FACULTY OF SEXUAL & REPRODUCTIVE HEALTHCARE

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Faculty of Sexual & Reproductive Healthcare Clinical Guidance



Contraceptive Choices for Young People

Clinical Effectiveness Unit

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ABBREVIATIONS USED

BMD	bone mineral density
BMI	body mass index
BASHH	British Association for Sexual Health and HIV
CEU	Clinical Effectiveness Unit
CHC	combined hormonal contraception
COC	combined oral contraception
Cu-IUD	copper-bearing intrauterine device
DMPA	depot medroxyprogesterone acetate
EC	emergency contraception
FSRH	Faculty of Sexual and Reproductive Healthcare
HIV	human immunodeficiency virus
HPV	human papillomavirus
IUD	intrauterine device
LARC	long-acting reversible contraception
LNG-IUS	levonorgestrel-releasing intrauterine system
NCSP	National Chlamydia Screening Programme
NET-EN	norethisterone enantate
NICE	National Institute for Health and Clinical Excellence
POEC	progestogen-only emergency contraception
POP	progestogen-only pill
SIGN	Scottish Intercollegiate Guideline Network
STI	sexually transmitted infection
UKMEC	*UK Medical Eligibility Criteria for Contraceptive Use*
UPSI	unprotected sexual intercourse
VTE	venous thromboembolism

GRADING OF RECOMMENDATIONS

A — Evidence based on randomised controlled trials

B — Evidence based on other robust experimental or observational studies

C — Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

✓ — Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the multidisciplinary group

DETAILS OF CHANGES TO ORIGINAL GUIDANCE DOCUMENT

Since this set of guideline was first published, the following changes have been made:

May2019 - Removed Appendix 5 and 7. Updated Appendix 6. Updated section 4.4 ,4.5, 5.7 and 6.1 to align with updated FSRH Clinical Guideline *Emergency Contraception (2016), Quick Starting Contraception (2016) and* Combined Hormonal Contraception (2019). Added Table 1.

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SUMMARY OF KEY RECOMMENDATIONS

Legal and Ethical Framework

✓ Practitioners may wish to inform a young person of the law in relation to sexual activity.

C A clinician should assess a young person's competence to consent to treatment by their ability to understand information provided, to weigh up the risks and benefits, and to express their own wishes.

C Competence to consent to treatment should be assessed and documented at each visit where relevant (e.g. for under-16-year-olds).

✓ Health professionals may wish to use checklists (e.g. Fraser Guidelines) to assess competence and risk when providing contraceptive advice or treatment to young people.

C Young people should always be made aware of the confidentiality policies for the service they are attending, including the circumstances in which confidentiality may need to be breached.

C All sexual and reproductive health care services should have a named person identified as the local lead for child protection.

C All staff involved in contraceptive services for young people should receive appropriate training to alert them to the possibility of exploitation or coercion. Staff should know who they can contact for advice and how to act on child protection issues in accordance with local policy and procedures.

Contraceptive Options for Young People

✓ Young people should be informed about all methods of contraception, highlighting the benefits of long-acting reversible contraception (LARC).

✓ Young people may be advised to return for follow-up within 3 months of starting hormonal contraception. This allows side effects or other concerns to be addressed and helps ensure correct use of the method.

C Young people should be encouraged to return at any time if they develop problems with contraception.

C Age alone should not limit contraceptive choices, including intrauterine methods.

✓ Young people should be made aware of the different types of emergency contraception (EC) available, when they can be used and how they can be accessed.

✓ Even if presenting for EC within 72 hours of unprotected sexual intercourse (UPSI), women of all ages should be offered the copper-bearing intrauterine device or advised how they can access it.

Addressing Young People's Health Concerns and Risks

Weight Gain

B Young people may be advised that there is no evidence of weight gain with combined hormonal contraception (CHC) use.

C Young people may be advised that weight gain can occur with depot medroxyprogesterone acetate (DMPA) use but there is little evidence of a causal association between other progestogen-only methods and weight gain.

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SUMMARY OF KEY RECOMMENDATIONS

Addressing Young People's Health Concerns and Risks (continued)

Acne

B Young people may be advised that combined oral contraception (COC) use can improve acne.

✓ Young women whose acne fails to improve with COC may wish to consider switching to a COC containing a less androgenic progestogen or one with a higher estrogen content.

C Co-cyprindiol (Dianette®) is indicated to treat severe acne that has not responded to oral antibiotics. In those with less severe symptoms it should be withdrawn 3-4 months after the condition has resolved. For women with known hyperandrogenism, longer use with specialist review may be warranted.

C Young people should be advised that the progestogen-only implant may be associated with improvement, worsening or onset of acne.

Mood Changes and Depression

C Young people may be advised that hormonal contraception may be associated with mood changes but there is no evidence that hormonal contraceptives cause depression.

Fertility

C Individuals should be advised that there is no delay in return of fertility following discontinuation of the progestogen-only pill or CHC.

B Individuals should be advised that there is no delay in return of fertility after discontinuation of intrauterine contraception or the progestogen-only implant.

C Individuals should be advised that there can be a delay of up to 1 year in the return of fertility after discontinuation of DMPA.

Bleeding Patterns and Dysmenorrhoea

C Individuals should be informed that altered bleeding patterns can occur with hormonal contraception use.

B Primary dysmenorrhoea may improve with use of CHC.

Bone Health

B Young people should be informed that use of the progestogen-only injectable contraceptive is associated with a small loss of bone mineral density which is usually recovered after discontinuation.

C DMPA can be used in women under the age of 18 years after consideration of other methods.

✓ Women who wish to continue using DMPA should be reviewed every 2 years to reassess the benefits and risks.

Thrombosis

B Young people may be informed that although the risk of venous thromboembolism is increased with CHC, the absolute risk is very small.

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SUMMARY OF KEY RECOMMENDATIONS

Addressing Young People's Health Concerns and Risks (continued)

Cancer

B Young people may be advised that COC use is not associated with an overall increased risk of cancer.

B Young people may be advised that COC use reduces the risk of ovarian cancer and that the protective benefit continues for 15 or more years after stopping.

B Young people may be advised that any increase in breast cancer with hormonal contraception use is likely to be small and to reduce after stopping.

B Young people may be advised that there may be a very small increase in the risk of cervical cancer with prolonged COC use.

Sexually Transmitted Infections and Young People

B The correct and consistent use of condoms should be advised to reduce the risk of transmission of sexually transmitted infections (STIs).

✓ When advising condom use, young people should be informed about correct use of condoms and lubricants, different sizes, types and shapes of condoms, and how to access further supplies, STI screening and EC.

C Young people should be advised to have STI tests 2 and 12 weeks after an incident of UPSI.

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Faculty of Sexual and Reproductive Healthcare
Clinical Effectiveness Unit

A unit funded by the FSRH and supported by NHS Greater Glasgow & Clyde to provide guidance on evidence-based practice

FSRH Guidance (March 2010) Contraceptive Choices for Young People

(Update due by March 2015)

1 Purpose and Scope

This guidance is most relevant to young people under 18 years of age but may also apply to young people up to the age of 25 years. The guidance is intended for use by health professionals providing contraceptive services to young people. Recommendations are based on available evidence and consensus opinion of experts. They should be used to guide clinical practice but they are not intended to serve alone as a standard of medical care or to replace clinical judgement in the management of individual cases. A key to the Grading of Recommendations, based on levels of evidence, is provided on the inside front cover of this document. Details of the methods used by the Clinical Effectiveness Unit (CEU) in developing this guidance are outlined in Appendix 1. The guidance focuses on contraceptive choices for young people with some additional discussion of related sexual health, ethical and legal issues. For information on contraceptive choices for young people with particular lifestyle risk factors, medical conditions or concomitant medication, health professionals should refer to the *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC)[1], *British National Formulary*[2] and the *electronic Medicine Compendium*.[3] For detailed information on legal and child protection matters, practitioners should consult the relevant acts of parliament, government guidance, professional bodies, and local policies and protocols (Appendix 2).

2 Background

Young people in the UK have relatively poor sexual health compared with older members of the population and in comparison with their peers in other European countries. The key public health issues with regard to young people's sexual health are unintended pregnancy and sexually transmitted infections (STIs). Despite wide availability of various contraceptive methods and condoms, teenage pregnancy rates in the UK are higher than in other European countries[4,5] and sexually active young people are disproportionately affected by STIs.[6,7] Sexual health inequalities can be even greater among vulnerable young people and those from minority groups.

Important determinants of sexual health include the ability to have safe and happy relationships free from coercion; the ability to negotiate safer sex; having access to sexual health and relationship services; and being informed about rights including the right not to have or delay having sex.[8–10] First intercourse amongst young people is often associated with regret, feeling pressured and alcohol consumption.[11,12] Research suggest that early age at first intercourse is associated with teenage pregnancy and lack of sexual competence (based on regret, willingness, contraceptive use, autonomy).[12]

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The factors influencing sexual health are complex and diverse. Therefore, improving sexual health requires a multifaceted approach. Sexual health strategies for England, Wales[10] and Scotland[9] and Northern Ireland[8] aim to improve sexual health outcomes through better access to sex education, contraception, STI testing and sexual health advice. This guidance provides health professionals with advice for supporting young people in making appropriate contraceptive choices.

3 Legal and Ethical Framework

3.1 Sexual activity

Whilst the age of consent to sexual activity in the UK is 16 years, surveys suggest that approximately one in three young people have had sexual intercourse by this age.[4,12,13] Although unlawful, mutually agreed sexual activity between under-16-year-olds of similar age would not generally lead to prosecution unless there was evidence of abuse or exploitation. Different legislation on sexual activity applies to England and Wales, Northern Ireland and Scotland.[14–16] (Appendices 2 and 3).

