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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

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Background

The rate of teenage pregnancy in England and Wales remains the highest in Western Europe (Population Action International, 2007) despite the decline in rates of both under 18 and under 16 conceptions over the last 20 years (Office for National Statistics, 2007). The current targets to halve the under 18 conception rate by 2010 would require a considerable acceleration in progress in order to be met (Department for Education and Skills, 2006). Teenage pregnancies have a high cost implication for public funding. They place significant pressures on local authority social care, housing and education services. In 2006/7 local authorities spent £23 million on support services for teenage parents (Department for Children Schools and Families, 2008). The cost to the NHS of induced abortions for women younger than 25 was £48,680,949 in 2006.

There is significant variation in local area performance. In 2006, the under 18 conception rate in England was 40.4 conceptions per 1000 young women (Department for Children, Families and Schools, 2008); but almost half of these conceptions (49%) occurred in the most deprived 20% of local authority wards (Department for Children, Families and Schools, 2007). Access to contraceptive services is most problematic for people in disadvantaged communities. There is a six-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent.

This review forms part of the main review that was undertaken to support the development of NICE programme guidance on the NHS provision of contraceptive services for socially disadvantaged young people (SDYP) (up to the age of 25). The views review supports the main review by providing a systematic synthesis of the published literature on the views of young people, (especially socially disadvantaged young people), and also service providers, regarding the use of contraceptives and contraceptive services. It does not

encompass views of interventions that are part of a school curriculum, as these will be covered by the public health programme guidance on school, college and community-based personal, social and health education [PSHE] that is currently in progress.

Methods

The primary research question for this review is:

- What are socially disadvantaged young people and their families' perceptions, views and beliefs about contraception and contraceptive services, and, what are the views of relevant service providers?

Subsidiary research questions are:

- What is the short term and longer term success of contraceptive services for socially deprived young people?
- What internal factors may have influenced the effectiveness of contraceptive services (e.g. content delivery, setting intensity)?
- What external factors may have influenced the effectiveness of contraceptive services (e.g. setting of targets, adequacy of guidance and support to service providers?)
- How does the effectiveness of contraceptive service interventions vary with factors such as age, teenage parenthood, drug use, school college attendance etc?
- How does the effectiveness of the contraceptive service interventions vary with factors such as ethnicity?
- How effective have contraceptive services been in reaching socially disadvantaged young people?
- What are the facilitators and what are the barriers to implementing effective contraceptive services and interventions?

A full systematic search of key health and medical databases was undertaken. The search strategy included terms relating to young people, contraceptive services, family planning and pregnancy prevention. The only restrictions that were applied to this search were in terms of date (limited to 1995-2008 to pre-

date the Teenage Pregnancy Strategy) and limiting the search to humans (to avoid animal studies relating to contraception). No restrictions were placed in terms of study type, language or place of publication. In addition to searching via electronic databases, the reference list of included papers was examined and papers not already identified were added to the database for consideration. Also, cited reference searches were undertaken on all the included studies in Google Scholar and Web of Science Cited Reference Search. No date, study type or language restrictions were placed on this search. Only studies carried out in the United Kingdom were included for the views review, as these would ensure contextual relevance. Studies were excluded when they were conducted with people aged 25 and older. Papers which contain data for both under 25s and over 25s were included if at least 50% of participants were aged 25 or younger. There was no cut-off limit for the youngest age of inclusion.

All search results were downloaded to Reference Manager. Items in the data base were sifted, with exclusion at this stage where it was possible to identify from the abstract that the work had been carried out in non-UK countries, or was not relevant to the review question, or reported general discussion or opinion rather than study data. Potentially relevant papers were taken through to the next stage of obtaining and examining full papers. Data relating to the research question, funding source, theoretical approach and data collection, data analysis, population, key themes, study limitations and any reported gaps in evidence described were extracted by one reviewer using the NICE (2009) extraction form. Extractions were independently checked for accuracy by a second reviewer. Disagreements were resolved by consensus and consulting a third reviewer where necessary. The qualitative papers were assessed for study quality by taking note of the methodology checklist set out by NICE in the CPHE Methods Manual. Quality indicators for survey papers included in this review were: sample size; return rates; whether the questionnaire was piloted; appropriateness of study conclusions; and relevance.

The searches identified 99 papers that met the inclusion criteria. Of these 64 reported qualitative data and 35 reported quantitative data from surveys, 18 papers reported data from mixed method studies. Of the 64 qualitative papers, 12 were rated as ++ (high quality), 33 rated as + (good quality), and 19 papers were rated as – (poor quality). The main limitations of study quality were in relation to the numbers of papers that reported only one method of qualitative data collection, or one method within a larger study. The mixed method papers generally reported poor quality qualitative data, with a tendency to focus on the quantitative findings and add a small number of participant quotes with little discussion of data analysis strategy or qualitative data set. Survey data was generally presented using questionnaires devised for the occasion and with no discussion of piloting the novel survey instruments. In most cases data was limited to the percentages of responses given to a specific question with p values or odds ratios provided in around half the studies.

Results of the review

The papers focused on service user views of services provided, service provider views of services, papers reporting general views and perceptions of contraceptive methods, and papers exploring views and perceptions of pregnancy and young motherhood. The review examines this data within 10 key themes relating to contraception and the delivery of contraceptive services. These are: accuracy and depth of knowledge of contraception; beliefs and socio-cultural norms about contraception: peer group norms about contraception; knowledge of and trust in contraceptive services; beliefs about contraceptive services; barriers and facilitators to using contraceptive services; sources of information about contraceptive services; accuracy of information about contraceptive services; credibility of information about contraceptive services for young people; and service provider views of service delivery.

Knowledge

The review suggests that young people lack knowledge regarding contraception in respect of correct usage, what is available, and the existence of emergency contraception. This lack of knowledge also extends to knowledge of how and where to access services. The findings also suggest that a strong sense of embarrassment amongst young people regarding contraception is a factor inhibiting contraception and service use.

Beliefs and socio-cultural norms

A key theme that emerged relates to the importance of context in young people's sexual behaviour and contraception use. The findings suggest that young people's concept of risk and risk-taking behaviour may be important in understanding whether contraception is used or not, with alcohol use in particular being linked to an increase in risky sexual behaviour. The importance of understanding the particular situation of a young person, and the context within which sexual relationships operate is highlighted by studies which link changing contraceptive use with the type of relationship. This work suggests that longer term or "trusting" relationships may lead to less careful use of contraception, in addition to having a significant impact on the decision regarding whether to continue with or terminate a pregnancy. The context may also be important in views regarding the prospect of motherhood and emphasis placed on avoiding becoming pregnant. In addition to the nature of the relationship, the review suggests that social background may influence attitudes to abortion and teenage pregnancy amongst young people.

Views of particular forms of contraception are described within the included papers. There is evidence of diversity in views regarding condoms, with concerns regarding a physical barrier and also negative connotations of girls carrying condoms, together with positive views of condom use being socially responsible. Similarly, views regarding oral hormonal contraception are mixed, with concerns regarding the ingestion of chemicals, together with positive views of this form of contraception being less expensive, more reliable and giving control over menstruation. Cost of contraception was mentioned as a concern by some young people. Emergency hormonal contraception may also

be perceived by young people as causing concerns regarding the ingestion of chemicals and the potential for being unsafe or having side effects. There is evidence of negative perceptions amongst service providers regarding easy access to EHC for young people.

Peer group norms

Peer group norms were not specifically described in the papers, although age and gender differences in perceptions of contraception are suggested.

Knowledge of and beliefs about local services

In regard to perceptions of service delivery, the limited knowledge of local services amongst young people is highlighted. The value of having trust and confidence in services is described. Concerns regarding attending GP practices for contraceptive services are indicated, together with family planning clinics being perceived as only for girls or older married women.

Barriers and facilitators

The importance of accessibility of services in terms of a convenient location, opening hours and having choice in where to go is outlined. Evidence regarding preference for appointment systems versus drop in clinics indicates a lack of consensus. A significant concern for young people is the preservation of anonymity and confidentiality when accessing services, in particular in rural areas or when attending a GP practice. These concerns may contribute to the perceptions of anxiety experienced by young people when accessing a service, particularly for the first time.

Other aspects of service delivery described in the papers relate to the attitude of staff, content of the consultation, and the clinic environment. It is reported that young people value staff that have a respectful and non judgemental attitude towards them, and prefer a welcoming and non-clinical environment that is informal and comfortable. Aspects of the consultation that are suggested as important are brevity, the establishment of trust and a “good relationship”.

Sources of information

The significance of friendship networks for information and advice is highlighted in the review, particularly amongst young women. The role of parents was reported to vary between individuals, with evidence also that schools act as a source of information. It is suggested that online sources may have a secondary role to other sources of information and advice.

Service provider views

The review suggests that service providers have concerns regarding limited resources for sexual health services and the need for greater training. Also, the perception that good service organisation and different agencies working together is of importance.

Implications for interventions

Findings from the views review may provide further insight into the delivery of interventions in education, health care and community settings examined in the effectiveness reviews. As the papers from the views review encompassed only studies undertaken in the UK, they may also serve to apply a UK context to the effectiveness reviews that were largely USA based.

Knowledge of contraception

In regard to views review findings describing a lack of knowledge of the different forms of contraception, the effectiveness reviews suggest that some interventions in each setting had the potential to improve contraception knowledge. Increased knowledge was a common outcome measure used to assess effectiveness (see for example Healthcare review Evidence Statement 4, Education review Evidence Statement 4, Community review Evidence Statements 1, 2, 3).

The views review found that emergency contraception was an area of particularly limited knowledge amongst young people. The Healthcare setting review (Evidence Statement 2) supported the advanced provision of emergency contraception supplies which would potentially impact on this low reported knowledge. It was suggested however that advanced provision could

promote risky sexual behaviour in adolescent mothers. The evidence of effectiveness of advanced provision is also measured by self-reported use of EHC, rather than measuring effectiveness in terms of avoidance of unintended pregnancies.

Knowledge of where to access supplies

The views review also suggested that young people had limited knowledge in relation to knowing where to obtain contraception supplies. The intervention reviews in contrast tend to measure and provide data on contraceptive knowledge rather than knowledge of how and where to obtain supplies (although clinic attendance rates may act as a surrogate measure of this). The Healthcare setting and Education setting reviews provide evidence that newly-developed services targeting young people could improve contraception use (Healthcare review Evidence Statement 1). Also, indicate that interventions which encouraged access to existing services could be effective in improving contraception use (Education review Evidence Statement 3). The Healthcare review cautions however, that whilst new teenage clinic interventions were successful in increasing attendance rates, there was no impact on teenage pregnancy rates. The views review emphasises the importance of embarrassment in relation to accessing services, yet there is no corresponding discussion or evidence relating to interventions which may impact on this potential barrier to young people accessing services.

Behaviour change

Having knowledge of contraception may not always lead to behavioural change, and factors underpinning the use or non-use of contraception are described in the views review. In particular the potential relationship between alcohol and risky sexual behaviour, and factors underpinning the changing use of contraception over time are described. Evidence from the healthcare setting review suggests that a cognitive behavioural therapy intervention can have an impact on the rate of unprotected sex (Evidence Statement 3) also that a “transactional intervention” may facilitate contraceptive adherence (Evidence Statement 4). The education setting review describes a motivational interviewing intervention which reduced alcohol-exposed

pregnancy (Evidence Statement 2). This review also outlines a school-based health centre intervention (Evidence Statement 3) which it is claimed reduced risky behaviours (although analysis of the findings questions this).

Perceptions of young parenthood

The effectiveness evidence largely considers measurements such as self-reported knowledge, self-reported contraception use and pregnancy rates, rather than discussing perceptions of motherhood or a young person's desire to become a mother. The views review in contrast explores perceptions regarding young motherhood and decisions to continue or not with a pregnancy. The findings highlight that individuals differ in regard to the emphasis placed on avoiding becoming pregnant. These individual differences may be significant in the varying success of intervention programmes amongst young people. The views review also suggests that exploration of the value judgements underpinning contraception may be important to include in intervention programmes. The only intervention studies which contain elements related to parenthood are papers in the education setting review which examine the use of infant simulator interventions. However, these programmes measured knowledge, attitudes and behaviour relating to contraception and sexual behaviours rather than motherhood.

The effectiveness reviews all include programmes targeting the reduction of repeat pregnancies, aiming to address various aspects ranging from "inner wellbeing", interpersonal skills, and contraceptive use, to career planning. Some of these programmes include aspects relating to life choices, although the evidence of effectiveness is mixed (Healthcare review Evidence Statement 5, Education review Evidence Statement 2, Community review Evidence Statement 2).

Perceptions of different forms of contraception

The effectiveness reviews indicate that interventions across all settings can increase the use of condoms and hormonal contraception (see for example Community review Evidence Statement 1). The report of negative as well as

positive perceptions reported in the views review may be important however, if uptake and usage is to be maximised via these interventions. There are reports in particular of concerns relating to the ingestion of chemicals or "unnatural" hormones contained in hormonal and emergency hormonal contraception. Barriers reported in the views review regarding adverse perceptions of EHC amongst women and also health professionals may need consideration in any programmes aiming to increase uptake of this form of contraception. It is suggested that there may be age and gender differences in regard to perceptions of contraception however, this is not reported in any of the intervention studies.

Service delivery

The views review suggests that young people may perceive that family planning services are for married women and older people. This may link with the benefit of services specifically for teenagers, outreach services, and the effectiveness of specific signposting to main stream services for young people reported in the Education review (Evidence Statements 1, 3).

In contrast to the views review which explored the perceptions of young people regarding aspects of the service such as appointments, confidentiality and anonymity; the intervention studies provide no details regarding how these concerns may have been addressed. The strength of importance of these factors to young people reported in the views review suggests that these aspects are important to consider when planning interventions. Similarly, the value placed by young people on staff having respectful and non-judgemental attitudes should be taken into account. The Education review suggests that having culturally matched social workers may add to the effectiveness of an intervention (Evidence Statement 1).

The views review highlights the importance of the building of a good relationship, brevity and trust during consultations, also the creation of a comfortable welcoming atmosphere in contraceptive service premises. These aspects may be facilitators or provide barriers to young people taking up

available services and therefore the effectiveness of interventions, although were not described in the reported studies.

The community and health care settings reviews do not discuss any factors specifically related to location. The education services review indicated that school clinics which were on-site and offered a dispensing service could be effective (Evidence Statement 3). This may link with the perceived importance of accessibility of services, and convenient location and opening hours reported in the views review.

Evidence statement 1. Lack of knowledge

A.

Three qualitative studies describe a lack of knowledge amongst young people regarding potential consequences of sexual activity. Croghan (2006-) describes a lack of knowledge prior to first sexual experience and lack of knowledge about the consequences of sexual activity in interviews with 16-21 year olds as part of a mixed method study. This was echoed in interviews with 16-23 year old black and ethnic minority young people (Coleman & Testa 2008+) who reported a lack of knowledge in regard to risky sexual activity. Also, interviews with young mothers aged 14-16 years (Hoggart, 2006++) who were reported to have gaps in knowledge about becoming pregnant and abortion.

B.

Three qualitative studies describe a lack of knowledge regarding correct use of contraception amongst young people. Gaps in knowledge about aspects of contraception are reported in young mothers aged 14-16 years (Hoggart, 2006++) a mixed group of 16-25 year old women (Free et al. 2005++) and a mixed group of 15-18 year olds (Curtis et al. 2005-). One qualitative study suggests that a lack of knowledge regarding contraception methods may be greater in young people from deprived areas. Jewell et al. (2000++) found that lack of knowledge regarding contraception methods was greater in socially disadvantaged young women in the 16-20 year old range.

C.

One qualitative interview study (Free et al. 2005++) highlights emergency hormonal contraception as an area of particular lack of knowledge amongst 16-25 year old young women. Survey data suggests knowledge of emergency contraception in 78-90% of school aged girls. (Stevenson 1996, Salihi et al. 2002) One survey (Graham et al. 1996) linked less knowledge of emergency contraception to being a pupil at a school with lower academic achievement.

D.

There is a lack of consensus from survey data regarding levels of reported knowledge or awareness of services. Study findings range from 62-93% of young people having reported knowledge or awareness of where to go for information or to obtain contraception. French et al. (2007) report 77-65% amongst 13-21 year old males and females, Burrack (2000) report 68% amongst 13-15 year olds of both genders, Pearson et al. (1995) report 93% amongst 14-15 year olds of both genders. Samanagaya (2007) reports 62% amongst a specific population of black and ethnic minority 16-28 young men.

E.

Survey data indicate gender differences in knowledge of contraception and where to access contraceptives. Girls scored higher on sexual health knowledge (Wight et al. 2000) were more likely to know where to get advice or contraceptives (Van den Akker, 1995, French et al. 2007, Stevenson, 1998), and had greater knowledge of how to use contraceptives (Van den Akker, 1995).

Evidence statement 2. The obstacle of embarrassment

A.

One qualitative study reports that discussion of sex and contraception is embarrassing. In a study of mixed 16-25 year old young city dwellers (Free et al. 2005++) it is reported that the younger participants reported that discussing sex or any type of contraception was embarrassing.

B.

The potential for feelings of embarrassment to inhibit young people from using contraception services is outline in seven papers accessing views from a variety of groups of young people. Clients of family planning clinics (Ziebland et al. 2005++) describe embarrassment or stigma associated with accessing contraceptive supplies. Young people from ethnic minorities (French et al. 2005-) also describe embarrassment if they are seen accessing a service. 66% of clients of a male drop in service (Samangaya, 2007 survey) reported that embarrassment would stop them using a service. Young people of school age (Lester & Allen, 2006+, Salmon & Ingram, 2008+) echo this embarrassment being linked with accessing services. Stone & Ingham (2003, survey) report 20-24% of 11-39 year old women had been embarrassed or scared or concerned in regard to using a sexual health service. Free et al. 2002+ describe women of 16-25 years old feeling embarrassed using contraceptive services. Mixed groups of young people (Sixsmith et al. 2006+) described embarrassment as being a barrier to accessing condoms. This importance of clinics needing to overcome young people's feelings of embarrassment was also recognised by staff (Fairhurst et al. 2004+ GPs and practice nurses, Hayter et al. 2005a+ nurses).

C.

Two papers report embarrassment related specifically to particular services. Schubotz et al. (2003+) report that young people aged 14-25 years perceive that at times teachers are clearly embarrassed when discussing sexual issues leading to the young people also feeling embarrassed. Donavon et al. (1997 survey) reports 63% of females and 46% of males aged 1516 years reported embarrassment in relation to attending a consultation with a GP in regard to sexual health.

D.

One study describes a particular aspect of accessing a service that is embarrassing. Baraitser (2003+) reports that young people aged from under 16-24 feel embarrassed when giving their name and address at a reception desk.

Evidence statement 3. Perceptions of risk

Two qualitative studies describe the importance of addressing young people's perceptions of risk in use or non use of contraception. One study (Free et al. 2005++) interviewed a mixed group of 16-25 year old women in London and reported that risky sexual behaviour was part of an overall attitude to taking risks. Hoggart (2006++) describes a risky and seemingly random use of contraception amongst young mothers in inner London. An additional study (Coleman & Cater 2005++ 14-17 year olds) highlights that alcohol can impact on a young person's perceptions leading to increased risky sexual behaviour.

Evidence statement 4. Variation in individual situations

A.

The importance of understanding young women's individual situations and changing use of contraception over time is highlighted by one study of 16-25 year old young women resident in London (Free et al., 2002+). The young people in this study described how factors particular to a young person such as their personal situation, their experiences, their access and use of information all impacted on their contraceptive use. The women reported that as these factors changed over time, so there was change in their contraceptive use.

B.

Three studies suggest the importance of a link between contraception use and the nature of a young person's relationship. Mixed groups of young people describe greater risks being taken in relationships with strong emotional attachment or long-term trusting relationships (Jewell et al. 2000++ 16-22 year old young women , Curtis et al. 2005- 15-18 year old black and ethnic minority young people). Another study describes the avoidance of conflict or need to give greater pleasure as reasons for non use of condoms outlined by a mixed group of 16-25 year old women (Free et al. 2005++).

Evidence statement 5. Attitudes to pregnancy and motherhood

Seven studies report varying attitudes to becoming pregnant amongst young people (Hoggart 2006++ 14-16 year olds, Cheung and Free 2005++ 16-25 year olds, Free et al. 2005 ++ 16-25 year olds, Jewell et al. 2000++ 16-22 year olds, Curtis et al. 2005- 15-18 year olds) also young parents from ethnic minorities (Higginbottom et al.,2006 ++, Higginbottom et al., 2008-). The papers link these differing attitudes to differing usage of contraception, with those placing a higher value on avoiding pregnancy being more regular with their contraception use or using multiple methods. Young mothers in one paper (Hoggart 2006++) seemed to have ambivalent attitudes, reporting that they had not intended to become pregnant but had been careless with contraception.

Two studies suggest differences between young people from advantaged and less advantaged backgrounds in regard to perceptions of teenage pregnancy. Jewell et al. (2000++) report that early pregnancy and young motherhood seemed generally more acceptable to 16-22 year old women from disadvantaged backgrounds. Aria (2003+) compared views of women who had their first child before the age of 20 in more and less advantaged areas and suggested that positive views of early childbearing occur amongst young mothers from both backgrounds, but for different underlying reasons (an alternative vocation or a way to be loved).

Evidence statement 6. Contraceptive use and positive values

Three studies describe an association between using contraception and positive values amongst young people. Free et al. (2005++) describe the use of contraception as being part of a positive image of female sexuality amongst 16-25 year old young women including some who were pregnant and young mothers. Curtis et al. (2005-) reports 15-18 year old women perceiving that obtaining and using contraception was responsible behaviour. In addition, Hayter (2005a-) examines young women's (over 16 years old) use of terminology relating to pregnancy and contraception, and describes contraception being viewed positively as a form of protection.

Evidence statement 7. Views of condoms

Three studies suggest that condoms can be perceived negatively as uncomfortable or a barrier to intimacy amongst some teenagers. Lester and Allan (2006+) and Free et al. (2005++) report these negative views amongst some 14-15 year old teenagers, and teenagers including those who were young mothers or pregnant. Ogden and Harden (1995) similarly report a mix of positive and negative perceptions of condom use amongst 12-13 year olds and 16-17 year olds. Four studies suggest that young women carrying condoms can be perceived as having negative connotations by some young people in studies of teenagers (Curtis et al.,2005- 15-18 year olds, Ogden and Harden, 1995- 12/13 and 16/17 year olds, Free et al.,2005++ 16-25 year olds, Salmon & Ingram, 2008+ school aged).

Evidence statement 8. Views of hormonal contraception

A.

Two studies describe positive views that hormonal contraception is more reliable and less expensive (Morrison et al. (1997- young people mean age 17), and that it offers more control Cheung and Free (2005++ 16-25 year olds).

B.

Three studies describe negative perceptions, with concerns voice regarding potential harm from artificial and unnatural hormones (Free et al. (2005++ 16-25 year olds) Ziebland et al. (1998+ women clinic attenders mean age 21),Curtis et al. (2005- 15-18 year olds).

Evidence statement 9. Views of emergency hormonal contraception

A.

Six studies report views regarding the use of EHC amongst young women. Four studies describe negative views including guilt, shame, the perception of being linked to negative behaviour and concerns that EHC was unsafe or produced side effects (Ziebland and Maxwell 1998+ women mean age 21, Barrett and Harper 2000+ age mid 20s-50s, Folkes et al., 2001+ age 18-29, Free et al., 2002+ women aged 16-25). Two studies report variation in views among women. One (Bell and Millward, 1999+) reports that older women viewed EHC as a necessary inconvenience whereas young women viewed it with apprehension. Ziebland et al. (1996-) describes variation in views amongst women (no age range).

B.

Eight papers report service provider perceptions that easy access to EHC has a negative impact on sexual behaviour or describe negative perceptions amongst service providers of young people requesting and especially repeat requesting EHC (Bissell and Anderson 2003++ pharmacists, Barrett and Harper 2000+ pharmacists, Bissell et al. 2006+ pharmacists, Ziebland 1998+ GPs, Ziebland and Maxwell 1998+ GPs, Fallon 2003+ A&E nurses, Fairhurst 2004+ primary care nurses.

Evidence statement 10. Age and gender differences in discussion of contraception

A.

Three studies describe gender differences, with girls appearing to talk more frequently and more seriously about sex and sexual health than boys (Lester and Allen 2006+ aged 14-15, Pearson 2003+ young men aged 13-21). This may be linked to the Van Teijlingen et al. (2007+ 12/13 and 16-17 year olds) study suggesting that boys may have higher levels of embarrassment, and also the Morrison (1997- young people mean age 17) study which reported that contraception tended to be viewed as a female responsibility.

B.

Three studies describe age-related differences with younger participants being more embarrassed and more light-hearted and humorous when discussing sex or any type of contraception (Teijlingen et al. 2007+ 12/13 and 16-17 year olds, Free et al. 2005++ 16-25 year olds, Ogden and Harden 1995- 12/13 and 16/17 year olds).

Evidence statement 11. Knowledge of local services

Three studies describe uncertainty amongst young people in regard to where to go to access contraceptives, especially amongst young men and younger participants (French et al. 2005++ 16-25 year olds, Sixsmith et al. 2006+ 14-19 year olds, Donnelly 2000+ 15-25 year olds).

Evidence statement 12. Perception of trust in services

Five papers describe the importance of young people perceiving that contraceptive services are trustworthy and legitimate, enabling them to feel confident, and being in control when using them (Ingram and Salmon 2007++ 14-18 year olds, Selwyn and Powell 2006+ 12-19 year olds, Craig and Stanley 2006 – 12-18 year olds, Croghan 2006–16-21 year olds,
Powell 2008+ 12-19 year olds).

Evidence statement 13. Perception of clinics

Five papers suggest that young people can perceive that family planning and sexual health clinics are where girls go or are only for married or older women (Sixsmith et al. 2006+ 14-19 year olds, Lester and Allan 2006+ 14-16 year olds, Pearson 2003+ 13-21 year olds, Donnelly 2000+ 15-25 year olds, Morrison et al. 1997- mean age 17).

Evidence statement 14. Concerns regarding GP-based services

Five studies report that some young people have concerns in regard to attending a GP practice for contraceptive services. This seems a particular concern in rural communities and in regard to potential loss of confidentiality (French et al. 2005++ 16-25 year olds, Griffiths et al. 2008+ 16-21 year olds, Pearson 2003+ 13-21 year olds, Bell and Millward 1999+ 18-34 years, Salmon & Ingram, 2008+ school aged).

Evidence statement 15. Accessibility of services

Eleven studies suggest the importance of accessibility of services for young people, with convenient location, extended opening hours, and choice in location as important elements (Bissell and Anderson, 2003++ pharmacists, Higginbottom et al. 2006++ young mothers, Ingram and Salmon 2007++14-18 year olds, French et al. 2005++ 16-25 year olds, Folkes et al. 2001+ 18-29 year olds, Griffiths 2008++ 16-20 year old ethnic minority young people, Free et al. 2002+ 16-25 year olds, Baraitser et al. 2003+ under 16-25 year olds, Sixsmith et al. 2006+ 14-19 year olds, Craig and Stanley 2006 –12-18 year olds, Ingram & Salmon 2008+ school-aged).

Evidence statement 16. Appointment systems

Studies report varying views in regard to whether an appointment system or a drop-in service provides greater accessibility for young people. Bissell and Anderson, 2003++ and Bissell et al., 2006+ (pharmacists) suggest an appointment-free system offers convenience. Ingram and Salmon 2007++ (14-18 year olds), also suggest a drop-in service is more convenient and Bloxham (1997- community service staff) echoes this reporting that a no-appointment system is preferable in a sexual health clinic. Baraister et al. (2003)+ however report that staff perceive that waiting times in a clinic are not an obstacle to accessibility. One survey of young people (Nwokolo et al. 2009 11-18 year olds) reported that 62% would prefer a walk-in service. Another survey (Ross et al. 2007 age 16-24) suggested that the ability to make appointments via telephone was an option that may be appreciated by young people.

Evidence statement 17. The importance of anonymity

Eight studies report that preserving anonymity when accessing services is a significant concern for young people (French et al. 2005++ 16-25 year olds, Sixsmith et al. 2006+ 14-19 year olds, Lester and Allan 2006+ 14-15 year olds, Griffiths 2008+ aged 16-20+, Pearson 2003+ young men aged 13-21, Donnelly 2000+ 15-25 year olds, Powell 2008+ 12-19 year olds, Craig and Stanley 2006– 12-18 year olds). These concerns regarding anonymity are also perceived by staff (Ziebland et al. 1998+ GPs, Pitts et al. 1996+ GPs and practice nurses, Bissell et al. 2006+ pharmacists, Bissell and Anderson 2003++ pharmacists, Mackie et al. 2002 – health board members and pharmacists).

Evidence statement 18. The importance of confidentiality

Eleven papers report that confidentiality Is a key concern to young people in accessing a sexual health service. Concerns regarding confidentiality feature particularly in regard to rural areas and GP practices (Ingram and Salmon 2007++ 14-18 years, French et al. 2005++ 18-25 years, Coleman and Testa 2008++ Black and minority ethnic youth 16-23 years, Donnelly 2000+ 15-25 year olds, Hayter et al. 2005b+ 13-18 years, Griffiths et al. 2008+ 16-20 year olds, Pearson 2003+ young men 13-21, Stanley 2005+ 12-17 year olds, Craig and Stanley 2006 -12-18 year olds, Croghan 2006 –16-21 year olds, Salmon & Ingram, 2008+ school aged).

Evidence statement 19. 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 (Ingram and Salmon 2007++ age 14-18 years, French et al. 2005++ age 18-25, Higginbottom et al. 2006++ young mothers, Free et al. 2005++ 16-25 year old women, Ingram and Salmon 2007++ 14-18 year olds, Folkes et al. 2001+ age 18-29, Pearson 2003+ young men 13-21, Donnelly 2000+ 15-25 year olds, Hayter 2005a+ women over 16 years, Baraitser et al. 2003+ under 16-25 years, Free et al. 2002+ 16-25, Sixsmith et al. 2006+ 14-19 years, Lester and Allan 2006+ 14-15 years, Craig and Stanley 2006 –12-18 year olds, Salmon & Ingram, 2008+).

Five papers report that staff also recognise the importance of being non-judgemental, however they highlight that some individual staff may have ambivalent or varying attitudes towards young people and sexuality (Fallon 2003+ A&E nurses, Pitts et al. 1996+ GPs and practice nurses, Baraitser et al. 2003+ clinic staff, Bloxham 1997- community service staff, Chambers et al. 2002 survey health professionals).

Evidence statement 20. Concerns regarding cost

Three studies report that the cost of contraception is a concern for some young people (Bissell and Anderson 2003++ pharmacists, Folkes et al. 2001+ 18-29 year olds, Sixsmith et al. 2006+ 14-19 year olds).

Evidence statement 21. Feelings of anxiety

Two studies specifically highlight the anxiety felt by young people when accessing sexual health services (Baraitser et al. 2003+ under 16-25 years, Lester and Allan 2006+ 14-15 year olds). Anxiety also relates to the evidence concerning confidentiality and embarrassment.

Evidence statement 22. Clinic atmosphere

Four studies provide evidence from young people regarding the importance of a comfortable, and welcoming atmosphere in sexual health service premises (Ingram and Salmon 2007++ 14-18 year olds, Baraitser et al. 2003+ under 16-25 years, Salmon & Ingram, 2008+, Pearson 2003+ 13-21 year old men. This is echoed in a study of staff views (Bloxham 1997- community staff).

Evidence statement 23. Aspects of the consultation

Five studies describe young people's views regarding aspects of the consultation that are important such as brevity, trust and a good relationship (French et al. 2005++ 13-21 year olds, Free et al. 2005++ 16-25 year olds, Lester and Allan 2006+ 14-15 year olds, Pearson 2003+ 13-21 year old men, Schubotz et al. 2004+ no details of participants). Three studies echo these findings, indicating that staff also view the building of a good relationship as important (Fallon 2003+ A&E nurses, Pitts et al. 1996+ GPs and practice nurses, Bloxham 1997- community staff).

Evidence statement 24. Sources of information

A.

Seven studies suggest the importance of friends of young people acting as a source of information and advice regarding contraception. Jewell et al. 2000++ 16-22 year olds, Baraitser et al. 2003+ under 16-25 year olds, Lester and Allan 2006+ 14-15 year olds, Bell and Millward 1999+ 18-34 year olds, Ziebland and Maxwell 1998+ women attending for EHC, Powell 2008+ 12-19 year olds, Free et al. 2002+ 16-25 year olds). One survey suggests that use of friendship networks may be more important for 11-19 year old girls (Van den Akker et al. 1999).

B.

Five papers indicate variation amongst young people regarding their use of parents for information and advice. Studies suggest that this variation may be dependent on the parent-child relationship (Lester and Allan 2006+ 14-15 year olds, Van Teiglingen 2007+ 12-13 and 16-17 year olds, Curtis et al. 2005- 15-18 year olds, Stone and Ingham 2002 survey 16-18 year olds, Campbell and Macdonald 1996 survey 13-15 year olds).

Evidence statement 25.

Availability of resources

There is evidence from five studies that staff have concerns regarding limited availability of resources for sexual health services (Hoggart 2006++ range of professionals from different services, French et al. 2006- key informants, Fallon 2003+ A&E nurses, McCann et al. 2008 – no details of participants, Jolley 2000- nurses.

Evidence statement 26. Agencies working together

There is evidence from six studies that staff perceive the importance of well-organised services, and different agencies working together effectively (Hoggart 2006 ++ professionals from different agencies, French et al. 2005++ stakeholders/professionals, Higginbottom et al. 2006++ service providers, Jolley 2001– nurses, Chamber et al. 2002 survey, health professionals, Salmon & Ingram 2008+ service providers of a school outreach service).

Evidence statement 27. Staff training

There is evidence from six studies that staff perceive a need for greater training in regard to providing contraceptive services for young people (Seston et al. 2001+ pharmacists, Barrett and Harper 2000+ pharmacists, McCann et al. 2008- nurses, Jolley 2001- nurses, Bloxham 1997- community health service staff, French et al. 2006- stakeholders/professionals).

1. INTRODUCTION

1.1. Aims and objectives

This views review forms part of the main review that has been undertaken to support the development of NICE programme guidance on the NHS provision of contraceptive services for socially disadvantaged young people (SDYP) (up to the age of 25). For the purposes of this guidance, “NHS provision” has been interpreted as including both direct provision and indirect provision (via funding in whole or in part). The main review will provide a systematic evaluation of the published literature on 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).

The views review supports the main review by providing a systematic synthesis of the published literature on the views of young people, (especially socially disadvantaged young people, and also service providers), regarding the use of contraceptives and contraceptive services. It does not encompass views of interventions that are part of a school curriculum, as these will be covered by the NICE public health programme guidance on school, college and community-based personal, social and health education [PSHE] that is currently in progress.

The review was preceded by a mapping review to describe the available literature on the full range of interventions that aim to encourage young people, especially socially disadvantaged young people, to use contraceptives and contraceptive services. The mapping review also included work reporting the views of service users and providers, together with an examination of current policy to identify themes within government policy documents, available internet resources, and documents from relevant agencies (see Appendix 6).

Analysis of the views and perceptions of service users and service providers is intended to provide additional depth and context to the intervention reviews, enabling the widest sources of evidence to be examined to underpin NICE

programme guidance. Also, the qualitative aspects of a programme or intervention impact on its success, and qualitative data may provide the most appropriate answers to questions of acceptability, and delivery of services (NICE, 2006).

1.2 Research question

The primary research question for this review is:

- What are socially disadvantaged young people and their families' perceptions, views and beliefs about contraception and contraceptive services, and, what are the views of relevant service providers?

Subsidiary research questions are:

- What is the short term and longer term success of contraceptive services for socially deprived young people?
- What internal factors may have influenced the effectiveness of contraceptive services (e.g. content delivery, setting intensity)?
- What external factors may have influenced the effectiveness of contraceptive services (e.g. setting of targets, adequacy of guidance and support to service providers?)
- How does the effectiveness of contraceptive service interventions vary with factors such as age, teenage parenthood, drug use, school college attendance etc?
- How does the effectiveness of the contraceptive service interventions vary with factors such as ethnicity?
- How effective have contraceptive services been in reaching socially disadvantaged young people?
- What are the facilitators and what are the barriers to implementing effective contraceptive services and interventions?

2. BACKGROUND

2.1 Definitions and terminology

Fraser guidelines:

It is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lords' ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security. These are 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.

2.2 English government policy on contraceptive service provision

This guidance will specifically support the national service framework on children, young people and maternity services (Department of Health 2004) and will complement NICE guidance on preventing sexually transmitted infections and under 18 conceptions, looked after children and long-acting reversible contraception.

2.3 The need for guidance

The rate of teenage pregnancy in England and Wales remains the highest in Western Europe (Population Action International 2007) despite the decline in rates of both under 18 and under 16 conceptions over the last 20 years (Office for National Statistics 2007). The current targets to halve the under 18 conception rate by 2010 would require a considerable acceleration in progress in order to be met (Department for Education and Skills 2006).

In addition, there is significant variation in local area performance. In 2006,the under 18 conception rate in England was 40.4 conceptions per 1000 young women (Department for Children, Families and Schools 2008); but almost half of these conceptions (49%) occurred in the most deprived 20% of local authority wards (Department for Children, Families and Schools 2007). Virtually every local authority includes hotspots where annual conception rates are greater than 60 per 1000 women aged 15-17 (Department for Education and Skills 2006) and approximately 20% of births conceived under the age of 18 are to women who are already teenage mothers (Department for Children, Schools and Families 2008).

Teenage pregnancies have a high cost implication for public funding. They place significant pressures on local authority social care, housing and education services. In 2006/7 local authorities spent £23 million on support services for teenage parents (Department for Children Schools and Families 2008). The cost to the NHS of induced abortions for women younger than 25 was £48,680,949 in 2006.

Access to contraceptive services is most problematic for people in disadvantaged communities. There is a six-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent. Under 18 conceptions can lead to socioeconomic deprivation, mental health difficulties and lower levels of education. In addition, resulting children are at greater risk of low education attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injury (Department for Children, Schools and Families 2008).

3. METHODS

3.1 Search methods

A full systematic search of key health and medical databases was undertaken for the mapping review of literature that preceded the main review. The search strategy was developed by the ScHARR information specialist and was agreed with the NICE information specialist. Full details of the search strategy (search terms and databases used) can be found in Appendix 4.

The search strategy included terms relating to young people, contraceptive services, family planning and pregnancy prevention. The only restrictions that were applied to this search were in terms of date (limited to 1995-2008 to pre-date the Teenage Pregnancy Strategy) and limiting the search to humans (to avoid animal studies relating to contraception). No restrictions were placed in terms of study type, language or place of publication.

