

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

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NHS provision of contraceptive services for socially disadvantaged young people up to the age of 25

NICE public health guidance x

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance on the NHS provision of contraceptive services for socially disadvantaged young people up to the age of 25.

The guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, contraceptive services. This includes those working in local authorities, education and the wider public, private, voluntary and community sectors. It may also be of interest to young people, their parents and carers and other members of the public.

The guidance complements but does not replace NICE guidance on preventing sexually transmitted infections and under 18 conceptions, looked after children, long-acting reversible contraception and personal, social and health education focusing on sex and relationships and alcohol education (for further details, see section 7).

The Programme Development Group (PDG) has considered both the evidence reviews and the economic analysis.

This document sets out the Group's preliminary recommendations. It does not include all sections that will appear in the final guidance. NICE is now inviting comments from stakeholders (listed on our website at: www.nice.org.uk).

Note that this document does not constitute NICE's formal guidance on contraceptive services for socially disadvantaged young people. The recommendations made in section 1 are provisional and may change after consultation with stakeholders and fieldwork.

The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Group will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Group will produce a second draft of the guidance.
- The draft guidance will be signed off by the NICE Guidance Executive.

For further details, see 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available from www.nice.org.uk/phprocess

The key dates are:

Closing date for comments: 23 June 2010.

Next PDG meeting: 14 and 15 July 2010.

Members of the PDG are listed in appendix A and supporting documents used to prepare this document are listed in appendix E.

This guidance was developed using the NICE public health programme process.

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1 Recommendations

When writing the recommendations, the Programme Development Group (PDG) (see appendix A) considered the evidence reviews, cost effectiveness reports and expert testimony. Note: this document does not constitute NICE's formal guidance on this programme. The recommendations are preliminary and may change after consultation.

The evidence statements underpinning the recommendations are listed in appendix C.

Several recommendations refer to the need to provide information and advice on the full range of contraceptive methods. This will enable young people to choose the method of contraception that best suits their needs and lifestyle and make it less likely that they will decide not to use it. This information should include, but is not restricted to:

- Detailed information on the full range of contraceptive choices, focusing on offering the most effective choices first.
- Printed information for the young person to take away, to accompany verbal information.
- Information on the benefits and risks for each contraceptive choice, and the options for effectively managing any side effects.

The evidence reviews, supporting evidence statements and economic analysis are available at www.nice.org.uk/guidance/index.jsp?action=folder&o=47358

Recommendation 1: assessing local need and capacity to target services

Who is the target population?

- All young women and men.

Who should take action?

- Strategic health authorities (SHAs), public health observatories, those responsible for data collection and analysis in SHAs and primary care trusts (PCTs), directors of public health, local authorities, local strategic partnerships, PCT commissioners and practice-based commissioners, directors of children's services, children's trusts.
- Managers of contraceptive and sexual health services in PCTs and acute trusts, voluntary sector and private sector providers of contraception, sexual and reproductive health services for young people, public health practitioners with responsibility for contraception and sexual health, teenage pregnancy coordinators and those responsible for Connexions services and other services for young people.

What action should be taken?

- Involve young women and men, including socially disadvantaged young women and men, both in assessing their need for services (including their preferred configuration, such as type of services offered and opening hours and location of services) and in the planning, monitoring and evaluation of those services by working collaboratively across organisational and geographical boundaries.
- Assess local need:
 - Public health observatories should gather anonymised regional and local demographic data and information on contraception and sexual health inequalities. In conjunction with teenage pregnancy coordinators and sexual health leads, they should disseminate the data to inform needs assessments and target resources and services to those with the greatest need, while maintaining universal access.
 - With support from public health observatories and local public health networks, commissioners should make full use of anonymised regional and local health intelligence and routinely collected surveillance data (for example, conceptions, births and contraceptive prescribing data, numbers of young people visiting contraceptive services and sexually

transmitted infection [STI] data) to identify areas of local need (both geographically and in terms of specific population groups, for example, black and minority ethnic communities and people with physical or learning disabilities.

- Regional public health leads, public health observatories and SHAs, working with PCTs, local authorities and local strategic partnerships, should develop and publish comprehensive joint strategic needs assessments for contraceptive and sexual health services for young people, including socially disadvantaged young people, across the local area.
- Audit capacity:
 - Map the current range of services, service activity levels, and capacity for the local population across all contraceptive service providers, including GP, pharmacy-based, school and college-based, and voluntary sector services, and ‘out of hours’ (evening and weekend) and outreach services. Staffing levels and range of professional skills (including GP practices) for the locality, including size of premises, location, opening hours and accessibility, should be included.
- Target services:
 - Use these data to develop an action plan setting out organisational responsibilities for the delivery of local services for young people, including socially disadvantaged young people at times and in locations to meet their needs.
 - Regularly evaluate these services in the context of this guidance, and in the context of changing local needs use local accountability mechanisms (for example, local authority overview and scrutiny committee reports) to examine specific issues.

Recommendation 2: commission integrated and comprehensive services

Who is the target population?

- All young women and men.

Who should take action?

- Commissioners in PCTs, local authorities and GP practices with responsibility for hospital, community and education-based contraception and sexual health services, primary care services and young people's services, pharmacies, and services provided by voluntary and independent sector organisations.

What action should be taken?

- Identify local priorities and targets based on local need, using appropriate tools, such as health equity audit and equality impact assessment, making use of NHS commissioning and local area agreement processes, as appropriate.
- Establish collaborative evidence-based commissioning arrangements between PCTs to provide contraception and sexual health services for young people at convenient, accessible locations such as city centres, colleges and schools so that no young person is denied services because of where they live.
- Ensure that all contraception and sexual health services (including those provided in general practice) meet the 'You're welcome' quality criteria (DH 2007) as a minimum requirement and the draft revised standards for sexual and reproductive health services as specified by the Faculty of Sexual and Reproductive Healthcare (2010a) and the Department of Health/Medical Foundation for AIDS and Sexual Health (Medical Foundation for AIDS and Sexual Health/DH 2005).
- Develop joint commissioning of needs-led contraceptive services for young people:

- Ensure that there are integrated and managed service networks and comprehensive referral pathways for all young women and men both into and out of contraceptive services.
- Ensure these referral pathways cover abortion services, maternity services and all other relevant health, social care and children's services, youth and community services, education, and the voluntary and private sectors. When commissioning provision of contraceptive services, including emergency contraception, ensure that pharmacies, walk-in centres and all services that are commissioned to provide contraceptive services (including emergency hormonal contraception) do so consistently, rather than variably depending who is on duty.

Recommendation 3: contraceptive services for young people

Who is the target population?

- All young women and men.

Who should take action?

- Managers, doctors, nurses, pharmacists, receptionists and other staff of NHS and NHS-funded contraception and sexual health services, including GP services, pharmacies, walk-in centres, acute and emergency care, the voluntary and independent sector.

What action should be taken?