In England, Wales and Northern Ireland, those under the age of 13 years are considered unable to legally consent to sexual activity.[14,15] In Northern Ireland, there is no statutory duty under criminal law to report to the police cases of sexual activity involving children under the age of 16 years unless the child is under 13 years or the other party is aged 18 years or over. When the Sexual Offences Scotland Act 2009[17] comes into force, sexual activity with a male or female aged under 13 years will be "rape of a young child".

✓ Practitioners may wish to inform a young person of the law in relation to sexual activity.

3.2 Consent, confidentiality and safeguarding young people

The legal framework on consent, confidentiality and safeguarding (child protection) is covered by the General Medical Council publication, *0–18 Years: Guidance for All Doctors*.[18] This document includes more detailed information covering each of the UK nations (see also Appendix 3). The following is a summary of key issues for sexual health providers.

3.2.1 Consent

In law, any competent young person in the UK can consent to medical treatment[19] including contraception. Young people over 16 years of age, including those with a disability/impairment, are presumed to be competent to give consent to medical treatment unless otherwise demonstrated. For young people under the age of 16 years, however, competence to consent has to be demonstrated (Box 1). A young person must have sufficient understanding and maturity to understand fully what is proposed (England, Wales and Northern Ireland) or be capable of understanding the nature and possible consequences of the treatment (Scotland).[20]

The assessment of a young person's capacity to make a decision about contraception or medical treatment is a matter of clinical judgement guided by professional practice and legal requirement.[19] Assumptions should not be made about an individual's capacity to consent based on age alone or disability.[21,22]

In England, Wales and Northern Ireland, in order to provide contraception to young people under 16 years of age without parental consent, it is considered good practice to follow the Fraser Guidelines/criteria (Box 2).

In Scotland, although the Fraser Guidelines are sometimes used by health professionals, they have no authority in Scottish law. The primary legislation when determining 'competency' is the Age of Legal Capacity (Scotland) Act 1991[20] whereby the only criterion is that the child understands the nature and consequence of the treatment.

Box 1 Assessing competence[19]

Competence is demonstrated if the young person is able to:
- Understand the treatment, its purpose and nature, and why it is being proposed
- Understand its benefits, risks and alternatives
- Understand in broader terms what the consequences of the treatment will be
- Retain the information for long enough to use it and weigh it up in order to arrive at a decision.

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Box 2 Fraser Guidelines/criteria

- The young person understands the professional's advice.
- The young person cannot be persuaded to inform their parents.
- The young person is likely to begin, or to 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.

C A clinician should assess a young person's competence to consent to treatment by their ability to understand information provided, to weigh up the risks and benefits, and to express their own wishes.

C Competence to consent to treatment should be assessed and documented at each visit where relevant (e.g. for under-16-year-olds).

✓ Health professionals may wish to use checklists (e.g. Fraser Guidelines) to assess competence and risk when providing contraceptive advice or treatment to young people.

3.2.2 *Confidentiality*

It is important to maintain confidentiality so that young people access services. The duty of confidentiality owed to a young person is similar to that for an adult. Duty of confidentiality will differ between professionals working with young people, for example, health staff and teachers. Professionals should be aware of their own policies with regard to the circumstances in which a breach of confidentiality may be justified and the correct procedures to follow. Appendix 2 lists some relevant documents including the British Medical Association statement on information sharing in relation to sexual activity amongst young people.

C Young people should always be made aware of the confidentiality policies for the service they are attending, including the circumstances in which confidentiality may need to be breached.

3.2.3 *Safeguarding young people*

When working with young people either directly or indirectly, professionals need to consider the possibility of physical, sexual and emotional harm including coercion and/or exploitation. National frameworks on safeguarding children are available[23,24] (see also Appendices 2 and 3). In addition, local areas will have their own child protection policies and procedures. Professionals working with young people should attend the training available from local child protection services. Staff working with young people should know:

- How to access national and local child protections guidance and procedures
- Who provides further advice and expertise on child protection issues locally or within their service
- Under what circumstances child protection procedures should be initiated according to their working protocols
- What services are available locally, when and how to refer
- How child protection procedures may affect different groups (e.g. those under 13 years, under 16 years and vulnerable groups).

C All sexual and reproductive health care services should have a named person identified as the local lead for child protection.

C All staff involved in contraceptive services for young people should receive appropriate training to alert them to the possibility of exploitation or coercion. Staff should know who they can contact for advice and how to act on child protection issues in accordance with local policy and procedures.

3.3 Consultation

Developing rapport with a young person and creating a safe and comfortable environment (Box 3) during the consultation may enable health professionals to assess risk and tailor advice and treatment to the individual.

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Box 3 Suggestions for facilitating consultations with young people

Initial contact	*Reception staff* ● As they are often the first point of contact for the young person with the service, the reception staff should provide a friendly and non-judgemental welcome.
Consultation process	*Clinical staff* ● Wherever possible the young person should be allowed as much time in the consultation as they need. ● Time should be taken to explain the confidentiality to be expected from all medical and non-medical staff in the health care team and the limits of confidentiality. ● Avoid making assumptions about reason for visit; sexual behaviour; sexual orientation; risk or capacity based on age, gender or disability. ● Avoid appearing to moralise about sex, sexuality and contraceptive choice and be aware of cultural and sexual diversity. ● Avoid writing notes whilst listening and observing. ● Barriers such as desks and computer screens should be minimised.

Issues relating to child protection might not be disclosed during the young person's first visit; therefore, opportunities for disclosure should be available throughout a young person's care pathway. Appendix 4 contains examples of questions that may help those working with young people to consider sexual risk and the possibility of coercion.

Health professionals should be aware that parental involvement does not always exclude child protection/competence issues. Whilst efforts should be made to encourage parent/carer/partner involvement where appropriate, when a young person is accompanied by an adult, the young person should also be seen alone if possible. It is good practice to document who accompanied the young person and, if they were offered time alone, whether this was accepted or declined.

4 Contraceptive Options for Young People

4.1 Contraceptive use among young people

Despite the wide range of contraceptives available on the UK market rates of unintended pregnancy remain high. There has been an increasing trend in young people's contraceptive use, with the majority of young people reporting use of contraception at last intercourse, and less than one-fifth of those surveyed reporting non-use.[13,25] Use and non-use of contraception at first and subsequent intercourse may be influenced by various factors: individual factors (knowledge, attitude, personal aspirations, previous use, perceived risk); familial (family structure, parent–child relationship, socioeconomic status); relationship (partner characteristics) and social (social norms, peer influences, access to services).[12,26–30]

In the UK, the contraceptive pill and condom remain the two most commonly used methods. Office of National Statistics survey data (2008/2009)[31] indicate that among women aged 16–29 years who were at risk of pregnancy, 78% were using the contraceptive pill and/or the condom (46% and 47%, respectively, 15% used both).[31] Long-acting reversible methods of contraception (LARC) (i.e. the progestogen-only implant, injectable and intrauterine methods) are used by a minority of women,[31] but there is a trend towards increasing use.[32] Use of the progestogen-only injectable and implant is greater in young women compared with older women.[31]

Young women's choice of contraception may be influenced by a number of factors: effectiveness, discreetness, safety, side effect profile, invasiveness, knowledge of the method, ease of use or how difficult it is to forget.[33]

4.2 Non-adherence and discontinuation

For all women, typical failure rates with use of combined oral contraception (COC) and male condoms are as high as 8% and 15%, respectively, in the first year of use.[34] A survey in the USA showed that women aged under 20 years experienced a contraceptive failure rate of about 16% in the first 12 months of use, compared with a rate of 8% in married women aged 30 years and older.[35] LARC methods [defined by the National Institute of Health and Clinical Excellence (NICE) as those methods that require administering less than once per cycle or month][36] are less user dependent than shorter-acting methods. Thus LARC methods have lower failure rates with typical use and they are more cost effective than COC or condoms if

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used for 1 year or longer. [See Appendix 5 for typical and perfect use failure rates of various contraceptive methods.]

Discontinuation of methods may also be a factor in unintended pregnancies. In the USA it has been estimated that at 12 months after initiation, between 65% and 70% of all contraceptive methods used by women aged 14–55 years have been discontinued. The majority of discontinuation occurs in the first 6 months of use,[37] and approximately 45–50% of discontinuation is for method-related reasons.[37] Side effects (perceived or experienced) are often cited as the reason for method discontinuation.[37–41] Despite this, the probability of resuming contraception is relatively high and total abandonment of contraception far lower.[37] A small qualitative study of 16–25-year-olds found that women who had no prior concern about the nature of hormones switched to another method when they experienced unwanted effects, whereas those who had prior concerns were more likely to return to inconsistent condom use or stop using contraception altogether.[41]

Health professionals should aim to maximise a young person's adherence with contraception by providing a wide and appropriate choice of methods, dealing with specific health concerns (see Section 5), discussing specific health benefits and providing appropriate follow-up. Verbal information should be backed up with appropriate written information and/or information in other formats.

✓ Young people should be informed about all methods of contraception, highlighting the benefits of LARC

✓ Young people may be advised to return for follow-up within 3 months of starting hormonal contraception. This allows side effects or other concerns to be addressed and helps ensure correct use of the method.

C Young people should be encouraged to return at any time if they develop problems with contraception.

