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Implementing the United Kingdom Government's 10-Year Teenage Pregnancy Strategy for England (1999–2010): Applicable Lessons for Other Countries

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ABSTRACT

Purpose: Teenage pregnancy is an issue of inequality affecting the health, well-being, and life chances of young women, young men, and their children. Consequently, high levels of teenage pregnancy are of concern to an increasing number of developing and developed countries. The UK Labour Government's Teenage Pregnancy Strategy for England was one of the very few examples of a nationally led, locally implemented evidence-based strategy, resourced over a long duration, with an associated reduction of 51% in the under-18 conception rate. This article seeks to identify the lessons applicable to other countries.

Methods: The article focuses on the prevention program. Drawing on the detailed documentation of the 10-year strategy, it analyzes the factors that helped and hindered implementation against the World Health Organization (WHO) ExpandNet Framework. The Framework strives to improve the planning and management of the process of scaling-up of successful pilot programs with a focus on sexual and reproductive health, making it particularly suited for an analysis of England's teenage pregnancy strategy.

Results: The development and implementation of the strategy matches the Framework's key attributes for successful planning and scaling up of sexual and reproductive health programs. It also matched the attributes identified by the Centre for Global Development for scaled up approaches to complex public health issues.

Conclusions: Although the strategy was implemented in a high-income country, analysis against the WHO-ExpandNet Framework identifies many lessons which are transferable to low- and medium-income countries seeking to address high teenage pregnancy rates.

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IMPLICATIONS AND CONTRIBUTION

The UK Government's 10-year Teenage Pregnancy Strategy for England is an example of a nationally led, locally implemented program with associated reduction in rates. This article analyzes the strategy against the WHO-ExpandNet framework and identifies key lessons which are applicable to low- and middle-income countries.

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This article begins with a description of how the United Kingdom Government's 10-year Teenage Pregnancy Strategy for England (1999–2010) was designed and implemented and the impressive results it achieved. Using an analytic framework developed by the World Health Organization (WHO), it then analyzes what it took to make this happen. It concludes by drawing out the lessons learned from this experience that are applicable elsewhere.

Teenage pregnancy is an issue of inequality affecting the health, well-being, and life chances of young women, young men, and their children. Consequently, high levels of teenage pregnancy are of concern to an increasing number of developing and developed countries [1]. Tackling England's historically high teenage pregnancy rate¹ and its impact on young people's life chances and intergenerational inequality was one of the early initiatives of the 1997-elected Labour Government. A newly formed Social Exclusion Unit was commissioned to identify the reasons behind the high rates, review the international evidence for reducing teenage pregnancy, and develop a comprehensive strategy. Launched in 1999 by the then Prime Minister, the 10-year evidence-based strategy [2] set a goal of halving the under-18 conception rate [3] from 46.6 conceptions per 1,000 15- to 17-year-old females in 1998 to 23.3 per 1,000 in 2010. The strategy was framed around the following themes: joined up action at national and local level; better prevention for girls and boys—improving sex and relationships education (SRE) and access to contraception; a national communications campaign to reach young people and their parents; and coordinated support for young parents². A detailed plan set out the national actions for the government to establish and begin implementation of the strategy. Local reduction targets of the under-18 conception rate were agreed with each of the 150 local government areas.

A resource team was established at national, regional, and local levels: the national Teenage Pregnancy Unit (Unit), Regional Teenage Pregnancy Coordinators (regional coordinators), and Local Teenage Pregnancy Coordinators (local coordinators). Each local government area appointed a Teenage Pregnancy Partnership Board (Board) to work with the local coordinator to develop and implement a local teenage pregnancy strategy, informed by guidance documents issued by the Unit. Funding was allocated to local areas, through a strategy implementation grant, and for national strategy activities. Both the resource team and funding were maintained throughout the 10-year program. An Independent Advisory Group on Teenage Pregnancy (Advisory Group) was appointed to monitor progress and advise ministers [2].

