NICE National Institute for Health and Care Excellence

Contraceptive services with a focus on young people up to the age of 25

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Contents

Introduction: scope and purpose of this guidance

What is this guidance about?

This guidance aims to improve access to high quality contraceptive services, especially for young people up to the age of 25. The recommendations cover:

- Assessing local need and capacity to target services.
- Commissioning coordinated and comprehensive services.
- Providing contraceptive services for young people.
- Tailoring services for socially disadvantaged young people.
- Seeking consent and ensuring confidentiality.
- Providing contraceptive services after a pregnancy.
- Providing contraceptive services after an abortion.
- Providing condoms in addition to other methods of contraception.
- Communicating with young people.
- Training and continuing professional development.

Who is this guidance for?

The guidance is for: commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, contraceptive services. This includes those working in the NHS, 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.

Why is this guidance being produced?

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce this guidance.

The guidance should be implemented alongside other guidance and regulations (for more details see sections 4 and 7 on implementation and related NICE guidance respectively).

How was this guidance developed?

The recommendations are based on the best available evidence. They were developed by the Programme Development Group (PDG).

Members of the PDG are listed in appendix A.

The guidance was developed using the NICE public health programme process. See appendix B for details.

Supporting documents used to prepare this document are listed in appendix E.

What evidence is the guidance based on?

The evidence that the PDG considered included: reviews of the evidence, economic modelling, the testimony of expert witnesses, stakeholder comments and fieldwork. Further detail on the evidence is given in the considerations section (section 3) and appendices B and C.

In some cases the evidence was insufficient and the PDG has made recommendations for future research.

More details of the evidence on which this guidance is based, and NICE's processes for developing public health guidance, are on the NICE website.

Status of this guidance

The guidance complements, but does not replace, NICE guidance on: long-acting reversible contraception, looked after children and preventing sexually transmitted infections and under 18 conceptions (for further details, see section 7).

1 Recommendations

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

The Programme Development Group (PDG) considers that the recommended measures are cost effective.

For the research recommendations, see section 5.

The evidence reviews, supporting evidence statements and economic modelling report are available.

Introduction

The recommendations advocate providing information and advice on all types of contraception. The aim is to help young men and women choose the method that best suits their individual needs and lifestyle, so making it more likely that they will use contraception and use it effectively. The information should comprise verbal advice and printed material giving details about the:

- full range of contraceptive methods available, but with a focus on the most effective and appropriate choice for the individual concerned
- benefits and risks of each method and how to manage any side effects.

Definitions

For the purposes of this guidance **young men and women** refers to everyone aged under 25 who is competent to consent to contraceptive treatment under the best practice guidance set out by the Department of Health[1]. This guidance states: 'A doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- she/he understands the advice provided and its implications
- her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.'

In addition, it is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, commonly known as the Fraser Guidelines:

- the young person understands the health professional's advice
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment
- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer
- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent.

Note: some of the recommendations, for example those on information provision, may also be relevant to young people who are not competent to consent to treatment.

The recommendations are based on interventions and programmes proven to be effective with all young people aged under 25. They emphasise the need for services that are universal and inclusive. They also emphasise the need to offer additional tailored support to meet the particular needs and choices of those who are **socially disadvantaged** or who may find it difficult to use contraceptive services. (The latter might include those who are members of some faith and religious groups.) The guidance is based on the principle of progressive universalism[2] (Marmot 2010).

For the purposes of this guidance 'socially disadvantaged young people' may include those who are:

- living in a deprived area
- from a minority ethnic group (including gypsy and traveller communities)
- refugees, asylum seekers and people recently arrived in the UK
- teenage parents or the children of teenage parents

- looked after or leaving care
- excluded from school or do not attend regularly or have poor educational attainment
- unemployed or not in education or training
- homeless
- living with mental health problems
- living with physical or learning disabilities
- living with HIV or AIDS
- substance misusers (including alcohol misusers)
- criminal offenders.

Contraceptive services refers to the whole range of contraceptive, sexual and reproductive health services. This includes services:

- in primary care
- offered by community, education and pharmacy outlets (commissioned by local authorities from the NHS, the private or voluntary sectors)
- commissioned by clinical commissioning groups (for example, termination of pregnancy [abortion] services)
- commissioned by the NHS Commissioning Board (for example, contraceptive services provided within other specialist services, such as maternity services).

Recommendation 1 Assessing local need and capacity to target services

Whose health will benefit?

All young women and men aged up to 25.

Who should take action?

- Health and wellbeing boards, local authority commissioners and other commissioners of young people's services.
- Directors of public health and directors of children's services.
- Those responsible for joint strategic needs assessment, data collection and analysis in local authorities, children's services and their partners.
- Managers of contraceptive services in primary and acute care, the voluntary and private sectors.
- Public health practitioners with a responsibility for contraception and sexual health.
- Those responsible for young people's advisory services.

What action should they take?

- Directors of public health, public health practitioners and public health surveillance systems should collect and analyse anonymised regional and local demographic data and information on local contraception and sexual health inequalities. In conjunction with sexual health leads in the NHS and local authorities, they should disseminate the data to inform local strategic needs assessments, so that resources and services can be provided for those with the greatest need.
- Commissioners, with support from members of local public health networks, should use anonymised local health data and routinely collected surveillance data on, for example, conceptions, abortions, births and contraceptive prescribing, to identify local needs. These data could be geographical or in relation to specific population groups.
- Health and wellbeing boards, including directors of public health, local public health leads and local authorities, should carry out and publish the results of comprehensive joint strategic needs assessments for young people's contraceptive services. This should include details on socially disadvantaged young people.
- Map the current range of local services, service activity levels and capacity across all contraceptive service providers. (Take account of services further afield that may be used by local young people, for example, large pharmacies in nearby town centres.) The mapping should include, but should not be limited to:

  - services provided by GPs, community contraceptive clinics, paediatricians, pharmacies, the voluntary sector and within schools and colleges
  - 'out of hours' (evening and weekend) and outreach provision
  - staffing levels and the range of professional skills available (including for GP practices)
  - the size of premises, location, opening hours and accessibility.

