Reproductive healthcare across lifecourse – a whole systems approach

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Overview

- Contraception in context of life-course
- Teenage pregnancy strategy and preventing unplanned pregnancy strategy – same or different
- Focusing on solutions
A

Unmet need

Contraceptive need

Not fertile

Trying to conceive

Not having sex

Proportion of age group (%)

16-19 years
20-24 years
25-29 years
30-34 years
35-39 years
40-44 years
45-49 years
50-54 years
55-59 years
60-64 years
65-69 years
70-74 years

Women (5-year age bands)

B

No contraception used
3rd less effective contraception used
Effective contraception used
Permanent contraception or no longer fertile
Intention to conceive or pregnancy in current or past year
No vaginal sex in the past year

Men (5-year age bands)
Teenage pregnancy strategy: rationale and aims

Teenage pregnancy is associated with disproportionately poor outcomes for young parents and their children: health, education, economic and wellbeing.

Previous approaches (Health of the Nation) focusing on health alone were unsuccessful: increased SRH service provision but failed to engage other parts of the system.

Ambitious target to halve under-18 conception rate and support young parents through comprehensive cross-government action plan.

Strategy based on improving knowledge and confidence, access to youth friendly services – universal & targeted combining means and motivation – delivered through multi-agency joined up action.

Strong stakeholder endorsement – evidence based programme for improving choice for young people ‘near universal support for the strategy’s aims’ (Independent evaluation of 1st phase of strategy).
Joined up implementation for a ‘whole systems’ approach: ten factors of effective local strategies

- Strategic leadership & accountability
- SRE in schools and colleges
- Youth friendly contraceptive & SH services + condom schemes
- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
- Training on relationships and sexual health for health and non-health professionals
- Advice and access to contraception in non-health education and youth settings
- Consistent messages & service publicity to young people, parents & practitioners
- Dedicated support for teenage parents – including SRE, contraception & sexual health
- Strong use of data for commissioning and monitoring of progress
Improving knowledge & skills

Universal - in schools & colleges. Statutory RSE from 2019!

Supporting significant Others – parents and carers

Accurate information and consistent messaging - to YP, parents & practitioners

Senior leadership & accountability

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- Consistent messages to young people, parents and practitioners
- Dedicated support for teenage parents – including SRE and contraception

Fig. 1
Statutory RSE – next steps

• *Children and Social Work Act* introduces **statutory relationships** and **sex education** across **all** secondary schools, and **statutory relationships education** across **all** primary schools.

• **Faith schools** will retain the right to teach according to the tenets of their faith – **within requirement of Equality Act** - **Church of England and Catholic Education Service** in support of statutory status.

• **DfE to consult widely with education and young people’s sectors** to determine content of the regulations and statutory guidance, and on the fit between RSE and PSHE, with scope to make PSHE statutory.

• **Draft regulations and guidance will be developed for consultation.** **Final statutory guidance will be published in 2018**, ready for delivery in September 2019, but..

• **Schools do not need to wait** to make improvements to quality and delivery of RSE – the legislation will **build on existing effective practice**.
Improving access to RH care – universal and targeted

Universal - effective and welcoming services, including GPs, matching You’re Welcome criteria

Targeted - advice & provision in range of non-health settings

Targeted and opportunistic – training for staff in touch with young people at risk
Mapping the prevention pathway around young people’s lives – an illustrative example from NE Lincs
Integrating TP actions into other relevant programmes

Visible and sustained leadership to maintain focus

Highlighting how progress on TP contributes to other PH & NHS outcomes

System leadership, outcomes and accountability

- Strong use of data for commissioning and monitoring of progress
- Dedicated support for teenage parents – including SRE and contraception
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- Advice and access to contraception in non-health youth settings
- Training on relationships and sexual health for health and non-health professionals
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- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
Highlighting how progress on teenage pregnancy contributes to PHOF and NHS outcomes

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

**Stillbirth:**
13% higher risk for children born to women under 20

**Incidence of low birth weight of term babies:**
18% higher risk for babies born to women under 20

**Infant mortality rate:** 56% higher risk for babies born to women under 20

**Smoking status at time of delivery:**
Mothers under 20 are three times more likely to smoke throughout pregnancy

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

**Maternal mental health** (placeholder):
Mothers under 20 have higher rates of poor mental health for up to three years after birth

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

**Rates of adolescents not in education, employment or training (NEET):**
21% of estimated number of female NEETs 16-18, are teenage mothers
Understanding of teenage pregnancy as a cross cutting issue has resulted in on-going commitment from local government.
## Comparable?

<table>
<thead>
<tr>
<th></th>
<th>Teenage Pregnancy Strategy</th>
<th>Increasing “planned-ness” of pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>Expanding choices and therefore delaying conception</td>
<td>Expanding choices and therefore increase proportion of pregnancies planned and appropriately timed</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td>Reduction in teenage conceptions – clear outcome and good data</td>
<td>NO clear measure of success</td>
</tr>
<tr>
<td><strong>Stakeholder buy-in</strong></td>
<td>Commitment to improving lives of young people</td>
<td>Focus on service provision</td>
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</tbody>
</table>
Highlighting how progress on reducing unplanned pregnancy contributes to PHOF and NHS outcomes

- Low birth-weight of babies
- Smoking at delivery
- Infant mortality
- Self harm, domestic abuse

45% all pregnancies are unplanned or ambivalent (0.5m per year) (Wellings 2013)

57% lead to abortion.