The search results were downloaded into Reference Manager for sifting by the systematic reviewer. Following the sifting of database entries, articles for potential inclusion were obtained for further examination.

In addition to searching via electronic databases, additional methods to identify evidence were also undertaken as follows:

- The reference list of included papers was examined and papers not already identified were added to the database for consideration
- Cited reference searches were undertaken on all the included studies in Google Scholar and Web of Science Cited Reference Search. No date, study type or language restrictions were placed on this search
- Additional references were suggested by an expert group.

3.2 Inclusion and exclusion criteria

All the retrieved literature was screened at title and abstract level for relevance, and those that had potential for inclusion were taken through to full paper appraisal. The application of pre-specified inclusion / exclusion criteria was undertaken as per the established methods (NICE, 2006).

The review excludes views solely of curriculum-based interventions delivered by classroom teachers or health professionals (as these will be the subject of separate NICE guidance on PSHE, which focuses on sex and relationships education). However, where views regarding the curriculum are reported alongside contraceptive services or general views of contraception, the study has been included but the curriculum aspects have not been incorporated in the data extraction.

Studies were excluded when they were conducted with people aged 25 and older. Papers which contain data for both under 25s and over 25s were included if at least 50% of participants were aged 25 or younger. There was no cut-off limit for the youngest age of inclusion.

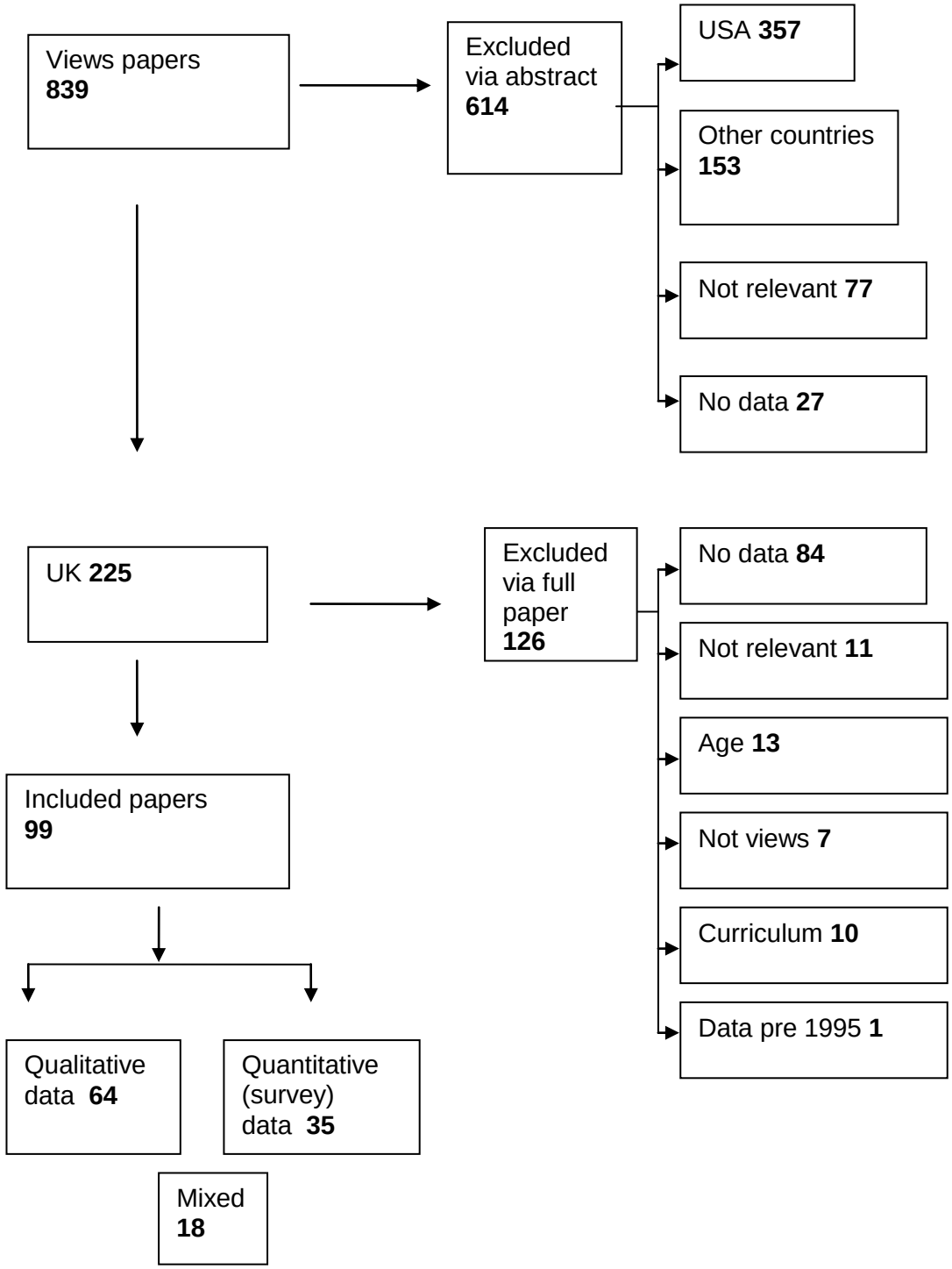
As a key strength of qualitative research is the consideration and understanding of context in findings, only studies carried out in the United Kingdom were included. In addition to considerations of contextual relevance, this decision was taken in light of the mapping review, which indicated that including UK only work would provide sufficient numbers of papers for a detailed synthesis.

Several activities and interventions will not be covered by this (or any subsequent) review in this programme. These are:

- sexual health services that do not provide contraceptive services
- sterilisation, including vasectomy
- abortion (services which do not also provide contraception)
- use of contraceptive methods for non-contraceptive reasons, for example, for menorrhagia (heavy periods).

Figure 1 provides an illustration of the process of inclusion and exclusion of papers, indicating how the 839 papers identified in the searches were reduced to the 99 papers that have been included in the views review.

Figure 1. Flow chart illustrating the inclusion and exclusion process



3.3 Data extraction strategy

Data relating to the research question, funding source, theoretical approach and data collection, data analysis, population, key themes, study limitations and any reported gaps in evidence described were extracted by one reviewer using the NICE (2006) extraction form. Extractions were independently checked for accuracy by a second reviewer. Disagreements were resolved by consensus and consulting a third reviewer where necessary. The data extraction tables are presented in Appendix 1.

3.4 Quality assessment criteria for included studies

There is no established hierarchy for evidence derived from sources such as qualitative research and surveys, with the strength of evidence depending on quality, quantity and relevance to the UK population and settings (NICE, 2006). The qualitative papers were therefore assessed taking note of the methodology checklist set out by NICE in the CPHE Methods Manual, rather than by a study design hierarchy. Currently there is no checklist for cross-sectional studies; therefore quality indicators for survey papers included in this review were sample size, return rates, whether the questionnaire was piloted, appropriateness of study conclusions and relevance.

The qualitative studies were placed in one of three grades as follows based on the methodology checklist:

Table 1. Criteria used for study grading

Code	Quality criteria
++	All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions of the study or review are thought very unlikely to alter
+	Some of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are through unlikely to affect conclusions
-	Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter

3.5 Summary of study identification

All search results were downloaded to Reference Manager. Items in the data base were sifted, with exclusion at this stage where it was possible to identify from the abstract that the work had been carried out in non-UK countries, or was not relevant to the review question, or reported general discussion or opinion rather than study data. Potentially relevant papers were taken through to the next stage of obtaining and examining full papers. From these initial searches a list of key authors was devised to facilitate further searching. Citation searching of key papers as well as scrutinising reference lists was also carried out in further searching iterations. 161 papers were identified through the primary database search, 29 via the secondary citation searching, and 34 additional papers were identified through scrutinising reference lists (Table 2). One additional included paper was suggested by an expert reference group. 126 of these obtained papers were subsequently found to be outside the scope of the review. A list of these papers excluded at this stage and the reasons for their exclusion is given in Appendix 3.

Table 2. Summary of study identification.

Source	Number of hits	Potential papers identified
Mapping review searches	634	161
Citation/key author searches of included papers	169	29
Reference list of included papers	42	34
Suggested by expert reference group		1

4. RESULTS OF THE VIEWS REVIEW

4.1. Quantity of the evidence available

The searches identified 99 papers that met the inclusion criteria. Of these 64 reported qualitative data and 35 reported quantitative data from surveys, 18 papers reported data from mixed method studies. The papers focused on service user views of services provided, service provider views of services, papers reporting general views and perceptions of contraceptive methods,

and papers exploring views and perceptions of pregnancy and young motherhood.

As Table 3 indicates there were several studies that reported different sections of data in different papers, with for example data from service users reported in one paper and from service providers in a separate paper, or alternatively focus group data in one and data from interviews in another. Some authors also reported different themes derived from data collected in a single study in different papers. In assessing the quantity of the available evidence this multiple reporting of findings from a single study needs to be considered. However, multiple reporting of qualitative studies is a common method of research dissemination due to the richness and detail of much qualitative data. Examination of the content of these multiple papers suggests that they should be recognised as contributing separate data to the review, with only one of the papers reporting such similar data to a second paper as to be considered a duplicate (Ziebland, 1999). Table 3 indicates where data relates to findings from a single study.

Table 3. Multiple papers from a single study

Paper	Comment
Bissell and Anderson (2003)	Same study as Bissell et al. (2006), different data
Donnelly (2000)	Same study as McCann et al. (2008), different data
Fairhurst et al. (2005)	Same study as Fairhurst et al. (2004), different data
Free et al. (2005)	Same study as Cheung and Free (2005) and Free et al. (2005), different data
Griffiths et al. (2008)	Same study as French et al. (2006), different data
Higginbottom et al. (2008)	Same study as Higginbottom et al. (2006), different data
Powell (2008)	Same study as Selwyn and Powell, different data
Schubotz et al. (2004)	Same study as Schubotz et al. (2003) and Rolston et al. (2004), different data
Stanley (2005)	Same study as Craig and Stanley (2006),

Ziebland (1999)	different data Same study data as Ziebland et al (1998) and Ziebland and Maxwell (1998)

In terms of study methodology, the greatest number of papers reported a single method of data collection, with individual interviews the most frequently reported, followed by focus groups. Sixteen papers reported more than one qualitative method, however as previously outlined; some authors reported data from a single study in different papers according to the method used.

Table 4. Included qualitative papers by data collection method

Interview	37
Focus groups	9
Non-participant observation	1
Interviews and non-participant observation	1
Interviews and focus groups	15
Free text	1

See Appendix 5 for papers listed by study design.

4.2 Populations and settings

The criteria for inclusion required papers to report data from a UK population. The included papers provide evidence from a fair geographical spread within the UK (see Table 5). As the table indicates, 5 papers reported findings from studies in Northern Ireland. The other studies encompass evidence from major cities, urban areas, rural areas and all 3 countries of Great Britain. It was not possible to identify specific population in some studies where detail was not provided concerning geographical location, perhaps due to ethical considerations where participant numbers were smaller or where services and staff delivering them may be identifiable. Particular potential issues regarding geography were noted by some authors in regard to study population selection, with purposeful selection of rural populations and young people in seaside areas in particular in some studies.

Five papers were primarily concerned with exploring issues relating to black and minority ethnic young people. Only three papers included families of a

young parent in data collection. Papers varied in terms of level of detail regarding demographics of individuals such as ethnicity, age, and socio-demographic factors. A number of papers reported the participants to be of "mixed" backgrounds, or reported particular features of the town or city rather than the individual participants. Due to anonymity of the source of data it is challenging to identify particular groups such as socially deprived young people within study findings from these mixed groups. A study by Jewell et al. (2000) however offers particularly relevant findings to this review, by contrasting findings from "advantaged" and "disadvantaged" groups within the mixed study population. The Salmon and Ingram (2008) study is also reported to have been carried out in schools within areas of high social deprivation.

The studies that recruited participants from family planning clinics or GP surgeries tend to have the widest age range, although only papers reporting data from more than 50% of participants under the age of 25 have been included. Studies reporting data collected via school recruitment have the narrowest age range and tend to reflect a younger age group. These papers were only included where the data or aspects of the data described views of services provided outside the school curriculum.

Papers reporting data from staff participants responsible for service delivery encompassed a range of community and primary care health service staff. Five papers in particular examined views of pharmacists regarding the introduction of over-the-counter emergency hormonal contraception. The earlier published papers here may now have limited value in reporting current perceptions, due to changes in service delivery in pharmacy and accident and emergency in the intervening years since publication.

Table 5a. Included qualitative papers by participant population

Staff participants	Details as available in the paper
Allen (2004)	Nurses in one urban/one rural locality
Arai (2003)	TPU co-ordinators
Bloxham (1997)	Community health service staff
Fairhurst et al. (2004)	Primary care nurses
Fairhurst et al. (2005)	GPs and Practice nurses
Fallon (2003)	A&E nurses

French et al. (2005)	Professional/community reps London/Manchester/Birmingham
French et al. (2005)	Stakeholders/professionals
Hayter (2005a)	Nurses
Higginbottom et al. (2008)	Service providers
Hoggart (2006)	Professionals
Mackie et al. (2002)	Representatives of a health board and a pharmaceutical retailer
Mason (2005)	Nurses and Brook Counsellors NW England
Pitts et al. (1996)	GPs and practice nurses, school nurses
Salmon & Ingram (2008)	Service managers, nurses and youth workers
Jolley (2001)	Nurses
Ziebland (1999)	GPs
Ziebland et al. (1998)	GPs
Barrett and Harper (2000)	Community Pharmacists London
Bissell et al. (2006)	Community Pharmacists London, Manchester
Bissell and Anderson (2003)	Community Pharmacists N West England
Cooper et al. (2008)	Community Pharmacists N England
Seston et al. (2001)	Pharmacists
Sexual health service user participants	**Details**
Arai (2003)	London/Northumberland/Manchester
Bell and Millward	GP patients South West England
Fairhurst et al. (2004)	GP patients Scotland
Folkes et al. (2001)	Clients of FPC/Brook clinic SW England
Hayter (2005b)	Clients of sexual health clinic Doncaster (described as an economically deprived area)
Ingram and Salmon (2007)	Clients of clinics mixed areas, half areas of social deprivation
Ziebland (1999)	Clients of FP clinic London/Oxford
Ziebland and Maxwell (1998)	Clients of FP clinic London/Oxford
Ziebland et al. (1996)	Clients of FP clinic London/Oxford
Ziebland et al. (2005)	Women who had received pack of EHC Scotland
Bissell and Anderson (2003)	Women seeking emergency contraception
General young people participants	**Details**
Baraitser (2003)	Mixed population
Brown et al. (2007)	White North of England
Cheung and Free (2004)	White London
Coleman (2001)	Mixed Southampton
Coleman and Cater (2005)	Vast majority White urban SE England
Croghan (2006)	Mixed
Curtis et al.	Mixed groups including challenging groups
Pearson (2003)	Young men mixed locations
Free et al. (2005)	Mixed London including pregnant young people, young mothers, deprived inner city, homeless.
Free et al. (2002)	Mixed women, London
French (2002)	Mixed young people
Harden and Willig (1998)	White middle class
Hoggart (2006)	Mixed London + young mothers
Jewell et al. (2000)	Advantaged and disadvantaged areas of Bristol including young mothers/pregnant young women
Mackereth and Forder (1996)	Gateshead mixed with some high deprivation
Morrison et al. (1997)	Mixed Glasgow
Powell (2008)	Mixed Manchester
Sixsmith et al. (2006)	Mixed North Derbyshire
Particular groups of young people	**Details**
Coleman and Testa (2008)	Black/Minority Ethnic London
Craig and Stanley (2006)	Young people, transient people, seaside towns with high TP rates
French et al. (2005)	Ethnic minority groups London/Manchester/Birmingham
Griffiths et al. (2008)	Mixed including minority ethnic individuals, various sexuality, areas of higher than average deprivation scores across England

Higginbottom et al. (2006)	Young mothers, young fathers, ethnic minority individuals Bradford, Sheffield, London
Higginbottom et al. (2008)	Young mothers, young fathers, ethnic minority individuals, 3 cities.
Stanley (2005)	Schools + mixed seaside resorts
Garside et al. (2002)	Teenagers in rural locations
Smith (2001)]	"working class" Cardiff
Selwyn and Powell (2006)	Mixed school students and other young people Cardiff, described as most deprived districts in the city
Participants outside GB	**Details**
Donnelly (2000)	Mixed young people N Ireland
Rolston et al.	Mixed young people N Ireland
Schubotz et al. (2003)	Mixed young people N Ireland
Schubotz et al. (2004)	Mixed young people N Ireland
MCCann et al. (2008)	Key informants/practice and school nurses N. Ireland
Family members	**Details**
French et al. (2005)	Parents of teenage mothers
Higginbottom et al. (2006)	Grandmothers of young mothers
Higginbottom et al. (2008)	Mothers of teenage mothers
School-age only participants	**Details**
Jones et al. (1997)	School students
Lester and Allan (2006)	School students
Salmon & Ingram (2008)	Users and non users of a in-school outreach service within 16 schools in Bristol in areas of high social deprivation
Odgen and Harden (1995)	School students
Van Teijlingen et al. (2007)	School students Aberdeen and Edinburgh

Table 5b. Included survey papers by participant population

Young people, community	
French et al. (2007)	Young people, home (doorstep). UK
Van den Akker et al. (1999)	City centre, library, youth clubs. UK
Young people, schools	
Thomas et al. (2006)	Comprehensive schools. Sheffield
Nwokolo	Secondary schools and PRU. Central London
Stone and Ingham (2002)	School/college students. England/Wales
Burack (2000)	Secondary schools. London
Hooke et al. (2000)	Schools. Ayrshire
Thomson et al. (1999)	Secondary schools. Scotland
Bradby and Williams (2009)	Secondary schools. Glasgow
Donovan et al. (1997)	Schools. England (outside major conurbations)
Graham et al. (1996)	Secondary schools. SE Scotland
Reeves et al. (2006)	Secondary schools. N Wales
Wight et al (2000)	Schools. UK
Coleman and Testa (2007)	High schools. London
Hagley et al. (2002)	Schools. Cambridge
Parkes et al. (2004)	Schools. Scotland
Salihi et al. (2002)	Schools. Ayrshire
Burrack (1999)	Secondary schools. London
Harden and Ogden (1999)	Educational institutions. London
Stevenson (1996)	Schools. NE England
Campbell and Macdonald (1996)	Schools. Fife
Young people, higher/further education	
Fayers et al.	Medical students. Bristol
Clinic users	
Stone and Ingham (2003)	Youth targeted sexual health services. UK
Woodward (1995)	Hospital anti-natal clinic and community based FPC. Cambridge
Samangaya (2007)	Male drop in service. Bradford
Pearson et al. (1995)	Antenatal/NHS termination attendees. Devon

Mixed young people	
Ross et al. (2007) Chamber et al. (2002)	Young people community/GU clinic. London Young people N. Staffs
Health professionals	
Wellings et al. (2007) Glasier and Wellings (2007) Garside et al. (2000) Stokes and Mears (2000) Gbolade et al (1999) Sengupta (1998) Chamber et al. (2002)	GPs/ nurse practitioners. UK Primary care doctors and nurses. UK GPs. Devon. Practice nurses. Leicestershire A&E departments. UK GPs. Scotland Health professionals. N. Staffs

4.3 Quality of the evidence available

The NICE methods manual outlines 14 key questions to be considered when rating a qualitative study:

1. Is a qualitative approach appropriate?
2. Is the study clear in what is seeks to do?
3. How defensible is the research design?
4. How well was the data collection carried out?
5. Is the role of the researcher clearly described?
6. Is the context clearly described?
7. Were the methods reliable?
8. Is the data analysis sufficiently rigorous?
9. Are the data rich?
10. Is the analysis reliable?
11. Are the findings credible?
12. Are the findings relevant?
13. Are the conclusions adequate?
14. How clear and coherent is the reporting of ethics?

Each of these aspects is then considered and a judgement made as to whether the criteria have been fulfilled and the checklist item can be considered to be appropriate/clear/reliable/rigorous or otherwise the criteria has not been fulfilled and the item is inappropriate/unclear/unreliable/not rigorous/poor.

Of the 63 qualitative papers, 12 were rated as ++, 32 rated as +, and 19 papers were rated as – for quality (see Table 6 and Table 7).

Table 6. Included qualitative papers by quality criteria grade

Paper	Grade
Bissell and Anderson (2003) Cheung and Free (2005) Coleman and Cater (2005) Coleman (2001) Free et al. (2005) French (2002) French et al. (2005) Higginbottom et al. (2006) Hoggart (2006) Ingram and Salmon (2007) Jewell et al. (2000) Ziebland et al. (2005)	++
	Grade
Arai (2003) Baraitser et al. (2003) Barrett and Harper (2000) Bell and Millward (1999) Bissell et al. (2006) Brown et al. (2007) Coleman and Testa (2008) Cooper et al. (2008) Donnelly (2000) Fairhurst et al. (2005) Fairhurst et al. (2004) Fallon (2003) Folks et al. (2001) Free et al. (2002) Griffiths et al. (2008) Harden and Willig (1998) Hayter (2005a) Jones et al. (1997) Lester and Allan (2006) Mason (2005) Pearson (2003) Pitts et al. (1996) Powell (2008) Salmon & Ingram (2008) Schubotz et al. (2003) Selwyn and Powell (2006) Seston et al. (2001)	+

Sixsmith et al. (2006) Stanley (2005) Van Teiglingen et al. (2007) Ziebland et al. (1998) Ziebland and Maxwell (1998) Ziebland (1999)	
	Grade
Allen (2004) Bloxham (1997) Craig and Stanley (2006) Croghan (2006) Curtis et al. (2005) French et al. (2006) Garside et al. (2002) Hayter (2005b) Higginbottom et al. (2008) Jolley (2001) Mackereth and Forder (1996) Mackie et al. (2002) McCann et al. (2008) Morrison et al. (1997) Ogden and Harden (1995) Rolston et al. (2004) Schubotz et al. (2004) Smith (2001) Ziebland et al. (1996)	-

Table 7. Quality rating of included qualitative papers.

****** Appropriate/clear/reliable/rigorous/rich

* Inappropriate/unclear/unreliable/ not rigorous/poor

0 Unsure/unable to judge

Paper	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**Quality grade**
Allen (2004)	**	**	0	0	0	0	0	*	*	0	0	**	0	*	-
Arai (2003)	**	**	**	0	**	**	0	**	**	0	**	**	**	**	+
Baraitser et al. (2003)	**	**	**	**	**	0	**	**	**	0	**	**	**	0	+
Barrett and Harper (2000)	**	**	0	**	**	**	0	**	**	**	**	**	**	*	+
Bell and Millward (1999)	**	**	**	**	**	**	0	0	*	0	**	**	**	**	+
Bissell et al. (2006)	**	**	**	**	0	**	0	**	**	**	**	**	**	0	+

Bissell and Anderson (2003)	**	**	**	*	0	**	**	**	**	**	**	**	**	**	++
Bloxham (1997)	**	**	0	0	0	**	0	*	*	0	**	**	**	0	-
Brown et al. (2007)	**	**	**	**	**	**	0	0	**	0	**	**	**	**	+
Cheung and Free (2005)	**	**	**	**	**	**	**	**	**	**	**	**	**	**	++
Coleman (2001)	**	**	**	**	0	0	**	**	**	**	**	**	**	**	++
Coleman and Cater (2005)	**	**	**	**	**	**	0	**	**	**	**	**	**	**	++
Coleman and Testa (2008)	**	**	0	**	0	**	0	0	*	0	**	**	**	**	+
Cooper et al. (2008)	**	**	0	**	0	**	0	**	**	**	**	**	**	**	+
Craig and Stanley (2006)	**	**	**	0	0	**	0	0	**	0	**	**	**	0	-
Croghan (2006)	**	**	*	0	0	*	0	*	*	0	**	**	**	**	-
Curtis et al. (2005)	0	0	0	0	0	*	0	0	**	0	0	0	**	0	-
Donnelly (2000)	**	**	**	**	****	0	0	**	0	**	**	**	**	**	+
Fairhurst et al. (2005)	**	**	**	**	**	*	0	**	**	**	**	**	**	*	+
Fairhurst et al. (2004)	*	0	**	**	0	0	0	**	**	**	**	0	**	**	+
Fallon (2003)	**	**	**	**	**	**	0	0	**	0	**	**	**	**	+
Folkes et al. (2001)	**	**	**	**	**	**	0	0	*	**	**	**	**	**	+
Free et al. (2002)	**	**	**	0	**	**	**	0	**	0	**	**	**	**	+
Free et al. (2005)	**	**	**	**	**	**	0	**	**	0	**	**	**	**	++
French et al. (2005)	**	**	**	**	**	**	**	**	0	**	**	**	**	**	++
French et al. (2006)	0	0	*	0	0	*	*	*	*	0	0	0	0	**	-
French (2002)	**	**	**	**	**	**	**	**	**	**	0	**	**	**	++
Garside et al. (2002)	**	0	**	0	0	*	0	0	0	0	0	**	0	*	-
Griffiths et al. (2008)	**	**	**	**	0	**	0	**	**	0	**	**	**	**	+
Harden and Willig (1998)	**	**	**	0	**	**	**	0	**	**	**	**	**	*	+
Hayter (2005a)	**	**	**	**	**	**	0	**	**	0	**	**	**	**	+
Hayter (2005b)	**	**	**	0	0	*	0	0	*	0	**	**	**	**	-
Higginbottom et al. (2006)	**	**	**	**	**	**	**	**	**	0	**	**	**	**	++
Higginbottom et al. (2008)	**	0	0	0	0	*	0	**	0	0	0	**	**	**	-
Hoggart (2006)	**	**	**	**	**	**	**	**	**	**	**	**	**	**	++
Ingram and Salmon (2007)	**	**	**	**	**	**	**	**	0	**	**	**	**	**	++
Jewell et al. (2000)	**	**	**	**	**	**	**	**	**	**	**	**	**	**	++
Jones et al. (1997)	**	**	0	0	**	**	0	**	**	**	**	**	**	**	+
Jolley (2001)	**	**	0	**	**	**	0	0	**	0	**	**	**	0	-

Lester and Allan (2006)	**	**	0	0	**	**	0	**	**	**	**	**	**	**	+
Mackereth and Forder (1996)	**	0	0	0	0	*	0	0	0	0	0	0	0	**	-
Mackie et al. (2002)	0	*	0	0	0	*	0	*	*	*	**	**	0	0	-
Mason (2005)	**	**	**	**	0	**	0	**	**	0	**	**	**	0	+
McCann et al. (2008)	**	**	**	0	0	*	0	*	*	*	0	**	0	0	-
Morrison et al. (1997)	0	0	0	**	*	**	0	*	*	0	0	**	**	0	-
Ogden and Harden (1995)	**	**	0	*	**	0	*	*	*	0	0	0	0	*	-
Pearson (2003)	**	**	**	0	**	**	**	0	**	0	**	**	**	**	+
Pitts et al. (1996)	**	**	**	**	**	**	0	0	**	0	**	**	**	0	+
Powell (2008)	**	**	**	**	*	**	**	**	**	0	**	**	**	0	+
Rolston et al. (2004)	**	**	**	0	*	*	0	0	0	0	0	**	0	0	-
Salmon & Ingram (2008)	*	**	*	*	*	**	*	*	*	*	**	**	*	**	+
Schubotz et al. (2004)	**	**	**	**	**	**	0	0	**	0	0	**	**	**	+
Schubotz et al. (2003)	0	0	**	0	0	*	0	*	*	0	*	**	0	**	-
Selwyn and Powell (2006)	0	**	**	**	*	**	**	**	**	0	**	**	**	0	+
Seston et al. (2001)	**	**	**	**	0	0	0	**	**	**	**	**	**	**	+
Sixsmith et al. (2006)	**	**	**	**	0	**	**	0	**	0	**	**	**	**	+
Smith (2001)	0	*	0	0	0	*	0	0	*	0	0	0	0	0	-
Stanley (2005)	**	**	**	0	0	**	0	0	**	0	**	0	**	**	+
Van Teiglingen et al. (2007)	**	**	**	**	0	**	0	0	**	0	**	**	**	**	+
Ziebland et al. (1996)	0	**	0	0	**	0	**	0	*	0	0	**	**	0	-
Ziebland et al. (1998)	**	**	0	**	**	**	0	**	**	**	**	**	**	**	+
Ziebland and Maxwell (1998)	**	**	**	0	0	**	0	0	**	0	**	**	**	**	+
Ziebland (1999)	**	**	0	**	0	*	0	**	0	**	**	**	**	0	+
Ziebland et al. (2005)	**	**	**	**	**	**	**	**	**	**	**	**	**	**	++

4.3.1 Limitations on study quality

The main limitations on study quality were in relation to the numbers of papers that reported only one method of data collection, or one method within a larger study. The assessment of reliability and validity within qualitative research is controversial, however the use of different data sources is often considered to add strength to study findings. Reporting data across different papers also

misses the opportunity to compare and contrast findings from different data sources during analysis, which can add depth to findings.

The mixed method papers generally reported poor quality qualitative data, with a tendency to focus on the quantitative findings and add a small number of participant quotes with little discussion of data analysis strategy or qualitative data set. There was some variation in quantity and depth of quotations used to illustrate findings across the set, with the higher quality papers providing more insight into participant views via greater number of quotes to illustrate points made.

There was some inconsistency in describing the theoretical underpinning to studies, with some papers not including any information regarding any particular perspectives held by the study authors, or describing a grounded theory approach which did not seem to be borne out by the data analysis strategy. Also, a number of papers were unclear regarding the process of analysis or did not report the process in sufficient depth to be able to make a judgement regarding quality. As can be seen from Table 6 (above) it was not possible to make a judgement regarding quality indicators in many instances due to the lack of detail in reporting.

Survey data were generally presented using questionnaires devised for the occasion and with no discussion of piloting the novel survey instruments. In most cases data were limited to the percentages of responses given to a specific question with p values or odds ratios given in around half the studies. Owing to these restrictions, these data are used in the narrative synthesis only to support the qualitative findings (or to question where differences occur).

4.4 Outcomes

A number of outcomes for the views review were identified in the protocol, and the findings of the review will be reported within these, with additional views of service providers regarding services in the final section.

4.4.1 Accuracy and depth of knowledge of contraception

Six qualitative studies reported findings relating to the knowledge of young people regarding different methods of contraception.

Croghan (2006) reported a lack of knowledge about contraception prior to a first sexual experience amongst 16-21 year olds during interviews. She also describes a lack of knowledge regarding the consequences of unplanned sexual activity amongst the young people. Coleman and Testa (2008) describe a lack of knowledge amongst 16-23 year old black and ethnic minority young people in certain areas of sexual health such as sexually transmitted infections and risky sexual behaviour. Free et al. (2005) describe a lack of knowledge amongst pregnant girls and young mothers, and Curtis et al. (2005) describe lack of knowledge regarding correct use of contraceptives amongst mixed sex 15-18 year olds. Jewell et al. (2000) describe differences in knowledge regarding contraception methods between socially advantaged and disadvantaged young women aged 16-20 years. Hoggart (2006) similarly describes differences in levels of knowledge amongst participants, highlighting that many of the young mothers in the study who demonstrated gaps in knowledge about contraception and abortion had dropped out of school or had limited attendance, therefore limited sex education. In the same study the authors describe a particular gap in knowledge as being regarding oral emergency hormonal contraception.

Supporting survey data was identified in nine studies. Contraceptive knowledge was discussed positively in terms of the awareness and knowledge of services in six papers. This was reported as percentages (no other statistics) who knew where to go for information (77% females and 65% males aged 13-21 (French et al. 2007), awareness of available contraception (Salihi et al. 2002, school aged girls), awareness of sexual health services offered by GPs (68% of 13-15 year olds) (Burrack 2000), awareness of sexual health services (62% of 16-28 year old BME men) (Samanagaya 2007), knowing where to obtain contraception and information (98% of pregnant teenagers mean age 17.6) (Pearson et al. 1995) and having knowledge of emergency contraception (93% of 14-15 year olds) (Graham et al., 1996).

In contrast knowledge of emergency hormonal contraception was shown to be poor by Stevenson (1996) who reported that one in five girls and one in three boys (aged 15 to 16) did not appear to know about the existence of any postcoital contraception. In addition Graham et al. (1996) despite the positive result described above, showed that pupils attending schools rated low for academic achievement were less likely to have heard of emergency contraception and more likely to be sexually active.

A further survey discussed knowledge of where to get advice without parental involvement (Van den Akker et al., 1999). Girls were significantly more likely than boys to know where teenagers can get helpful advice about sex and relationships without their parents finding out ($p<0.0001$). More boys than girls did not know what contraceptives were, how to use them and did not feel able to discuss them with their partner ($p<0.01$). Actual contraceptive use was evenly split between boys and girls (23.3% boys and 26.4% girls). In a separate study females also scored significantly higher (no further data) than males (age 15-18) on sexual health knowledge scores (Wight et al., 2000).

Evidence statement 1. Lack of knowledge

A

Three qualitative studies describe a lack of knowledge amongst young people regarding potential consequences of sexual activity. Croghan (2006-) describes a lack of knowledge prior to first sexual experience and lack of knowledge about the consequences of sexual activity in interviews with 16-21 year olds as part of a mixed method study. This was echoed in interviews with 16-23 year old black and ethnic minority young people (Coleman & Testa 2008+) who reported a lack of knowledge in regard to risky sexual activity. Also, interviews with young mothers aged 14-16 years (Hoggart, 2006++) who were reported to have gaps in knowledge about becoming pregnant and abortion.

B.

Three qualitative studies describe a lack of knowledge regarding correct use of contraception amongst young people. Gaps in knowledge about aspects of contraception are reported in young mothers aged 14-16 years (Hoggart, 2006++) a mixed group of 16-25 year old women (Free et al. 2005++) and a mixed group of 15-18 year olds (Curtis et al. 2005-). One qualitative study suggests that a lack of knowledge regarding contraception methods may be greater in young people from deprived areas. Jewell et al. (2000++) found that lack of knowledge regarding contraception methods was greater in socially disadvantaged young women in the 16-20 year old range.

C.

One qualitative interview study (Free et al. 2005++) highlights emergency hormonal contraception as an area of particular lack of knowledge amongst 16-25 year old young women. Survey data suggests knowledge of emergency contraception in 78-90% of school aged girls. (Stevenson 1996, Salihi et al. 2002) One survey (Graham et al. 1996) linked less knowledge of emergency contraception to being a pupil at a school with lower academic achievement.

D.

There is a lack of consensus from survey data regarding levels of reported knowledge or awareness of services. Study findings range from 62-93% of young people having reported knowledge or awareness of where to go for information or to obtain contraception. French et al. (2007) report 77-65% amongst 13-21 year old males and females, Burrack (2000) report 68% amongst 13-15 year olds of both genders, Pearson et al. (1995) report 93% amongst 14-15 year olds of both genders. Samanagaya (2007) reports 62% amongst a specific population of black and ethnic minority 16-28 young men.

E.

Survey data indicate gender differences in knowledge of contraception and where to access contraceptives. Girls scored higher on sexual health knowledge (Wight et al. 2000) were more likely to know where to get advice or contraceptives (Van den Akker, 1995, French et al. 2007, Stevenson, 1998), and had greater knowledge of how to use contraceptives (Van den Akker, 1995).

4.4.2 Beliefs and socio-cultural norms about contraception

a) Embarrassment

A recurrent theme within the data concerned the perception of embarrassment surrounding contraception, and obtaining contraception. 14 studies report young people's perceptions of embarrassment. Fairhurst et al. (2004) described the reduction of embarrassment when women (GP patients) were given supplies of emergency hormonal contraception, rather than having to seek supply from a doctor when needed. Hayter (2005a) highlighted the perception of nurses in sexual health clinics that the supply of contraception should not make young clients feel embarrassed. A study by Sixsmith et al. (2006) describes the embarrassment felt by young people (a mixed group of ages/ethnicity) when obtaining condoms. Baraitster et al. (2003) report the embarrassment felt by 16-24 year olds when giving personal details at a clinic reception desk. Salmon & Ingram (2008 school age) report that half the participants in their study reported embarrassment at using a school-based service which lead to them preferring to use an outside-school service. Whereas the other half perceived that it would be less embarrassing to use the school-based service. Other studies - Lester and Allan (2006 school age), Free et al. (2002, 2005 16-25 year olds), French et al. (2005 mixed age young people from ethnic minorities), Schubotz et al. (2003 14-25 year olds), Ziebland et al. (2005 family planning clinic clients) echo young people's association of embarrassment with using contraceptive services.

Three surveys reported supporting data in relation to embarrassment as a factor affecting contraception and service use. Stone and Ingham (2003) in a study into the use and non use of services by women (aged 11-39, median 17 years old) reported that 20-24% of women had felt embarrassed or scared to use a service. In a study on attitudes towards GP consultation for contraception, Donovan et al. (1997) reported that 63% of females and 46% of males (age 15-16) would feel embarrassed by consulting their GP about contraception. In a study by Samangaya (2007) on young BME men's views, 66% said embarrassment would stop them attending a sexual health service.

Evidence statement 2. The obstacle of embarrassment

A.

One qualitative study reports that discussion of sex and contraception is embarrassing. In a study of mixed 16-25 year old young city dwellers (Free et al. 2005++) it is reported that the younger participants reported that discussing sex or any type of contraception was embarrassing.

B.

The potential for feelings of embarrassment to inhibit young people from using contraception services is outline in seven papers accessing views from a variety of groups of young people. Clients of family planning clinics (Ziebland et al. 2005++) describe embarrassment or stigma associated with accessing contraceptive supplies. Young people from ethnic minorities (French et al. 2005-) also describe embarrassment if they are seen accessing a service. 66% of clients of a male drop in service (Samangaya, 2007 survey) reported that embarrassment would stop them using a service. Young people of school age (Lester & Allen, 2006+, Salmon & Ingram, 2008+) echo this embarrassment being linked with accessing services. Stone & Ingham (2003, survey) report 20-24% of 11-39 year old women had been embarrassed or scared or concerned in regard to using a sexual health service. Free et al. 2002+ describe women of 16-25 years old feeling embarrassed using contraceptive services. Mixed groups of young people (Sixsmith et al. 2006+) described embarrassment as being a barrier to accessing condoms. This importance of clinics needing to overcome young people's feelings of embarrassment was also recognised by staff (Fairhurst et al. 2004+ GPs and practice nurses, Hayter et al. 2005a+ nurses).

C.

Two papers report embarrassment related specifically to particular services. Schubotz et al. (2003+) report that young people aged 14-25 years perceive that at times teachers are clearly embarrassed when discussing sexual issues leading to the young people also feeling embarrassed. Donavon et al. (1997 survey) reports 63% of females and 46% of males aged 1516 years reported embarrassment in relation to attending a consultation with a GP in regard to sexual health.