- Use the data to develop an action plan setting out organisational responsibilities for local services for young people, including those who are socially disadvantaged. Ensure provision is at times and in locations that meet young people's needs.
- Regularly evaluate services in the context of this guidance and changing local needs. Use local accountability mechanisms (for example, health scrutiny reports) to examine specific issues.
- Ensure the mapping process involves young women and men, including those who are socially disadvantaged, in assessing the need for services (including the type of services needed, opening hours and location).
- Involve young men and women, including those who are socially disadvantaged, in planning, monitoring and evaluating services.

Recommendation 2 Commissioning coordinated and comprehensive services

Whose health will benefit?

All young women and men aged up to 25.

Who should take action?

- Health and wellbeing boards and commissioners in local authorities and clinical commissioning groups with responsibility for hospital, community, education-based and primary care contraceptive services.
- Primary care, maternity and young people's services and pharmacies.

- Contraceptive services provided by NHS, voluntary and private sector organisations.

What action should they take?

- Identify priorities and targets based on local need, using tools such as health equity audit and equality impact assessment.
- Use Commissioning for Quality and Innovation (CQUIN) indicators and other arrangements and processes to improve the uptake of effective methods of contraception, as appropriate.
- Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live.
- Provide contraceptive services within genitourinary medicine and sexual health clinics, either as part of that clinic's services or by hosting contraceptive services provided by another organisation.
- Ensure all contraceptive services (including those provided in general practice) meet, as a minimum requirement, the You're welcome quality criteria. They should also meet the Service standards for sexual and reproductive healthcare specified by the Faculty of Sexual and Reproductive Healthcare. In addition, services should follow clinical guidance on contraceptive choices for young people.
- Develop joint commissioning of needs-led contraceptive services for young people. This should include coordinated and managed service networks. It should also include comprehensive referral pathways that include abortion, maternity, genitourinary medicine, pharmacy and all other relevant health, social care and children's services. Referral pathways should also cover youth and community services, education, and services offered by the voluntary and private sectors.
- Ensure pharmacies, walk-in centres and all organisations commissioned to provide contraceptive services (including those providing oral emergency contraception) maintain a consistent service. If this is not possible, staff should inform young people, without having to be asked, about appropriate alternative, timely and convenient services providing oral emergency contraception.

Recommendation 3 Providing contraceptive services for young people

Whose health will benefit?

All young women and men aged up to 25.

Who should take action?

Managers, doctors, midwives, nurses, pharmacists, receptionists and other staff working in contraceptive services, including those offered in education, GP services, pharmacies, maternity and postnatal care services, walk-in centres, acute and emergency care, and the voluntary and private sectors.

What action should they take?

- Ensure young people have access, without delay, to confidential, dedicated young people's contraceptive services that, as a minimum requirement, meet the quality criteria set out in recommendation 2.
- Doctors, nurses and pharmacists should:
    - offer culturally appropriate, confidential, non-judgmental, empathic advice and guidance according to the needs of each young person
    - set aside adequate consultation time to encourage young people to make an informed decision, according to their needs and circumstances
    - provide information about the full range of contraceptives available, including emergency contraception (both oral and intrauterine) and long-acting reversible contraception (LARC)[3], and the benefits and side effects
    - offer advice on the most effective methods and how to use them effectively and consistently
    - if possible, provide the full range of contraceptive methods, including LARC, condoms to prevent transmission of sexually transmitted infections (STIs) and emergency contraception (both oral and intrauterine). If this is not possible, provide contraception

to meet immediate needs and provide access to services that can offer advice and timely provision of the full range of methods

- provide free and confidential pregnancy testing with same-day results and, if appropriate, offer counselling or information about where to obtain free counselling
- assess the risk of an STI, advise testing if appropriate, and provide information about local STI services.

- Service managers, with the support of doctors, nurses and other staff, should offer services that:
  - are flexible, for example, offer 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
  - provide appointments within 2 working days
  - strive to ensure that scheduled appointments run on time and that the waiting time for drop-in consultations is less than 60 minutes
  - inform young people about the amount of time they can expect to wait
  - provide accurate information about opening times and make it clear whether they operate on a drop-in or appointment basis, or a mix of both
  - are open to young people aged under 16 who present for any service without a parent or carer.
- Service managers, doctors, nurses, receptionists, pharmacists and other staff should promote contraceptive services (including those that provide both oral and intrauterine emergency contraception) to young people. They should encourage both young men and women to use them by:
  - providing clear information on all local services in a range of formats that appeal to young people, including leaflets, posters and other formats that are accessible for those with sensory impairments and learning disabilities, with low levels of literacy, or whose English may be poor

- advertising them through the local media, the Internet (for example, via social networking sites), local and community networks (for example, youth services and youth inclusion projects), schools, colleges and other education settings
- working with school and college governors, head teachers, college principals and personal, social, health and economic (PSHE) education lead teachers.

Recommendation 4 Tailoring services for socially disadvantaged young people

Whose health will benefit?

Socially disadvantaged young people aged up to 25.

Who should take action?

Service managers and staff working in contraceptive services. This includes doctors, nurses and pharmacists.

What action should they take?