Unplanned pregnancies are associated with:

- no folic acid; smoking; more stress; lower relationship satisfaction; less social support (Goosens et al, 2016)
- proneness to pre and postnatal depression (Lanzi, 2009)
- poor obstetric, neonatal and child health outcomes (Mohilajee, 2007; Gipson, 2008)
The challenge

- 51% population are women
- 50-75% of 15-49 need contraception at one time
- 10% (of these) with unmet need – highest impact

**Personalised choice “best fit” contraception 90%**

**Identify unmet need and support change 10%**
**Improving Knowledge & skills**

- Understanding
- Risk perception
- Motivation

(Opportunities to enact)

**WHERE – What are the opportunities?**

- Sex and relationships education in schools
- Youth friendly contraceptive/SH services and condom schemes
- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
- Training on relationships and sexual health for health and non-health professionals
- Advise and access to contraception in non-health youth settings
- Consistent messages to young people, parents and practitioners
- Dedicated support for teenager parents – including SRE and contraception
- Strong use of data for commissioning and monitoring of progress

**WHO – which Significant others are the influencers?**

- Significant others

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**Accurate Information and consistent messaging to women, significant others & practitioners**

What are the key messages?
Access to services
Universal and targeted

High quality Services eg GP, SRH services – with “you’re welcome” equivalent standard

Support for vulnerable women particularly post pregnancy

Targeted support for Those at greatest risk

Outreach in a range of settings Eg FE colleges, drugs and alcohol

Training for health and non-healthcare staff for MECC approach Eg midwifery, pharmacy – bridging
1.32m LARC prescriptions
General Practice

840 000 new contraceptive consultations
SRH

700 000 live births
=10%

180 000 Abortions

920 000 (3.6%)
Emergency contraception

Smears
60-75% coverage
20-25% per year

Other contact opportunities - MECC?
# Targeting at risk populations

<table>
<thead>
<tr>
<th></th>
<th>Adj OR for Unplanned Pregnancy</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic qualifications</strong></td>
<td>None beyond age 16</td>
<td>1.98</td>
<td>1.17-3.33</td>
</tr>
<tr>
<td><strong>Sex Education</strong></td>
<td>Not at school</td>
<td>1.84</td>
<td>1.12-3.00</td>
</tr>
<tr>
<td><strong>First SI</strong></td>
<td>&lt;16</td>
<td>2.85</td>
<td>1.77-4.57</td>
</tr>
<tr>
<td><strong>Sexual competence</strong></td>
<td>Not at first SI</td>
<td>1.9</td>
<td>1.17-3.08</td>
</tr>
<tr>
<td><strong>Binge drinking</strong></td>
<td>Monthly</td>
<td>1.13</td>
<td>0.60-2.13</td>
</tr>
<tr>
<td></td>
<td>Weekly/daily</td>
<td>2.01</td>
<td>1.00-4.07</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>Ex-smoker</td>
<td>1.29</td>
<td>0.61-2.71</td>
</tr>
<tr>
<td></td>
<td>Current smoker</td>
<td>2.47</td>
<td>1.46-4.18</td>
</tr>
<tr>
<td><strong>Drug use</strong></td>
<td>Cannabis only</td>
<td>0.88</td>
<td>0.39-1.99</td>
</tr>
<tr>
<td></td>
<td>Other drugs</td>
<td>3.41</td>
<td>1.64-7.11</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>Yes</td>
<td>1.96</td>
<td>1.10-3.47</td>
</tr>
</tbody>
</table>
Among single women, black Caribbean (88%) and black African (82%) women reported using less contraception compared with white (95%) and Indian (100%) women. **Women from all BME groups were less likely to use hormonal and permanent methods and more likely to use barrier methods.**

Saxena, 2006
Mapping the Prevention Pathway

- Ensuring the prevention pathways is mapped around peoples’ lives
- Identify areas of highest need – which indicators
- Map service provision – General Practice and specialist services - to maximise effectiveness in 90%
- Identify highly used facilities – eg adult education, children’s centres, big employer, leisure centre, maternity services – to reach 10%
Access AND Personalised care

- Offered full range of choices at point of access
  - Increase reach and range of providers
  - Basic knowledge and skills for frontline practitioners
  - Raising the conversation

- Reach method of best fit
  - Motivation, opportunity and capability

- Maintain method of best fit for as long as is needed
  - Clear information for women
  - Opportunities to deal with complications
  - Clearly defined pathways
Integrate actions into other relevant Programmes – monitor Implementation through Process indicators Eg %age staff receiving training

SYSTEM LEADERSHIP and accountability

Senior leadership & accountability

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Outcome measures

No central accountability

Range of imperfect outcomes

- Access to services
- Abortion
- LARC uptake

User based measures

- ? Survey
- ? User based measure eg LMUP
- ?a dashboard
Delivering a whole systems approach

Focus on

- Knowledge
- Service access
- System leadership and accountability

What are the top three things that you would like to see happen at national level?

What innovative examples are there that could be scaled?
Thank You

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