D.

One study describes a particular aspect of accessing a service that is embarrassing. Baraitser (2003+) reports that young people aged from under 16-24 feel embarrassed when giving their name and address at a reception desk.

b) Use versus non-use of contraception

Seven studies provide helpful insights into the decisions and circumstances underpinning young people's use or non-use of contraceptives. Free et al. (2005) in an interview study of young people resident in London, including deprived inner city, mixed inner city, homeless young people, and suburban dwellers describe the variations in perceptions regarding the acceptability or desirability of pregnancy and contraception use. This study suggests that understanding perceptions of risk-taking is important in understanding use or non-use of contraception. The authors report that taking risks with contraception was part of a broader attitude to taking risks or pushing boundaries, which could include taking risks with drugs, missing school or lying to parents.

Two studies explore taking risks in relation to how alcohol use could impact on the use or non-use of contraceptives. Coleman and Cater (2005) found that just under two thirds of participants in their study of 14-17 year olds reported an experience of risky sexual behaviour following a session of high alcohol consumption. The participants reported that they associated this with alcohol lowering inhibitions, impairing judgement and causing a lack of control over situations. Mason (2005) identified that nursing staff in an accident and emergency department also report a link between alcohol and risky sexual behaviour with excess alcohol leading to requests for emergency contraception in case unplanned sexual intercourse had taken place.

Four studies describe a link between the use of contraception and personal circumstances, or type of relationship. Free et al. (2002) describe women's

contraception use as being fluid, varied, and changing over time in response to situations, experience and information. Hoggart (2006) describes “the often random use” of contraception amongst young mothers in a study carried out in inner London. Curtis et al. (2005) report that use of contraception amongst teenagers in East London including BME and “challenging groups” might lapse as a relationship becomes more long term. The link between a perceived long-term relationship and less careful use of contraception is also made by Jewell et al. (2000), who report participants explaining risk-taking behaviour as being associated with strong emotional attachments to a partner. Curtis et al. (2005) found that some young men associated being in a trusting relationship with not using a condom if their partner was taking the contraceptive pill. Hoggart (2006) reports that the strength of the relationship also impacts on decisions beyond contraceptive use, with the biggest influence on the decision to terminate or continue a pregnancy being a young women’s relationship with the father of the baby.

Free et al. (2005) describe the non-use of condoms in a relationship as being linked to giving greater sexual pleasure to a sexual partner, avoiding embarrassment or avoiding conflict in this study of London teenagers including those who were pregnant and young mothers. The need for skills and power within a relationship to negotiate condom use is also described. The study contrasts consistent use of condoms with young people who have high self esteem, self efficacy, and the ability to prepare and plan for intercourse versus other young people who struggle to communicate intentions, negotiate in scenarios of conflicting intentions or plan and prepare less.

Evidence statement 3. Perceptions of risk

Two qualitative studies describe the importance of addressing young people’s perceptions of risk in use or non use of contraception. One study (Free et al. 2005++) interviewed a mixed group of 16-25 year old women in London and reported that risky sexual behaviour was part of an overall attitude to taking risks. Hoggart (2006++) describes a risky and seemingly random use of contraception amongst young mothers in inner London. An additional study

(Coleman & Cater 2005++ 14-17 year olds) highlights that alcohol can impact on a young person's perceptions leading to increased risky sexual behaviour.

Evidence statement 4. Variation in individual situations

A.

The importance of understanding young women's individual situations and changing use of contraception over time is highlighted by one study of 16-25 year old young women resident in London (Free et al., 2002+). The young people in this study described how factors particular to a young person such as their personal situation, their experiences, their access and use of information all impacted on their contraceptive use. The women reported that as these factors changed over time, so there was change in their contraceptive use.

B.

Three studies suggest the importance of a link between contraception use and the nature of a young person's relationship. Mixed groups of young people describe greater risks being taken in relationships with strong emotional attachment or long-term trusting relationships (Jewell et al. 2000++ 16-22 year old young women , Curtis et al. 2005- 15-18 year old black and ethnic minority young people). Another study describes the avoidance of conflict or need to give greater pleasure as reasons for non use of condoms outlined by a mixed group of 16-25 year old women (Free et al. 2005++).

c) Views regarding becoming pregnant

Seven papers explore views and perceptions regarding young motherhood and decisions to continue or not with a pregnancy. Papers by Hoggart (2006), Cheung and Free (2005), Free et al. (2005), Higginbottom et al. 2006 and 2008, and Curtis et al. (2005) and Jewell et al. (2000) report data suggesting differences between individuals in regard to the desire to avoid becoming pregnant. These differences are associated with differing contraceptive use. The paper by Cheung and Free (2005) describes 16-25 year old young

women's use of contraception as relating to the value that they placed on avoiding pregnancy. Those with a strong desire to avoid pregnancy tended to report being consistent and persistent contraceptive users, whereas those who did not place such a high value on avoiding pregnancy were more irregular with their contraceptive use. Free et al. (2005) similarly describe that some young women participants in their study reported using multiple contraceptives in order to achieve "extra safety" from pregnancy, with aspirations other than motherhood being linked to the use of contraception. Curtis et al. (2005) report in contrast that some young women seemed to have a lack of concern regarding the potential consequences of non-use of contraceptives.

The paper by Hoggart (2006) explores in depth the views of young mothers regarding their pregnancy. The author reports that there seemed to be confusing messages from participants, with many acknowledging that while they had not intended to become pregnant they were careless regarding use of contraception. Similar data are reported by Free et al. (2002) who describe some young women as putting the risk of pregnancy to the back of their mind, with individuals varying in regard to the perception of their own personal vulnerability to pregnancy. Jewell et al. (2000) differentiate between "advantaged" and "disadvantaged" women in respect of attitudes to abortion and teenage pregnancy, with early pregnancy and young motherhood generally more acceptable to the disadvantaged women. Abortion and emergency contraception were more acceptable to the advantaged women.

The papers by Higginbottom et al. (2006 & 2008) provide a detailed examination of perceptions regarding young parenthood among minority ethnic communities in England. The papers reports diverse views regarding pregnancy and termination, with some groups such as African Caribbean and dual ethnic origin young mothers often being pleased about becoming a young parent after the initial shock (Higginbottom et al. 2006). The authors report that for many of these participants early parenthood was not perceived as a barrier to a successful independent life. Aria (2003) also reports that amongst a small sample of women using sexual health services who had their

first child before the age of 20 early child bearing can be seen as “a positive and rational behaviour”. The author suggested that while participants from “less fraught backgrounds” and those who had experienced “severe early life adversity” both could perceive early child-bearing as a rational option, for the first group it represented an “alternative vocation” whereas for the latter group it could be perceived as “a way to be loved”.

The Arai (2003) study also examines and contrasts the perceptions of teenage pregnancy unit co-ordinator staff regarding teenage pregnancy and parenthood. This small-scale interview study reports that staff perceive a link between poverty, deprivation, lack of opportunity and early pregnancy/motherhood. It reports that while staff perceive that in some situations young motherhood can be beneficial, that mostly it was unfortunate and that young mothers “had the odds against them”.

Evidence statement 5. Attitudes to pregnancy and motherhood

Seven studies report varying attitudes to becoming pregnant amongst young people (Hoggart 2006++ 14-16 year olds, Cheung and Free 2005++ 16-25 year olds, Free et al. 2005 ++ 16-25 year olds, Jewell et al. 2000++ 16-22 year olds, Curtis et al. 2005- 15-18 year olds) also young parents from ethnic minorities (Higginbottom et al.,2006 ++, Higginbottom et al., 2008-). The papers link these differing attitudes to differing usage of contraception, with those placing a higher value on avoiding pregnancy being more regular with their contraception use or using multiple methods. Young mothers in one paper (Hoggart 2006++) seemed to have ambivalent attitudes, reporting that they had not intended to become pregnant but had been careless with contraception.

Two studies suggest differences between young people from advantaged and less advantaged backgrounds in regard to perceptions of teenage pregnancy. Jewell et al. (2000++) report that early pregnancy and young motherhood seemed generally more acceptable to 16-22 year old women from disadvantaged backgrounds. Aria (2003+) compared views of women who

had their first child before the age of 20 in more and less advantaged areas and suggested that positive views of early childbearing occur amongst young mothers from both backgrounds, but for different underlying reasons (an alternative vocation or a way to be loved).

d) Views regarding contraception

Three papers explore beliefs regarding contraception generally and the use of contraception. Free et al. (2005) describe contraception use as being linked to "a positive evaluation of female sexuality", with the ability to use services perceived as behaving in a responsible and mature way, whilst the failure to use contraception was negatively evaluated by young people. This study explores in depth the importance to young women of maintaining a positive sexual identity, describing how the concerns about what others think of them may deter young women from accessing contraceptive services. Curtis et al. (2005) describe a similar positive view of contraception in their participants' perception of obtaining and using contraception as being equated with a sense of responsibility.

Hayter (2005a) in a study examining staff perceptions analysed data from recorded consultations in a family planning clinic. He noted the predominance of terminology such as "risk" and "protection" used by nurses to describe contraceptive use. The author suggests that this reflects and perpetuates a negative and clinical perception of the female body, suggesting that the use of more positive terms such as "control" and "ability" in consultations would promote a more empowering perception of contraception.

Evidence statement 6. Contraceptive use and positive values

Three studies describe an association between using contraception and positive values amongst young people. Free et al. (2005++) describe the use of contraception as being part of a positive image of female sexuality amongst 16-25 year old young women including some who were pregnant and young mothers. Curtis et al. (2005-) reports 15-18 year old women perceiving that obtaining and using contraception was responsible behaviour. In addition,

Hayter (2005a-) examines young women's (over 16 years old) use of terminology relating to pregnancy and contraception, and describes contraception being viewed positively as a form of protection.

e) Views regarding particular forms of contraception

In addition to these general views of contraception, the set of papers includes data that describes views and perceptions of particular forms of contraception.

Perceptions of condoms

Perceptions of condoms amongst young people were reported in papers by Lester and Allan (2006), Ogden and Harden (1995), Free et al. (2005) and Curtis et al. (2005). Lester and Allen's focus group study of mixed sex teenagers (14-15 year olds) in an area of high incidence of chlamydia, reported perceptions of condoms being uncomfortable and sex being better without using them. Free et al. (2005) reported in their interviews with teenagers including those who were pregnant and young mothers, that the physical barrier of a condom was seen as a barrier to intimacy in sex as relationships became longer term, and non use of contraceptives such as condoms could be perceived as leading to a more positive sexual experience. Ogden and Harden (1995) reported both negative and positive comments regarding the appearance and feel of condoms amongst 12-13 and 16-17 year old young people. Participants in the study perceived an association between condom use and social responsibility as well as personal behaviour, with the authors suggesting that it seemed young people were engaged in a process of weighing up the pros and cons of using condoms.

Three of the studies (Curtis et al., Ogden and Harden, Free et al.) describe differing perceptions of girls carrying condoms amongst 15-25 year olds of both sexes. Young women carrying condoms was viewed as sensible by many, but as sending the wrong signals by others in the Lester and Allan study. Also, young women with condom supplies was described as having negative connotations in the Ogden and Harden study. In the Curtis et al. paper it was construed by participants as being either promiscuous or in

contrast described as being aware/clued up. Salmon & Ingram (2008) also report a perception amongst some school-age girls that they would be called "a slag" if fellow students saw them accessing a school sexual health service.

Evidence statement 7. Views of condoms

Three studies suggest that condoms can be perceived negatively as uncomfortable or a barrier to intimacy amongst some teenagers. Lester and Allan (2006+) and Free et al. (2005++) report these negative views amongst some 14-15 year old teenagers, and teenagers including those who were young mothers or pregnant. Ogden and Harden (1995) similarly report a mix of positive and negative perceptions of condom use amongst 12-13 year olds and 16-17 year olds. Four studies suggest that young women carrying condoms can be perceived as having negative connotations by some young people in studies of teenagers (Curtis et al.,2005- 15-18 year olds, Ogden and Harden, 1995- 12/13 and 16/17 year olds, Free et al.,2005++ 16-25 year olds, Salmon & Ingram, 2008+ school aged).

Views of oral hormonal contraception

Five studies describe perceptions of oral contraceptives amongst young people, with study participants ranging from 15-25 year olds and including both sexes. Morrison (1997) reports the positive view that oral contraceptives are more reliable and less expensive than condoms which need to be purchased. Cheung and Free (2005) describe the value for women of having control over menstruation that hormonal contraception offers. Four papers (Ziebland et al. 1998, Free et al., 2005, Curtis et al., 2005, and Cheung and Free 2005) report more negative perceptions of the contraceptive pill being "unnatural", containing "unnatural or artificial hormones", causing side effects, or being potentially unsafe or harmful to the body. 16-25 year old participants in the Cheung and Free paper emphasised the importance of being normal and natural, with women stopping taking oral contraceptives and needing to take breaks from using them.

Evidence statement 8. Views of hormonal contraception

A.

Two studies describe positive views that hormonal contraception is more reliable and less expensive (Morrison et al. (1997- young people mean age 17), and that it offers more control Cheung and Free (2005++ 16-25 year olds).

B.

Three studies describe negative perceptions, with concerns voice regarding potential harm from artificial and unnatural hormones (Free et al. (2005++ 16-25 year olds) Ziebland et al. (1998+ women clinic attenders mean age 21),Curtis et al. (2005- 15-18 year olds).

Views of oral emergency hormonal contraception

A large group of papers report findings relating to the supply of oral emergency hormonal contraception (EHC). No papers reported on the use of intrauterine devices as emergency contraception. Seston et al. (2001) describe the special status of EHC perceived by pharmacist providers, due to the hormonal content, potential damage if used repeatedly, together with the significance of the social context and importance of outcome. For women accessing EHC there was reported variability in whether they viewed it as a necessary inconvenience (older women) or viewed it with apprehension (younger women) (Bell and Millward, 1999). In a study by Ziebland et al. (2005) women were given advance supplies of EHC, and participants described the benefits in terms of convenience, quicker use, saving doctor's time, the option to share supplies with friends, and the comfort in having a supply. However, they also expressed reservations that having a supply might "send the wrong message", with the risk that younger women might "abuse" having the supply.

Free et al. (2002) describe women's feelings of guilt or shame when using emergency contraception, and the perception that EHC was linked with undesirable behaviour. Similarly Ziebland et al. (2005) describe women distinguishing between using EHC in a steady relationship and using it when drunk or with multiple partners. These negative perceptions regarding use of

EHC were raised in particular in relation to repeat use of EHC. The Free et al. (2005) study found in contrast that some women portrayed using EHC as responsible behaviour; however for others emergency contraception was linked to a negative evaluation of women's sexuality. Participants in the Bell and Millward (1999) study perceived that if they requested EHC they would be judged, and felt guilty making the request. The Folkes (2001) study draws an interesting distinction between young women's perceptions of their own use of EHC as valid and responsible, but concerns at the use by other young girls.

Seven papers (Ziebland et al., 1996, Ziebland et al., 1998, Ziebland and Maxwell, 1998, Barrett and Harper, 2000, Folkes et al., 2001, Bell and Millward, 1999, and Free et al., 2002) describe concerns amongst women that use of EHC was unsafe or produced side effects of concern. In these papers there is a reported perception that EHC is dangerous due to the ingesting of large amounts of hormones, that it causes nausea, vomiting and long-term side effects, and that repeated use posed considerable health risks.

Eight papers report service provider perceptions regarding the provision of EHC. Bissell and Anderson (2003), Barrett and Harper (2000), Bissell et al. (2006), Ziebland (1998) and Ziebland and Maxwell (1998), Fallon (2003), Seston et al. (2001) report pharmacists perceptions that deregulation of EHC would have a negative impact on sexual behaviour, with concerns that there would be an increase in unprotected sex, concerns regarding repeated use of EHC, concerns that women would abandon other forms of contraception or that women could be coerced into taking part in non-consensual sex. Papers report in particular negative perceptions of women seeking repeat use of EHC, with participants in the Seston et al. (2001) study describing repeated use as "abuse", and with the perception that women would use supplies inappropriately. Fairhurst et al. (2004) and Bissell et al. (2006) highlight the perception of a contradiction for some GPs, practice nurses and pharmacists between the promotion of safe sex practices and a view that EHC sanctioned promiscuous behaviour.

Data in these papers presents a perception amongst many service providers including pharmacists, GPs and practice nurses, and A & E nurses; of a stereotypical image of a women seeking EHC as being a young, unmarried, irresponsible women (Seston et al., 2001, Barrett and Harper, 2000, Cooper et al., 2008) In the data there is differentiation between responsible and irresponsible use of EHC, with adolescent users perceived as reckless and irresponsible (Fallon, 2003, Fairhurst et al., 2004, Bissell et al., 2006, Folkes, 2001). Papers exploring GP perceptions of EHC describe the unacceptability of it as a method of choice (Ziebland et al., 1998, 1999), and the view that it is not “proper contraception” (Fairhurst et al., 2005).

In addition, two survey papers reported on attitudes towards, and use of emergency contraception. In a survey by Graham et al. (1996) 32% of sexually active girls (age 14-15) had used emergency contraception, and 84% believed it to be effective in preventing pregnancy (although also more dangerous than oral contraception). Gbolade et al. 1999 looked at staff opinions on the provision of emergency contraceptives in A&E departments. Only just over half (56%) of the A&E staff supported this but it is important to note that this study is ten years old and as such pre-dates over the counter provision of emergency contraception.

Evidence statement 9. Views of emergency hormonal contraception

A.

Six studies report views regarding the use of EHC amongst young women. Four studies describe negative views including guilt, shame, the perception of being linked to negative behaviour and concerns that EHC was unsafe or produced side effects (Ziebland and Maxwell 1998+ women mean age 21, Barrett and Harper 2000+ age mid 20s-50s, Folkes et al., 2001+ age 18-29, Free et al., 2002+ women aged 16-25). Two studies report variation in views among women. One (Bell and Millward, 1999+) reports that older women viewed EHC as a necessary inconvenience whereas young women viewed it with apprehension. Ziebland et al. (1996-) describes variation in views amongst women (no age range).

B.

Eight papers report service provider perceptions that easy access to EHC has a negative impact on sexual behaviour or describe negative perceptions amongst service providers of young people requesting and especially repeat requesting EHC (Bissell and Anderson 2003++ pharmacists, Barrett and Harper 2000+ pharmacists, Bissell et al. 2006+ pharmacists, Ziebland 1998+ GPs, Ziebland and Maxwell 1998+ GPs, Fallon 2003+ A&E nurses, Fairhurst 2004+ primary care nurses.

4.4.3 Peer group norms about contraception

No evidence was found in the papers specifically regarding peer group norms; however data regarding differences in views according to age and gender may be of relevance to this aspect.

Lester and Allen (2006) suggest that there may be gender differences in perceptions regarding contraception, with girls seeming to talk more seriously about sex than boys. Pearson (2003) reports a lack of discussion of sexual health dilemmas amongst the young men participants. Morrison et al. (1997) reports the perception amongst young women that contraception is a female responsibility. It also identifies a key difference between young men and women in regard to contraception, in that males are able to circumvent the need to attend sexual health services by obtaining contraceptives from other sources, whilst young women who do not wish to use condoms must access other contraceptives via a sexual health service. Van Teijlingen et al. (2007) provide data suggesting that there may be gender differences regarding levels of embarrassment. This study found that focus groups consisting only of boys described feelings of embarrassment less than focus groups of girls.

The Van Teijlingen study in Scotland also indicated that there may be age related differences in levels of embarrassment, with older (16-17 year olds) talking less about embarrassment than younger (12-13 year olds). This finding regarding age related differences in embarrassment is also reported by Free et al. (2005) in their study of 16-25 year olds, where “the youngest

participants" are described as finding discussing sex or any type of contraception as embarrassing. Ogden and Harden (1995) supported age-related differences in perceptions regarding contraception, describing younger participant (12-13 year olds) in London being more light-hearted and humorous regarding sexual matters, whilst older participants (16-17 year olds) were more serious.

Evidence statement 10. Age and gender differences in discussion of contraception

A.

Three studies describe gender differences, with girls appearing to talk more frequently and more seriously about sex and sexual health than boys (Lester and Allen 2006+ aged 14-15, Pearson 2003+ young men aged 13-21). This may be linked to the Van Teijlingen et al. (2007+ 12/13 and 16-17 year olds) study suggesting that boys may have higher levels of embarrassment, and also the Morrison (1997- young people mean age 17) study which reported that contraception tended to be viewed as a female responsibility.

B.

Three studies describe age-related differences with younger participants being more embarrassed and more light-hearted and humorous when discussing sex or any type of contraception (Teijlingen et al. 2007+ 12/13 and 16-17 year olds, Free et al. 2005++ 16-25 year olds, Ogden and Harden 1995- 12/13 and 16/17 year olds).

4.4.4 Knowledge of and trust in contraceptive services

Sixsmith et al. (2006) report in their study of young people in Manchester that there appeared to be uncertainty amongst participants regarding where to go to get condoms. Donnelly (2000) in a study in Northern Ireland found a degree of uncertainty regarding local services and facilities, particularly amongst younger participants. French et al. (2005) similarly reported a lack of

knowledge about local services, particularly amongst young men. These findings are supported by a large number of the survey papers.

Five papers describe young people's views regarding the importance of trust in sexual health services. Ingram and Salmon (2007) describe positive perceptions of confidence and being in control in relation to a drop-in clinic in South West England. Craig and Stanley (2006) report the importance of having trust in professionals staffing sexual health services in rural areas. Croghan (2006) describes a lack of confidence in using sexual health services amongst a small sample of young people including those of a black and minority ethnic background. Powell (2008) reports the importance of perceived legitimacy of the source of information or advice, which may be associated with having experience in the area and being perceived as an appropriate source. Selwyn and Powell (2006) in a study examining the use of the internet by young people in deprived districts identified that participants reporting using only a limited repertoire of online sources, preferring websites hosted by big organisations that were perceived as trustworthy.

Evidence statement 11. Knowledge of local services

Three studies describe uncertainty amongst young people in regard to where to go to access contraceptives, especially amongst young men and younger participants (French et al. 2005++ 16-25 year olds, Sixsmith et al. 2006+ 14-19 year olds, Donnelly 2000+ 15-25 year olds).

Evidence statement 12. Perception of trust in services

Five papers describe the importance of young people perceiving that contraceptive services are trustworthy and legitimate, enabling them to feel confident, and being in control when using them (Ingram and Salmon 2007++ 14-18 year olds, Selwyn and Powell 2006+ 12-19 year olds, Craig and Stanley 2006 – 12-18 year olds, Croghan 2006–16-21 year olds, Powell 2008+ 12-19 year olds).

4.4.5 Beliefs about contraceptive services

Beliefs regarding services are reported in the papers as individual perceptions of particular services.

Perceptions of family planning and sexual health clinics are reported by Sixsmith et al. (2006), Lester and Allan (2006), Pearson (2003), Morrison et al. (1997), and Donnelly (2000). Key themes from these papers encompass the view that clinics implied a place where only girls go (Sixsmith et al., Pearson), and that family planning means older couples (Pearson) where older married women go (Donnelly).

Pharmacy services are perceived positively as being helpful in a paper by Bissell and Anderson (2003 pharmacists), as being easy to visit (Folkes et al., 2001 clients of sexual health clinics) and being less regulated than a GP/family planning clinic (Ziebland et al., 1998 GPs).

GP surgeries are considered by some to lack confidentiality (French et al., 2005), particularly for some ethnic minority groups (African and Indian), although not all (Non-Indian Asians), (Griffiths et al. 2008), and especially in rural communities (Pearson, 2003). There were reported concerns regarding getting past the surgery receptionist (Bell and Millward, 1999), with women reluctant to consult a GP for EHC (Bell and Millward, 1999). The Salmon and Ingram (2008) study indicates opposing views amongst a school-aged population, with some having concerns about GP services in regard to information reaching their parents, and others preferring a GP service rather than a school-based service.

A hospital accident and emergency department was reported to make women uncomfortable in one study (Bell and Millward, 1999) with a perception that GPs, hospital doctors, and hospital midwives had been disapproving (Higginbottom et al., 2006).

Staff views regarding particular services are reported in papers by Mackie et al. (2002), Pitts et al. (1996), French et al. (2005), and Ziebland et al. (1998). Mackie describes staff perceptions that using premises that are not health

service sites had drawbacks in terms of transporting drugs and a lack of client records on site. Participants in the Pitts et al. study echo young people's concerns that the receptionist in a GP surgery could act as a barrier. Some of the GP participants in the Ziebland study voiced concerns regarding the environment of a pharmacy for emergency contraception provision. French et al. (2002) describe staff views that satellite and outreach services are important stepping stones for young people in to more mainstream services.

Evidence statement 13. Perception of clinics

Five papers suggest that young people can perceive that family planning and sexual health clinics are where girls go or are only for married or older women (Sixsmith et al. 2006+ 14-19 year olds, Lester and Allan 2006+ 14-16 year olds, Pearson 2003+ 13-21 year olds, Donnelly 2000+ 15-25 year olds, Morrison et al. 1997- mean age 17).

Evidence statement 14. Concerns regarding GP-based services

Five studies report that some young people have concerns in regard to attending a GP practice for contraceptive services. This seems a particular concern in rural communities and in regard to potential loss of confidentiality (French et al. 2005++ 16-25 year olds, Griffiths et al. 2008+ 16-21 year olds, Pearson 2003+ 13-21 year olds, Bell and Millward 1999+ 18-34 years, Salmon & Ingram, 2008+ school aged).

4.4.6 Barriers and facilitators to using contraceptive services

Users or potential users of services identified a number of elements that would facilitate or act as a barrier to them accessing the service. These themes have been grouped into access, appointment systems, anonymity/privacy, confidentiality, respect/non judging, anxiety, cost,

environment, and the consultation. Papers reporting staff views regarding these themes are also outlined here.

a) Access

Eleven papers provide data describing young people's views regarding the importance of services being easy to access. Bissell and Anderson (2003) describe women participants as finding pharmacy provision easy to access due to extended opening hours, and weekend provision. These elements are echoed in the Folkes et al. (2001) study, which similarly describes greater accessibility in terms of convenient location, flexible opening hours and rapid consultation. Ingram and Salmon (2007) similarly conclude that services should be in close proximity to the young person's location, with Griffiths (2008) also describing convenience as a key theme. The theme of access is also reported in the Griffiths study, with participants reporting the perception that timings of sexual health clinics make them difficult to access. Salmon & Ingram (2008) report that school-aged participants emphasised the convenient location and ease of access of a school-based service. Baraitser et al. (2003) also report that easy access to services is important, with a complex process of obtaining appointments and long waiting times once at the clinic being off putting to young people.

The Baraitser et al. (2003) study also reports that the perceptions that young people use services near to their homes may not always be the case. In this study of family planning clinics, new clients often used services near to a friend's house or to their school rather than their home, and tended to continue to use that clinic. French et al. (2005) similarly report that closeness to home is not always preferred. They describe varied views regarding location, with some young people preferring clinics outside of their home locality to avoid being seen by people they know. Others preferred services located in town centres or locally to increase accessibility, with participants suggesting outreach into venues that young people accessed such as hairdressers, nightclubs, snooker halls, fast food outlets, youth services, events, sports shops, music shops and churches. Craig and Stanley (2006) highlight that whilst venues should be accessible; they need to be convenient

so that the young person could travel there without being reliant on a parent for transport.

Sixsmith et al. (2006) describe the importance of accessibility in terms of lifestyle and lack of age restrictions. In this study young people describe the lack of condom machines in female toilets, and inaccessibility of machines to young people unable to enter pubs or nightclubs, suggesting that machines should be located where 14-16 year olds and 17-19 year olds spend their free time. Studies by Craig and Stanley (2006) in a rural area, and Higginbottom et al. (2006) amongst minority ethnic young people, highlight the perception amongst some participants of having a lack of choice regarding which services they could access.

Service user views regarding the importance of accessibility are reflected in 7 papers that report staff views. Fallon (2003), Pitts et al. (1996) and Donnelly (2000) describe staff as identifying easy access as important elements of a service. Ziebland et al. (1998), Bissell and Anderson (2003) and Bissell et al. (2006) report that staff as well as young people recognise that accessibility of pharmacy services is a benefit.

These data are supported a survey suggesting that young people would prefer services to be open after school (71%, age 11-18) or on Saturdays (49%) (Nwokolo et al. 2009). Older pupils were more likely to find after school clinics (p=0.001) or lunchtime clinics (p=0.038) useful than younger ones.

Evidence statement 15. Accessibility of services

Eleven studies suggest the importance of accessibility of services for young people, with convenient location, extended opening hours, and choice in location as important elements (Bissell and Anderson, 2003++ pharmacists, Higginbottom et al. 2006++ young mothers, Ingram and Salmon 2007++14-18 year olds, French et al. 2005++ 16-25 year olds, Folkes et al. 2001+ 18-29 year olds, Griffiths 2008++ 16-20 year old ethnic minority young people, Free et al. 2002+ 16-25 year olds, Baraitser et al. 2003+ under 16-25 year olds,

Sixsmith et al. 2006+ 14-19 year olds, Craig and Stanley 2006 –12-18 year olds, Ingram & Salmon 2008+ school-aged).

b) Appointment systems

Three studies provide evidence regarding young people's preference regarding appointment or drop-in clinic systems. Bissell and Anderson (2003) and Ingram and Salmon (2007) describe views that the lack of a need to make an appointment and drop in service is valued by young people. However, Baraitser et al. (2003) found variation in preferences amongst the young people first time clinic users in this study. The work by Free et al. (2005) describing accessibility (in the previous section) is relevant here, with young people finding long waiting times off-putting, which may be a result of a drop in rather than appointment-based system.

Papers by Bissell and Anderson (2003) and Bissell et al. (2006) describe staff perceptions that the lack of need to make an appointment at pharmacies for emergency contraception was a key benefit for young people. Bloxham (1997) describes that a no-appointment system in sexual health clinics is perceived as preferable by staff. Baraitser et al. (2003) report that staff recognise that waiting times can be too long in a family planning clinic, although perceive that the clinic is accessible despite this. Pitts et al. (1996) report that GPs perceive that having an appointment system is an advantage in terms of being available.

In terms of the survey data, Ross et al. (2007) reported that young people (age 16-24) would prefer to make appointments by telephone rather than in person (93%) and that men were less likely to use web based services than women (72% vs 82%, OR 0.59 [0.38-0.91]). Nwokolo et al. (2009) reported that 11-18 year olds would prefer a walk in service to an appointment service (62% vs 35%) and 24% would not be prepared to wait longer than 15 minutes to be seen. Interest in a telephone advice line was demonstrated by Hagley et al. (2002), with 84% of male and 89% of female respondents (mean age

15.8/16) being in favour, but more women (71%) than men (39%) said they would actually use such a service.

Evidence statement 16. Appointment systems

Studies report varying views in regard to whether an appointment system or a drop-in service provides greater accessibility for young people. Bissell and Anderson, 2003++ and Bissell et al., 2006+ (pharmacists) suggest an appointment-free system offers convenience. Ingram and Salmon 2007++ (14-18 year olds), also suggest a drop-in service is more convenient and Bloxham (1997- community service staff) echoes this reporting that a no-appointment system is preferable in a sexual health clinic. Baraister et al. (2003)+ however report that staff perceive that waiting times in a clinic are not an obstacle to accessibility. One survey of young people (Nwokolo et al. 2009 11-18 year olds) reported that 62% would prefer a walk-in service. Another survey (Ross et al. 2007 age 16-24) suggested that the ability to make appointments via telephone was an option that may be appreciated by young people.

c) Anonymity/privacy

This element was a key theme within the included papers, with nine papers reporting the importance of young people's identity remaining unknown when they were accessing sexual health services. Bissell and Anderson (2003), Sixsmith, (2006), Lester and Allan (2006) Griffiths (2008), Pearson (2003), Donnelly (2000), Craig and Stanley (2006), French et al. (2009) and Powell (2008) describe young people's concerns regarding services being discreet and anonymous, with the fear of being seen, being uncomfortable in case they were recognised by someone, and fear of their anonymity being compromised. There was the suggestion from study participants that they would prefer the use of numbers rather than names in a clinic situation (Donnelly, 2000, French et al. 2005) and the preference for services where it was not possible to identify the reason for the visit (French et al. 2005), also

the preference for waiting rooms to be separated by gender (French et al. 2009). The Powell (2008) study suggested that telephone help lines, magazines, chat rooms or television were valued sources of information and advice due to their anonymity.

Papers by Ziebland et al. (1998), Mackie et al. (2002), Pitts et al. (1996) and Bissell et al. (2006) report staff perceptions that anonymity is important to young people.

Evidence statement 17. The importance of anonymity

Eight studies report that preserving anonymity when accessing services is a significant concern for young people (French et al. 2005++ 16-25 year olds, Sixsmith et al. 2006+ 14-19 year olds, Lester and Allan 2006+ 14-15 year olds, Griffiths 2008+ aged 16-20+, Pearson 2003+ young men aged 13-21, Donnelly 2000+ 15-25 year olds, Powell 2008+ 12-19 year olds, Craig and Stanley 2006– 12-18 year olds). These concerns regarding anonymity are also perceived by staff (Ziebland et al. 1998+ GPs, Pitts et al. 1996+ GPs and practice nurses, Bissell et al. 2006+ pharmacists, Bissell and Anderson 2003++ pharmacists, Mackie et al. 2002 – health board members and pharmacists).

d) Confidentiality

Confidentiality was often linked to anonymity by the young people participants in the studies, with eight studies identifying the importance of confidentiality for young people. Studies by Hayter et al. (2005b), Ingram and Salmon (2007), Donnelly (2000), Craig and Stanley (2006), French et al. (2005), Croghan (2006), Salmon and Ingram (2008) and Coleman and Testa (2008) specifically identified confidentiality as a theme. Young people described professionals having their name and address, or a personal file on them to be a concern, with some concerned that staff would breach confidentiality either deliberately or by omission. Hayter et al. (2005b) report in particular the

description of concerns at discussing sexual health matters at a youth club due to the noisy environment and proximity of other people. Croghan (2006) describes the concerns of young Pakistani women regarding confidentiality from health professionals of the same background, and the Griffiths et al. (2008) study also reports particular concerns regarding confidentiality of a GP amongst particular ethnic groups (African and Indian). School-aged participants held opposing views regarding whether a school-based service or a GP service provided greater confidentiality in the Salmon and Ingram (2008) study. Issues regarding confidentiality were raised in particular in regard to young people living in rural areas, where it was a small community and staff at clinics, surgeries or pharmacies may know the young person or their friends, or be friends with the parents of a young person (Craig and Stanley, 2006, Stanley, 2005). There were fears that clinic reception staff with access to records may breach confidentiality. These concerns seemed to be most often reported as related to GP surgeries (Griffiths et al. 2008, Pearson, 2003, French et al. 2005).

Six papers report staff views regarding the importance of confidentiality. Bloxham (1997) highlights that facilities not linked to schools may be perceived as having greater confidentiality. Hoggart (2006) reports the staff view that schools vary in regards to their policies on confidentiality. Bissell and Anderson (2003) describe staff reports of women deliberately travelling to an unfamiliar neighbourhood to seek emergency contraception in order to allay fears of lack of confidentiality at their local pharmacy. Mackie et al. (2002) report that staff have concerns regarding a lack of privacy on a pharmacy shop floor waiting area. McCann et al. (2008) reports the perception of staff in a rural area of Northern Ireland that procedures regarding confidentiality were well managed and consistent among different professional groups.

The theme of confidentially was strongly supported in the survey data. In a study of the importance of confidentiality in sexual health clinics (with 13-14 year olds) Thomas et al. (2006) reported that 86% would use a service if it was confidential, and only 55% would use a non confidential service. 63%

would not attend a clinic if they thought that child protection services would be informed and 46% would not want their GP to be informed of their attendance. In addition 56% of respondents said they would rate confidentiality as the most important feature of a service. In a second study, Stone and Ingham (2003) reported that young women under 16 were the most likely to report concerns over confidentiality as a reason for delaying service use. Thirdly, Pearson et al. (1995) reported that 44% of their respondents (mean age 17.6) had been put off using a family planning clinic due to perceived lack of confidentiality.

In addition, in a survey study of general practitioners, Garside et al. (2000) reported that 76% of GPs preferred that parents were informed when a young person consulted them about contraception. Burrack (2000) reported that 58% of their respondents (age 13-15) were concerned that their confidentiality would not be preserved by their GP.

Evidence statement 18. The importance of confidentiality

Eleven papers report that confidentiality Is a key concern to young people in accessing a sexual health service. Concerns regarding confidentiality feature particularly in regard to rural areas and GP practices (Ingram and Salmon 2007++ 14-18 years, French et al. 2005++ 18-25 years, Coleman and Testa 2008++ Black and minority ethnic youth 16-23 years, Donnelly 2000+ 15-25 year olds, Hayter et al. 2005b+ 13-18 years, Griffiths et al. 2008+ 16-20 year olds, Pearson 2003+ young men 13-21, Stanley 2005+ 12-17 year olds, Craig and Stanley 2006 -12-18 year olds, Croghan 2006 –16-21 year olds, Salmon & Ingram, 2008+ school aged).

e) Respectful/non judgemental staff

Ten papers make reference to the value to young people of staff being respectful and non judgemental. Hayter (2005b), Baraitser et al. (2003), Ingram and Salmon (2007), Folkes et al. (2001), Pearson (2003), Donnelly

(2000), Craig and Stanley (2006), French et al. (2005), Higginbottom et al. (2006) and Mason (2005) describe views and perceptions that the attitudes of staff towards young people are important. Baraitser et al. (2003) report that young people were more likely to comment on the attitudes of staff than to make an assessment of their knowledge or technical competence. In the Folkes (2001) study, some participants had experience of negative encounters with professionals when they were seeking emergency hormonal contraception, when they felt that they were being judged. The fear of being judged is described by young people in 8 of these studies, with Mason (2005) concluding that staff needed to be more understanding of why girls wanted to have sex, and the suggestion from the Pearson (2003) study that young people perceived that staff nearer to their own age may have less disapproving beliefs. The Free et al. (2002) paper similarly describes the perception of young people accessing emergency contraception that they were being "told off", and that more youthful staff would have less disapproving beliefs.

Young people reported that they were aware of the potential disapproval of adults towards them becoming sexually active, with concerns regarding what staff and other adults would think of them (Sixsmith et al., 2006, Lester and Allan, 2006, Free et al. 2005). Young people described concerns to preserve their image and social standing, and not lose their reputation or be stigmatised (Pearson, 2003, Craig and Stanley, 2006, Free et al., 2005). Participants reported in the Ingram and Salmon (2007) study that they would like to be treated as an adult and not be made to feel ashamed by adults. The approachability and friendliness of staff in a school clinic was highlighted as a particularly positive aspect by participants in the Salmon and Ingram (2008) study.