- Ensure that young people have access, without delay, to dedicated confidential contraception and sexual health services for young people which, as a minimum requirement, meet quality criteria such as 'You're welcome' (DH 2007) and local and national standards for contraceptive services, such as those specified by the Faculty of Sexual and Reproductive Healthcare (2010a) and the Department of Health/Medical Foundation for AIDS and Sexual Health (Medical Foundation for AIDS and Sexual Health/DH 2005) and clinical guidance on contraceptive choices for young people (Faculty of Sexual and Reproductive Healthcare 2010b).
- Doctors, nurses and pharmacists should:

- Where possible, provide the full range of contraceptive methods, especially long-acting reversible contraception (LARC)¹, condoms to prevent transmission of STIs and emergency contraception (both hormonal and timely insertion of an intrauterine device). Services that cannot offer the full range of contraceptive methods should provide accessible and timely routes into services that can.
 - Provide information about the full range of contraceptive methods, including emergency contraception (both hormonal and intrauterine) and LARC, and offer advice on the most effective methods and how to use them effectively and consistently.
 - Offer culturally sensitive, confidential, non-judgmental, empathic advice and guidance according to the needs of the young woman and/or man involved.
 - Set aside adequate consultation time to encourage and support informed decision-making.
- Service managers, with the support of other staff, should offer services that:
 - Are flexible, for example, out-of-hours services at weekends and in the late afternoon and evening.
 - Are available both without prior appointment (drop-in) and by appointment in any given area. Appointments should be available within 2 working days. Services should advertise clearly whether they operate on a drop-in, appointment or mixed basis.
 - Strive to ensure that scheduled appointments run on time and that the waiting time in the clinic is less than 60 minutes.
 - Provide accurate information about availability and opening times.
 - Are open to young people under 16 who present for any service without a parent or carer.
 - Service managers, doctors, nurses, receptionists and other staff should:
 - Promote contraception and sexual health services to young men, and encourage young men to use them.

¹ Also referred to as lasting and reliable contraception.

- Ensure clear information is available about all local services, in the form of leaflets and posters. Services should be advertised through local media, including the internet, for example social networking media.
- Disseminate accurate and up-to-date information about the availability of local contraception and sexual health services, including those that provide emergency contraception, using local and community networks for example, youth services and youth inclusion projects. Publicise this information in schools and education settings working with personal, social, health and economic (PSHE) education, and sex and relationships education lead teachers and coordinators and teenage pregnancy coordinators
- Produce this information in formats that appeal to young people and that can be distributed widely across the local area.

Recommendation 4: socially disadvantaged young people

Who is the target population?

- Socially disadvantaged young people, including those not in education, employment or training, and those with special needs, disabilities or health problems.
- Young people from minority cultural or ethnic communities.

Who should take action?

- Service managers and staff in contraception, sexual and reproductive health services in the NHS and in NHS-funded voluntary and independent sector organisations.
- Doctors, nurses and pharmacists providing contraception, sexual and reproductive health services for young people.

What action should be taken?

- Provide additional support for disadvantaged young people to enable them to gain access to contraceptive services without delay and to support them as necessary in using the service (for example, access to interpreters, one-

to-one support, facilities for people with physical and sensory disabilities, and assistance for those with learning disabilities).

- Encourage and enable teenage and young mothers to attend services, for example by working with family nurse partnerships or children's centres.
- Offer support and referral to specialist services, for example for young people who misuse drugs and/or alcohol and those who may have been sexually exploited, trafficked, or are the victims of sexual violence.
- Provide outreach services that offer the full range of treatment options, information and tailored advice and support for socially disadvantaged young women and men and those in rural areas who cannot reach existing clinics and contraception and sexual health services.
- Offer culturally sensitive, confidential, non-judgmental, empathic advice and support. Tailor this to the needs of the young person involved, for example, providing relevant information in small manageable amounts, checking whether it has been understood, and being prepared to reiterate and revise information if required.

Recommendation 5: young people's services

Who is the target population?

- All young women and men

Who should take action?

- Professionals with a responsibility for the health and wellbeing of young women and men in social care, children's services, and voluntary and independent sector organisations, including youth workers, probation officers, education welfare officers, youth counsellors, and Connexions personal advisers.
- Doctors and nurses specialising in genitourinary medicine, child and adolescent mental health services, drug and alcohol services, emergency

and acute care and community care, including GPs, practice nurses, school nurses, and midwives.

What action should be taken?

- Provide information to young men and women about the location and opening times of local contraception and sexual health services, including GP and pharmacy services.
- Use every appropriate opportunity to offer sensitive, non-judgemental information and advice about contraception and sexual health.
- Routinely provide printed, quality assured information, to support verbal information and information about local contraceptive services when providing a related intervention, such as:
 - screening for chlamydia or other STIs
 - pregnancy testing
 - emergency hormonal contraception
 - postnatal care
 - post-abortion care
 - treatment for STIs.

Recommendation 6: consent and confidentiality

Who is the target population?

- All young women and men.

Who should take action?

- Managers, professionals and staff in services that provide contraception and contraceptive advice to young people, including pharmacies and voluntary and independent sector organisations.
- Managers and staff in children's services, social care organisations and young people's advisory and support services.

What action should be taken?

- Ensure that all staff have received training that enables them to understand the need for confidentiality, according to the relevant recommendations and standards from their professional organisation.
- All staff should be familiar with, and work to, the best practice guidance on the provision of advice and treatment to young people under 16 years on contraception and sexual and reproductive health (Department of Health 2004) and local and national guidance on working with vulnerable young people. They should be able to assess the competence of young people under 16 to consent to contraceptive provision and treatment, their ability to understand information provided, to weigh up the risks and benefits, and to voluntarily express their own wishes.
- Ensure young people who use the services understand that confidentiality will be respected with regard to their personal information and the reason for their visit. Reassure young people that they will not be discussed without their explicit consent, except to seek or share guidance from immediate colleagues about their case, or under the provisions made by law if there are concerns about their wellbeing or safety, for example safeguarding. The organisation's confidentiality and complaints policy should be prominently displayed in waiting areas and reception areas and should be in a format that is appropriate for young people.
- Ensure that staff are adequately supported and supervised and have opportunities for debriefing within the organisation. This will ensure that staff are not tempted to breach confidentiality by seeking external support.

Recommendation 7: preventing unintended pregnancies following a birth**Who is the target population?**

- Young women who are pregnant or have had a baby, and their partners.

Who should take action?

- Midwives, GPs, pharmacists, health visitors, sexual health nurses and school nurses. Health professionals working in primary and community

services (including family nurse partnerships), acute and emergency care, contraception, sexual and reproductive health services.

What action should they take?

- During pregnancy discuss post-birth contraception, explain the full range of contraceptive methods and help them to identify the most effective method that best meets their needs and how to obtain it.

- Midwives should:
 - discuss the full range of contraception with new mothers after the birth and should provide contraception wherever possible. If this is not possible, take responsibility for offering a referral to contraceptive services before discharge from midwifery services.
 - be mindful that mothers who are breastfeeding will need particular advice about their choice of contraception².

- Offer contraceptive advice and choice of effective contraceptive methods to young women as soon as possible after the birth, to prevent them becoming pregnant again unintentionally. This will require liaison between maternity services, primary care and contraceptive and sexual health services and agreed local pathways. Maternity services and other professionals engaged with new mothers, such as health visitors and family nurse practitioners, should consider using outreach or home services to provide contraception and contraceptive information.

- Health visitors should check that new mothers have the opportunity to obtain contraception or discuss contraception during the handover from the midwife, and make any arrangements to enable them to obtain the information, advice and treatment they may need.

² Faculty of Sexual and Reproductive Healthcare (2009) Clinical guidance: Postnatal sexual and reproductive health. www.ffprhc.org.uk/admin/uploads/CEUGuidancePostnatal09.pdf

Recommendation 8: preventing unintended pregnancies after an abortion

Who is the target population?

- Young women who have an abortion and their partners.

Who should take action?

- GPs, primary care teams, contraception and sexual health teams, abortion providers, counsellors working with abortion services.

What action should they take?

- Before and as soon as possible after an abortion, discuss contraception and explain the full range of contraceptive methods. Help young women and their partners to identify and obtain the most effective method that best meets their needs.
- Offer contraceptive advice and contraception to prevent a repeat unwanted or unintended pregnancy. If this is not possible, the young woman should be offered a prompt referral to appropriate contraceptive services
- Offer to follow up all young women after an abortion using a method of their choice (for example by text messages), to offer advice and support to help choose the most effective and suitable method of contraception for them.
- Services should consider using outreach or home services to provide contraception and contraceptive information.

