Appendix A

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance (from topic experts or initial internal intelligence gathering)	Impact
PH51-01 **Recommendation 1 Assessing local need and capacity to target services** **evidence statements V15, V25, V26, ER-IHYP, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
PH51-02 **Recommendation 2 Commissioning coordinated and comprehensive services** **evidence statements V2, V12, V15, V19, V22, V25, V26, ER-IHYP, IDE**		
No evidence identified	Initial intelligence gathering identified the following: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf: provides a guide to whole system commissioning for sexual health, reproductive health and HIV. In the section on interfaces in commissioning responsibilities and local solutions the document states “Agree an integrated abortion care pathway including contraceptive advice and provision, STI and HIV testing (taking account of the recommendations for young people in NICE PH51 guidance).”	**No new evidence was identified, no changes** The government publication identified through the surveillance review is in line with *recommendation 2* on commissioning coordinated and comprehensive services. .

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PH51-03 **Recommendation 3 Providing contraceptive services for young people** **evidence statements C1a, C1c, H4, V1a, V1b, V2, V11, V12, V15, V16, V19, ER-IHYP, IDE**		
No evidence identified	Initial intelligence gathering identified the following documents from the National chlamydia screening programme (NCSP) on sexually transmitted infections (STIs) and chlamydia screening in England: NCSP: standards and National chlamydia screening programme (NCSP): data tables which states that anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner and retested 3 months after a positive result.	**No new evidence was identified, no changes** Current recommendation does not advise chlamydia testing for all attendees aged 15-24. Recommendation 3 indicates "assess the risk of an STI, advise testing if appropriate, and provide information about local STI services". This is broadly in line with current NCSP publications. Recommendation 3 should be refreshed with the link to NCSP guidance on sexually transmitted infections and chlamydia screening.
PH51-04 **Recommendation 4 Tailoring services for socially disadvantaged young people** **evidence statements C2d, H1b, H4, E6a, V1a, V2, V12, V15, V19, ER-IHYP, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
PH51-05 **Recommendation 5 Seeking consent and ensuring confidentiality** **evidence statements V2, V12, V14, V17, V18, ER IHYP, IDE**		
No evidence identified	Initial intelligence gathering identified the following:	**No new evidence was identified, no changes**

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	Spotting the Signs of CSE proforma: a national proforma for identifying risk of child sexual exploitation (CSE) in sexual health services. A topic expert indicated that the forthcoming government guidance on the child sexual exploitation: Child sexual exploitation: definition and guide for practitioners may have implications for recommendation 5.	The Spotting the Signs of CSE proforma guidance provides questions to help practitioners identify a young person's circumstances or behaviours – including non-verbal signs of CSE. This is more relevant to NICE guideline in progress on Child Abuse and Neglect. Expected publication date: October 2017.
PH51-06 **Recommendation 6 Providing contraceptive services after a pregnancy** **evidence statements C2a, H1b, E6a, V1a, IDE**		
No evidence identified	Initial intelligence gathering identified the following: Teenage mothers and young fathers: support framework (May 2016). This document highlights the importance of improving outcomes for young parents as part of long term prevention of teenage pregnancy. An RCT on Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks) that was highlighted by a topic expert, found that adding nurse-led intensive home-visitation programme (Family Nurse Partnership (FNP)) for first-time teenage mothers (n=823) compared to usual care (n=822) provided no additional short-term	**New evidence was identified that does not have an impact on the recommendation.** Recommendation 6 highlights the importance of contraceptive services after a pregnancy. The information within the Teenage mothers and young fathers: support framework reinforces the content within recommendation 6 and does not indicate that any changes are required to the recommendation. An RCT on Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks) found that FNP programme had no effect on reducing subsequent pregnancy by 24 months for first-time teenage mothers. FNP home

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	(24 months) benefit to pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months and A&E attendances and hospital admissions in first two years of life.	visitation programme was not recommended in recommendation 6 therefore no impact is anticipated.
PH51-07 **Recommendation 7 Providing contraceptive services after an abortion** **evidence statements C2a, H1b, E6a, V1a, IDE**		
No evidence identified	A mix methods study highlighted by a topic expert on "I thought I was protected" Abortion, contraceptive uptake and use among young women: a quantitative survey" found that there is a need to improve access to, and provision of, the full range of contraceptive methods including emergency contraception. Providing continuing support to women and improving the quality of information about fertility available to women including advice on the quick return to fertility after abortion was also emphasised.	**New evidence was identified that does not have an impact on the recommendation.** Recommendation 7 highlights the importance of providing contraceptive services after an termination of pregnancy. Findings from a mix methods study supports continuing support to women and improving the quality of information about fertility available to women including advice on the quick return to fertility after a termination of pregnancy and is in line with recommendation 7.
PH51-08 **Recommendation 8 Providing school and education-based contraceptive services** **evidence statements E3a, V1a, V2, V11, V12, V15, V19, IDE**		
21 studies (7 systematic reviews, 1 RCT and 13 observational studies) were identified that reported on school and education-based contraceptive	Initial intelligence gathering identified the following: Good progress but more to do: Teenage	**New evidence was identified that does not have an impact on the recommendation.** Recommendation 8 highlights the importance of