Staff perceptions regarding their own and other staff attitudes towards young people are reported in 4 papers. Fallon (2003) describes staff views in an accident and emergency department that some medical staff could demonstrate a lack of sympathy for young people requesting emergency contraception. In this study the author describes that while staff recognise the

importance of being non-judgemental that there was some ambivalence in staff attitudes between being sympathetic and being judgemental towards adolescents. Pitts et al. (1996) also report ambivalent emotions and language in regard to teenage sexuality, suggesting some unease amongst sexual health service staff participants regarding the onset of sexual activity in young people. The authors conclude that there was a potential tension between the underlying attitude to young people's sexual behaviour and the need to help. Baraitser et al. (2003) reports the perception amongst family planning service staff that there was a difference in attitudes between staff members, Bloxham (1997) describes the view amongst sexual health service staff that staff needed to accept a young person's sexual status.

In terms of the survey data Chambers et al. (2002) sought the views of young people (aged 12-20) and health professionals and found that both groups suggested that staff should be educated to be more sensitive in relating to young people. In a second survey, practice nurses reported feeling more confident in discussing sexual health issues with young female patients (89%) than males (54%) and nurses who had received specific training reported more positive attitudes towards discussing sexual health issues with young people.

Reeves et al. (2006) asked young people aged 15-16 about the most important list of features a sexual health clinic should have, and found that "a friendly atmosphere" and staff who were "easy to talk to" rated the highest.

Evidence statement 19. 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 (Ingram and Salmon 2007++ age 14-18 years, French et al. 2005++ age 18-25, Higginbottom et al. 2006++ young mothers, Free et al. 2005++ 16-25 year old women, Ingram and Salmon 2007++ 14-18 year olds, Folkes et al. 2001+ age 18-29, Pearson 2003+ young men 13-21, Donnelly 2000+ 15-25 year

olds, Hayter 2005a+ women over 16 years, Baraitser et al. 2003+ under 16-25 years, Free et al. 2002+ 16-25, Sixsmith et al. 2006+ 14-19 years, Lester and Allan 2006+ 14-15 years, Craig and Stanley 2006 –12-18 year olds, Salmon & Ingram, 2008+).

Five papers report that staff also recognise the importance of being non-judgemental, however they highlight that some individual staff may have ambivalent or varying attitudes towards young people and sexuality (Fallon 2003+ A&E nurses, Pitts et al. 1996+ GPs and practice nurses, Baraitser et al. 2003+ clinic staff, Bloxham 1997- community service staff, Chambers et al. 2002 survey health professionals).

f) Cost

Three papers make reference to cost issues for young people accessing contraceptive supplies. Bissell and Anderson (2003) and Folkes et al. (2001) describe cost concerns from young people in relation to over-the-counter emergency contraception. Sixsmith et al. (2006) describe concerns regarding the cost of condoms.

Evidence statement 20. Concerns regarding cost

Three studies report that the cost of contraception is a concern for some young people (Bissell and Anderson 2003++ pharmacists, Folkes et al. 2001+ 18-29 year olds, Sixsmith et al. 2006+ 14-19 year olds).

g) Anxiety

Anxiety underpins much of the data concerning young people's views regarding confidentiality and anonymity; however 2 papers specifically highlight the anxiety felt by young people when accessing a service for the first time, and one paper reports anxiety in regard to emergency contraception

supplies. Baraitser et al. (2003) describe the sense of relief and accomplishment felt by a young person following an appointment, and Lester and Allan (2006) highlight the lack of confidence felt by young people attending a clinic. Fairhurst et al. (2004) describe the easing of anxiety felt by young women who were provided with emergency contraception in advance.

Evidence statement 21. Feelings of anxiety

Two studies specifically highlight the anxiety felt by young people when accessing sexual health services (Baraitser et al. 2003+ under 16-25 years, Lester and Allan 2006+ 14-15 year olds). Anxiety also relates to the evidence concerning confidentiality and embarrassment.

h) Environment

Views regarding the clinic environment are outlined in four papers. Baraitser et al. (2003) report that clients made more comments on the waiting room than any other topic in their mixed method evaluation of a family planning service. Young people disliked a clinical appearance, wanted a more homely and more cosy space resembling a communal living space in a private home. Also, participants requested improved entertainment in the waiting area as this was perceived as a very stressful time, with long waiting times and stressful and silent waiting room areas reported as leading some people to leave before they were seen. Ingram and Salmon (2007) in their evaluation of a nurse-led drop in clinic similarly reported that the social nature of the clinic was viewed as a positive aspect. Pearson (2003) also described a welcoming and friendly atmosphere as important for young people, echoed by Salmon & Ingram (2008) who report young people's positive views of a clinic as being comfortable and relaxed.

Staff views reported in one study echo these of young people with participants in the Bloxham (1997) study describing the importance of an informal and comfortable atmosphere that was non-clinical and young-person friendly.

Evidence statement 22. Clinic atmosphere

Four studies provide evidence from young people regarding the importance of a comfortable, and welcoming atmosphere in sexual health service premises (Ingram and Salmon 2007++ 14-18 year olds, Baraitser et al. 2003+ under 16-25 years, Salmon & Ingram, 2008+, Pearson 2003+ 13-21 year old men. This is echoed in a study of staff views (Bloxham 1997- community staff).

i) The consultation

Seven papers report young people's views regarding specific elements of a consultation with a service staff member. Lester and Allan (2006) describe young people as preferring someone who got "straight to the point". Pearson (2003) also suggested that brevity was important, with the male study participants valuing minimal contact time with no personal questioning or counselling. Free et al. (2005) reports that young people would like a professional, friendly, matter of fact approach, someone who shows understanding and that they could build a relationship with. Building a relationship is also referred to in the Schubotz et al. (2004) paper with perceived trust important in building the relationship. Powell (2008) describes the importance of being easy to talk to, someone that a young person can feel comfortable with. French et al. (2005) explore views in particular of ethnic minority young people, describing diversity in views regarding whether the ethnicity of the member of staff was important, and whether the age and gender of the staff member was important.

Staff views regarding a consultation focus on the importance of establishing a relationship with the young person, reported by Fallon (2003), Bloxham (1997) and Pitts et al. (1996). In the Pitts study GPs stressed that their knowledge of a young person in a family context and broader relationship with them was beneficial. Bloxham (1997) similarly describes staff perceptions that familiarity with a young person was important. This study reports the view of staff that youth and community workers establish a different kind of relationship with

young people from other professionals such as teachers. The benefit of youth works using colloquial expressions and explicit language in discussions is also described.

Evidence statement 23. Aspects of the consultation

Five studies describe young people's views regarding aspects of the consultation that are important such as brevity, trust and a good relationship (French et al. 2005++ 13-21 year olds, Free et al. 2005++ 16-25 year olds, Lester and Allan 2006+ 14-15 year olds, Pearson 2003+ 13-21 year old men, Schubotz et al. 2004+ no details of participants). Three studies echo these findings, indicating that staff also view the building of a good relationship as important (Fallon 2003+ A&E nurses, Pitts et al. 1996+ GPs and practice nurses, Bloxham 1997- community staff).

4.4.8 Sources of information about contraceptive services

The significance of friendship networks in gaining information and advice regarding contraceptives and contraception services for young people is reported in 7 studies Baraitser et al. (2003) describe friends as an important source of information and support, Lester and Allan (2006) report friends and school were the main sources for learning about contraception in a school-based population. Bell and Millward (1999) and Ziebland and Maxwell (1998) in studies of emergency contraception confirm that information was obtained primarily from friends and peers amongst clinic clients. Powell (2008) similarly highlights the importance of friends and peers in discussing sex and relationships with most female participants reporting that friends were the first people that they would go to, findings echoed by Jewell et al. (2000). Free et al. (2002) describe that friends and parents influenced attitudes and were sometimes instrumental in supporting young women in obtaining or not obtaining contraceptives.

A survey by Van den Akker et al. (1999) reported that more girls than boys (mean age 15) thought their friends were truthful about their sexual experiences ($p<0.05$).

The role of parents in advice, information and support is reported to vary between individuals. Hayter (2005b) describes the perception of participants that they were not able to talk to parents about sexual health or relationships. Participants in the Curtis et al. (2005) study also discuss a reluctance to talk with parents about sex and contraception due to embarrassment. In the Lester and Allan (2006) study it is reported that where parents were involved it was often in a negative way, with a perception of over-emphasis on abstinence. In the Powell (2008) study opinions on parental support differed between the participants. The author attributes these differences to the nature of different parental relationships and the nature of the issue.

Survey data to support this is reported by Stone and Ingham (2002) who reported that having parents who portrayed sexual activity as positive during childhood and early teenage was associated with use of contraception at first sex among young men (age 16-18) [OR1.16]. ($p<0.01$). The "warmth and availability of parents" was also a factor for young women [OR 1.04]. ($p<0.01$). In a second study by Campbell and Macdonald 1996) parents (along with the family doctor and youth advisors) were reported as one of the major sources of help for 13 to 15 year olds (for all problems, not just those related to sexual health). For contraceptives these were 31%, 30% and 26% respectively.

In regard to extended families the study suggests that the pre-existing relationship impacts on whether information, advice or support was sought. It is suggested in this paper that needs differ according to age with younger people needing formal sources of information and advice, whereas older adolescents are more likely to turn to peers, also that gender, ethnic group, and religion are influential in determining information and advice needs. The Van Teiglingen (2007) study supports this reported variation in role of parent, with the suggestion that young people can talk to parents only if they are close to them.

The role of school in providing information is highlighted in Lester and Allan (2006), Bell and Millward (1999), French et al. (2005), Coleman and Testa (2008).

Advice columns, articles in teenage magazines, help lines and the internet were mentioned as providing information in the French et al. (2005) study. Selwyn and Powell's (2006) study concluded that the majority of young people in a deprived area were not using the internet to actively find out about sex, sexual health or relationships. They describe instead a trend for young people to come across information in passing via chatrooms and bulletin boards rather than on purpose, and conclude that online sources have a peripheral role in relation to other sources of information and advice.

Evidence statement 24. Sources of information

A.

Seven studies suggest the importance of friends of young people acting as a source of information and advice regarding contraception. Jewell et al. 2000++ 16-22 year olds, Baraitser et al. 2003+ under 16-25 year olds, Lester and Allan 2006+ 14-15 year olds, Bell and Millward 1999+ 18-34 year olds, Ziebland and Maxwell 1998+ women attending for EHC, Powell 2008+ 12-19 year olds, Free et al. 2002+ 16-25 year olds). One survey suggests that use of friendship networks may be more important for 11-19 year old girls (Van den Akker et al. 1999).

B.

Five papers indicate variation amongst young people regarding their use of parents for information and advice. Studies suggest that this variation may be dependent on the parent-child relationship (Lester and Allan 2006+ 14-15 year olds, Van Teiglingen 2007+ 12-13 and 16-17 year olds, Curtis et al. 2005- 15-18 year olds, Stone and Ingham 2002 survey 16-18 year olds, Campbell and Macdonald 1996 survey 13-15 year olds).

4.4.9 Accuracy of information about contraceptive services

There were no papers that explored the accuracy of information about services.

4.4.10 Credibility of information about contraceptive services for young people

There were no papers that explored the credibility of information specifically, although work reported above in relation to knowledge of and trust in contraceptive services may have relevance.

4.4.11 Service provider views of service delivery

Staff providing services described views regarding how the services were currently being delivered or should ideally be delivered within the themes of resources, interagency working, and staff training.

a) Resources

Five papers report staff concerns regarding limited resources (Hoggart, 2006, McCann et al., 2008, Jolley, 2001, French et al. 2006, and Fallon 2003). The Jolley paper describes staff concerns in a gynaecology department that these limited resources resulted in a lack of promotional material and information resources in regards to sexual health. Staff in the French study voiced concerns that commissioning priorities around sexual health including both contraception and genitourinary medicine were patchy. Hoggart reports that staff perceived the restrictions of geographically limited initiatives, and Fallon reports the perception that emergency contraception is a low priority in accident and emergency departments.

Evidence statement 25. Availability of resources

There is evidence from five studies that staff have concerns regarding limited availability of resources for sexual health services (Hoggart 2006++ range of professionals from different services, French et al. 2006- key informants, Fallon 2003+ A&E nurses, McCann et al. 2008 – no details of participants, Jolley 2000- nurses.

b) Interagency working

Papers by Hoggart (2006), Jolley (2001), French et al. (2005), Salmon & Ingram (2008) and Higginbottom et al. (2006) report concerns regarding the success of working between different agencies delivering sexual health services. Issues regarding the need for improved connection between agencies and an integrated strategy (Hoggart), the need for leadership (Jolley), the need for collaborative networks with clear signposting and consistent messages between services (French et al.) and concerns regarding role limitations or confusion (Higginbottom, Jolley) are reported. Salmon & Ingram (2008) report that while joint working between agencies had been a particularly successful aspect of a school service innovation, that there was still a need for links between the service and other community agencies to be improved.

In a survey of professionals (and young people) and their attitudes towards contraception and preventing teenage pregnancy, the professionals stressed that the re-organisation of sexual health and education services was key (Chamber et al. 2002).

Evidence statement 26. Agencies working together

There is evidence from six studies that staff perceive the importance of well-organised services, and different agencies working together effectively (Hoggart 2006 ++ professionals from different agencies, French et al. 2005++ stakeholders/professionals, Higginbottom et al. 2006++ service providers, Jolley 2001– nurses, Chamber et al. 2002 survey, health professionals, Salmon & Ingram 2008+ service providers of a school outreach service).

c) Staff training

Lack of training for staff was perceived as a major barrier to high quality service provision by participants in the McCann et al. (2008) study, and echoed in Jolley (2001). Seston et al. (2001) and Barrett and Harper (2000) describe in particular a lack of knowledge or confusion regarding emergency hormonal contraception, amongst pharmacists, and Bloxham (1997) describes concerns amongst teachers at a lack of training. French et al. (2006) describe

a traditional historical divide between GUM clinics and contraceptive services with many staff now employed in one stop shop services not trained in both. Jolley (2001) describes nurses concerns regarding variation between individual staff in regard to taking a sexual history, and also the perception of a lack of support and training in how to deal with aspects of work with young people that they found upsetting, or the young person found embarrassing. Some staff in this study perceived that the particular needs of working with teenagers required a specialist service.

Evidence statement 27. Staff training

There is evidence from six studies that staff perceive a need for greater training in regard to providing contraceptive services for young people (Seston et al. 2001+ pharmacists, Barrett and Harper 2000+ pharmacists, McCann et al. 2008- nurses, Jolley 2001- nurses, Bloxham 1997- community health service staff, French et al. 2006- stakeholders/professionals).

5. DISCUSSION

5.1. Summary of identified research

The review has identified a number of themes relating to contraception and the delivery of contraceptive services. The evidence suggests that young people across the age range and of both sexes, lack knowledge regarding contraception in respect of correct usage, what is available, and the existence of emergency contraception. This lack of knowledge also extends to knowledge of how and where to access services. The findings also suggest that a strong sense of embarrassment amongst young people regarding contraception is a factor inhibiting contraception and service use. In the time since the studies have reported their findings, there may have been significant changes in provision of services and provision of emergency contraception. In particular the findings regarding views of pharmacists and the provision of emergency contraception via accident and emergency may be of less relevance.

A key theme that emerged relates to the importance of context in young people's sexual behaviour and contraception use. The findings suggest that young people's concept of risk and risk-taking behaviour may be important in understanding whether contraception is used or not, with alcohol use in particular being linked to an increase in risky sexual behaviour. The importance of understanding the particular situation of a young person, and the context within which sexual relationships operate is highlighted by studies which link changing contraceptive use with the type of relationship. This work suggests that longer term or "trusting" relationships may lead to less careful use of contraception in addition to having a significant impact on the decision regarding whether to continue with or terminate a pregnancy. The context may also be important in views regarding the prospect of motherhood and emphasis placed on avoiding becoming pregnant. In addition to the nature of the relationship, the review suggests that social background may influence attitudes to abortion and teenage pregnancy amongst young people.

Views of particular forms of contraception are described by the included papers. There is evidence of diversity in views regarding condoms, with concerns regarding a physical barrier and also negative connotations of girls carrying condoms, together with positive views of condom use being socially responsible. Similarly, views regarding oral hormonal contraception are mixed, with concerns regarding the ingestion of chemicals together with positive views of this form of contraception being less expensive, more reliable and giving control over menstruation. Cost of contraception was mentioned as a concern by some young people. Emergency hormonal contraception may also be perceived by young people as causing concerns regarding the ingestion of chemicals and the potential for being unsafe or having side effects. There is evidence of negative perceptions amongst service providers regarding easy access to EHC for young people.

Peer group norms were not specifically described in the papers, although age and gender differences in perceptions of contraception are suggested.

In regard to perceptions of service delivery, the limited knowledge of local services amongst young people is highlighted. The value of having trust and confidence in services is described. Concerns regarding attending GP practices for contraceptive services are indicated, together with family planning clinics being perceived as only for girls or older married women. The importance of accessibility of services in terms of a convenient location, opening hours and having choice in where to go is outlined. Evidence regarding preference for appointment systems versus drop in clinics indicates a lack of consensus. A significant concern for young people is the preservation of anonymity and confidentiality when accessing services, in particular in rural areas or when attending a GP practice. These concerns may contribute to the perceptions of anxiety experienced by young people when accessing a service, particularly for the first time.

Other aspects of service delivery described in the papers relate to the attitude of staff, content of the consultation, and the clinic environment. It is reported that young people value staff that have a respectful and non judgemental attitude towards them, and prefer a welcoming and non-clinical environment that is informal and comfortable. Aspects of the consultation that are suggested as important are brevity, the establishment of trust and a “good relationship”.

The significance of friendship networks for information and advice is highlighted in the review, particularly amongst young women. The role of parents was reported to vary between individuals, with evidence also that schools act as a source of information. It is suggested that online sources may have a secondary role to other sources of information and advice.

The review suggests that service providers have concerns regarding limited resources for sexual health services and the need for greater training. Also, the perception that good service organisation and different agencies working together is of importance.

5.2 Research questions for which no evidence was found

There were no papers that specifically explored the accuracy of information about services, or the credibility of information about services. As Table 5a indicates, often the study population was broad, with limited information provided by authors regarding more specific details (this may have been linked to confidentiality issues with small qualitative studies). None of the studies indicated that they included young people with learning disabilities.

5.3 Implications of the review findings for interventions

Findings from the views review may provide further insight into the delivery of interventions in education, health care and community settings examined in the effectiveness reviews. As the papers from the views review encompassed only studies undertaken in the UK, they may also serve to apply a UK context to the effectiveness reviews that were largely USA based.

Knowledge of contraception

In regard to views review findings describing a lack of knowledge of the different forms of contraception, the effectiveness reviews suggest that some interventions in each setting had the potential to improve contraception knowledge. Increased knowledge was a common outcome measure used to assess effectiveness (see for example Healthcare review Evidence Statement 4, Education review Evidence Statement 4, Community review Evidence Statements 1, 2, 3).

The views review found that emergency contraception was an area of particularly limited knowledge amongst young people. The Healthcare setting review (Evidence Statement 2) supported the advanced provision of emergency contraception supplies which would potentially impact on this low reported knowledge. It was suggested however that advanced provision could promote risky sexual behaviour in adolescent mothers. The evidence of effectiveness of advanced provision is also measured by self-reported use of

EHC, rather than measuring effectiveness in terms of avoidance of unintended pregnancies.

Knowledge of where to access supplies

The views review also suggests that young people had limited knowledge in relation to knowing where to obtain contraception supplies. The intervention reviews in contrast tend to measure and provide data on contraceptive knowledge rather than knowledge of how and where to obtain supplies (although clinic attendance rates may act as a surrogate measure of this). The Healthcare setting and Education setting reviews provide evidence that newly-developed services targeting young people could improve contraception use (Healthcare review Evidence Statement 1). Also, indicate that interventions which encouraged access to existing services could be effective in improving contraception use (Education review Evidence Statement 3). The Healthcare review cautions however, that whilst new teenage clinic interventions were successful in increasing attendance rates, there was no impact on teenage pregnancy rates. The views review emphasises the importance of embarrassment in relation to accessing services, yet there is no corresponding discussion or evidence relating to interventions which may impact on this potential barrier to young people accessing services.

Behaviour change

Having knowledge of contraception may not always lead to behavioural change, and factors underpinning the use or non-use of contraception are described in the views review. In particular the potential relationship between alcohol and risky sexual behaviour, and factors underpinning the changing use of contraception over time are described. Evidence from the healthcare setting review suggests that a cognitive behavioural therapy intervention can have an impact on the rate of unprotected sex (Evidence Statement 3) also that a “transactional intervention” may facilitate contraceptive adherence (Evidence Statement 4). The education setting review describes a motivational interviewing intervention which reduced alcohol-exposed pregnancy (Evidence Statement 2). This review also outlines a school-based

health centre intervention (Evidence Statement 3) which it is claimed reduced risky behaviours (although analysis of the findings questions this).

Perceptions of young parenthood

The effectiveness evidence largely considers measurements such as self-reported knowledge, self-reported contraception use and pregnancy rates, rather than discussing perceptions of motherhood or a young person's desire to become a mother. The views review in contrast explores perceptions regarding young motherhood and decisions to continue or not with a pregnancy. The findings highlight that individuals differ in regard to the emphasis placed on avoiding becoming pregnant. These individual differences may be significant in the varying success of intervention programmes amongst young people. The views review also suggests that exploration of the value judgements underpinning contraception may be important to include in intervention programmes. The only intervention studies which contain elements related to parenthood are papers in the education setting review which examine the use of infant simulator interventions. However, these programmes measured knowledge, attitudes and behaviour relating to contraception and sexual behaviours rather than motherhood.

The effectiveness reviews all include programmes targeting the reduction of repeat pregnancies, aiming to address various aspects ranging from "inner wellbeing", interpersonal skills, and contraceptive use, to career planning. Some of these programmes include aspects relating to life choices, although the evidence of effectiveness is mixed (Healthcare review Evidence Statement 5, Education review Evidence Statement 2, Community review Evidence Statement 2).

Perceptions of different forms of contraception

The effectiveness reviews indicate that interventions across all settings can increase the use of condoms and hormonal contraception (see for example Community review Evidence Statement 1). The report of negative as well as positive perceptions reported in the views review may be important however, if

uptake and usage is to be maximised via these interventions. There are reports in particular of concerns relating to the ingestion of chemicals or “unnatural” hormones contained in hormonal and emergency hormonal contraception. Barriers reported in the views review regarding adverse perceptions of EHC amongst women and also health professionals may need consideration in any programmes aiming to increase uptake of this form of contraception. It is suggested that there may be age and gender differences in regard to perceptions of contraception however, this is not reported in any of the intervention studies.

Service delivery

The views review suggests that young people may perceive that family planning services are for married women and older people. This may link with the benefit of services specifically for teenagers, outreach services, and the effectiveness of specific signposting to main stream services for young people reported in the Education review (Evidence Statements 1, 3).

In contrast with the views review which explored the perceptions of young people regarding aspects of the service such as appointments, confidentiality and anonymity; the intervention studies provide no details regarding how these concerns may have been addressed. The strength of importance of these factors to young people reported in the views review suggests that these aspects are important to consider when planning interventions. Similarly, the value placed by young people on staff having respectful and non-judgemental attitudes should be taken into account. The Education review suggests that having culturally matched social workers may add to the effectiveness of an intervention (Evidence Statement 1).

The views review highlights the importance of the building of a good relationship, brevity and trust during consultations, also the creation of a comfortable welcoming atmosphere in contraceptive service premises. These aspects may be facilitators or provide barriers to young people taking up available services and the effectiveness of any intervention, although were not described in the reported studies.

The community and health care settings reviews do not discuss any factors specifically related to location. The education services review indicated that school clinics which were on-site and offered a dispensing service could be effective (Evidence Statement 3). This may link with the perceived importance of accessibility of services, and convenient location and opening hours reported in the views review.

7. REFERENCES FOR BACKGROUND SECTION

Department for Children, Families and Schools (2008) Teenage parents: who cares? A guide to commissioning and delivering maternity services for young parents. London: Department for Children, Families and Schools.

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Office for National Statistics (2007). Conception statistics in England and Wales 2006. London: Office for National Statistics.

Population Action International (2007). A measure of survival: calculating women's sexual and reproductive risk. Washington DC: Population Action International

8. APPENDICES

Appendix 1: Extraction tables for included studies

1.1 Qualitative studies

Reference	Research question	Theoretical approach and data collection	Data analysis	Population	Key themes	Limitations	Evidence gap
Allen, B (20040 Drop-In clinics in secondary schools: the perceptions and experiences of school nurses	What are the experiences and perceptions of nurses running drop in clinics?	Grounded theory Focus groups and interviews Four focus groups 6 interviews Opportunistic sample for focus groups recruited via written invitation Interviewees purposefully selected from focus group participants	Data analysis conducted alongside data collection. Emerging theories identified from key themes.	N = 28 Grades E,F,G,H Two localities, one urban one mixed urban/rural	Moral dilemma of giving contraception to pupils without parental knowledge. Feeling of being over-whelmed, unprepared and anxious. Issue of limited time available with individuals. Importance of active support and promotion from the school, with regular communication between nurses and key school staff. Importance of establishing trust between nurse and school staff in maintaining pupil confidentiality and between pupils and nurse. Needs to take time to build up. Need for suitable surroundings and congenial surroundings. Drop in clinics run by nurse together with a co-worker were reported as beneficial. Role of school nurse in facilitating access to other services. Concerns regarding inadequately resourced service.	Small number of direct quotes used. Difficult to tell how representative these are, not traceable. Described as grounded theory but doesn't develop any theory.	
Arai, L. (2003) Low expectations, sexual attitudes and knowledge:	What are young	Interviews	Thematic analysis.	9 Teenage pregnancy	Co-ordinators viewed low expectations and sexual attitudes and knowledge both contributing to teenage pregnancy and	Single data source	

explaining teenage pregnancy and fertility in English communities. Insights from qualitative research.	mothers' and teenage pregnancy co-ordinators' accounts of pregnancy and motherhood? Funding: Queen Mary and the University of London Central Research Fund.	Carried out by author.		local co-ordinators Purposive sampling of different types of areas (rural, urban, north, south, high teenage pregnancy, high abortion). 12 women who had their first child before age 20. Inner London, Northumberland, Manchester.	parenthood. Co-ordinators recognised link between poverty, deprivation, lack of opportunity and early pregnancy/motherhood. None of the teenage mothers considered that they came from a poor family and most not from poor communities, but often mentioned rough places where the used to live or were near their homes. Co-ordinators perceive link between young women with career aspirations or education and reduced likelihood of early pregnancy/abortion. Many young mothers had a weak attachment to the education system before they became pregnant, and many in low paid jobs. Co-ordinators' perception that no simple relationship between sexual health services, sex education, and reproductive outcomes. Accounts given by teenage mothers suggest that improved sexual health services may make little difference. Most reported that they had been using contraception when they had got pregnant. Early child bearing can be seen as a positive and rational behaviour. Viewed as an alternative vocation, or childbearing as a way to be loved. Examples of individuals who have been in care reacting to pregnancy with joy or prospect of having a better life. Co-ordinators in contrast whilst recognising that in some situations motherhood could be beneficial also perceived	Single researcher	

					early motherhood was unfortunate and young mothers had the odds against them.		
Baraitser et al. (2003) Barriers to the involvement of clients in family planning service development: lessons learnt from experience	How feasible is the use of peer interviewers in family planning clinics? How do the results of this approach with what is already known about users views of contraceptive services? What are staff views of this approach to user consultation?	Participatory approach Interviews + staff survey open question data Clinic users trained to interview their fellow clinic users. Interviewers recruited via posters in the waiting room. Trained in interviewing skills, honorary contract, paid a fee per interview. Interviews used visualisation of bricks for negative aspects of the service and leaves for positive. Participants to be interviewed recruited in clinic waiting room by interviewer, received gift voucher. Convenience sample.	Data sorted by timeline (occurrence of events). Thematic analysis. Particular attention paid to negative instances.	N = 46 12 under 16 years, 19 16-19 years, 15 20-25 years M = 4 F = 42 8 white British, 8 black Caribbean, 6 black British, 6 black African. Staff survey N = 22	Friends an important source of information and support. Almost half reported visiting the clinic for the first time with a friend, usually someone already familiar with the service. New clients often used services close to their friend's house or school rather than their own. Often they continued to use this clinic rather than their local one as it is familiar. Clients made more comments on the waiting room than any other topic. Disliked clinical appearance, wanted more homely, more cosy, colours. A preference for a waiting space resembling a communal living space in a private home. Also preference to improved entertainment, as waiting in silence is stressful. Giving personal details at reception stressful including name and address, causing embarrassment. Variability regarding preference for drop-in service or appointments. Combination of long waiting times and stressful atmosphere in the waiting room could cause people to leave. Participants more likely to comment on the attitudes of staff than to make an assessment of their knowledge or technical competence. Positive comments related to staff being non-judgemental and being listened to. Following the appointment report of sense of relief and being proud that they had accomplished a difficult thing.	No details regarding who analysed the data. Convenience sampling of participants.	Further work needed on identifying common goals between staff and clients in terms of improvements to services.

					Staff Perceived practical difficulties in responding to suggestions re environment. Agreed waiting times too long. Perception of being accessible despite long waiting times. Differences in attitudes between staff members.		
Barrett, G. & Harper, R. (2000) Health Professionals' attitudes to the deregulation of emergency contraception (or the problem of female sexuality)	What are the views of community pharmacists and GPs towards the possible deregulation of emergency contraception? Funding source: None stated	No theoretical approach identified although influence of feminist research. Interviews. Conducted by the second author. Interviews took place in pharmacy or GP surgery 1996.	Use of Framework method. Described as a thematic reconstruction of professionals' responses.	N = 24 M = 21 F = 3 Age mid 20s – late 50s. 16 Asian origin, 8 White. 18 community pharmacists and 6 GPs. 3 health authorities in South Thames region. Purposive sampling. This data part of a study evaluating consultation areas in pharmacies. No details regarding	Overwhelmingly negative attitude to deregulation. Only 3 participants provided positive comments. Deregulation was reconstructed as a social as well as a medical question. Assumptions being made by participants about the sexuality of women who used emergency contraception. Perception of typical user as sexually irresponsible, chaotic and devious. Anticipation that deregulation would affect sexual behaviour. Restrictions on availability acted as a control on sexual behaviour. Deregulation was associated with sexual excess. Lying to obtain, stockpiling, abuse the use of it. Assumption that users of emergency contraception would be young unmarried women. Concerns regarding the safety of emergency contraception used as a justification for the need for control of it. Need for training for pharmacists, concern that existing practices on shop floor not suitable for emergency contraception. GPs perceived a need to further educate the public.	Nature of the sample, high proportion Males and Asian. Recruitment process not described. Data obtained as part of a larger study. Single data source.	

				recruitment methods.			
Bell, T. & Millward, J. (1999) Women's experiences of obtaining emergency contraception: a phenomenological study	What are women's attitudes and beliefs regarding emergency contraception? Funding source: None identified	Heideggerian phenomenology. Interview. Conducted at the surgery. First author interviewer.	Used Giorgi's five stage process – no other details. Single researcher analysed data.	N = 8 Age range 18-34 years. 2 married 6 single. Women who had asked for emergency contraception at a GP practice in South West England. Practice located in a city centre and close to a university. Convenience sample. 14 approached, 6 later declined.	Information regarding emergency contraception was obtained primarily from friends, peers. School reported as a primary source of information for one participant. Health professionals not considered a resource for information. Women reluctant to consult a doctor for EC and approached friends before contacting a health professional. Terminology used "the morning after pill" rather than emergency contraception. Concerns regarding obtaining EC. Problems getting past the doctor's receptionist to get an appointment Report of being made to feel uncomfortable in A&E. "failure of EC" rather than failure of contraception. Perception of being judged, feeling guilty asking for EC. Fear that if they had taken EC several times it might be denied in the future. Variation amongst participants in whether they viewed EC as a necessary inconvenience "had to be done" (older women) or viewed with apprehension (younger women). Apprehension regarding the effects of the pill on their bodies. View among younger women that taking EC to often could be hazardous to health.	Single researcher. Employed at the practice being studied.	Need to remove obstacles to obtaining EC. Increased knowledge and awareness of EC needed. Information leaflets should be widely available.

					Reservations from women regarding de-regulation.		
Bissell, P. & Anderson, C. (2003) Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers	What are the views of pharmacists and service users regarding community pharmacies providing emergency hormonal contraception? Funding source: Manchester, Salford and Trafford Health Action Zone	Interviews + focus groups Stratified sample Interviews took place Oct 2000-Jan 2001. Interviews carried out by first author. Focus group participants recruited via service. Groups carried out early 2001.	Thematic analysis. Coding and checking by both authors.	Interviews N = 24 pharmacists Age early 20s to late 50s. M = 14, F = 10. 16 White British, 6 south Asian origin, 2 Chinese origin. Focus groups N = 11 (2 groups) Age 18-41. All women 8 White British, 1 Black British, 2 British Asian.	All but one pharmacist perceived clear benefits of the scheme in terms of easier access to EHC, opening hours, and lack of need to make an appointment. Over half reported that a key benefit was that it was free at the point of delivery. Others less convinced about free provision. Pharmacists perceived as a superior route for supply as more thorough than other service providers linked to specialist training. Confidentiality of the service an important advantage providing anonymity. Report of women travelling to other neighbourhoods in order to remain anonymous. Benefits for pharmacy profession in terms of reassessment of perceptions by the public, and extension of role. Most commonly voiced concern that supply might lead to increase in unprotected sexual intercourse. Differentiation between responsible and irresponsible requests for EHC. Users expressed generally positive assessments of the service, pharmacists helpful, convenient, and speedy, lack of need to make appointment, extended opening hours, weekend provision, discrete and anonymous, detailed explanation given, free at point of need. Concerns regarding potential for increase in STIs and increase in unprotected sex.		Need for work investigating the ways in which pharmacy supply of EHC shapes attitudes towards sexual risk taking. Need for further investigation of the dynamics of contraceptive decisions and the contextual influences on these decisions.
Bissell, P. Savage, I., & Anderson, C. (2006) A qualitative study of pharmacists	What are pharmacists views and experiences of supplying emergency	Interviews Purposive sampling of participants to provide spread in terms of gender, ethnicity, age	Thematic analysis. Coded by one member of team and checked by	N- 44 Community pharmacists supplying EHC in Manchester,	Predominantly positive views regarding supplying EHC. Most commonly cited benefit was improved access or availability due to opening hours, and no appointment. Also confidentiality /anonymity seen as an important advantage. Report of women travelling out of their local area to obtain EHC.	Single data source. No details regarding recruitment process.	Relationship between EHC supply, use of routine contraception and unwanted

perspectives on the supply of emergency hormonal contraception via patient group direction in the UK	hormonal contraception?	and sociodemographics. Interviews carried out in pharmacy by member of research team.	another. Techniques of constant comparison and attention to negative instances.	Salford, Trafford, Lambeth, Southwark and Lewisham. Age early 20s-late 50s. M = 32 F = 12 Ethnic mix of South Asian, white British and Chinese.	Positive regarding the protocol behind the supply of EHC. Also back up from family planning pharmacists. Certain aspects problematic Distinction between valid or responsible use in cases of mistakes or contraceptive failures and invalid choices to have unprotected sex. Concern regarding widened availability leading to increased unprotected sex, or repeated use of EHC. Variation in responses concerning discussing appropriate contraceptive practices at the point of supply of EHC. Potential conflict between desire to promote use of other forms of contraception whilst ensuring that women were not deterred from using the EHC service. Concerns younger or less assertive women might be coerced into taking part in non-consensual sexual acts.		pregnancies.
Bloxham, S. (1997) The contribution of interagency collaboration to the promotion of young people's sexual health	To examine interagency collaboration in the field of young people's sexual health Funding source: None	Case study design Interview method No other details	"Categorised different elements of provision and identified respondent's views" .	25 Staff from community health service (8) health promotion (4) youth and community service (8) and four secondary schools (6) Includes 1	Benefits of using external staff in schools. Informal/ comfortable atmosphere. Benefit of familiarity with staff. Youth and community workers establish a different kind of relationship with pupils. Benefits of drop-in facilities. Confidentiality of facilities not linked to school. Not attracting the attention of peers/staff. Being aware of services available. Perception of informal, detached work. Use of young people's colloquial expressions and explicit language in discussion. No-appointment system, non judgemental, non-clinical,	Interview schedule not piloted and changed after 6 interviews. Outlines what aspects were focussed on but not how the analysis was done. No quotes included.	Effectiveness of sexual health services is unclear. Need for evaluation of multiple agency provided services.

				joint appointment health promotion/youth community. Managers + those delivering services Medium sized town in the North of England	young-people friendly atmosphere. Importance of familiarity with person seeing. Constraints Lack of suitable accommodation Concerns regarding lack of training for teachers Need for counselling services to complement other services		
Brown et al. (2007) A qualitative analysis of accounts of hormonal contraceptive use: experiences and beliefs of British adolescents	What are the experiences and beliefs of British middle-class teenagers concerning contraception, particularly hormonal methods?	Interviews Recruitment from 2 classes of a sixth form college. 1st author conducted the interviews	IPA approach	N=16 M = 5 F = 11 Age: 16-18 years "middle class" Town in the North of England. None pregnant, or had previously been pregnant	Concerns regarding adverse effects of hormonal contraceptives – health, weight gain. Reports of positive benefits from oral contraception. More than one method used at the start of a relationship. Doctors perceived as promoting oral contraception in respect of regulating the menstrual cycle.	Small number of participants, of particular demographic. Few details regarding process of data analysis. Single data source and single researcher collecting data and analysing.	
Cheung, E., &	What are the	Interviews	Thematic analysis,	N = 40 Age 16-25	Those with strong desire to avoid pregnancy were consistent and persistent contraceptive users. Those who		Need to develop

Free, C.(2004) Factors influencing young women's decision making regarding hormonal contraceptives: a qualitative study	factors influencing young women's decision-making regarding hormonal contraceptives? Funding source: one author DoH	Participants recruited from family planning clinics, GP surgeries, hostels for homeless people, youth groups and schools. Interviews took place in a private room. Topic guide developed iteratively as interviews progressed. Recruitment until data saturation reached.	elements of Framework.	Predominantly White British (25). Residents of London area	did not place such a high value on avoiding pregnancy were more irregular with their contraceptive use. Concerns regarding the nature of hormones, that they would harm the body or be unsafe or dangerous. Perception of hormones being "unnatural" leading to some women avoiding them altogether, or stopping using them if experiencing side effects, or taking breaks from using them. Perception of having a regular period as normal and natural. Reluctance to use methods causing irregular bleeding or no period. Value of having control over menstruation that hormonal contraception offered.		attitudinal scales in order to identify those at risk of stopping contraception, taking breaks or reverting to inconsistent use of less effective methods.
Coleman, L. (2001) Young people's intentions and use of condoms: qualitative findings from a longitudinal study	What are the processes that facilitate and hinder the consistent use of condoms among young people? Funding: NHS R&D Directorate	Interviews (part of longitudinal study) Described as Interpretative Phenomenological Analysis. Recruitment via 8 young people's family planning clinics, 4 youth clubs, 2 youth advisory centres.	Thematic analysis, using principles of constant comparison.	N = 14 Age: 16-19 Southampton Young people who had experienced intercourse with a new partner in last 8-10 months. (Participants able to be contacted for initial	6 patterns of condom use/non use – consistent users, converted users, influenced users, over-optimists, resigned, consistent non-users. Consistent users of condoms exhibited high self esteem and self-efficacy in particular in the ability to discuss condom use with their partners. Consistent users likely to have the foresight and ability to prepare and plan for instances of intercourse. Description of triggers for some in increasing their self-efficacy and general confidence in using condoms, for one a pregnancy scare, for another a partner talking about condoms and it seeming natural. Importance of taking the first step in talking about	Authors describe lack of generalisability, small sample size, process of selection of interviewees and geographical limitation.	Need for further investigation of gender differences. Particular interventions may be more relevant to some young people than others.

