IfG CASE STUDY | POLICY MAKING

Joined-up policy making

Lessons from the Teenage Pregnancy Strategy 1998–2010

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About this report

The current government came into office committing to a new approach of mission-led government – working in a more joined-up way to deliver ambitious and measurable long-term objectives. The aspiration has much in common with the policy goals and delivery approach of the last Labour government of the late 1990s and 2000s.

This case study explores the lessons the government can learn from the joined-up policy approaches of those previous administrations, looking at the design and implementation of England's teenage pregnancy strategy.

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Summary

The current government came into office committing to a new approach of mission-led government – working in a more joined-up way to deliver ambitious and measurable long-term objectives. The aspiration has much in common with the policy goals and delivery approach of the last Labour government of the late 1990s and 2000s.

This case study explores the lessons the government can learn from the joined-up policy approaches of those previous administrations, looking at the design and implementation of England's teenage pregnancy strategy.

The teenage pregnancy strategy

In the late 1990s, the teenage birth rate was one of many youth issues where the UK had fallen behind internationally. This was a significant driver of disadvantage and inequalities: teenage mothers and young fathers faced disproportionate risk of poor mental health, poverty and being 'not in education, employment or training' (NEET); their children faced higher rates of low birthweight and stillbirth, infant mortality, development delays and being taken into care.

In turn, childhood disadvantage was one of the drivers of teenage pregnancy. Experience of family poverty, school absence, time spent in the care system, adverse childhood experiences and alcohol use were all associated with higher risk of early pregnancy.

On entering office in 1997 the Blair government began to tackle the problems of youth disadvantage in a coordinated way, and in 1998 commissioned a strategy to tackle teenage pregnancy specifically.

The strategy, published in 1999, argued that a high teenage pregnancy rate was not inevitable if the right actions were put in place. It set out a 10-year programme of prevention spanning multiple departments, with the goal of halving the under-18 conception rate by 2010.* It put in place better relationships and sex education, and redesigned contraception services that were accessible for all young people.

New programmes of support were introduced to try to prevent further disadvantage for teenagers who went on to become parents, promoting the health and welfare of both young parents and their children. And the strategy created a strong national and local action network, with a dedicated lead in every local area working closely with related programmes on early years, child poverty, school absence and NEETs.

* Teenage pregnancy is the everyday term for the teenage conception rate. Calculated by the Office for National Statistics, conception rates include all pregnancies whether they end in abortion or birth. The data is published for under-18s and also for under-16s. The female population aged 15 to 17 is used as the denominator for under-18 rates. And the 13- to 15-year-old population is the denominator for under-16 rates. Birth rates and abortion rates for these age groups are also published.

The results

Under-18 conception rates in England fell, first in Inner London, and then nationwide. The reduction was rapid in all regions from 2007 onwards. By 2014 the under-18 conception rate had halved, and it fell further through the rest of the decade. The proportion of 16 to 24-year-old girls and women who were NEET because of family or caring responsibilities fell by as much as three quarters between 2000 and 2021. Reflecting the significance of the results that were achieved, *The Lancet* in 2016 described the teenage pregnancy strategy as "an impressive example of how a sustained, multi-level, and multicomponent intervention… can impact a complex health and social issue, with high-cost effectiveness".[1]

The lessons

The Starmer government came to office pledging to 'break down barriers to opportunity' and to embed a greater focus on prevention in healthcare and supporting services – goals similar to those that underpinned the teenage pregnancy strategy. Its 'mission-led' approach also seeks to recognise the cross-cutting nature of key policy challenges. This case study offers lessons both for cross-cutting issues in general and for the issue of teenage pregnancy and young parents in particular.

Box 1: Recommendations on cross-cutting issues

- **Establish clear ownership and leadership over the issue**. Clear ownership and leadership inside government was essential both for the strategy to be developed, and for it to be implemented.
- **Draw on a full range of data and evidence**. Data and evidence were key to the development and delivery of the strategy, clarifying the scale of the issue and the drivers which needed to be addressed.
- **Set clear goals and metrics to drive progress**. A clear goal set the ambition and provided the basis to track progress.
- **Develop a clear and concrete action plan**. A comprehensive action plan harnessed contributions from all departments and set the path for the strategy
- **Join up delivery to reach all intended beneficiaries**. The government paid close attention to implementation to ensure that the key prevention policies were well delivered, had a good chance of reaching all young people, and were designed to be trusted and accessible
- **Combine prevention with mitigation of negative effects**. The strategy combined prevention and mitigation, introducing practical support programmes for young parents to minimise negative outcomes.
- **Build effective national-local partnerships**. The government invested in an implementation network and supported local areas in delivering change.
- **Develop a strategic national approach to child and youth disadvantage**. Work on teenage pregnancy and young parents benefitted from a joined-up approach to child and youth disadvantage that spanned many government departments.

Teenage pregnancy and young parents: the picture now

The formal teenage pregnancy strategy came to an end early in the Coalition period. Central government support for the strategy dwindled during the 2010s, and disappeared completely in 2021, although many local areas retained their focus on reducing teenage conceptions and supporting vulnerable young families.

There are now signs that progress on teenage pregnancy has stalled. The most recent data for conceptions in England is for 2022 and shows that the under-18 conception rate had risen two years in a row. Abortion rates for teenagers have also risen in two successive years. There are continuing inequalities between local areas. Some of the risk factors for teenage pregnancy, such as persistent absence from school,* stand at very high levels. Although there are many fewer teenage parents, young mothers and fathers continue to enter parenthood with a significant burden of disadvantage and a high risk of poor outcomes for them and their children.

Since coming to office, the government has taken important steps in this policy area. It has published new guidance on relationships sex and health education and plans to extend it up to age 18. The Best Start in Life strategy, which will expand the network of Family Hubs, includes young parents as a priority group.

And more recently, the new Women's Health Strategy published in April 2026[2] sets a long-term ambition to reduce teenage conception rates and says the government will relaunch the teenage pregnancy prevention framework, updating it with recent developments but maintaining the same successful 'whole system' approach.

The experience outlined in this case study suggests eight key areas where the government could apply the lessons of past success to address the issue today. Chapter 4 ends with eight specific recommendations for government as it develops its policies in this area:

1. **Establish clear government leadership on teenage pregnancy and young parent families**
2. **Ensure a flow of timely and granular data to support delivery**
3. **Set a specific goal to drive further progress in reducing teenage conceptions**
4. **Ensure the new relationships and sex education requirements are delivered in full and supported by adequate workforce training**
5. **Ensure local sexual and reproductive health services include provision for the needs of young people**
6. **Identify and address the specific needs of young parent families**
7. **Collaborate with the frontline**
8. **Put in place a strategic national approach to youth disadvantage**

* The issue of school absence is the subject of another IfG case study by the author. See Wallace M, *Reducing school absence: Innovation lessons from the last Labour government*, 2025, www.instituteforgovernment.org.uk/publication/reducing-school-absence

1. How did the last Labour government approach teenage pregnancy?

Across the world, teenage pregnancy and teenage parenthood are seen as significant social and public health challenges that can cut short girls' educational opportunities, lead to poor health outcomes and contribute to inter-generational cycles of disadvantage and poverty. How did the Labour governments of 1997–2010 approach the issue?

The context

High-income countries tend to have lower rates of teenage pregnancies and births, reflecting better contraception and more economic opportunities for women. But when the last Labour government came into office, teenage birth rates in the UK were significantly out of line with its neighbours. Most of western Europe had seen large falls in teenage birth rates from the 1970s through to the 1990s. But while rates in the UK had fallen in the 1970s, in the 1980s they stopped falling and began to rise (Figure 4).[3]

Then, as now, the vast majority of these pregnancies were unplanned. Many teenage pregnancies end in abortion, while others lead to teenagers becoming parents with few resources and little preparation. Becoming pregnant or starting a family so early in life is a challenge, and many of the young people who experience early pregnancy and parenthood are already disadvantaged. Experience of the care system, adverse childhood experiences, family poverty, school absence or dislike of school and alcohol use are all associated with higher risk of becoming pregnant before 18. Young fatherhood is also associated with previous disadvantage.

These factors, exacerbated by lack of support, mean that young parents and children as a group are at disproportionate risk of poor maternal and infant health, development delays, poverty, and care proceedings.[*]

The starting point, 1997–98

When Labour came to office in 1997, England's high teenage pregnancy rate was widely seen as intractable. The previous government had set a target to halve the under-16 conception rate as part of its 1992 *Health of the Nation* white paper, and taken some steps to improve contraceptive access.[4] But by 1997 the under-16 conception rate in England was no better than it had been in 1991.[5] In that single year, over 40,000 under-18 girls, many of them vulnerable, were ending up in a situation where they had to choose between having an abortion and becoming parents in their teens.

The new government was concerned about teenage pregnancy rates, but took time to decide a way forward.[6] A consensus grew that the issue should be remitted to the Social Exclusion Unit (SEU), a cross-cutting team of civil servants and staff from

* A fuller discussion of risk factors, the links with poverty and disadvantage, and the evidence about outcomes can be found in the Annex to this report.

frontline agencies, which the prime minister had created to find 'joined-up solutions to joined-up problems'.* In July 1998, the SEU was remitted to develop an integrated strategy both to cut rates of teenage parenthood and to combat the risk of social exclusion for vulnerable teenage parents and their children.

The SEU's other new task was to produce proposals to reduce the number of 16 to 18 year olds not in education, work or training (NEET): the two studies were seen as complementary, since parenthood was a significant driver of young women being NEET.[7]

The SEU's analytical and consultative approach

The unit approached teenage pregnancy using an analytical framework that put heavy emphasis on understanding data, costs and root causes before developing solutions. In this case, the analysis covered:

- Scale/trends/distribution of teenage pregnancy and parenthood
- The relationship with social exclusion
- The economic and social costs
- Why rates in the UK were so high
- Teenagers' knowledge of sex
- Teenagers' experience of sex
- Teenagers and contraception
- What happens to pregnant teenagers
- How teenagers cope with parenthood
- Case studies of promising approaches

The SEU engaged widely inside and outside government to understand the key issues, scrutinising existing research and data and commissioning new analysis. Multiple departments across Whitehall helped to explain how their policies worked (or did not) for teenagers, and how they might be modified, including:

- **The Department of Health**:** on contraception, abortion, maternity care, health services for parents and children, social care for teenagers, and young parent families
- **Department of Education and Employment**: on school attainment, attendance, relationships and sex education, school policies on pregnancy and education of

* One of this report's two authors, Moira Wallace, was Director of the Social Exclusion Unit from 1997 to 2001.
** All departments' names and initials are given as they were at the time.

teenage mothers, post-16 progression, the Education Maintenance Allowance, NEETs, early years policy, and the New Deal for Lone Parents

- **Home Office**: on the law on sexual offences and the age of consent, family policy, education within the youth justice system

- **Department of the Environment, Transport and Regions**: on housing for young parents, local government, regional government offices, area inequalities and neighbourhood renewal

- **Department of Social Security**: on the benefit system, the child poverty strategy, child maintenance

- **The Treasury**: on the child poverty strategy, tax credits, overall spending.*

In addition, an external call for evidence produced 700 responses from service providers and representative bodies, setting out the frontline perspective from health, education, youth work, social care, youth justice, housing, family support and other fields. SEU members visited around 70 projects and organisations in the UK and overseas.

Through all this, the unit also put significant weight on hearing directly from teenagers themselves, and their parents, who highlighted in stark detail that young people often lacked accurate information about sex, were not confident about accessing and using contraception, and were not equipped with the knowledge or skills to manage relationships. Parents felt embarrassed and unsupported in trying to talk to their children about sex and relationships. Teenagers who had gone on to be parents talked about how it felt to discover they were pregnant, the pressure under which decisions had to be made and the difficulties of bringing a child up as a teenage parent. The input from all these sources revealed that many things needed to change.

The Teenage Pregnancy Strategy 1999

The SEU report, *Teenage Pregnancy*, was published as government policy in June 1999,[8] and set out the government's strategy on tackling the issue. Its main components are summarised here.

Teenage pregnancy had multiple drivers

The report drew together the multiple causal factors associated with teenage pregnancy. It found that teenage pregnancy was rarely a deliberate choice but was instead driven by social and educational risk factors, weaknesses in sex education and contraception, mixed messages about sex and policy neglect:

- **Social and educational risk factors**: living in poverty, disliking school, being absent from school and using alcohol were all risk factors associated with teenage pregnancy, and all stood at high levels in England.

* There was also close liaison with the Scottish Office and Welsh Offices, and later with the devolved administrations which were being established in Scotland and Wales. More detail about policy development on teenage pregnancy in Scotland and Wales is included in the Annex.

- **Weaknesses in sex education and contraception**: for many young people, education about sex and relationships was inadequate.* Many also found contraception very hard to access. Young people were unsure about the confidentiality of contraceptive services and the UK stood out amongst comparator countries for its low rate of contraceptive use by sexually active teenagers.

- **Mixed messages**: young people were bombarded with sexually explicit material, but parents and public institutions were, as the report put it, "at best embarrassed and at worst silent, hoping that if sex isn't talked about, it won't happen"

- **Fragmentation and policy neglect**: the causes of teenage pregnancy spanned the responsibilities of multiple departments, but – as with many other issues of youth disadvantage – there was no collective approach to tackling it.

The report found that the approach to teenagers who became pregnant was similarly fragmented. Once a pregnancy was confirmed, teenagers often faced a welter of stressful issues, at speed, with very little support. Decisions about whether to have an abortion or keep the baby were often made in hugely difficult circumstances. Girls who became pregnant were frequently pushed out of school. And many pregnant teenagers delayed getting advice and ended up having abortions late in pregnancy.

Those who went on to keep their babies frequently missed out on antenatal care and faced isolation and stress, often against a background of poverty, family conflict, lack of support and unsuitable housing. Four in ten teenage mothers suffered from depression within a year of having a child. There was often no attention to the needs of young parents who were extremely vulnerable, such as those who were estranged from parents, had been in care, had experienced violence and abuse or had missed large amounts of school.

Fathers, too, were often sidelined by services, or simply invisible to them – despite having similar vulnerabilities to young mothers and lacking support for their own personal development or their development as young parents. The report highlighted that these problems were by no means universal and could often be mitigated with the right support.

A common thread through the analysis was that teenage pregnancy and teenage parents were 'joined-up issues'. To address them, action would be needed from the whole of society and across government. But if they were addressed effectively there would be countless benefits both for generations of young people – and across many different departments' budgets and objectives.

These benefits had been missed because no agency or individual had been asked to deliver an integrated response with the necessary components and power, or to connect the different players and help them to share good practice. Within the SEU, this was known as the 'who's in charge' question, and commonly featured as a contributor to the problems the unit was investigating.

* Relationships and sex education is now the term most commonly used, abbreviated to RSE. This is the term used in the rest of the report.

Prevention and support

The new strategy combined cross-cutting prevention and support with contributions from a range of different government departments and frontline services.

Better relationships and sex education

The evidence base was clear that accurate and appropriate relationships and sex education (RSE) was key to prevention, contributing to a delay in the age of first sex and to improved contraceptive use.* The strategy promised new guidance on RSE in schools, enhanced teacher training and a determined effort to ensure that young people who weren't in mainstream school also got RSE. It said that in secondary schools, RSE should provide full information about contraception and how it could be accessed locally, as well as giving young people the confidence to judge what kind of relationships they wanted and avoid being pressured into unwanted or unprotected sex.

The strategy stopped short of making relationships and sex education statutory and limiting parents' right to withdraw their children from RSE lessons. Many felt this was a key gap.

Direct communication with young people and their parents and carers

The strategy promised a national campaign to help parents talk to their sons and daughters about sex, as well as information campaigns for young people themselves. These would be aimed at giving young people more accurate information and helping them to make active choices about sex and relationships, and to combat the taboo of discussing anything to do with sex.

More effective contraception services

The strategy announced several measures to raise the quality of contraceptive services and advice, including clearer guidance for health professionals on confidential contraception care for under-16s, and new principles to make contraception services for young people more accessible and welcoming, more effective, and better publicised.