- Provide additional support for socially disadvantaged young people to help them gain immediate access to contraceptive services and to support them, as necessary, to use the services. This could include providing access to trained interpreters or offering one-to-one sessions. It could also include introducing special facilities for those with physical and sensory disabilities and assistance for those with learning disabilities.
- Encourage and help young mothers (including teenage mothers) to use contraceptive services, for example, by working with family nurse partnerships or children's centres.
- Offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol and those who may have been (or who may be at risk of being) sexually exploited or trafficked may need such support. The same is true of those who have been the victim of sexual violence.
- Provide outreach contraceptive services that offer information, advice, and the full range of options. This includes provision for those living in rural areas who cannot reach existing clinics and services.

- Offer culturally appropriate, confidential, non-judgmental, empathic advice and support tailored to the needs of the young person. Tailored support might involve, for example, providing relevant information in small manageable amounts, checking whether it has been understood, and reiterating and revising information if required. It could also include using more pictures and diagrams than text.

Recommendation 5 Seeking consent and ensuring confidentiality

Whose health will benefit?

All young women and men up to the age of 25.

Who should take action?

- Managers and staff, including receptionists and administrators, working in services that provide contraception and contraceptive advice to young people. This includes education, maternity services, pharmacies and voluntary and private sector organisations.
- Managers and staff in children's services, social care organisations and young people's advisory and support services. This includes guardians, chaperones, interpreters and advocates.

What action should they take?

- Ensure staff are trained to understand the duty of confidentiality and adhere to the recommendations and standards laid out in their organisation's confidentiality policy.
- Ensure staff are familiar with best practice guidance on how to give young people aged under 16 years contraceptive advice and support[1]. Ensure they are also familiar with local and national guidance on working with vulnerable young people.
- Ensure those providing contraceptive services can assess the competence of young people aged under 16 to consent to receiving contraceptive advice and any treatment that may involve. They should also be able to assess the competence of other young people who may be vulnerable, for example, those with learning disabilities. Staff need to be able to gauge the young person's ability to understand the information provided, to weigh up the risks and benefits, and to voluntarily express their own wishes. Staff should also encourage young

people to involve a parent or person with parental responsibility in the decision-making, where possible.

- Ensure young people understand that their personal information and the reason why they are using the service will be confidential. Even if it is decided that a young person is not mature enough to consent to contraceptive advice and treatment, the discussion should remain confidential.
- Reassure young people that they will not be discussed with others without their explicit consent. Explain that sharing information with another professional may be necessary if there are concerns, for example to protect a young person from possible harm or abuse. If this is the case, the young person should be told who needs to be informed and why.
- Ensure the organisation's confidentiality and complaints policy is prominently displayed in waiting and reception areas, and is in a format that is appropriate for all young people.
- Ensure young people are asked in private whether they wish anyone else to be present at their consultation
- Ensure staff are adequately supported and supervised. This includes establishing a formal debriefing process to help maintain client confidentiality and respect.

Recommendation 6 Providing contraceptive services after a pregnancy

Whose health will benefit?

Young women aged up to 25 who are pregnant, or who have recently been pregnant, and their partners.

Who should take action?

- Midwives, obstetricians and all those working in maternity and postnatal care services.
- GPs, health visitors, pharmacists, school nurses and other health professionals working in contraceptive services, primary and community services, family nurse partnerships and acute and emergency care.

What action should they take?

- Midwives should discuss with pregnant women what type of contraception they intend to use after their pregnancy. They should provide information on the full range of options and should advise them (and their partners, if appropriate) on an effective method that best meets their needs. They should also provide information on how and where to obtain it.
- After pregnancy, midwives should check that women have chosen a method of contraception. If not, they should offer contraceptive advice on a range of effective methods tailored to the woman's circumstances and sensitive to any concerns she may have. This includes advice on contraception for women who are breastfeeding, in accordance with guidance from the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists (see Postnatal Sexual and Reproductive Health). (They should discuss the benefits and risks of different methods so that those who are breastfeeding are able to continue.)
- Midwives should provide women with the contraceptive they want before they are discharged from midwifery services. If this is not possible, they should offer a referral to contraceptive services.
- Health visitors, family nurse practitioners and health professionals working with new mothers should check that women have been given advice on contraception and do have contraceptives. If not, they should help them obtain information and advice so that they can choose and receive effective and appropriate contraceptives. Where necessary, they should consider using outreach or home services to provide this support.

Recommendation 7 Providing contraceptive services after an abortion

Whose health will benefit?

Young women aged up to 25 who have had an abortion and their partners.

Who should take action?

- GPs and other primary care practitioners.
- Contraceptive services.

- Abortion services (including those providing early medical abortion).
- 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 available. Help young women and their partners identify and obtain the most effective method that best meets their needs. Dispel the myth that there is no need for contraception after an abortion and explain that women are fertile immediately following an abortion.
- Provide contraception to prevent another unintended pregnancy or refer them to contraceptive services for advice and contraception. If appropriate, offer counselling.
- If the young woman does not want to be referred on, offer to contact her after her abortion to give advice on the most effective and suitable method of contraception for her, using a communication method of her choice (for example, text messages). Also consider using outreach or home services to provide information and contraceptives.

Recommendation 8 Providing school and education-based contraceptive services

Whose health will benefit?

Young people up to age 25 who are of school age or in education.

Who should take action?

- Nurses, doctors and counsellors working in contraceptive services within, or associated with, schools, sixth form and further education colleges, universities and other education-based settings. This includes short-stay schools and young offender institutes.
- Governors, head teachers, teachers, student welfare officers and youth workers in schools, principals and tutors in sixth form and further education colleges and universities and staff in short-stay schools and young offender institutes.

What action should they take?