4.3 Medical eligibility

Young people generally are at lower risk of cardiovascular and other age-related conditions. However, they may have specific risks relating to pubertal development, risk of STIs, or other medical conditions. In addition, factors such as ability to adhere with contraception, eating disorders, family situation, obesity, and recreational drug/alcohol use also need to be taken into account. Appendix 4 provides sample questions that may help support appropriate history taking.

The *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC)[1] provides guidance on which contraceptive methods can be used safely in individuals with certain conditions/circumstances. Table 1 outlines what each category means, while Table 2 lists the categories for each method in relation to age.

There are no restrictions on using any of the above methods based on nulliparity alone (UKMEC 1).[1]

C Age alone should not limit contraceptive choices, including intrauterine methods.

Table 1 Definition of *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC) categories for use of hormonal contraception, intrauterine devices and barrier methods[1]

Category	Definition
UKMEC 1	A condition for which there is no restriction for the use of the contraceptive method.
UKMEC 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
UKMEC 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. Provision of a Category 3 method requires expert clinical judgement since use of that method is not usually recommended unless other more appropriate methods are not available or not acceptable.
UKMEC 4	A condition which represents an unacceptable health risk if the contraceptive method is used.

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Table 2 *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC) categories based on age[1]

Method	Age	UKMEC Category
Combined hormonal contraception (combined oral contraception, vaginal ring, patch)	Menarche to <40 years ≥40 years	1 2
Progestogen-only pill	Menarche onwards	1
Progestogen only implant	Menarche onwards	1
Progestogen-only injectable (DMPA or NET-EN)	Menarche to <18 years 18–45 years >45	2 1 2
Barrier methods (condoms, diaphragms, cervical caps)	Menarche onwards[a]	1
Copper-bearing intrauterine device	Menarche to <20 years ≥20 years	2 1
Levonorgestrel-releasing intrauterine system	Menarche to <20 years ≥20 years	2 1

[a]The CEU recommends that condoms can be used before menarche if required.
DMPA, depot medroxyprogesterone acetate; NET-EN, norethisterone enantate.

4.4 Starting hormonal contraception in young people

The method-specific guidance documents produced by the Faculty of Sexual and Reproductive Healthcare (FSRH) provide recommendations on starting each method.[42–46] The CEU does not support the use of regular hormonal contraception prior to menarche and recommends advising use of condoms to young people requiring contraception before this time. Progestogen-only emergency contraception (POEC) can, however, be given to premenarchal women if required.

'Quick starting' is the immediate administration of a hormonal method of contraception rather than a conventional start, which would involve waiting until the start of the next menstrual period. The method may then be continued indefinitely or used as a bridging method until the next period or withdrawal bleed, when a longer-acting method can be commenced. Waiting may result in the individual never starting the method, perhaps because of waning enthusiasm or the inconvenience of rescheduling an appointment. In theory, although 'quick starting' may help to reduce such barriers for young people, there is currently limited evidence that immediate start of hormonal contraception reduces unintended pregnancies or increases method continuation.[47] Further information is available in FSRH Clinical Guideline *Quick Starting Contraception*.[140]

4.5 Emergency contraception

Use of emergency contraception (EC) is common in those aged under 30 years.[48,49] Qualitative studies have found that use of EC may be influenced by factors such as perceived pregnancy risk, personal and perceived attitudes towards EC and confidence in asking for it.[50–52] Data from the Office of National Statistics indicates that whilst 86% of individuals aged 16–19 years had heard of emergency hormonal contraception, only 35% had heard of the emergency intrauterine device (IUD).[48]

There are now three methods of EC available in the UK: POEC, the copper-bearing intrauterine device (Cu-IUD), and the progesterone-receptor modulator (ulipristal acetate). Although all three methods can be used up to 120 hours (5 days) after unprotected sexual intercourse (UPSI), POEC is only licensed for use up to 72 hours. The Cu-IUD may also be used up to 5 days after the earliest expected date of ovulation regardless of the number of episodes of UPSI. For further information on EC refer to the FSRH's guidance on EC[53] and new product review of ulipristal acetate.[54]

Access to EC is important as the efficacy of POEC decreases with time since UPSI.[55] 'Advance provision' of POEC, where a spare supply is provided for future use, does not negatively affect sexual health outcomes and can increase use of EC, but it has not yet been shown to reduce unintended pregnancy rates when compared with 'conventional' provision.[56] In the UK, POEC can be purchased from community pharmacies. It is supplied free of charge in pharmacies throughout Scotland and may be free through local pharmacy schemes in other

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parts of the UK. Some pharmacies may also offer free pregnancy and chlamydia testing. Health professionals should be aware of local provision and young people should be made aware of all services offering EC in their area.

All available methods of EC should be offered to women attending for EC, regardless of age or parity, even if presenting within 72 hours of UPSI. If Cu-IUD insertion is delayed, oral EC should be given at the time of the initial consultation in case the Cu-IUD cannot be inserted or the young woman changes her mind. If ulipristal acetate[57] is used, hormonal contraception should not be started for 5 days. Further information is available in FSRH Clinical Guideline *Emergency Contraception*.[53]

✓ Young people should be made aware of the different types of EC available, when they can be used and how they can be accessed.

✓ Even if presenting for EC within 72 hours of UPSI, women of all ages should be offered the Cu-IUD or advised how they can access it.

5 Addressing Young People's Health Concerns and Risks

Evidence indicates that concerns about safety, misconceptions about hormonal contraception and negative attitudes towards contraceptive methods may affect use and choice of contraception.[41,51,52,58–66] Practitioners themselves may have misconceptions about contraceptive side effects, which may in turn affect their provision of certain methods.[67] Health professionals should familiarise themselves with the risk and benefits of contraceptive methods in order to address individuals' concerns and support use. More detailed information on individual methods and their relationship to health concerns such as weight, bone mineral density and thrombosis can be found in the method-specific guidance documents produced by the FSRH CEU.[42,44,45]

5.1 Weight gain

Weight gain is often cited as a reason for hormonal contraception discontinuation. However, some weight gain during the reproductive health years is normal. Studies investigating weight gain and hormonal contraception are often limited by their retrospective design, lack of consensus as to what constitutes excessive weight gain and a lack of controls.

The limited data that exist suggest no clear effect on weight with COC use, and there is currently insufficient evidence to prove a clear causal association between most other hormonal contraceptives and weight gain.[43,44,46,68] It is, however, acknowledged that depot medroxyprogesterone acetate (DMPA) use may be associated with a gain of 2–3 kg in weight over 1 year.[36] Weight gain with DMPA use may be predicted by body mass index (BMI) prior to use.[69,70] In a prospective study of obese and non-obese, predominately black adolescents, those with a BMI>30 had significantly increased weight gain with DMPA over 18 months compared with non-obese young women.[71]

Whilst concerns about weight gain with a contraceptive method should not be dismissed, other lifestyle factors such as levels of physical activity and diet should be explored. The provision of information on diet and physical activity may be useful for young women who are concerned about weight gain.

B Young people may be advised that there is no evidence of weight gain with COC use.

C Young people may be advised that weight gain can occur with DMPA use but there is little evidence of a causal association between other progestogen-only methods and weight gain.

5.2 Acne

COC use may improve acne and thus can be considered in those who require contraception. Overall, few differences have been found between COC types in terms of their effectiveness for treating acne.[72] In the UK, co-cyprindiol (Dianette®)[73,74] should not be used solely for contraception and is licensed for treatment of severe acne that has not responded to oral antibiotics. Ideally it should be withdrawn 3–4 months after the condition has resolved. However, for women with known hyperandrogenism, longer use may be warranted with specialist review. In all women, co-cyprindiol can be restarted at any time if acne or hirsutism recurs on stopping treatment.[74]

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Acne does not appear to be associated with DMPA use.[36] The progestogen-only implant can be associated with improvement, worsening or onset of acne.[75–80] Whilst there may be an increased risk with the levonorgestrel-releasing intrauterine system (LNG-IUS) it is not usually a reason for discontinuation.[36]

B Young people may be advised that COC use can improve acne.

✓ Young women whose acne fails to improve with COC may wish to consider switching to a COC containing a less androgenic progestogen or one with a higher estrogen content.

C Co-cyprindiol is indicated to treat severe acne that has not responded to oral antibiotics. In those with less severe symptoms it should be withdrawn 3–4 months after the condition has resolved. For women with known hyperandrogenism, longer use with specialist review may be warranted.

C Young people should be advised that the progestogen-only implant may be associated with improvement, worsening or onset of acne.

5.3 Mood changes and depression

Whether or not hormonal contraception is the causative factor and the extent to which other factors have a role to play is often difficult to assess as studies of mood change are largely based on women's own perceptions. Mood changes have, however, been cited as a reason for discontinuation of several methods of contraception,[78] and depression is listed as an undesirable effect of combined hormonal contraception (CHC) methods and progestogen-only methods.[2,3]

Studies looking at COC have generally found no difference between pill users and non-users.[81,82] One study found that although two-thirds or young women aged 14–19 years anticipated mood changes with COC use, only 9% experienced such symptoms.[83] A randomised controlled trial of young women aged under 19 years experiencing dysmenorrhoea found similar numbers and types of oral contraceptive side effects, including depression, amongst those treated with COC and those with a placebo.[81] Premenstrual mood has been found to be largely unchanged by CHC use, but may improve in some women and deteriorate in others.[84] Deterioration may in part be influenced by a prior history of depression.[84] A small prospective study of mood changes in adolescents using DMPA found that DMPA use does not result in depressive symptoms or a worsening of pre-existing depression.[85]

C Young people may be advised that hormonal contraception may be associated with mood changes but there is no evidence that hormonal contraceptives cause depression.

