’t stop people really”

The following barriers to young people’s access to sexual health and contraception service were identified:

- Clinics near gangs – “like Oliver Road and Beaumont”
- Not enough services
- “Some GPs can act as a barrier”
- Location, opening times restrict access
- Not enough advertising

Service location was the most mentioned, and the reasons were mainly either too far or they were scared to go to those locations.

Suggestions for improving young people’s access to sexual health and contraception service were:

- More outreach and one to one
- More young people’s clinics
- More accessible locations
- GPs not to be judgemental

5.5 Performance against action plan and communication plan

The Teenage Pregnancy Team has an action plan for 2010/11 which sets out the work areas. The action plan covers the team’s two main aims - Prevention and Support to
teenage parents - with priority actions for each area. The priorities in each area are consistent with the national Teenage Pregnancy Strategy. The lead officers for the actions come from different agencies/services. This highlights that it is a multi-agency action plan, which is required to effectively tackle teenage pregnancy.

However, the action plan does not mention the specific targets set by the National Teenage Pregnancy Strategy, which were:
- to reduce teenage conceptions by half by 2010 and
- to increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion.

This means there were no measurable milestones towards the achievement of the targets and no indication of how they would be monitored. This was probably due to the fact that no specific milestones were set as part of the national strategy.

Actions are RAG rated but this is incomplete so it is not possible to ascertain the status of a number of actions. For those actions that have a RAG rating, majority are green, indicating that they have been achieved/are on target.

Part of the communication plan was to launch a website for young people. However, there were very long delays and when the website was finally launched it had some teething problems that did not appear to be resolved satisfactorily.

The communication plan also had an action to provide sexual health information packs to all 14 -19 year olds in schools and colleges. These packs were sent to schools but feedback from some teachers suggests that they did not reach the students.

5.6 Waltham Forest compared to best practice

Table 4 provides a summary of best practice in reducing teenage pregnancy, and what happens in Waltham Forest. It shows a number of initiatives in the borough and some important gaps to be addressed.