- Involve young people in the design, implementation, promotion and review of on-site and outreach contraceptive services in and near schools, colleges and other education settings.
- School nurses, doctors and counsellors working with 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 them will be confidential, except under the provisions made by law, for example, in relation to child protection.
- Ensure accurate and up-to-date contraceptive advice, information and support is readily available to all young women and men. Information on the location and hours of local services should be available outside designated clinic hours.
- Ensure contraceptive advice, free and confidential pregnancy testing and the full range of contraceptive methods, including both LARC and emergency contraception, is easily available. If the full range is not available, offer prompt and easy referral to appropriate local contraceptive services outside the school or college.
- Ensure continuity of service, for example by making it clear to young people when and where local services are available during school, college or university holidays.
- Ensure services not only provide contraceptives but are staffed by people trained to be respectful and non-judgmental. They should also be trained to help young men and women identify, choose and use contraception that is the most appropriate for them.

Recommendation 9 Providing emergency contraception

Whose health will benefit?

Young women up to the age of 25.

Who should take action?

Managers, doctors, nurses (including school nurses), pharmacists and reception staff working in: contraceptive services, schools, primary and community care, acute and emergency services, pharmacies, maternity services, walk-in centres and voluntary and private sector health services.

What action should they take?

- Establish patient group directions (PGDs)[4] and local arrangements to ensure all young women can easily obtain free oral emergency contraception.
- Ensure young women (and young men) know where to obtain free emergency contraception.
- Inform young women that an intrauterine device is a more effective form of emergency contraception than the oral method and can also be used on an ongoing basis.
- Ensure young women have timely access to emergency contraception using an intrauterine device.
- Ensure young women who are given oral emergency contraception are:
    - advised that this needs to be used as soon as possible after sex and that it is only effective if taken within a limited time
    - advised that other methods are more effective and reliable as a primary method of contraception
    - encouraged to consider and choose a suitable form of contraception for their future needs
    - referred to, or given clear information about, local contraceptive services
    - offered immediate referral for an intrauterine device, if they choose this method
    - advised where they can obtain a free, confidential pregnancy test with same-day results.
- Ensure all health professionals providing oral emergency contraception are aware that they can provide this to young women aged under 16 without parental knowledge or consent, in accordance with best practice guidance[1]. Also ensure they are aware that they have a duty of care and confidentiality to young people under the age of 16.
- Health professionals, including pharmacists, who are unwilling (or unable) to provide emergency contraception should give young women details of other local services where they can be seen urgently.

- Ensure arrangements are in place to provide a course of oral emergency contraception in advance, in specific circumstances where the regular contraceptive method being used, for example condoms or the pill, is subject to 'user failure'[h].

Recommendation 10 Providing condoms in addition to other methods of contraception

Whose health will benefit?

All young men and women up to the age of 25.

Who should take action?

- Managers and staff working in contraceptive services (including GP services, pharmacies, maternity services, walk-in centres, acute and emergency care), the voluntary and private sector.
- Practitioners with a responsibility for the health and wellbeing of young people in social care and children's services and the voluntary and private sector. This includes social care professionals, workers in drug and alcohol services, youth workers and counsellors, and people involved with condom distribution schemes.
- Public health specialists, PSHE education and sex and relationships education teachers, and all others who provide information about contraception and sexual and reproductive health.

What action should they take?

- Advise all young people to use condoms consistently and correctly in addition to other contraception. Condoms should always be provided along with other contraception because they help prevent the transmission of STIs.
- Advise them to use a water-based lubricant with a condom if they want or need a lubricant.
- Ensure free condoms (including female condoms) are readily accessible (this could include, for example, at schools, colleges and youth clubs).
- Ensure information and advice on using condoms is available at all condom distribution points and, where possible, young people should be shown how to use them correctly.

- When providing condoms, offer information about emergency contraception and other contraceptive services, including when, where and how to access them locally.

Recommendation 11 Communicating with young people

Whose health will benefit?

Young people up to the age of 25 who use contraceptive services or who might need information on contraception.

Who should take action?

- Commissioners and providers of contraceptive services.
- Information service providers including, for example, libraries, job centres, schools, colleges and youth services.

What action should they take?

- Use a range of methods, including the latest communication technologies, to provide young people, especially socially disadvantaged young people, with advice on sexual health and contraception. This could include using:
    - bespoke websites or dedicated pages on social networking sites which enable young people to discuss sensitive issues anonymously
    - NHS websites such as NHS Choices and NHS Direct
    - websites provided by specialist service providers such as Brook or FPA that provide reliable, up-to-date, evidence-based health information and advice (schools and colleges should ensure their firewalls do not block these websites)
    - telephone helplines offering up-to-date and accurate information and details about local services – for example, 'Ask Brook'. These should, where possible, use local numbers that qualify for free calls as part of many mobile phone contracts.
- Wherever possible, ensure schools, colleges, youth clubs and other places that young people visit have up-to-date and accessible information on contraceptive methods and local services.

- Ensure information is available in a range of formats. For example, it should be available in languages other than English, in large print, or text relay (for those who are deaf or hard of hearing). It should also be distributed via a range of media, for example, via mobile phones (text messaging or calls) or emails. (Practitioners should be mindful of confidentiality when using these media.)
- Involve young people in the design of any media and distribution strategies.

Recommendation 12 Training and continuing professional development

Whose health will benefit?

Young people up to the age of 25 who use contraceptive services or who might need information on contraception.

Who is the target population?

- Doctors, midwives, nurses, pharmacists, and other health professionals who provide contraceptive services.
- Managers and staff working in, or involved with, young people's contraceptive services.

Who should take action?

- Commissioners and managers of young people's contraceptive services.
- Primary and community care services, children's services, social services and young people's advisory and support services.
- Royal colleges and professional associations, further and higher education training boards, and organisations responsible for setting competencies and developing continuing professional development programmes for health professionals, healthcare assistants and support staff.

What action should they take?