Recommendation 9: school and education-based services

Who is the target population?

- All young men and women in education or of school age.

Who should take action?

- Contraceptive services within, or associated with, schools, further education colleges, universities and other education-based settings, including pupil referral units and young offender institutes.

- Head teachers, teachers, school governors in schools, pupil referral units, and young offender institutes, principals and tutors in colleges and further and higher education.

What action should they take?

- Involve young people in the design, implementation, promotion and review of on-site and outreach contraception and sexual health services in and near schools, colleges and other education settings.
- School nurses, doctors and counsellors working with individual children and young people in schools, colleges and universities should conform to health service standards of confidentiality and to those set by their professional body. All young people should be made aware that one-to-one consultations with health professionals and counsellors in school will be confidential except under the provisions made by law, for example safeguarding.
- Ensure that accurate and up-to-date contraceptive advice, information and support is readily available to all young men and women as well as information on the location and hours of local services. This information should be available outside of designated clinic hours.
- Ensure that contraception and sexual health advice, pregnancy testing and the full range of contraception methods, including both long-acting and emergency contraception, is easily available. If the full range of methods is not available, young people should be seamlessly referred into appropriate services.
- Ensure continuity of service provision, for example, by making clear to young people when and where services are available during school or college holidays.
- Ensure services not only provide contraception to young people, but are staffed by people trained to be respectful and non-judgmental and to

support young men and women through identifying, choosing and using the most appropriate contraception for them.

- Ensure the service provides clear and easy referral into specialist services that can meet young people's contraception and sexual health needs that cannot be met in the school or college setting.
- School nurses should have clear referral pathways into contraception and sexual health services and should have up-to-date information about local services.

Recommendation 10: emergency contraception

Who is the target population?

- Young women and young men

Who should take action?

- Managers, doctors, nurses, pharmacists and staff in contraception and sexual health services, including primary and community care, acute and emergency services, pharmacies, walk-in centres, the voluntary and independent sector.

What action should they take?

- Ensure all young women are able to obtain free emergency hormonal contraception, including advance provision.
- Alongside emergency hormonal contraception, young women should be:
 - encouraged to consider their contraceptive needs and to make a choice that is appropriate and suitable for them
 - referred to or given information about local services.
 - advised that emergency contraception is more effective the sooner it is used
 - advised that an intrauterine device is a more effective form of emergency contraception and can also be used for continuing contraception.

- given information about the limitations of emergency hormonal contraception as a primary method of contraception and the need for a pregnancy test after taking emergency hormonal contraception.
- Ensure young men and young women know where to obtain free advanced provision of emergency hormonal contraception
- In addition to providing emergency hormonal contraception, professionals should ensure that all young women who obtain emergency hormonal contraception are offered clear information about, and referral to, contraception and sexual health services. Ensure that all professionals dispensing emergency hormonal contraception are aware that young women under 16 years old are entitled to emergency hormonal contraception without an adult's presence, in accordance with best practice guidance on the provision of advice and treatment to young people under 16 years (Department of Health 2004).

Recommendation 11: condom provision in addition to other methods of contraception

Who is the target population?

- All young men and women.

Who should take action?

- Managers, doctors, nurses, pharmacists and staff of NHS and NHS funded contraception and sexual health services (including GP services, pharmacies, walk-in centres, acute and emergency care), the voluntary and independent sector.
- Professionals with a responsibility for the health and wellbeing of young women and men in social care, children's services, voluntary and independent sector organisations including youth workers, drug and alcohol services, youth workers and counsellors, Connexions personal advisers and people working in C-Card schemes.

- Public health specialists, PSHE education and sex and relationships education coordinators and teachers, and all those providing information about contraception, sexual and reproductive health.

What action should they take?

- Encourage all young people to use condoms and lubricant in every sexual encounter, irrespective of their other contraceptive choices, because condoms help to prevent the transmission of STIs. Condoms should be provided alongside other methods of contraception.
- Young people should be informed that condoms alone are not the most effective method of contraception.
- Ensure free condoms are readily accessible (this could include, for example, at schools and youth clubs). These condoms should be available in a range of types and sizes.
- Information on the use of condoms should be available at all condom distribution points, and where possible, young people should be shown how to use them properly.
- In addition to the provision of condoms young men and women should be informed about emergency contraception and other contraceptive services, including when, where and how to access them locally.
- If unable to provide free condoms inform young people where and when free provision is available.
- Encourage young men and women to carry and use condoms irrespective of their contraceptive choices or those of their sexual partners.

Recommendation 12: communication

Who is the target population?

- All young people who use contraception and sexual health services or who might need contraceptive and sexual health information.

Who should take action?

- Those providing/commissioning contraception and sexual health services.
- Those providing information services: for example, libraries, job centres, Connexions.

What action should they take?

- Use a range of methods including up-to-date communication technology to support young people, especially socially disadvantaged young people, with sexual health advice and in making their contraceptive choices. This could include the use of websites that link with national government and NHS contraception and sexual health campaign sites including:
 - bespoke websites or dedicated pages in social networking sites to enable young people to discuss sensitive information anonymously
 - NHS websites such as NHS Choices
 - websites provided by specialist service providers such as Brook or fpa that provide reliable, up-to-date, evidence-based health information and advice to adults and agencies that work with young people
 - telephone helplines offering up-to-date and accurate information and details about local services, such as the fpa telephone helpline – these should be publicised.
- Wherever possible, places that young people visit should have a library of information on contraception methods and local services.
- Ensure all communication is available in a range of formats.
- Ensure a choice of communication is offered to young people who are using services, for example text messages or emails to remind them about appointments or test results, rather than letters or telephone calls to the family home.

Recommendation 13: training

Who is the target population?

- Doctors, nurses, pharmacists and other health professionals providing contraception, sexual and reproductive health services.
- Managers and staff working in or involved with young people's Contraception, sexual and reproductive health services.

Who should take action?

- Royal colleges and professional associations such as the Royal College of General Practitioners, the Faculty of Sexual and Reproductive Health of the Royal College of Obstetricians and Gynaecologists, Royal College of Nursing, Royal College of Midwives, Royal Pharmaceutical Society of Great Britain.
- British Association for Sexual Health and HIV, Society of Sexual Health Advisers.
- Voluntary sector organisations including fpa, National Youth Agency.
- Commissioners and managers of contraception and sexual health services for young people, primary and community care services, children's services, social services, young people's advisory and support services including Connexions.
- Further and higher education institutions.

What action should they take?

- Ensure all doctors, nurses, pharmacists and other health professionals working in contraceptive services have received the initial training required by their professional body and can show evidence of maintaining their skills and competencies.
- All staff working with young people, particularly socially disadvantaged young people should have an understanding and experience of working

with young people – especially communications skills for working with young people, and cultural awareness and sensitivity training.

- All staff who work in contraception, sexual and reproductive health services with young people should receive training, both formal training and on-the-job training, in offering basic information and advice about contraception. They should understand the range of methods, the advantages and disadvantages of each method, the measures that can be taken to ameliorate any side effects and an understanding of pregnancy and abortion. Training should be regularly updated and tailored to individual needs to ensure staff have the necessary skills and knowledge relevant to their role.
- Ensure all staff, including administrative staff have knowledge of confidentiality issues and safeguarding issues/legislation.
- Ensure that all staff working with young people receive appropriate training on the best practice guidance on the provision of advice and treatment to young people under 16 years, are alert to the possibility of exploitation or coercion and are aware of local mechanisms for reporting concerns according to safeguarding policy and procedures.
- Ensure all staff know the location of and referral pathways into local services (including abortion services) so that they can direct young people to services where they can get advice on relationships and contraception, can obtain the most effective contraception for them, and can obtain condoms and emergency contraception.
- As part of their continuing professional development, develop a multi-professional training strategy for health professionals, including doctors, nurses, pharmacists, youth workers and counsellors to promote and support contraception advice and provision.
- Ensure that performance management and appraisal systems are in place for all staff and that they are kept up to date. If possible, take into account

the opinions of young people as part of the performance management process.