Wraparound support for teenage parents

A range of measures were announced to help young people who went on to be parents. Building on Sure Start (which was just beginning to roll out) the government piloted 'Sure Start Plus' with a dedicated adviser delivering coordinated support and mentoring to teenage parents covering healthcare, childcare, budgeting, parenting skills, housing and contraceptive advice. The Department for Education committed to offering more support to encourage mothers under 16 to get back into education, and piloting subsidised childcare to allow 16- and 17-year-old parents to continue in further education or training.

* Sex and relationships education, and its abbreviation SRE, were the most-used terms in the 1990s and 2000s. Personal social and health education (PHSE) was and is another common term. Nowadays, it is more common to talk about relationships and sex education, or sometimes relationships, sex and health education, and they are abbreviated to RSE and RSHE. All these acronyms can be found in the literature on this subject.

And the government amended housing policy to set the expectation that by 2003 all under-18 lone parents who could not live with family or partner would be placed in supervised semi-independent housing with support, and not an independent tenancy.

Broader social policies

Joined-up action was one of the key principles set out in the strategy, and the report made links to a range of other developing government initiatives tackling related issues of disadvantage among children and young people. These included Sure Start, the Excellence in Cities programme aimed at improving educational achievement in disadvantaged areas, the Education Maintenance Allowance, and many other policies covering health, poverty and the experience of young people in care.

These policies were relevant to teenage pregnancy in three ways: addressing the social risk factors associated with teenage pregnancy; supporting babies and young children to get the best start in life; and helping teenage parents to connect or reconnect with education and employment.[9]

Implementation structures, targets and funding

The strategy grouped all its measures under a clear action plan with the long-term goals of achieving two targets: halving under-18 conceptions by 2010 and increasing the proportion of 16–19-year-old parents who were participating in education, employment or training.* The choice of conceptions rather than births as the outcome meant that the target put the onus on prevention. And selecting 18 rather than 16 as the indicator for teenage conceptions reflected the government's belief that being in education, employment or training until 18 should be the norm, to ensure young people had the skills the modern economy would demand, and got a good start in the labour market. By the end of its time in office, Labour had legislated to raise the 'participation age' to 18.**

The strategy established new leadership and coordination arrangements nationally and locally, to tackle the 'who's in charge' question for teenage pregnancy, cement joint working and correct for past policy neglect (see Figure 1):

- a new Teenage Pregnancy Unit (TPU) was established in the Department of Health, to lead on delivery of the action plan
- the TPU was charged with creating and guiding a network of funded local coordinators in every local authority (upper tier authorities) supported by a regional coordinator in each of the nine government offices
- a Ministerial Taskforce was set up to oversee progress, chaired by Tessa Jowell as minister for public health
- an Independent Advisory Group of experts was established to provide challenge and support.

* A precise participation target was not set initially, but by 2002 the figure of 60% was chosen.
** The Education and Skills Act 2008 created a duty for young people to remain in learning until their 18th birthday: this came fully into effect in 2015.

Figure 1 **Teenage Pregnancy Strategy implementation structure**

Ministerial Taskforce

Teenage Pregnancy Unit

Nine regional teenage pregnancy coordinators

150 local teenage pregnancy coordinators and multi-agency partnership boards

Independent Advisory Group of external experts

Horizontal and vertical communication

As spending plans for the next three years had already been set at the 1998 spending review, the initial costs had to be found from within existing budgets. Tessa Jowell persuaded her own department and colleagues in other departments to contribute to a total £60m pot.

That this was successful reflects the level of commitment to collaboration among the ministers involved. Many started with deep understanding of the issues from their own constituencies. Once in government they found themselves regularly working together on related social and preventive policy issues, and acted on the belief that, over time, the costs and benefits would net out across departments.

This commitment was sustained. Subsequent spending reviews reaffirmed the priority of the strategy, and the 2010 target featured in Public Service Agreement targets for the rest of Labour's time in government.

Ministers and the politics

The publication of the strategy was well received, but this could not be taken for granted. The issue of teenage pregnancy touched on a range of sensitive issues including sex education, contraception, the age of consent and abortion. Media and public attitudes to teenage parents were often stereotyping and stigmatising. The government risked being criticised for being too permissive, or for intruding or

'nannying'. And teenage sexuality and contraception were not subjects that many politicians felt comfortable discussing.

Ministerial leadership was vital in creating the space for the strategy to be well received. The prime minister chaired an event at Downing Street to launch the strategy and addressed the most likely negative public reactions in his foreword to the report. His message was that the government did not condone teenage sex, but had a responsibility to prepare young people to make responsible decisions by providing adequate sex education and access to contraception. This high-level leadership complemented Tessa Jowell's hands-on involvement in the strategy and her ability to engage with the detail and head off political storms.

Building the implementation structures

The new structures described in the action plan were set up quickly. The Teenage Pregnancy Unit was established in the Department of Health in the autumn of 1999, jointly funded by several departments and staffed by a mix of career civil servants and staff with frontline experience from relevant public services and the voluntary sector. Cathy Hamlyn, an experienced NHS senior leader, was appointed as its director, to be succeeded four years later by Alison Hadley who had joined the unit in 2000 from the sexual health charity Brook.

At local level, each (upper tier) authority was asked to appoint a teenage pregnancy coordinator and set up a partnership board with representation from health, education, social services, youth services, housing and the voluntary sector. The TPU proposed local targets agreed with each area, in exchange for which each area received a local implementation grant, usually between £300,000 and £400,000.

The targets were designed to meet the national target: greater reductions were expected from higher-rate areas, but they were allocated a larger grant in return.

By the autumn of 2000, three quarters of local areas had employed teenage pregnancy co-ordinators to champion and lead local action, and this rose to almost all by late 2001. Many came from a health, social services, education or youth work background. By 2002, almost half of areas had a partnership board meeting at least once every two months, and a third met more frequently. The TPU provided areas with good practice guidance on both generalist and specialist issues, and every area submitted an annual progress report, with a good flow of information in both directions.

Key prevention actions

- **2000**: Actions to improve contraception and RSE were early priorities: the TPU issued best practice guidance on contraceptive advice services for young people, going into detail about issues such as location, opening hours, confidentiality, access to emergency contraception, and suitability for boys as well as girls.[10] The number of areas in which there was at least one contraception/sexual health service dedicated to young people increased from 68% at the beginning of 2000 to 84% by the end of 2001.[11] These improvements were supported by the broader Sexual Health and HIV Strategy aimed at modernising sexual health services so as to cut

rates of unintended pregnancy for all ages, as well as reducing transmission of HIV and sexually transmitted infections.[12]

- **Late 2000**: The first national information campaign targeted at young people began in October 2000. It ran on radio and in teenage magazines and was aimed at reaching as many 13- to 17- year-old girls and boys as possible. The focus was on resisting peer pressure, reassurance about the confidentiality of advice and contraception, and using condoms to prevent pregnancy and sexually transmitted infections. The campaign included a dedicated website and publicised the 'Sexwise' telephone helpline, whose call volumes rose by 58% after the campaign launched.[13]

- **2001**: the Department for Education and Skills (DfES) published new statutory guidance for RSE in schools, followed by regional seminars, training materials for school governors, and a new professional development programme for teachers and school nurses.[14] Relationships and sex education was also made an essential element for schools to achieve Healthy Schools accreditation.

- **By 2002**: the government had also launched a national campaign to encourage parents to talk to their children about sex. 'Time to Talk' included materials that were distributed locally through pharmacies, GP surgeries and community settings.[15]

Support for young parents

Rapid progress was also made on the strategy's actions to improve support for young parents. By the summer of 2002 the government reported that:

- **'Sure Start Plus' pilots** were under way in 20 areas, providing personal support for pregnant teenagers and teenage parents on health, education, benefits and housing issues.

- The **Teenage Pregnancy Standards Fund** grant had provided funding of £5 million per year to help 89 local areas and schools with above average teenage conception rates to support school age parents and overcome their barriers to learning, and DfES had issued guidance on the same subject to all schools and local education authorities.

- The **Housing Corporation** had approved funding for over 1,500 new units of supported housing for teenage parents.

- Nine pilot areas were testing how best to provide childcare for teenage parents, to help them return to education, training or employment.[16] By 2004 the childcare pilots became a national scheme, '**Care to Learn**' which helped young parents who started a course before the age of 20 with the cost of childcare during classes, travel and private study.[17]

The impact of other children's and youth policies

These focused programmes were underpinned by a vast range of other government policies and budgets which were beginning to tackle some of the wider risk factors for teenage pregnancy. For example:

- **1998**: the national push to reduce school absence, discussed in a separate IfG report, began to reduce one of the key risk factors for teenage parenthood, as well as increasing the likelihood that young people would be present in school to receive RSE.

- **1998 spending review**: £450 million was allocated to the new Sure Start programme in the spending review, and the first 60 Sure Start 'trailblazer' districts were announced in January 1999, supporting families with children under 4 through outreach, home visiting, good quality play, learning and childcare, healthcare and advice about child health and development, and support for those with special needs.[18]

- **1999/2000**: That spending review also significantly increased school funding, and between 1999/2000 and 2009/10 spending per pupil in secondary schools increased by 6% a year in real terms. Greater targeting to deprived schools meant it was more likely to reach the pupils most at risk of teenage conception. Pupils who were struggling became more likely to get help as pupil teacher ratios improved, and there was improved recognition of special educational needs.[19]

- **1999**: the government set a target to halve the number of children living in relative poverty. The years that followed saw a series of real-terms increases in benefits to children both for families in and out of work.[20]

- **2001**: Following recommendations in the Social Exclusion Unit's report on NEETs, a new youth support service, 'Connexions', was rolled out nationally on a phased basis from 2001. It was built on a personal advisor model and worked with a range of agencies to offer a one-stop advice, support and guidance service to young people from 13 to 19.[21] In parallel, following successful pilots, the education maintenance allowance began to be rolled out nationally to support low income 16- to 18-year-olds to remain in education or training.[22]

- **2003**: a variety of government initiatives were introduced aimed to reduce alcohol use by young people. These included significantly increased enforcement of the law on underage selling, controls on drinking in public places, and public information campaigns on the risks of teenage drinking.[23]

Post-2000: Coordinating children and young people's policy

Although all these policy strands began life in different departments, there were clear intersections between the issues and the groups they were addressing, and the risk factors underlying them. In March 2000, a further report by the Social Exclusion Unit, with a foreword by the chief secretary to the Treasury Paul Boateng, called for more focus on prevention and greater coordination on children and young people's policy –

shared objectives across departments, as well as a cross-government Youth Unit and a ministerial group to pull departments together, with similar levels of coordination at local level.[24]

This work led on to a cross-cutting theme in the 2000 spending review which announced that new resources for Connexions and some other children's programmes would be overseen by a new committee of the kind the SEU had suggested and administered by what became the Children and Young People's Unit in DfES.[25]

Further moves to brigade children and youth policies came in 2003. The June reshuffle moved many child-related responsibilities into DfES, including the TPU, but also responsibility for children's social services, family policy, teenage pregnancy, family law, and the Children and Family Court Advisory and Support Service.

In September the *Every Child Matters* green paper signalled a new commitment to multi-agency work to protect children, built around integrated service delivery, joint commissioning and budget pooling, and five key outcomes: being healthy; staying safe; enjoying and achieving; making a positive contribution; and economic well-being. The paper announced that in each local authority a new post of Director of Children's Services should be accountable for both education and children's social services and signalled the intention to require local authorities to integrate key services for children and young people through Children's Trusts. The Treasury played a key role in paving the way for this green paper and Chief Secretary Boateng led its development at ministerial level and presented it to parliament.

For the TPU, these developments were positive. The unit gained new alliances from moving into DfES but remained closely linked with health services. New delivery programmes such as Sure Start and Connexions created a strong foundation for prevention across the board. And at local level the new coordination arrangements raised the profile of joint working and brought different professionals working with children and young people into even closer alignment.[26]

A mid-course review on teenage pregnancy

Progress on teenage conceptions was measured using regular quarterly and annual data provided by the Office for National Statistics, and there was a full evaluation of the programme in 2005. These showed a clear change of pace from the largely static rates of the previous two decades, with the England under-18 conception rate having fallen by 11%.

Young people's views of sex education had improved, and under-16s had become less likely to overestimate how many of their contemporaries were having sex, so that false perceptions did not contribute to peer pressure. But there were still shortfalls in contraception use, and in general, young people were less likely than older women to be offered longer acting, more reliable methods of contraception.[27]

The pace of change was not fast enough to meet the 2010 target, and some local areas had not made progress. Nationally, the proportion of teenage conceptions ending in abortion had risen, which highlighted that access to contraception had

not improved enough. A 'deep dive review' identified the common factors in the areas that were improving most: senior local sponsorship and engagement of all key partners; well-publicised and trusted youth- focused contraception and sexual health services; strong delivery of RSE by schools; a focus on at-risk groups of young people, in particular looked-after children; workforce training on sex and relationship issues across agencies; and a well-resourced youth service, with a clear remit to tackle big social issues, such as teenage pregnancy.

These lessons were cascaded to local areas, and ministers and the TPU also met face-to-face with local government leaders and their health partners in 21 areas, at Director and Chief Executive level. Beverley Hughes, minister for children and young people and lead minister for teenage pregnancy from 2005 to 2009 took most of these meetings personally, often jointly with the health minister, Caroline Flint, to emphasise cross-government commitment. The meetings were an opportunity to alert areas that were not making progress to the outcomes being achieved elsewhere, to convince them they could improve.

Following up these meetings, the TPU provided national support to help these partnerships strengthen their actions, through a Teenage Pregnancy National Support Team, a self-assessment toolkit to review progress and address gaps, and updated evidence briefings to help them identify groups most at risk and work with partners to reach them.[28,29]

Prioritising access to contraception

At national level, the government pushed harder on raising contraceptive use. A further media campaign strengthened messages for teenagers on delaying sex until they felt ready and encouraged condom use and take-up of confidential contraception advice. There was a major push to raise awareness of long-acting reversible contraceptive methods (abbreviated to LARCs).

These methods, which include implants, intra-uterine devices and injections, are highly effective in preventing unwanted pregnancy, and do not depend on the user remembering to use them or obtaining regular repeat prescriptions. In 2005, the National Institute for Health and Care Excellence (NICE) issued guidance promoting the use of LARCs.[30] NICE followed this with further guidance in 2007 drawing attention to their place in sexual health services for young people.[31] And from 2009/10 a GB-wide incentive scheme was introduced to encourage primary care physicians to inform women of all ages about LARC options.[32] The Department of Health secured £33 million additional funding in its budget settlement for 2008-11 to make further improvements in access to contraception.[33]

The government became bolder about encouraging school and college-based services. Ministers issued joint statutory guidance to the further education system encouraging them to offer sexual health services on site.[34] A national charity, the Sex Education Forum, was commissioned to provide practical advice on establishing school-based clinics.[35]

The government also attempted to legislate to put relationships and sex education on a statutory basis but the legislation was lost in cross-party negotiations at the end of the parliament.

Young parents

To ensure a continued focus on support for young parents as well as prevention, new guidance was issued in 2007 asking areas to give teenage parents particular priority in ante-natal care, children's centres, youth services, benefits and employment provision, and to ensure that teenage parents were not housed in unsupported tenancies.[36] This guidance made links to relevant maternity and early years policies and programmes and highlighted the importance of involving young fathers as well as young mothers.

Care to Learn continued, administered by the Young People' s Learning Agency. The Sure Start pilots came to an end but many of their ingredients were included in the Family Nurse Partnership (FNP), a US-developed programme with a long record of success which began to be rolled out from 2007. After initial piloting the FNP programme received a further £30 million in 2008 to cover rollout to 70 test sites by 2010-11.[37]

Safeguarding

The continued emphasis on joint working at local level dovetailed with an increasing focus on identifying and tackling sexual exploitation of children. Those working with teenagers who were sexually active and/or vulnerable were key players in looking out for warning signs of abusive or exploitative relationships and the government issued several important guidance notes highlighting issues to look out for and how these cases should be treated.[38] The safeguarding needs of teenagers and of young parent families were key concerns of local areas, and safeguarding leads were often members of local partnership boards.