- Managers should ensure all doctors, midwives, nurses, pharmacists and other health professionals working in contraceptive services have received the post-registration training

required by their professional body. They should also have evidence to show that they are maintaining their skills and competencies.

- Health professionals (including pharmacists) who advise young people about contraception should be competent to help them compare the risks and benefits of the different methods, according to their needs and circumstances. They should also be able to help them understand and manage any common side effects[6].

- Colleges and training organisations should ensure doctors and nurses offering contraceptive services have easy, prompt access to pre- and post-registration theoretical and practical training in all methods of contraception. This includes intrauterine devices and systems and contraceptive implants.

- Ensure all support staff who may come into contact with young people, particularly socially disadvantaged young people, are experienced in working with them. This includes being able to communicate with those who have physical or learning disabilities. It also includes being aware of, and sensitive to, the needs of young people from different ethnic and faith communities in relation to contraception.

- Ensure all support staff who work in contraceptive services with young people receive both formal and on-the-job training in how to offer basic information and advice about contraception. They should be aware of the range of methods available, the advantages and disadvantages of each method, and the measures that can be taken to manage any side effects. Training should be regularly updated and tailored to individual needs to ensure staff have the skills and knowledge relevant for their role.

- Ensure all staff working for contraceptive services for young people, including administrative staff, know about the duty of confidentiality and child protection processes and legislation. They should be trained in Department of Health best practice guidance on the provision of confidential advice and treatment to young people aged under 16[1]. They should also be aware of local mechanisms for reporting concerns relating to safeguarding policy and procedures.

- Ensure all staff are aware of local contraceptive service referral pathways so that they know how to direct young people to the services they need – whether it is for advice on, or the provision of, contraceptives (including condoms and emergency contraception) or abortion services.

[1] Department of Health (2004) Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health.

[2] Marmot M (2010) Fair society, healthy lives: strategic review of health inequalities in England post-2010. London: University College London.

[3] Also referred to as lasting and reliable contraception.

[4] Patient group directions enable suitably qualified nurses and pharmacists to dispense specific medicines in specific circumstances. See NICE good practice guidance on PGDs.

[5] Methods where there can be 'user failure' are those that the user has to think about regularly or each time they have sex and which must be used according to instructions (such as condoms or the pill).

[6] This is an edited extract from Long-acting reversible contraception, NICE clinical guideline 30 (2005).

2 Public health need and practice

Background

Young people's adolescent years, and the period up to their mid-twenties, are 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 6-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-term 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. Figures for England and Wales show that the 2010 under-18 conception rate (35.5 conceptions per 1000) is the lowest estimated rate since 1969. The 7.3% decline in under-18 conceptions from 2009 to 2010 represents the greatest single year decrease since 1975/76.

Data for England and Wales show that conception numbers and rates fell among all age groups under-18. Younger age groups (especially those under 15) continue to account for a very small

proportion of teenage conceptions. In 2010, under-15s accounted for 5% of under-18 conceptions (Department for Education 2012).

National progress masks significant variation in local area performance. In England, the north east region had the highest pregnancy rate of 44.3 per 1000 young women aged 15–17 years while the east of England had the lowest rate at 29.8 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 1 method of contraception, abortion rates have increased since the Teenage Pregnancy Strategy was published (Office for National Statistics 2009).

In 2009, the highest abortion rate was in women aged 19–21, at 33 per 1000 pregnancies (DH 2010). The abortion rate for those under 16 was 4 per 1000, and for those under 18 the rate was 17.6 per 1000 (DH 2010). Repeat abortions accounted for 25% of all abortions in women under 25 in 2009.

The percentage of conceptions among women under 25 that end in abortion demonstrates that many of these 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.

The contraceptive and sexual health needs of those aged between 19 and 24, a group that has high rates of unintended or unwanted pregnancy, may have been neglected. Campaigns and services aimed at teenagers may not be as relevant to this group (Independent Advisory Group on Sexual Health and HIV and Medical Foundation for AIDS and Sexual Health 2008).

Teenage pregnancies have a high cost implication for public funds. It has been estimated that the cost to the NHS is £63 million a year (Department for Children, Schools and Families 2006).Teenage pregnancies 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). National Statistics data on abortions during 2009, combined with reference cost data for the same year, indicate that abortions for women aged under 25 cost the NHS approximately £53.3 million in 2009.

Government action

The Framework for Sexual Health Improvement in England aims to reduce unwanted pregnancies by ensuring people:

- have access to the full range of contraception
- can obtain their chosen method quickly and easily
- can plan the number of children they have and when.

A review of the previous National Strategy for Sexual Health and HIV identified that contraceptive services needed further attention (Independent Advisory Group on Sexual Health and HIV and 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 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 was focused on developing services in more schools and colleges and extending the range of services they provide, although the Teenage Pregnancy Independent Advisory Group was concerned that take up of the new money had been patchy and there was 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).

From 1 April 2013, local authorities have a mandatory responsibility for commissioning and delivering all community and pharmacy contraceptive services (apart from services provided by general practitioners). Clinical Commissioning Groups are responsible for commissioning termination of pregnancy services (abortions) and a fully integrated range of contraception, STI testing and treatment services. They are also responsible for commissioning vasectomy and female sterilisation services.

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 UK healthcare system differs from the US system in its organisation, use of resources and access. Furthermore, the ethnic composition of the UK population differs in a number of respects. There was little direct evidence about young people from socially disadvantaged groups. In addition, the PDG had to consider, on a case by case basis, whether it was reasonable to apply evidence derived from the USA (for example, on African Americans) to socially disadvantaged young people in the UK.

3.2 The PDG was clear that service providers should not be discriminating and judgmental, and should respect young people's choices and way of life. Attitudes that could be perceived as critical might deter young people, particularly socially disadvantaged young people, from attending services again. Services must be fully accessible for young people with disabilities and should prioritise individual needs.