5.4 Fertility

Young people may have concerns about the impact of hormonal contraceptives, particularly longer-lasting methods, on fertility. They can be reassured that there is no clinically significant delay in return to fertility with intrauterine or progestogen-only methods,[43,44] other than with the progestogen-only injectable.[45] After discontinuation of DMPA, return of fertility can be delayed for up to a year, but there is no evidence of reduced fertility in the long term.[45] A non-systematic review of return to fertility following discontinuation of cyclic oral contraceptives suggests that return of fertility in former oral contraceptive users (cyclical, continuous or extended) is similar to that with other methods.[86]

C Individuals should be advised that there is no delay in return of fertility following discontinuation of the POP or CHC.

B Individuals should be advised that there is no delay in return of fertility after discontinuation of intrauterine contraception or the progestogen-only implant.

C Individuals should be advised that there can be a delay of up to 1 year in the return of fertility after discontinuation of DMPA.

5.5 Bleeding patterns and dysmenorrhoea

Young people may be concerned about changes to their usual menstrual pattern if they are not adequately counselled prior to starting a method of contraception. Altered bleeding patterns are common with progestogen-only methods of contraception, including the LNG-

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IUS.[43,44] With the copper-IUD, altered bleeding patterns may be common in the first 3–6 months after insertion and then settle.[43] It should be explained that amenorrhoea may be normal and that unscheduled bleeding does not necessarily signify reduced efficacy if the method has been used correctly. Likely causes of unscheduled bleeding with the COC include missed pills, STIs and malabsorption. The FSRH CEU has produced guidance on the management of unscheduled bleeding in women using hormonal contraception.[87]

The LNG-IUS, COC and progestogen-only injectable are recognised treatments in the treatment of heavy menstrual bleeding,[88] and the COC has been shown to improve primary dysmenorrhoea.[89] The LNG-IUS may have beneficial effects on secondary dysmenorrhoea associated with endometriosis and adenomyosis.[90–92] Theoretically, other cyclical symptoms may be alleviated by hormonal methods that induce amenorrhoea or inhibit ovulation such as CHC, the desogestrel POP, the progestogen-only implant and injectable hormonal contraceptives.

C Individuals should be informed that altered bleeding patterns can occur with hormonal contraception use.

B Primary dysmenorrhoea may improve with use of CHC.

5.6 Bone health

A number of studies have investigated the influence of hormonal contraception on the bone health of young women.[93–101] The studies are often limited by high rates of method discontinuation and small sample size. A Cochrane review has concluded that for women of reproductive age, combined contraceptives do not appear to affect bone mineral density (BMD) but the progestogen-only method, DMPA, may reduce BMD.[102] There has been particular concern about the use of DMPA in women aged under 18 years who may not have attained their peak bone mass. The CEU endorses the advice of the Department of Health Medicines and Healthcare product Regulatory Agency (MHRA), which indicates that DMPA can be used in women under the age of 18 years after consideration of other methods.

Women with eating disorders may also be at risk of reduced BMD. As the bone loss is likely to be multifactorial, CHC cannot be relied on for prevention or treatment of osteoporosis and is not a substitute for restoring normal nutrition.

B Young people should be informed that use of the progestogen-only injectable contraceptive is associated with a small loss of BMD that is usually recovered after discontinuation.

C DMPA can be used in women under the age of 18 years after consideration of other methods.

✓ Women who wish to continue using DMPA should be reviewed every 2 years to reassess the benefits and risks.

5.7 Thrombosis

The incidence of venous thromboembolism (VTE) in young women is very low. CHC methods are known to be associated with an increased risk of VTE. Please refer to Table 3. See FSRH Clinical Guideline *Combined Hormonal Contraception.*[42]

Table 3: European Medicines Agency estimated risk of developing a venous thromboembolism (VTE) in a year according to type of combined hormonal contraception (CHC) used[141]

Type of CHC used	Risk of developing a VTE in a year (incidence in 10 000 women)
Women **not using** combined hormonal pill/patch/ring and not pregnant	~2
Women using CHC containing **levonorgestrel, norethisterone** or **norgestimate**	~5–7
Women using CHC containing **etonogestrel** or **norelgestromin**	~6–12
Women using CHC containing **drospirenone, gestodene** or **desogestrel***	~9–12

*Evidence suggests that co-cyprindiol is associated with similar VTE risk to combined oral contraceptive containing drospirenone, gestodene or desogestrel.[230]

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Due to the observational design of studies looking at VTE risk, bias and confounders cannot be completely excluded and, therefore, the true relative risks of different CHC methods remain in doubt. In clinical practice, COCs containing the so-called second-generation progestogens such as levonorgestrel and norethisterone are advised as the first-line choice for young women.42 Standard dose (30 or 35 µg in UK) COCs may offer the advantage of better cycle control and lower risk of pregnancy with imperfect use. Other pills may be considered as second-line pills after trying a first pill. A low-dose (e.g. 20 µg ethinylestradiol) COC may be appropriate for women who experience side effects at higher doses. The combined vaginal ring (NuvaRing) offers good cycle control in addition to relatively low estrogen exposure.

Few studies have been large enough to evaluate the risk of VTE with progestogen-only methods. However, the data available suggest that there is little or no increase in the risk of VTE with progestogen-only methods.[107,116]

Factors such as immobility and obesity may increase an individual's risk of VTE,[117,118] and use of a contraceptive method may be contraindicated or advised with caution. Further details are available in UKMEC.[1]

B Young people may be informed that although the risk of VTE is increased with CHC, the absolute risk is very small.

5.8 Cancer

A large UK cohort study[119] has shown that oral contraception use is not associated with an overall increased risk of cancer, and indeed oral contraception may reduce overall cancer risk.

COC use is associated with a reduced risk of ovarian and endometrial cancer[119–125]. The effect on ovarian cancer appears to continue for 15 years or more after cessation of COC.[121,123,125] Some studies have indicated a significant increase in the risk of breast cancer with COC use,[126] while others have found no increase or a very small increase.[119,121,127] Long-term use of the COC is associated with a small increase in risk of cervical cancer.[119,121,128–131] Women should be informed about the link between human papillomavirus (HPV) and cervical cancer and be advised that they can reduce their risk of cervical cancer through condom use, HPV vaccination and regular cervical screening.

The evidence with regard to cancer risk and progestogen-only methods is more limited. There are no consistent associations between use of POP or injectable progestogens and breast cancer incidence.[126,132–135] No studies were indentified in relation to use of the LNG-IUS or progestogen-only implant and risk of breast cancer in young women. As with other progestogen-only methods, any attributable risk is likely to be very small.

When advising women with a strong family history of cancer, health professionals should refer to UKMEC[1] and local criteria for referral to genetic services.

B Young people may be advised that COC use is not associated with an overall increased risk of cancer .

B Young people may be advised that COC use reduces the risk of ovarian cancer and that the protective benefit continues for 15 or more years after stopping.

B Young people may be advised that any increase in breast cancer with hormonal contraception use is likely to be small and to reduce after stopping.

B Young people may be advised that there may be a very small increase in the risk of cervical cancer with prolonged COC use.

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6 Sexually Transmitted Infections and Young People

6.1 Prevention and testing

Young people accounted for 65% of diagnosed chlamydia, 55% of genital warts and 50% of gonorrhoea cases diagnosed in UK genitourinary medicine clinics in 2007.[7] The British Association for Sexual Health and HIV (BASHH) has produced a *United Kingdom National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People*.[136] Sexually active young people under the age of 25 years should be offered chlamydia testing (as a minimum) in accordance with the National Chlamydia Screening Programme (NCSP) and Scottish Intercollegiate Guideline Network (SIGN) guidance.

Young people attending for contraception should be informed:

- About STIs and routes of transmission
- That condoms and oral dams offer protection against STIs including HIV and syphilis
- How to use condoms correctly, including choosing the right size and shape, use of non-oil-based lubrication to reduce the risk of latex condom breakage and checking for a kite or CE mark and expiry date
- Where and how to access free condoms and lubricant
- About using condoms with any new or additional partners.

Condom demonstrations may be appropriate for first-time users in particular. Condoms lubricated with spermicide are not recommended, as nonoxynol-9 may increase the risk of HIV and STI transmission.[137]

Young people should be encouraged to have regular STI testing, particularly when there has been a new sexual partner. An STI screen should be offered if the individual presents immediately following UPSI. However, this may only identify pre-existing infections and a repeat screen may be necessary after the window period to detect any recently acquired infection. Young people need to be told that repeat testing up to 12 weeks after the last UPSI may be required. Following high-risk sexual exposure or assault, the need for specialist assessment for HIV post-exposure prophylaxis should be considered.[138]

B The correct and consistent use of condoms should be advised to reduce the risk of transmission of STIs.

✓ When advising condom use, young people should be informed about correct use of condoms and lubricants, different sizes, types and shapes of condoms, and how to access further supplies, STI screening and EC.

C Young people should be advised to have STI tests 2 and 12 weeks after an incident of UPSI.