Progress over Labour's period in office

By the final year of the Labour government, considerable progress had been made in reducing teenage pregnancy (as discussed in more detail in the next chapter). By the time it left office, teenage pregnancy rates had fallen by just over a quarter, and the downward trend was pronounced. The proportion of young people sexually active in their early teens had fallen, and rates of contraceptive use had risen. Many of the wider risk factors for teenage pregnancy, such as school absence, child poverty, and alcohol use had also fallen significantly. The proportion of young mothers aged 16-19 in education, training or employment had risen.

Although there was further to go to meet the target reduction in under-18 conception rates, these results showed that problems thought to be intractable could be addressed by coordinated and determined action, soundly based in evidence. And an extraordinary network of good practice and partnerships had been established. In Alison Hadley's 2018 account of the teenage pregnancy strategy's implementation, four teenage pregnancy coordinators spoke about how they experienced this cooperation network:

"In 2000, during the early days of the strategy, I was working in a local teenage pregnancy team coordinating an RSE programme. It was an exciting time as it felt like an army was being mobilised all over the country. We were part of a network of individuals with a shared set of values and a deep commitment to see the strategy succeed."

"The local partnership board was always well attended with multi agency commitment and interesting debate about the direction of our local strategy. There was a spirit of mutual support to spend the grant in the best way possible to get the best outcomes. The local meetings were supported by a fantastic regional and national network."

"The information shared by the TPU and regional coordinators helped the local strategy progress quicker as if we had a problem locally we could get advice from others tackling the same issues and find solutions quicker."

"Having national government so close to the reality of local implementation, and being able to nimbly adapt the support provided, was crucial to success and totally unheard of before, or since."[39]

The strength of these local networks, and the commitment of those involved, would prove to be a crucial resource as priorities – and budgets – changed in the decade that was to follow.

2. How did the Coalition and Conservative governments approach teenage pregnancy?

The 2010 general election ushered in a Conservative–Liberal Democrat Coalition, which was followed by Conservative majority governments from 2015. These governments brought with them new approaches to public health, which affected policies towards teenage pregnancy, support for young parents and disadvantaged young people.

A new approach to public health

In its first year of government, the Coalition announced a significant change to the delivery of public health, passing to local government 'the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area'.[40] Directors of Public Health moved from the NHS into local government in 2012 and a new body, Public Health England (PHE), was set up to support the new system. From 2013, local government became responsible for commissioning contraception and sexual health services, while abortion and maternity care remained in the NHS.

Although the principle of devolution was welcomed by local government, the funding stream for local authorities to do this work – the public health grant – was not increased to keep up with inflation or population growth. Between 2015/16 and 2025/26 its real value fell by 26% on a per-person basis.[41] Sexual health spending fell, as did access: two in five councils surveyed said they commissioned fewer contraception sites in 2018/19 than in 2015/16, and almost one in five now did not commission any community outreach to deliver contraception (17%).[42]

Ministers did not review sexual and reproductive health policy as services struggled. Although the government published a Women's Health Strategy for England in 2022, the strategy and its implementation did not have a specific focus on teenage pregnancy, or young people's sexual and reproductive health needs.[43]

Reduced support for work on teenage pregnancy

The Coalition stood down the main elements of the teenage pregnancy strategy soon after coming to office. The Independent Advisory Group was abolished in 2010, treated as a quango, rather than an inexpensive source of expert external advice.[44] By 2012, the Teenage Pregnancy Unit (TPU) had closed, national and regional support had disappeared, the ring -fenced teenage pregnancy grant had gone, and decisions about coordinators and partnership boards were left to local government.

The government said that it continued to see the under-18 conception rate as a key indicator for showing progress in narrowing equalities and reducing child poverty, and that local areas should continue prioritising action to reduce teenage pregnancy rates.[45] Public Health England was asked to play a residual role in supporting local

areas and appointed Alison Hadley, the outgoing TPU head, as an advisor. Alison also established the Teenage Pregnancy Knowledge Exchange at Bedfordshire University, but it was not government-funded.

Many local areas retained coordinator posts, but with a broader remit also covering other functions. The reduction in under-18 conceptions continued, and conception figures for 2014 showed that the target of a 50% reduction had been passed: this was widely acknowledged as a significant public health achievement.[46] Local areas asked for continuing guidance and resources, and the Local Government Association and PHE published updated guidance in the Teenage Mothers and Young Fathers: Support Framework (2016) and the Teenage Pregnancy Prevention Framework (2018).[47]

But in 2021, when the Boris Johnson government replaced PHE with the UK Health Security Agency, teenage pregnancy was not included in its remit and national leadership on teenage pregnancy ceased.

Declining funding for prevention

The change of government in 2010 reduced attention on disadvantaged children and young people. The Department for Children, Schools and Families became the Department for Education again and the children and families agenda found it difficult to get attention.[48] Under the pressure of the deficit reduction programme, prevention funding was squeezed: many programmes were merged into the local authority Early Intervention Grant, but the grant was first cut, then merged into revenue support grant with no ringfence.[49]

Many of the programmes which were most important for vulnerable teenagers, including those at risk of early pregnancy, were massively reduced or ceased entirely. There was a real-terms reduction of 71% in youth service spending between 2010/11 and 2018/19. The Coalition implemented the requirement to stay in education until age 18 without the key measures intended to make it a success – namely Connexions, the Education Maintenance Allowance and adequately funded local authority support.[50]

Local authority children's services budgets became increasingly dominated by statutory and crisis services such as child protection and looked-after children.[51] A series of policy changes made the benefit and tax credit system for families with children less generous, and with falling per-pupil expenditure in secondary schools, and reduced support for those with special educational needs, overall there was much less resource available to combat the drivers of youth disadvantage.[52]

Coordination of policy towards children and young people

Over time, coordination across government departments declined. The government had no targets for youth outcomes and the *Every Child Matters* coordination mechanisms were dropped. Responsibility for local youth services moved department twice, first from the Department for Education to the Cabinet Office, then to the Department of Culture Media and Sport. The Troubled Families programme, which had several strands related to children and young people's behaviour, was set up in the Department for Communities and Local Government.

By 2023, an NAO report found that spending on programmes to support families, vulnerable adolescents and children was spread across as many as seven different departments, but that there was no overall strategic assessment of whether vulnerable adolescents' needs were being addressed and whether there were gaps or overlaps in the support.[53]

Relationships and sex education

During Theresa May's 2016-19 administration, an important step forward on relationships and sex education was achieved. It had long been argued that sex education should be made statutory but attempts to get this through parliament had foundered. In March 2017 Education Secretary Justine Greening announced that the government would put relationships and sex education on a statutory footing. The amended Children and Social Work Act would also make health education mandatory in state-funded schools, and address new challenges such as safety online, and how to recognise healthy and unhealthy relationships.[54]

The 2017 Act required all English primary schools to teach age-appropriate relationships education, and all secondary schools to teach age-appropriate relationships and sex education.* This requirement applied to academies, free schools and independent schools, and for the first time parents' right of withdrawal was limited: children were given a right to opt in to sex education three terms before they reached the age of 16, irrespective of the wishes of their parents. The associated guidance, which requires schools to have a written policy and to consult with parents, was approved in parliament in 2019 with only 21 votes against.[55]

Implementation was less straightforward. Promised investment in training was underspent, and the planned implementation date of September 2020 had to be relaxed because of the pandemic.[56] Then parent protests at a small number of primary schools about the materials being used and matters being discussed (including sexually explicit material and teaching on gender identity) caused the government to change course.[57,58]

The Sunak government issued new draft guidance on RSE in 2024 which proposed to ban some topics and restrict the coverage of contraception and explicit sexual activity until Year 9, when most pupils are aged 13 or 14. This draft guidance did not come into force before the election, and the new government took a different approach, covered in Chapter 4.

Support for young parents

Support services for young children went through a series of stops and starts under the Coalition and Conservatives. Sure Start centres declined in number over the decade. The Family Nurse Partnership, now the only remaining national focus on young parents, initially expanded, reaching 9,000 places in 80 local areas in 2012, but fell back to 45 by 2024.[59,60] Late in the Conservatives' tenure, a review chaired by Dame Andrea Leadsom, proposed 'family hubs' as a focus for support in the first 1,001 days of a baby's life: this idea has survived into the approach of the current government.[61]

* RSHE also covers mental health, drugs and alcohol, sleep, vaccinations and menstrual well-being.

Impact of the pandemic

The Covid pandemic, and the lockdowns associated with it, had many impacts on young people, the services that worked with them and on vulnerable young parents. Lockdowns and school absences meant that many young people missed some or all of their RSE during the pandemic. Contraception services were affected by staff illness, lockdowns and pressures across the health system. Despite some services moving to digital delivery, access was reduced.[62]

During the pandemic the government issued guidance to change the arrangements for 'early medical abortion', so as to allow both tablets for early medical abortion to be taken at home, without the need to attend a hospital or clinic first. These provisions were subsequently made permanent, in 2022.[63]

Families with children suffered during the pandemic as a result of increased parental anxiety, stress and social isolation and reduced opportunities for exercise, social stimulation and positive activities. The impact was greatest for babies and young children from disadvantaged backgrounds.[64]

Data on teenage pregnancy trends

Under-18 conception rates continued to fall until relatively late in the Conservatives period in office. As Chapter 3 will show, 2020 was the lowest under-18 conception rate in the series, probably artificially depressed by the socialising restrictions of the pandemic. But the rate then rose in 2021 and 2022. Because of long delays in preparation of statistics (see Box 2) no more recent data is available. Young parent families – although hugely reduced in number – continued to face disproportionately poor outcomes.

Box 2: The delay in teenage conception statistics in England and Wales

Serious delays have arisen in publication of conception statistics for England and Wales. National and local data used to be made available on a rolling quarterly basis, about 15 months after the period in question. Since 2021 the quarterly publications from the Office of National Statistics have dried up, as has the provision of ward-level data. The delay in producing calendar-year figures has risen to 2.5 years, attributed to operational delays to the DHSC abortion statistics.[65] This delay damages transparency, and deprives local areas of data on which they would wish to base their actions and commissioning decisions.

Scotland published its 2023 figures in July 2025: the corresponding figures for England are still awaited.

Although national leadership on teenage pregnancy came to an end in 2021, teenage pregnancy work continued in many local areas. The years since 2010 have produced many examples of joint working by statutory services and the voluntary sector both to prevent teenage pregnancy, and to support teenage parents, as demonstrated by case studies published by the Local Government Association.[66] The frontline continues to collaborate through the Teenage Pregnancy Knowledge Exchange and with the English HIV and Sexual Health Commissioners Group.

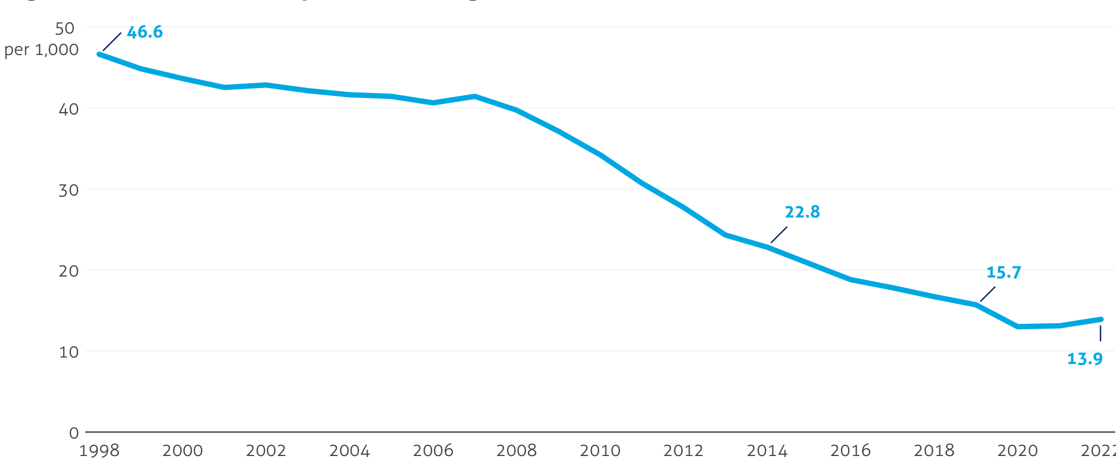
3. What happened to outcomes?

This chapter sets out the key trends in teenage conceptions and in NEET rates for young women over the years since the teenage pregnancy strategy was launched, alongside comparisons with other countries. Fuller background analysis, including analysis of birth and abortion data, and outcomes for young parents, is contained in the annex.

Teenage conception rates

Between 1998 and 2020 the under-18 conception rate fell by 72% (Figure 2). The fall was gradual, then accelerated after 2007. The target of halving the under-18 conception rate was met nationally in 2014. Since 2020, under-18 conception rates have risen slightly again: in 2022 there were 13,400 conceptions to girls under 18 in England, compared with over 41,000 in 1998.

Figure 2 **Under-18 conception rate, England, 1998–2022**



Source: Institute for Government analysis of ONS, 'Conceptions in England and Wales', March 2023 and July 2025.
Notes: The ONS calculates the under-18s conception rate as the number of conceptions per 1,000 15–17-year-olds.

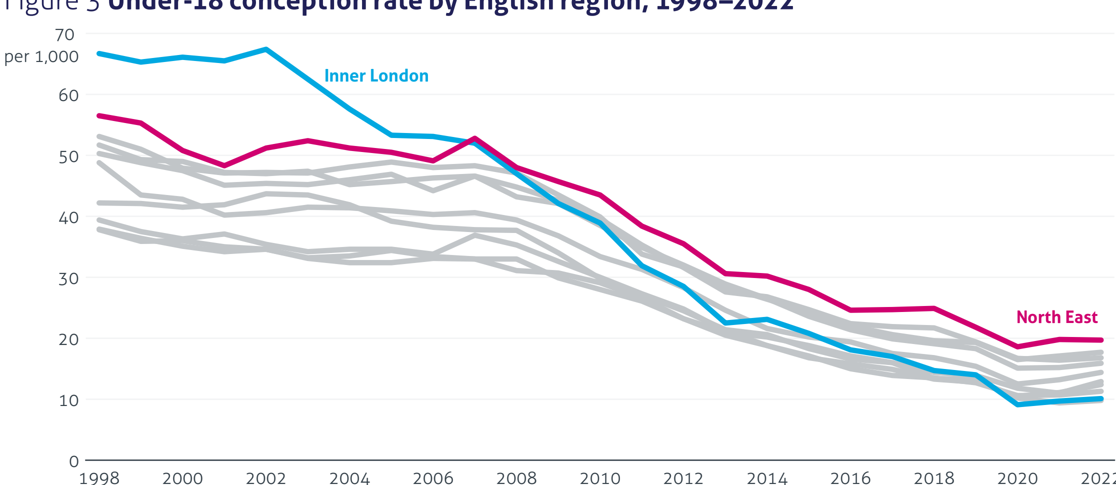
Teenage births

Those 13,400 under-18 conceptions in 2022 led to more abortions (7,800) than births (5,600). Compared with 1998, there were 18,000 fewer births for this age group and nearly 10,000 fewer abortions. Within the declining total of girls who became pregnant, the proportion opting for abortion has been rising and in 2022, some 58% of under-18 pregnancies ended in abortion.

Regional patterns in conceptions

Under-18 conception rates declined in all regions of England, but inner London began to improve much earlier than other regions, with a sharp downward trend beginning from 2002 (Figure 3). Inner London switched from having the highest teenage conception rate to one of the lowest in little more than a decade. This change in performance relative to other cities and regions mirrors similar above-average improvements in London in educational attainment for low-income children, and in school absence.[67] The North East has been the English region with the highest rate of under-18 conceptions since 2007.

Figure 3 **Under-18 conception rate by English region, 1998–2022**



Source: Institute for Government analysis of ONS, 'Conceptions in England and Wales', March 2023 and July 2025.
Notes: The ONS calculates the under-18s conception rate as the number of conceptions per 1,000 15–17-year-olds.