<table>
<thead>
<tr>
<th>Best practice</th>
<th>What happens in Waltham Forest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective sex and relationship education helps young people gain the skills to handle the pressure to have sex as well as equips them with the knowledge and skills to avoid unwanted pregnancies and STIs</td>
<td>The Christopher Winter Project, which trains teachers to deliver SRE, has been rolled out in a number of schools in Waltham Forest. Youth workers and TPT staff have been trained to deliver the project. The vast majority of the young people who took part in the survey for this report had some knowledge of contraception and positive attitude towards contraception. Most of them reported that this was gained from school. Almost all of them thought that getting pregnant under 18 years was not a good idea</td>
</tr>
<tr>
<td>Easy access to young people-oriented</td>
<td>The SRE that is delivered in Waltham Forest</td>
</tr>
<tr>
<td><strong>contraceptive and sexual health services</strong></td>
<td>schools incorporates a focus on increasing access to services. However, about 30% of the students who took part in the survey as part of this evaluation were not aware of the location of young people's sexual health services. This may be due to the fact that all the young people’s clinics provided by the ONEL CS community sexual health and gynaecology service have been centralised to the Oliver Road hub. The CFC Team have developed a DVD in consultation with young people, which highlights the services available. This will help raise awareness and improve access. The Teenage Pregnancy Team routinely provides information about services to young people. However, changes in service configurations are not always communicated in a timely manner.</td>
</tr>
<tr>
<td><strong>Appropriate method(s) of assessment and evaluation being built into PSHE programmes ensures effective outcomes</strong></td>
<td>Support is provided to schools through training and promotion of the SRE Core Curriculum for London which includes assessment. However, there are still improvements to be made in this area. The Healthy Schools whole school review provides a mechanism for monitoring and evaluating policies and programmes in PSHE.</td>
</tr>
<tr>
<td><strong>The most effective SRE programmes use trained teachers/facilitators, include content that is specific to reducing risk and involve interactive and participatory techniques</strong></td>
<td>Most schools in Waltham Forest use PSHE co-ordinators or assistant coordinators to deliver PSHE including SRE lessons. The 6th Forms use ‘generic’ tutors to deliver PSHE, and this generates negative comments from students.</td>
</tr>
<tr>
<td><strong>The use of small group work, focused on skills and attitudes (rather than knowledge) is effective in reducing sexual risk behaviour</strong></td>
<td>The PSHE departmental reviews undertaken by CFC highlighted many examples of excellent lesson plans with varied activities, including group work.</td>
</tr>
<tr>
<td><strong>Provide one to one advice on how to prevent unwanted pregnancies, covering all methods of reversible contraception including LARC. This should include vulnerable young women such as those from disadvantaged backgrounds, those who are in or leaving care, and those who have low educational attainment</strong></td>
<td>This is provided by clinicians at the young people’s sexual health clinics, the teenage pregnancy link nurse, the Teenage Pregnancy Team and Opportunity and Development Workers. The abortion service offers advice and fitting of LARC to all women who undergo termination of pregnancy. The condom distribution scheme in Waltham Forest has not been very effective in getting young people registered to receive free condoms. Waltham Forest has recently signed up to the pan London scheme, which would help improve access.</td>
</tr>
<tr>
<td><strong>Regularly visit vulnerable women aged under 18 who are pregnant or who are already mothers and support them towards preventing unwanted pregnancies</strong></td>
<td>There is a gap in terms of outreach to young women who are in or leaving care. This is currently being addressed.</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Where appropriate, refer young women aged under 18 who are pregnant or who are already mothers to relevant agencies, including services that support reintegration into education and work</strong></td>
<td>The teenage pregnancy team members regularly visit young mothers on their caseloads from all backgrounds but there is a gap in terms of those in care. The Family Nurse Partnership also works with pregnant mothers from all over the borough. However not all teenage mothers are eligible for FNP support and a pathway has now been developed for those who are not eligible. In addition, there is a lack of joined up work between the TPT and FNP, even though they may be working with the same individuals. A lot of effort went into getting the FNP and TPT to work more collaboratively but there was a lack joined up work. This is being resolved to ensure that all partner agencies work more collaboratively.</td>
</tr>
<tr>
<td><strong>Youth development programmes – focusing on personal development including self confidence and self-esteem</strong></td>
<td>The Teenage Pregnancy Team had a reintegration officer who supports young mothers towards reintegration. The team also had a Connexions worker specifically targeting young fathers. With the team being wound down, these roles have been picked up by Opportunity and Development Workers.</td>
</tr>
</tbody>
</table>
| **Address the underlying risk factors such as low educational attainment, low aspirations, lack of engagement in learning post-16 and poverty** | These are part of the Waltham Forest Joint Inequalities Strategy. The action plan for the strategy is being developed and includes specific actions to:  
- identify and support young people at risk of failing in school  
- work with the families of young people at risk of gang affiliation  
- support young people and long term unemployed into work |
6. Discussion

The teenage pregnancy team in Waltham Forest only got off the ground some ten years after the publication of the Teenage Pregnancy Strategy. A lot of time was lost during those years as we did not have a ‘functional’ team in place. There was no focus and strategic direction in the early days, resulting in a lack of coherence operationally during this period. This might have contributed to the high rates of teenage pregnancies in the borough, as policies and interventions take time to achieve outcomes.

Since 2008 the team has had a defined structure with clear lines of accountability. It was a multi agency team with staff from the Youth Support Service, social services and NHS co-located. They developed good links with other agencies through the Teenage Pregnancy Strategic and Implementation Board. Having a teenage pregnancy outreach nurse from the NHS based with the team was very positive and provided prompt referral to sexual health and contraception services.

