What caused the drop in teenage pregnancy from 1999 to 2015? A review of reviews of hypothesised causes

# Introduction

As demonstrated in the literature in the previous chapter, high rates of pregnancy amongst teenagers has prompted action to reduce these in several developed countries. In the last few decades, large drops in rates have occurred in several of these countries. Observers have suggested that a number of interventions intended to reduce risk of pregnancy amongst teenagers may have each contributed to this overall decrease. Other potential candidates for explaining the effects seen across several countries have also been suggested as global changes to the teenagers’ culture and environment. Figure 1, produced from the literature, presents some initial hypothesised pathways.

Several examples of policies and interventions, shown in the top left of Figure 1, are known to have been piloted and evaluated, with varying estimates of effect size. Randomised controlled trials can be used to estimate the effects of an intervention on a sample population, but results may not be generalisable to a population, or implementation of a previously tested intervention may not achieve the full effectiveness as in the experimental condition (Black, 1996). Additionally, many of the exposures listed in the bottom right of the figure are not able to be applied to or withheld from a population in an experiment, and so cannot be tested in this way. Population-level observations of changes in pregnancy rates associated with possible causes may not be able to adjust for all possible confounders and adequately test causation. However, observations can sometimes produce some confidence in attributing an observed effect to a cause (Glasziou, Chalmers, Library, Lind, & Rawlins, 2007).

The aim of this review is twofold. First, by searching available literature I aim to scope the wide range of suggested causes of reduction in teenage pregnancy, presented in the literature with supporting evidence. These may be trials of interventions in experimental situations, evaluations of interventions across larger populations, or observations of changing environments associated with decreasing rates. I restricted searches to published reviews of relevant studies to address the expectedly large volume of literature of all types on the topic. Reviews were taken as likely the most influential on policy and I anticipated that the most important hypothesised causes would be addressed in such reviews.

Evidence of the effectiveness of each is assessed to evaluate the plausibility of effects of each. This data is used to update the logic model, removing pathways where the evidence indicates no effect and adding pathways not previously known.

From this broad list of potential causes, I aim to select those with some degree of plausibility of contribution to the UK’s large declines in rates. I use several methods to assess the strength of evidence, the exposure of the population to the intervention or cultural change and the likely effect size using the RE-AIM framework (Glasgow, Vogt, & Boles, 1999).

Key points:

* Teenage pregnancy prompts public health action
* Policies were introduced across the UK, though potentially with limited effect
* Rates dipped anyway, consistent with global trends (cite our ITS/SC paper if published?)
* Finding explanations for the trend would be valuable in future policy decisions
* An initial review of the literature highlighted several paths [figure]
* To examine each of these, and detect other hypotheses of possible causes, we conducted a systematic review of reviews, including both interventions and exposures to other changes in society

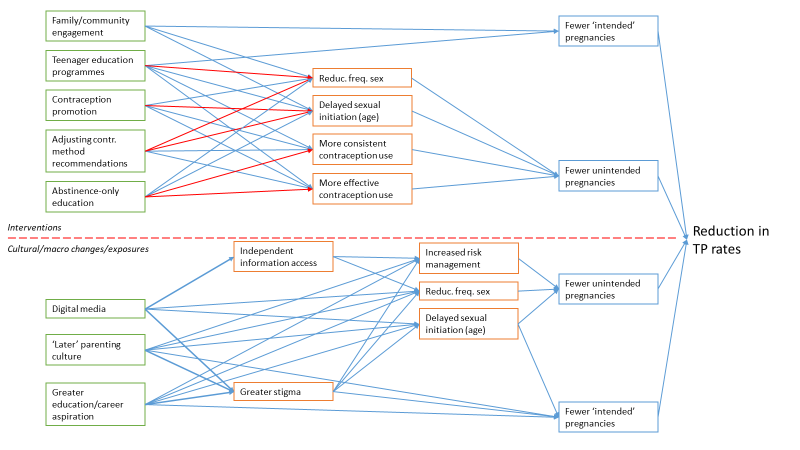


Figure 1 - Theory of change for teenage pregnancy, showing a range of potential causes

# Methods

## Aim and Research Questions

The aim of this review was to identify plausible hypothesised causes of decreasing rates of teenage pregnancy, observed in the UK from 1999 to 2015. This was done by answering two research questions:

RQ1: What changes in interventions, culture, policy and environment are hypothesised to cause reductions in teenage pregnancy in the UK and similar countries?