In 2005 a midcourse review was undertaken to explore the wide variation in local area reductions; this was led by the national Unit with high-level government backing. Three areas with declining rates were compared with three areas of similar socioeconomic levels, where rates were static or increasing. The findings were clear³. Areas with better reductions had developed their strategies fully in line with the national guidance(s), involved all agencies, and had strong senior leadership to prioritize the strategy, harness resources, and monitor progress. The poorer performing areas were only implementing some aspects of the guidance(s) or confining their efforts to small geographical locations or target groups and had devolved leadership to officials with less seniority and influence over decisions and resources. The actions taken by the high performing areas to implement all the strategy guidance were

described as the 10 key factors for an effective local strategy (Figure 1). These factors were set out in new national guidance [4] with more prescription of the “must do” actions for all areas, to minimize variation in local implementation. Additional data were provided to inform targeted prevention for young people most at risk. The guidance was accompanied by a self-assessment tool, which was issued to help local areas identify and address gaps in their strategies. In poorer performing areas, local leadership was strengthened by Ministers' direct engagement with senior leaders [5] and additional support was provided to their resource teams [6].

In 2008, data showed that within the steady downward trend in the conception rate, conceptions leading to births were declining more steeply than those leading to abortions. To improve young people's awareness and use of effective contraception, particularly long-acting reversible contraception, additional government investment was secured for 3 years [7]. Further national guidance, *Teenage Pregnancy Strategy: beyond 2010*, was published in February 2010 informed by an updated evidence review and lessons from effective local practice [8].

The latest annual data for 2013 [9] showed a 51% reduction in the under-18 conception rate from 1998, the baseline year for the strategy; all 150 local government areas showed reductions, and conceptions leading to births and abortions were declining in parallel.

As Figure 2 illustrates, the reduction accelerated after 2008 with further reductions continuing to 2014. As teenage pregnancy is a complex issue requiring a multifaceted approach, the steeper decline in the later stages of the strategy is likely to be due to a combination of factors: The increasing priority in local areas following the midcourse review [4,5]; an increase in under 18s choosing more effective long-acting reversible contraception methods [10]; and the cumulative impact of the strategy's long-term prevention program.

Descriptions of England's Strategy and the results it achieved are available elsewhere [11,12]. This article adds to the body of knowledge by examining the decisions made and the actions taken by policy makers, program managers, and implementers to translate a nationwide, multilevel, multisectoral strategy into action, to track its implementation and make midcourse corrections to achieve the intended goal.

Methods

We examined the planning and management of England's Strategy using the WHO-ExpandNet Framework [13]. This was facilitated by the detailed documentation of the strategy during the 10-year implementation, in government responses to annual reports from the Advisory Group, strategy guidance(s), and reviews and evaluations undertaken as part of the strategy.

The ExpandNet Framework strives to improve the planning and management of the process of scaling up of successful pilot programs with a focus on sexual and reproductive health, making it particularly suited for an analysis of England's teenage pregnancy strategy. The Framework provides a series of recommendations for program planning and management to successfully scale-up programs. According to the Framework, success of the scaling-up strategy is determined by multiple interacting factors (Figure 3).

Results

The WHO-ExpandNet Framework provides a series of recommendations for program planning and management, to successfully scale-up programs. According to the Framework, success

¹ See for example, UNICEF Innocenti Report Card (<http://www.unicef-irc.org/publications/328>).

² The support program for young parents was an important contribution to the prevention strategy. In the short term by reducing further unplanned pregnancies and in the long term by breaking intergenerational cycles of poverty and disadvantage and reducing the risk factors for teenage pregnancy.

³ The sheer complexity of the factors involved in teenage conceptions makes it impossible to isolate precisely which precise combinations of factors make the difference. The characteristics of successful locations were derived from detailed consideration by the members of the expert teams that took part in the extended site visits.