2 Public health need and practice

Young people's adolescent years and the period up to their mid twenties is a time when they are exploring and establishing sexual relationships. According to the 2000/01 'National survey of sexual attitudes and lifestyles' (Johnson et al. 2005), the median age of first intercourse was 16 years for both men and women. It is estimated that between one quarter and one third of all young people have sex before they reach age 16. Among those leaving school at 16 with no qualifications, 60% of boys and 47% of girls had sex before they were 16 (Wellings et al. 2001). Among those aged 16–19, 7% of men and 10% of women reported using no form of contraception at first intercourse.

Unprotected first sex was more likely for the youngest age groups (Johnson et al. 2001). A survey of young people aged 16–18 in London reported that 32% of black African men, 25% of Asian women, 25% of black African women and 23% of black Caribbean men did not use contraception at first intercourse (Testa and Coleman 2006).

Access to contraceptive services is most problematic for people in disadvantaged communities. There is a six-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent. There is a clear link between sexual ill-health, deprivation and social exclusion; unintended pregnancies can have a long impact on people's lives. Under-18 conceptions can lead to socioeconomic deprivation, mental health difficulties and lower levels of educational attainment. In addition, resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries (Department for Children, Schools and Families 2008).

England has one of the highest rates of teenage pregnancy in western Europe. Although under-18 conception rates have fallen from 46.6 per 1000 in 1998 to 40.4 per 1000 in 2008, a reduction of more than 13% over 10 years, and are now at their lowest for more than 20 years (Office for National

Statistics 2010) they are still much higher than comparable European Union countries (Population Action International 2007). The government's commitment to halve the under-18 conception rate by 2010, which became a public service agreement target in 2005, has not been met, despite the Teenage Pregnancy Strategy (Department for Children, Schools and Families 2010).

National progress masks significant variation in local area performance. In England, the north east region had the highest pregnancy rate of 49 per 1000 young women aged 15–17 years while the east of England had the lowest rate at 31.4 per 1000. In virtually every local authority, there are hotspots in which annual conception rates are greater than 60 per 1000 young women aged 15–17. However, some of the most deprived boroughs in the country have achieved reductions of more than 25% since 1998 (Department for Children, Schools and Families 2010).

Although 88% of women in a heterosexual relationship report using at least one method of contraception, abortion rates have increased since the teenage pregnancy strategy was published (Office for National Statistics 2009). Just under half (49%) of pregnancies among 15–18 year olds led to an abortion. Repeat abortions account for 11% of abortions in under 19 year olds, and this rises to almost 20% in some local authority areas.

The percentage of conceptions that end in abortion demonstrates that many teenage pregnancies are unwanted. It suggests that contraceptive services are failing to meet the needs of young people, who are not getting access to effective methods of contraception and advice about using contraception effectively. Since the teenage pregnancy strategy was published in 1999, the focus has been on reducing under-18 conceptions.

Abortion and repeat abortion rates are particularly high in the 18–24 age group (DH 2009). In 2007, the highest abortion rate was in women aged 19 at 36 per 1000; for women aged 20–24 the abortion rate was 33 per 1000.

The contraceptive and sexual health needs of those over 18 and under 25 years, groups that have even higher rates of unintended or unwanted pregnancy, may have been neglected. Campaigns and services aimed at teenagers may not be as relevant to this group (Teenage Pregnancy Independent Advisory Group/MedFASH 2008).

Teenage pregnancies have a high cost implication for public funds. They place significant pressures on local authority social care, housing and education services. In 2006/07 local authorities spent £23 million on support services for teenage parents (Department for Children, Schools and Families 2008). In 2006 the cost to the NHS of induced abortions for women up to the age of 25 was £48,680,949.

Government action

One of the aims of the National Strategy for Sexual Health and HIV was to improve services and support and reduce unintended pregnancies, by ensuring a range of contraceptive services is provided for those that need them and addressing disparities in abortion services across the country. A recent review of the strategy identified that contraceptive services need further attention (Independent Advisory Group on Sexual Health and HIV/Medical Foundation for AIDS and Sexual Health 2008). Some local areas have suffered from disinvestment in community contraceptive services, although young people and those from vulnerable communities generally prefer these services to primary care services (Independent Advisory Group on Sexual Health and HIV 2009).

The recommended standards for sexual health services suggest that people should have access to accurate information about, and free provision of, all contraceptive methods (Medical Foundation for AIDS and Sexual Health/DH 2005). To reinforce these standards and the continuation of the teenage pregnancy strategy, the Department of Health announced additional resources for primary care trusts and strategic health authorities between 2008 and 2011 to improve access to and uptake of effective contraception. The additional funding is focused on developing services in more schools and

colleges and extending the range of services they provide, although the Teenage Pregnancy Independent Advisory Group is concerned that take up of the new money has been patchy and there is no national monitoring (Teenage Pregnancy Independent Advisory Group 2009). From April 2009, GPs have been provided with incentives, through the quality outcomes framework, to provide advice on contraception and particularly long-acting methods, and abortion services are required to provide advice on contraception to all their clients (Department for Children, Schools and Families 2010).

3 Considerations

The Programme Development Group (PDG) took account of a number of factors and issues when developing the recommendations.

- 3.1 Most of the evidence considered for the reviews of effectiveness is from the USA. The PDG was aware that this could potentially affect its applicability to the UK setting.
- 3.2 There is little direct evidence about socially deprived groups, and it may be unreasonable to transfer evidence from African–American and Latin–American groups to socially deprived UK groups.
- 3.3 There is a general lack of evidence, particularly economic evidence.
- 3.4 Although the PDG respected the rights of professionals and service providers to hold personal beliefs, including cultural and religious beliefs, they were clear that service providers should prioritise the needs of individual young people and inform them about alternative services if they are unable to provide the service requested.
- 3.5 The PDG was clear that there is no evidence to support the contention that advance provision of EHC encourages risky sexual behaviour among young people. This is confirmed by a Cochrane review (Polis et al 2007).
- 3.6 The PDG recognised that condoms are not the most effective form of contraception in terms of preventing pregnancy but that they do prevent

the transmission of most STIs. The focus of the guidance is on the provision of effective contraceptive services, which should enable young people to understand that the most appropriate contraceptive method for them may offer no protection against STIs.

- 3.7 The PDG recognised that sexual health is an important aspect of the physical and mental wellbeing of young people, and that contraceptive services should be delivered in the broader context of sexual, physical, emotional and mental health and wellbeing.
- 3.8 The PDG felt that there was no single 'best way' in terms of contraception. Assumptions about where young people prefer to get their services must be avoided, and a range of contraceptive services may be required to meet the needs of young people. All services should be young people friendly.
- 3.9 The PDG acknowledged that the term 'socially disadvantaged young people' covers a range of people that may not be easily identified.
- 3.10 The PDG felt it is important to consider that not all young people want to avoid pregnancy and that the role of services is to provide information and advice to enable women to make informed decisions over their contraceptive needs.
- 3.11 The PDG felt that sexual health is important throughout life and people's needs for information and demands for services will vary according to their age, way of life and sexual orientation.
- 3.12 The PDG believed that the guidance should be implemented universally, but that a greater focus should be given to areas that have a higher concentration of social disadvantage.
- 3.13 The PDG acknowledged that health and societal inequalities will not be changed by simply reducing the birth rate in socially disadvantaged young people. The wider determinants of health need addressing too.