The area deprivation gap also narrowed across England. Between 1998 and 2013, the under-18 conception rate declined by 16 per 1,000 in the least deprived areas compared with 33 per 1000 in the most deprived areas.[68] Nonetheless, the latest figures show that significant inequalities remain by deprivation level, and there is a nearly sevenfold difference between the local authority area with the highest rate (34.4 per 1,000) and the area with the lowest rate (5.1 per1,000).[69]

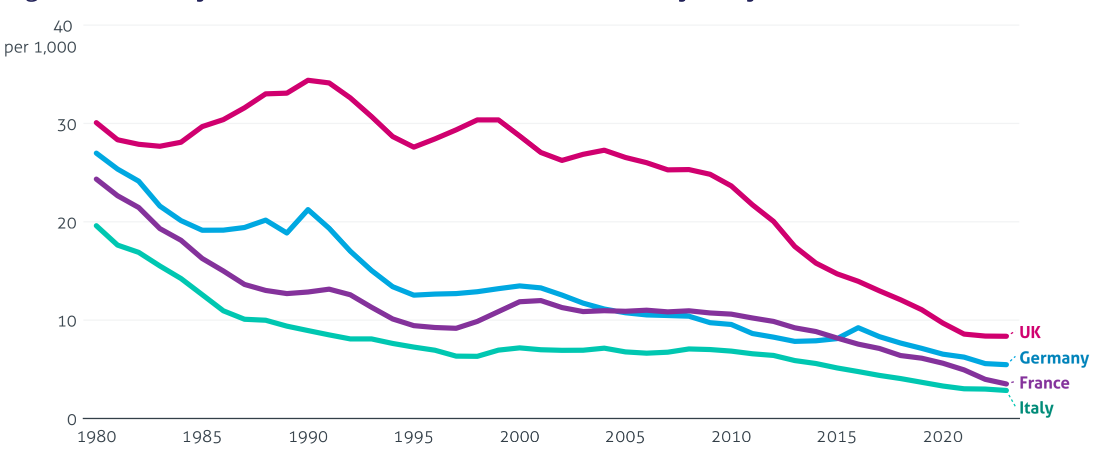
Scotland and Wales

Scotland and Wales measure conception rates in the same way as England. Under-18 conception rates followed a similar downwards trajectory in Wales from 1998 until 2020, but were flat or rising in Scotland between 2000 and 2007 before falling until 2020. (Figure 8 in Annex)

International comparisons

Broader international comparisons have to use teenage *birth* rates, as few other countries collect conceptions data. Figure 4 compares the UK with the other European G7 nations: it shows the UK first diverging from a wider trend of falling rates during the 1980s, then starting to catch up in the 2000s and 2010s. However, despite progress, the UK still stands out an outlier in western Europe (see Figure 7 in the Annex).

Figure 4 **15–19-year-old birth rate, UK, France, Germany, Italy, 1980–2023**



Source: Source: Institute for Government analysis of UN Department of Economic Affairs (Population Division), 'World Population Prospects', 2024.

Changes in the drivers of teenage pregnancy

It is not possible to pin down definitively the factors which caused the decline in teenage pregnancy in England.[70] Many interacting policy changes were introduced simultaneously to try to influence teenagers' behaviour; the setting was real life, not a research lab; and many other contextual factors in adolescents' lives were changing at the same time. However, the data below sheds some light on what happened to the drivers of teenage pregnancy.

Changed sexual behaviours

Survey evidence and service data for this period show a combination of reduced sexual activity and improved contraception use in successive cohorts of teenagers:

- **Later age of first intercourse**: It appears that in the 2000s and 2010s the previous trend towards a lower age of first sex stopped and reversed. The regular Health Behaviour in School-aged Children (HBSC) survey for England shows that the proportion of 15-year-old female pupils saying they had already had sexual intercourse more than halved between 2002 and 2018 (falling from 40 % to 18%). The proportion reporting first sex at age 12 or younger fell over the same period from 9% to 2% (see Figure 6 in the Annex)[71,72]

- **Increased use of effective contraception methods**: HBSC surveys also show increases in the proportion of sexually active teenagers who used effective contraceptive methods. The proportion of sexually active 15-year-old girls in England using the pill at last intercourse rose from 23% in 2006 to 35% in 2018. In sexual health clinics in England, the proportion of teenage clients using long-acting reversible contraception (LARCs) grew from 10% of 16–17-year-olds in 2006/07 to 34% in 2018/19, and other research found substantial growth in take-up of LARCs by young people between 2004/05 and 2013/14 across England, Scotland and Wales.[73,74]

Reductions in the social risk factors

This data suggests success in rectifying the weaknesses in RSE and contraception that were identified in the government's original strategy. But there were also improvements in the social and educational risk factors for teenage pregnancy:

- **Poverty**: Low-income households with children benefited from measures to reduce child poverty. By 2010/11, the proportion of 11–18-year-olds whose household incomes were below the absolute poverty line was 17 percentage points lower than in 1996/97.

- **School absence**: A long-term downward trend in school absence began after 2000–01 and continued for more than a decade. Between 2006-07 and 2013–14 persistent absence in secondary schools nearly halved, from 24.9% to 13.6%.

- **School attainment**: There were sizeable improvements in the proportion of pupils obtaining 'Level 2' (five GCSEs) by age 16 from the early 2000s onwards. For pupils eligible for free school meals, the proportion obtaining Level 2 more than doubled, from less than one in four in 2000 to almost half the cohort in 2010.

- **Staying-on rates**: Staying-on rates after age 16 increased significantly. For 17-year-olds in England, participation in full-time education rose by 15 percentage points between 2001 and 2010, from 58.7% to 73.8%.

- **Alcohol use**: Between 2002 and 2018 the proportion of 15-year-old girls who said they had been drunk at least twice more than halved, from 55% in 2002 to 25% in 2018. The figure for 13-year-olds fell from 27.5% to 8% over the same period.[75]

Participation in education, employment and training

The teenage pregnancy strategy had a secondary goal to increase teenage parents' participation in education, employment and training. Available data suggests some progress was made but the 60% participation target was not achieved.

Analysis of Labour Force Survey data in 2010 found that the proportion of 16- to 19-year-old mothers in education, employment or training had risen from 22.2 % in 1997–99 to 32.9 % in 2007–09.[76] A separate assessment using another survey found very similar progress with 36% of the 2010–12 cohort of 18- to 24-year-old mothers in education, employment or training, compared with 22% in 1999–2001.[77]

Though these increases are modest, in combination with the large reduction in numbers of young mothers, the effect on overall female NEET rates was sizeable. Figure 5 shows that between 2000 and 2021 the proportion of 16- to 24-year-old young women and girls who were NEET because they were looking after home or family fell from 8.5% to 2.1%. The reduction was a significant driver of overall improvements in young women's NEET rates in the 2000s and 2010s, and took NEET rates for young women below those of young men.[78]

Figure 5 **Women and girls aged 16–24 in England not in education, training or employment, 2000–25**

Source: Institute for Government analysis of DfE, 'NEET age 16 to 24: 2025', March 2026.

Did teenage pregnancy reductions save money?

The reduction in teenage pregnancies that has occurred in England has had a wide range of impacts. Fewer abortions, fewer births and a falling NEET rate for girls will have had a significant impact on costs in the health service, the benefit system and social care.[79]

In the UK context, a full reckoning of the fiscal and economic benefits of reducing teenage conceptions has never been undertaken. A more limited analysis of the benefits of public investment in contraception (for all ages) in 2018 estimated that the return on investment over 10 years, was £9 for every £1 invested.[80] In the US it has been estimated that the 428,000 fall in teenage births between 1991 and 2015 saved $4.4 billion in public spending in 2015 alone.[81]

Current and future trends in teenage conceptions

As Figure 1 showed, the decline in teenage conceptions continued until 2020, but under-18 conception rates in England rose in 2021 and 2022. Because of the delays in data production, there are no more up to date figures, and as of April 2026 it is unclear when the teenage conception statistics for 2023 or 2024 will be published.

Other indicators of sexual behaviour and access to services, however, give cause for concern:

- **Age of first intercourse**: after a long trend of improvement, survey data shows that the proportion of girls sexually active in their early teens has risen again. In 2022, some 6% of 15-year-old girls said they had already had sex at 12 or younger (up from 2% in 2018), and 22% had had sex by the age of 15 (up from 18% in 2018; see Figure 6 in Annex).

- **RSE access and quality**: Many young people have missed out on RSE in their school years because of Covid lockdowns or school absence. Quality is patchy: a recent national survey of 16- and 17-year-olds found that half of those polled learnt either nothing at all, or not enough, about how to access local sexual health services.[82]

- **Contraception**: sexual health services have been described by the Local Government Association as being 'at breaking point'.[83] Local contraception services have shrunk to a point where only 25% of services still fund a drop-in for young people.[84] Attendance rates at sexual health services by under-25s in 2024 were 30% below 2019 levels.[85]

- **Use of hormonal contraception**: the overall prescribing rate of both LARCs and the contraceptive pill has not recovered since the pandemic and remains below 2019 in the latest published data.[86] There is also some evidence of increased 'hormone hesitancy', possibly connected with misinformation on social media.[87]

- **Abortions**: The most recent abortion data showed a large jump in abortions, across all age groups.[88] The proportion of under-18 conceptions ending in abortion in 2022 was the highest in a quarter of a century, indicating the high rate of unplanned pregnancies.[89]

- **STIs**: Several sexually transmitted infections are at concerning levels, both in the population generally, and among young people.[90]

Trends in the social risk factors for teenage pregnancy are also worrying. In 2024/25 27% of children in the UK were living in poverty.[91] In the 2024–25 academic year over 1.3 million pupils were persistently absent from school in England, with a particularly serious problem in secondary schools, for girls, and for pupils eligible for free school meals.[92] Young people's enjoyment of school fell steeply between 2014 and 2022 and by 2022, less than a quarter of 15-year-old girls from low-income backgrounds felt they belonged in their school.[93] And the number of children being home-educated reached 126,000 in autumn 2025, having risen by more than a quarter in two years.[94] These developments are concerning in their own right but also form part of the backcloth to understanding future trends in teenage pregnancy.

4. Lessons for government today

The experience of the teenage pregnancy strategy – its development, implementation and outcomes – contains valuable lessons for this and future governments. These can be applied to any area of social policy that involve cross-cutting challenges, as well as to policies focussing on teenage pregnancy and young parents today.

Recommendations on cross-cutting challenges

Teenage pregnancy was, and is, a key public health issue with complex causes that required joint action by multiple players. The same is true of many of the issues government finds hardest to tackle. Below we identify eight key elements of the teenage pregnancy strategy's success that offer useful lessons for a wide range of other cross-cutting policy challenges.

1. Establish clear ownership and leadership over the issue

The government established clear ownership and leadership on teenage pregnancy inside government, first through the Social Exclusion Unit, then through the Teenage Pregnancy Unit, both of which coordinated the different departments that needed to work together. This was essential both for the strategy to be developed, and for it to be implemented.

2. Draw on a full range of data and evidence

Data and evidence were key to the development and delivery of the strategy. Marshalling the evidence – including drawing on the perspectives of the young people affected – helped to highlight the scale of the issue and its costs, identified the underlying drivers which needed to be addressed, and built a case for action that gained widespread support. As the strategy was implemented, timely and granular data informed local delivery decisions, showed where a different approach was needed, and tracked national and local progress.

3. Set clear goals and metrics to drive progress

A clear goal set the ambition for policy and provided the basis to track progress. The goal was demanding but was based on outcomes that other comparable countries had already achieved. The target of a 50% reduction had a long timeframe to recognise the scale of change that would be required.

4. Develop a clear and concrete action plan

The strategy set out a comprehensive action plan of the issues that needed to be tackled, with assigned owners and transparent deadlines. The plan harnessed contributions from many departments and set a basis for local implementation and monitoring.

5. Join up delivery to reach all intended beneficiaries

The government took steps to ensure that the key policies were designed and delivered so as to have a good chance of reaching all young people. For relationships and sex education this meant investing in training and guidance, covering all education settings, and including frontline services such as youth workers who were in contact with the most disadvantaged young people.

Contraception and sexual health advice were redesigned to be trusted, accessible and user-friendly: young people's needs and concerns were taken into account in organising how and where services were provided. Media and information campaigns targeted at young people, parents and carers publicised and reinforced these policies.

6. Combine prevention with mitigation of negative effects

The strategy's primary goal was to reduce teenage conception rates, but it had a secondary goal of mitigating negative outcomes for those who went on to become parents. This meant a focus on ensuring that those who became pregnant could access support and advice, and developing practical support tailored to the challenges faced by young parents. Bringing these issues together made sense both for government and for service-users, and contributed to tackling intergenerational cycles of disadvantage.

7. Build effective national–local partnerships

The government invested in an implementation network from the outset, working closely with local government, NHS and the voluntary sector, promoting local partnerships with a dedicated coordinator, and issuing clear guidance on how to operationalise prevention. Good communication continued throughout the life of the strategy, with national support and regional networks benefitting the frontline, and local areas knowing how to escalate issues quickly to central government.

8. Develop a strategic national approach to child and youth disadvantage

The teenage pregnancy strategy benefited by being part of a cross-government approach to youth, whose elements were mutually reinforcing. The expectation was that increasing educational participation and attainment and reducing the number of NEETs would help to reduce teenage pregnancy, and that the converse was also true.

At the frontline, the joined-up approach to child and youth disadvantage meant staff tackling teenage pregnancy were able to collaborate with a wider youth workforce addressing issues such as being absent from school, being NEET, or being care-experienced, so that young people received more seamless and coherent support. There were similar mutually beneficial links between many different strands of children and youth policy.

Current policy on teenage pregnancy and young parents

Since coming to office, the current government has taken important steps that will help to address teenage pregnancy and the challenges faced by young parent families.

- **RSE**: In July 2025, revised guidance was issued on relationships sex and health education – rejecting the previous government's proposed age limits on certain topics, updating the range of subjects to be tackled to recognise the new challenges affecting children and young people, and calling for a carefully sequenced approach to equip young people with the knowledge to navigate experiences before they occur.[95] The government's strategy on violence against women and girls, published in December 2025, announced extra funding for implementation of the new RSE guidance and accepted in principle that RSE should be mandatory for under-18s in further education.[96]

- **Teenage pregnancy prevention**: the new Women's Health Strategy sets a long-term ambition to reduce teenage conception rates and says the government will relaunch the teenage pregnancy prevention framework, updating it with recent developments but maintaining the same successful 'whole system' approach. The Women's Health Strategy says that this will be backed by more detailed teenage conceptions data to support local interventions. The government has also committed to a Sexual and Reproductive Health Framework for England. [97]

- **Access to contraception**: Several other actions in the document are aimed at ensuring that women have straightforward access to contraception that meets their preferences. with a full range of contraception options across primary care, pharmacies, sexual health services and neighbourhood hubs.

- **Young people's health**: The Department of Health and Social Care's Neighbourhood Health Framework announced that a 'modern service framework' will be developed for children and young people.[98] And the government's Healthy Child Programme highlights the important role of school nurses in preventive health, including preventing early or unprotected sexual activity.[99]

- **Support for young parents**: The government has added young parents as a priority group in key guidance documents which define its expectations covering safeguarding and the new Best Start Family Hubs, and included young parent families in the Healthy Child Programme as a group likely to require additional support from health visitors during the antenatal and early postnatal period.[100]

The government has also announced or extended various wider initiatives aimed at young people, including 'Young Futures Hubs' and 'Youth Hubs'. It also published a National Youth Strategy in December 2025. However, these make no mention of prevention of teenage pregnancy or support for young parents.[101]

Recommendations on teenage pregnancy and young parents

The government's commitment to a renewed focus on teenage pregnancy prevention is a welcome response to the apparent stalling of teenage conception rates. Addressing this issue is a sensible step for any government: the poor outcomes experienced by young parents and their children affect their health and life chances and add to the pressures on public spending. Young parent families are an important group for the 'opportunity mission' whose key target is school readiness,[102] and are also important in relation to other government goals such as reducing infant mortality, reducing the number of NEETs, and constraining pressures on the children's social care system.