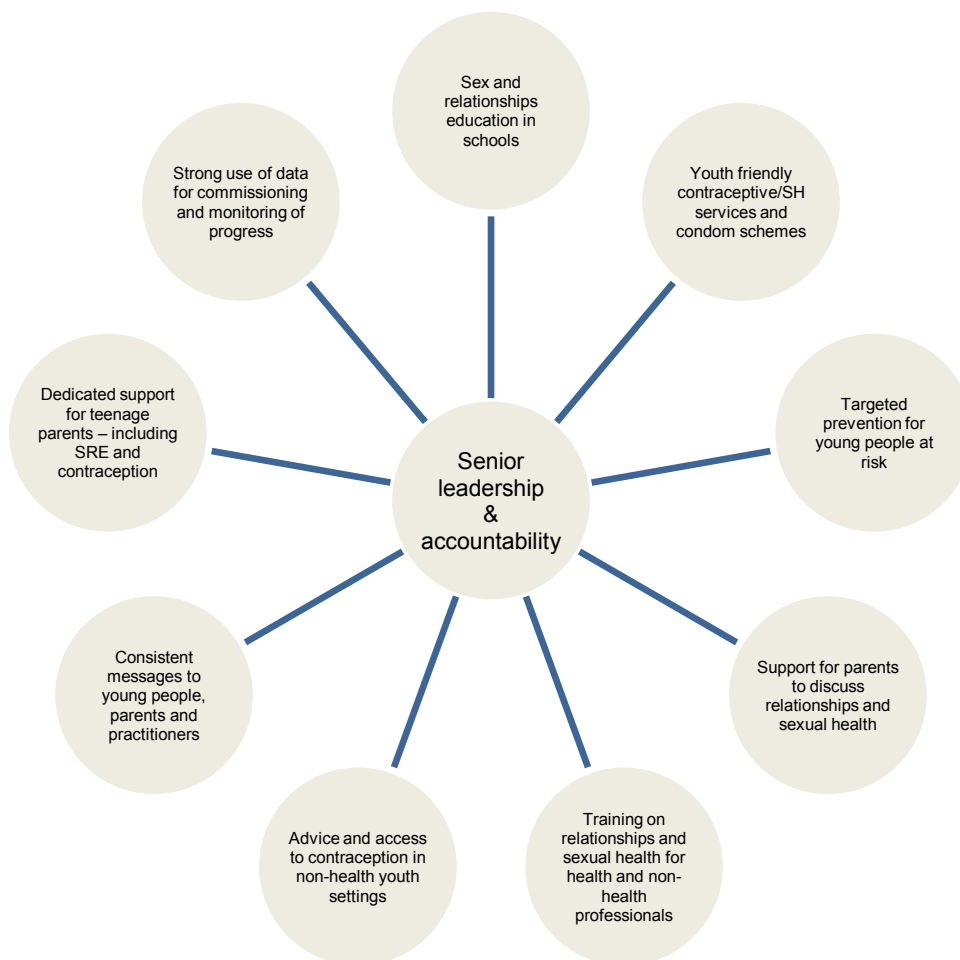


Figure 1. The 10 key factors for an effective local strategy.

of the scaling-up strategy is determined by multiple interacting factors. Effectiveness of a scaling-up strategy depends on characteristics of innovation to be scaled up, and characteristics of the resource team and the user organization, each of which is influenced by the environment in which they operate. Successful management of the scaling-up process requires attention to four strategic choice areas—dissemination and advocacy, organizational processes, resource mobilization, and monitoring and evaluation. We examine each of these areas in turn.

Scaling-up strategy—the innovation

The innovation was the comprehensive package of coordinated actions in the strategy's 30-point plan, which was framed around the strategy's four themes. In the first phase, this involved actions to improve school-based SRE; establish and expand youth-friendly contraceptive and sexual health services⁴; engage youth workers and social care practitioners to support young people to access services early; develop a national

communications campaign targeting young people, supported by a free telephone helpline, and a separate campaign to encourage parents to talk to their children about sex and relationships.

In the second phase, this involved a further set of actions responding to the midcourse review: more prescriptive guidance for local areas, setting out more clearly the actions required from each agency, a local self-assessment toolkit, further data analysis and advice on strengthening targeted prevention with young people most at risk, and the development of an additional communications campaign to reach sexually active older teenagers. Youth participation was strengthened through the appointment of young people to the Advisory Group and the development of a pupil audit tool for schools to assess the quality and relevance of SRE.