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services: A systematic review(1) of 5 studies comparing peer education with standard practice or no intervention found that there is no clear evidence of the effectiveness of peer education concerning HIV prevention, adolescent pregnancy prevention and sexual health promotion for young people. A an overview(2) of 37 systematic reviews of school-based sexual-health interventions found that comprehensive interventions, those targeting HIV prevention, and school-based clinics were effective in improving knowledge and changing attitudes, behaviours and health-relevant outcomes; while abstinence-only interventions were not effective. A list of 32 design, content and implementation characteristics that may enhance effectiveness of school-based sexual-health interventions was generated. A systematic review(3) included 11 RCTs (10 cluster RCTs, most from the USA and UK) assessing the effects of school-based interventions to improve contraceptive use among adolescents was identified. The findings reported that the participants in the intervention groups (school-based interventions; interactive sessions on pregnancy prevention, multifaceted two-year programme on risk reduction) were more likely than the standard-curriculum group	pregnancy and young parenting. Published by LGA and PH February 2016. The briefing highlights the importance of a continued focus on teenage pregnancy to reduce intergenerational inequalities and reduce long term demand on health and social care. The third National Survey on Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal-3), of 15,162 men and 5686 women aged 16-74 years in Britain, found that the pregnancies in women aged 16-19 years were most commonly unplanned (45.2%). However, most unplanned pregnancies were in women aged 20-34 years (62.4%). Factors strongly associated with unplanned pregnancy were first sexual intercourse before 16 years of age, current smoking, recent use of drugs other than cannabis, and lower educational attainment. Unplanned pregnancy was also associated with lack of sexual competence at first sexual intercourse, higher frequency of sex, receiving sex education mainly from a non-school-based source, and current depression. A topic expert indicated that “it would be helpful to note the Institute for Fiscal Studies Teenage Pregnancy in England report. The analysis	school and education-based contraceptive services. The information within the Good progress but more to do: Teenage pregnancy and young parenting reinforces the content within recommendation 8 and does not indicate that any changes are required to the recommendation. Findings from the third National Survey on Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal-3) indicate that the pregnancies in women aged 16-19 years were most commonly unplanned. Recommendation 8 states that contraceptive advice, free and confidential pregnancy testing and the full range of contraceptive methods, including both LARC and emergency contraception, should be easily available. If the full range is not available, prompt and easy referral to appropriate local contraceptive services outside the school or college should be offered. The evidence from school based sex education studies seem to support the recommendation 8 that school based sex education involving a combination of education and contraception promotion (multiple interventions) were likely to reduce unintended pregnancy. Comprehensive interventions, those targeting HIV prevention, and school-based clinics, school-based sexual and reproductive health

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to report condom use and using effective contraception during last sex. A systematic review(4) including 8 cluster-RCTs (n=55,157 participants, 2/8 trials from the UK) aiming to evaluate the effects of school-based sexual and reproductive health programmes on STIs and pregnancy among adolescents concluded that schools may be a good place in which to provide these services. The authors concluded that incentive-based interventions that focus on keeping young people in secondary school may reduce adolescent pregnancy. A systematic review(5) that included 53 RCTs (n=105,368) comparing interventions (school-based, community/home-based, clinic-based, and faith-based) to prevent unintended pregnancy among adolescents with various control groups (mostly usual standard sex education offered by schools) indicated that only interventions involving a combination of education and contraception promotion (multiple interventions) were likely to reduce unintended pregnancy over the medium-term and long-term follow-up. Studies used a variety of interventions included health education or counselling only, health education plus skills-building, health education plus contraception education, contraception education and distribution, faith-based group or individual counselling. The authors noted that study quality was	found that the strongest risk factors for pregnancy before 18 were free school meal eligibility, persistent school absence by age 14, and slower than expected academic progress between ages 11-14. However the report concluded that most young women becoming pregnant before 18 did not have specific risk factors, so to have a significant impact on teenage pregnancy rates, prevention has to be universal as well as targeted.”	programmes on contraception, emergency contraception, STI testing and treatment, pregnancy tests, and referral to other services) tended to be effective in improving knowledge and changing attitudes, behaviours and health-relevant outcomes. While there is some evidence that the lessons at school were associated with a reduction in risk of unprotected intercourse, it appears that an intervention is more likely to be effective if this goal is tailored multicomponent school-based interventions, including school policy changes, parent involvement, and work with local communities, and if it includes factual information, taking account pupil’s preferences for the content and delivery of sex education. Evidence from analysis of a report (Institute for Fiscal Studies Teenage Pregnancy in England report) on risk factors for teenage pregnancy is in line with recommendation 8 that indicates the contraceptive services should be available to all young men and women and also is in line with recommendation 4 that states additional support should be provided for socially disadvantage young people.