Poor access to contraception and condoms increases costs for the NHS by pushing up rates of abortion and sexually transmitted infections. Paying attention to teenage conceptions can help to identify children and young people who are being coerced or exploited into sex. And good relationships and sex education contribute to many dimensions of physical and mental health and safety, building young people's understanding of healthy relationships and giving them skills and information to manage their own health and wellbeing.

As the government develops its policies in this area, the experience outlined in this case study suggests eight key areas where government could apply the lessons of past success.

1. Establish clear government leadership on teenage pregnancy and young parent families

Clear ownership of teenage pregnancy was critical to success under the last Labour government. But after 2021, government leadership on teenage pregnancy and support for young parents ended. The new commitment to relaunch the teenage pregnancy prevention framework is therefore a very welcome sign. Delivering an effective approach now requires reestablishing a clear national lead, harnessing the contribution of key partners across central and local government, other frontline services and the voluntary sector and setting out a clear action plan.

There are many different ways that government can design these responsibilities, but the core requirements are a clear lead, a strong partnership between departments, a small shared unit or team, and shared governance. DHSC and DfE are the departments most central to this – through their health, education, early years and children's social care responsibilities – but other departments have important roles, such as DWP in relation to benefits, employment and the NEETs review, the ONS because of its role in delivering the key conception statistics, DCMS because it is responsible for youth services, and the criminal justice departments in relation to safeguarding and the law on sexual offences.

2. Ensure a flow of timely and granular data to support delivery

Success in reducing teenage pregnancy rates in the 2000s and 2010s was underpinned by timely and granular data, published every quarter, 15 months after the year of conception. But the official statistics on teenage conceptions have become much less useful. The ONS no longer publishes this information each quarter as it becomes available and the annual figures themselves are being published much more slowly (two and a half years after the year of conception in the case of 2022). Release dates for the 2023 and 2024 data have not been announced. It is therefore welcome that the government has committed to provide more local data. The timely publication of the figures is also key, otherwise local areas end up having to use already stretched resources to generate their own data from maternity and abortion services.

DHSC and the ONS should resolve these delays as soon as possible, so that local areas can once again rely on a flow of timely and granular data on teenage conceptions at national and local level. Resolving delays in the provision of abortion statistics is also vital: these are important public health statistics in their own right.

3. Set a goal to drive further progress in reducing teenage conceptions

Setting a clear goal for reducing teenage conceptions was an important factor in driving progress under the last Labour government and would help to focus action again now. The government has set a long-term aim to reduce teenage conception rates but not specified a level of ambition. If the government sought to mirror the past rate of progress, this would imply bringing the under-18 conception rate down to 10 per 1,000 by the end of the decade. This would also help to bring England's teenage birth rate closer to other comparable countries.

4. Ensure the new relationships and sex education requirements are fully delivered and supported by adequate workforce training

The government has announced significant changes to relationships sex and health education in the last 12 months, increasing the focus on prevention and skills for healthy relationships. The new guidance is due for implementation in September 2026, an extension to under-18s further education colleges is being developed, and the government has committed that that 'by 2029, every secondary school in England will have a credible offer for educating students about healthy and respectful relationships, with every child able to access support'.[103]

This is a welcome and ambitious goal but will require concerted action to achieve with investment in teacher training and processes for monitoring improvements in teacher confidence and pupil satisfaction. Implementation needs to meet the needs of both boys and girls, and attention needs to be given to the many young people who are out of mainstream school. Now, as with the major changes brought in during the 2000s, the frontline will need support to deliver the new approach and access to suitable training for staff in schools and other settings. Publishing a clear roadmap, with milestones to monitor progress, will help meet that 2029 goal. This should involve national and local stakeholders, include systematic feedback from young people, measures on teacher confidence and regular reports from Ofsted inspections to monitor the leadership and status of RSE in schools.

5. Ensure local sexual and reproductive health services include provision for the needs of young people

Creating contraception and sexual and reproductive health services that were youth-friendly was a key part of the success of the teenage pregnancy strategy. But many of these services have been squeezed over the last 15 years. As the government develops its new sexual and reproductive health framework, there are several lessons from the past: the need for some dedicated young people's services; the importance of confidentiality; the national and local links required to build cooperation with schools, colleges, neighbourhood health services, school nurses, and youth services; and the importance of outreach to take RSE and contraception/sexual health advice to reach all young people.

The framework should maximise the strengths of local authority commissioned services and the opportunities arising from the NHS neighbourhood health approach to provide young people with multiple access points to contraception and sexual health advice. Commissioners should use data and consultation with young people to ensure commissioning meets local need, and monitor under-18 conception trends as part of their strategic oversight.

6. Identify and address the specific needs of young parent families

The last Labour government developed several programmes to tackle the specific needs of young parent families, but the focus on this issue has since diminished. To address this, several simple changes could be made. First, as is beginning to happen, young parent families – both mothers and fathers, and including parents under 25 – should be identified as a priority group in government guidance in early years health,

education and social care programmes. Similarly, the needs of young fathers and mothers could be explicitly recognised and addressed in the government's future policies on NEETS.

Second, the government should issue more detailed advice for frontline services on the specific needs of young parent families, updating past guidance and covering pre- and post-natal support for both parents and child.

Third, the government should publish key data on parental and infant outcomes disaggregated by parental age, so that inequalities in outcomes for those aged 24 or less can be better understood. This should apply to key indicators of health, school readiness, education, and social care, and also capture how many young people who are NEET are also young mothers – or young fathers.

7. Collaborate with the frontline

National support to local government and their partners was an important factor in the success of the teenage pregnancy strategy. This left a legacy after national support disappeared, and many local areas have maintained a focus on teenage pregnancy and young parenthood, as evidenced in the recent LGA briefings to councillors.[104] But councils are at the limit of what they can achieve without more support and have asked for a restoration of national leadership, data and support. If teenage pregnancy and young parents had an owner in government that could offer coordination and support, there would be the basis for a fruitful partnership that got the best out of limited resources.

8. Put in place a strategic national approach to youth disadvantage

The teenage pregnancy strategy benefited from being located within an overarching joined-up strategy for children and young people. Teenage pregnancy fell off the radar when children and youth policy ceased to be coordinated. Childhood and youth disadvantage includes multiple issues from school readiness, school absence and the attainment gap through to young parenthood and youth unemployment – it is a prime example of an area where policies need to join up and individual objectives will be better achieved if tackled as part of a coordinated overarching strategy.

The government has significant objectives in these areas, and a variety of new initiatives and family and youth-related 'hubs' intended to promote local action and coordination. But these initiatives do not yet add up to an integrated strategy, and there are gaps and overlaps, policy blind spots, and a lack of machinery to join up.[105] For a government that wants to improve delivery and reduce costs, there would be significant benefits in rebuilding a proper government coordinating mechanism for policy on children and young people, to include issues such as teenage pregnancy prevention and support for young parents.

Annex: Background facts

This annex provides more detail on the following issues:

A. Risk and protective factors for teenage pregnancy

B. Experiences and outcomes for teenage parents and their children

C. Supplementary data on conceptions and births in England

D. Comparing teenage birth rates across Europe

E. Teenage pregnancy policy and outcomes in Scotland and Wales

A: Risk and protective factors for teenage pregnancy

Research in the UK and internationally has identified a number of factors that are associated with a higher risk of teenage pregnancy.

- Looked-after children: Young people who have been looked after are three times more likely than others to be a parent by 18.[106]

- Adverse childhood experiences: People who have experienced four or more adverse childhood experiences* have higher odds of having sex aged less than 16, having an accidental teenage pregnancy, becoming a teenage parent, or having a diagnosis of a sexually transmitted infection.[107]

- Poverty: eligibility for free school meals has been found to be independently associated with teenage pregnancy.[108]

- School absence: Multiple studies show an association between school absenteeism and teenage pregnancy.[109]

- School dislike/declining attainment: Dislike of school is strongly associated with early sexual activity, unprotected sex, and pregnancy.[110] Declining attainment during school years is associated with teenage conception and birth, as is expecting or wanting to leave school at the first opportunity.[111]

- Alcohol use: Early regular alcohol consumption is associated with early onset of sexual activity, and several different studies have found associations between adolescent alcohol use and unprotected sex.[112]

- Missing relationship and sex education: Cohort research has shown that young people who did not receive any RSE in schools were more likely to go on take more sexual risks, including intercourse before the legal age of consent, unprotected sex and contraction of a sexually transmitted infection.[113]

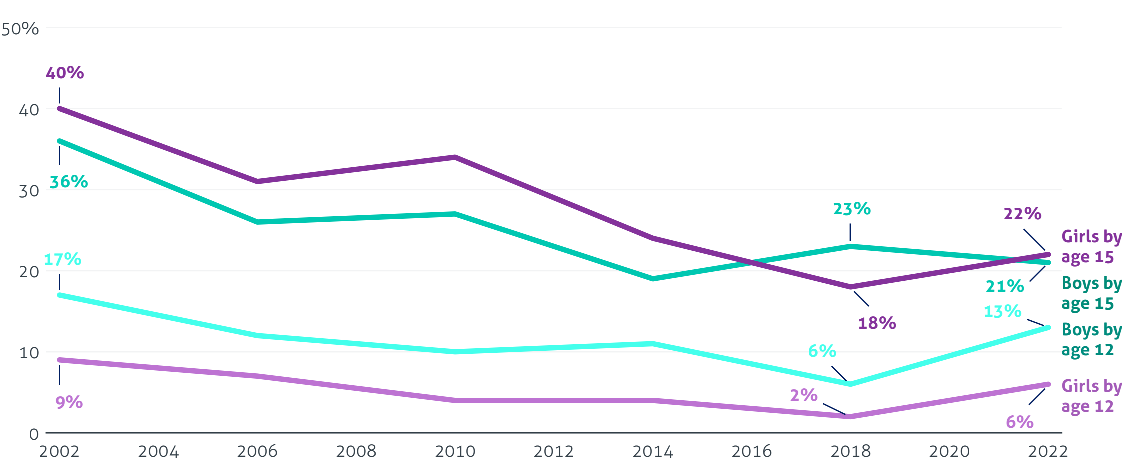
* Adverse childhood experiences, or ACEs, is a shorthand term for traumatic childhood events that can have a lasting impact on health and wellbeing. Many different experiences are included in the concept: examples include being a victim of abuse or neglect, or being exposed to domestic violence.

Many of these risk factors apply both to young women and men, although the debate is often framed solely in terms of young women.*

Many of the risk factors listed above are modifiable. So, for example, action to tackle poverty, increase school engagement and attendance, and reduce alcohol use may all help to prevent teenage pregnancy. And evidence shows that relationship and sex education has a protective effect: school-based sex education delays the onset of sexual activity and increases contraceptive use among sexually active young people, and citing school as the main source of information has a significant association with older age at first sex.[114,115]

In the early 2000s, the HBSC survey of school pupils found that 40% of 15-year-old girls and 36% of 15-year-old boys said they had already had intercourse: 17% of boys and 9% of girls had had sex by age 12. This survey is conducted every four years, and as Figure 6 below shows, these figures more than halved in the following sixteen years, until 2018 when the trend changed.

Figure 6 **Adolescents in England reporting having had sexual intercourse, by age and sex, 2002–22**



Source: Institute for Government analysis of WHO, 'Health Behaviour in School-aged Children' 2002, 2006, 2010, 2018, and 2022. Notes: Data based on survey of 15-year-olds only.

Other data suggests that by the late teens a majority of young people have had sex. The last large national survey found that amongst women aged 16 to 25 in 2012 the median age of first intercourse was 16. Cohort data covering a more recent period (young people aged 18 and 19 in 2018) found that 70% had already had intercourse.[116]

B: Experiences and outcomes for teenage parents and their children

This section focuses on how life plays out for young people who become parents in their teens. It is a sensitive issue to write about. The birth of a child is a joy and a moment of huge potential, whatever challenges lie ahead. Generalising about any group of parents and their families conceals hugely different experiences. And writing about young parents can easily lead to, or be interpreted as, stigmatising or 'deficit thinking'.

* For a fuller discussion of contextual data about adolescent fatherhood see Neale B and Tarrant A, *The Dynamics of Young Fatherhood*, Policy Press, 2024.

However, for families that need support to have more chance of getting it, it is important to understand whether and how young parents are disadvantaged, and what factors lie behind that.

The first thing to note is that many young people begin parenthood already facing significant challenges in their lives. The risk factors listed above are a lived reality for many young parents and are often experienced in combination. As an example, in 2022 a young parents project in Cornwall analysed its caseload of 352 young parents revealing that 76% had experienced childhood trauma, 63% had experienced self-harm and suicidal ideation, 39% substance abuse, 27% domestic abuse and 26% sexual abuse.[117]

Some key indicators set out below show that young parents and children as a group are at risk of poorer outcomes in some domains of health, child welfare and economic wellbeing:

- Mothers under 20 are at increased risk both of postnatal depression, and young mothers are also more likely than older mothers to experience depression, anxiety, PTSD during and after pregnancy[118]
- Babies of adolescent mothers are at significantly increased risk of being born extremely pre-term or with extremely low birthweight[119]
- Babies born to mothers under 20 have a higher risk of infant mortality than those born to mothers in their twenties or thirties[120]
- Young mothers have a high risk of being involved in care proceedings. An England wide study of linked health and court records found that that 6.7% of mothers aged under 20 when they first gave birth were involved in one or more care proceedings by the time their child reached 10, compared with an all-age average of 1.3%. Mothers aged 21 to 24 have the next highest percentage, and in total over three-quarters of mothers involved in care proceedings were younger than 25 years at the birth of their first child.[121]
- Poverty rates are higher for young parents. Scottish government data from 2015-2018 found that 55% of children in households with a mother aged under 25 lived in poverty compared with 24% of children overall.[122]
- There are some differences in age 5 cognitive scores between children of teenage mothers and those of older mothers: however, a 2013 study found that many of the differences were largely explained by background factors, except for a delay of about five months in average verbal skills.[123]

The Millennium Cohort Study is a rich resource for understanding the circumstances of teenage parents and the connection with outcomes for them and their children in later life. The cohort is a representative sample covering around 19,000 children born in the UK between September 2000 and January 2002. A 2025 study analysing this cohort shows that mothers who gave birth for the first time below the age of 20 were more likely to have a range of characteristics associated with poor outcomes later.

Comparing this group with mothers who had their first child at age 25 to 34, the younger group were **more likely** to:

- Have had an unplanned pregnancy (87% compared with 27%)
- Be a single parent (51.5% compared with 6.8%)
- Have smoked during pregnancy (35.2% compared with 8.5%)
- Have no qualifications (25.5% against 3.6%)
- Have been in care as a child (3.5% compared with 0.8%)
- Be living on a low income (average weekly household income for the former teenage parents was around a third of the 25-24 year old group)

Again comparing with mothers who had their first child at age 25 to 34, the younger group were **less likely** to

- Breast feed (47.3% compared with 84.5%)
- Have two household members in work (15.7% compared with 64%)
- Use a childminder or nursery (4.8% compared with 23.8%)

There were also (negative) differences between the two groups in parenting styles, mother-child relationships, and scores for maternal psychological distress.

These differences are vital context to understanding the outcomes for the children in the cohort when they reached the age of 17. At that age, the children of teenage mothers were significantly less likely than children born to older mothers to achieve good GCSE results and were more likely to be overweight or obese. But these differences could be almost entirely explained by differences in the mothers' pre-birth characteristics, maternal health behaviours, and by disparities in the educational, emotional and material environment of the home.[124]

This analysis makes the case for a two-strand approach to preventing poor outcomes. The first strand is to equip young people with the knowledge and skills to avoid unplanned pregnancies, and delay starting a family until they are ready. The second strand is to provide intensive and joined-up support to young parents during pregnancy and beyond to support them both to reach their own potential and address any past experience of disadvantage, and to shape an educational, emotional and material environment that will contribute to their children's health and learning.

C: Supplementary data on conceptions and births in England

Under-18 and under-16 conception rates

Figure 2 showed the fall in conception rates to girls under 18 in England. Table 1 below shows the trend in numbers of under-18 conceptions and Table 2 shows the figures for under-16s.