6.2 STIs and contraception

UKMEC provides guidance on using methods of contraception with particular conditions including STIs. It is important to check for possible interactions between STI treatments and contraception. Information is available in the B*ritish National Formulary* (www.bnf.org), the *electronic Medicines Compendium* (www.emc.medicines.org.uk) and the CEU guidance on 'Drug interactions with hormonal contraception'.[139]

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References

1 Faculty of Sexual and Reproductive Health Care. *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC 2009). http://www.fsrh.org.uk/admin/uploads/UKMEC2009.pdf [Accessed 16 February 2010].
2 *British National Formulary*. Volume 58. September 2009. http://www.bnf.org [Accessed 16 February 2010].
3 Datapharm Communications Limited. *electronic Medicines Compendium* (eMC). Summaries of Product Characteristics (SPC). http://www.emc.medicines.org.uk [Accessed 16 February 2010].
4 Unicef Innocenti Research Centre. *Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries (Report Card 7)*. 2007. http://www.unicef.org.uk/publications/pdf/rc7_eng.pdf [Accessed 16 February 2010].
5 Unicef Innocenti Research Centre. *A League Table of Teenage Births in Rich Nations (Report Card 3)*. 2001. http://www.unicef-irc.org/publications/pdf/repcard3e.pdf [Accessed 16 February 2010].
6 Sexually Transmitted Infection Epidemiology Advisory Group. *Scotland's Sexual Health Information (SSHI) Report*. Edinburgh, UK: Health Protection Scotland and Information Services Division, 2008.
7 Health Protection Agency. *Sexually Transmitted Infections and Young People in the United Kingdom: 2008 Report*. London, UK: Health Protection Agency, 2008.
8 Department of Health SSaPS. *Sexual Health Promotion: Strategy and Action Plan 2008–2013*. Belfast, UK: Department of Health, Social Sciences and Public Safety Northern Ireland, 2008.
9 Scottish Executive. *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health*. Edinburgh, UK: Scottish Executive, 2005; 1–21.
10 Department of Health. *The National Sexual Health Strategy for Health and HIV. Implementation Action Plan*. London, UK: Department of Health Publications, 2002.
11 Wight D, Henderson M, Raab G, Abraham C, Buston K, Scott S, *et al*. Extent of regretted sexual intercourse among young teenagers in Scotland: a cross sectional survey. *BMJ* 2000; **320**: 1243–1244.
12 Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer CH, *et al*. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; **358**: 1843–1850.
13 Godeau E, Gabhainn SN, Vignes C, Ross J, Boyce W, Todd J. Contraceptive use by 15-year-old students at their last sexual intercourse. *Arch Pediatr Adolesc Med* 2008; **162**: 66–73.
14 Northen Ireland Office. The Sexual Offences (Northen Ireland) Order 2008. 2009. Report No.: 1769.
15 Office of Public Sector Information. Sexual Offences Act 2003. http://www.opsi.gov.uk/acts/acts2003/30042--b.htm [Accessed 16 February 2010].
16 Criminal Law (Consolidation) (Scotland) Act 1995 (c.39) Part I Sexual Offences. London, UK: The Stationery Office, 2004.
17 Sexual Offences (Scotland) Act 2009 (asp 9). http://www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp_20090009_en.pdf [Accessed 16 February 2010].
18 General Medical Council. *0–18 Years Guidance for All Doctors*. 2007. http://www.gmc-uk.org/static/documents/content/GMC_0-18_years_2007.pdf [Accessed 16 February 2010].
19 British Medical Association (BMA). *Consent Toolkit* (4th edn). London, UK: BMA, 2008.
20 Age of Legal Capacity (Scotland) Act 1991. London, UK: Her Majesty's Stationery Office, 1991.
21 Office of Public Sector Information. Mental Capacity Act (2005). 2005. http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1 [Accessed 16 February 2010].
22 Adults with Incapacity (Scotland) Act 2000 (asp 4). http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2000/20000004.htm [Accessed 16 February 2010].
23 Scottish Executive. *Protecting Children and Young People: Framework for Standards*. Edinburgh, UK: Scottish Executive, 2004.
24 Department of Health, Home Office, Department of Education and Employment. *Working Together to Safeguard Children (Report No. 1)*. London, UK: The Stationery Office, 1999.
25 Santelli JS, Morrow B, Anderson JE, Lindberg LD. Contraceptive use and pregnancy risk among U.S. high school students, 1991–2003. *Perspect Sex Reprod Health* 2006; **38**: 106–111.
26 Stone N, Ingham R. Factors affecting British teenager's contraceptive use at first intercourse: the importance of partner communication. *Perspect Sex Reprod Health* 2002; **34**: 191–197.
27 Manlove J, Ryan S, Franzetta K. Contraceptive use patterns across teens' sexual relationships: the role of relationships, partners and sexual histories. *Demography* 2007; **44**: 603–621.
28 Kinsella EO, Crane LA, Ogden LG, Stevens-Simon C. Characteristics of adolescent women who stop using contraception after use at first sexual intercourse. *J Pediatr Adolesc Gynecol* 2007; **20**: 73–81.
29 Manlove J, Ikramullah E, Mincieli L, Holcombe E, Danish S. Trends in sexual experiences, contraceptive use and teenage childbearing:1992–2002. *J Adolesc Health* 2009; **44**: 413–423.
30 Iuliano AD, Speizer IS, Santelli J, Kendall C. Reasons for contraceptive nonuse at first sex and unintended pregnancy. *Am J Health Behav* 2006; **30**: 92–102.
31 Office for National Statistics. *Contraception and Sexual Health 2008/2009*. 2009. http://www.statistics.gov.uk/downloads/theme_health/contra2008-9.pdf [Accessed 16 February 2010].
32 National Institute for Health and Clinical Excellence. *NICE Implementation Uptake Report: Long-acting Reversible Contraception (LARC)*. 2009. http://www.nice.org.uk/media/386/C2/ImpUptakeReportCG30.pdf [Accessed 16 February 2010].
33 Say R, Mansour D. Contraceptive choice for young people. *J Fam Plann Reprod Health Care* 2009; **35**: 81–85.
34 Trussell J. Summary table of contraceptive efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Stewart FH, Kowal D (eds), *Contraceptive Technology* (20th edn). New York, NY: Ardent Media, 2011.
35 Fu H, Darroch JE, Haas T, Ranjit N. Contraceptive failure rates: new estimates from the 1995 National Survey of Family Growth. *Fam Plann Perspect* 1999; **31**: 56–63.
36 National Institute for Health and Clinical Excellence (NICE). *Long-acting Reversible Contraception: The Effective and*

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Appropriate Use of Long-acting Reversible Contraception. 2005. http://www.nice.org.uk/nicemedia/pdf/CG030fullguideline.pdf [Accessed 16 February 2010].
37 Vaughan B, Trussell J, Kost K, Singh S, Jones R. Discontinuation and resumption of contraceptive use: results from the 2002 National Survey of Family Growth. *Contraception* 2008; **78**: 27–283.
38 Lakha F, Glasier A. Continuation rates of Implanon in the UK: data from an obervational study in a clinical setting. *Contraception* 2006; **74**: 287–289.
39 Rai K, Gupta S, Cotter S. Experience with Implanon in a north-east London family planning clinic. *Eur J Contracept Reprod Health Care* 2004; **9**: 39–46.
40 Smith A, Reuter S. An assessment of the use of Implanon in three community services. *J Fam Plann Reprod Health Care* 2002; **28**: 193–196.
41 Cheung E, Free C. Factors influencing young women's decision making regarding hormonal contraceptives: a qualitative study. *Contraception* 2005; **71**: 426–431.
42 Faculty of Sexual & Reproductive Healthcare. Combined Hormonal Contraception. *2019. https://www.fsrh.org/standards-and-guidance/documents/combined-hormonal-contraception/* [Accessed 27 February 2019].
43 Faculty of Sexual and Reproductive Health Care. *Intrauterine Contraception.* 2007. http://www.fsrh.org.uk/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf [Accessed 16 February 2010].
44 Faculty of Sexual and Reproductive Health Care. *Progestogen-only Implants*. 2007. http://www.fsrh.org.uk/admin/uploads/CEUGuidanceProgestogenOnlyImplantsApril08.pdf [Accessed 16 February 2010].
45 Faculty of Sexual and Reproductive Health Care. *Progestogen-only Injectables.* 2008. http://www.fsrh.org.uk/admin/uploads/CEUGuidanceProgestogenOnlyInjectables09.pdf. [Accessed 16 February 2010].
46 Faculty of Sexual and Reproductive Health Care. *Progestogen-only Pills.* 2008. http://www.fsrh.org.uk/admin/uploads/CEUGuidanceProgestogenOnlyPill09.pdf [Accessed 16 February 2010].
47 Lopez LM, Newmann SJ, Grimes DA, Nanda K, Schulz KF. Immediate start of hormonal contraceptives for contraception. *Cochrane Database Syst Rev* 2008; **2**: CD006260.
48 Lader D, Hopkins G. *Contraception and Sexual Health 2007/2008. A Report on Research Using the National Statistics Omnibus Survey Produced on Behalf of the NHS Information Centre for Health and Social Care*. London, UK: Office of National Statistics, 2008.
49 Ineichen B, Logie J, Rowlands S, Lawrenson R. Patterns of prescription of PC4 by general practitioners in England and Wales. *Eur J Contracept Reprod Health Care* 2000; **5**: 241–247.
50 Williamson LM, Buston K, Sweeting H. Young women's perceptions of pregnancy risk and use of emergency contrcaeption: findings from a qualitative study. *Contraception* 2009; **79**: 310–315.
51 Free C, Lee RM, Ogden J. Young women's accounts of factors influencing their use and non-use of emergency contraception: in depth interview study. *BMJ* 2002; **325**: 1393–1396.
52 Free C, Ogden J. Emergency contraception use and non-use in young women: the application of a contextual and dynamic model. *Br J Health Psychol* 2005; **10**: 237–253.
53 Faculty of Sexual & Reproductive Healthcare. *Emergency Contraception. 2017. https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/ [Accessed 19 February 2019]*
54 Faculty of Sexual and Reproductive Health Care. *New Product Review: Ulipristal Acetate (ellaOne®)*. 2009. http://www.fsrh.org.uk/admin/uploads/42_ellaOneNewProductReview1009.pdf [Accessed 16 February 2010].
55 Cheng L, Gulmezoglu AM, Van Look PFA. Interventions for emergency contraception. *Cochrane Database Syst Rev* 2008; **2**: CD001324.
56 Polis CB, Schaffer K, Glasier A, Harper C, Grimes DA. Advance provision of emergency contraception for pregnancy prevention. *Cochrane Database Syst Rev* 2007; **2**: CD005497.
57 HRA Pharma UK Ltd. ellaOne: Summary of Product Characteristics (SPC). 2009 www.emc.medicines.org.uk. [Accessed 16 February 2010].
58 Hamani Y, Sciaki-Tamir Y, Deri-Hasid R, Miller-Pogrund T, Milwidksy A, Haimov-Kochman R. Misconceptions about oral contraception pills among adolescents and physicians. *Hum Reprod* 2007; **12**: 3078–3083.
59 Tanfer K, Wierzbicki S, Payn B. Why are U.S. women not using long-acting contraceptives? *Fam Plann Perspect* 2000; **32**: 176–183.
60 Clark LR. Will the pill make me sterile? Addressing reproductive health concerns and strategies to improve adherence to hormonal contraceptive regimens in adolescent girls. *J Pediatr Adolesc Gynecol* 2001; **14**: 153–162.
61 Davidson AR, Kalmuss D. Topics for our times: Norplant coercion – an overstated threat. *Am J Public Health* 1997; **87**: 550.
62 Peipert JF, Gutmann J. Oral contraceptive risk assessment: a survey of 247 educated women. *Obstet Gynecol* 1993; **82**: 112.
63 Silverman J, Torres A, Forrest JD. Barriers to contraceptive services. *Fam Plann Perspect* 1987; **19**: 94.
64 Scott CS, Shifman L, Orr L, Owen RG, Fawcett N. Hispanic and black American adolescents' beliefs relating to sexuality and contraception. *Adolescence* 1988; **XXIII**: 667–688.
65 Mollen CJ, Barg FK, Hayes KL, Gotcsik M, Blades NM, Schwarz DF. Assessing attitudes about emergency contraception among urban, minority adolescent girls: an in-depth interview study. *Pediatrics* 2008; **122**: 395–401.
66 Glasier A., Scorer J, Bigrigg A. Attitudes of women in Scotland to contraception: a qualitative study to explore the acceptability of long-acting methods. *J Fam Plann Reprod Health Care* 2008; **34**: 213–217.
67 Wellings K, Zhihong Z, Krentel A, Barrett G, Glasier A. Attitudes towards long-acting reversible methods of contraception in general practice in the UK. *Contraception* 2007; **76**: 208–214.
68 Gallo MF, Lopez LM, Grimes DA, Schulz KF, Helmerhorst FM. Combination contraceptives: effects on weight. *Cochrane Database Syst Rev 2008;4:CD003987.*
69 *Mangan SA, Larsen PG, Hudson S. Overweight teens at increased risk for weight gain while using depot medroxyprogesterone acetate. J Pediatr Adolesc Gynecol 2002; 15: 79–82.*