- 3.14 The PDG agreed that the age at which someone from a socially disadvantaged background has a child does not have a significant impact on health outcomes later in life; rather, the level of social disadvantage is the main determinant.
- 3.15 In the economic modelling undertaken for this topic, it was argued that the savings in government-funded benefits to young mothers having fewer teenage births was a real saving to the community. In most cases, transfers of money from taxpayers to recipients (known as ‘transfer payments’) are not counted as either costs or benefits from a societal perspective because they cancel out, and involve simply a redistribution of existing wealth. However, in the case of government-funded benefits to single mothers, the need for paying the benefits is removed if there is no baby. The funds that would have been used for this purpose can be used for something else. The PDG considered the argument that reductions in government-funded benefits were a saving of costs and concurred with it. The modelling considered the cases where the increased use of contraception delays pregnancy until the woman reaches her 20s, and where it results in the absence of a future pregnancy altogether.

This section will be completed in the final document.

4 Implementation

NICE guidance can help:

- NHS organisations, social care and children's services meet the requirements of the DH's 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.
- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Government's 'The new performance framework for local authorities and local authority partnerships'.

- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for multi-sector partnerships for health, such as local strategic partnerships.

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued (www.nice.org.uk/PHxx).

5 Recommendations for research

This section will be completed in the final document.

More detail on the gaps in the evidence identified during development of this guidance is provided in appendix D.

6 Updating the recommendations

This section will be completed in the final document.

7 Related NICE guidance

Published

Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007). Available from www.nice.org.uk/guidance/PH3

Postnatal care. NICE clinical guideline 37 (2006). Available from www.nice.org.uk/guidance/CG37

Long-acting reversible contraception. NICE clinical guideline 30 (2005).

Available from www.nice.org.uk/guidance/CG30

Under development

The physical and emotional health and wellbeing of looked after children and young people. NICE public health guidance. Publication expected September 2010.

Personal, social and health education focusing on sex and relationships and alcohol education. NICE public health guidance. Publication expected January 2011.

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Appendix A Membership of the Programme Development Group (PDG), the NICE project team and external contractors

Programme Development Group

PDG membership is multidisciplinary, comprising public health practitioners, clinicians (both specialists and generalists), local authority officers, teachers, social care professionals, representatives of the public, patients, carers, academics and technical experts as follows.

Amar Abass

Chief Executive, Youth Action (North West) & Community Member

Penny Barber

Chief Executive, Brook Birmingham

Simran Chawla

Commissioning Co-ordinator, Young Peoples' Sexual Health, London
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Lucy Dallimore

GP and staff grade in GU Medicine and Family Planning, Honorary University
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Teenage Pregnancy Link-Midwife, Royal Devon & Exeter NHS Foundation Trust; PhD Researcher and Associate Lecturer, University of Plymouth

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NICE project team

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Alastair Fischer

Technical Adviser Health Economics

Rachael Paterson

Senior Editor

Alison Lake/Susan Burlace

Editors

External contractors

Evidence reviews

Review 1: 'Mapping review: contraceptive services for socially disadvantaged young people' was carried out by the School of Health and Related Research (SchARR) at the University of Sheffield. The principal authors were: Lindsay Blank, Nick Payne, Louise Guillaume, Sue Baxter and Hazel Pilgrim.

Review 2: 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in education settings' was carried out by SchARR at the University of Sheffield.

The principal authors were: Lindsay Blank, Nick Payne, Louise Guillaume, Susan Baxter and Hazel Pilgrim.

Review 3: 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: views review' was carried out by SchARR at the University of Sheffield. The principal authors were: Susan Baxter, Lindsay Blank, Nick Payne, Louise Guillaume and Hazel Pilgrim.

Review 4: 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in healthcare settings' was carried out by SchARR at the University of Sheffield. The principal authors were: Lindsay Blank, Nick Payne, Louise Guillaume, Hazel Pilgrim and Sue Baxter.

Review 5: 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in community settings' was carried out by SchARR at the University of Sheffield. The principal authors were: Lindsay Blank, Nick Payne, Louise Guillaume, Hazel Pilgrim and Sue Baxter.

Cost effectiveness

The economic analysis 'Modelling the cost effectiveness of interventions to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services' was carried out by SchARR at the University of Sheffield. The principal authors were: Hazel Pilgrim, Nick Payne, Jim Chilcott, Lindsay Blank, Louise Guillaume and Sue Baxter.

Expert testimony

Expert paper 1: 'Improving healthcare for young people' by Lily Makurah, Department of Health.

Expert paper 2: 'Teenage Pregnancy Strategy: NICE meeting: 17 September' by Alison Hadley, Teenage Pregnancy Unit, Department for Children Schools and Families.

Expert paper 3: 'Access to Health Care: How do we reach vulnerable groups? Learning from the Teenage Health Demonstration Sites' by Catherine Dennison, Department of Health.

Expert paper 4: 'Contribution to NICE guidance on contraceptive services for socially disadvantaged young people' by Kate Guthrie, Sexual and Reproductive Healthcare Partnership, Hull and East Yorkshire PCT.

Expert paper 5: 'Department of Health evidence: NICE guidance on contraception for socially disadvantaged young people' by Kate Laverty, Judith Hind, Jacquie Rowlands, Department of Health.

Appendix B Summary of the methods used to develop this guidance

Introduction

The reviews and economic analysis include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PDG meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available at <http://guidance.nice.org.uk/PHG/Wave18/50>

Guidance development

The stages involved in developing public health programme guidance are outlined in the box below.

Draft scope released for consultation

2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic modelling undertaken and submitted to PDG
6. PDG produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PDG amends recommendations
9. Final guidance published on website
10. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching questions were:

- What is the effectiveness and cost effectiveness of interventions to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services (including access to, and information about, contraceptive services)?
- What are socially disadvantaged young people and their families' perceptions, views and beliefs about contraception and contraceptive services, and where do they get their information about contraception and contraceptive services?

These questions were made more specific for each review (see reviews for further details).

Reviewing the evidence

Evidence reviews

Five reviews were conducted:

- a mapping review
- three settings-based reviews of effectiveness
- a review of views and barriers.

Identifying the evidence

The following databases were searched in August 2008 for both quantitative and qualitative studies (1995 to 2008) for all of the reviews:

- Applied Social Science Index and Abstracts (ASSIA)
- British Nursing Index
- Cochrane Database of Systematic Reviews
- Cinahl
- Cochrane – Central

- Cochrane DARE
- Cochrane Health Technology Assessment
- Embase
- MEDLINE
- PsycINFO
- Science and Social Science Citation Indices
- Social Care Online

Additionally, the following websites were searched for relevant publications:

- British Association for Sexual Health and HIV
- British Medical Association
- Brook
- Centre for Reviews and Dissemination
- Connexions
- Department for Children, Schools and Families
- Department of Health
- Every Child Matters
- Faculty of Public Health
- FPA
- Health Protection Agency
- Joseph Rowntree Foundation
- Margaret Pyke Centre
- Medical Foundation for AIDS and Sexual Health
- National Electronic Library for Health – Guidelines Finder
- National Electronic Library for Health – Public Health
- NICE (and HDA)
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal Pharmaceutical Society of Great Britain
- Sex Education Forum

- Sex Education Forum at the National Children's Bureau
- SIGN (Scottish Intercollegiate Guidelines Network)
- Social Care Institute for Excellence
- South West Public Health Observatories
- Teenage Pregnancy Unit
- US National Guidelines Clearinghouse
- Welsh Assembly Government – Health Promotion Wales
- World Health Organisation

Selection criteria

Studies were included in the effectiveness reviews if:

- They included under 25s.