From 2008, further developments focused on accelerating improvements in SRE, increasing awareness and uptake of effective contraception through additional funding, and a new communications campaign to increase knowledge and encourage open discussion about sexual health.

Relevance. The strategy was developed to address England's high teenage pregnancy rates that were significantly higher than those in comparable European countries and had shown no sustained downward trend since the early 1980s.

⁴ The Strategy's Guidance on the Provision of Effective Contraception and Advice Services for Young People was later developed into the Department of Health's You're Welcome quality criteria for young people-friendly services, endorsed by WHO.

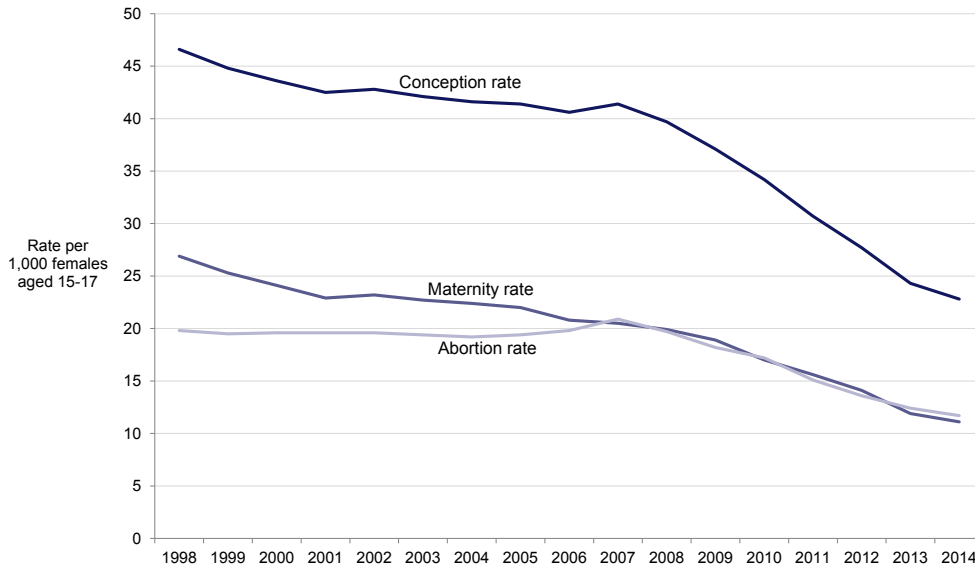


Figure 2. England under-18 conception rate: 1998-2014.

Credibility. The strategy was strongly endorsed by professional organizations and nongovernmental organizations (NGOs), which had long advocated for more focused efforts to address the high rates. It was grounded in international evidence that high-quality SRE and easy access to contraceptive services enable young people to make positive and informed choices. Stakeholders valued the strategy’s additional research program, the regular reviews of progress, and the additional actions developed to strengthen implementation. A challenge to the strategy’s credibility was the failure to include a commitment to statutory SRE, an action strongly supported by professional organizations and NGOs and recommended by the Advisory Group.

Clarity. The strategy had a clear target and implementation plan with well-defined actions for national and local areas. Preliminary guidance for the development of local strategies set out a framework for what needed to be in place, although the essential actions required of each agency may not have been sufficiently clear. The second phase’s more prescriptive guidance may have been useful at the outset.

Compatibility. Opinion polls and surveys conducted before and during the strategy indicated a majority support for the strategy’s key strands but negative and misleading media reporting often masked this consensus. Although this declined over time, it