RQ2: Which causes are more likely to have applied to the UK from 1999 to 2015?

## Search strategy

I searched four databases (Medline, Embase, Scopus and Cochrane Database of Systematic Reviews) for reviews of adolescent/teenage pregnancy and prevention or reduction in rates. In some cases when reviews of reviews were found, I manually added all reviewed citations to screening. Full search strategies are presented in [Appendix x].

## Screening

### Inclusion criteria

##### Population

The focus of this review is on female adolescents, aged 13-19 years living in High-Income Countries (HICs) and consequently experiencing similar political and economic contexts and potentially similar interventions. The selection of countries was taken from two sources. Populations of the 31 countries included in EURO-PERISTAT reporting (Euro-Peristat, 2018); representing European countries were eligible, alongside four English-speaking HICs: Australia, Canada, New Zealand and the United States of America (see Box 1).

Austria

Australia

Belgium

Bulgaria

Canada

Croatia

Cyprus

Czech Rep.

Denmark

Estonia

Finland

France

Germany

Greece

Hungary

Iceland

Ireland

Italy

Latvia

Lithuania

Luxembourg

Malta

Netherlands

New Zealand

Norway

Poland

Portugal

Romania

Slovakia

Slovenia

Spain

Sweden

Switzerland

UK

United States of America

Box 1 A list of the 35 countries to be included in this review

(compiled from Euro-Peristat countries plus other high-income countries to compare with the UK)

##### Intervention/Exposure

Reviews evaluating interventions which either explicitly aimed to reduce teenage pregnancies or associated sexual health risk behaviours were included. Reviews which focussed on the effects of broader cultural-macro changes on pregnancies and risks were also included. These include reviews evaluating interventions designed to be applied to a population, or vulnerable subset of a population. Interventions aimed at culturally distinct subgroups of a population, not comparable to a UK context, were not included.

##### Control

Only reviews reporting a comparison between exposed and unexposed populations were included. Interventions measured either with a control group for medium to long-term outcomes (such as pregnancy), or reporting pre/post measurements of short-term outcomes (such as contraceptive use) were included. Other broader cultural changes measured between populations or across time were included.

##### Outcome

Our primary outcome was rates of pregnancies or births to women aged under 20. Other behaviours affecting pregnancy risk – sexual activity and contraceptive use – were included.

##### Study type

Only reviews of other published literature were included.

### Exclusion criteria

I excluded reviews which only looked at abortions, maternal and infant health, and other outcomes after conception.

Additionally, studies which evaluated associations of hypothesised determinants of pregnancy risk across population, with no analysis of changes of exposure over time, were not included.

## Data extraction and synthesis

I constructed a table with a row for each hypothesised cause identified in Figure 1 and extracted from each review a summary of the evidence presented for causes addressed.

## Synthesis

Reviews which addressed a single defined intervention model were first grouped into broad categories determined by context of delivery and characteristics of participants. These were then sub-categorised into distinguishable intervention models. Papers which evaluated several interventions were then analysed and each model assigned to existing or newly created categories.

Cultural, environmental and policy changes which were reviewed as potentially causative of changing rates, or proposed by reviews as time-varying confounders, were collated as one broad category. These were then grouped by distinguishable hypothesised pathways.

For each intervention, data was extracted on the description of the intervention, the context of delivery, the countries and periods studied (dated by publication of papers used, as data-collection dates were not always available), targeted participants, relevant outcomes tested, and evidence presented for effects on primary and secondary outcomes.