3.3 The local pharmacy has a vital role in meeting the needs of diverse communities, particularly the needs of young people who may be anxious about approaching contraceptive services. Pharmacists, including those working for private retail chains, are part of a local primary care and wider health service network. The pharmacy section in a large supermarket may be the only service that is easily available and accessible within some rural areas. The PDG recognised that all health professionals and service providers have the right to refuse to provide or prescribe contraception, if doing so is contrary to their personal or religious beliefs. However, the PDG did not think it acceptable that provision of contraception, including emergency contraception, should depend on whoever happens to be on duty. If, for any reason, there is limited or variable provision in the local pharmacy, young people requiring urgent treatment, for example emergency contraception, may find it difficult to reach alternative services. This was a cause of concern.

3.4 The evidence shows that advance provision of oral emergency contraception does not encourage risky sexual behaviour among young people. Evidence also shows that women who have emergency contraception in advance are more likely to use it, and to use it sooner after unprotected sex. Having emergency contraception on hand does not affect the use of other kinds of contraception (Polis 2007).

3.5 The PDG felt that advance provision of free oral emergency contraception could fulfil an unmet need for some young people. It might also provide an early opportunity to discuss contraception and broader sexual health issues and needs.

3.6 The focus of the guidance is on the provision of effective contraceptive services, but not all methods of contraception are designed to protect against STIs. Young people may not always realise that the most appropriate contraceptive method for them may offer no protection against STIs. Only the condom is effective against STIs, including HIV.

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 Self-referral to contraceptive services through GP services, young people's services, community contraceptive services and 'one stop shops' is valuable. Assumptions about where young people prefer to get their services must be avoided, and a range of 'young-people friendly' contraceptive services will continue to be required. Young people's needs for information and demands for services may differ according to their age, way of life and cultural background.

3.9 It is important that contraceptive services are available for all young people. A universal service does not imply that every young person has the same needs. Socially disadvantaged young people are likely to need more support than others. Some may need more personalised and tailored advice and support. The guidance applies to all young people but there is a greater focus on young

people who could be considered to be socially disadvantaged, and those from areas with a higher concentration of socially disadvantaged young people.

3.10 The PDG acknowledged that the term 'socially disadvantaged young people' covers a range of people who may not be easily identified, that those considered to be socially disadvantaged might vary in different local areas, and that people may move in and out of social disadvantage at different points in their lives.

3.11 There are some socially disadvantaged groups who have very limited access to contraceptive services, for example asylum seekers or Gypsy and traveller communities.

3.12 Some socially disadvantaged young people may have multiple health and sexual health needs. They may also need or be receiving support from social, voluntary or children's services, which is often fragmented or inconsistent. Information and advice about contraception and sexual health may be provided by different teams and different provider organisations.

3.13 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 cases in which increased use of contraception delays pregnancy until the woman reaches her 20s, and those in which it results in the absence of a pregnancy altogether.

3.14 Good quality contraceptive services for young people depend on doctors and nurses who not only are sensitive to their needs but properly trained. The PDG believes that all doctors and nurses need access to high quality pre- and post-

registration contraception and sexual health training modules and courses and clinical placements without delay.

3.15 There are unseen barriers to contraceptive use for some socially disadvantaged young people. For example some hormonal methods may not be suitable for women on highly active antiretroviral therapy (HAART). In addition, some young women might be worried if their periods stop or become irregular as a result of some forms of contraception.

3.16 There was no evidence on the effectiveness of national media campaigns. It would be beneficial for any future national media campaigns to be planned with involvement of local organisations.

3.17 There is variation in practice across the country in terms of meeting the standards set out in 'You're welcome' (DH 2007). Some services will surpass the standards, whereas others will not yet have met them.

3.18 The high rates of unwanted and unintended pregnancy among women aged 19–24 years is a cause for concern. There was little evidence about their attitude towards contraception and their use of contraceptive services. Service providers have focused on targets and priorities related to the Teenage Pregnancy Strategy, yet the needs of those who are slightly older, particularly those who are socially disadvantaged, are not well understood and are not being met.

3.19 The PDG acknowledged that there are many myths surrounding contraception, for example, the idea that using 2 condoms is better than using 1, or that you cannot get pregnant the first time you have sex. Lack of knowledge and misinformation about pregnancy risk and contraception is likely to prevent young women from seeking advice and support when they most need it.

4 Implementation

NICE guidance can help:

- Commissioners and providers of NHS services to meet the requirements of the NHS outcomes framework 2013–14. This includes helping them to deliver against domain 1: preventing people from dying prematurely.
- Local health and wellbeing boards to meet the requirements of the Health and Social Care Act (2012) and the Public health outcomes framework for England 2013 to 2016.
- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE has developed tools to help organisations put this guidance into practice.

5 Recommendations for research

The Programme Development Group (PDG) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful/negative side effects.

1. What are the most effective and cost effective ways to provide contraceptive services for socially disadvantaged young people to prevent unwanted pregnancies? In particular, what are the most effective and cost effective ways to provide contraceptive services for looked after children, those with learning difficulties, those who are not in education, employment or training or women who have had an abortion?

2. What are the most effective ways to get socially disadvantaged young women and men involved in designing contraceptive services that meet their needs and reduce the barriers to access?

3. How effective and cost effective are interventions that reduce unintended conception and abortion rates among young people aged under 25 years?

4. What is the differential impact of interventions that aim to reduce unintended conception and abortion rates among young people aged under 25 years on subgroups of socially disadvantaged young people?

5. What interventions and service models enable young people from diverse faith and cultural communities to access contraceptive services and meet their contraceptive needs?

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

6 Updating the recommendations

This guidance will be reviewed 12 months after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted at the NICE website.