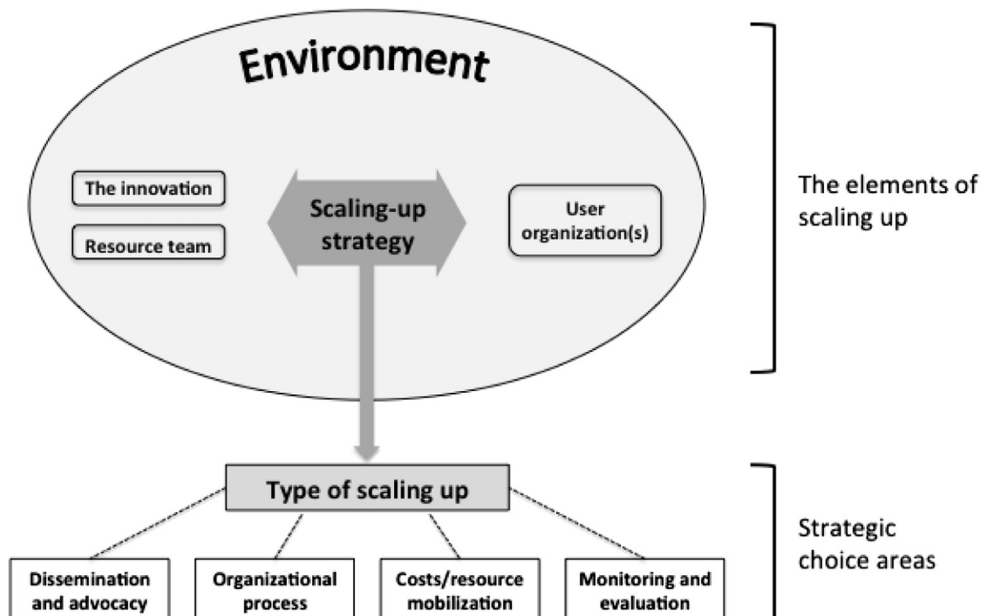


Figure 3. The WHO-ExpandNet framework for scaling up [13].

posed significant challenges in some local areas. [14] A national, government-led media strategy from the beginning, in partnership with young people, parents, professionals, and NGOs, including faith organizations, might have helped counter misinformed reports and helped to make consensus more visible.

Ease or difficulty to install. This was a complex strategy to install, both because of its comprehensive, multiagency scope and because of the culture shift required to effect change. Installation was facilitated by having a clear detailed action plan to establish the strategy, a dedicated national Unit to lead implementation, strong regional and local structures to support implementation, additional expertise provided by NGOs and the Advisory Group, funding for local areas and national activities, and sustained government commitment to the strategy.

Scaling-up strategy—resource team

The Unit, regional, and local coordinators worked as a unified resource team. The wider resource team included the Advisory Group and the cross-departmental ministerial and officials group.

Leadership and commitment. The resource team provided visible leadership at all government levels. The Unit had responsibility for delivering the strategy's action plan, providing funding, supplying evidence-based guidance and reliable data, leading the midcourse review and the subsequent actions, and sustaining the priority and resources over the 10-year period. The regional coordinators, supported by Regional Directors of Public Health, provided expert support to local areas and convened panels of regional policy leads to strengthen engagement from all relevant agencies. The local coordinators, working with the Chairs of the Boards led the development, delivery, and monitoring of local strategies. Some challenges included securing the necessary local senior leadership and expertise over a long period in all areas, achieving systematic engagement from all agencies through persuasion rather than mandate and maintaining morale and commitment to such an ambitious target while the strategy actions took time to have an impact.

Capacity. The capacity of the resource team was inherent through its hub and spoke structure, which involved partnerships at all levels. Communication between the Unit, regional, and local coordinators was key for proper dissemination of strategy information and for barrier identification. Following the midcourse review, additional specialist support was given to resource teams in poorly performing areas from the Department of Health National Support Team.

Credibility. Credibility of the resource team was established through high-level political commitment for the strategy and maintained over the course of its implementation. The trustworthiness of the resource team was enhanced by the appointment of experts to support delivery. The Unit was a combination of civil servants and external specialists on teenage pregnancy, drawn from the statutory sector and NGOs. The regional and local coordinators had relevant experience in adolescent health, youth work, or social care, in addition to strategic skills. The appointment of expert stakeholders to the Advisory Group provided reassurance that monitoring of the strategy and recommendations to government were informed by evidence and specialist knowledge.