However, the nurse had to leave the team and move back to the sexual health clinic due to a number of reasons. This resulted in a gap in the prompt processing of referrals between the sexual health service and teenage pregnancy team. It was also difficult for the teenage pregnancy team to be kept informed of the nurse’s work with teenagers and any follow-up required from the team.

In terms of process the team’s work was driven by a work plan as discussed above. There are established processes for midwives to refer to the team and good links with schools and other young people’s services. Even though the TPT reported making efforts to work more collaboratively with the FNP, working relationships were not adequately developed. It appears there are no established processes in place to ensure sustained outreach to at-risk and difficult-to-engage young people such as Looked After Children. This is currently being addressed.

The TPT delivered a number of outputs, even though the overarching target of a 50% reduction in teenage conceptions by 2010 will not be achieved. Some of the outputs were quite successful but others, such as the condom distribution scheme, were less successful. It is important to ensure that the new condom distribution scheme is monitored effectively, especially in the absence of the Teenage Pregnancy Team, to ensure that it is successful. It is not clear if there is data to assess performance of the target to increase the participation of teenage parents in education, training and employment by 60% by 2010.

As with other parts of the country, teenage pregnancy rates in Waltham Forest are linked with deprivation. Areas with high deprivation generally have high rates of teenage pregnancy. For example the four wards with teenage pregnancy rates that are among the highest in the country (Higham Hill, Lea Bridge, Cathall and Leyton) are also among the most deprived wards in the borough. Therefore actions to achieve a sustained reduction in teenage pregnancy should be pursued in the context of broader strategies to reduce levels of deprivation and inequalities.

The TPT had a focus on and interventions targeting the high rate wards. For example, they set up a condom distribution scheme linked to a children’s centre in Higham Hill, drop-in in two schools in Leyton, and worked with gangs in Cathall. However, Lea Bridge ward, which has consistently had a high teenage pregnancy rate, does not have dedicated young people’s contraception and sexual health service or c-card registration point (for condom distribution).
As shown in table 1 the team members spent almost twice as much of their time in supporting pregnant teenagers and teenage mothers than primary prevention work targeting the general young people population. This might be because historically the TPT was set up to work with young mothers; and providing support is more resource intensive. However, as prevention is as equally important as support for pregnant young people, there should be some balance overall in time allocated to both activities. Specific individuals may specialise in either area of work, and thus spend more time in that area.

Easy access to contraception and sexual health services is identified as an effective way of reducing teenage conceptions. However, the location of sexual health services was highlighted as a barrier to access by some young people, and for example ‘clinics near gangs’. In addition, the centralisation of clinics at Oliver Road might restrict access. This needs to be explored by service providers in order to ensure that services are easily accessible by young people.

Long Acting Reversible Contraceptives (LARCs) are very effective methods of preventing unwanted pregnancies. While the Teenage Pregnancy Team cannot provide LARC, they encourage young women to choose LARC as a method. However, in Waltham Forest LARC is currently only available at ONEL CS, abortion services (for those undergoing abortion) and some GP Practices.

Given that ONEL CS has closed all young people’s clinics and centralised them at Oliver Road, it is important to understand if this will adversely affect access to LARC, and explore ways of increasing access. For example providing LARC through outreach has been found to be effective in some parts of the country and should be explored. This would involve working with schools, other young people’s service providers and Opportunity and Development Workers.

The Department for Children, Schools and Families’ Teenage Pregnancy Self Assessment Toolkit guidance recommended that boroughs develop Integrated Youth Support Services (IYSS) with a clear remit to tackle teenage pregnancy. The Teenage Pregnancy Team was integrated into YSS - the team had joint training with YSS staff, attended joint meetings, conferences etc. Attempts were made to work with Children Centres but it appears that this was not as successful.

Young people and service providers identified inadequate publicity/communication and health promotion as a gap in service provision. The teenage pregnancy communications plan needs to be set in the context of the overall Youth Support Service communications to ensure information about teenage pregnancy is embedded within the Youth Support Service and partner agencies including the NHS.