Table 1 **Conceptions and conception rates for under-18s England, 1998 to 2022**

	1998	2014	2020	2022
Under-18 Conceptions (number)	41,089	21,282	11,878	13,424
Under-18 Conceptions (rate per 1,000)	46.6	22.8	13.0	13.9

Source: ONS, Conceptions in England and Wales: 2021 (Table 6) and Conceptions in England and Wales 2022 (Table 4)

Table 2 **Conceptions and conception rates for under-16s, England and Wales, 1998 to 2022**

	1998	2014	2020	2022
Under-16 Conceptions (number)	8,452	4,160	2.085	2,369
Under-16 Conceptions (rate per 1,000)	9.0	4.4	2.1	2.2

Source: ONS, Conceptions in England and Wales: 2020 (Table 1a) and Conceptions in England and Wales 2022 (Table 4) Single years figures are not published on an England only basis

Abortions and births

The 13,400 under-18 conceptions in 2022 led to more abortions (7,800) than births (5,600). Compared with 1998, there were 18,000 fewer births for this age group and nearly 10,000 fewer abortions. But the proportion of pregnant teenagers who opt for abortion has been rising. In 2022, with just over 58% of under-18 pregnancies ended in abortion, the highest proportion on record.

Table 3 **Abortions and births resulting from under-18 conceptions, England, 1998 to 2022**

	1998	2014	2020	2022
Abortions (number)	17,422	10,875	6,295	7,812
Abortions as % of conceptions	*42.4%*	*51.1%*	*53.0%*	*58.2%*
Births (number)	23,667	10,407	5,583	5,611
Birth rate (births per 1,000)	26.9	11.1	6.1	5.8

Source: IFG analysis of ONS, Conceptions in England and Wales: 2021, Table 6 and Conceptions in England and Wales 2022

Age of fathers

The data above is categorised by the age of mothers, not fathers. Published birth registration data tells us more about young fathers. In 2024, nearly 80% of the births to women under 20 in England and Wales were jointly registered, so that the father's age was also recorded. Of these, nearly 45% of the fathers were also aged under 20 and another 41% were aged 20–24.[125]

The area distribution of teenage pregnancy

There is, and always has been, a wide range of variation in teenage pregnancy rates between local areas, although the patterns have changed slightly over time (see Chapter 3). The highest rates now tend to be found in deprived areas in the North, the Midlands, in coastal areas and communities affected by deindustrialisation. The local authority area with the highest rates in 2022 had 34.4 births per 1,000 and the area with the lowest rates just 5.1 births per 1,000.* This data is for counties, unitary

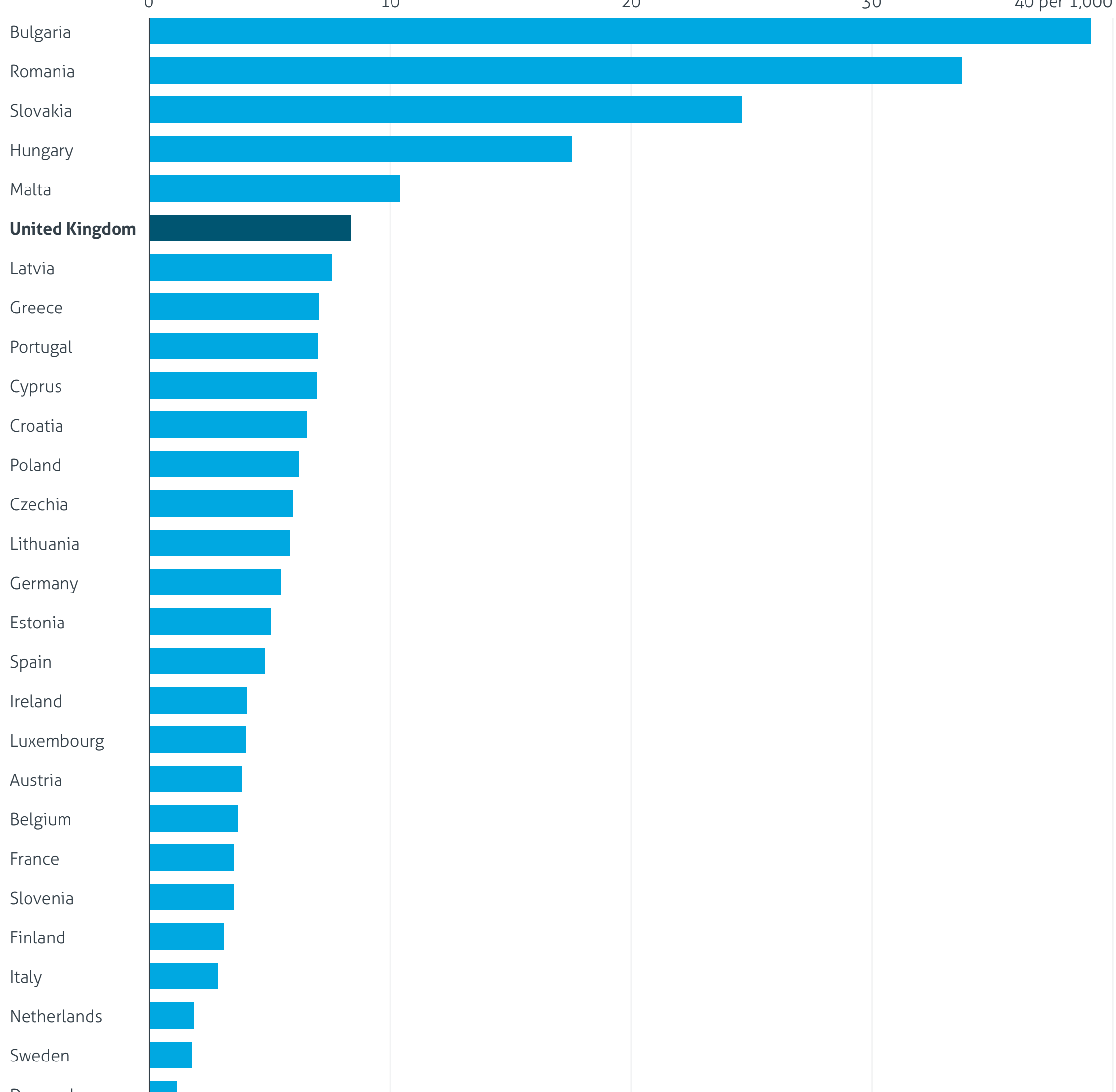
* Full area data can be found here.

authorities, and London boroughs. The variations are even wider at the level of smaller geographies, such as districts or wards.

D: Comparing teenage birth rates across Europe

Figure 7 below shows the teenage birth rate for the UK alongside the EU27 nations. Despite the reduction over recent decades, the UK has the 6th highest rate out of these 28 countries.

Figure 7 **15–19-year-old birth rate, EU countries plus UK, 2023**



Source: Institute for Government analysis of UN Department of Economic Affairs (Population Division), 'World Population Prospects', 2024.

E: Teenage pregnancy policy and outcomes in Scotland and Wales

Only some of the policies and actions described in this report affected Scotland and Wales. The TPU developed programmes which were mainly England-only, with the exception of the national media campaigns which were UK-wide. The NICE guidance on long-acting reversible contraception applied in England and Wales and measures to encourage primary care doctors to discuss LARCs with patients applied in England, Scotland and Wales.[126] Changes to the benefit system applied throughout Great

Britain, as did the Education Maintenance Allowance. In addition, the long-established Barnett formula allocates Scotland, Wales and Northern Ireland a share of spending increases allocated to England-only programmes.

When the Teenage Pregnancy Strategy for England was published in 1999 it noted the interest of the Scottish, Welsh and Northern Ireland Offices, and the devolution process that was underway, with both the Scottish parliament and Welsh assembly in the process of establishment. In due course tailor-made strategies were introduced in Wales and Scotland.

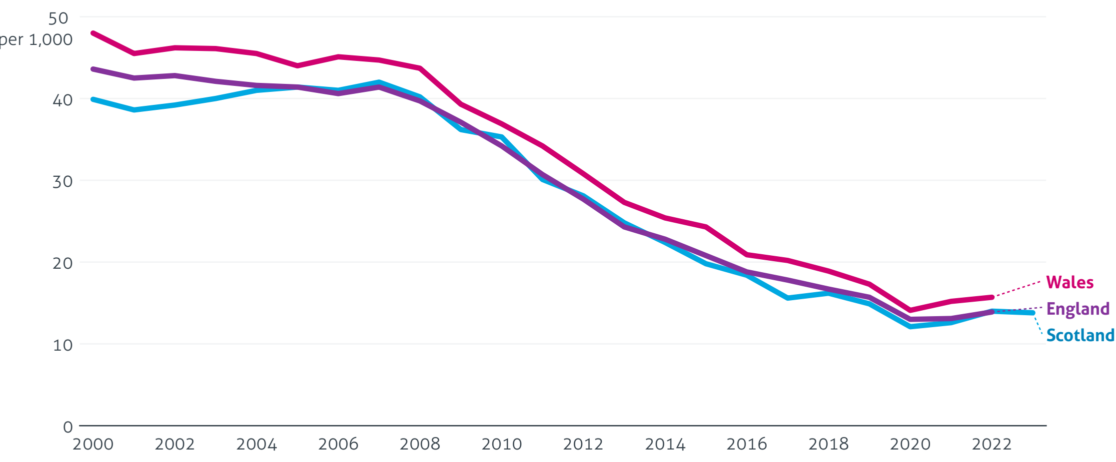
Following consultation, *A Strategic Framework for Promoting Sexual Health in Wales* was published in 2000 with the aim of reducing rates of teenage conceptions, sexually transmitted infections and ensuring access to good quality sexual health advice. Like the English teenage pregnancy strategy it included a broad range of actions, including revising guidance on school based relationships and sex education.[127]

The Scottish government began work on a national sexual health strategy slightly later, in 2002, and published a consultation document in 2003.[128] The final document was published in 2005.[129] It sought to address high teenage pregnancy rates and rising rates of diagnosed sexually transmitted infections across all ages. It established a ministerially-led National Sexual Health Advisory Committee with cross-departmental membership. The action plan set out clear responsibilities for the committee, education and health departments, and local authorities who were to designate a strategic lead for sexual health.

It noted that the Scottish executive would continue to support full implementation of new principles of sex education in Scottish schools; aimed to ensure that all pupils, including vulnerable and excluded young people, receive high-quality relationships and sex education and that pupils across Scotland should have equitable information about sexual health services and how to access them. It committed to a target of reducing by 20% the under-16 conception rate from 8.5 per 1,000 in 1995 to 6.8 per 1,000 by 2010. This target was met by 2011.[130]

Data on teenage conceptions in Scotland and Wales is shown, alongside England, in Figure 8 below. Teenage conception rates followed a similar downwards trajectory in Wales from 1998 until 2020. Rates in Scotland were flat or rising between 2000 and 2007 then fell steadily, again until 2020.[131]

Figure 8 **Under-18 conception rate, England, Scotland and Wales, 2000–23**



Source: Institute for Government analysis of ONS, 'Conceptions in England and Wales: 2021', March 2023; ONS, 'Conceptions in England and Wales: 2022', July 2025; and Public Health Scotland, 'Teenage pregnancies: Year of conception, ending 31 December 2023', July 2025. Notes: The ONS calculates the under-18s conception rate as the number of conceptions per 1,000 15–17-year-olds.

References

1 Skinner R and Marino J, 'England's Teenage Pregnancy Strategy: a hard-won success', *The Lancet*, 2016 vol. 388, no. 10044, pp. 538–40.

2 Department of Health and Social Care, The Renewed Women's Health Strategy for England, Gov.uk, 2026, www.gov.uk/government/publications/renewed-womens-health-strategy-for-england

3 Social Exclusion Unit, *Teenage Pregnancy*, Cm 4342, The Stationery Office, 1999. https://dera.ioe.ac.uk/id/eprint/15086/

4 Department of Health, *The Health of the Nation: A Strategy for Health in England*, Cm 1986, The Stationery Office, 1992.

5 Office for National Statistics, *Birth Statistics: Review of the Registrar General on Births and Patterns of Family Building in England and Wales*, The Stationery Office, 1999.

6 House of Commons, *Hansard*, 'Young Women, Volume 307', 24 February 1998, col 4.

7 House of Commons, *Hansard*, 'Social Exclusion Unit', 31 July 1998, vol 317.

8 Social Exclusion Unit, *Teenage Pregnancy*, Cm 4342, The Stationery Office, 1999.

9 Social Exclusion Unit, *Teenage Pregnancy*, Cm 4342, The Stationery Office, 1999, Annex 2.

10 Teenage Pregnancy Unit and Department of Health, *Best Practice Guidance on the Provision of Effective Contraceptive and Advice Services for Young People*, DH, 2000 https://archive.org/details/b3223157x/page/n7/mode/2up.

11 Wellings K, Wilkinson, P, Grundy P and others, *Teenage pregnancy strategy evaluation final report synthesis*, Department of Health, 2005, www.researchgate.net/publication/308169936_Evaluation_of_the_National_Teenage_Pregnancy_Strategy_Final_Synthesis_Report

12 Department of Health, *The national strategy for sexual health and HIV*, Department of Health, 2001. https://webarchive.nationalarchives.gov.uk/ukgwa/20031208041730/http://www.doh.gov.uk:80/sexualhealthandhiv/sexhealthandhivstrategy.htm

13 The archived website is at https://webarchive.nationalarchives.gov.uk/ukgwa/20091012204742/http://www.ruthinking.co.uk/

14 Hadley A, *Teenage Pregnancy and Young Parenthood: Effective Policy and Practice*, Routledge, 2024.

15 Davis L, Cullen M, Davis H. and Lindsay, G., 'Evaluation of Time to Talk Community Programme: Engaging Parents in Parentline Plus ' Time to Talk' Community Programme as Part of England's Teenage Pregnancy Strategy', *Children and Society*, 2012, vol. 26, no. 6, pp. 443–455.

16 Department of Health, Department for Education and Skills, Department for Work and Pensions, Office of the Deputy Prime Minister, and Home Office, *Government Response to the First Annual Report of the Independent Advisory Group on Teenage Pregnancy*, 2002 https://webarchive.nationalarchives.gov.uk/ukgwa/20050111000618/http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002754&chk=q4OyuW

17 Department for Education and Skills, *Care to Learn for Young Parents*, DfES, 2004. https://webarchive.nationalarchives.gov.uk/ukgwa/20040722023208/http://www.dfes.gov.uk/caretolearn/indexnoflash.shtml; Riley T, Lane P, Davies M and others, *The impact of Care to Learn: tracking the destinations of young parents funded in 2008/09, 2007/08 and 2006/07*, Young People's Learning Agency, 2010. https://dera.ioe.ac.uk/id/eprint/1373/1/care_to_learn_report_23-09-10.pdf

18 Bate A and Foster D, *Sure Start (England)*, House of Commons Library, 2017, https://commonslibrary.parliament.uk/research-briefings/cbp-7257/; Eisenstadt N, *Providing a Sure Start: How government discovered early childhood*, Policy Press, 2011

19 Wallace M, *Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019)*, Centre for the Analysis of Social Exclusion, 2023, pp. 226–229, https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf

20 Hills J, *Labour's Record on Cash Transfers, Poverty, Inequality and the Lifecycle 1997 – 2010*, Centre for the Analysis of Social Exclusion, 2013.

21 Social Exclusion Unit, *Bridging the Gap: New Opportunities for 16–18 Year Olds Not in Education, Employment or Training*, Stationery Office, 1999.

22 Bolton P, *Education Maintenance Allowance Statistics*, House of Commons Library, 2011. https://commonslibrary.parliament.uk/research-briefings/sn05778/

23 For more detail on these policies see Wallace M, *Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019)*, Centre for the Analysis of Social Exclusion, 2023, https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf.