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mostly low due to methodological weaknesses. A systematic review(6) that included 55 studies investigating effective elements of school health education across three particular behavioural domains (substance abuse, sexual behaviour, nutrition) found that five effective elements of school health promotion were found to be similar across the three behavioural domains. The five elements were the use of theory; addressing social influences, (especially social norms); addressing cognitive-behavioural skills; training of facilitators; and multiple components. A systematic review(7) including 22 studies aiming to develop an overview of the potential of alternative school-based approaches reported that multicomponent school-based interventions, including school policy changes, parent involvement, and work with local communities, are effective for promoting sexual health and preventing bullying and smoking. Economic incentives to keep girls in school can reduce teenage pregnancies. The authors noted that there is little evidence that, on their own, sexual-health clinics, antismoking policies, and various approaches targeting at-risk students, are effective. An RCT(8) among n=449 at-risk girls age 13/14 in England that examined teenage pregnancy prevention intervention (18-20 weekly sessions in		

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pre-school nurseries) combining youth development and voluntary service in a nursery was identified. There was no evidence of benefits for primary outcome; last sex without contraception, but evidence of benefits was observed for secondary outcomes: low self-esteem; low sexual health knowledge; and difficulty discussing the contraceptive pill. A HTA (Health Technology Assessment) including a survey(9) of school nurses in all parts of the UK, interviews with service coordinators in NHS and local authority) and an evidence synthesis was identified that aimed to identify the current forms of school-based sexual health services (SBSHS) and school-linked sexual health services (SLSHS) in the UK, on effectiveness, acceptability and cost-effectiveness of these types of services. Three types of UK sexual health service provision were identified; SBSHS staffed by school nurses, offering 'minimal' or 'basic' levels of service; SBSHS and SLSHS staffed by a multi-professional team, but not medical practitioners, offering 'basic' or 'intermediate' levels of service. SBSHS and SLSHS staffed by a multi-professional team, including medical practitioners offering 'intermediate' or 'comprehensive' levels of service. The findings reported that broad-based services, which include medical practitioner input within a multi-professional team, was the most preferred option by staff and by young people.		

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A study(10) was identified that examined a theory-driven classroom-based intervention on contraceptive behaviour and experiences of contraceptive use in a sample of adolescents. Among sexually active participants with relatively low levels of intention to use contraception at the outset, the intervention increased outcome measures including intention and behaviour. Findings supported the potential for effective delivery of behaviour change theory-driven interventions in classroom settings. A study including five semi-structured focus groups(11) (N = 30 Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ)) was identified that investigated the sexuality education experiences of LGBTQ youth and to solicit youth suggestions for improving the inclusiveness of sexuality education curricula. The findings indicated that LGBTQ youth perceive current sexuality education as primarily "exclusive," although examples of "inclusive" sexuality education were provided. In addition, participants provided suggestions for creating a more inclusive experience, such as directly discussing LGBTQ issues, emphasising STIs prevention over pregnancy prevention, and addressing healthy relationships. A study(12) was identified that evaluated an economic model of school based behavioural interventions to prevent STIs and to teach skills to		

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practice safer sex. For a cohort of 1000 boys and 1000 girls aged 15 years, the model estimated that the behavioural interventions would avert two STI cases and save 0.35 Quality Adjusted Life Years (QALYs). A cohort study(13) at 27 schools in England investigating the effectiveness of sex education led by peers found no evidence that intervention (three one hour sessions of peer led education between the ages of 13 and 14) prevent unprotected sex, sex under pressure from a partner, or STIs in boys or girls. Teenagers taught by older peers were just as likely to have an abortion by the age of 20 as controls taught by teachers. An observational study(14) (on-line survey) of a university students (n=711) on school-based sexual education found that both age at first intercourse and learning about sex from lessons at school were associated with reductions in risk of unprotected intercourse. Factors associated with fewer STIs were age at first intercourse (17% reduction per year of delayed intercourse) and learning about sex from lessons at school (85% reduction) from friends of the same age (54% reduction) and from first boy/girlfriend (85% reduction) compared with learning from one's mother. An observational study(15) of young people (n=394;		