7 Related NICE guidance

Looked-after children and young people. NICE public health guidance 28 (2010)

Antenatal and postnatal mental health. NICE clinical guideline 45 (2007)

Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007)

Postnatal care. NICE clinical guideline 37 (2006)

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

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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, local authority officers, teachers, social care professionals, representatives of the public, 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 Borough of Ealing

Lucy Dallimore
GP and staff grade in GU Medicine and Family Planning, Honorary University Fellow, Peninsula Medical School, Plymouth

Ros Delaney
Senior Lecturer, Sexual Health & Midwifery, University of Greenwich

Alaina Dingwall
Community member

Pat Farley
Specialist Sexual Health Practitioner – Children and Young Peoples' Service, Hull PCT

Karen Harrison
Community member

Ruth Hine
Specialist Contraceptive and Sexual Health Nurse, Great Yarmouth and Waveney PCT

Lesley Hoggart
Principal Research Fellow, School of Health and Social Care, University of Greenwich

Rhiannon Holder MBE
Community member

Ifigeneia Mavranezouli
Senior Health Economist, The National Collaborating Centre for Mental Health

Pauline McGough
Consultant in Sexual and Reproductive Health, Sandyford, NHS Greater Glasgow & Clyde

Karen Spooner
Assistant Director, Community Pharmacy Commissioning, NHS Barnet

Faye Sutton
Teenage Pregnancy Link-Midwife, Royal Devon & Exeter NHS Foundation Trust; PhD Researcher and Associate Lecturer, University of Plymouth

Kim Tanner
Sexual Health Specialist Nurse and Manager of Time 4U (Young Peoples' Sexual Health) Services in Worcestershire

Anne Weyman OBE
(Chair) Member of GMC, Non-executive Director, NHS Islington

Babs Young
Independent Nurse Adviser, specialising in children's and young peoples' public health

NICE project team

Mike Kelly
CPH Director

Tricia Younger
Associate Director

Chris Carmona
Lead Analyst

Kay Nolan
Analyst

Clare Wohlgemuth
Analyst

Alastair Fischer
Technical Adviser Health Economics

Rachael Paterson/Sue Jelley
Senior Editors

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.

Fieldwork

The fieldwork 'Fieldwork for draft guidance on contraceptive services focusing on socially disadvantaged young people' was carried out by GHK.

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 focusing on 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 focusing on 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 Programme Development Group (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 online.

Guidance development

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

1. 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

Effectiveness reviews

Five reviews were conducted:

- a mapping review
- 3 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 3 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.

Fieldwork

Fieldwork was carried out to evaluate how relevant and useful NICE's recommendations are for practitioners and how feasible it would be to put them into practice. It was conducted with practitioners and commissioners who are involved in contraceptive services, including those working in the NHS, private providers, education and the voluntary sector.

The fieldwork comprised:

- Focus groups carried out nationally by GHK with practitioners and commissioners working in the NHS, education and the private and voluntary sectors.

- telephone interviews carried out by GHK.

The 2 studies were commissioned to ensure there was ample geographical coverage. The main issues arising from these 2 studies are set out in appendix C under fieldwork findings. The full fieldwork report is Fieldwork for draft guidance on contraceptive services focusing on socially disadvantaged young people.

How the PDG formulated the recommendations

At its meetings in 2009 and 2010, the Programme Development Group (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).

The guidance was due to be published in November 2010. However it was put on hold pending a Government review of NICE's public health work and while the Department of Health finalised its sexual health framework.

The recommendations have not changed, only factual amendments have been made, for example, where names of organisations have been changed.

Appendix C The evidence

This appendix lists the evidence statements from 4 reviews (3 settings-based reviews and a views review) 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 5 expert reports and their links to the recommendations and sets out a brief summary of findings from the economic analysis and the fieldwork.

The 4 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, economic analysis and fieldwork report are available. 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 V2, V12, V14, V17, V18, ER IHYP, IDE

Recommendation 6: evidence statements C2a, H1b, E6a, V1a, IDE

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

Recommendation 8: evidence statements E3a, V1a, V2, V11, V12, V15, V19, IDE

Recommendation 9: evidence statements H2, V1a, V1b, V1c, V11, V20, IDE

Recommendation 10: evidence statements H3, V1a, V1b, V7, IDE

Recommendation 11: evidence statements C1a, C1c, E6b, V1a, V2, V11, V17, IDE

Recommendation 12: 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 5 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 1 randomised controlled trial (RCT) (++) showed that a computer based intervention could significantly reduce pregnancy and improve emergency hormonal contraception (EHC) use, as well as improving knowledge and attitudes based outcomes).

C1c. Social marketing campaigns

Weak evidence from 2 before-and-after studies (2 −) 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, participants in 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 increase in condom use at last sexual experience.

C2: Interventions to prevent repeat pregnancy

There is inconsistent evidence from 8 studies to suggest that community based interventions may be effective in preventing repeat pregnancy:

C2a. Home visitor interventions

Inconsistent evidence from 3 RCTs (2 ++, 1 +) suggests that home visitors may be effective in preventing repeat pregnancy; only 2 of the 3 studies measured repeat pregnancy rate as an outcome and only 1 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 1 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.

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 5 studies (2 +, 3 −) 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 likely to report consistent contraception 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 start using 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 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: Advance supply of emergency hormonal contraception

There is strong evidence from 4 RCTs (3 ++, 1 +) to support the advance provision of EHC to young people 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 1 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 advance provision) EHC use at 6-month follow up was significantly greater in the advance provision group than the clinical access group. Pharmacy access did not affect EHC use when compared with clinic access. In the third study (++), the advance 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 advance 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 5 studies (4 ++, 1 −) 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 significant increase in 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 2 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 affected reliability. Applicability in the UK may also be limited because most of the studies were conducted in the USA/Canada (2 in populations that were majority black American and 1 population who were African American/Latino).