24 Social Exclusion Unit, Policy Action Team 12: Young People, The Stationery Office, 2000. https://webarchive.nationalarchives.gov.uk/ukgwa/20010612024657/http://www.cabinet-office.gov.uk:80/seu/2000/pat12-youngpeople.pdf

25 HM Treasury, *Prudent for a Purpose: Building Opportunity and Security for All*. Cm 4807, The Stationery Office, 2000

26 HM Government, *Every child matters*, Cm 5860, The Stationery Office, https://assets.publishing.service.gov.uk/media/5a7c95a4e5274a0bb7cb806d/5860.pdf

27 Wellings K, Wilkinson, P, Grundy P and others, *Teenage pregnancy strategy evaluation final report synthesis*, Department of Health, 2005, www.researchgate.net/publication/308169936_Evaluation_of_the_National_Teenage_Pregnancy_Strategy_Final_Synthesis_Report

28 Department for Education and Skills, *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies*, DfES, 2006. https://webarchive.nationalarchives.gov.uk/ukgwa/20140107104857/https:/media.education.gov.uk/assets/files/pdf/t/teenage%20pregnancy%20next%20steps%20%20%20guidance%20for%20local%20authorities%20and%20primary%20care%20trusts%20on%20effective%20delivery%20of%20local%20strategies.pdf

29 Department of Health, *Teenage Pregnancy National Support Team: evaluation of impact*, DH, 2011, https://assets.publishing.service.gov.uk/media/5a7c17e0e5274a25a9140686/dh_126091.pdf

30 National Institute for Health and Clinical Excellence, *Long-acting reversible contraception*, NICE, 2005.

31 National Institute for Health and Care Excellence, *Sexually Transmitted Infections and Under-18 Conceptions: Prevention*, NICE, 2007.

32 Ma, R, Cecil E, Bottle A and others, 'Impact of a pay-for-performance scheme for long-acting reversible contraceptive (LARC) advice on contraceptive uptake and abortion in British primary care: An interrupted time series study', *PLoS Medicine*, 2020, vol. 17, no. 9, pp. 1–16, https://pubmed.ncbi.nlm.nih.gov/32925909

33 Hadley A, Ingham R and Chandra-Mouli V, 'Implementing the United Kingdom's Ten-Year Teenage Pregnancy Strategy for England (1999–2010): How Was This Done and What Did It Achieve?', *Reproductive Health*, 2016, vol. 14, no. 1, pp. 1–11, https://pubmed.ncbi.nlm.nih.gov/27876052

34 Department for Education and Skills and Department of Health, *Improving Access to Sexual Health Services for Young People in Further Education Settings*, DfES, 2007, www.choiceforum.org/docs/shsfe.pdf

35 Thistle, S, *Secondary schools and sexual health services*, National Children's Bureau, 2003, https://webarchive.nationalarchives.gov.uk/ukgwa/20060213211002/http://www.wiredforhealth.gov.uk/cat.php?catid=1073

36 Department for Children and Families and Department for Health, *Teenage Parents Next Steps: Guidance for Local Authorities and Primary care Trusts*, DCSF, 2007. https://webarchive.nationalarchives.gov.uk/ukgwa/20080514091823/http://www.everychildmatters.gov.uk/_files/02136ED4F02D7233CEE60B88D3727F3E.pdf

37 Social Exclusion Task Force, *Think Family: Improving the life chances of families at risk*, Cabinet Office, 2008. https://webarchive.nationalarchives.gov.uk/ukgwa/20080728154721/http://www.cabinetoffice.gov.uk/social_exclusion_task_force/~/media/assets/www.cabinetoffice.gov.uk/social_exclusion_task_force/think_families/think_family_life_chances_report%20pdf.ashx ; Department of Health, *Departmental Report 2009*, Cm 7593, The Stationery Office, 2009.

38 HM Government, *Working Together to Safeguard Children*, The Stationery Office, 2006. https://webarchive.nationalarchives.gov.uk/ukgwa/20080610150242/http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/ ; Department for Children Schools and Families, *Safeguarding Children and Young People from Sexual Exploitation*, DCSF, 2009. https://webarchive.nationalarchives.gov.uk/ukgwa/20090810171830/http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/safeguarding/

39 Hadley A, *Teenage Pregnancy and Young Parenthood: Effective Policy and Practice*, Routledge, 2024.

40 Department of Health, *Healthy lives, healthy people: our strategy for public health in England*, Cm 7985, The Stationery Office, 2010. https://webarchive.nationalarchives.gov.uk/ukgwa/20110802151944/http://www.official-documents.gov.uk/document/cm79/7985/7985.asp

41 Finch D, Gazzillo A and Vriend M, 'Investing in the public health grant', The Health Foundation, 7 February 2025, retrieved 15 April 2026, www.health.org.uk/reports-and-analysis/analysis/investing-in-the-public-health-grant

42 Advisory Group on Contraception, *Shining a light on access to contraception in England: an overview of 2019–2020 data*, AGC, 2020. www.theagc.org.uk/our-work

43 Department of Health and Social Care, *Women's Health Strategy for England*, DHSC, 2022, www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

44 Gash T, Magee I, Rutter J, and Smith N, and Smith N, *Read Before Burning: Arm's length government for a new administration*, IFG, 2010. www.instituteforgovernment.org.uk/publication/read-burning-arms-length-bodies

45 Sarah Teather, 13 January 2011, *Hansard* , https://publications.parliament.uk/pa/cm201011/cmhansrd/cm110113/text/110113w0004.htm

46 Skinner R and Marino J, 'England's Teenage Pregnancy Strategy: a hard-won success', *The Lancet*, 2016 vol. 388, no. 10044, pp. 538–40.

47 Public Health England and Local Government Association, *A framework for supporting teenage mothers and young fathers*, PHE, 2019. www.gov.uk/government/publications/teenage-mothers-and-young-fathers-support-framework; Public Health England and Local Government Association, *Teenage Pregnancy Prevention Framework*, PHE, 2018. www.gov.uk/government/publications/teenage-pregnancy-prevention-framework

48 Tim Loughton, quoted in Purcell C, *The Politics of Children's Services Reform: Re-Examining Two Decades of Policy Change*, Policy Press, 2020.

49 Hooley T and Watts A, *Careers Work with Young People : Collapse or Transition? An Analysis of Current Developments in Careers Education and Guidance for Young People in England*, University of Derby, 2011; Purcell C, *The Politics of Children's Services Reform: Re-Examining Two Decades of Policy Change*, Policy Press, 2020.

50 Dickson M, Maguire S, Ventura Alfaro M and others, *Keeping young people in learning until the age of 18 – does it work? Evidence from the Raising of the Participation Age (RPA) in England*, University of Bath Institute of Policy Research, 2025. www.bath.ac.uk/publications/keeping-young-people-in-learning-until-the-age-of-18-does-it-work/

51 Kelly E, Lee T, Sibieta L and Waters T, *Public Spending on Children in England: 2000 to 2020*, Office of the Children's Commissioner, 2018. www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/Public-Spending-on-Children-in-England-CCO-JUNE-2018.pdf

52 Kerris Cooper and John Hills, *The Conservative Governments' Record on Social Security: Policies, Spending and Outcomes, May 2015 to Pre-COVID 2020*, Centre for the Analysis of Social Exclusion, LSE, 2021. https://sticerd.lse.ac.uk/CASE/_new/publications/abstract/?index=7765 National Audit Office, *Funding for Disadvantaged Pupils*, NAO, 2015. www.nao.org.uk/reports/funding-for-disadvantaged-pupils/ Comptroller and Auditor General, *School Funding in England, Session 2021–22 (HC 300)*, National Audit Office, 2021. www.nao.org.uk/wp-content/uploads/2021/07/School-funding-in-England.pdf ; Sibieta L, *School Spending in England: Trends over Time and Future Outlook*, IFS, 2021. https://ifs.org.uk/publications/school-spending-england-trends-over-time-and-future-outlook

53 Comptroller and Auditor General, *Support for Vulnerable Adolescents*, Session 2022–23, (HC 800) National Audit Office, 2023, www.nao.org.uk/reports/support-for-vulnerable-adolescents/?nab=1

54 House of Commons, *Hansard*, 'Sex and Relationships Education', 1 March 2017, https://questions-statements.parliament.uk/written-statements/detail/2017-03-01/HCWS509

55 Department for Education, *Relationships Education, Relationships and Sex Education (RSE) and Health Education: Stautory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers*, DfE, 2019, https://assets.publishing.service.gov.uk/media/62cea352e90e071e789ea9bf/Relationships_Education_RSE_and_Health_Education.pdf

56 House of Lords, 'Relationships and Sex Education. Question for Department for Education', HL537, 20 January 2020, https://questions-statements.parliament.uk/written-questions/detail/2020-01-20/HL537 ; House of Commons, 'Relationships and Sex Education. Question for Department for Education', 27622, 29 June 2022, https://questions-statements.parliament.uk/written-questions/detail/2022-06-29/27622

57 BBC News, 'LGBT school lessons protest spread nationwide', 16 May 2019, www.bbc.com/news/uk-england-48294017

58 House of Commons, *Hansard*, 'Backbench Business', 30 June 2022, vol 717.

59 Department of Health, *Locations of the Family Nurse Partnership Programme (FNP) in England*, DH, 2012. www.gov.uk/government/news/locations-of-the-family-nurse-partnership-programme-fnp-in-england

60 Office for Health Improvement and Disparities, *Guidance: Family Nurse Partnership programme*, DHSC, 2024. www.gov.uk/guidance/family-nurse-partnership-programme#where-the-fnp-programme-is-delivered-in-england

61 HM Government, *The Best Start for Life: The Early Years Healthy Development Review Report*, The Stationery Office, 2021. https://assets.publishing.service.gov.uk/media/605c5e61d3bf7f2f0d94183a/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

62 Hadley A, *Teenage Pregnancy and Young Parenthood: Effective Policy and Practice*, Routledge, 2024. p. 105.

63 Rough E, Early medical abortion at home during and after the pandemic, House of Commons Library, 2025; https://researchbriefings.files.parliament.uk/documents/CBP-9496/CBP-9496.pdf; Department of Health and Social Care, 'At home early medical abortions made permanent in England and Wales' DHSC, 23 August 2022, www.gov.uk/government/news/at-home-early-medical-abortions-made-permanent-in-england-and-wales; Royal College of Paediatrics and Child Health, *Safeguarding guidance for children and young people under 18 accessing early medical abortion services*, RCPCH, 2022, https://childprotection.rcpch.ac.uk/resources/safeguarding-guidance-for-children-and-young-people-under-18-accessing-early-medical-abortion-services/

64 Hogg S and Mayes G, *Casting Long Shadows: The ongoing impact of the COVID-19 pandemic on babies, their families and the services that support them*, Institute of Health Visiting, 2023. https://ihv.org.uk/news-and-views/news/casting-long-shadows-report/

65 Office for Health Improvement and Disparities and Department of Health and Social Care, *Abortion statistics in England and Wales*, January 2026. www.gov.uk/government/collections/abortion-statistics-for-england-and-wales

66 Local Government Association, *Teenage pregnancy prevention: Strengthening local leadership*, LGA, 2025. www.local.gov.uk/publications/teenage-pregnancy-prevention-strengthening-local-leadership#case-studies; Local Government Association, *Supporting young parents to reach their full potential*, LGA, 2025. www.local.gov.uk/publications/supporting-young-parents-reach-their-full-potential

67 Wallace M, *Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019)*, Centre for the Analysis of Social Exclusion, 2023, https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf

68 Wellings K, Palmer M, Geary R and others, 'Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000–12: an observational study', *The Lancet*, 2016, vol. 388, no. 10044, pp. 586–595, https://pubmed.ncbi.nlm.nih.gov/27229190/

69 Full area data can be found here.

70 For a fuller discussion see: Skinner R and Marino J, 'England's Teenage Pregnancy Strategy: a hard-won success', *The Lancet*, 2016 vol. 388, no. 10044, pp. 538–40. Wellings K, Palmer M, Geary R and others, 'Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000–12: an observational study', *The Lancet*, 2016, vol. 388, no. 10044, pp. 586–595. https://pubmed.ncbi.nlm.nih.gov/27229190/; Katie L. Heap, Ann Berrington, and Roger Ingham, 'Understanding the Decline in Under-18 Conception Rates throughout England's Local Authorities between 1998 and 2017', *Health and Place*, 66 (2020); Wallace M, *Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019)*, Centre for the Analysis of Social Exclusion, 2023, https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf; Hadley A, *Teenage Pregnancy and Young Parenthood: Effective Policy and Practice*, Routledge, 2024.

71 S Hulbert and others, *HBSC England National Report Findings from the 2021–2022 HBSC Study for England* (University of Kent, 2023). https://hbscengland.org/

72 For other evidence of declining rates of early sexual experience see Hazel Stewart and others, *Experiences of Relationships and Sex Education, and Sexual Risk Taking: Young People's Views from LSYPE2* (DfE, 2021) https://assets.publishing.service.gov.uk/media/619e69cb8fa8f50381640349/DfE_Appendices_SRE_and_sexual_risk-taking_research_brief_Nov-21.pdf. Results from the fourth wave of the National Survey of Sexual Attitudes and Lifestyles due to report in 2026 (NATSAL-4) should provide additional insight into long-term changes in age of first sex. www.natsal.ac.uk/projects/natsal-4/

73 Wallace M, *Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019)*, Centre for the Analysis of Social Exclusion, 2023, pp126 and 161 https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf

74 Ma, R, Cecil E, Bottle A and others, 'Impact of a pay-for-performance scheme for long-acting reversible contraceptive (LARC) advice on contraceptive uptake and abortion in British primary care: An interrupted time series study', *PLoS Medicine*, 2020, vol. 17, no. 9, pp. 1–16, https://pubmed.ncbi.nlm.nih.gov/32925909/; Pasvol, Thomas Joshua, et al. "Time trends in contraceptive prescribing in UK primary care 2000–2018: a repeated cross-sectional study." *BMJ sexual & reproductive health* 48.3 (2022): 193–198.

75 Wallace M, Trends in Adolescent Disadvantage: Policy and Outcomes for Young People under Labour, the Coalition, and the Conservatives (1997 to 2019), Centre for the Analysis of Social Exclusion, 2023, pp. 51, 59, 173 & 210. https://sticerd.lse.ac.uk/dps/case/spdo/spdorp15.pdf Wallace M, Reducing School Absence: Innovation lessons from the last Labour government, Institute for Government, 2025. www.instituteforgovernment.org.uk/publication/reducing-school-absence

76 Riley T, Lane P, Davies M and others, *The impact of Care to Learn: tracking the destinations of young parents funded in 2008/09, 2007/08 and 2006/07*, Young People's Learning Agency, 2010. https://dera.ioe.ac.uk/id/eprint/1373/1/care_to_learn_report_23-09-10.pdf

77 Wellings K, Palmer M, Geary R and others, 'Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000–12: an observational study', *The Lancet*, 2016, vol. 388, no. 10044, pp. 586–595.