		Purposive sampling using screening questionnaires or discussion to achieve diversity of socio-demographic characteristics and sexual behaviour.		and follow up phase of study).	condoms. Some participant's use of condoms seemed particularly subject to their partner's actions. Lesser ability to communicate their intentions, to negotiate in scenarios of conflicting intentions, plan and prepare for intercourse results in having less control over whether condoms are used. Over optimist does not lack will power or belief in their capability to use condoms, but does lack the facility to transfer intentions and expectations into subsequent behaviour. Resigned –express less willpower and have negative expectations of their own ability to determine condom use. Consistent non-users – negative attitude towards condom use.		
Coleman, L. & Cater, S. (2005) A qualitative study of the relationship between alcohol consumption and risky sex in adolescence	How may alcohol consumption over a single session affect the likelihood of risky sex in adolescence? Funding: Joseph Rowntree Foundation	Interviews Event specific perspective Participants recruited from secondary schools, colleges, youth clubs, youth offending services and Connexions services. Purposive sampling of a diverse population via initial questionnaire approach or direct approach.	Interpretative Phenomological Analysis Initial thematic analysis and coding by one researcher, checking by a second.	N = 64 Age: 14-17 South East England "Vast majority White". "Equally divided by gender" Vast majority living in urban areas. 52% living in areas in the upper	Just under two thirds reported an experience of risky sexual behaviour that had followed a session of heavy alcohol consumption. Sexual behaviour following alcohol consumption was not always reported as risky. Lowering of inhibitions by alcohol consumption – participants reported a greater ability to approach people when drunk and also a drunk person was perceived to be more receptive to such advances. Alcohol reported to impair judgement, manifested through an inability to control or recognise a potentially risky situation. Impaired judgement could result in risky sex by obstructing intended behaviour. Description of memory loss following alcohol	Small sample size, geographical limits, self selection of participants.	Further certainty regarding the different explanations given regarding the relationship between alcohol and risky sexual behaviour.

				quartile for multiple deprivation. Previous experience of heavy single session drinking or being "very drunk".	consumption. Resulting in complete lack of control over a situation with contraception being left to the other partner.		
Coleman, L. & Testa, A. (2008) Sexual health beliefs, attitudes and perceptions among black and minority ethnic youth	What are the sexual health attitudes of BME youth? No funding source identified.	Interviews Sample via "snowball" recruitment method. Variety of recruitment locations across London – 18 invitation via a different survey study, 11 via youth sexual health clinics, 21 via a variety of community groups.	Thematic analysis, no further details.	N = 50 Black and Minority Ethnic youth. London. Age: 16-23 (70% aged 16-18). Ethnic origin – Black (18), Asian (14) Middle Eastern (3) Other (1). Religious affiliation: Other Christian (14) Muslim (9) no affiliation (9) Hindu	Conflicting sexual norms and values between their family and/or cultural and religious community and their life. Expectations and values connected to sex within the family were rarely if ever discussed. Perception that expectations within the family and community prevented any discussion or recognition of young people's sexuality and need for information or support. Need for accurate and clear information about sex and relationships. Evidence of poor knowledge in certain areas such as STIs. Preference for an independent sexual health professional or sexual health expert to deliver education in school. Objective and knowledgeable, external to school thus assuring confidentiality. Preference to receive information from school over all other possible alternatives such as family friends or internet. Religion played a significant influence in beliefs, attitudes and behaviours. Sexual health attitudes and experiences	Single data source. Limited details regarding analysis. Recruitment method. No details regarding interview schedule or interviewer.	Need for research to take into account the influence of religion and faith on young BME people's sexual health

				(6) Sikh (5), C of E (3), RC (3), Other (1). 9 participants gay or bisexual.	better explained and understood by religious context than ethnicity.		
Cooper, R., Bissell, P. & Wingfield, J. (2008) Ethical, religious and factual beliefs about the supply of emergency hormonal contraception by UK community pharmacists	What are the views and ethical concerns of pharmacists regarding EHC	Interviews Data collected Jan 2004-July 2005 Recruitment, interviewing and analysis undertaken by one of authors. Purposive sampling for gender, age, ethnicity and employment status. Recruitment via telephone call or letter	Framework together with constant comparison and deviant case analysis. Initial coding by one researcher, discussion with others.	N = 23 Pharmacists 2 counties in North of England. No data regarding demographics.	Dispensing EHC on a prescription was ethically unconcerning for all but one pharmacist. Dispensing by sale had led to ethical concerns and distress for some. Perception of it causing an abortion against religious views. Variability in views if dispensed by sale or by prescription. Importance of women's right to choose treatment. Decision as to whether pharmacists should supply EHC should be left to individual pharmacists, however recognition that this could inconvenience or deny women treatment. Perceived as benefiting the pharmacy profession by some but having a negative value on the profession by others. Use of term morning after pill by many pharmacists. The location of a pharmacy and type of customer frequenting was significant for several pharmacists. Age and type of customer a factor linked to perceptions about the motivation for using EHC. Older customers perceived as more genuine and less likely to try to obtain	Single data source	Variability in pharmacist perceptions

					EHC regularly.		
Craig, G. & Stanley, N. (2006) Visibility, immobility and stigma: young people's use of sexual health services in rural areas.	The experiences of young people in rural areas in regard to access to and use of sexual health services Gvt funded	Not specified Multiple (3) case studies Group discussions + individual interviews No other details	No details of method	Numbers for study as a whole given but not numbers for the work reported here. 63 group discussions with young people age 12-18. Included school students and those outside mainstream provision (exclusion, in care, PRUs). Also 116 individual interviews with "transient" young people, young parents and professionals. "Rural	Experiencing criticism/judgement from older people/professionals Losing reputation Being stigmatised Being seen (high visibility) accessing services Desire for anonymity Accessible venues Travel to without parent Convenient opening times Scarcity of services/lack of choice Trust in professionals – teacher/doctor. Extent of confidentiality/privacy Professionals having name/address, keeping a file/personal details	None described No details on data analysis process or whether any negative instances No interview schedule or details of group discussion	

				hinterland" areas of seaside towns in the Midlands, North of England and South of England. Described as having relatively high teenage conception rates.			
Croghan, E. (2006) Sexual health: is it different for young ethnic minority people	What are the attitudes and behaviours of young people from all ethnic groups to sex and sexual health, as well as knowledge of sexual health information and service	Mixed method Interviews + survey Participants for interviews recruited via workers in sexual health services, school health services, surestart and a specialist clinic. Interview venue chosen by the participant.	Thematic analysis	N= 8 M = 3 F = 2 Age 16-21. 1 White British, 1 White Irish, 1 mixed race, 1 Afro Caribbean, 3 Pakistani.	Lack of knowledge prior to first sexual experience Frequency of unplanned sexual activity and lack of knowledge about the consequences of such activity, lack of confidence using sexual health services, and concern regarding confidentiality of services. Concern from young Pakistani women regarding confidentiality and judgements from health professionals of the same cultural background.	Lack of quotes to support description of themes. Confusion between content analysis and thematic analysis	

	provision. Funding source: South Staffs PCTs						
Curtis, K. et al. (2005) Contraception and unsafe sex in East London teenagers: protective and risk factors for use of contraception among black and minority ethnic young people in East London	What are protective and risk factors for sexual activity amongst young people in East London? Funding: TPU, DfES, DoH.	Mixed method. Survey + focus groups, web based discussion forum, 3 interviews. 30 groups, 16 single sex, 14 mixed sex. No details regarding recruitment in this paper.	Not reported in this paper.	N = 146 Age: 15-18. Wide range of ethnic groups: Bangladeshi, black African, black Caribbean, Indian, Pakistani, white Other, white, British and mixed ethnicity. 62 participants from "particularly challenging groups" including looked after teenagers,	Women carrying condoms could be viewed by men as being promiscuous or as being aware/clued up. Some young women reported carrying condoms as being the role of the man. Some young men reported that if they were in a trusting relationship with a partner they would not use a condom if the women was on the pill. Expression of a sense of responsibility in obtaining and using contraception. Perception of side effects. Problems using contraception correctly. Lack of concern regarding the potential consequences. Concerns about the impact on the sexual encounter, or interruption of the sexual encounter. Attitudes towards contraception associated with wanting to pursue a career and life options. Stable relationship seen as a prerequisite for bringing up a child. Use of contraception might lapse as a relationship	Mixing of different evidence sources. Lack of detail regarding analysis. Analysis rather superficial.	

				learning disabled, young carers, gay, bisexual, lesbian, refugees, asylum seekers, young parents.	becomes more long term. Reluctance to talk with parents about sex and contraception due to embarrassment.		
Donnelly, C. (2000) Sexual health services: a study of young people's perceptions in Northern Ireland	What are young people's views on the best way to target and provide sexual health services Funding source: none	Approach not specified. Focus group method (6 groups). Data collected in 3 youth units. Groups facilitated by youth leader at each site. Researcher attended all but one group.	No details provided	N = 35 M = 12 F = 23 Age range 15-25. Purposive sampling of study sites, convenience sampling of participants. Residents within one regional Health Board in Northern Ireland. Youth units in 3 areas within the region selected. Areas described as	Degree of uncertainty about the details of local services and facilities. Younger participants had limited awareness of locally available services whilst older participants mentioned a range of services. Agreement that services were poorly advertised and it was difficult to find out what was available and where. Perception that existing services where primarily for older women and married women in particular. Males in one area reported feeling that "family planning clinics" were exclusively for married women, with the title being off-putting to men. Feelings of being uncomfortable, fear of being seen, fear of anonymity being compromised, perception of timings making services difficult to use. Concerns regarding attitude of staff providing services in particular regarding confidentiality, being labelled and/or judged. Lack of available information. Importance of accessibility and acceptability in regard to location of services. Locally available services preferable, some participants wanted staffing with individuals outside the area. No clear view on ideal age or gender although consensus regarding need for experience and being understanding.	Study identifies recruitment of participants on voluntary basis, small sample, and gender imbalance in participants. Potential for views expressed in groups to differ from individual.	Need for further studies to gauge acceptability of services to young people.

				having above the average rates of teenage pregnancy for the region. Users and non-users of existing sexual health services recruited.	Younger participants wished to see services within the youth unit setting. Preference for using numbers rather than names in waiting-to-be-called situation and for tests. Concerns regarding dispensing of treatment via local chemist by staff who knew them in rural areas. 3 things most important features of a service – confidentiality, friendly advice, and support and a listening ear.		
Fairhurst et al. (2005) Not that sort of practice: the views and behaviour or primary care practitioners in a study of advanced emergency contraception	Why were some general practices more successful in delivering advance supplies of EC than others? Funding: Wellcome Trust	Multiple case studies. "Realistic evaluation". Interviews. Purposive sampling of 11 GP surgeries with diverse socio economic areas. Interviews carried out by 4th author Nov 2000-June 2001.	Thematic analysis, principles of constant comparison and attention to deviant examples.	N = 44 GPs and practice nurses.	Passive, reactive and pro-active mechanisms for giving advance supplies. Passive – giving out only in response to a direct request. Reactive – offering supplies when women presented with immediate need or presented to discuss contraception. Pro-active – offer of pack to women regardless of consultation. Pro-active strategies use by only two practices. Most commonly professionals held ambivalent views of EC regarding it as a generally safe method but seeing its promotion as potentially contradictory of safe sex messages and responsible planned contraception. Distribution rates linked to actions of health professionals. Professional views of the suitability of their practice population for advanced supplies may have influenced their approach to delivery. Distribution stifled by	Single data source.	

					perceptions of the practice population as too chaotic to use the supplies appropriately.		
Fairhurst, K. Ziebland, S., Wyke, S., Seaman, P. & Glasier, A. (2004) Emergency contraception: why can't you give it away? Qualitative findings from an evaluation of advance provision of emergency contraception	Why did a project which offered advance supplies of emergency contraception not reduce abortion rates? Funding: Wellcome Trust	Case study Purposive sampling of 10 GP surgeries to represent a range of socioeconomics, locations, also the central family planning clinic. Data collection Nov 2000-June 2002. Interviews carried out by 4th Author. Women participants recruited via questionnaire distributed at the central family planning clinic or posted to women registered with GP surgeries.	Thematic analysis. Constant comparison with attention to negative instances. All authors read a sample.	N = 44 GP or primary care nurses. N = 22 women who had received emergency contraception supplies. Lothian Scotland	Professionals reported women rarely asked for advance supplies of EHC, and they were reluctant to routinely offer supplies. Concerns regarding potentially contradictory messages implied by offer of advance supplies. Association of EHC supplies with chaotic behaviour by women. View that EHC is not proper contraception. Less reliable than pill and use requires no forward planning. Rational and planned approach preferred by professionals. Fears women would abandon more reliable methods and overuse EC. Contrary to promotion of safe sex practices. View that advance supplies might be seen as sanctioning promiscuous behaviour further. Perceived lack of need for women to keep supplies at home or perceived inability to use supplies appropriately. Professional fears that it might be inappropriate to offer advance supplies in routine consultations. Women participants perceived a number of benefits to having advance supplies – convenience, saving time and embarrassment of visiting the doctor, and easing of anxiety. Women reported being reluctant to ask for supplies to keep at home. Perceived as not proper contraception, perceived that they would be judged.		

					Distinction of irresponsible users and responsible users.		
Fallon, D. (2003) Adolescents accessing emergency contraception in the A&E department – a feminist analysis of the nursing experience	To describe nurse's understanding of their experiences interacting with adolescents assessing EC in the A&E department	Feminist perspective Grounded theory Interview	Constant comparison	N=5 Nurses in 3 A&E departments in NW England	Perception that the service is a low priority in A&E. Perception of being easy access. Importance of establishing a connection with the person. Perceived lack of sympathy by some medical staff. Being non-judgemental perceived as important. Need for EC linked to irresponsibility. Complexity of adolescent being both reckless and responsible. Returners produced complicated feelings. Both sympathetic and judgemental attitudes towards adolescents		
Folkes, L., Graham, A. & Weiss, W. (2001) a qualitative study of the views of women aged 18-29 on the over-the-counter availability of hormonal contraception.	What are women's views on the deregulation of hormonal contraception prior to it becoming deregulated? No funding source reported.	Interviews. Data collected August – November 2000. Recruited from a family planning clinic, a Brook centre, a non-profit making under 25s sexual health service and a GP surgery. Non English speakers	Thematic coding, development of coding framework, use of constant comparison. Coding by one researcher, checking by team.	N = 27 Age: 18-29. Urban area, South West England. Use of EC varied from never to nine times. 13 of the women had used EC under 19 years old.	Fear of judgemental attitude major factor in choice of EC provider. Several recalled negative encounters with doctors in other settings. Majority of respondents reported contraceptive failure as reason for request for EC. Several had been advised that repeated use posed considerable health risks. Positive advantages of greater accessibility, convenient location, more flexible opening times, speed of consultation.	Single data source. Initial sampling via questionnaire responses may have affected sample obtained. Only 4 quotes + some part sentences included to	

		excluded. Purposive sample identified via a questionnaire to include women with variety of experience of using EC, and from variety of sites. Interviews conducted by member of the research team at the site where recruited.			Perceived ease of visiting the pharmacy, but some concerns at this ease in regards to young girls using it as a form of contraception or spread of STIs. Perception that they themselves would make an informed choice but that others especially young girls wouldn't. Casual contraception rather than increase in casual sex was the main reservation. Abiding image of EC user a women who had deliberately engaged in sex without contraception, regardless of own personal experience of contraceptive failure. Cost likely to present a barrier to many women.	support findings.	
Free, C., Ogden, J. & Lee, R. (2005) Young women's contraception use as a contextual and dynamic behaviour: a qualitative study	What are the factors and processes involved in changes to contraception use/non use over time? Funding: NHS R&D Research Fellowship	Interviews Purposive sampling in regard to place of abode, educational experience and teenage pregnancy experience. Recruitment from a range of community settings and health services. Interviews carried out location of participant's choice.	Interpretative phenomological analysis Principles of constant comparison.	N = 30 Age 16-25. 8 pregnant or mothers (7 had become pregnant in their teens). 21 white British, 4 Afro Caribbean, 2 black British, 3 white Other. Residents of London area. 11 deprived inner city, 10 mixed inner city, 3	Impact of a range of social goals on contraception use which reflected where women positioned themselves in their social world, and aspects of their identity and relationships with others. Variation in life aspirations and perceptions regarding the acceptability or desirability of pregnancy and contraception use. Aspirations other than motherhood were linked to the use of contraception to avoid pregnancy. Aspirations linked to attitudes towards risk. Description of being safe as influencing the choice of contraception and using one known to be more effective. Taking risks with contraception was part of a broader attitude to taking risks or pushing boundaries such as with drugs, not going to school, going out all night, lying to parents. Risk identity linked to use and non-use of contraception. Almost all women had experienced contraceptive risks at times.	Single data source.	Contraceptive use should be viewed as a dynamic process with multifaceted, complex and contradictory attitudes depending on the social goal that contraception use is evaluated against.

				homeless, 6 suburban.	Maintaining a positive sexual identity was another social goal with negative evaluations of young women a feature of many of the interviews. Youngest reported discussing sex or any type of contraception was embarrassing. Contraception use was generally linked to positive evaluation of female sexuality, with not using contraception negatively evaluated. Termination of pregnancy and emergency contraception specifically linked to negative evaluations of young women's sexuality. Although in contrast some women portrayed using emergency contraception as responsible behaviour. The physical barrier of the condom was seen as a barrier to intimacy in sex and as relationships became steady, previously tolerated condoms simply got in the way. The seeking of a positive sexual experience was linked to the non-use of contraception – especially condoms. The importance to women of maintaining a sexual relationship was linked to the non-use of condoms in regard to giving sexual pleasure to the sexual partner, avoiding embarrassment and avoiding conflict. The importance of a regular cycle and keeping the body in balance reflected the importance of avoiding unwanted or harmful physical effects of contraceptives. Concerns regarding unnatural or artificial hormones taken into the body. Termination of pregnancy and emergency contraception use could be influenced by the importance of acting according to one's own moral stance. Perceptions of vulnerability to pregnancy depended on		

					women's own definitions of risky behaviour. Women tended to focus on safe rather than unsafe behaviour, minimise risks, cite personal invulnerability to pregnancy, and put risks to the back of their mind. Reports of a lack of knowledge preventing women using contraceptives correctly. Description of lack of skills and power within a relationship to negotiate condom use. Reports of being unable to bring up condom use or ask the man to wear a condom, asking requiring strength and persistence. Situational factors such as alcohol use or life circumstances influenced how contraceptives were used. Particularly difficult if life did not have a routine, at times of change, stress or when really busy. Obstacles to contraception use – access to services, cost, getting appointments and long waits were off putting. Friends and parents influenced attitudes and were sometimes instrumental in supporting young women in obtaining or not obtaining contraceptives. Contraception use described as being fluid, varied and changing over time in response to changes in situation, experience, and new information. Evaluations of vulnerability to pregnancy changes over time in different situations.		
Free , C., Lee, R. & Ogden, J. (2002) Young women's accounts of factors influencing their	To explore young women's accounts of their use and non-use of emergency	Interviews carried out by first author at recruitment site or home	No details	N = 30 Women aged 16-25 sexually active. Recruited from GPs,	Extra safety conferred by multiple contraceptive use. Perception of level of personal vulnerability to pregnancy. Embarrassment using contraceptive services. Guilt/shame using emergency contraception Concerns regarding what others think (reputation). EC linked to undesirable behaviour. Putting the risk of pregnancy to the back of mind.	None reported	Need to promote attitudes and personal skills needed to obtain emergency

use and non-use of emergency contraception: in-depth interview study	contraception			hostels, youth groups, FP clinics, schools. London area. 11 deprived inner city, 3 homeless, 10 mixed inner city, 6 suburban	Limited knowledge. Easy access Side effects of emergency contraception. Professional friendly, matter of fact, understanding, good relationship helpful. Feeling told off, focussing on risks that had been taken unhelpful.		contraception. Attitudes and concerns of young women especially from deprived inner cities may render them least willing and least able to obtain EC.
French, R. et al. (2006) One stop shop versus collaborative integration: what is the best way of delivering sexual health services	What are the strengths and weaknesses of different approaches to the design of young people's sexual health services? Funding: DoH	Interviews + telephone interviews Purposeful sampling of different stakeholders/professions (no details provided of composition achieved).	Thematic analysis using principles of Framework Analysed by two members of team.	N = 11 Key informants involved in developing the National Strategy for Sexual Health and HIV. No further details.	Some of the interviewees reported that it was more important and realistic to establish collaborative networks, with clear signposting and consistent messages between services rather than focusing on one stop shops. Contraceptive and GUM services have closely related health issues. Satellite and outreach services were seen as important stepping stones into more mainstream fuller services. Health professionals key to reducing any stigma around using sexual health services. Historical divide between GUM clinics and contraceptive services, many staff not trained in both. Commissioning priorities around sexual health patchy.	Lack of information regarding participants. Data from study heavily embedded within literature discussion. Limited use of supporting quotes. Single data source, small number of participants.	

French, R. (2002) The experience of young people with contraceptive consultations and health care workers	What are young people's attitudes towards and experiences of consultations with health care providers about contraception? Funding: Camden and Islington HA	Interviews and focus groups Recruited from health services, secondary schools, community projects. Observation of consultations. 4 focus groups held. Observations made at four sites, one a young people's service, others not described.	Grounded theory	London, Camden and Islington. Interviews N = 32 Age: 16-21 M = 8 F = 12 ?incorrect figures 2 from young mothers support group, 6 from pregnancy termination clinics, 9 from youth community project, 15 from young people's contraception services. Focus groups N = 28 M = 20 F = 8 13 participants from boy's school, 6	Impact of drinking on contraceptive use. Majority of young people had not thought about the consequences of a pregnancy. Burden of having a child viewed in terms of the economic consequences. Lack of time in a 5-10 minute consultation to discuss personal factors. Feeling of being rushed and lacking the opportunity to ask questions. Perceptions that young persons' attitudes towards different methods and identification of any potential problems were not always discussed. Description of discontinuing methods due to the side effects. Consultation contained a large amount of detailed information. Back up information in the form of leaflets was appreciated. Views regarding what was wanted from consultations and experiences of consultations often conflicted. Fear of judgemental responses, nervous about first visit. Perceptions of "medicalisation" of consultation with a doctor. Young people relieved if a health care worker initiated a conversation regarding contraception when attending the surgery for other reasons. In general experiences of young people's contraceptive and sexual health services were more positive than experiences of services provided within primary car or family planning clinics. Young people's services described as acting like a stepping stone into more adult services provided in family planning clinics and GP surgeries. Need for friendly and welcoming clinic where staff have time to deal properly with young people. The young men generally preferred more anonymous and	Limited description of data analysis	

				from mixed sex school, 6 from youth club, 3 from young offenders unit Observations N =18 consultations Nurses 2, doctors 2, health visitor 1 ?incorrect figures	convenient access to supplies.		
French et al. (2005) Exploring the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people in relation to reproductive and sexual health	To better understand the attitudes and behaviour of Bangladeshi, Indian and Jamaican young people relating to sexual behaviour, contraceptive use, pregnancy and young parenthood	Participatory research. Interview + focus group methods. Stratified sample recruited via random approach (doesn't detail which locations), snowballing, and via community groups. Interviews conducted in setting chosen by participant. Carried out by experienced researchers. Data collected Feb-April 2003.	Thematic analysis using Framework principles. Analysis discussed within research team.	Interviews - N = 75 (?78) Age 13-21 Bangladeshi = 25, Indian = 25, Jamaican = 25. Resident in London (25), Manchester (24) or Birmingham (26). M = 30 F =	Lack of knowledge about local services particularly amongst young men. Concerns regarding confidentiality and privacy. Potential for embarrassment if seen, against Islam to be seen using a service. Fear of being judged. Preference for services where not possible to identify the reason for the visit. Concerns regarding privacy of information discussed with GP being fed back to families. Limited vocabulary of words in English relating to sex. Anonymity – separated by gender in waiting room, called by number rather than name. School identified as useful advice and information source. Advice columns and articles in teenage magazines and help lines and internet mentioned as providing information. Varied views regarding location. Some preferred clinics	Limited use of quotes to support points made Recruitment described as difficult with those who agreed to talk freely about sex possibly not being representative of their ethnic group. Participants	

	Funding source: Teenage Pregnancy Unit	Focus groups carried out in "most appropriate setting" Respondent validation + comparison between different groups. Many groups gender specific.		48 (table of participants adds up to 78 rather than 75) Focus groups – N = 33 professional /community representatives N = 33 young people N = 11 parents Aged 15 or above. London, Manchester and Birmingham. 13 groups held.	outside of their locality avoiding being seen by people they know. Others preferred service located in town centres or locally to increase accessibility. Suggestion of services in schools and colleges, near hospitals, or "in good areas". Outreach into venues that young people accessed was recommended such as hairdressers, nightclubs, snooker halls, fast food outlets, youth services, events, sports shops, music shops, churches. Importance of images used by services to include ethnic groups. Diversity of views regarding preference for same ethnic group staff in clinics. Some participants reported they would not want to see staff of the same ethnic background as they perceived that they would be judged. Other perceived that having staff from a range of backgrounds available was important. Age of staff seen as important by some participants. Gender generally seen as more important than ethnicity, on the whole young people reported they would feel more comfortable discussing sexual health issues with a member of the same gender. Time required to build up good relationships between young people and providers. Need to develop partnerships between services and community groups. Diversity in views between individuals and between ethnic groups.	described as high achievers or having aspirations to be high achievers with the vast majority fluent in English.	
Garside et al. (2002) Anonymity and confidentiality: rural teenagers concerns when accessing sexual	What are the concerns regarding sexual health services of young people in a rural area?	Mixed method Survey + focus groups 18 focus groups Single sex, 4-9 participants in each group	No details regarding process of data analysis	Number of participants not provided. Age of participants not	Fear of being seen attending a health service. Fear of visit being reported to their parents either through concern or gossip. Wide network of friends, relatives or acquaintances who may scrutinise of share information makes privacy difficult to achieve. Teenagers aware of doctor's duty of confidentiality, but	No details regarding population or data analysis. Quote not assigned to an individual only	

health services	Funding: NHS S&W R&D Directorate	Either under or over 16 year olds. Recruited via youth workers and college nurses Variety of locations. Focus groups used a series of scenarios No details regarding who carried out the data collection		provided. Devon 5 locations in North and East.	major power of gossip perceived in the local area. Concerns regarding professional confidentiality when individuals had personal relationships with parents. Concern regarding potential for sexual health visit to resurface at a future consultation when a parent might be present. Perception of doctor disproval, being judged by staff.	the group.	
Griffiths, C., Gerressu, M. & French, R. (2008) Are one stop shops acceptable? Community perspectives on one-stop shop models of sexual health service provision in the UK	How are one stop shops (GUM and contraceptive services on one site) viewed in comparison to more traditional models of service delivery? Funding: DoH	Interviews and focus groups Ethnically matched male interviewer for male participants, female interviewer for female participants.	Thematic analysis Principles of Framework	N = 19 interviews with minority ethnic individuals. N = 103 focus group participants. 48 heterosexual men (age 16-21), 46 men who have sex with men (10 age 16-18 and 5 20+), 14 Asian men and women (age 20+). 9 sites	Convenience Anonymity A nurse rather than a doctor Perceived lack of confidentiality in GP surgery amongst African & Indian participants. Non Indian Asian participants perceived GP surgery to be preferable as convenient, not stigmatising and familiar. Concept of one stop shop acceptable to young men and BME but not MSM.	Recruitment process not described Few if any participants had experienced the one-stop shop service	Need for applicability of different types of approaches in different areas to be investigated further

				across England with high residential occupancy and higher than average deprivation scores. No details Various recruitment sites including school, college, projects, clubs, community organisations.			
Harden, A. & Willig, C. (1998) An exploration of the discursive constructions used in young adults' memories	What is the meaning and significance of contraception for young adults?	Social constructionism and discourse analysis Data collected during a memory work group and two group discussions led by first	Thematic analysis, constant comparison, analysis of how contraception represented or referred to in	N = 16 M = 3 F = 13 Age of memory group 24-30 years (5 participants)	Themes from group discussions only Condoms constructed as a highly visible and superior method of contraception. Distinction between the pill and the condom on the basis that the condom was the only method that protects against STI, thus evaluated as health promoting. Construct of responsibility associated with using condom in contrast to characterisation of irresponsible, ignorant,	Concerns regarding recruitment Limited participant characteristics	Need to establish ways of promoting condom use as compatible with a long term relationship

and accounts of contraception	Funding source: None	author. Group discussions held in different schools	discourse.	Age of discussion groups 17 & 18 years (11 participants) Convenience sample – work group friends of the first author (psychology graduates), other two groups recruited via course leader in school. "All white, heterosexual, predominantly middle class"	irrational person not likely to use contraception. Responsibility for health choice therefore placed on the individual. Pill, cap, coil, injectable contraception construed as more of an intangible entity, with less accessible information about it available, and need for a doctor to provide understanding of its use (a medical/scientific context). Femidom perceived as large and awkward to use, gender related constructions of sexuality related to limited acceptability of femidom and male pill. Type of contraception linked to type of relationship with perception of condom for casual encounters and pill for longer-term relationships. Using condoms in a long term relationship constructed as a threat to trust.	Views expressed in a group may differ to private views.	Need to analyse discourses from different socio-economic backgrounds and ethnic groups Need for research to explore ways in which limiting constructions of contraception can be challenged. Need for studies to explore accounts of using or not using contraception.
Hayter, M. (2005a) The social construction of reproductive vulnerability in	What constructions of contraceptive use underpin nurse	Grounded theory. Interviews 2 large family planning clinics in the North of England. Theoretically	Thematic analysis Open coding followed by axial coding with searching	N = 14 nurses	Use of terminology of protection and risk, with construct of women's reproductive system as vulnerable to pregnancy and requiring protection. Terms used – at risk, covered, protection, precautions, danger.	Single data source. Small number of sites and participants.	Use of alternatives to medical discourse with more empowering

family planning clinics.	consultations with women in family planning clinics?	sampled. Data collected 2001-2. 49 consultations recorded between nurses and women over the age of 16.	for negative instances.				terms to describe contraception.
Hayter, M. (2005b) Reaching marginalised young people through sexual health nursing outreach clinics: evaluating service use and the views of service users		Mixed method Survey + interviews Purposive sampling for spread across 10 clinics, gender and age range. Participants approached during consultation.	Thematic analysis Analysis carried out by author with sample of transcripts (5) read by a second researcher.	N = 20 Age 13-18 years. Attending sexual health nursing outreach clinics in Doncaster. No demographic data.	Value of confidentiality stressed. Some concern at siting in youth club due to noisy environment and close proximity of other people. Respectful and non judgemental attitudes of staff perceived as a strength. Staff didn't make young person feel embarrassed. Perception of not being able to talk to parents about sexual health or relationships.	Single data source 4 quotes only used.	
Higginbottom et al. (2008) I didn't	What are the patterns of	Ethnography Purposive sampling via	Use of Framework	N = 88 young BME people	Most young women stated that the pregnancy was unplanned, only a small number stated that they had	Limited detail regarding the	

do it cause I wanted a baby: sexual decision making, roles and choices in relation to early parenthood amongst black and minority ethnic young parents in England	sexual decision-making that precede pregnancy?	health and social care professionals and teenage pregnancy co-ordinators. Also via stakeholders invited to briefing events using a snowballing approach. Data collection via focus groups (19 participants) Interviews (60) telephone survey of providers	method	M = 6 F = 82 Included 53 teenage parents and 34 young women with children older than 1 year who had been teenage parents. 10 mothers of teenage parents 41 service providers 3 cities in England. Wide variety of ethnic backgrounds, largest group Jamaican/English	planned to become pregnant. Range of emotions experienced including happiness, shock, anger, disappointment and despondency. Acceptance and adjustment to becoming a parent. Influence of extended family networks important.	data collection, in particular no detail regarding any interview outline or how the focus groups were conducted. Limited number of quotes.	
Higginbottom et al. (2006) Young people of minority ethnic origin in England and early parenthood: views	What are the perceptions regarding parenthood in minority ethnic communities in England?	Described as ethnographic tradition. Interviews, focus groups and telephone interviews.	Described as use of Framework followed by thematic analysis to construct a	N = 19 focus group participants young mothers aged 20 or over who	Concern amongst professionals to counter taken for granted assumptions such as the stereotype of young Muslim women being sexually inactive outside of marriage. Diverse views regarding pregnancy and termination including the perceived risk of missing out on parenthood	Small number of young fathers. Some confusions in methodology terminology.	

from young parents and service providers.		Initial recruitment via professionals followed by snowball technique. Interviews conducted in participant's home. A number of interviewers including two members of research team, two women of African Caribbean origin, and a man of South Asian origin in their 20s.	narrative. No details regarding who carried out analysis.	had become pregnant at 19 or under. N = 15 interview participants young mothers in their 20s. N=45 interviews with young mothers up to age 19 N=6 interviews with young fathers N = 10 interviews with grandmothers. Located in Bradford, Sheffield, and London. Demographic information included - 16 African-Caribbean origin, 19 multiple ethnicity, 10	and issue of termination not arising. Preference for one-to-one antenatal and postnatal support services reported by practitioners. Flexible non judgemental approach explicitly valued. Community based approaches perceived as approachable and valuable. Perception of GPs hospital doctors and hospital based midwives mixed with description of disapproval or dismissal attributed to age. Report of concerns regarding input of different services/programmes conflicting in terms of role or overloading support. Concern regarding prioritising of prevention rather than support. Married women of Muslim faith often especially pleased about becoming parents after initial shock. Aware of views of older people regarding early pregnancy however own views reflected strong personal aspirations and a sense that motherhood and a successful independent life should not be mutually exclusive. Overwhelming majority of young mothers had clear career aspirations. Explicit aspirations to enjoy parenthood not marginalise it. Professionals also recognised that young mums were positive about being pregnant, having a baby and usually made a good job of parenting. Some professionals described the transition to parenthood	Limited information regarding analysis.	

				Muslim faith (Bangladeshi, Pakistani, Yemeni, Somali, Turkish origin). N = 41 service providers interviewed by telephone – no further details.	as a positive turning point for young person. Most young people had strong family ties and close relationships with mothers. Many of the young mothers had been born to young single mothers themselves. Report of less strong ties with fathers, siblings, grandmothers and parents-in-law. Practitioners reported marginalisation of young fathers. Young fathers felt that practitioners and lay people treated pregnancy, birth and early parenting as female matters.		
Hoggart, L. (2006) Young women sex and choices: a study of young motherhood in Haringey	What makes some young women engage in unprotected sex, what influences some of these to access emergency contraception and what influences decisions about whether or not to terminate pregnancies? Funding:	Interviews + Focus groups 4 focus groups with 8-12 participants held in schools, led by researchers. Convenience sample recruited via teachers in two schools. Interview participants a convenience sample recruited via contact with sexual health professionals and	Thematic analysis. Use of constant comparison. Individual and team analysis.	Focus groups N not specified between 37-47. Age: 14-16 Mixed ethnicity "but with a higher representation of white British than interviews". Interviews	Professional interviews Some evidence of tension between working positively with young mothers and discouraging teenage pregnancy. Variation in schools' policies on confidentiality and disclosure. Recognised need for targeting work amongst ethnic minority communities, but concerned regarding danger of labelling. Concerns regarding reaching refugee and asylum-seeker groups. Perception of strength of 4YP programme in regard to confidentiality policy and ability to provide answers to questions from young people.	Limited recruitment of participants who had experienced termination.	Research into rapid repeat pregnancies, sexual health of refugees and asylum seekers, differences in attitudes towards young parenthood, and sexual exploitation and sexual violence.

	Middlesex University and Haringey PCT	schools. Also via mothers' groups and family planning clinics. Intention had been purposive sampling of half total number to be women who had a termination, but recruitment difficulties.		N = 13 12 young mothers + 1 young person who had termination. 5 mothers reported having a previous termination. Age: 14-21. 3 white British, 1 black British, 7 African Caribbean, 2 black African. Working class backgrounds, less than half had educational qualifications. Interviews N = 25 professionals from different agencies,	Perception of insufficient support for teenage mothers over the age of 16. Concerns in regard to limited resources, difficulties in establishing boundaries in inter-agency working, and geographically limited initiatives. Reported need for connection between agencies and community regeneration schemes to develop an integrated strategy. Lack of work with young fathers. Interviews and focus groups SRE did not deal with their real concerns and experiences. Evidence of myths regarding getting pregnant or not. Sex education not early enough. Teachers not best people to deliver SRE, too biological. Need for somewhere to go for confidential advice or information or to talk to if worried about being pregnant. Gaps in knowledge about some aspects of contraception and abortion. Many of young mothers had dropped out of school or had limited attendance therefore limited sex education. Wide variety of views and experiences in relation to sexual behaviour. Many had more than one sexual partner. Most first sexual experience at 13-14 years old (2 11-12 years). Contrast between interviews and focus groups in regard to negotiating sexual encounters. Use of contraception often random, more concerned about STIs.		