Scaling-up strategy—user organizations

The user teams were the local coordinators, the Boards, and the partnership agencies tasked with contributing to the local strategy: health, education, youth support services, social services, and NGOs.

Credibility. The national strategy's grant requirement of every local area to appoint a local coordinator and establish a board gave the user team credibility as leaders of local action. Appointed members reinforced their credibility locally through their expertise and track record. NGOs' credibility was influenced by their specialist knowledge and understanding of young people's needs.

Commitment. Commitment of the user team was entrenched through their agreement with the Unit to help implement the strategy. The local coordinators displayed a particularly high level of commitment because of their relevant experience with young people. After the midcourse review and with the close involvement of ministers, commitment significantly improved with the recognition that the strategy was effective, even in deprived areas.

Capability and authority. Although there was a high level of capability in many areas, user teams' implementation of strategy actions varied. The seniority of the appointed local coordinator and the Chair of the Board influenced this. It was also affected by the status of board members within the partner agencies. Seniority and commitment of the user team was important in facilitating decisions on resource investment and accountability for implementing the agreed actions.

Scaling-up strategy—environment

A key strength of the environment was government's recognition of teenage pregnancy as an issue that contributes to intergenerational disadvantage. The development of the strategy by the Social Exclusion Unit and the launch by the Prime Minister signaled a commitment that progress on teenage pregnancy was central to achieving government's wider ambition of reducing inequalities and regenerating disadvantaged communities. This was a marked change from earlier government initiatives, which had focused largely on the health sector and had no implementation plan or support structures. Critically, the strategy challenged the view that high teenage pregnancy rates were an intractable part of English life.

The priority of teenage pregnancy was maintained by including the target in national and local performance management frameworks and integrating some of the strategy actions into wider government programs. The provision of long-term funding was also vital. Although the local implementation grant was not intended or sufficient to cover all strategy actions, the grant ensured that all areas appointed a local coordinator, established a board, developed a local strategy, and provided the Unit with annual progress reports. In the interest of efficiency and cost-effectiveness, central strategy actions were developed on a national scale, such as the communications campaign, the Continuing Professional Development program for teachers and nurses, and additional guidance and support for local areas commissioned by the Unit from NGOs with specific expertise.

NGO involvement added specialist expertise and extended the strategy to their own constituencies of practitioners, parents, and young people, thereby facilitating a supportive environment. The campaign partnerships with teenage media and youth brands added to the environment by helping to normalize information and discussion about relationships and sexual health.

A weakness was the nonstatutory status of SRE. Although the strategy achieved a significant reduction in the conception rate, it is likely that trained educators, curriculum time, and program of study resulting from statutory status would have contributed to more rapid progress.

Managing scale up

A combination of vertical and horizontal approaches was used for managing scale up.

Managing scale up—dissemination and advocacy

National scale up was central to the strategy with every area in the country expected to have a plan to reach the agreed reduction targets. However, it was the findings of a midcourse review that helped to strengthen and reshape the scale up. These were communicated to the user teams through established structures but with increased ministerial involvement. Renewed commitment from NGOs and the Advisory Group contributed to the accelerated progress.

Managing scale up—organizational processes

The new ministerial guidance published after the midcourse review provided the framework for scale up. The guidance translated the evidence into actions for each partner agency to achieve a “whole systems” approach. The accompanying self-assessment toolkit, with suggested monitoring measures, helped to strengthen local performance management in all areas. The ministerial focus on local senior leaders and additional support from regional coordinators, Public Health National Support Teams and the Advisory Group, helped address the variation in local performance and contributed to the scale up of effective strategies.

Continued collaboration with NGOs strengthened the reach of the strategy, particularly to young people most wary of accessing statutory services. Interweaving the national campaign messages through trusted communication channels and popular youth products helped to extend the reach of the strategy to young people in their daily lives.

Critical to scaling up was sustaining the priority over the course of the strategy. Including the target in the Government Public Service Agreements and embedding it into the performance frameworks of health, social services, and local government helped to achieve this. Integrating actions into other government programs focused on sexual health and narrowing inequalities helped reinforce the importance of partnership work. New legislation aided the cooperation between local areas and partner agencies to improve the health and well-being of young people.