78 Murphy L, *Not Working: Exploring changing trends in youth worklessness in the UK, from the 1990s to the Covid-19 pandemic*, Resolution Foundation and Health Foundation, 2022. www.resolutionfoundation.org/app/uploads/2022/06/Not-working.pdf

79 Skinner R and Merino J, 'England's Teenage Pregnancy Strategy: a hard-won success', *The Lancet*, vol. 388, no. 10044, pp. 538–540, www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30589-X/fulltext

80 Public Health England, *Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for Publicly Funded Contraception in England*, PHE, 2018. https://assets.publishing.service.gov.uk/media/5b5ee5b1ed915d0b66bc375d/contraception_return_on_investment_report.pdf

81 Power to Decide, 'Progress Pays Off', Power to Decide, 17 January 2018, https://powertodecide.org/sites/default/files/media/savings-fact-sheet-national.pdf

82 Sex Education Forum, 'Young People's RSE Poll 2025', SEF, 2025. www.sexeducationforum.org.uk/resources/evidence/young-peoples-rse-poll-2025

83 Local Government Association, *Breaking point: Securing the future of sexual health services*, LGA, 2022. www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services

84 Women and Equalities Committee, *Oral evidence: Prevalence of STIs among young people*, HC 463, https://committees.parliament.uk/work/8122/prevalence-of-stis-among-young-people/publications/oral-evidence/

85 Office for Health Improvement and Disparities, *Sexual and reproductive health profiles: statistical commentary*, DHSC, 2026. www.gov.uk/government/statistics/sexual-and-reproductive-health-profiles-february-2026-update/sexual-and-reproductive-health-profiles-statistical-commentary-february-2026

86 Office for Health Improvement and Disparities, *Sexual and reproductive health profiles: statistical commentary*, DHSC, 2026. www.gov.uk/government/statistics/sexual-and-reproductive-health-profiles-february-2026-update/sexual-and-reproductive-health-profiles-statistical-commentary-february-2026

87 McNee R, 'Tackling contraceptive misinformation on social media', *British Medical Journal*, 2024, vol. *384:q472*; Reid L and Webster R, 'Exploring the Relationship Between Medicine Related Beliefs and Side-Effect Experience Among White Oral Contraceptive Users in the UK', *Perspectives on Sexual and Reproductive Health*, 2025; 57:133–137

88 Office for Health Improvement and Disparities and Department of Health and Social Care, *Abortion statistics in England and Wales*, January 2026. www.gov.uk/government/collections/abortion-statistics-for-england-and-wales

89 Office for National Statistics, *Conceptions in England and Wales: 2022*, ONS, 2025

90 UK Health Security Agency, *Sexually transmitted infections and screening for chlamydia in England: 2024 report*, UKHSA, 2025. www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2024-report#overall-trends

91 Department for Work and Pensions, 'Households Below Average Income: an analysis of the UK income distribution: FYE 1995 to FYE 2025', DWP, 2026, www.gov.uk/government/statistics/households-below-average-income-for-financial-years-ending-1995-to-2025/households-below-average-income-an-analysis-of-the-uk-income-distribution-fye-1995-to-fye-2025#children-in-low-income-households relative poverty measure, after housing costs (Figure 15).

92 Department for Education, Pupil absence in schools in England, Academic year 2024/25, DfE, 2026. https://explore-education-statistics.service.gov.uk/find-statistics/pupil-absence-in-schools-in-england/2024-25#section-persistent-and-severe-absence

93 Hulbert S., Eida T, Ferris E, Hrytsenko V and Kendall, S. *HBSC England National Report: Findings from the 2021–2022 HBSC study for England*, University of Kent. 2023. Fig.4.14 https://hbscengland.org/

94 https://explore-education-statistics.service.gov.uk/find-statistics/elective-home-education/2025-26-autumn-term#headlines-section

95 Department for Education, *Statutory guidance: Relationships and sex education (RSE) and health education*, DFE, 2025. www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education

96 Home Office, *Freedom from violence and abuse: a cross-government strategy*, HO, 2025, www.gov.uk/government/publications/freedom-from-violence-and-abuse-a-cross-government-strategy

97 Department of Health and Social Care, *The Renewed Women's Health Strategy for England*, DHSC, 2026, www.gov.uk/government/publications/renewed-womens-health-strategy-for-england

98 Department of Health and Social Care, *Neighbourhood health Framework*, DHSC, 2026, www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

99 Department of Health and Social Care, *High Impact Areas For School Nursing*, DHSC, 2026, www.gov.uk/government/publications/healthy-child-programme-high-impact-area-framework/high-impact-areas-for-school-nursing-ages-5-to-19

100 UK government, *Working Together To Safeguard Children*, 2026, https://assets.publishing.service.gov.uk/media/69c2c4ce380a2a73a7cf9df4/Working_together_to_safeguard_children_2026.pdf; Department for Education and Department of Health and Social Care, *Best Start Family Hubs and Healthy Babies: guidance for local authorities*, 2026, www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities, Department of Health and Social Care, *High Impact Areas For Health Visiting (ages 0 to 5)*, DHSC, 2026, www.gov.uk/government/publications/healthy-child-programme-high-impact-area-framework/high-impact-areas-for-health-visiting-ages-0-to-5

101 Department for Culture, Media and Sport, *Young Futures Guidance*, DCMS, 2025, www.gov.uk/guidance/young-futures-hubs; Department for Work and Pensions, 'Major boost for young people with 80 new Youth Hubs as SPFL Trust partners with DWP', press release, 26 March 2026, www.gov.uk/government/news/major-boost-for-young-people-with-80-new-youth-hubs-as-scottish-premier-league-partners-with-dwp; Department for Culture, Media and Sport, *Youth Matters: Your National Youth Strategy*, DCMS, 2025, www.gov.uk/government/publications/youth-matters-your-national-youth-strategy

102 Prime Minister's Office, *Plan for Change: Milestones for Mission-Led Government*, 2024, www.gov.uk/missions/opportunity

103 Home Office, *Freedom from violence and abuse: a cross-government strategy*, HO, 2025, www.gov.uk/government/publications/freedom-from-violence-and-abuse-a-cross-government-strategy

104 Local Government Association, *Teenage pregnancy prevention: Strengthening local leadership*, LGA, 2025. www.local.gov.uk/publications/teenage-pregnancy-prevention-strengthening-local-leadership#case-studies; Local Government Association, *Supporting young parents to reach their full potential*, LGA, 2025. www.local.gov.uk/publications/supporting-young-parents-reach-their-full-potential

105 Comptroller and Auditor General, *Support for Vulnerable Adolescents*, Session 2022–23, (HC 800) National Audit Office, 2023, www.nao.org.uk/reports/support-for-vulnerable-adolescents/?nab=1; Wallace M, Reducing School Absence: Innovation lessons from the last Labour government, Institute for Government, 2025. www.instituteforgovernment.org.uk/publication/reducing-school-absence; Davidson N and Metcalfe S *Policy making blind spots: Why some children are left behind from the start*, IFG, 2025, www.instituteforgovernment.org.uk/publication/policy-making-blind-spots

106 Public Health England, *A framework for supporting teenage mothers and young fathers*, PHE, 2019, https://dera.ioe.ac.uk/id/eprint/26423/1/PHE_LGA_Framework_for_supporting_teenage_mothers_and_young_fathers.pdf

107 Wood S, Ford K, Madden H and others, 'Adverse Childhood Experience and Their Relationship with Poor Sexual Health Outcomes: Results from Four Cross-Sectional Surveys', *International Journal of Environmental Research and Public Health*, 2022, vol. 19, no. 14, https://pubmed.ncbi.nlm.nih.gov/35886718/

108 Office for National Statistics, *Conceptions in England and Wales: 2018*, ONS, 2020, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018; Crawford C, Cribb J and Kelly E, *Teenage Pregnancy in England*, Institute for Fiscal Studies, 2013, https://ifs.org.uk/sites/default/files/output_url_files/caytreport06.pdf

109 *Ibid*; Hosie A, '"I Hated Everything About School": An Examination of the Relationship between Dislike of School, Teenage Pregnancy and Educational Disengagement', *Social Policy and Society*, 2015, vol. 6, no. 3, www.cambridge.org/core/journals/social-policy-and-society/article/abs/i-hated-everything-about-school-an-examination-of-the-relationship-between-dislike-of-school-teenage-pregnancy-and-educational-disengagement/1EDD729D5633F59FD2D6BD2DF32255BF; Department for Education and Skills, *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies*, DfES, 2006, https://democracy.leics.gov.uk/documents/s42147/Appendix%201%20-%20Teenage%20Pregnancy%20Next%20Steps.pdf; Sanders J, Owen-Jones E and Robling M, 'Evaluating the family nurse partnership in England: the Building Blocks trial', *Practising Midwife*, 2011, vol. 14, no. 7, pp. 13–15, https://pubmed.ncbi.nlm.nih.gov/21853694/; Mike Robling, *Evaluating the Family Nurse Partnership in England: The Building Blocks Trial*, Cardiff University, 2015.FSM and persistent absence are highest risk factors, also slower than expected progress 11-14 and (weaker

110 Bonell C, Allen A and Strange V, 'The effect of dislike of school on risk of teenage pregnancy: testing of hypotheses using longitudinal data from a randomised trial of sex education', *Journal of Epidemiology and Community Health*, 2005, vol. 59, no. 3, pp. 223–30, https://pubmed.ncbi.nlm.nih.gov/15709083

111 Kiernan K, 'Becoming a young parent: a longitudinal study of associated factors', *British Journal of Sociology*, 1997, vol. 48, no. 3, pp. 406–28, https://pubmed.ncbi.nlm.nih.gov/9372635; Crawford C, Cribb J and Kelly E, *Teenage Pregnancy in England*, Institute for Fiscal Studies, 2013, https://ifs.org.uk/sites/default/files/output_url_files/caytreport06.pdf; Harden A, Brunton G, Fletcher A and Oakely A, 'Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies', *BMJ*, 2009, vol.

12, no. 339, pp. 1182–85, https://pubmed.ncbi.nlm.nih.gov/19910400; Cater S and Coleman L, *'Planned' teenage pregnancy: Perspectives of young parents from disadvantaged backgrounds*, Polity, 2006; Kneale D, Fletcher A, Wiggins R and Bonell C, 'Distribution and determinants of risk of teenage motherhood in three British longitudinal studies: implications for targeted prevention interventions', *Journal of Epidemiology and Community Health*, 2013, vol. 67, no. 1, pp. 48–55, https://pubmed.ncbi.nlm.nih.gov/22705657

112 Bellis M, Morleo M, Tocque K and others, *Contributions of Alcohol Use to Teenage Pregnancy: An initial examination of geographical and evidence based associations*, North West Public Health Observatory, 2009, www.drugsandalcohol.ie/19467/1/NWPHO_Teenage_Pregnancy_Contributions_of_Alcohol.pdf; Coleman L and Cater S, 'A qualitative study of the relationship between alcohol consumption and risky sex in adolescent', *Archives of Sexual Behaviour*, 2005, vol. 34, no. 6, pp. 649–61, https://pubmed.ncbi.nlm.nih.gov/16362249; Royal College of Physicians, *Alcohol and sex: a cocktail for poor sexual health*, RCP, 2011, www.rcp.ac.uk/media/esylnvdp/alcohol-and-sex-a-cocktail-for-poor-sexual-health.pdf; Imamura M, Tucker J, Hannaford P and others, 'Factors associated with teenage pregnancy in the European Union countries: a systematic review', *European Journal of Public Health*, 2007, vol. 17, no. 6, pp. 630–36. https://pubmed.ncbi.nlm.nih.gov/17387106/ ; Stewart H, Adewoye M, Bayliss D and Khandker R, *Experiences of Relationships and Sex Education, and sexual risk taking: Young people's views from LSYPE2*, Department for Education, 2021. www.gov.uk/government/publications/experiences-of-relationships-and-sex-education-rse

113 Stewart H, Adewoye M, Bayliss D and Khandker R, *Experiences of Relationships and Sex Education, and sexual risk taking: Young people's views from LSYPE2*, Department for Education, 2021. www.gov.uk/government/publications/experiences-of-relationships-and-sex-education-rse

114 Kirby, D, Laris B and Rolleri L, 'Sex and HIV education programs: their impact on sexual behaviour of young people throughout the world', *Journal of Adolescent Health*, 2007, vol. 40, no. 3, pp. 206–17, https://pubmed.ncbi.nlm.nih.gov/17321420

115 Macdowall W , Jones K, Tanton C and others, 'Associations between source of information about sex and sexual health outcomes in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)', *BMJ Open*, 2015, vol. 5, no. 3, https://pubmed.ncbi.nlm.nih.gov/25743154

116 Stewart H, Adewoye M, Bayliss D and Khandker R, *Experiences of Relationships and Sex Education, and sexual risk taking: Young people's views from LSYPE2*, Department for Education, 2021. www.gov.uk/government/publications/experiences-of-relationships-and-sex-education-rse

117 Hadley A, *Teenage Pregnancy and Young Parenthood: Effective Policy and Practice*, Routledge, 2024. p155.

118 Reid V, and Meadows-Oliver M. 'Postpartum depression in adolescent mothers: an integrative review of the literature', *Journal of Pediatric Health Care*, 2007, vol. 21, no.5, pp. 289–98; Lanzi R, Bert S, Jacobs B, 'Depression among a sample of first-time adolescent and adult mothers'. *Journal of Child and Adolescent Psychiatric Nursing*, 2009 vol. 2, no. 4, pp. 194–202; Estrin G, Ryan E, Trevillion K and others 'Young pregnant women and risk for mental disorders: findings from an early pregnancy cohort', *BJPsych open*, 2019, vol. 5, no. 2.

119 Khasan A, Baker P, and Kenny L. 'Preterm birth and reduced birthweight in first and second teenage pregnancies: a register-based cohort study', *BMC pregnancy and childbirth* , 2010, vol. 10, no. 1; Marvin-Dowle K, Kilner K, Burley VJ, and Soltani H. Impact of adolescent age on maternal and neonatal outcomes in the Born in Bradford cohort. *BMJ Open*. 2018, vol. 8, no. 3.

120 Office for National Statistics, *Child and infant mortality in England and Wales: 2023*, ONS, 2025. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2023

121 Ireland G, Wijlaars L, Jay M and others, *Social and health characteristics of mothers involved in family court care proceedings in England*, UCL Great Ormond Street institute of Child Health, 2024. www.nuffieldfoundation.org/wp-content/uploads/2019/11/Nuffield_Social_Health_Mothers-in-care-proceedings_final20240829.pdf

122 Tackling Child Poverty and Social Justice Directorate, *Tackling child poverty delivery plan: fourth year progress report 2021–2022 - focus report on households with mothers aged 25 or under*, Scottish Government, 2022. www.gov.scot/publications/tackling-child-poverty-delivery-plan-fourth-year-progress-report-2021-22-focus-report-households-mothers-aged-25-under/pages/3/

123 Morinis J, Carson C, and Quigley M, 'Effect of Teenage Motherhood on Cognitive Outcomes in Children: A Population-Based Cohort Study', *Archives of Disease in Childhood*, 2013, vol. 98, no. 12, pp. 959–64.

124 Fitzsimons E and Villadsen A 'Adolescent motherhood and the development of adolescent offspring: Examining the role of selection versus early environmental factors', *SSM Population Health*, 2025, vol. 30.

125 Office for National Statistics, *Births in England and Wales: Birth registrations* (2024 edition), ONS, 2025. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsinenglandandwalesbirthregistrations, Table 6.

126 Ma, R, Cecil E, Bottle A and others, 'Impact of a pay-for-performance scheme for long-acting reversible contraceptive (LARC) advice on contraceptive uptake and abortion in British primary care: An interrupted time series study', *PLoS Medicine*, 2020, vol. 17, no. 9, pp. 1–16.

127 The National Assembly of Wales, *A strategic framework for promoting sexual health in Wales*, National Assembly for Wales, 2000. https://webarchive.nationalarchives.gov.uk/ukgwa/20050302055203/http://www.hpw.wales.gov.uk/English/topics/sexualhealth/sexual_health_action_e.pdf

128 Scottish Executive National Sexual Health and Relationship Strategy Reference Group, *Enhancing sexual wellbeing in Scotland : a sexual health and relationships strategy: proposal to the Scottish Executive*, Scottish Executive, 2003; Scottish Parliament, Debate on Sexual Wellbeing, 12 November, 2003. www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/chamber-and-committees/official-report/what-was-said-in-parliament/meeting-of-parliament-12-11-2003?meeting=4471&iob=32488

129 Scottish Executive, *Respect and responsibility : strategy and action plan for improving sexual health*, Scottish Executive, 2005.

130 BBC, 'Teen pregnancy rate in Scotland falls but misses target', BBC website, 26 June 2012, www.bbc.co.uk/news/uk-scotland-18598086; However, current editions of the long-term data suggest the target was met in 2010: Public Health Scotland, *Teenage pregnancies: Year of conception, ending 31 December 2023*, www.publichealthscotland.scot/publications/teenage-pregnancies/teenage-pregnancies-year-of-conception-ending-31-december-2023/

131 *Teenage pregnancies: Year of conception, ending 31 December 2023*, Public Health Scotland (2025), www.publichealthscotland.scot/publications/teenage-pregnancies/teenage-pregnancies-year-of-conception-ending-31-december-2023/

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