Studies were excluded if:

- They focused solely on people aged 25 and older. Although a younger age cut off was not explicitly stated, consideration was also given to the Fraser guidelines for competence to consent.
- They covered sexual health services that do not provide contraceptive services
- They covered sterilisation, including vasectomy
- They covered abortion (services which do not also provide contraception)
- They covered use of contraceptive methods for non-contraceptive reasons, for example, for menorrhagia (heavy periods).

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for the development of NICE public health guidance' (see appendix E). Each study was graded (++, +, –) to reflect the risk of potential bias arising from its design and execution.

Study quality

- ++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.
- + Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.
- Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guidance. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the public health collaborating centre (see appendix A). The statements reflect their judgement of the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations and an economic modelling exercise.

Review of economic evaluations

One economic evaluation was identified within the three reviews which considered the cost effectiveness of an intensive, school-based intervention for teen mothers to prevent repeat pregnancies. This economic evaluation was poorly reported and appeared to contain some errors within the

calculations. No other economic evaluations that met the inclusion criteria were identified by the reviews.

Economic modelling

A number of assumptions were made that could underestimate or overestimate the cost effectiveness of the interventions (see review modelling report for further details).

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The results are reported in: 'Modelling the cost-effectiveness of interventions to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services'. They are available on NICE's website at:

<http://guidance.nice.org.uk/PHG/Wave18/50>

Fieldwork

This section will be completed in the final document.

How the PDG formulated the recommendations

At its meetings in 2009/10, the PDG considered the evidence and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- where relevant, whether, on balance, the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.

- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where evidence was lacking, the PDG also considered whether a recommendation should only be implemented as part of a research programme.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

Appendix C The evidence

This appendix lists the evidence statements from four reviews provided by the public health collaborating centre (see appendix A) and links them to the relevant recommendations. (See appendix B for the key to quality assessments.) The evidence statements are presented here without references – these can be found in the full review (see appendix E for details). It also lists five expert reports and their links to the recommendations and sets out a brief summary of findings from the economic analysis.

The four reviews of effectiveness are:

- A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in education settings.
- A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: views review.
- A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in healthcare settings.
- A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in community settings.

Evidence statement E1a indicates that the linked statement is numbered 1a in the review 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in education settings'.

Evidence statement V1a indicates that the linked statement is numbered 1a in the review 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: views review'.

Evidence statement H1a indicates that the linked statement is numbered 1a in the review 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in healthcare settings'.

Evidence statement C1a indicates that the linked statement is numbered 1a in the review 'A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: services and interventions in community settings'.

ER-IHYP indicates evidence in the expert report 'Improving healthcare for young people'

ER-TPS indicates evidence in the expert report 'Teenage Pregnancy Strategy'

ER-AHC indicates evidence in the expert report 'Access to Health Care: How do we reach vulnerable groups?'

ER-CSSDP indicates evidence in the expert report 'Contribution to NICE guidance on contraceptive services for socially disadvantaged young people'

ER-DH indicates evidence in the expert report 'DH evidence: NICE guidance on contraception for socially disadvantaged young people'

The reviews, expert reports, and economic analysis are available at www.nice.org.uk/phxx. Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Recommendation 1: evidence statements V15, V25, V26, ER-IHYP, IDE

Recommendation 2: evidence statements V2, V12, V15, V19, V22, V25, V26, ER-IHYP, IDE

Recommendation 3: evidence statements C1a, C1c, H4, V1a, V1b, V2, V11, V12, V15, V16, V19, ER-IHYP, IDE

Recommendation 4: evidence statements C2d, H1b, H4, E6a, V1a, V2, V12, V15, V19, ER-IHYP, IDE

Recommendation 5: evidence statements C4, H4, V1a, V11, V19, IDE

Recommendation 6: evidence statements V2, V12, V14, V17, V18, ER-IHYP, IDE

Recommendation 7: evidence statements C2a, H1b, E6a, V1a, IDE.

Recommendation 8: evidence statements V1a, IDE

Recommendation 9: evidence statements E3a, V1a, V2, V11, V12, V15, V19, IDE

Recommendation 10: evidence statements H2, V1a, V1b, V1c, V11, V20, IDE

Recommendation 11: evidence statements H3, V1a, V1b, V7, IDE

Recommendation 12: evidence statements C1a, C1c, E6b, V1a, V2, V11, V17, IDE

Recommendation 13: evidence statements V1a, V1b, V2, V12, V14, V18, V19, V27, IDE

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the review team's report to make them more consistent with each other and NICE's standard house style.

Community review evidence statements

C1: Media based interventions

There is mixed evidence from five studies to suggest that media based interventions may reduce teenage pregnancy, increase contraceptive use and improve the knowledge and attitudes of young people in relation to these outcomes:

C1a. Computer based interventions

Moderate evidence from one randomised controlled trial (RCT) showed that a computer based intervention could significantly reduce pregnancy, and improve EHC use as well as improving knowledge and attitudes based outcomes).

C1c. Social marketing campaigns

Weak evidence from two before and after (BA) studies suggest that social marketing campaigns may have a significant effect on the use of contraception or EHC as well as knowledge and attitude based outcomes. In the first study, compared with the controls, the intervention group were significantly more likely to have heard of EHC, know the mechanism of action of EHC, have discussed EHC with a care provider, received an advanced prescription for EHC, and intend to use EHC in the future if needed. The second study showed that increased exposure to the social marketing campaign was associated with a significant increased in condom use at last sexual experience.

C2: Interventions to prevent repeat pregnancy

There is inconsistent evidence from eight studies to suggest that community based interventions may be effective in preventing repeat pregnancy:

C2a. Home visitor interventions

Inconsistent evidence from three RCTs suggests that home visitors may be effective in preventing repeat pregnancy; only two of the three studies measured repeat pregnancy rate as an outcome and only one of these provided evidence of clear benefit. The first RCT showed a significant reduction in repeat birth for the intervention group. The second RCT showed a

significant improvement in parenting scores for the intervention group, but the effect on repeat pregnancy was not significant. The third RCT showed a significant improvement in contraceptive use for the intervention group, but did not measure repeat pregnancy.

C2d. Generic programmes for teenage mothers

Moderate evidence from one RCT suggests that generic programmes for teen mothers (to prevent repeat pregnancy, increase school retention, reduce substance abuse, and improve wellbeing) could be effective in significantly reducing repeat pregnancy and consequent births.

C4: Generic interventions

Conflicting evidence from two studies suggests that a generic youth programme run after school could be effective in preventing pregnancy, reducing sexual activity and improving contraceptive use. One RCT showed a reduction in pregnancy and initiation of sexual activity, and an increase in contraceptive use and use of contraceptive service. However, one case control study showed that transferring this intervention to the UK context resulted in potentially negative effects (which the authors suggest may be accounted for by study design) resulting in increased pregnancy rate, level of sexual activity, and expectation of pregnancy. This study had notable between group differences at baseline.

Healthcare review evidence statements

H1: Interventions to provide new adolescent services and to encourage access to existing services

H1b. Outreach to existing mainstream services

Moderate evidence from five studies suggests that outreach programmes to encourage young people to attend mainstream sexual health services may be effective in increasing service use, but the effect on reducing teenage pregnancy rates is unclear. In the non-RCT study, compared with control, the outreach group was significantly more likely to report consistent birth control use, and women were also less likely to report pregnancy. In the first cohort study condom use increased and pregnancy decreased, but the impact of the intervention is unclear because of poor reporting. In the second cohort

study, during the 5 years of the intervention, the number of attendees at family planning clinics aged under 20 and under 16 significantly increased.