© FSRH 2010

70 Risser WL, Gefter LR, Barratt MS, Risser JM. Weight changes in adolescents who use hormonal contraception. *J Adolesc Health* 1999; **24**: 433–436.

71 Bonny AE, Ziegler J, Harvey R, Debanne SM, Secic M, Cromer BA. Weight gain in obese and nonobese adolescent girls initiating depot medroxyprogesterone, oral contraceptive pills, or no hormonal contraceptive method. *Arch Pediatr Adolesc Med* 2006; **160**: 40–45.

72 Arowojolu AO, Gallo MF, Lopez LM, Grimes DA, Garner SE. Combined oral contraceptive pills for treatment of acne. *Cochrane Database Syst Rev* 2007; **1**: CD004425.

73 Committee on Safety of Medicines (CSM). Cyproterone acetate (Dianette): risk of venous thromboembolism (VTE). *Current Problems in Pharmacovigilance* 2002; **28**: 9–10.

74 Medicines and Healthcare products Regulatory Agency and the Commission on Human Medicines. *Drug Safety Update*. **1**[9]. 2008.

75 Funk S, Miller MM, Mishell DR, Archer DF, Poindexter A, Schmidt J, *et al*. Safety and efficacy of Implanon, a single-rod implantable contraceptive containing etonogestrel. *Contraception* 2005; **71**: 319–326.

76 Otero Flores JB, Balderas ML, Bonilla MC, Vázquez-Estrado L. Clinical experience and acceptability of the etonogestrel subdermal contraceptive implant. *Int J Gynecol Obstet* 2005; **90**: 228–233.

77 Bitzer J, Tschudin S, Alder J, Swiss Implanon Study Group. Acceptability and side-effects of Implanon in Switzerland: a retrospective study by the Implanon Swiss Study Group. *Eur J Contracept Reprod Health Care* 2004; **9**: 278–284.

78 Yildizbas B, Sahin GH, Kolusari A, Zeteroglu S, Kamaci M. Side effects and acceptability of Implanon: a pilot study conducted in eastern Turkey. *Eur J Contracept Reprod Health Care* 2007; **12**: 248–252.

79 Croxatto HB, Urbancsek J, Massai R, Coelingh Bennik H, van Beek A, The Implanon Study Group. A multicentre efficacy and safety study of the single contraceptive implant Implanon. *Hum Reprod* 1999; **14**: 976–981.

80 Urbancsek J. An integrated analysis of nonmenstrual adverse events with Implanon. *Contraception* 1998; **58**: 109S–115S.

81 O'Connell K, Davis AR, Kerns J. Oral contraceptives: side effects and depression in adolescent girls. *Contraception* 2009; **75**: 299–304.

82 Duke JM, Sibbritt DW, Young AF. Is there an association between the use of oral contraception and depressive symptoms in young Australian women? *Contraception* 2007; **75**: 27–31.

83 Rosenthal SL, Cotton S, Ready JN, Potter LS, Succop PA. Adolescents' attitudes and experiences regarding levonorgestrel 100 mcg/ethinyl estradiol 20 mcg. *J Pediatr Adolesc Gynecol* 2002; **15**: 301–305.

84 Joffe H, Cohen LS, Harlow BL. Impact of oral contraceptive pill use on prementrual mood: predictors of improvement and deterioration. *Am J Obstet Gynecol* 2003; **189**: 1523–1530.

85 Gupta N, O'Brien R, Jacobsen LJ, Davis A, Zuckerman A, Supran S, *et al.* Mood changes in adolescents using depot-medroxyprogesterone acetate for contraception: a prospective study. *J Pediatr Adolesc Gynecol* 2001; **14**: 71–76.

86 Barnhart KT, Schreiber CA. Return to fertility following discontinuation of oral contraceptives. *Fertil Steril* 2009; **91**: 659–663.

87 Faculty of Sexual and Reproductive Health Care. *The Management of Unscheduled Bleeding in Women Using Hormonal Contraception.* 2009. http://www.fsrh.org/admin/uploads/UnscheduledBleedingMay09.pdf [Accessed 16 February 2010].

88 National Institute for Health and Clinical Excellence. *Heavy Menstrual Bleeding* (NICE Clinical Guideline 44). 2007. http://www.nice.org.uk/nicemedia/pdf/CG44NICEGuideline.pdf [Accessed 16 February 2010].

89 Wong CL, Farquhar C, Roberts H, Proctor M. Oral contraceptive pill as treatment for primary dymenorrhoea. *Cochrane Database Syst Rev* 2009; **2**: CD002120.

90 Vercellini P, Frontino G, De Giorgi O, Aimi G, Zaina B, Crosignani PG. Comparison of a levonorgestrel-releasing intrauterine device versus expectant management after conservative surgery for symptomatic endometriosis: a pilot study. *Fertil Steril* 2003; **80**: 305–309.

91 Abou-Setta AM, Al-Inany HG. Levonorgestrel-releasing intrauterine device (LNG-IUD) for symptomatic endometriosis following surgery. *Cochrane Database Syst Rev* 2006; **4**: CD005072.

92 Sheng J, Zhang WY, Zhang JP, Lu D. The LNG-IUS study on adenomyosis: a 3-year follow-up study on the efficacy and side effects of the use of the levonorgestrel intrauterine system for the treatment of dysmenorrhoea associated with adenomyosis. *Contraception* 2009; **79**: 189–193.

93 Scholes D, Lacroix AZ, Ichikawa LE, Barlow WE, Ott SM. Change in bone mineral density among adolescent women using and discontinuing depot medroxyproegesterone acetate contraception. *Arch Pediatr Adolesc Med* 2005; **159**: 139–144.

94 Beksinska ME, Kleinschmidt I, Smit JA, Farley TMM. Bone mineral desnity in adolsecents using norethisterone enanthate, depot-medroxyprogesterone acetate or combined oral contraceptives for contraception. *Contraception* 2007; **75**: 438–443.

95 Scholes D, La Croix AZ, Ichikawa LE, Barlow WE. The association between depot medroxyprogesterone acetate contraception and bone mineral density in adolescent women. *Contraception* 2004; **69**: 99–104.