### Quality assessment

I used the questions developed by Aromataris et al, (2015; Table 1) in assessing the quality of each review. I omitted questions assessing the appropriateness of recommendations for ongoing research or policy and practice as these were not relevant.

### Analysis

#### Assessing feasibility using adapted questions

To assess the plausibility of each hypothesised cause, I developed a series of questions to determine the strength of evidence presented in the included reviews. The criteria developed by Bradford Hill were used as a starting point (Hill, 1965). Adaptation of these was necessary to account for the anticipated heterogeneity of evidence presented in the reviews and the likely complexity of the proposed exposures to be tested. An updated model for this purpose is presented by Howick et al. (2009). This is intended to account for various types of evidence available in the ‘evidence hierarchy’, allowing some confidence of causation to be drawn from non-RCT evidence (Table 1).

|  |  |  |
| --- | --- | --- |
| Type of evidence | Revised, structured guidelines | Hill's original guidelines |
| *Direct* | Size of effect not attributable to plausible confounding | Experiment |
| Appropriate temporal and/or spatial proximity (cause precedes effect and effect occurs after a plausible interval; cause occurs at the same site as the intervention) | Strength |
| Dose‐responsiveness and reversibility | Temporality |
| *Mechanistic* | Evidence for a mechanism of action (biological, chemical, mechanical) | Biological gradient  Biological plausibility |
| Coherence | Coherence |
| *Parallel* | Replicability | Consistency |
| Similarity | Analogy |

Table 1 Bradford Hill's original guidelines and proposed revisions (Howick et al., 2009; Table 1).

'Coherence' is moved from the 'Parallel' subheading to 'Mechanistic', in accordance with the paper's summary of the guidelines

Use of the criteria for assessing non-randomised evidence for public health interventions is also discussed by Schünemann et al. (2011) and Hultcrantz et al. (2017).

In this systematic review, it was expected that multiple types of study would be present, fitting the purposes of these revised guidelines. Additionally, evidence would often be missing as to the proportions of populations exposed to each hypothesised causal pathway. The presence of such evidence would strengthen causal inference, however its absence may not be sufficient cause to eliminate the causal pathway from the final model. This would present challenges to the goal of assessing the plausibility of causation of nationally observed decreases in rates of teenage pregnancy.

To account for this, a set of questions was devised to be applied to each causal pathway. These correspond to the revised, structured guidelines of Table 1 (the category of ‘Similarity’ was omitted, as reviews being assessed tend to pre-empt this question):

1. Is data presented which shows an effect while controlling for plausible confounding? [Direct]
2. Is this hypothesis:
   1. Tested across the population of a whole nation (as included in this analysis – see Box 1); *OR*
   2. Tested amongst a large proportion of the population, or a high-risk group (e.g. targeting prevention of repeat pregnancies; low socio-economic status of participant); *OR*
   3. Noted by authors to have been applied to a population other than the observed groups, but within this review’s observation period (1990-)? [Direct]
3. Is a logic model, or narrative synthesis of mechanisms presented? [Mechanistic]
4. Is the model coherent with what is currently known? [Mechanistic - Coherence]
5. Are results seen consistently in different national contexts? [Replicability]

For interventions which are presented as effective in an experimental population, but for which no evidence is presented for national implementation which may have occurred after the reviews were conducted, further evidence was sought to determine whether this model had been widely applied. Policies and guidelines for the appropriate UK providers was consulted when needed to answer question 2. For each intervention the five questions were presented narratively, then summarised in tabular format.

#### Presenting hypothesised causes by plausibility

By comparing across hypothesised pathways, the most plausible causes were identified as those presenting evidence to answer all five questions. Further causes which presented persuasive evidence were also considered to be plausible. Hypotheses which offered no further evidence were excluded. For each included pathway, a simplified logic model was extracted from the relevant papers. This was used to produce a finalised logic model, based on the initially proposed model (Figure 1).

## References

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