				"most had worked with young mothers and/or with young people for a number of years". No further details.	Some inadequate information about contraception, some reported contraception failure. High proportion became pregnant in the gap between infections. Often messages confusing or difficult to interpret. For many acknowledgement that they were careless regarding use suggested lack of concern to avoid pregnancy. Noticeable reluctance to discuss emergency contraception, one of the gaps in knowledge identified in the focus groups. Influence of alcohol or drugs on sexual behaviour. Many described unhappy personal circumstances, non traditional family relationships. For many their own relationships with the father of their baby was non traditional. Although many young mothers said that they had not intended to become pregnant it was clear it was not an outcome they were very concerned to avoid or feared. Most very matter of fact, an accident. In most cases had considered and rejected abortion. Single biggest influence on decision to continue with pregnancy was relationship with father of the baby.		
Ingram, J. & Salmon, D. (2007) No worries: Young people's experiences of nurse-led drop in	Evaluation of the patterns of use, effectiveness and acceptability of a service.	Mixed method. Interviews + attendance data + survey Data collected Nov 04 to Feb 05. Interviews carried out by "2 experienced	Thematic analysis. Coding carried out by two researchers and themes checked by 2	N = 18 F = 15 M = 3 Age 14-18 years Purposive sampling	Ease of use – close proximity, range of services, confidential and professional, drop in nature, accessibility of staff, social nature of clinic. High profile of service within community. Importance of developing a relationship with friendly, non-judgemental, reassuring staff. Confidence in using the clinic. Gaining accurate advice and information.	Gender imbalance of participants	Attention needs to be given to views of hard to reach or excluded individuals.

sexual health services in South West England	Funding source: North Somerset PCT and the University of the West of England	researchers familiar with working with young people"	independent researchers	from clinic attendees. 3 clinics in GP surgeries or health centres. 2 in areas of social deprivation with high rates of teenage conceptions. 1 in area of recent increase in conception rates. 1 area deprived housing estate, 1 suburb of large town, 1 small rural town.	Discussing issues without embarrassment. Confidentiality. Confidence, more in control. Treated like an adult, not ashamed.		
Jewell, D., Tacchi, J. & Donovan, J. (2000) Teenage pregnancy: whose problem is it?	Do pregnant teenagers differ from non-pregnant teenagers in terms of their attitudes	Ethnography Participant observation and interviews Observational data collected in 2 young mother's groups, a	Thematic analysis and some influence of framework analysis	N = 34 F = 34 Age 16-22 years Purposeful sampling of young mothers/pre	Differences in attitude towards abortion and teenage pregnancy in advantaged versus disadvantaged background participants. Advantaged women put more emphasis on career, university, money, personal development. Advantaged women perceived later ideal age for starting a family. Advantaged group reported they would be likely to opt for	Unclear which data came from field notes vs interviews. Unable to recruit any young	Need for greater understanding of perceptions of young women

	towards health, sex and pregnancy? Funding source: South West Research and Development Directorate	young mothers' peer education project, and a young mothers' video project by 2nd author over 12-18 month period.		gnant women (16) and non mothers/never pregnant women (18). Also, advantaged (18) and disadvantaged (16) socio-economic areas of Bristol 12 members of groups observed interviewed 22 recruited for interview by GPs/via sexual health clinic/other participants.	an abortion in their teens if they became pregnant. Some young mothers reported they had considered but were unable to go through with an abortion or had concealed their pregnancy. Within long term relationships careful contraception not always maintained. Emotional attachments were used by some to explain risk-taking behaviour. Differences in knowledge regarding contraception methods between advantaged and disadvantaged groups. Other young women major source of information. Difference in response to risky behaviour with more advantaged women reporting taking emergency contraception.	mothers from advantaged areas.	
Jolley, S. (2001) Promoting teenage sexual health: an investigation into	What are the knowledge, activities and perceptions of nurses in relation to	Mixed methods. Survey (some free text questions) + interview. Interview schedule developed from the questionnaire.	Thematic analysis.	N = 10 Nurses working in a gynaecology unit. Nottingham. Random sample for	Influence of embarrassment from a teenager on how well a sexual history can be taken by a nurse. Need for protocol or guidelines regarding taking a sexual history as variation between individual nurses. Perception of limited nursing role in promoting sexual health in teenagers. Lack of promotional material/information/resources.	Pre-existing relationship between researcher and participants.	Feelings of nurses involved in the work are powerful and need further investigation.

the knowledge, activities and perceptions of gynaecology nurses	teenagers sexual health? Funding source: None reported	Researcher known to the participants.		interview selected from nurses surveyed.	Need for leadership, a key person with responsibility Need for more organised delivery of service. Need for staff training Specific difficulties of working with teenagers requiring a separate teenage service. Nurses revealed aspects of the work which they found upsetting, the immaturity of patients, lack of support for them and the termination procedure.	Single researcher analysing data.	Need for investigation of teenagers views of sexual health services. Need for training for nurses. Investigation regarding the perceptions of community sexual health staff regarding the role of gynaecology nurses.
Jones et al. (1997) Teenage sexual health through the eyes of the teenager: a study using focus groups	What are teenagers' needs opinions and concerns regarding sexual health?	Focus groups 14 focus groups, single sex. 4 schools. Selection of participants by teacher during PSHE lesson. Participants attended groups twice.	No details.	N = 61 Age: 14 & 15 Cardiff school pupils, range of socioeconomic backgrounds.	Opening hours of services during school time was a barrier to access. Greater publicity of existing services was required, in areas teenagers frequent such as schools and youth clubs. Availability of free condoms for adolescents should be increased. City centre clinics more accessible, more discreet and anonymous. Concern regarding GP surgery staff being judgemental. Concern that confidentiality would be breached via a "slip up" in conversation with their parents or a subsequent visit.	Selection of participants by teacher. Group dynamics within focus groups.	

					Reports of emergency contraception at A&E not being available in practice. Perception from girls that boys believe that contraception and pregnancy are solely female concerns. Majority had been told by mothers that they should take the contraceptive pill as soon as they become sexually active.		
Lester, C. & Allan, A. (2006) Teenage sexual health needs: asking the consumers.	What are teenage perceptions of sex education, access to services, and attitudes relevant to STI?	Focus groups. 4 single sex groups carried out in schools. Groups led by experienced young facilitator plus an observer.	Grounded theory approach. Constant comparison method. Data analysed by two researchers.	N = 32 M = 16 F = 16 Age 14-15 Three schools, one mixed, two single sex comprehensive schools. In area of high chlamydia prevalence. Sampling described as theoretical - based on school perception of maturity	Main sources for learning about contraception were friends and school. Where parents were involved it was often in a negative way. Term family planning not liked as implying that it was not for them, some thought contraceptive clinic would be a better title. Emphasis on being "straight to the point". Privacy important motivator for accessing condoms from machines. Participants preferred to attend clinics with designated sessions for young people rather than their GP. Accessing services linked with embarrassment, lack of confidence and worries about what staff and others would think of them. Girls carrying condoms was viewed by many as sensible, but by some as sending the wrong signals. Clinics less embarrassing than a shop. Perception of condoms being uncomfortable and sex better without. Embarrassment caused by taking a while to put on. Girls found it easier to take seriously about sex than boys. Perception of over-emphasis on abstinence by teachers and parents.	Teacher selection of participants. Parents giving opt out choice but not young person? Single data source. Study encompassed both contraception and prevention of STI.	

					Differing perceptions male-female.		
Mackereth, C. & Forder, J. (1996) Assessing the sexual health needs of young people.	What are the sexual health needs of young people in a deprived area of Gateshead?	Focus groups Recruited via a publicity day event. Not described how individuals given invitations to attend were selected, or which locations participants were from. Single sex groups, age differentiated 11-13 years and 14-16 years.	Thematic analysis	N = 40 Age: 11-16 Gateshead – described as an area of high deprivation	Gender differences – young men talked of the illegalities of sex which was equated with mischief, trouble and guilt. Embarrassment was overwhelming feature in the female groups. Mothers an important source of information, fathers mentioned only occasionally. Wide difference in levels of knowledge about the services available. Embarrassment obtaining condoms Anonymity of machines liked. Limited knowledge regarding emergency contraception.	Group dynamics within focus group discussions. Few details regarding selection of participants.	
Mackie, C. Elliott, L., Thomson, A., Bigrigg, A., McAllister, K. (2002) Public and private collaboration in establishing a young person's sexual health clinic in a	To ascertain views of staff regarding a new sexual health service 6 months after introduction.	Interviews. 10 in person, 3 telephone interviews. Single interviewer.	Thematic analysis, no details of method	N =13 staff 5 representatives of the local health board, 4 represented the local family planning service, 4 represented the	Publicity (even though adverse) regarding the clinic was a positive help to the clinic. A city centre location was viewed as being ideal to attract young people being easy to reach by public transport and offering anonymity. Drawbacks in using a location outside health service premises in terms of transporting drugs, lack of client records on site, and lack of privacy in shop floor waiting area.	Lack of quotes to support themes. Lack of detail regarding data analysis. No information regarding any interview schedule used.	

commercial setting	Funding source: None			pharmaceutical retailer. New service introduced was based in a pharmacy.		No detail regarding process of recruitment.	
Mason, L. They haven't a clue. A qualitative study of staff perceptions of 11-14 year old female clinic attenders	What issues do staff feel are important to 11-14 year old girls? Funding source: None	No theoretical underpinning identified. Interviews Convenience sample, recruitment concluded at data saturation. Recruited at two Brook Centres on basis of availability. Interviewer not identified, conducted in the clinic.	Labelled as content analysis but describes thematic analysis with some elements of conversation analysis.	8 staff 5 nurses and 3 counsellors, all female. North West England, one major city centre and one in small town service. Described as mixed population with areas of high deprivation and pockets of wealth.	Excess alcohol leading to request for emergency contraception "just in case" had unplanned sex Peer pressure amongst girls to have sex Lack of self assertiveness/self esteem in clients Lack of knowledge of biology and physiology of reproduction Earlier sex education Need for education about relationships Need for education in regard to assertiveness Need for staff to understand why girls wanted to have sex Need for staff to understand issues around pressure in order to help girls empower themselves		Understanding young girls' experience of sex. Understanding the dynamics of peer and media pressure. Issues of self esteem.

McCann et al. (2008) Sexual health services for young people in a rural area of Northern Ireland: a study of the key issues for those who provide them	What is the potential and what are the limitations of service provision in regard to sexual health services for young people	Mixed method Survey, interviews, focus groups.	No details	N = 22 interviews with key informants Four focus groups, one practice nurses and three school nurses. Rural area of Northern Ireland with high percentage of young people under 20 and rising rate of STI.	Wide range of services being provided. Perception of procedures regarding confidentiality being well managed and consistent among professional groups. Lack of training perceived as a major barrier to high quality service provision. Lack of resources identified as an issue.	No data provided, only narrative of broad findings.	
Morrison, A., Mackie, C., Elliott, L., Elliott, L., Gruer, L. & Bigrigg, A. (1997) The Sexual health help centre: a service for young people	What are young people's experiences of a sexual health help centre compared to conventional family planning services	Mixed method. Interviews. Carried out June 95-June 96. Convenience sample. Participants recruited from clinic attenders, and from a variety of community settings including schools, youth clubs and sports clubs. Interviews conducted by	Thematic analysis. No details provided.	N = 368 Mean age 17.2. No age range provided by authors. Glasgow. Clinic attenders- = 151, non clinic attenders = 217. Clinic attenders =	Oral contraceptives more reliable and less expensive than condoms Perception of contraception as female responsibility. Males are able to obtain contraceptives from other sources, thus circumventing the need to attend family planning services. Most males cited a pharmacy as source of contraception. Most clinic clients already using condoms, but came to the clinic to change to another form of contraception.	Very limited use of supporting quotes. Lack of description of data analysis process. Quantitative data discussed more fully.	

	Funding source:	independent research staff.		99% Female, non clinic attenders = 69% female. 55% Carstair's deprivation category 1-4 and 45% category 5-7.			
Ogden, J. & Harden, A. (1995) Beliefs about condoms in 12/13 and 16/17 year olds	What are the beliefs and attitudes of 12/13 year olds and 16/17 year olds towards condoms?	Mixed method. Qualitative data free text as part of a survey. Data collected during a class supervised by a form teacher. Response to being asked "to give a free account of their knowledge of and beliefs about condoms and their use.	Described as content analysis	N = 211 148 12/13 year olds, 63 16/17 year olds provided free text data. Pupils of a secondary school in London.	Both negative and positive comments regarding the appearance and feel of condoms. Many subjects mentioned both positive and negative comments suggesting they were weighing up the pros and cons, suggesting an ambivalent attitude. Perceived association between condom use and social responsibility as well as personal behaviour. Discussed in the context of responsibility and morality. 2 participants described the connotations involved in the use of condoms by women. Differences between the younger and older participants. Younger more light-hearted and humorous, older more serious. Good understanding of factual aspects of condom such as where to buy them and their use.	Free text data completed during a class supervised by a form teacher. Potential for participant responses to be affected by this context. Very brief extracts only provided. Data analysis superficial.	Young people have complex belief systems regarding condoms.

Pearson, S. (2003) Promoting sexual health services to young men: findings from focus group discussions.	Do young men need sexual health services, are they appropriate and accessible, and what promotion strategies would encourage use?	9 Focus groups. Data collected by research team. School/college/youth clubs/drop in centres. 7 hypothetical sexual health dilemmas discussed.	4 stage process. Thematic analysis. No details regarding whether one or more coders.	N = 75 Young men aged 13-21. England. Urban, semi-urban and rural locations. "Various recruitment methods" 2/3 in education. Both users and non-users of services.	Preserve image/social standing. Lack of discussion of sexual health dilemmas within male social groups. Preference for anonymity, reluctance to provide personal details. Services orientated towards women. Connotation of "family planning" as meaning older couples. Friendly and welcoming atmosphere important, although minimal contact time with no personal questioning or counselling. Staff youthful without disapproving beliefs. Confidentiality where GP knew parents. Information available discretely and confidentially. Style of consumer advertising, use of humour.	Author reports potential weakness of focus group method as being participants not revealing views or personal information in front of others. No detail of dilemmas used in focus group discussion. Involvement of research team members not clear.	Promotion of services should increase awareness and advance a positive image.
Pitts, M., Burntney, D., & Dobraszczyc, U. (1996) There is no shame in it any more: how providers of sexual health advice view young people's sexuality.	What are the general attitudes of providers to their role as family planning advisors to young people?	Interviews. Conducted at the participant's workplace. Conducted by a female social science graduate with specific interviewer training. Had shadowed participants and "was well known to them by the time of the	No details	N = 19 Age 30-55 years GPs = 5 Practice nurses/family planning nurses = 5 School nurses = 4 Community medical officers = 5 Stratified	Different parts of the service emphasised different strengths. GPs stressed their knowledge of a young person in a family context and the broader relationship with them. Also their availability via an appointment system. FP clinics/young person's centres stressed the clinic atmosphere and the accessibility of the service. Also the acceptance of a young person's sexual status and anonymity of a clinic. Little data on any perceived weaknesses of the services except inability for all to access a service and barrier of the receptionist in a GP surgery. Anonymity is more sought for than confidentiality. FP clinic seen as less likely to contain someone known	No details regarding data analysis. Single data source.	

	Funding source: None reported	interview".		sampling. GPs in each locality listed, one chosen randomly. Family planning nurses in each locality listed, one chosen randomly. All school nurses who had received family planning training recruited. Random recruitment of CMO who were directly involved in family planning clinics/young person's services.	personally to the young person or their parents. Perception of different type of person going to GP surgery in contrast to going to a family planning clinic. Staff displayed ambivalent emotions and language in regard to teenage sexuality. Often indicating an unease regarding onset of sexual activity in young people. View that young people lack knowledge of capabilities to assume appropriate responsibility for the outcomes of sexual relationships. Potential tension between the underlying attitude to young people's sexual behaviour and the need to help.		

Powell, E. (2008) Young people's use of friends and family for sex and relationships information and advice.	How are young people using family members and friends to obtain information and advice about sex and relationships? How does this fit in with their use of other sources of information? How are these uses patterned by demographic characteristics? What factors influence engagement with family members and friends? Funding: Cardiff Children and Young People's Partnership	Mixed method Survey and focus groups 12 groups of 3-8 participants. Grouped according to friendship or work groups. Conducted by one of three researchers, one male, two female. Groups carried out in schools and out of school youth settings.	Thematic analysis using techniques of constant comparison.	N = 57 Age 12-19 years M = 37 F = 20. Purposive sampling of Three secondary schools and six out of school youth settings. Cardiff, southern area of the city described as encompassing the 16 most deprived districts of the city.	Importance of friends and peers in discussing sex and relationships. Most female participants reported that friends were the first people that they would go to, associated with commonality of experience, or a shared set of values. Some interviewees reported older and or opposite sex friends were valuable sources of information and advice. Opinions on parental support differed between young people. Interactions in regard to sex and relationships associated with nature of parental relationships, and differed according to the nature of the issue. In regard to extended family similar reasoning was shown with comfortableness rooted in the pre-existing nature of the relationship. Female participants tendency to use mothers for sex and relationships information and advice, male preference for using their fathers. Perception of different needs according to age. Younger people described as needing formal sources of information and advice, whereas as young person got older more likely to turn to peers and partners. Influence of gender, ethnic group, religion and age in perceptions of information and advice needs. Importance of perceived legitimacy of source of information/advice. This associated with prior experience of the issue involved. Importance of information source being easy to speak to,	Participants may be constrained by group discussion. Details regarding recruitment process not provided.	Young people's information and advice seeking is haphazard and sporadic therefore providing information where young people have to intentionally go may not be most effective. May be receiving opinions rather than balanced information and advice. Information acquisition highly context-dependent and differed between individuals suggesting need for a multi-faceted approach.

					and feeling comfortable to be with. Importance of information source providing anonymity or privacy. Often raised in relation to advice via media such as telephone help lines or magazines, chat rooms or TV. Importance of appropriateness of the information source.		
Rolston, B., Schubotz, D. & Simpson, A. (2004) The first time: young people and sex in Northern Ireland.	Attitudes of young people to first sexual experience and the use of contraception Funding: National lottery charities board, Family Planning Assoc of NI	Mixed methods Discussion groups Interviews	No qualitative data reported	Northern Ireland 14-25 years 71 discussion groups held in schools 15 individual interviews No details regarding selection of participants for this part of study or numbers. Reported that "more males than females took part in focus groups".	No data reported	Possible recruitment bias due to refusal of some schools to participate and resistance from some individuals "schools more likely to be state controlled (Protestant) or planned integrated than (Catholic) maintained schools". Describes benefits of triangulating data but has not done this	
Salmon, D & Ingram, I. (2008) An evaluation of Brook Sexual	Evaluation of an in-school sexual health outreach clinic	Mixed method, although little of reported survey data describes views, object	Thematic analysis although only notes made	Bristol 16 schools where new service was	Survey – 11% reported that they would change something about the clinic, 45% would have liked a better room to hold the clinic in and 18% would have liked the clinic open more than once a week.		?Represent-ativeness of the young people who

Health Outreach in Schools. Final Report.	service Funded: Neighbour-hood Renewal	more related to service evaluation and epidemiology. Interviews with service providers/managers and focus groups with young people.	rather than audio-recorded transcripts so only limited data	being provided. Reported as being deprived areas with high incidence of teenage pregnancy. N=222 surveys completed in 10 schools. N=44 from 3 schools attended focus groups or interviews, both users and non users of the service. F=27 M=17 Years 7, 8, 10 & 11 Interviews with staff N=7 2 managers, 2 nurses, 3 youth workers.	Focus groups & interviews with young people - Participants "reported that they liked the attitude of the staff (friendly, easy to talk to, non judgemental), that information was easily available and that the clinic felt comfortable and relaxed". Those using or prepared to use the service emphasised the location, ease of access, approachability and friendliness of the staff as key to its success. Participants liked the fact that they could attend with friends. Perception of a lot of people using the service. One group of girls said that they perceived that some boys were using the service just to get free condoms to give themselves status. Half of one of the groups thought it would be less embarrassing to use the school-based service than an outside service. Half of the second group thought it would be more embarrassing to use the school-based service as people would see you going there and know why you were attending. Whereas at a doctors you could be going for any reason. A group of Asian students felt that Muslim students would not use a school drop in service in case someone saw them. One group of girls worried that they would be called "a slag" if people saw them using the service. Others were worried that fellow students would make fun of them and would prefer to go to the doctors. More comfortable with the nurses at the school. Thought parents wouldn't find out. Confidentiality a key theme – those prepared to use the service were confident of privacy, those not prepared to use the service were worried about information being shared with school staff or parents. Interviews with staff – focussed on positive relations that had been built up between themselves and the service users. Successful collaboration between services and voluntary agencies. Availability of specialist staff.		were interviewed Notes rather than recording limits available data and risks potential bias in retrospective analysis.

					Believed that school service had enabled those not previously likely to access a service to do so. Some staff felt that had provided them with career development opportunities. Some concerns regarding young people attending with friends – confidentiality, bravado. Quality of the space allocated important. Issues with young people who have English as an additional language. Groups where there were cultural or religious issues needed additional resources. Need for more collaboration with other agencies with youth worker role being used more effectively. Service should be more generic as a way of de-stigmatising young people's attendance.		
Schubotz, D., Rolston, B. & Simpson, A. (2004) Sexual behaviour of young people in Northern Ireland: first sexual experience		Mixed method Survey + focus groups and interviews 71 focus groups 17 interviews. Data collected May 2000 to March 2002. No details regarding recruitment for qualitative data.	No details	Details only of survey. No details regarding focus group or interview participants.	Impact of peer pressure	Only 5 quotes from qualitative data reported.	
Schubotz, D., Simpson, A. &	What are the sexual attitudes and lifestyles	Interview using naturalistic interview method.	Narrative presentation.	N = 15 14-25 years Northern Ireland	Limitation of teaching about sex within marriage or committed relationship. Emphasising sex within marriage can create confusion, tension between young people and	Data presented as narrative rather than further	

Rolston, B. (2003) Telling it like it is. Young people's experiences of relationships and sex in Northern Ireland	of young people?	Data reported here (part of larger study encompassing a survey, focus groups and interviews) Data collected May 2000-March 2002. Interviews carried out by male researcher in location chosen by participant.		Some purposive sampling to provide a range of participants. Recruited via survey responses, focus group participants and via network of organisations with access to young people.	parents and marginalise them from peers living with two parents. Suggestion teachers place emphasis on love At times teachers are clearly embarrassed when discussing sexual issues leading to pupils feeling embarrassed. Use of external agencies can be an effective way of overcoming this embarrassment. Trust identified as the most important and influential aspect of any relationship.	analysed. A limited number of quotes used to develop key recommendations	
Selwyn, N. & Powell, E. (2006) Exploring working-class young people's (non) use of the internet for sexual health information and advice	How are working class people using the internet to obtain information and advice?	Mixed method Survey and focus groups. 12 focus groups carried out in schools or out of school settings. Grouped according to friendship or work groups. Conducted by one of three researchers, one male, two female.	Thematic analysis. Constant comparison.	N = 57 M = 37 F = 20. Age 12-19 Cardiff, 16 most deprived districts of the city. 3 schools and six out of school settings.	Report of use of limited repertoire of favoured online sources, preferring websites hosted by big organisations you can trust. These sites preferable as they could be trusted and got straight to the point. Majority not using internet to actively find out about sex, sexual health or relationships. Trend of coming across information in passing rather than on purpose, use of chatrooms and bulletin boards. Internet based communication tended to be general in nature and confined to peers via chat services. Issue of trust pervaded engagement. Peripheral role of online sources within a range of other sources of information and advice.	Participants may be constrained by group discussion. Details regarding recruitment process not provided.	

Seston et al. (2001) Emergency hormonal contraception : the community pharmacy perspective	What are the views of pharmacists toward the deregulation of EHC?	Focus groups Two groups, one with pharmacists with experience of EHC, one with no experience. Recruitment of pharmacists via previous poll – those who had shown positive attitude or not opposed. Those previously indicating moral or ethical opposition were excluded. Groups took place at a local University.	Thematic analysis Carried out by two authors.	N = 18 community pharmacists North West of England. 8 involved in supply, 6 not involved in supply.	Lack of knowledge regarding EHC or confused understanding. Perception that EHC could pose potential risk. Concern regarding potential for legal repercussions/consequences. Perception of special status of EHC due to hormonal content, or potential damage if used repeatedly. Differences related to social context of taking the drug and importance of outcome. Recurrent theme of "abuse" used as a synonym for repeated or multiple use. Stereotyping of type of women who might access emergency services rather than recognising EHC as a rational and responsible act. Stereotyping of use by either irresponsible young women having casual sex or ladies who had financial means and would use in place of their regular contraception.	Single data source Characteristics of sample.	
Sixsmith, J., Griffiths, J., Hughes, J., Wren, J., Penfold, S. & Natusch, H. (2006) Accessibility of condoms to young people in Manchester UK.	What knowledge to young people have regarding condoms? Where do young people obtain condoms? What are the barriers to obtaining	Mixed method Interviews + survey. Interviews in home. 3 interviewers collected data (gender matched to participants and aged 22-30).	Thematic analysis No info re who analysed	N = 6 14-19 years M = 4, F = 2 Opportunistic sampling Greater Manchester area Youth clubs, parks, residential	Some uncertainty regarding where to go to get condoms. Preference for anonymity in purchasing condoms Embarrassment a barrier to accessing condoms. Potential disapproval of adults. Clinic – a place where girls go Lack of condom machines in female toilets Cost of condoms. Accessibility in terms of lifestyle and without age restrictions. Varied locations for spending free time 14-16 year olds and 17-19 year olds. None	Small sample	Distribution of condom vending machines in locations accessible to women. Gender differences in perceptions of embarrassment

	condoms? How might accessibility be improved?			streets, school districts, nightclubs/ pub, shopping areas.			
Smith, A. (2001) Young people's contraception and sexual health: report of a local needs assessment in Stavely North Derbyshire	How should a community family planning service be tailored to meet the needs of people under 25 Funding source: North Derbyshire Community Family Planning Service	Mixed methods. Survey + interviews + focus groups Recruitment for survey described as via school PSHE co-ordinators, youth workers and FP service staff – not described for interviews/focus groups.	Not described	N = 13 F = 7 M = 6 13-25 years.	No qualitative data reported.	Lacking any reporting of qualitative data. Style of a service evaluation rather than research study.	
Stanley, N. (2005) Thrills and spills: young people's sexual	What are attitudes to sexual risk taking among	Grounded theory School interviews during PSHE lessons. Other interviewees	Thematic analysis	N=467 Age: 12-17 14 schools (n=341)	The holiday season created a "carnivalised atmosphere" the pursuit of pleasure where casual sex was likely to happen. Alcohol readily available with casual sexual encounters fuelled by drink and hedonism.	Little detail regarding data analysis process. Described as	Need for services to be sensitive to local context.

behaviour and attitudes in seaside and rural areas	young people in rural and seaside areas? Funding: Teenage Pregnancy Unit	recruited via local professionals. Young people's advisory groups established to comment on emerging findings.		40 interviews with young people excluded from school, transient resident young people, young people from minority ethnic groups and with special needs. 46 interviews with young parents. 40 interviews with local professionals. 3 seaside towns and associated rural hinterlands. Midlands, North and South of England.	Present moment of sexual desire subsuming other longer-term considerations. Association between heavy drinking and casual unprotected sex also described in remote rural areas. Reputation as something that could be gained or lost through sexual behaviour. Gender differences in how sexual activity was viewed. Reputation of girls particularly precarious in small country towns with tight networks of local people. Many young people believed girls who carry condoms would be thought of badly. Assertive young women (mostly over 13) described themselves as always carrying condoms and insisting on their use. Confidence about using the morning after pill which could be used without the need for negotiation with a partner. Loss of reputation seen in the context of the wider local community rather than peers. Young mothers in rural areas experienced stigma and judgemental attitudes. The shame could also extend to their families. Embarrassment a key factor impeding use of sexual health services. Younger boys and girls expressed feelings of embarrassment more forcefully. In rural towns the likelihood of public exposure intensified these feelings. Young men able to avoid the embarrassment by obtaining condoms from dispensing machines. Young women choosing to use forms of contraception they could control were required to negotiate with a health professional. In some cases concern regarding negative professional attitudes identified as contributing to damage to their social identity/stigma. Confidentiality seen as essential feature of a trustworthy	grounded theory but does not describe grounded theory analysis. No details regarding data collection.	

					service. However uncertainty regarding rights to confidentiality. Anxieties regarding lack of confidentiality particularly evident in rural areas where health professionals more likely to have links to social or family networks. Reports of receiving advice and contraception from professionals who were non-judgemental, knowledgeable and trustworthy.		
Van Teijlingen, E. et al. (2007) Embarrassment as a key emotion in young people talking about sexual health	To what extent do young people in secondary schools view sexual health and sex and relationship education as embarrassing? Funding: Scottish Executive Health Department	Focus groups Conducted in secondary schools. Gender specific groups. Gender matched researcher led groups. Groups held on school premises.	Thematic analysis	N = 32 groups – number of participants not detailed. M = 16 groups F = 16 groups. Age: 12-13 and 16-17 Aberdeen and Edinburgh Rural & mixed socioeconomic = 8 Urban and higher socioeconomic = 8 Urban and lower socioeconomic = 16	Gender differences – embarrassment referred to less often in the boy's focus groups. Generally mixed feelings about speaking to parents about sexual health issues, perception of embarrassment. Focus groups with older pupils spoke less about embarrassment, and when they did it was about other people being embarrassed. Could talk to parents if they were close to them or other relatives who were slightly more removed. Several groups adamant they would not discuss relationships with their teachers. Embarrassment about approaching sexual health services and getting condoms in particular. Some raised issue of gender of doctor. Some boys preferring female doctor, girls also. For some anonymity of a specialist agency was an advantage – no need for embarrassment as staff did not know them and young person unlikely to return.	No information regarding how participants within each school recruited. Participants drawn from pre-existing class groups and may not have spoken openly. No details regarding who carried out the analysis. Single data source.	Further research needed to understand the nature of and reasons for embarrassment around sexual health and sex education.

					Phone line and internet service were regarded as more anonymous and hence less embarrassing to use. Perception of parent and some teachers being embarrassed talking about the topic.		
Ziebland, S. (1999) Emergency contraception: an anomalous position in the family planning repertoire?	What are GP attitudes to prescribing emergency contraception? Funding source: Oxford and Anglia R&D and Camden and Islington HA	Telephone interviews with GPs Interviews with patients. Conducted by researcher (also a family planning trained GP)	Thematic analysis with principles of constant comparison. Coded by one researcher and checked by another. Use of NUDIST to manage data.	N = 76 GPs in 3 health authorities. Random sample selected from lists of GPs. N = 53 Women seeking EC at a family planning clinic. London and Oxford	GP concerns that EC being available in pharmacies would be a lost opportunity to fully discuss future contraceptive needs. Different approaches by GPs at first request for EC compared to second, with a more forceful approach described at a consultation for a repeat request. Invitation to attend for follow- up consultation for further discussion but few GPs perceived it likely that a woman would attend for follow up. Women reported that the way in which the topic of future contraception was raised may be off-putting. Women's reasons for avoiding repeated use of EC related to concerns about the safety of the method. GPs seemed more concerned that women should arrange a "proper" method for the future. Unacceptability of EC as a method of choice. Concern among women regarding side effects of nausea and vomiting or long term adverse effects. Concerns among GPs that it would be used as the main form of contraception.	No details regarding recruitment of patient participants. No details regarding ethics. Single data collection method.	
Ziebland and Maxwell (1998) Not a proper solution? The gap	What are the views regarding emergency	Mixed method Survey + interviews Family planning cinics	Coding and thematic analysis supported by	N = 53 women attending for	Belief that EC was relative risky, a high dose of hormones. Concerns regarding long term use of the contraceptive pill. Concerns about risk of contraception weighed against the risk of becoming pregnant.	No details regarding who carried out data analysis	

between professional guidelines and user views about the safety of using emergency contraception	contraception of women using it? Funding: Camden and Islington HA	in London and Oxford. Recruitment in the waiting room. Morning and evening clinics. 2 members of the team carried out the interviews at the clinic.	NUD*IST Construction of a coding tree with hierarchical categories	emergency contraception 38 Oxford, 15 London Mean age: 21 66% at school or college. 57% used EC before	Concerns regarding side effects, long term and/or short term, women reported that they had heard that side effects were common and very unpleasant. Some of information reported to have received unreliable. Important role of friends in informing, encouraging and accompanying woman to the clinic Need to use EC was sometimes presented as evidence of regrettable or irresponsible behaviour by the respondent Worries regarding being judged although few reported concrete examples of negative experiences. Importance of the manner in which the woman is received.		
Ziebland, S., Maxwell, K. & Greenhall, E. (1996) It's a mega dose of hormones isn't it. Why women may be reluctant to use emergency contraception	What are the knowledge, attitudes, beliefs and sources of knowledge about emergency contraception?	Mixed method Survey + interviews. Carried out May 1995. Carried out by researcher. Participants asked to elaborate on their reasons for responses to the questionnaire.	No details, "Word for windows used to organise the text".	N = 53 Women seeking emergency contraception. Family planning clinic London and Oxfordshire. No data regarding age of participants	Some women unconcerned about risk of taking emergency contraception, others concerned about the strength of the treatment. Perception of contraceptive pill being unnatural, not good for body. Emergency method compared with this. Source of information regarding emergency contraception mainly from friends. Reports of piecing information together from a number of different sources. 72 hour rule learned from staff at family planning clinics, publicity materials, or GPs.	Participants those attending family planning clinic. No details regarding analysis. Qualitative data used to supplement survey only.	Belief that EC is strong or hazardous needs to be addressed by professionals and publicity.

Ziebland, S. et al. (2005) What happened when Scottish women were given advance supplies of emergency contraception? A survey and qualitative study of women's views and experiences.	What are women's views and experiences of keeping advance supplies of emergency contraception at home? Funding: Wellcome Trust	Interviews Conducted by one member of the research team. Recruitment via survey element of the study. Purposive sampling for diversity in terms of age, single/in relationship, different patterns of EC use. Interviews mostly carried out in participant's home.	Thematic analysis Techniques of constant comparison. Analysis carried out by two of the research team.	N = 22 women who had received supply of EC. No information regarding demographics of participants.	Women supplied with 5 packets, perceived that this might be sending the wrong message. Concerns regarding younger women using it too often. Suggestion of younger women "abusing" use of it. Other women perceived as being less careful. Distinction between using EC in a steady relationship and use when drunk or multiple partners. Perception of GP/family planning clinic distribution being more regulated than pharmacy provision. All participants described why they thought home supplies were a good idea for themselves and their social circle. Benefits – convenience, quicker use, saving doctor's time, option to share supplies with friends, comfort knowing it's there. Also suggestion it could reduce the embarrassment or stigma associated with accessing supplies. None of the participants suggested that EC should be used regularly. Personal experience of side effects, impact on periods. Condom problems reported as main reason for use of EC, also when taking antibiotics or when they had missed a pill. Some description of advance supplies used as the only form of contraception. In every case interviewees emphasised that sex was with their regular partner. Two participants reported using when they had been drinking. EC not regarded as proper contraception, described as a last resort, rather than an alternative to regular forms of contraception. Perception of danger of ingesting a large amount of hormones.	Participants volunteers. Lack of demographic data.	

					Participants resisted the view that advance supplies would have a negative effect due to reluctance to use EC. Perception that if people are going to have unprotected sex they would do anyway, having EC increase likelihood of taking it or take it more quickly but not encourage someone.		
Ziebland, S., Graham, A. & McPherson, A. (1998) Concerns and cautions about prescribing and deregulating emergency contraception: a qualitative study of GPs using telephone interviews	What are GP views and beliefs about repeat prescribing of emergency hormonal contraception? Funding: Oxford and Anglia Health Authority	Telephone interviews Random sample of GPs. Practices which provided family planning services. One GP from a practice. Recruited via letter. Interview schedule piloted before use.	Thematic analysis Also content analysis. Analysis carried out by two of the research team.	N = 76 F = 21 M = 55. GPs from 3 health authorities. One low (n=25), one medium (n=25), one high prescribing area (n=26).	Concerns regarding women missing out on the benefits of the consultation in terms of having medical history, creating a record, discussing future needs. Concerns regarding lack of control over frequency of use. Concerns regarding environment of the pharmacy. Advantages – easy access, a chemist more anonymous, save GP time	Telephone rather than in person interviews. 25 GPs approached refused to take part. Single data source.	Variation in practice of delivering EC and attitudes about repeat prescribing. Potential for using family planning trained practice nurses rather than GPs.

1.2 Survey studies

Author, year,	Population	Sample	Outcome measures	Methods and analysis Response rate	Main findings
Bradby and Williams 2009	Young people	492 Asian(50%) and Non-Asian Age 14-15 (mean age 17.46/16.48 Asian/Non Asian)	Sexual behaviour (self reported)	Interview at home 100%	Asians and particularly Asian women were far less likely to report heterosexual intercourse than non Asian (19% vs 48% p<0.01). Asian women who did have intercourse were more likely to do so at an older age than non Asian (17.46 vs 16.48 p<0.01) and with an older partner (age 21.31 vs 18.81 p<0.001). Asian women were less likely to report using the pill (48% vs 76% p<0.001) Asian men were less likely than non Asian to report using condoms 32% vs 84% p<0.05) Asian sexual abstinence was reported to be for religious reasons (59% men, 83% women)
Burack 1999	Young people	N=1500 Aged 13-18	Attitudes towards sex and declared sexual practices	Questionnaire 99%	20% of 13 year olds reported having sex or oral sex with a partner The reasons for having sex included Feeling peer pressure; teenage boys were significantly more influenced (p<0.001) Condoning promiscuity: teenage boys were significantly more influenced (p<0.001) Having already claimed to have sex (p<0.0001) 40% remained concerned about HIV-AIDS (more girls than boys p<0.001) 17% believed contraceptive pills protected against AIDS (significantly more boys p<0.01) 10% would be prepared to have unprotected sex (more boys than girls p<0.001)
Burack. 2000	Young people	N=1045 Aged 13-15	Opinions and attitudes towards general practice based sexual health care services	Questionnaire completed during school hours. 98%	68% (709) were aware of the sexual health services offered by GPs 75% (786) were positive about being given helpful advice at a consultation 54% (567) believed they had to be over 16 years old to access sexual health services. 58% (604) were concerned about their confidentially not being preserved by their GP 30% (314) were concerned about the GP not having the time or skills to deal with their problems.
Campbell and Macdonald 1996	Young people	13-15 years 2 schools	Views on youth advisory services	Questionnaire ?	The family doctor and youth advisors and parents were the major sources of help for all problems. For contraceptives this were 31%30% and 26% respectively For sexual matters these were 25%, 30% and 11% respectively For STD these were 63%, 26% and 18%

Chambers et al. 2002	Young people and professionals	Professionals n=66 (36% male) Young people n=55 (35% male). Aged 12-20. Mostly from deprived wards.	Views on ways to reduce teenage pregnancy	Workshop discussion. Delphi questionnaires 85% professions 25% young people	Young people emphasised the importance of interventions being young person centred. Professionals stressed that re-organisation of sexual health and education services was key. Both groups advocated peer education and recognised the need for developing help and services for young men. Both suggested that staff should be educated to be more sensitive in relating to young people. Both advocated the locating of sexual health services for teenagers in youth settings.
Coleman and Testa 2007	Young people	N=2602 Age 15-18 White British (559), White other (256), Black (710, Asian (1077) 1175 deprived 16 high schools	Sexual health knowledge, attitudes and behaviours	Self administered questionnaire 99%	Females reported higher sexual health knowledge scores than males (scores given but no stats) White British males and females recorded the highest levels of sexual health knowledge Lowest knowledge: Pakistani males and females, Black African males, White other males, Bangladeshi males. Males reported more liberal attitudes overall. White British males more liberal than others ($p<0.0001$) White British females also more liberal than other females ($p<0.0001$) Effective contraception was used by 82% of males and 85% of females Males were more likely to report ever having had sex without a condom than females.
Donovan et al. 1997	Young people	30 schools N=4481 51.6% male Age 15-16 years (mean 16.2)	Attitudes towards GP consultation and contraceptive services	Questionnaire - part of an evaluation of a novel sex education programme ?	Over 60% of adolescents attended their consultation with a parent. 27.5% of males and 25.1% of females felt that the discussion with their GP could be relayed to their parent against their wishes Other difficulties with GP appointments were identified as: Embarrassment (63% females, 46% males) Difficulty getting a quick appointment (44% males and females) Unsympathetic GP (32% females, 20.5% males) An increased number of consultations was associated with greater likelihood of consulting alone ($p<0.0001$) Teenagers with three or more consultations per year were more likely to say they believed consultations were confidential (RR=1.07: CI 101-1.14) p=0.01) More females than males found it hard to see their GP (62.1% vs 44.3% RR=1.47, CI=1.38=1.57 $p<0.0001$).