96 Hartard M, Kleinmond C, Wiseman M, Weissenbacher ER, Felsenberg D, Erben GR. Detrimental effect of oral contraceptives on parameters of bone mass and geometry in a cohort of 248 young women. *Bone* 2007; **40**: 444–450.

97 Cromer BA, Bonny AE, Stager M, Lazebnik R., Rome E, Ziegler J, *et al.* Bone mineral density in adolescent females using injectable or oral contraceptives: a 24-month prospective study. *Fertil Steril* 2008; **90**: 2060–2067.

98 Cromer BA, McArdle Blair J, Mahan J, Zibners L, Naumovski Z. A prospective comparison of bone density in adolscent girls receiving depot medroxyprogesterone acetate (Depo-Provera), levonorgestrel (Norplant), or oral contraceptives. *J Pediatr* 1996; **129**: 671–675.

99 Scholes D, La Croix AZ, Ott SM, Ichikawa LE, Barlow WE. Bone mineral density in women using depot medroxyprogesterone acetate for contraception. *Obstet Gynecol* 1999; **93**: 233–238.

100 Busen NH, Britt RB, Rianon N. Bone mineral density in a cohort of adolescent women using depot medroxyprogesterone acetate for one to two years. *J Adolesc Health* 2003; **32**: 257–259.

101 Edwards CP, Hertweck SP, Perlman SE, Goldsmith LJ, Sanfilippo JS. A prospective study evaluating the effects of depo provera on bone mineral density in adolescent females: a preliminary report. *J Pediatr Adolesc Gynecol* 1998; **11**: 201–210.

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102 Lopez LM, Grimes DA, Schulz KF, Curtis KM. Steroidal contraceptives: effect on bone fractures in women. *Cochrane Database System Rev* 2006; **4**: CD006033.

103 Hannaford P. The collection and interpretation of epidemiological data about the cardiovascular risks associated with the use of steroid contraceptives. *Contraception* 1998; **57**: 137–142.

104 Jick H, Kaye JA, Vasilakis-Scaramozza C, Jick SS. Risk of venous thromboembolism among users of third generation oral contraceptives compared with users of oral contraceptives with levonorgestrel before and after 1995: cohort and case-control analysis. *BMJ 2000*; **321**: 1190–1195.

105 Jick SS, Kaye JA, Russmann S, Jick H. Risk of nonfatal venous thromboembolism with oral contraceptives containing norgestimate or desogestrel compared with oral contraceptives containing levonorgestrel. *Contraception* 2006; **73**: 566–570.

106 Dinger JC, Heinemann LAJ, Kuhl-Habichl D. The safety of drospirenone-containing oral contraceptive: final results from the European Active Surveillance Study on oral contraceptives based on 142,475 women-years of observation. *Contraception* 2007; **75**: 344–354.

107 Lidegaard O, Lokkegaard E, Svendsen AL, Agger C. Hormonal contraception and risk of venous thromboembolism: national follow-up study. *BMJ* 2009; **339**: b2890.

108 van Hylckama Vlieg A, Helmerhorst FM, Vandenbroucke JP, Doggen CJ, Rosendaal FR. The venous thrombotic risk of oral contraceptives, effects of oestrogen dose and progestogen type: results of the MEGA case-control study. *BMJ* 2009; **339**: b2921.

109 World Health Organization. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception. Venous thromboembolic disease and and combined contraceptives: results of international multicentre case-control study. *Lancet* 1995; **346**: 1575–1582.

110 Gupta S, Hannaford P. Combined oral contraceptives – myocardial infarction, stroke and venous thromboembolism. *J Fam Plann Reprod Health Care* 1999; Review No. 99/01 (insert distributed with the journal).

111 Walker AM. Newer oral contraceptives and the risk of venous thromboembolism. *Contraception* 1998; **57**: 169–181.

112 Dinger J. Oral contraceptives and venous thromboembolism: old questions revisited. *J Fam Plann Reprod Health Care* 2009; **35**: 211–213.

113 Cole JA, Norman H, Doherty M, Walker AM. Venous thromboembolism, myocardial infaction, and stroke among transdermal contraceptive system users. *Am J Obstet Gynecol* 2007; **109**: 339–346.

114 Jick S, Kaye JA, Li L, Jick H. Further results on the risk of nonfatal venous thromboemolism in users of the contraceptive transdermal patch compared to users of oral contraceptive containing norgestimate and 35 ug of ethinyl estradiol. *Contraception* 2007; **76**: 4–7.

115 Faculty of Sexual and Reproductive Health Care Clinical Effectiveness Unit. *New Product Review: Combined Vaginal Ring (NuvaRing®)*. 2009. http://www.fsrh.org/admin/uploads/NuvaringProductReview240309.pdf [Accessed 16 February 2010].

116 World Health Organization. Cardiovascular disease and use of oral and injectable progestagen only contraceptives and combine injectable contraceptives. Results of an international, multicentre, case control study. *Contraception* 1998; **57**: 315–324.

117 National Institute for Health and Clinical Excellence (NICE). *Venous Thromboembolism: Reducing the Risk of Venous Thromboembolism (Deep Vein Thrombosis and Pulmonary Embolism) in Patients Admitted to Hospital.* (Guideline 92). 2010. http://www.nice.org.uk/nicemedia/pdf/CG92FullGuideline.pdf [Accessed 16 February 2010].

118 Scottish Intercollegiate Guideline Network (SIGN) Guideline. *Prophylaxis for Venous Thromboembolism: A National Clinical Guideline.* Edinburgh, UK: SIGN, 2002.

119 Hannaford PC, Selvaraj S, Elliot AM, Angus V, Iversen L, Lee AJ. Cancer risk among users of oral contraceptive: cohort data from the Royal College of General Practitioner's oral contraceptive study. *BMJ* 2007; **335**: 651.

120 Ness RB, Grisso JA, Klapper J, Schlesselman JJ, Silberzweig S, Vergona R, *et al*. Risk of ovarian cancer in relation to estrogen and progestin dose and use characteristics of oral contraceptives. *Am J Epidemiol* 2000; **152**: 233–241.

121 Vessey M, Painter R. Oral contraceptive use and cancer. Findings in a large cohort study, 1968–2004. *Br J Cancer* 2006; **95**: 385–389.

122 International Agency for Research on Cancer. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Combined Estrogen-Progestogen Contraceptives* (Volume 91). 2005. http://www-cie.iarc.fr/htdocs/monographs/vol91-91-contraceptives.pdf [Accessed 16 February 2010].

123 Lurie G, Wilkens LR, Thompson PJ, McDuffie KE, Carney ME, Terada KY. Combined oral contraceptive use and epithelial ovarian cancer risk: time-related effects. *Epidemiology* 2008; **19**: 237–243.

124 Lurie G, Thompson P, McDuffie KE, Carney ME, Terada KY, Goodman MT. Association of estrogen and progestin potency of oral contraceptive with ovarian carcinoma risk. *Obstet Gynecol* 2007; **109**: 597–607.

125 Collabortative Group on Epidemiological Studies of Ovarian Cancer. Ovarian cancer and oral contraceptives: collaborative reanalysis of data from 45 epidemiological studies including 23 257 women with ovarian cancer and 87 303 controls. *Lancet* 2008; **371**: 303–314.

126 Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast caner and 100 239 women without breast cancer from 54 epidemiological studies. *Lancet* 1996; **347**: 1713–1727.

127 Marchbanks PA, McDonald JA, Wilson HG, Folger SG, Mandel MG, Daling JR, *et al.* Oral contraceptives and the risk of breast cancer. *N Engl J Med* 2002; **346**: 2025–2032.

128 Moreno V. Oral contraceptives and cervical cancer. *Lancet* 2002; **360**: 409.

129 International Collabortation of Epidemiological Studies of Cervical Cancer. Cervical cancer and hormonal contraceptives: collaborative renalysis of individual data for 16573 women with cervical cancer and 35509 women without cervical cancer from 24 epidemiological studies. *Lancet* 2007; **370**: 1609–1620.

130 Vanakankovit N, Taneepanichskul S. Effects of oral contraceptives on risk of cervical cancer. *J Med Assoc Thai* 2008; **91**: 7–12.

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131 Moreno V, Bosch FX, Munoz N. Effects of oral contraceptives on risk of cervical cancer in women with human papilloma virus infection: the IARC multicentric case-control study. *Lancet* 2002; **399**: 1085–1092.
132 Chilvers CE. Depot medroxyprogesterone acetate and breast cancer. A review of current knowledge. *Drug Saf 1996*; **15**: 212–218.
133 Shapiro S, Rosenberg L, Hoffman M, Truter H, Cooper D, Rao S, *et al.* Risk of breast cancer in relation to the use of injectable progestogen contraceptives and combined estrogen/progestogen contraceptives. *Am J Epidemiol* 2000; **151**: 396–403.
134 Skegg DC, Noonan EA, Paul C, Spears GF, Meirik O, Thomas DB. Depot medroxyprogesterone acetate and breast cancer. A pooled analysis of the World Health Organization and New Zealand studies. *JAMA* 1995; **273**: 799–804.
135 McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. *Contraception* 1994; **50**: S159–S188.
136 British Association for Sexual Health and HIV (BASHH). *United Kingdom National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People*. 2009. http://www.bashh.org/documents/2275 [Accessed 16 February 2010].
137 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Male and female condoms. *J Fam Plann Reprod Health Care* 2007; **7**: 1–16.
138 Fisher M, Benn P, Evans B, Pozniak A, Jones M, MacLean S, *et al*. BASHH Guideline: UK Guideline for the use of post-exposure prophylaxis for HIV following sexual exposure. *Int J STD AIDS* 2006; **17**: 81–92.
139 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Drug interactions with hormonal contraception. J Fam Plann Reprod Health Care 2005; 31: 139–150
140 Faculty of Sexual & Reproductive Healthcare. *Quick Starting Contraception.* 2017. https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/quick-starting-contraception
141 European Medicines Agency. Press release: Benefits of combined hormonal contraceptives (CHCs) continue to outweigh risks. 2013. https://www.ema.europa.eu/en/news/benefits-combined-hormonal-contraceptives-chcs-continue-outweigh-risks-chmp-endorses-prachormonal_contraceptives/European_Commission_final_decision/WC500160277.pdf

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APPENDIX 1: DEVELOPMENT OF CEU GUIDANCE

GUIDELINE DEVELOPMENT GROUP

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Written feedback was provided by **Kenneth Norrie**, Professor of Law, Strathclyde University; **Shirley M Fraser**, Health Improvement Programme Manager, NHS Health Scotland; and **Josh, Stephanie, Amanda, Sinead** and **Ryan** from The Big Shout ER Youth Group.