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15 to 18 years old) on effective sex education found that it is vital that sex education contains factual information. Young people wished to gain knowledge on how to establish healthy respectful, communicative relationships, knowing how babies are made, when one's ready physically and emotionally for sex, how to use a condom, who to go to for information and how best to talk about sexual issues. They wanted to be taught by people whom they can trust to deliver information accurately, confidentially and with confidence. An observational study(16) (questionnaire survey n=1959 pupils and n=155 teachers from secondary schools) of knowledge and attitudes of teachers and pupils regarding their school nurse found that older pupils and male pupils are the least impressed with the contribution made by their school nurse. The findings suggest that school nurses at present may not be contributing effectively to sexual health education in secondary schools and furthermore, particularly in rural areas. A cohort study(17) investigating the effectiveness of youth development in reducing teenage pregnancy and substance use in young people (54 youth service sites n=2724) found no evidence that the intervention (multicomponent youth development programme including sex and drugs education) was effective in delaying heterosexual experience or reducing		

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pregnancies, drunkenness, or cannabis use. A focus group study(18) of 25 female and 23 male pupils aged 13-16 years was identified that explored teenagers' beliefs about emergency contraception (EC) within a Theory of Planned Behaviour (TPB) framework. Participants were recruited from schools in Central England and indicated positive beliefs about the effectiveness of EC and reported high self-efficacy in accessing EC, but had concerns over confidentiality and access. A qualitative study(19) on young people's views on a school-based sexual health drop-in service in 16 secondary schools in a deprived area of a city found that a wide range of services were taken up including contraception, emergency contraception, STIs testing and treatment, pregnancy tests, and referral to other services. Young people reported high levels of satisfaction with staff attitudes and clinic environment. Barriers to contraceptive use included: worries about embarrassment, cultural issues, and confidentiality. A cross-sectional survey(20) that investigated the relationship between school sex education and sexual health behaviours at first sex and later in adulthood, using nationally representative data was identified. Respondents who received sex education were more likely to have first sex at an older age and		

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use contraception on this occasion. Sex education also significantly increased the likelihood of using contraception at first sex, when first sex occurred before 17 years of age. Sex education increased the likelihood of having a history of sexually transmitted infection testing and decreased the likelihood of having experienced a crisis pregnancy. A cross-sectional study(21) of 13 to17 year-olds (n=3334) from 10 English urban and suburban secondary schools on preferences for the content and delivery of sex and relationships education (SRE), found that the differences in preferences for the content and delivery of sex education were presented particularly between male and female pupils.		
PH51-09 **Recommendation 9 Providing emergency contraception** **evidence statements H2, V1a, V1b, V1c, V11, V20, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
PH51-10 **Recommendation 10 Providing condoms in addition to other methods of contraception** **evidence statements H3, V1a, V1b, V7, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**

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PH51-11 **Recommendation 11 Communicating with young people** **evidence statements C1a, C1c, E6b, V1a, V2, V11, V17, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
PH51-12 **Recommendation 12 Training and continuing professional development** **evidence statements V1a, V1b, V2, V12, V14, V18, V19, V27, IDE**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
Research recommendations		
What are the most effective and cost effective ways to provide contraceptive services for socially disadvantaged young people to prevent unwanted pregnancies? In particular, what are the most effective and cost effective ways to provide contraceptive services for looked after children, those with learning difficulties, those who are not in education, employment or training or women who have had an abortion?		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
Research recommendations		
What are the most effective ways to get socially disadvantaged young women and men involved in designing contraceptive services that meet their needs and reduce the barriers to access?		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**

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Research recommendations		
How effective and cost effective are interventions that reduce unintended conception and abortion rates among young people aged under 25 years?		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
Research recommendations		
What is the differential impact of interventions that aim to reduce unintended conception and abortion rates among young people aged under 25 years on subgroups of socially disadvantaged young people?		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
Research recommendations		
What interventions and service models enable young people from diverse faith and cultural communities to access contraceptive services and meet their contraceptive needs?		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**
Gaps in the evidence		
Gap – 01 There is little UK evidence about the effectiveness of interventions in this field. **Gap – 02 There is little evidence about the effectiveness of services and interventions for socially deprived young people, or evidence that searches for a differential effect among different groups of young people** **Gap – 03 There are few UK data about the cost effectiveness of contraceptive service provision**		
No evidence identified	No evidence identified	**No new evidence was identified, no changes**

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