					Teenagers with more consultations were less likely to be embarrassed about talking about personal problems (p<0.0001).
Fayers et la. 2003	Medical students	30% response rate n=213. 110 females, 103 males. 5 responses excluded	Sexual health knowledge	Questionnaire 30%	In all years: Significantly more females (57-91%) than males (11-68%) knew that oral contraceptive pills reduce the risk of ovarian and endometrial cancers (p<0.001). Females did significantly better than males with regard to knowledge about emergency contraception (p=0.012).
French et al. 2007	Young people	N=8879 Age 13-21 49.8% male	Effect of the teenage pregnancy strategy on knowledge and use of contraception services	Face to face and multi media computer assisted interviewing 12 waves over 4 years. N=8879	77% of females and 65% of males knew a service where they could obtain info about sex. The most common source of contraceptives was general practice for young women (54%) and commercial venues for young men (54%). Young women's use of school based services increased significantly from 15.4% in Year 1 to 24.4% in Year 4, p<0.001. Young men's use of the commercial sector significantly declined over the same time (60.3% to 50.6%, p=0.002), and their use of GP and family planning clinics increased (from 8.9% to 12.4%, p+0.008 and from 21.2% to 29.1%, p=0.054 respectively). A significant association was found d in terms of greater effort put into delivery of the service and young men's increased use of services (p=0.022), and between distance to service and service use for young women (p=0.008).
Garside et al. 2000	General practitioners	N=235 (73% response)	Attitudes to sexual activity in under sixteens	self administered questionnaire 73%	Only 15 (6.5%) rejected the notion that the same duty of care applies to under sixteens as older patients. 76% did prefer that parents knew that they had been consulted about contraception Only 7 believed that provision of contraception encourages under-age sex. 25% believed that under sixteen year old girls and too young to have sex. Only 16% stated that they followed written guidelines when treating under sixteens for sexual health.
Gbolade et al. 1999	A+E staff	N=355 Responded included consultants, GPs and nurses depending on the size of the	Thoughts on providing emergency contraception service	Questionnaire (postal) 63.4%	Requests for EC were received by 96% of units but only 57% provided treatment 82.9% of the 187 providing units felt it was a worthwhile service. 56% thought EC should be provided by A+E units. But 91 units could identify at least one group within the hospital who were antagonistic to A=E provision: non A+E medical staff formed the largest group. Over the counter provision of EC was not supported by 62% of respondents. Note: this study is 10 years old.

		unit and who was in charge.			
Glasier and Wellings 2007	Health professionals	Primary care doctors and nurses. N=420	Changes in practice in response to prescribing advice re. DMPA.	Self completed questionnaire 100%	16.2% (11.3-22.0) would deter all women, 32.8% (26.3-39.8) would deter young women from using DMPA. 22.2% (16.6-28.7) would limit use of DMPA to 2 years. 8.1% (4.7-12.8) would suggest contraceptive implants as an alternative contraception. Younger practitioners (less 50) significantly more likely than older practitioners (over 50) to change practice according to advice (78.0% [71.6-83.5) vs 60.8% [48.8-72.0] p=0.004). Male GPs signif more likely to deter all users than female GPs or nurses (39.5% [19.1-44.8] vs 9.1% [4.9-17.6] or 10.0% [4.9-17.6] p=0.001). Nurses more likely than GPs to provide advice for patients to make informed choice (56% [45.7-65.9] vs 30.9% [19.1-44.8] p=0.001).
Graham et al. 1996	Young people	N=1206 (612 boys) 14-15 years old	Level of knowledge of EC	Questionnaire ?	Girls were more likely than boys to reporting having had sexual intercourse (32.7% vs 27.5%) although 16.5% of boys and 10.1 of girls preferred not to state whether they had been sexually active. 93% had heard of EC Of girls who had experienced sexual intercourse, 31.4% had used EC Knowledge of correct time limits was poor, sexually active girls being the most knowledgeable Pupils attending schools rated low for academic attainment were less likely to have heard of EC and more likely to be sexually active. 76.8% of pupils knew they could obtain EC from their doctor. 82.5% believed EC to be effective. 35.5% thought EC more dangerous than the oral conceptive pill.
Hagley et al. 2002	Young people	N=587 19 schools 214 female, 373 male Av age male 15.8, female 16	Interest in attending a walk in young persons sexual health clinic or sexual health website	Questionnaire 70%	Young females were more interested in seeing a full range of services provided at a young person's sexual health clinic. Especially pregnancy testing (89% vs 30%) and emergency contraception (86% vs 36%) Both young men and women were keen to have a telephone advice line (84% and 89%), but more young women than young men said they would use one (71% and 39%). More young women were interested in counselling being provided at the clinic (70% vs 41%). Young men expressed more interest in getting information about sexual health from a website (55% vs 37%), and having HIV testing available to them (60% but young women 77%).
Harden and Ogden. 1999	Young people	N=967 16-19 59.6% female 58 educational	Use of and beliefs about a range of contraception services	Questionnaire 22/58	Chemists and condom machines had been used the most Men favoured condom machines (p<0.001) and women preferred the GP (p<0.001) or family planning clinic (p<0.001).

		institutions			
Hooke et al. 2000	Young people	N= 129 14-15 year olds. 2 schools	Attitudes towards teenage pregnancy and early sex	Illustrated short story and questionnaire 100%	73% of girls but only 46% of boys advocated joint responsibility for contraception protection ($p<0.01$) Significantly more boys than girls saw nothing wrong with casual sex (21% vs 5% $p<0.01$) Significantly less boys than girls upheld the virtue of commitment in sexual relationships (27% vs 54% $p<0.01$). In giving reasons for young people having sex, twice as many girls as boys cited image/reputation as a factor (42% vs 19% $p=0.01$), and 3 times as many girls than boys cited feeling grown up/ready for sex as a factor (25% vs 8% $p=0.01$)
Nwokolo et al. 2009	Young people	N= 744 Aged 11-18 Six secondary schools and one PRU 294 males, 450 females 100% response	Provision of sexual health services	Focus group: Peer designed questionnaire 100%	Pupils wanted clinics to run more frequently than the usual once a week (85%) Staff attitudes that were most important were attitudinal rather than age, sex, or physical appearance. Young people wanted the clinic to be open after school (71%) or on a Saturday (49%). Older pupils were more likely to find after school clinics ($p=0.001$) or lunchtime clinics ($p=0.038$) useful than younger ones Girls preferred to attend with a friend A walk in service was preferred (62%) rather than an appointment service (35%). 24% would not wait longer than 15 minutes. Younger pupils (11-14 years) were more likely to prefer a hospital based clinic ($p=0.013$) than older pupils (15-18 years) Older pupils felt the entrance to the clinic should be on a side street ($p=0.0009$) and close to public transport ($p=0.058$) Younger pupils were more likely than older ones to require advice before having sex ($p=0.001$). Girls were more likely than boys to want this advice ($p=0.0001$). Girls were more likely to want relationship advice than boys, younger girls were more likely to want this than older ($p=0.0001$)
Parkes 2004	Young people	N=5747 15-16 years old 47 schools	Use of sexual health services	Self completed questionnaire 69%	33% had used and service; use was strongly related to sexual experience (as were family influences, and being a school leaver (class, ethnicity and religion were not associated) Proximity to a clinic was linked with greater use Low spending money and high parental monitoring were linked with lower use. Those with better knowledge, who rated their school sex education as effective, who were comfortable talking about sex, and who had discussed contraception with their peers more likely to use a service

Pearson et al. 1995	Young people (pregnant)	N= 167 Age 17.62 (1.25) years	Awareness and experience of, and attitudes to, family planning services	Survey 100%	92% used contraceptives prior to pregnancy 98.2% knew where to obtain contraceptives and advice 67% had become pregnant while using condoms 60% had seen a GP and 30% a family planning clinic regarding contraception 93% described their GP visit as private compared to 69% who described family planning visits as private (p=0.0005) 26% had been put off attending a family planning clinic due to lack of confidentiality or the importance of a friendly accessible service designed to meet their needs 44% had been put off going to their GPs due to confidentially or desire for a female GP
Reeves et al. 2006	Young people	N=360 (173 male, 97% White) Aged 15-16 years 3 schools	Requirements and perceptions of sexual health services and education in the context of their experience of sexual relationships and knowledge of sexual health	Questionnaire based cohort study 86%	Those young people who reported being sexually active (153, 45%) thought most sexual education topics should be taught around six months earlier than non sexually active respondents. Of those accessing sexual health services, 90% were happy with the service received, but only 44% of sexually active males and 76% of sexually active females had sought advice. Clinic "has a friend atmosphere" and staff "easy to talk to", ranked highest and "only people of your own age using the clinic" ranked lowest on a list of important features for sexual health clinics. The local health centre was the most popular setting for a sexual health clinic (60%) although sexually active respondents were more likely to want clinics in school (p=0.037) School nurses were favoured to teach about contraception (61% boys and 85% girls p<0.0001) and STIs (64% of all respondents)
Ross et al. 2007	Young people	542 community interviewees 202 patients Age range 16-25. 49% female. White 59.8%	Views on Information and Communication Technology (ICT) in delivery of sexual services.	Face to face interview 100%	Reported acceptable method of booking appointment: Telephone (community 93%, clinic 96%) In person (community 77%, clinic 54%) Email (community 10%, clinic 27%) Internet (community 7%, clinic 11%). Men were less likely to use the web-based service than women (72% [185] vs 82% [233], OR 0.59, 0.38-0.91). Electronic booking significantly less acceptable to Black Caribbean respondents than Black/other (12% [15] vs 29% [10], OR 4.54, 2.56-8.06).
Salihi et al. 2002	Young people (pregnant)	14-16 years N=80 (63% girls) school pupils aged 11-15 AND retrospective study of	Contraceptive use	Questionnaire 100% ?	99% said they would use contraception 73% of girls but only 52% of boys were aware of the service availability. 99% of girls but only 59% of boys knew about emergency contraception 33% thought they received too little sex education at school 32% received no sex education at home The study of pregnant teenagers showed that 69% went ahead with their pregnancies, 71% were not

		pregnant teens n=74, 14-16 years			habitually using contraception, and only 4% were using contraception at the time of conception.
Samangaya 2007	Young people	BME men mostly aged 16-28 (max age 25) 42% Pakistani, 18% Bangladeshi, 13% Indian, 11% Black Caribbean, 9% Black African, 7% Mixed Race	Awareness sexual health services and ease of access	Questionnaire 85%	62% were aware of sexual health services in their area. 31% had access services (not significant between ethnic differences) Patients were asked where they would go if they had a sexual health programme: 71% GP surgery, 38% "information shop", 13% did not know. What factors would stop them accessing sexual health services: 66% embarrassment, 40% not able to attend at appropriate time, 36% don't know where to go, 13% religious beliefs, 4% not sexually active.
Sengupta 1998	General practitioners	N=230 206 males 24 females Half trained on Indian subcontinent	Attitudes towards contraceptive service provision	Self completed postal questionnaire 57%	128 (98%) willing to provide contraceptive advice (89% of those trained in India compared with 99% of those trained in the UK, p=0.00253) 104 (79%) willing to provide contraceptive treatment (64% of those trained in India compared to 80% of those trained in the UK, p=0.00970) No difference between two groups in terms of further referral of patients (p=0.29870)
Stevenson 1996	Young people	15-16 years 2 schools	Knowledge of emergency contraception	Questionnaire 85% girls 73% boys	Despite extensive PSHE curricula, one in five girls and one in three boys did not appear to know about the existence of any postcoital contraception. 78% of girls responded with the morning after pill, compared with 39% of boys. 23 pupils gave time limits for the use of the emergency pill, only 11 of these were correct.
Stokes and Mears 2000	Practice nurses	N=234	Reported practice and training in sexual health, attitudes towards sexual health, barriers to discussing sexual health with patients.	Self administered postal questionnaire 79%	Nurses were more comfortable discussing sexual health issues with female patients (89%) and teenagers (77%) and less comfortable with males (54%) and those of different sexual orientations (45%). Nurses who had received training reported more positive attitudes towards discussing sexual health issues with patients.

Stone and Ingham 2002	Young people	963 full time students aged 16-18. 59.8% female. 92.1% White 33.3% high social deprivation	Factors which determine contraceptive use at first sex and whether use is discussed beforehand.	Quantitative self administered questionnaire 100%	Three factors were significantly associated with the odds of contraception use at fist sex among young men: Discussing contraception before hand (OR 5.7-13.8 p<0.05) Giving and intimate reason for having sex the first time (OR 6.4) Having parents who portrayed sexuality positively during childhood and early teenage (Or 1.16 p<0.05) For young women five factors predicted use: Communication (OR 6.24-14.95 p<0.01) Age at first sex (OR 1.76 p<0.05) Not having visited a service provider (OR 4.98 p<0.05) Feeling comfortable interacting with teenage males (1.19 p<0.05) "Sort of " or not expecting to have sex (0.2 and 0.4 respectively) In young men, having discussed contraception was associated with level of social deprivation (OR 0.12 p<0.01), length of relationship (OR 4.09-60.99 p<0.01) and parents' openness to talking about sex (OR 1.14 p<0.01). For young women the factors were number of intimate reasons given for having sex (OR 4.16-8.76 p<0.01) and the warmth and availability of parents (OR 1.04 p<0.01).
Stone and Ingham 2003	Young people	N=747 (88.8% female) Age 11-39 (median age 17, mean age 18). 95.4% White Mixed socioeconomic status.	Use of health services (and reasons for use)	Self administered questionnaire ?	29% had used sexual health service before ever having sex. 61% had used a service after sexual debut. 20-24% of women had been embarrassed or scared, or concerned about confidentiality or age. 32% had visited a provider because they had unprotected sex. 63% of men who delayed service use reported free condoms as the prompt to their first visit. Only 43% who postponed service use practiced contraception consistently before visiting a provider. The proportion who attended due to suspicion of pregnancy was higher in those young than 16 (16%) than those 16 or over (7%) p=0.04. In terms of reasons for delaying service use, women younger than 16 were more likely than those older to report not knowing about a service (14% vs 5% p<0.01) and more likely to cite concerns about age (34% vs 5% p<0.001) and confidentiality (25% vs 12% p=0.001).
Thomas et al. 2006	Young people	4 comprehensive schools N=295 Year 9 (age 13-14) 48.5% male	Importance of confidentiality of sexual health clinics	Questionnaire Completed in class 100%	Confidentiality in two different measures was rated as 8.84 and 8.59 (mean) on scales of 1(not important) to 10 (most important). 166 (56.3%) rated confidentiality as the most important feature of a service 254 (86.1%) were more likely to use a service if it was confidential 161 (54.6%) would not use a service that was not confidential 266 (90.2%) would give honest answers in a confidential service 186 (63.1%) would not attend a clinic if they believed child protection services would be informed.

					136 (46.1%) would not want their GP to be informed of attendance. 209 (70.8%) would like regular sexual health check ups 150 (50.8%) would prefer a young people clinic, but only 105 (35.6%) would prefer a "one-stop-shop".
Thomson et al. 1999	Young people	1990: n=350 (181 boys) Mean age 15.58 1994: n=310 (134 boys) Mean age 15.53	Scottish school children's knowledge, attitudes and perceived education needs in relation to HIV/AIDS	WHO Behaviour of School Age Children Study 2 samples 1990 and 1994	Between 1990 and 1994: Significant trend towards more classroom hours spent on HIV/AIDS ($p<0.001$) Significant decrease in HIV/AIDS discussion between young people and their parents Significant decrease in number who fell they need to know a lot more about AIDS or they have not been taught enough at school.
Van den Akker et al. 1999	Young people	N=212 Age 11-19 (mean 14.99 SD 2.215) 106 female, 91 male. Majority white (137).	Sexual knowledge, feelings and behaviour	Questionnaire 212/250	Girls received more sex education from parents, TV and books (all $p<0.05$) than boys Girls were significantly more likely to know where teenagers can get helpful advice about sex and relationships without their parents finding out ($p<0.0001$) than boys More girls than boys thought their friends were truthful about their sexual experiences ($p<0.05$) The majority of boys and girls would not have sex just because their friends did (17% and 5% $p<0.005$) Boys were more likely to have sex even if they did not really want to (46.2% vs 19.6%0 Girls were more able to say no (95% vs 65.9% $p<0.0001$) More boys than girls did not know what contraceptives were, how to use them and did not feel able to discuss them with their partner(7.2% vs 3.6% $P<0.01$) Actual contraceptive use was evenly split between boys and girls (23.3% boys and 26.4% girls)
Wellings et al. 2007	Health professionals	169 GPs, 148 nurse practitioners, 4 n/s. 74% female 74% age under 50, 26% over 50. 31% in socially disadvantaged	Views on safety, efficacy and acceptability of long acting contraceptives.	Self completed questionnaires. ?	81.2% (76.9-85.6) endorsed the role of LARC in preventing teenage pregnancy. Lack of skill in providing was seen as a barrier to provision by 60.6%. (55.1-66.0) 50.3% (44.7-55.9) thought irregular bleeding deterred women from using LARC 20.6% (16.0-25.1) were concerned about high discontinuation rates. Misconceptions about side effects were common

		area.			
Wight et al. 2000	Young people	N= 7395 (3665 boys, 3730 girls) mean age 14 yrs 2 months. 24 schools	Extent of regretted sexual intercourse	Questionnaire 94%	For boys, reporting that they had exerted pressure was associated with higher level of regret. For girls all variables were associated with regret (univariate) In multivariate analysis of girls, reports of being pressured, not having planned sexual intercourse with their partner and relatively high levels of parental monitoring were significantly related to regret.
Woodward 1995	Young people	30 teenagers with an unplanned pregnancy (ANC), age 16-19 mean 17.8(1.04) and 31 'never pregnant' teenagers using contraception (FPC) age3 15-19 mean 17.4 (1.38) 97% White	Family and partner stability, communication with parents or stable sexual partner about sexual matters	Self completed anonymous questionnaire 61/65	Both groups found sexual activity and sexual relationships hard to discuss, there were no significant differences between the groups. Teenagers in the ANC group sought information most from their mothers, FPC group most from books ANC were more likely to discuss personal rules and values with boyfriends and FPC with friends 73% of the ANC group had a regular boyfriend compared to 90% of the FPC group (p=0.01)

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Appendix 3: Excluded studies

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Appendix 4: Search strategies

List of databases searched

Medline via OVID SP
Embase via OVID SP
Cinahl via OVID SP
British Nursing Index via OVID SP
PsycINFO via OVID SP
ASSIA via CSA
Cochrane – CDSR via Wiley
Cochrane –DARE via Wiley
Cochrane –Central via Wiley
Cochrane –HTA via Wiley
Social Care Online
Science and Social Science Citation Indices via Web of Knowledge

EconLit via OVID SP
Cochrane – NHS EED via Wiley

Sample search strategy from MEDLINE

1 *adolescent/
2 teen*.ti,ab.
3 adolescen*.ti,ab.
4 underage.ti,ab.
5 youth*.ti,ab.
6 (Young adj2 (person or people or adult*)).ti,ab.
7 (School adj2 (child* or student* or age)).ti,ab.
8 minor*.ti,ab.
9 student*.ti,ab.
10 (under adj2 (eighteen or "18")).ti,ab.
11 (under adj2 (twenty five or "25")).ti,ab.

12 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11
13 *contraception/
14 *family planning services/
15 *birth control/
16 *contraceptive behavior/
17 (family adj2 planning).ti,ab.
18 (birth adj2 control).ti,ab.
19 sexual health service*.ti,ab.
20 sexual health clinic*.ti,ab.
21 (Contracepti* and (pharmacy or pharmacist* or community or service* or access* or provision or support* or clinic* or availab* or emergency or delivery or outreach or advice or information or intention*)).ti,ab.
22 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21
23 exp Pregnancy, Unwanted/
24 exp Pregnancy, Unplanned/
25 (Pregnan* adj2 (unwanted or unplanned or unintent* or accident*)).ti,ab.
26 conception*.ti,ab.
27 (Prevent* adj2 pregnancy).ti,ab.
28 23 or 24 or 25 or 26 or 27
29 22 or 28
30 12 and 29
31 limit 30 to (humans and yr="1995-2008")

Appendix 5. **Included qualitative papers by data collection method**

Arai (2003) Baraitser (2003) Bell and Millward Bissell et al. (2006) Barrett and Harper (2000) Bissell and Anderson (2003) Bloxham (1997) Brown et al. (2007) Cheung and Free (2004) Coleman and Testa (2008) Coleman (2001) Coleman and Cater (2005) Cooper et al. (2008) Croghan (2006) Fairhurst et al. (2004) Fairhurst et al. (2005) Fallon (2003) Folkes et al. (2001) Free et al. (2005) French et al. (2006) French (2002) Hayter (2005b) Ingram and Salmon (2007) Jolley (2001) Mackie et al. (2002) Mason (2005) Morrison et al. (1997) Pitts et al. (1996)	Interview (37)

Powell (2008) Schubotz et al. (2003) Sixsmith et al. (2006) Van Teijlingen (2007) Ziebland (1999) Ziebland and Maxwell (1998) Ziebland et al. (2005) Ziebland et al. (1996) Ziebland et al. (1998)	
Donnelly (2000) Free et al (2002) Garside et al. (2002) Harden and Willig (1998) Jones et al. (1997) Mackereth and Forder (1996) Pearson (2003) Selwyn and Powell (2006) Seston et al. (2001)	Focus groups (9)
Hayter (2005a)	Non-participant observation (1)
Jewell et al. (2000)	Interviews and non-participant observation (1)
Allen (2004) Craig and Stanley (2006) Curtis et al. (2005) French et al. (2005) Griffiths et al. (2008) Higginbottom et al. (2006) Higginbottom et al. (2008) Hoggart (2006) Lester and Allan (2006) McCann et al. (2008) Rolston et al. (2004) Salmon & Ingram (2008) Schubotz et al. (2004) Smith (2001) Stanley (2005)	Interviews and focus groups (15)
Ogden and Harden (1995)	Free text (1)

Appendix 6. Additional resources

DfCFS documents

Annual report 2007/08: Teenage Pregnancy Independent Advisory Group (DfCFS 2008)
http://www.library.nhs.uk/PUBLICHEALTH/ViewResource.aspx?resID=292558&tabID=290

Fifth annual report. Two strands of the TPU strategy – to halve the number of under 18 conceptions by 2010 and to increase the participation of young mothers aged 16-19 in education, employment and training to reduce the risk of social exclusion with a target of 60% participation by 2010.

Recommendations – need for government to provide strong leadership and ensure services work together effectively "joined up working", need for improved recording of data and maximum use made of data sources, need for clear communication strategies to teenagers about why reducing teenage pregnancy matters and to the public about the strategy. Need for removal of 9pm watershed for condom advertising and development of a safe portal for appropriate web based material. Contraception available widely cost-benefits of contraception particularly long acting reversible contraception recognised. Funding for abortion and contraception and recording of figures should be unified rather than separate, with improved access to computers in community services. Importance of need for sex and relationships education, beyond school. Need to extend training to include all staff working with young people, identify and develop further training and develop a new qualification. Role out a national programme of support and guidance for parents and carers such as the FPA Speakeasy programme, and include SRE in parenting strategies, and provide information packs. Greater support for teenage parents needed.

Enabling young people to access contraceptive and sexual health information and advice (DfCSF 2004)
http://www.everychildmatters.gov.uk/resources-and-practice/IG00214/

Legal and policy framework for social workers and social care staff. 4 key strands of the TPU strategy – joined up action, national media campaign, prevention by access to health and contraception services, and support for young parents.

Risk factors – poverty, in care, educational problems, not involved in education training or work, experience of abuse, mental health problems, trouble with police.

Question and answer format regarding actions that can be taken by staff in response to requests from a young person in regard to

providing information, advice, taking to services, onward referral, confidentiality, support.

Improving Access to Sexual Health Services for Young People in Further Education Settings (DfCSF/DH 2007)
http://www.everychildmatters.gov.uk/resources-and-practice/IG00244/

Guidance for senior managers, student service managers, 14-16 co-ordinators, enrichment managers, senior tutors, college counsellors and welfare officers working in FE colleges. Purpose to provide quick and ready access to information for further education settings on how to establish on-site sexual health services. Looks at sexual health issues and the impact they can have on learning, explains why further education settings should address sexual health, outlines the benefits of providers working together in partnership to provide services, provides practical advice and summarises good practice. Frequently asked questions section and a range of case studies.

The Children's plan: building brighter futures (DfCFS 2007)
http://www.dcsf.gov.uk/childrensplan/downloads/The_Childrens_Plan.pdf

Five principles underpin the plan. Of particular relevance – emphasis on parent role in bringing up children and need to do more to back families. Also, the need to support children to succeed, the importance of services being shaped by and responsive to service users, and emphasis on prevention. Keeping children on the path to success, chapter 6 – review best practice in effective sex and relationships education. Chapter 7 making it happen – have in place by 2010 consistent high quality arrangements to provide identification and early intervention for all children and young people who need additional help. Goals for 2020 – parents satisfied with the information and support they receive, all young people participate in positive activities to develop personal and social skills, promote wellbeing and reduce behaviour that puts them at risk.

DfES/Teenage Pregnancy Unit Documents

An exploration of the Teenage Parenting Experiences of Black and Minority ethnic Young People in England. Teenage Pregnancy Research Programme Research Briefing Number 6 (DfES 2006)

Study reporting interviews with young mothers and fathers, their parents and service providers in London, Sheffield and Bradford.
Key findings:
Young parents placed a high value on motherhood and children especially for those of a Muslim faith where norms concerning younger marriage and parenthood differed from the wider community.
Most young parents had clear career or educational goals and did not view early parenthood as obstructing these.

Family support was crucial to the experience of early parenthood.
Reports of Sure Start Plus services providing valuable support but experience of doctors and hospital based midwives was more mixed.
Young parents and service providers challenged the view that teenage parenthood is wholly negative.
Service providers see a need to improve monitoring systems and evaluation frameworks.

Enabling young people to access contraceptive and sexual health advice: guidance for youth support workers (DfES 2005)
http://www.everychildmatters.gov.uk/_files/YouthWorkersGuid2005FINAL.pdf

The guidance aims to clarify for youth support workers that they can and should encourage young people to seek advice and contraception and direct them to local services if it appears that they are or are thinking about becoming sexually active and cannot be persuaded to delay sexual activity. Need for development and review of policies, need for training to support youth workers, need for a nominated member of a team or organisation.

Exploring the Attitudes and Behaviours of Bangladeshi, Indian and Jamaican Young People in Relation to Reproductive and Sexual Health (TPU/DOH 2006)
http://www.everychildmatters.gov.uk/resources-and-practice/RS00038/

Report of a research study in London, Manchester and Birmingham 2002-2003 consisting of 75 in-depth interviews. The study found marked variations in reproductive and sexual health attitudes between the different groups. Cultural factors strongly impacted on how teenage pregnancy was viewed. Gender differences in attitudes and behaviour were strong with conflicting messages being given to young men and women. A gradual harmonisation of attitudes associated with wider British culture was apparent although this was moderated by cultural norms and religious beliefs. Many parents felt that they did not have adequate skills to engage with their children in regard to sexual and reproductive health. Current knowledge and use of existing services varied substantially across the cultural groups. Whilst there was diversity of opinion regarding need for culturally specific services, the need for appropriate role models and resources was identified as important. The report provides further information regarding knowledge and attitudes, sexual experience, pregnancy and parenthood, and sexual and reproductive health services.

Extended Schools: Improving access to sexual health advice services (DfES 20007)
http://www.everychildmatters.gov.uk/_files/SexualHealthAdvice.pdf

Guidance for senior managers and governing bodies in secondary schools. Important role of schools in meeting targets for reducing teenage pregnancy. Background information on how schools can help, 3 case studies, frequently asked question.

Guidance for developing contraception and advice services to reach black and minority ethnic (BME) young people (TPU/DOH 2000) http://www.nottinghamcity.gov.uk/tpu_bme_guidance.pdf

This document provides supplementary guidance to the Best Practice Guidance (TPU, 2000) providing more detail regarding how services should be reviewed and developed to meet the needs of BME communities. The document reports that currently there are no comprehensive statistics on teenage births or abortions for this community, as information only collected on mother's country of birth. This poses problems in understanding the extent of the problem and setting targets. Surveys suggest however young people from Bangladeshi, African and Pakistani communities are substantially more likely to be teenage parents than the national average. This may be partly associated with cultural practices and traditions of early childbirth in marriage, but likely to live in deprived areas.

Issues highlighted by young people from BME communities – barriers to services such as racism, lack of appropriate services, different moral value system, inappropriate and inaccessible services, concerns re confidentiality, lack of culturally appropriate images or messages, inaccessible information, poor staff attitudes and behaviour.

Recommendations – agencies work together to map existing provision, establish links with community and faith based organisations, review services against existing guidance, involve young people in development, evaluation and delivery. Need to have explicit confidentiality policy, staff need to be trained and adequately supervised. Need for culturally appropriate environments, and consultation with young people to decide best location for services, and convenient opening hours. Services should offer adequate time and support, provide knowledge regarding myths, risks and contraceptive methods via verbal and written means.

The report provides case studies of practice in 6 locations describing the type of work, profile of the client group, aims and objectives of the work, identification of funding, key partners, the process of development, young people's involvement, feedback and evaluation, chosen indicators of success, and useful lessons to share with others.

Living on the Edge: sexual behaviour and young parenthood in rural and seaside areas. Teenage Pregnancy Research Programme Research Briefing Number 2 (DfES 2006)

Research took place 2001-3 in 3 seaside resorts and surrounding rural areas. Discussion groups with 12 -17 year olds in secondary schools and those not in mainstream schooling. Also interviews with key professionals, young parents and transient workers.

Key findings:
Young people faced common factors in relation to sex, sexuality and relationships and some felt sexually and emotionally illiterate in dealing with them. Embarrassment, low aspirations, low family expectations and lack of self esteem were seen to be associated with risky behaviours.

Concluded that planning approval and policy and service development in both rural and seaside areas needed to avoid damaging impacts on young people. Organisations should take steps to consult with young people over developments. Local patterns of sexual health services should be reviewed to ensure they are adequate and accessible. Training and ongoing professional development must promote non-judgemental and non-stigmatising approaches.

National Evaluation of the Teenage Pregnancy Strategy (TPU/DH 2005)
http://www.everychildmatters.gov.uk/_files/full%20report%20final.zip

Teenage pregnancy strategy has 4 major components – national media awareness campaign, action to ensure co-ordination across agencies, improved sex and relationships education and access to contraception and sexual health services, and support for teenage parents. Local strategies led by teenage pregnancy partnership board.

Evaluation included a national survey 2000-2004 of over 9,000 13-21 year olds to monitor changes over time. Also routinely collected data on conception abortion, deprivation, intervention and non-intervention activity to explore variations in outcome at a local level. Analysis of regional and national press coverage. Evaluation of processes such as co-ordination of strategy activities and experiences of those implementing them.

Findings – local teenage pregnancy co-ordinator has been the lynchpin of implementation. Importance of school SRE as a source of learning confirmed. Messages about condom negotiation came through most strongly. Increasing use of school-based services, help lines and websites to gain contraceptive advice. Young women most likely to get advice from GP, young men from school. Young women less likely to be offered longer acting more reliable forms of contraception, and confusion remains regarding confidentiality. Participation rates of young mothers changed little during the evaluation period. Links between national and local level co-ordinators worked well.

Sexual behaviour measured by number reporting sexual intercourse, number using contraception at first intercourse, number using protected sex in last four weeks, and number obtaining contraceptive advice before first sexual intercourse.

Conception rate in under 18s fallen by about 9% by 2002 compared with 1998. Areas of greater deprivation and lower educational attainment showed substantially more decline, also changes related to level of expenditure. Suggests strategy has been well targeted in areas of greater need that have benefited the most. Linking decreased conception rates to more specific markers of the extent or quality of strategy related activities has proved more elusive.
Recommendations - future efforts should continue to be directed at tackling the underlying socio-economic determinants of teenage pregnancy with even greater focus on interventions that selectively advantage young people from poorer backgrounds and areas. Further work to ensure young people are well informed about sexual matters. Long acting contraceptives should be more widely available to young women. The school environment offers a key opportunity to evaluate the effectiveness of services. High quality SRE education should be mandatory in the national curriculum. Need for funding and continued role of teenage pregnancy co-ordinators.

Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies (DfES 2000)
http://www.everychildmatters.gov.uk/_files/8845F3C6EC567906D4E1F95616ED6BFB.pdf

Outlines the rationale for the teenage pregnancy strategy, highlighting the short and long term consequences of early parenthood. Makes the financial case for investing in measures to prevent early pregnancy and presents evidence on which women are at risk. Confirms strong link with deprivation, but also emphasises other factors in particular poor educational attainment and low aspiration have an impact over and above deprivation levels. Reports the main factors in successful programmes taken from the main guidance. Emphasises that young people need not just the means to access guidance and avoid early pregnancy but also the motivation. Action to tackle the root causes of teenage pregnancy therefore needs further consideration.

Protective and risk factors for early sexual activity and contraception use amongst black and minority ethnic adolescents in East London (TPU 2005)
http://www.everychildmatters.gov.uk/resources-and-practice/RS00037/

Study using quantitative and qualitative methods – survey (n=2369) collected in schools age 13-16 years. Focus groups, web discussion and interviews n=146 age 15-18 years. 83% of those who had intercourse reported using one or more forms of contraception, young women reported more unprotected sex than men. No ethnic

differences in types of contraception, but differences in rate of use. Parental communication and perceived disapproval of sex appeared to affect contraceptive use differently in different ethnic groups. Need to interventions to address issues around continuing protection in long term relationships as young people from non white ethnic groups were more likely to have unprotected sex if they had been in a relationship for 6 months or more. Special needs groups appear to need better access to services.

Conclusions – improving access to services and equipping young people with sound sexual health information would support their expressed desire to make the right choices. Need for investigation of high rates of lack of contraceptive use amongst young women especially in long term relationships. Differences between ethnic groups indicates need to tailor interventions. Continuing protection during long term relationships needs to be emphasised.

Teenage Pregnancy: accelerating the strategy to 2010 (TPU 2006)
http://www.everychildmatters.gov.uk/resources-and-practice/ig00156

Reports progress in the strategy since 1999. Progress in regard to lowered conception rates decline of 15.2% in under 16s and 11.1% in under 18s. Analysis of underlying causes of early pregnancy makes clear that effective delivery of local strategies is critical, but also role of underlying factors such as poverty, poor educational attainment and low aspirations. Teenage pregnancy matters is associated with the most deprived and socially excluded people, having children at a young age can damage a women's health and well-being and severely limit education and career prospects, effects of deprivation and social exclusion are passed from one generation to the next, cost to NHS.

Need to identify and target effectively those most at risk with both a geographical focus on high rate neighbourhoods and the identification of vulnerable groups.

Risk factors – early onset of sexual activity, poor contraceptive use, mental health/conduct disorder/involvement in crime, alcohol and substance misuse, teenage motherhood (20% are births to under 18s who are already teenage mothers), repeat abortions, low educational attainment, disengagement from school, leaving school at 16 with no qualifications, living in care, daughter of a teenage mother, ethnicity, parental aspirations. Young women experiencing five risk factors have a 31% probability of becoming a mother under 20, young men 23%.

Key factors in successful interventions – engagement of all providers, strong champion, well-publicised service, high priority given to PSHE in schools, focus on targeted interventions with young people at greatest risk, training for professionals in partner organisations, a well resourced youth service.

Outline of 6 SRE programmes in terms of key features and evaluation.

Prevent repeat pregnancies by supporting teenage parents to use contraception, disseminate information to agencies, identify and share best practice, liaise with relevant professional bodies, ensuring health visitors have skills and competencies.

Extension of media campaign, improved access to high quality mental health services. Support for emotional health and wellbeing in schools, and initiatives to improve attendance and behaviour and educational achievement. Neighbourhood renewal strategy to target the poorest areas has provided funding in deprived areas to support teenage pregnancy related projects and mainstream programmes. New Deal for Communities neighbourhood renewal programme – case studies of 4 programmes.

Need for further work to assess what support is needed by young fathers. Suggested that they are more likely to be disengaged from education, employment or training, live in deprived areas, have poor levels of educational attainment and have been in trouble with the police.

Teenage pregnancy next steps: guidance for local authorities and primary care trusts on effective delivery of local strategies (DfES, 2006)

This document outlines the rationale underpinning the teenage pregnancy strategy. It reports that whilst there has been progress nationally in reducing under 18 and under 16 conception rates, there is significant local variation in performance. The document is intended to support and help local services to review their strategies.