Pregnancy is reported to have 'remained low' but no data is given. In the third cohort study, those who attended an orientation session were significantly more likely to initiate services, and attendance at the 3-month booster session was associated with significantly higher continued clinic contact at 1 year. In the interrupted time series (ITS) study, the number of new users of family planning services aged under 26 years increased significantly in the first 18 months of the outreach programme.

H2: Advanced supply of emergency hormonal contraception

There is strong evidence from four RCTs to support the advanced provision of EHC to adolescents to increase EHC use. In most cases increased use was not at the expense of other contraceptive use, and did not promote risky sexual behaviour; the exception was one study with adolescent mothers. In the first study, at 6-month follow up EHC use was significantly higher in the intervention (advanced provision) group than the control, and the mean time to use EHC was significantly shorter in the intervention group compared with the control group. There were no differences in hormonal contraception or condom use between the groups. In the second study (with random allocation to receive EHC via pharmacy, clinical access or advanced provision) EHC use at 6-month follow up was significantly greater in the advanced provision group than the clinical access group. Pharmacy access did not affect EHC use when compared with clinic access. In the third study, the advanced EHC group reported (non-significantly) higher emergency contraception use and significantly sooner use. In the fourth study, at 12-month follow up those in the advanced provision group were significantly more likely than the controls to have used EHC but also more likely to have had unprotected sex in the past 6 months.

H3: Interventions to promote adolescent condom use

There is strong evidence from five studies to support interventions that combine discussion and demonstration of condom use to increase adolescent condom use and engagement with clinical services. In the first study, at 6-

month follow up intervention subjects reported statistically significantly increased condom use by their sexual partner for protection against STIs. In the second study, at 1 year clients were twice as likely to report having received condoms from the clinic. In the third study, of two methods of cognitive behavioural therapy (CBT) to reduce unprotected sex, those in the skills based CBT group were significantly less likely to have unprotected sex at 12 months than those in the information based CBT group or control group. In the fourth study, more of the intervention group than the comparator group returned for their scheduled clinic revisits (statistical significance not clear). In the fifth study, it is suggested that, compared with the rest of the country, attendance at the GUM clinic by young people is much higher, particularly at sites offering daily access and located geographically close to a school (no statistical data are given to validate this).

Although the studies were mostly well designed, the data were not always well analysed and reported, which may have affect reliability. Applicability in the UK may also be limited because most of the studies were conducted in the USA/Canada (two in populations that were majority black American and one population who were African American/Latino).

H4: Adolescent contraceptive use

Strong evidence from two RCTs and one non-RCT suggests that interventions aimed to improve adolescent contraceptive use by additional service provision can be effective, but this depends on the intervention. The first study was of a nurse led one-to-one intervention, the intervention group reported significantly greater oral contraception adherence than the controls. The second study was of a computer based contraception decision aid intervention. At 1-year follow up the first intervention group had significantly higher contraception knowledge and (non-significantly) fewer pregnancies than the non-intervention group. This finding was not replicated in a second study population. The third study was of an intervention to administer 'quick start' of contraception (immediately administered contraceptive injection), at 6-month follow up there were no differences in continuation rates or pregnancy rates between the groups.

Education review evidence statements

E3: School based health centres

E3a. On site dispensing

Strong evidence from four papers support the direct provision of contraceptives dispensed on site from school based health centres as a way to increase contraceptive provision. However, the use of those contraceptives or any subsequent outcomes is unclear. In the first study, significantly more of the intervention cohort selected hormonal contraception at the first or second visit than the control cohort, and were also significantly less likely to select no contraception. In the second study, adolescents in the intervention group were significantly more likely to receive condom/HIV instruction, and significantly less likely to report lifetime or recent sexual intercourse. Sexually active adolescents in the intervention group were twice as likely to use condoms but less likely to use other contraceptives. In the third study, direct provision led to a statistically significant increase in the number of contraceptives prescribed to young people. The data analysis in this paper is poor, giving only percentage increases, but it does appear to indicate that on site dispensing increases contraceptive provision.

E6: Curriculum interventions with additional components

E6a. Community outreach

Strong evidence from three studies suggests curriculum interventions that include community outreach components can be effective in preventing teenage pregnancy and risky sexual behaviour. In the first study rates of pregnancy, along with rate of school failure and academic suspension, were significantly lower in the Teen Outreach group than the control group. In the second study Teen Outreach was again shown to be effective, especially for those who were already teen parents. In the third study Reach for Health participants were significantly less likely than controls to report sexual initiation or recent sex.

E6b. Virtual world intervention

Moderate evidence from one study suggests that a virtual world intervention was effective when associated with a curriculum based intervention about

sexual risk behaviour. The intervention group had significantly better understanding than the control group of how reproduction works and the possible consequences of sex, and of the importance of behaving in ways that limit sexual experience.

Views review evidence statements

V1. Lack of knowledge

V1a. Gaps in knowledge about sexual activity

Three qualitative studies describe a lack of knowledge among young people about potential consequences of sexual activity. One paper covering interviews with 16-21 year olds as part of a mixed method study describes a lack of knowledge before first sexual experience and lack of knowledge about the consequences of sexual activity. This was echoed in interviews with 16-23 year olds from black and ethnic minority groups, who reported a lack of knowledge about risky sexual activity. Also, interviews with young mothers aged 14-16 years reported gaps in their knowledge about becoming pregnant and abortion.

V1b. Gaps in knowledge about use of contraception

Three qualitative studies describe a lack of knowledge about correct use of contraception among young people. Gaps in knowledge about aspects of contraception were reported in young mothers aged 14-16, in a mixed group of 16-25 year old women and in a mixed group of 15-18 year olds. One qualitative study suggests that a lack of knowledge about contraception methods may be greater in young people from deprived areas. One paper found that lack of knowledge regarding contraception methods was greater in socially disadvantaged young women aged 16-20.

V1c. Gaps in knowledge about emergency hormonal contraception

One qualitative interview study highlights emergency hormonal contraception as an area of particular lack of knowledge among young women aged 16–25. Survey data suggest knowledge of emergency contraception in 78–90% of school aged girls. One survey linked less knowledge of emergency contraception with being a pupil at a school with lower academic achievement.

V2: The obstacle of embarrassment*V2a. Embarrassment about discussing sex*

One qualitative study reports that discussion of sex and contraception is embarrassing. A study of mixed young city dwellers aged 16-25 reported that the younger participants reported that discussing sex or any type of contraception was embarrassing.

V2b. Embarrassment about using contraception services

The potential for feelings of embarrassment to inhibit young people from using contraception services is outlined in seven papers reporting views from a variety of groups of young people. Clients of family planning clinics describe embarrassment or stigma associated with accessing contraceptive supplies. Young people from ethnic minorities also describe embarrassment if they are seen accessing a service. At a male drop in service, 66% of clients reported that embarrassment would stop them using a service. Young people of school age echo this embarrassment about accessing services. One survey reports 20–24% of 11–39 year old women had been embarrassed, scared or concerned about using a sexual health service. Another paper describes women of 16-25 years old feeling embarrassed when using contraceptive services. Mixed groups of young people described embarrassment as a barrier to obtaining and using condoms. The importance of clinics overcoming young people's feelings of embarrassment was also recognised by staff (GPs and nurses).