There is good sex and relationships education (SRE) provision in Waltham Forest, which linked in well with the Teenage Pregnancy Team. Any successor set up for teenage pregnancy work in the borough needs to build on this partnership and others developed by the team. In addition, the Change for Children (Healthy Schools) Team, which co-ordinates PSHE including SRE will end in March 2012 but there is currently no alternative plan as to how this work will continue.

6.1 Limitations

There are some important limitations to this evaluation. The young mothers who took part in the telephone interviews were selected by the teenage pregnancy team due to their
established relationships with them. It may not be a representative sample, which could have biased the responses.

The questionnaires used for the student survey were designed as topic guides for discussion in focus groups – which would allow for probing and more detailed discussion. However, due to time constraints and to allow a larger number of students to participate, they were sent as questionnaires. This did not allow for probing and generation of discussion.

The student survey was anonymous so in most cases it is not possible to associate particular responses to specific schools. This would have allowed for more targeted work with schools that showed the greatest lack of awareness.
7. Conclusion and recommendations

This evaluation has highlighted the important role that the Teenage Pregnancy Team played in preventing teenage pregnancies and providing support to pregnant teenagers and young mothers. As a result of the team’s work and the SRE provision in schools, there is a high level of awareness of different types of contraception (apart from EHC) among the young people who completed the questionnaires. A significant minority did not know about local contraception and sexual health services; and most of them were not aware of any health promotion activities in the borough in relation to sexual health and contraception.

The aim of the evaluation was to assess the impact of teenage pregnancy strategy in Waltham Forest under the themes:

- Better prevention
- Better support
- Joined-up action
- Sustainability
- Involving young people

The Teenage Pregnancy Team had a good support system for pregnant teenagers and young mothers, which was led by the reintegration officer. This should be built upon to ensure that young people receive the support that they need. More needs to be done in terms of joined-up action within the Targeted Youth Support Service, NHS and the voluntary sector to embed teenage pregnancy prevention and support work in all services that work with young people. This will facilitate sustainability, which seems to be lacking with the demise the Teenage Pregnancy Team. There are systems in place for involving young people in service development and these should be strengthened as some of the initiatives, for example involving young people in service design and on the strategic and implementation board have not been very successful and sustainable.

From the information presented in this report, more work needs to be done to improve prevention and health promotion work. This is due to the high rates of teenage conceptions in Waltham Forest and lack of awareness of health promotion initiatives among young people. Efforts to reduce teenage conceptions and STIs should include different interventions delivered across various agencies, including SRE in schools; and within the context of broader strategies to reduce levels of deprivation and inequalities.

Recommendations

1. The Waltham Forest Young People’s Plan should consider strategies to tackle teenage pregnancy alongside child poverty and low educational attainment with a particular emphasis on wards with the highest rates

2. Set up a multi-agency drop-in centre in:
   a. the Walthamstow Central area which is easily accessible to young people,
   b. secondary schools
   to provide a one-stop shop for information, advice and clinics on contraception (condoms, EHC, LARCs), STIs and HIV, Chlamydia screening, substance misuse etc

3. The Teenage Pregnancy Strategic and Implementation Board should develop systems to facilitate the provision of outreach LARC by trained professionals, to
increase access to young people. This could involve setting up LARC clinics in other services, for example 722

4. Contraception and sexual health service providers should involve young people in decisions regarding the location of services to ensure that services are accessible and meet their needs.

5. Review the role of the teenage pregnancy outreach nurse and ensure that this role continues to be integral to teenage pregnancy work in the borough.

6. The current Healthy Schools Team, which co-ordinates and supports SRE provision in schools, ends in March 2012. The partnership should plan for how SRE would be supported beyond this date.

7. Increase access to pregnancy testing by exploring provision in schools/colleges or youth centres.

8. Establish a support pathway for Looked After Children at risk of becoming pregnant.