In order to assist this review it provides an overview of findings from "deep dive" reviews carried out by the Teenage Pregnancy Unit to inform a better understanding of what has worked in areas where rates have declined. Successful areas were characterised by having active engagement of all stakeholders, a strong champion leading strategy, a well-publicised sexual health service including health promotion work, emphasis on sex and relationships education in schools, targeted interventions with the most at risk young people, training of professionals, and a well-resourced youth service.

The document includes data supporting the need to consider teenage pregnancy a key inequality and social exclusion issue, together with the economic argument that investing in the strategy reduces the burden on the NHS and wider public services. It describes teenage pregnancy as a complex issue, with strong associations between teenage pregnancy and risk factors such as residential area, educational attainment, school attendance, ethnicity, living in care, and being the daughter of a teenage mother.

The “deep dive” reviews identified the importance of senior local sponsorship and engagement of all key partners in successful services. Also, that services adopting young people-focussed approaches trusted by teenagers and well-known by professionals had an impact on conception rates. Other features were: easy accessibility in the right location; convenient opening hours; provision of the full range of contraceptive methods; a focus on sexual health promotion; training of professionals; highly visible publicity; and a strong focus on the needs of young men. High performing areas also had condom distribution schemes involving a range of local agencies and/or access to emergency contraception in non-clinical settings.

The reviews indicated that these factors were largely absent or services were being delivered ineffectively in areas which had been less successful in reducing conception rates. It is suggested that in areas where rates were static or increasing, there was a long-standing culture of early pregnancy. There were low expectations and aspirations which stakeholders felt could not be challenged, resulting in a strong focus on supporting teenage parents rather than prevention measures.

Need for not just knowledge and skills in regard to sexual relationships combined with access to contraception and support/advice but also motivation to pursue career or further learning.

Key problems that need addressing:
1) Poor knowledge and skills among young people in relation to sex, relationships
and sexual health risks;
2) Poor and inconsistent contraceptive use among young people;
3) Lack of support for parents and professionals on how to engage with young people on relationships, sex, and sexual health issues.
4) Disengagement from/dislike of school among those most at risk;
5) Low attendance/attainment at school;
6) Lack of aspiration among young people in the most disadvantaged communities.

Working together: Connexions and teenage pregnancy (DfES, 2001).

Document setting out guidelines for joint working between the connexions service and those involved in teenage pregnancy strategies. The Connexions Service aims to provide integrated information, advice, guidance and personal development opportunities for all 13 –19 year olds in England. It works in particular with, homeless young people, teenage parents, young offenders and young people supported by Social Services to ensure that young people receive the support they need.

Key aims:

Raising aspirations – setting high expectations of every individual.
Meeting individual need – and overcoming barriers to learning.
Taking account of the views of young people – individually and collectively.
Inclusion – keeping young people in mainstream education and training and preventing them moving to the margins of their community.
Partnership – agencies collaborating to achieve more for young people, parents and communities than agencies working in isolation.
Community involvement and neighbourhood renewal – through involvement of community mentors and through personal advisers brokering access to local welfare, health, arts, sport and guidance networks.
Extending opportunity and equality of opportunity – raising participation and achievement levels for all young people, influencing the availability, suitability and quality of provision and raising awareness of opportunities.
Evidence based practice – ensuring that new interventions are based on rigorous research and evaluation into what works.

All young people will have access to a connexions personal advisor. Some will be directly employed by the Connexions Service, others will be seconded to the service and some will remain within their existing professional context, working under a Partnership Agreement with the Connexions Service. Young people will be allocated personal advisers with the relevant skills and background and who best reflect their needs and circumstances. Personal advisers will operate from a range of settings, including schools, colleges, onestop-shops and other outreach sites.

3 broad areas of service – support for those with multiple problems, in-depth guidance and help for those at risk of disengaging, help and guidance in relation to career/personal development.

Examples of different ways connexions, sure start and teenage pregnancy unit advisors could have different roles in different cases.

DH Policy Documents

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 (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960?IdcService=GET_FILE&dID=20838&Rendition=Web

Doctors and health professionals have a duty of care and a duty of confidentiality to all patients including under 16s. Concern about confidentiality remains the biggest deterrent to seeking advice. Publicity about the right to confidentiality is an effective element of an effective contraception and sexual health service. If a request for

contraception is made doctors and other health professionals should establish rapport and give the young person time and support to make an informed decision.

Better prevention, better services, better sexual health - the national strategy for sexual health and HIV (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133?IdcService=GET_FILE&dID=5539&Rendition=Web

Part of the focus of the strategy is to reduce unintended pregnancy rates. Strategy proposes that the benefits of more integrated sexual health services need to be evaluated, a range of contraceptive services should be provided.

The guidance was updated by MedFASH 2008 (see below). The MedFASH report was commissioned by the independent advisory group for sexual Health and is considered as an update of this 2001 strategy.

Choosing health: making healthier choices easier (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

New approaches to health of the public should respect the freedom of individual choice in a diverse, open and more questioning society. Principles of informed choice, personalisation, working together. Providers of local services need to be helped to tailor information and advice to meet people's needs, and provide practical support for people who lack basic skills to help them to use health information. Introduction of Children's Health Guides and a magazine for young men 16-30. Support implementation of the Teenage Pregnancy Strategy.

Health Inequalities (DH 2003)
http://www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm>

Actions likely to have the greatest impact over the long terms are improvements in early years support for children and families, improved social housing and reduced fuel poverty, improved educational attainment and skills development among disadvantaged populations, improved access to public services in urban and rural areas, and reduced unemployment and improved income among the poorest. To close the gap in infant mortality one of the short term interventions is preventing teenage pregnancy and supporting teenage parents. Programme organised around four themes – supporting families mothers and children, engaging communities and individuals, preventing illness, and addressing the underlying determinants of health.

Healthy Child Programme: From 5-19 years (DH 2009)
http://www.dh.gov.uk/publications

This guidance sets out a good practice framework for prevention and early intervention services. The foundations lie in the Every Child Matters outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing. The guidance is intended to help local service planners use their resources effectively, with services working together to provide a skilled and competent workforce and integrated service delivery. The programme emphasises the need for engagement of young people and parents in planning with the voluntary sector, charities and youth workers also playing an important role. It highlights that there should be choice in services and settings according to assessed need. Recommendations specifically in relation to teenage pregnancy are for joint working between local authorities and PCTs, with targeted support for young people most at risk such as young people leaving care and those with poor educational attainment. The guidance reports that links between teenage pregnancy and other risky behaviour, in particular alcohol and substance abuse have been made. The document provides a set of recommended actions for local areas to consider within the age bands of 5-11, 11-16 and 16-19.

Every Child Matters: change for children in health services (DH 2004)
http://www.everychildmatters.gov.uk/files/B20E1492383F6ACA9DC8F87450281153.pdf

Focus on improving outcomes in regard to health, safety, enjoyment and achievement, making a positive contribution and achieving economic well-being.

Need for a whole-system change to support more effective and integrated services, a move from intervention to prevention and meet the needs of the most vulnerable.

Findings of the baseline review of contraceptive services in England (DH 2007)
http://www.dh.gov.uk/en/Publicationsandstatistics/publications/publicationspolicyandguidance/dh_074727?IdcService=GET_FILE&dID=140489&Rendition=Web

Results of a review of services with returns from 82% of PCTs. 164 PCTs had performed a needs assessment of contraception provision. Over half reported consortium working arrangements. 72% reported informal networks such as telephone helplines for professionals, with 7% reporting formal networks. Average spend £11.67 per female.

Health economics of sexual health: a guide for commissioning and planning (DH 2005)

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/DH_4001942?IdcService=GET_FILE&dID=157428&Rendition=Web

Literature search. Found 148 articles. Conclusions – in regard to health promotion and disease prevention, screening, Interventions for STIs, Service delivery and organisation, fertility control services.
Fertility control services – it is suggested that cost savings may be derived from contraceptive services in themselves, move from oral hormonal to longer acting methods, reduced delay in abortions, access to over the counter oral contraception, and access to emergency contraception.

Health Inequalities (DH)
http://www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm

High quality care for all: NHS next stage review (DH 2008)
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825?IdcService=GET_FILE&dID=168197&Rendition=Web

People want care that is personal to them. Need for the NHS to work in partnership with other agencies.

NSF for children, young people and maternity services. Core Standards. (DH 2004)
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en

Standards regarding support to parents of teenage children. Also, respecting and involving young people in their care, health promotion for young people, access to services, and transition to adult services. Requirement for services to give young people and their parents increased information, power and choice over the support and treatment they receive, and involve them in planning their care and services. Focus on early intervention, improving access, tackling health inequalities. Term introduced – children in special circumstances including those excluded from school, those not in education, employment or training, and teenage parents.

This document refers to the DH guidance on the implementation of the Fraser guidelines (see also Fraser guidelines).

Our health, our care, our say: making it happen (DH 2006)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139925?IdcService=GET_FILE&dID=29516&Rendition=Web

White Paper issued following consultation exercise using data from questionnaires, surveys, interviews (n=140,000). Key areas of relevance – promotion of well-being, easier access to services, care in

the community, better information, joined up care, need to seek views and wishes of service users and act on these views by involving in decision-making.

Sex, drugs, alcohol and young people: a review of the impact drugs and alcohol have on young people's sexual behaviour. A Seminar. (DH 2007)
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/SexualHealthGeneralInformation/DH_4079794?IdcService=GET_FILE&dID=141996&Rendition=Web

There is a strong correlation between risky sexual behaviour and drug use. Many young people believe drugs have a positive effect on sex. Sexual health campaigns use drugs and alcohol as lifestyle images. Alcohol consumption must be reduced if there is to be an effect on risk. There are different reasons why young people engage in sex. The lifestyles of young people should be mapped to ensure information and campaigns are targeted at the right time and the right place. Some advertising clearly links sexual behaviour with a product. Those most at risk are from lower socio-economic groups.

Sexual Health and HIV guidance and publications
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/DH_4001942

List of resources in regard to sexual health and HIV strategy, primary care, training, commissioning, safer sex and sexual health advice, HIV, STIs, contraception, abortion, effective sexual health promotion toolkit, Health Select Committee reports.

Statement on Contraception and Teenage Pregnancy (DH 2008)
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/DH_085686

Abortion data (2007) show increases in abortion rate for all women aged under 20, most markedly for those under 18. Many PCTs need to significantly improve performance if targets are to be delivered. One priority of the Teenage pregnancy strategy is to ensure equitable access to contraception methods, provision of high quality advice and support. Benefits of switching to LARC. A further statement regarding improved access and additional funding for contraception for young people was published in June 2008. This details how, in February, the Public Health Minister, announced £26.8m new funding for 08/09 from the Comprehensive Spending Review to improve access to contraception.

'You're Welcome' Quality Criteria: Making Health Services Young People Friendly (DH 2007)
http://www.everychildmatters.gov.uk/_files/You%27reWelcomeQualityCriteria2007.pdf

Quality criteria cover ten topic areas – including accessibility, publicity, confidentiality and consent, the environment, staff training skills attitudes and values, joined up working, monitoring and evaluation, involvement of young people, need for programmes on sexual and reproductive health.

HM Government

Working together to safeguard children (HM Gov 2006)

http://www.everychildmatters.gov.uk/workingtogether/

Document addressed to practitioners and front-line managers who have responsibility for safeguarding and promoting the welfare of children. Need for shared responsibility and effective joint working if welfare of children to be promoted.

RCN Guidance

Contraception and sexual health in primary care. Guidance for nursing staff (RCN 2004)

http://www.rcn.org.uk/__data/assets/pdf_file/0005/78575/002016.pdf

All nurses working in primary care should attend a competency-based programme in sexual health skills. All nurses working in primary care, family planning and contraception and GU clinics should undertake a two day STIF course. At least one nurse in each practice should complete an approved course in family planning or contraception. Each practice should have access to clinical nurse specialists. All family planning and GU nurses should regularly update their skills and knowledge. No nurse should undertake family planning or GU screening unless trained.

Getting it right for teenagers in your practice (RCN 2002)

http://www.rcgp.org.uk/pdf/publicationsdatabase/getting_it_right.pdf

Teenage friendly means creating a welcoming environment, letting them know what services are on offer and reassuring them that confidentiality will be maintained. Ensure policy and practise in these areas is disseminated to all team members, audit the 10-18 year olds in the practice. Posters and information leaflets to let teenagers know what is provided. Consider running a young persons clinic, involve teenagers and parents.

Sexuality and sexual health in nursing practice (RCN 2000)

http://www.rcn.org.uk/__data/assets/pdf_file/0004/184585/000965.pdf

Document addressing sexuality and sexual health issues facing nurses, guidance to help nurses work effectively in the area. Raises

awareness of the professional role of nurses, professional development issues, guidance on the principles and practice and professional, legal and ethical guidance on best practice. Includes case studies.

The role of school nurses in providing emergency contraception services in educational settings (RCN 2006)
http://www.rcn.org.uk/ data/assets/pdf file/0005/78665/002772.pdf

Statement clarifying the responsibilities of school nurses in regard to students aged under 16 in educational settings. School nurses must ensure the young person understands the potential risks, benefits and alternatives, are legally obliged to discuss the value of parent/carer support (however must respect their confidentiality) and should assess whether physical or mental health is likely to suffer if emergency contraception is not provided. Nursing service must work in consultation with the school is developing guidelines and procedures and should inform parents that the service is available on the school premises.

RPSGB

Practice Guidance on the supply of emergency hormonal contraception as a pharmacy medicine (RPSGB, 2004)
http://www.rpsgb.org/pdfs/ehcguid.pdf

Guidance on best practice. Pharmacists must deal with requests personally and decide whether to supply the product or refer to an appropriate healthcare professional. Must ensure all necessary advice and information is available. Must handle requests sensitively with regard to right to privacy. Only in exceptional circumstances should supply the product to person other than the patient. Should whenever possible take reasonable measures to inform patients of regular methods of contraception, disease prevention and sources of help. Pharmacist who on religious or moral grounds choose not to supply the product should advise women on appropriate local sources of supply. Pharmacists are encouraged to take the lead in linking community pharmacies into existing networks for family planning services, working with local agencies to produce leaflets containing lists of services and contact points. May consider advertising that all advisory services are confidential and that a private area is available, and are encouraged to display a poster informing users that they can request a more private consultation.

NICE Guidance

Intervention
One to one interventions to reduce the transmission of STIs including

HIV and to reduce the rate of under 18 conceptions (NICE 2007)
http://www.nice.org.uk/PHI003

Recommendation 4 – PCT commissioners need to ensure sexual health services including contraception are in place to meet local needs. Define the role and responsibility of each service, ensure staff are trained, ensure there is an audit and monitoring framework in place.

Recommendation 5 – GPs nurses and other clinicians working in healthcare settings need to provide one to one sexual health advice on all methods of reversible contraception including LARC, how to get emergency contraception and other reproductive issues and concerns to vulnerable young people aged under 18.

Recommendation 6 – midwives and health visitors need to regularly visit vulnerable young women under 18 who are pregnant or already mothers to discuss how to prevent future unwanted pregnancies covering all methods of reversible contraception and how to get and use emergency contraception, and opportunities for returning to education, training and employment in the future.

Risk factors – risky behaviours, education-related factors, family background.
Sexual health interventions framework page 14.

Clinical Guideline

The effective and appropriate use of Long Acting Reversible Contraception (NICE 2005)
http://www.guideline.gov/summary/summary.aspx?doc_id=8228&nbr=4593

Recommendations – women requiring contraception should be given information about and offered a choice of all methods including LARC methods. Women should be provided with the method of contraception that is most acceptable to them provided it is not contraindicated. All LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use. IUDs, IUS and implants are more cost effective than injectable contraceptives. Increasing the uptake of LARC will reduce the number of unwanted pregnancies. Women considering LARC methods should be given detailed information, counselling should be sensitive to cultural and religious beliefs. Health professionals should be competent and receive training to develop and maintain skills.

US National Guidelines Clearinghouse

Adolescent Pregnancy: current trends and issues (2005) Klein J. Adolescent pregnancy: current trends and issues. Pediatrics 2005

Jul;116(1):281-6.
http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=7428&nbr=4387

Document aided at paediatricians based on review of literature. Paediatricians should encourage adolescents to postpone early sexual activity and encourage parents to educate their children. Ensure adolescents have knowledge of and access to barrier methods and emergency contraception. Encourage and participate in community efforts to delay onset of sexual activity and prevent first and subsequent adolescent pregnancies.

Prevention of unintended pregnancy in adults 18 years and older (2007)
Michigan Quality Improvement Consortium. Prevention of unintended pregnancy in adults 18 years and older. Southfield (MI): Michigan Quality Improvement Consortium; 2007 Jun. 1 p.
<http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=11553&nbr=5984>

Document from the Michigan quality improvement consortium aimed at practice nurses, and GPs in the United States. Provides guidelines regarding the key elements that should be included in discussion during a consultation relating to the risk of unintended pregnancy with over 18 year olds.

Other reports/guidelines

BMA Health Promotion Report - Adolescent Health (BMA 2003)
http://www.bma.org.uk/images/Adhealth_tcm41-19549.pdf

Sections on nutrition, exercise, obesity, smoking, drinking and drug use, mental health.
Section on sexual health describes considerable diversity in sexual experience among adolescents. Link between socio-economic deprivation and teenage pregnancy. The sexual health of adolescents does seem to be amenable to intervention. School-based education can be effective, also public health campaigns and community level programmes. Services to adolescents may be most effective when youth-orientated and geared to local needs with adequate follow up services and targeted towards those at greatest risk. Failure of contraception – especially condoms. There is no biological reason to suggest that having a baby before the age of 20 is associated with ill health. Teenage pregnancies can lead to an increase in relative poverty, unemployment, poorer educational achievements and poor health of the child born. Report of Labour Force Survey data, ONS longitudinal survey data.

Source of information about sex is significantly associated with sexual competence and use of contraception. Social exclusion unit report

attributed UK high rate to low expectation, ignorance and mixed messages. Review of effectiveness describing studies relating to education, public health campaigns, improved access to services, screening and targeted interventions.

Fraser Guidelines (Source:Brook)
http://www.brook.org.uk/content/M5_3_consenttreatment.asp

Young people under the age of 16 can consent to medical treatment if they have sufficient maturity and judgement to enable them fully to understand what is proposed. It is lawful for doctors to provide contraceptive advice and treatment without parental consent providing certain criteria are met, these criteria are known as the Fraser Guidelines. They require the professional to be satisfied that – the young person will understand the professional's advice, the young person cannot be persuaded to inform their parents, the young person is likely to begin or continue having sexual intercourse with or without contraceptive treatment, unless the young person receives contraceptive treatment their physical or mental health or both are likely to suffer, the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

Independent Advisory Group on Sexual Health & HIV
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4079794

The Independent Advisory Group on Sexual Health and HIV was established in 2003. This group provides a wide range of views from health professionals involved in all aspects of sexual health. It monitors progress and advises the government on implementation of the Sexual Health and HIV Strategy.

Publications include: Sex, Drugs, Alcohol and Young People: A review of the impact drugs and alcohol have on young people's sexual behaviour (2007)
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4079794?IdcService=GET_FILE&dID=141996&Rendition=Web

The following areas for intervention were suggested:
• Develop a national scheme incorporating all relevant agencies to provide holistic assessment, prevention, and intervention services to address drugs and alcohol misuse and risky sexual behaviour.
• Reduce the drug taking and alcohol consumption of young people.
• Ensure young people receive clear and factual information on the effects of drugs, alcohol and sex; and exposing the myths. This should be part of their compulsory education.
• Recognise the environment in which today's young people are growing up and determine what young people should be exposed to.

• Recognise the social, economic and emotional factors relevant to ensuring children and young people can be agents of their own health improvement.

Preventing and reducing the adverse effects of unintended teenage pregnancies. Effective Health Care 1997; 3 (1)
http://www.york.ac.uk/inst/crd/EHC/ehc31.pdf

Published paper from the CRD York summarising the research evidence on approaches to preventing teenage pregnancy aimed principally at purchasers and providers of services. Discusses evidence relating to educational approaches to intervention, and contraceptive service delivery.

Sexual Knowledge, attitudes and behaviours amongst Black and Minority Ethnic Youth in London (Coleman and Testa 2008)
http://www.sheu.org.uk/publications/eh/eh262lcat.pdf

Study reporting findings from 50 interviews. Three major themes emerged – conflicting sexual norms and values, learning about sex and related attitudes, religion versus ethnicity.

Sure Start Plus National Evaluation: Final Report (Social Science Research Unit, University of London, 2005).

Sure Start Plus is a UK Government pilot initiative to support pregnant young women and young parents under 18 years of age. It was expected that the pilot initiative would be built around the core role of a personal adviser offering co-ordinated, one-to-one support to pregnant young women under 18 years of age and young parents under 20 years of age. The Government's intention was for the selected pilot programmes to be innovative and explore different ways of delivering services. In addition, Sure Start Plus pilot programmes were to work towards reshaping existing services to make them more user-friendly and to fill gaps in provision, especially childcare. Unlike Sure Start local programmes, which were neighbourhood based, Sure Start Plus was to offer its services across an entire local authority or Health Action Zone area. 20 pilot areas funded 2001-2006, increased to 35 when the project became part of the Teenage pregnancy Unit in 2003.

The core aims set out at the beginning of the programme were to:

- Improve the social and emotional wellbeing of pregnant young women, young parents and their children.
- Strengthen the families and communities of pregnant young women and young parents.
- Improve the learning of pregnant young women, young parents and their children.
- Improve the health of pregnant young women, young parents and their children.

The National Evaluation of Sure Start Plus was made up of four components:

- The *service delivery study* that investigated the processes involved in planning, delivering and using Sure Start Plus.
- The *impact study* that investigated the impact of Sure Start Plus on outcomes related to the aims of the initiative.
- The *joined up policy and practice analysis* that investigated the links and relationships between Sure Start Plus and other key local initiatives.
- The *economic commentary* that investigated the costs of providing Sure Start Plus and explored how these related to the outcomes it was having.

Used methods of focus groups, interviews and questionnaires. Matched case control design for the 35 programmes using surveys with programme co-ordinators, service users and staff together with interviews with programme co-ordinators. Further detailed data from interviews with service users, service providers and other agencies for 12 of the programme sites. Also economic questionnaire.

Key findings – diversity in how the programme implemented, working across local authority boundaries affected programme implementation, differing starting points for programmes, issues regarding sure start name, difficulty accessing young fathers, different staffing, different programme delivery, different programme location influenced key objectives, variation in quality of partnerships, success of sure start plus adviser role.

Comparison of data from young people and professionals in Sure Start Plus and matched areas suggest that the Sure Start Plus programme has had mixed success in achieving its aims and objectives. Sure Start Plus appears to have been successful in addressing the crisis needs of pregnant young women and mothers. Following this, it has helped young women to lay foundations for their future lives. In some circumstances, Sure Start Plus programmes were able to then support young women to take the next steps of returning to education or seeking employment. There remained some objectives – notably to do with improving health issues, supporting children and improving circumstances for young fathers – which remained elusive.

National Mapping Survey of On-site Sexual Health Services in Education Settings: provision in FE and sixth form colleges (NCB 2008)

Full report available at
http://www.ncb.org.uk/dotpdf/open_access_2/sef_fe_survey_08.pdf
Also Emerson, L. (2008) *Education and Health*, 26, 4, pp74-76.

Work carried out by the Sex Education Forum covering 100% of mainstream further education and sixth form colleges in England. The survey found that 72% of FE and sixth form colleges provide some

level of on-site sexual health services for their students. The prevalence of this varied considerably between regions. The level of service offered also varied with 17% of colleges offering a wide range of services in some cases including LARC. Young people aged 14-16 years attending some colleges were excluded from services in some cases. The report recommends building clear messages into national policy, local authorities taking a strategic and co-ordinated approach, further extending services into the FE sector, developing tools and capacity to maximise service effectiveness, enabling professionals to share practice, tracking progress and celebrating success.

Health Protection Agency

A Complex Picture. HIV and other Sexually Transmitted Infections in the United Kingdom (HPA 2006)
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947365435

STIs only, nothing relevant to pregnancy.

Health Scotland

Sexual health policy analysis in selected European Countries (Health Scotland 2002)
http://www.healthscotland.com/documents/380.aspx

Document which examines and contrasts a selection of European policy approaches to the promotion of young people's sexual health. Examines policy in Finland, France, the Netherlands, Romania and Scotland. First step in policy is to acknowledge that young people have a right to their sexual health, rather than trying to "protect" them from sex and sexuality. In order to be responsible young people need to be provided with the tools and knowledge to use. Public education of parents is important to improve parent-child communication. A holistic approach to teenage sexual health is paramount with combining of efforts to prevent pregnancy with STI and HIV education. System of mixed sex and single sex provision would be a progressive step forward. Many young people are unable to access sexual health services that they are comfortable with, further research on school health service in on site school clinic as provided in Finland should be considered. Important to convey that what is being viewed as problematic is not sexual activity but unintended and unwanted pregnancy. A vision of life as a teenager that would be hindered by young parenthood should be promoted as in Holland. Need for co-operation between agencies to be further developed.

Key components of effective sex education – positive attitude to sex, positive public climate, curriculum location, open and safe classroom with single and mixed sex teaching also trained staff and use of active

learning methods, positive content, involvement of young men, inter-agency collaboration.

Issues to accessing sexual health services – geographical location, hidden from parental view, suitable opening times, confidentiality, informal and user friendly, professionals treat young person with respect, use of appropriate language, needs of young men recognised.

Medical Foundation for AIDS and Sexual Health

Progress and priorities - working together for high quality sexual health (MedFASH, 2008)

http://www.medfMedFASHash.org.uk/publications/documents/Progress_and_priorities_working_together_for_high%20quality_sexual_health_FULL_REPORT.pdf

A review assessing the impact of the National Strategy for sexual health and HIV. The report describes the changes in service delivery including more effective use of multi-disciplinary teams, the extension of nurse-delivered services, the development of new roles or broadening of roles to increase capacity, the use of non-healthcare providers in service delivery such as pharmacies, youth workers, and also advances in technology, and changes in approaches to patient management.

Progress across the country is reported to have been patchy, with the dominance of the clinical model rather than holistic model. Lack of prominence given to contraceptive and reproductive health, and need to given psychosexual support more prominence.

Key barriers to implementation – national targets include only some elements of sexual health, diversion of funds to meet deficits, lack of champions and senior figures involved, conflict between services, variable engagement of GPs, disinvestment in community contraceptive clinics, limited use of needs assessment and IT systems, slow building and disseminating of the evidence base, lack of progress in tackling stigma and absence of strong voice for service users.

Action needed in five areas. Prioritising of sexual health as a key public health issue, with high level leadership. Building of strategic partnerships to forge links and engage in joint planning. Adopting of a holistic commissioning model looking at sexual health in an integrated way. Investing more in prevention that is commissioned according to local need, is integral, co-ordinated, disseminates evidence with PSHE education a statutory subject. Delivering modern services by specifying local standards, establishing networks, open access, increased level and quality of services.

Recommended standards for sexual health services (MedFASH, 2005)
http://www.medfash.org.uk/publications/documents/Recommended_standards_for_sexual_health_services.pdf

Standards to support services in implementing the National Strategy. 10 standards.
The need to deliver services via managed service networks. The need for comprehensive, fully integrated multi-component programmes of sexual health promotion. The need to give individuals greater input into their care and planning and monitoring services. The need to associate sexual health with STIs. Access to services should be improved. Access to STI services should be improved. Need for prompt access to information about contraception and free provision of all contraceptive methods, with appointments available within two working days and well-advertised local services. Rapid access to confidential pregnancy testing services. Early abortion. Explicit confidentiality procedures should be in place.

NHS SDO

Improving children's health: can nurses, midwives and health visitors make a difference (NHS 2007)
http://www.sdo.lshtm.ac.uk/files/adhoc/68-research-summary.pdf

School nurses have a central role to play in providing education and services to adolescents to reduce the number of pregnancies. Nurses, midwives and health visitors working in this area help to identify risk and offer outreach contraceptive services, group teaching, and education of parents. This contribution has not been accurately measured or evaluated. Issues hindering the work of nurses midwives and health visitors – lack of role clarity, structural boundaries, lack of evidence to support practice, unclear outcomes, constraints imposed by the organisation, lack of evaluation of services and practices, legal factors to do with confidentiality and consent, and policy overload. Factors which aided work – flexible services, creative workforce development, inter-agency working, well organised work systems, technology, professional expertise and user involvement.

OFSTED

Time for change? Personal, social and health education (OFSTED 2000)
http://www.ofsted.gov.uk/content/download/1390/10002/file/Time%20for%20change_Personal,%20social%20and%20health%20education%20(Word%20format).pdf

Evaluation of the current PSHE curriculum based on school inspection reports and behavioural surveys. PSHE programme has a major part in developing knowledge, understanding and values and in preparing them effectively for opportunities, responsibilities and experiences.

Findings – knowledge and understanding of PSHE have improved over the last five years. Particular success in primary schools. The quality of teaching and learning has improved with use of specialist teachers. Need for improvement in lesson planning and assessment. Pupils needs not always identified clearly, and poor arrangements at transition. Monitoring and evaluation poor. Progress towards establishing drop in centres has been slow. Young people report parents and teachers not always good at talking to them about sensitive issues.

Recommendations – schools should involve pupils in planning the curriculum and determining outcomes. Need to improve assessment. Improve monitoring and evaluation of the quality of the provision and develop links with the range of support services.

RCOG FFPRHC

Contraceptive Choices for Young People (RCOG 2003)

http://www.ffprhc.org.uk/admin/uploads/YoungPeople.pdf

Guidance for clinicians and young people considering the use of contraception. Need for clinicians to assess a young persons competence to consent to treatment, and is assessed as competent need to document this in case notes as being Fraser ruling competent. A clinician can provide contraceptive advice or treatment to a competent young person without parental consent or knowledge. All staff involved in services should receive appropriate training and services should have a named clinician identified as local lead on child protection and procedure. Need to make young person aware of confidentiality status of information such as difference between medical staff and other staff. Good practice guidelines in regard to use of different types of contraception and medical contra-indications. Age should not limit contraception choice. Need for contraceptive and sexual health services to develop links with education authorities and schools.

Emergency contraception (RCOG, 2006)

http://www.fsrh.org/admin/uploads/384_EmergencyContraceptionCEUguidance.pdf

Document outlining when emergency contraception is indicated, and how it should be used. Advance provision can be offered to women considered at risk.

Service Standards for Sexual Health Services (RCOG, 2006)
http://www.fsrh.org/admin/uploads/ServiceStandardsSexualHealthServices.pdf

All sexual health services should have appropriately trained adequate leadership. Client need should be the key determiner of service development, provision, monitoring and evaluation. Service provision should include contraception, pregnancy and abortion, screening, STI services and counselling. Services should be non-discriminatory. All staff should receive appropriate training and must maintain their skills. Services should be evidence-based. Client right to confidentiality must be respected and maintained. Record keeping should be of a high standard. The role of nurses should be enhanced. All services should continually monitor and evaluate provision.

Standards on confidentiality for contraception and sexual health services (RCOG 2005)
http://www.fsrh.org/admin/uploads/StandardsOnConfidentiality.pdf

All services should have a written confidentiality policy. Ongoing training and support in regard to confidentiality is essential. All people irrespective of age are entitled to the same duty of confidentiality.

Scottish Government

Enhancing sexual wellbeing in Scotland - A Sexual Health and Relationships Strategy (Scottish Executive, 2005)
http://www.scotland.gov.uk/Publications/2005/01/20572/50619

Analysis of written responses to a public consultation 2003-4. Clear support for actions to reduce teenage pregnancies, however it was suggested that the draft strategy did not do enough to tackle some of the underlying causes such as deprivation. Recognition of the powerful role of the media. Need for particular requirements of different groups to be taken into account. Opposition to introducing SRE into pre and primary schools and mixed and opposing views in relation to having a consistent approach to SRE across Scotland. Key differences in attitude amongst the different respondent groups. Positive aspects of the strategy – positive role for parents, influence of the media, broad/holistic approach, positive about teaching young people about relationships.

SCIE

Access to primary care services for people with learning disabilities (SCIE, 2005)
http://www.scie.org.uk/publications/briefings/briefing02/index.asp

People with learning disabilities have problems accessing primary health care because of communication difficulties and barriers in encounters with staff. This can result in failure to access health services.

Preventing teenage pregnancy in looked after children (SCIE, 2005) http://www.scie.org.uk/publications/briefings/briefing09/index.asp

Policy briefing providing key messages. Looked after young people are at greater risk of early pregnancy. The principal risk factors for teenage pregnancy in looked after young people are socio-economic deprivation, limited involvement in education, low educational attainment, limited access to consistent positive adult support, being a child of a teenage mother, low self esteem, and experience of sexual abuse. There are few strategy or policy documents regarding services and practices to reduce teenage pregnancy in this population. Looked after children are known to have less access to good quality and consistent sources of sex and relationship education and advice. The limitations of school-based programmes for looked after children are widely recognised. Services that consult young people and develop specialist services have greater success.

The Road Ahead: information for young people with learning difficulties, their families and supporters at transition (SCIE, 2004) http://www.scie.org.uk/publications/tra/summary.asp

Explores the nature of information needed by young people with learning disabilities at transition.

Save the Children

Get real: providing dedicated sexual health services for young people (StC, 2002)
http://docserver.ingentaconnect.com/deliver/connect/ffp/14711893/v29n3/s28.pdf?expires=1231772166&id=48148903&titleid=4586&accname=University+of+Sheffield&checksum=0CE725BC502A7DB75549EF456C66AC31

A book “giving a snapshot of the sexual health services on offer to young people in England”.

Initiatives / service evaluations

BMA - Examples of good practice in sexual health in England (2006)
http://www.bma.org.uk/health_promotion_ethics/sexual_health/goodpracticeinsexualhealth.jsp?page=2

Margaret Pyke Centre, London
http://www.margaretpyke.org/

The Margaret Pyke Centre (MPC) is one of the biggest contraceptive centres in the world seeing between 600 and 900 patients per week. In addition they have a network of clinics across Camden and Islington in Central London.

RPSGB - Tacking Sexual Health on the High Street
http://www.rpsgb.org/pdfs/pharmcasestudyeht.pdf

The original EHC service was set up by the health authority in conjunction with local community pharmacies, 10 to start with, funded by the Lambeth, Southwark and Lewisham Health Action Zone. Women who've had unprotected sex are offered a consultation with a specially trained pharmacist, which is carried out in the pharmacy's private consultation area. If appropriate, the woman is offered EHC. There are currently 34 local pharmacies providing EHC but the aim is to increase this to 70 per cent of Lambeth and Southwark's 62 pharmacies by the end of 2008.

Sheffield Centre for HIV and Sexual Health
http://www.sexualhealthsheffield.nhs.uk/

The Centre for HIV and Sexual Health is a Sheffield based service that operates nationally as well as in the local community. It is described as offering a holistic model of working that acknowledges the political, social and cultural factors and health inequalities which affect and determine peoples sexual health, as well as issues relating to individual experience, emotions, sexuality, sensuality and spirituality.

Within the wider aim of working towards sexual health for all, the specific objectives include reducing unintended teenage pregnancies, prevention of HIV and other Sexually Transmitted Infections, the promotion of positive and mutually satisfying relationships and the provision of excellent Sex and Relationships Education. The Centre operates at a national level, through activities including: a comprehensive national training programme of courses delivered in Sheffield and throughout the UK and Ireland, contributing to emerging national strategies and policy, a wide range of publications, resources and materials, partnerships and collaboration with the other major national sexual health promotion agencies, national and regional conferences, seminars and workshops on a range of sexual health issues, service reviews, organisational audits and community needs assessments, consultancy on a range of sexual health and health promotion issues and input to conferences, seminars, study days and workshops, speeches, workshops and presentations on practice.

In Sheffield activities include: community development - particularly with marginalised, vulnerable or stigmatised groups, support for teachers, schools and youth workers in Sex and Relationships Education, consultancy, training, resources and support for those

working in Primary Care settings, training for staff in statutory services, voluntary and community-based organisations, HIV prevention initiatives, HIV and AIDS education and STI prevention projects, training and ongoing work to reduce unintended teenage pregnancy, subsidised and Centre-funded places for Sheffield participants on national training courses, conferences and seminars, strong partnerships with other organisations offering sexual health and related services, support for organisations in developing sexual health policies, strategies and action plans, free materials and resources for dissemination within Sheffield, a Directory of Local Sexual Health Services, multi-agency Forums and Think-Tanks, capacity-building communities through support, training, skills development and resources.

Young People Friendly Contraception and Sexual Health Services (Nottingham)
http://www.nottinghamcity.gov.uk/sitemap/services/wtchildrenand_young_people/teenagepregnancy/teenagepregnancy-youngpeople.htm

The Nottingham City Teenage Pregnancy Partnership aims to provide quality assessed young people focused contraception/sexual health services, that are trusted by teenagers and well known by professionals working with them. Successful young people friendly contraception services provide health promotion activities for young people as well as confidential treatment and advice. They are sited in young people friendly venues including non traditional settings such as youth clubs, colleges and schools and they are accessible for young men and hard to reach groups. The key to the development of young people friendly contraception services is the active and continued involvement of young people in the development and even delivery of the services. Young people have been involved in the development of all the young people's contraception and sexual health outreach clinics, the C-Card Scheme and Chlamydia Screening programme.

Statistics

Contraception and Sexual Health 2007/08
http://www.statistics.gov.uk/downloads/theme_health/contra2007-8.pdf
Local Authority Teenage Pregnancy Analysis (2008)
http://www.everychildmatters.gov.uk/_files/LA_teenage_pregnancy_analysis_v4bMar08.xls
NHS Contraceptive Services, England: 2007-08 (2008)
http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception/nhs-contraceptive-services-england:-2007-08-%5Bns%5D
Under Eighteen Conception Statistics 1998-2006 (2008)
http://www.everychildmatters.gov.uk/resources/IG00200/

Websites

Association for Young Peoples Health
http://www.youngpeopleshealth.org.uk/
British Association for Sexual Health and HIV
<http://www.bashh.org/>
Brook
<www.brook.org.uk>
Connexions Direct
<http://www.connexions-direct.com/index.cfm?pid=97>
fpa
<http://www.fpa.org.uk/>
NANCSH (National Association of Nurses for Contraception and Sexual Health) <http://www.nancsh.org.uk/>
Playing Safely (NHS)
<http://www.condomessentialwear.co.uk/>
Sex Education Forum from the NCB
<http://www.ncb.org.uk/Page.asp?originx_784wa_21042403840053g59p_200610203221g>
SHINE (Sexual Health Information News Exchange)
<http://www.sexualhealthsheffield.nhs.uk/news/index.php>
Teenage Pregnancy Unit
<http://www.everychildmatters.gov.uk/teenagepregnancy/>
The National Campaign to Prevent Teen and Unplanned Pregnancy
<http://www.thenationalcampaign.org/>