Managing scale up—resource mobilization

An annual local implementation grant remained the same for each local area over the 10 years to facilitate long-term planning.

The ring fencing of the grant was removed in 2006 to encourage more collaborative and integrated planning. As a result, some areas faced challenges in maintaining the same level of spending. Central funding was maintained during the 10 years for the communications campaign, the Continuing Professional Development program, and specialist support from NGOs. The strategy also benefited from the funding of the government’s sexual health initiative and programs to improve health and educational outcomes for young people. The additional Department of Health investment in 2008–2011 to increase access to effective contraception was aimed at young people up to 25 years but gave an important boost to scale up services to under 18s.

Managing scale up—monitoring and evaluation

The monitoring of the strategy benefited from having very reliable conception data at national and local levels, broken down into conceptions leading to abortion and conceptions leading to birth. Conception rates in smaller geographical areas provided additional data. The detailed data briefings provided by the Unit ensured a shared understanding, showing local areas their trends in conception, abortion and maternity, proxy indicators such as education attainment and comparisons with other statistically similar areas. Local areas were asked to report annually on progress, with performance management provided by the Unit and regional coordinators. The Advisory Group annual reports and recommendations to government helped maintain a national focus on progress and barriers to scale up. The solid data set was critical to identifying local variations in progress that led to the midcourse review and the resultant actions. Perhaps most significantly, the comparative data illustrated to senior leaders that, with the right actions, rates could be reduced even in areas with traditionally high rates.

A challenge to monitoring and evaluation was a lack of systematic monitoring of how the strategy actions were reaching young people. An annual national and local survey of young people to monitor improvements in SRE and access to contraception over the 10-year implementation would have provided some helpful proxy indicators of progress.

Discussion

The concerted and integrated effort of the 10-year Teenage Pregnancy Strategy for England, delivered within the Labour Government’s wider ambitions to narrow inequalities, appears to have contributed to a significant reduction in the under-18 conception rate. The continued decline in rates even after the Unit and supporting structures had been closed down in 2012 (because of the policies of the incoming coalition government in 2010) indicates that many of the attitudinal and other changes made during the time of the strategy have survived. The initial target of halving the under-18 conception rate has been achieved.

Key features that were associated with these successes were identified during the midcourse review that explored and compared the more and less successful areas. Subsequent analysis using the WHO-ExpandNet analytic framework has helped to identify features that contributed to the success of the program. These findings are in line with findings of the analyses of the scale up of sexuality education and adolescent-friendly health services from countries around the world: Estonia, Colombia, and Mozambique [15–17].

Based on an analysis of 20 public health programs from around the world that had been scaled up, had been sustained, and had demonstrated tangible results, the Centre for Global Development [18] identified the following seven attributes: political leadership and champions, technical consensus about an appropriate public health approach, innovation available at an affordable price and delivered through an effective delivery system, effective use of information, good management on the ground, strong partnerships, and predictable and adequate resources. Not surprisingly, England's strategy embraced each of these attributes.

In terms of the analysis presented in this article, a limitation which is shared with the analysis of other countries' scaled-up programs [15–17], is that the WHO-ExpandNet framework has been applied post hoc to the processes that occurred during the strategy's lifetime. Some, if not all, of the elements of the framework are very challenging to "measure" in a traditional scientific manner and, although performance management was implemented at local levels as the strategy developed, the data are not consistent enough to enable detailed statistical analysis. It is not possible to claim a direct causative pathway and to estimate the magnitude of the effect brought about by the different (separate and combined) elements of the program since the study design did not allow for this; random controlled trials at a national level are impossible to conduct, and finding a comparative country for the purposes of a retrospective naturalistic experiment is equally challenging. Having said this, however, the similarities between the elements of the framework that were identified in England with those in a number of other, demographically quite different, countries lend confidence to our conclusions regarding what is required for successful implementation in such a complex public health domain.

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