V2c. Embarrassment about particular services

Two papers report embarrassment related specifically to particular services. One reports that young people aged 14–25 perceive that at times teachers are clearly embarrassed when discussing sexual issues, leading to the young people also feeling embarrassed. The other states that 63% of young women and 46% of young men aged 15–16 years reported embarrassment about attending a consultation with a GP in regard to sexual health.

V2d. Embarrassment at reception

One study describes a particular aspect of accessing a service that is embarrassing. It reports that young people aged up to 24 feel embarrassed when giving their name and address at a reception desk.

V7: Views of condoms

Three studies suggest that condoms can be perceived negatively, as uncomfortable or a barrier to intimacy, among some teenagers. Two report these negative views among teenagers aged 14–15 and teenagers including those who were young mothers or pregnant, and another study reports a mix of positive and negative perceptions of condom use among 12–13 year olds and 16–17 year olds. Four studies suggest some young people think that there are negative connotations for young women carrying condoms.

V11: Knowledge of local services

Three studies describe uncertainty among young people about where to go to access contraceptives, especially among young men and younger participants.

V12: Perception of trust in services

Five papers describe the importance of young people perceiving that contraceptive services are trustworthy and legitimate, enabling them to feel confident, and being in control when using them.

V14: Concerns regarding GP-based services

Five studies report that some young people have concerns about attending a GP practice for contraceptive services because of a perceived potential loss of confidentiality. This seems to be a particular concern in rural communities.

V15: Accessibility of services

Eleven studies suggest the importance of accessibility of services for young people, with convenient location, extended opening hours, and choice in location as important elements.

V16: Appointment systems

Studies report varying views about whether an appointment system or a drop-in service provides greater accessibility for young people. Four suggest an appointment-free system offers convenience. However one reports that staff perceive that waiting times in a clinic are not an obstacle to accessibility. One survey of young people reported that 62% would prefer a walk-in service. Another survey suggested that young people may appreciate the option of making appointments by telephone.

V17: The importance of anonymity

Eight studies report that preserving anonymity when accessing services is a significant concern for young people. These concerns regarding anonymity are also perceived by staff.

V18: The importance of confidentiality

Eleven papers report that confidentiality is a key concern for young people in accessing a sexual health service. Concerns regarding confidentiality feature particularly in regard to rural areas and GPs.

V19: The importance of respectful and non-judgemental staff

A range of qualitative studies and survey data highlights that young people value staff who have a respectful and non judgemental attitude towards them.

Five papers report that staff also recognise the importance of being non-judgemental. However, they highlight that some staff may have ambivalent or varying attitudes towards young people and sexuality.

V20: Concerns regarding cost

Three studies report that the cost of contraception is a concern for some young people.

V22: Clinic atmosphere

Four studies provide evidence from young people regarding the importance of a comfortable and welcoming atmosphere in sexual health service premises.

This is echoed in a study of staff views.

V25: Availability of resources

There is evidence from five studies that staff have concerns regarding limited availability of resources for sexual health services.

V26: Agencies working together

There is evidence from six studies that staff perceive that well-organised services, and different agencies working together effectively, are important.

V27: Staff training

There is evidence from six studies that staff perceive a need for greater training in providing contraceptive services for young people.

Expert reports

- Improving healthcare for young people
- Teenage Pregnancy Strategy: NICE meeting: 17 September
- Access to Health Care: How do we reach vulnerable groups? Learning from the Teenage Health Demonstration Sites
- Contribution to NICE guidance on contraceptive services for socially disadvantaged young people
- Department of Health evidence: NICE guidance on contraception for socially disadvantaged young people

Cost-effectiveness evidence

The economic analysis indicates that, from a public sector perspective, the provision of contraceptives within schools is effective. Compared with no dispensing of contraceptives within schools it results in net cost savings. This result is robust to changes in the key model assumptions if the costs of government-funded benefits are included within the analysis; however if government-funded benefits are excluded from the analysis, dispensing contraceptives within schools has around a 50% probability of resulting in net cost savings. The analysis also suggests that dispensing hormonal contraceptives within schools is likely to be more effective for preventing pregnancies and may lead to greater cost savings than dispensing condoms within schools, although this comparison is subject to considerable uncertainty.

The economic analysis also suggests that, from a public sector perspective, intensive case management results in a cost per repeat teenage pregnancy averted of £4000 compared with no follow up after a teenage birth. Excluding government-funded benefits from the analysis leads to an estimated cost per repeat teenage pregnancy averted of £15,000.

Advanced provision of emergency hormonal contraception is estimated by the model to be more effective and less costly than no advanced provision of emergency hormonal contraception from a public sector perspective; however, when government-funded benefits are excluded from the analysis (that is, an NHS and personal social services perspective), the intervention is estimated to have a cost per pregnancy averted in the 15–19 age group of £310 compared with no advanced provision. Finally, the analysis suggests that the advanced provision of emergency hormonal contraception is likely to remain cost saving from a public sector perspective when provided alongside the dispensing of contraceptives within schools.

A number of social value judgements underpin these results. The first is that it is assumed that it is a benefit to society when very young women and girls do not conceive. A second social value judgement is the implied assumption that before conception, the value of a future baby in such circumstances is neither positive nor negative: society feels neutral towards the putative baby. Once a baby is born from such beginnings, however, the baby is invested in a life expectancy like any other baby, so that the loss of such a baby after birth can be measured as a loss of QALYs. From this, it is clear that preventing conception cannot be measured in QALY terms. The cost effectiveness can be measured in terms of cost per pregnancy averted. A societal judgement needs to be made as to what constitutes the maximum amount that society is prepared to pay per pregnancy averted. That is why it is important to know whether an intervention is cost saving, because in such cases, as long as society agrees that averting a pregnancy is a benefit, the unit in which the benefit is measured is immaterial.

A third judgement that has to be made is whether a government-funded benefit to young mothers is regarded as a transfer payment (from taxpayers to

young mothers) or as a real resource cost. If the former, the benefit to the mother is an equivalent cost to the taxpayers and these items cancel out. However, if the contraceptive intervention causes a baby not to be born, the fact that the would-be mother no longer is given a benefit from the government cannot be regarded as a loss to the young woman. This means that the money that would otherwise have been paid as a benefit can be used by the government for other purposes without any opportunity cost. Under this logic, the benefits saved by having fewer teenage births result in much greater cost saving than treating benefits as a transfer payment.

In the absence of evidence, an assumption was made to estimate the magnitude of the gain to the community for delaying a pregnancy in the case of, say, a 14-year-old girl until the age of, say, 16 rather than until she reached her 20s.

Appendix D Gaps in the evidence

The Programme Development Group (PDG) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There is little UK evidence about the effectiveness of interventions in this field.
2. There is little evidence about the effectiveness of services and interventions for socially deprived young people, or evidence that searches for a differential effect among different groups of young people.
3. There are few UK data about the cost effectiveness of contraceptive service provision.

Appendix E: supporting documents

Supporting documents are available at <http://guidance.nice.org.uk/PHG/Wave18/50>. These include the following.

- Evidence reviews:
 - Review 1: ‘Mapping review: Contraceptive services for socially disadvantaged young people’
 - Review 2: ‘A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: Services and interventions in education settings’
 - Review 3: ‘A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: views review’
 - Review 4: ‘A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: Services and interventions in health care settings’
 - Review 5: ‘A review of the effectiveness and cost effectiveness of contraceptive services and interventions to encourage use of those services for socially disadvantaged young people: Services and interventions in community settings’.
- Economic modelling: ‘Modelling the cost-effectiveness of interventions to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services’.
- Expert papers.

For information on how NICE public health guidance is developed, see:

- ‘Methods for development of NICE public health guidance (second edition, 2009)’ available from www.nice.org.uk/phmethods

- 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available from www.nice.org.uk/phprocess