H4: Adolescent contraceptive use

Strong evidence from 2 RCTs (2 ++) and 1 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 3 papers (2 +, 1 −) supports 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 3 studies (3 +) 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 1 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 (1 ++, 1 +, 1 −) 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 (2 ++, 1 −) 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 and 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 contraceptive services

The potential for feelings of embarrassment to inhibit young people from using contraceptive services is outlined in 7 papers (1 ++, 5 +, 1 −) 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 (2 +) 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) (2 +).

V2c. Embarrassment about particular services

Two papers (1 +, 1 ungraded survey) 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 (1 ++, 1 +, 1 −) suggest that condoms can be perceived negatively, as uncomfortable or a barrier to intimacy, among some teenagers. Two (1 ++, 1 +) 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 (1 ++, 1 +, 2 −) suggest some young people think that there are negative connotations for young women carrying condoms.

V11: Knowledge of local services

Three studies (1 ++, 2 +) 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 (1 ++, 2 +, 2 −) 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 (1 ++, 4 +) 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 (5 ++, 5 +, 1 −) 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 (2 ++, 1 +, 1 −) suggest an appointment-free system offers convenience. However, 1 (+) 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 (1 ++, 6 +, 1 −) report that preserving anonymity when accessing services is a significant concern for young people. These concerns regarding anonymity are also perceived by staff (1 ++, 3 +, 1 −).

V18: The importance of confidentiality

Eleven papers (3 ++, 6 +, 2 −) 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 (3 +, 1 −, 1 ungraded survey) 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 (1 ++, 2 +) report that the cost of contraception is a concern for some young people.

V22: Clinic atmosphere

Four studies (1 ++, 2 +, 1 −) 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 5 studies (1 ++, 1 +, 3 −) that staff have concerns regarding limited availability of resources for sexual health services.

V26: Agencies working together

There is evidence from 6 studies (3 ++, 1 +, 1 −, 1 ungraded survey) that staff perceive that well-organised services, and different agencies working together effectively, are important.

V27: Staff training

There is evidence from 6 studies (2 +, 4 −) that staff perceive a need for greater training in providing contraceptive services for young people.

Expert report/s

- 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 focusing on socially disadvantaged young people
- Department of Health evidence: NICE guidance on contraception focusing on socially disadvantaged young people

Cost-effectiveness evidence

The economic analysis indicates that, from a public sector perspective, providing contraceptives in schools and colleges is cost effective and results in net cost savings compared with no provision of contraceptives in these places. 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, providing contraceptives

within schools and colleges, while still being cost effective, has around a 50% probability of resulting in net cost savings.

The analysis also suggests that providing hormonal contraception within schools and colleges is likely to be more effective than providing condoms in terms of preventing pregnancies. This may also lead to greater cost savings than dispensing condoms. However, this comparison is subject to considerable uncertainty.

The economic analysis also suggests that, from a public sector perspective, intensive follow-up and support after a teenage pregnancy results in a cost of £4000 for every repeat teenage pregnancy averted. This is in comparison 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.

From a public sector perspective, advance provision of emergency hormonal contraception is estimated to be more effective and less costly than not providing it in advance. However, when government-funded benefits are excluded from the analysis (that is, an NHS and personal social services perspective is adopted), the intervention is estimated to cost £310 per pregnancy averted among those aged 15–19, compared with no advance provision.

Finally, the analysis suggests that providing emergency hormonal contraception in advance is likely to be cost saving from a public sector perspective, when provided within schools and colleges alongside other contraceptives These results are informed by the following:

- The Teenage Pregnancy Strategy's target to halve the under-18 conception rate by 2010.
- It has been assumed that before conception, the value of a future baby to society is neither positive nor negative. From this, it is clear that preventing conception cannot be measured in QALY terms, because future QALYs do not exist before conception. Thus the cost effectiveness of preventing a conception has been measured in terms of cost per pregnancy averted. However, once conceived and born, the baby is invested in a life expectancy, so that the loss of such a baby after birth can be measured as a loss of QALYs. A government-funded benefit given to young mothers can either be regarded as a transfer payment (from taxpayers to young mothers) or as a real resource cost. If it is seen as a transfer payment, the benefit to the mother is an equivalent cost to the taxpayer and these items cancel out. However, if the contraceptive intervention prevents a baby from being born, the money can be used by the government for other purposes without any opportunity cost. Following this

logic, having fewer teenage births results in a much greater cost saving than if such benefits are considered as a transfer payment.

Fieldwork findings

Fieldwork aimed to test the relevance, usefulness and feasibility of putting the recommendations into practice. The PDG considered the findings when developing the final recommendations. For details, see the fieldwork section in appendix B and the NICE website.

Fieldwork participants who work with socially deprived young people were very positive about the recommendations and their potential to help improve contraception service provision. Many participants stated that the recommendations represented best practice in the area, and although they did not offer an entirely new approach, they agreed that the measures had not been implemented universally. They believed wider and more systematic implementation would be achieved as a result of this guidance.

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.

The Group made 5 recommendations for research. These are listed in section 5.

Appendix E Supporting documents

Supporting documents include the following (see supporting evidence).

- Evidence review/s:
    - 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'.
- Fieldwork report: 'Fieldwork for draft guidance on contraceptive services focusing on socially disadvantaged young people'.
- A pathway for professionals whose remit includes public health and for interested members of the public. This is on the NICE website.
- For information on how NICE public health guidance is developed, see the NICE public health guidance process and methods guides.

About this guidance

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

The recommendations from this guidance have been incorporated into a NICE Pathway. Tools to help you put the guidance into practice and information about the evidence it is based on are also available.

Your responsibility
This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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