INDEPENDENT PEER REVIEWERS

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Dr McCormack has been involved in training and meetings supported by Bayer Schering Pharma and Schering Plough. No other competing interests were noted by members of the multidisciplinary group. Administrative support to the CEU team was provided by **Ms Janice Paterson.**

CEU Guidance is developed in collaboration with the Clinical Effectiveness Committee of the FSRH. The CEU Guidance development process employs standard methodology and makes use of systematic literature review and a multidisciplinary group of professionals. The multidisciplinary group is identified by the CEU for their expertise in the topic area and typically includes clinicians working in family planning, sexual and reproductive health care, general practice, other allied specialities, and user representation. In addition, the aim is to include a representative from the FSRH Clinical Effectiveness Committee, the FSRH Education Committee and FSRH Council in the multidisciplinary group.

Evidence is identified using a systematic literature review and electronic searches are performed for: MEDLINE (CD Ovid version) (1996–2009); EMBASE (1996–2009); PubMed (1996–2009); The Cochrane Library (to 2009) and the US National Guideline Clearing House. The searches are performed using relevant medical subject headings (MeSH), terms and text words. The Cochrane Library is searched for systematic reviews, meta-analyses and controlled trials relevant to contraceptive choices for young people. Previously existing guidelines from the FSRH (formerly the Faculty of Family Planning and Reproductive Health Care), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO) and the British Association for Sexual Health and HIV (BASHH), and reference lists of identified publications, are also searched. Similar search strategies have been used in the development of other national guidelines. Selected key publications are appraised using standard methodological checklists similar to those used by the National Institute for Health and Clinical Excellence (NICE). All papers are graded according to the Grades of Recommendations Assessment, Development and Evaluation (GRADE) system. Recommendations are graded as in the table on the inside front cover of this document using a scheme similar to that adopted by the RCOG and other guideline development organisations. The clinical recommendations within this guidance are based on evidence whenever possible. Summary evidence tables are available on request from the CEU. An outline of the guideline development process is given in the table on the inside back cover of this guidance document.

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APPENDIX 2: USEFUL SOURCES OF INFORMATION

Legislation

1 Northen Ireland Office. The Sexual Offences (Northen Ireland) Order 2008. 2009. Report No. 1769
http://www.opsi.gov.uk/si/si2008/uksi_20081769_en_1
2 Office of Public Sector Information. Sexual Offences Act 2003
http://www.opsi.gov.uk/acts/acts2003-30042--b.htm
3 Criminal Law (Consolidation) (Scotland) Act 1995 (c.39) Part I Sexual Offences. The Stationery Office, 2004
http://www.opsi.gov.uk/acts/acts1995/ukpga_19950039_en_1
4 Age of Legal Capacity (Scotland) Act 1991
http://www.opsi.gov.uk/acts/acts1991/ukpga_19910050_en_1
5 Adults with Incapacity (Scotland) Act 2000
http://www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1

Guidance Covering Ethics, Consent, Confidentiality and Safeguarding

1 General Medical Council (GMC). *0–18 Years: Guidance for All Doctors*
http://www.gmc-uk.org/guidance/archive/GMC_0-18.pdf
2 General Medical Council (GMC). *Confidentiality*
http://www.gmcuk.org/guidance/current/library/confidentiality.asp#6
3 British Medical Association (BMA). *Consent Toolkit* (4th edn). 2008
http://www.bma.org.uk/images/ ConsentToolKit2008_tcm41-175551.pdf
4 British Medical Association (BMA). *A BMA Statement on Information Sharing in Relation to Sexually Active Young People*. 2008
http://www.bma.org.uk/images/responsetoworkingtogether2008_tcm41-183775.pdf
5 HM Government. *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children*. 2006
http://www.everychildmatters.gov.uk/_files/ AE53C8F9D7AEB1B23E403514A6C1B17D.pdf
6 Royal College of General Practitioners and the National Society for the Prevention of Cruelty to Children (NSPCC). *Safeguarding Children and Young People in General Practice*
http://www.rcgp.org.uk/PDF/CIR_Toolkit%20document%20final%20edit.pdf
7 Scottish Government. *Framework for Standards for Professionals for Child Protection*. 2004 (modified 2006)
http://www.scotland.gov.uk/Resource/Doc/1181/0008818.pdf
8 Department of Health. *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*. 2004
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960

Service Standards

1 Department of Health. *You're Welcome Quality Criteria: Making Health Services Young People Friendly*. 2005
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121562
2 NHS Quality Improvement Scotland. *Sexual Health Services Standards*. 2008
http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MAR08.pdf
3 Faculty of Family Planning and Reproductive Health Care. *Service Standards for Record Keeping*. 2005
http://www.fsrh.org/admin/uploads/ServiceStandardsRecordKeeping.pdf

Pregnancy and Sexually Transmitted Infection Statistics

1 Teenage Pregnancy Unit
http://www.everychildmatters.gov.uk/teenagepregnancy
2 Information Services Division (ISD) Scotland (teenage pregnancy)
http://www.isdscotland.org/isd/2071.html
3 Health Protection Scotland
http://www.hps.scot.nhs.uk/
4 Health Protection Agency
http://www.hpa.org.uk/
5 General Registrar Office (Northern Ireland)
http://www.nisra.gov.uk/archive/demography/publications/annual_reports/2007/RG2007.pdf

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APPENDIX 3: KEY LEGISLATION AND GUIDANCE*

Refer to **General Medical Council (GMC) guidelines, "0–18 Years: Guidance for All Doctors"**, for full summary and references and www.opsi.gov.uk. The Scottish law on sexual offences was revised in 2009 and is awaiting implementation.

- **The Sexual Offences Act 2003 (England and Wales).** Under the Sexual Offences Act 2003, sexual activity under 16 years old is illegal. Those under the age of 13 years are deemed not capable of giving consent to sexual intercourse, and such sexual activity is therefore rape. The Act states that sexual health care providers are protecting a child if they are preventing sexually transmitted infections (STIs) or pregnancy, whether children are under 16 years or under 13 years old.

- **Fraser Guidelines** (Box 2). (NB. Guidelines do not apply in Scotland.) According to the ruling of Lord Fraser (Gillick vs West Norfolk and Wisbech AHA & DHSS 1985), young people under the age of 16 years can consent to medical treatment if they have sufficient maturity and judgement to enable them fully to understand what is proposed. In Northern Ireland, although separate legislation applies, the Department of Health and Social Services Northern Ireland stated that there was no reason to suppose that the House of Lords' decision would not be followed by the Northern Ireland Courts. The Fraser Guidelines specifically refer to consent for contraception, but the principles in England and Wales are deemed to apply to other medical care (Gillick competence). If someone under 16 years is not judged mature enough to consent to treatment, the consultation itself can still remain confidential. The Axon ruling also upholds this right of young people.

- **The Age of Legal Capacity (Scotland) Act 1991.** In Scotland, competence is determined by the Age of Legal Capacity (Scotland) Act. According to section 2(4), individuals under the age of 16 years have legal capacity to consent on their own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner, the individual is capable of understanding the nature and possible consequences of the procedure or treatment.

- **"Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment for Young People Under 16 on Contraception, Sexual and Reproductive Health"** produced by the Department of Health in 2004 upholds the right of young people to confidentiality.

- **"Working Together to Safeguard Children"** paragraph 5.8 indicates the need to consider child sexual abuse in those under-18-year-olds who are sexually active, and perform a risk assessment on under-16-year-olds. It states that there is a presumption of reporting under-13s to social services and the police. There is no mandatory reporting even for under-13s. All cases should be looked at individually. Local safeguarding children boards (LSCBs) should produce local guidelines based on this.

- **"Safeguarding Children and Young People from Sexual Exploitation. Supplementary Guidance to Working Together to Safeguard Children"** provides extra advice where exploitation is detected.

- **NHS (Venereal Disease) Regulations 1974 and NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000.** This prevents disclosure about anyone examined or treated for an STI except for the treatment or prevention of an STI. A government consultation on this is currently being undertaken.

*Adapted from BASHH Guidance[136] with kind permission.

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APPENDIX 4: SUGGESTIONS FOR HISTORY TAKING

History	Questions to consider
Social history	Do you attend school or college or are you working? Who do you get support or advice from? Who lives at home? Does (Do) your parent(s)/carer(s) know you have come here? Does (Do) your parent(s)/carer(s) know you are having sex and will you tell them? Do you have any problems at home? Do you have problems at school/college/work (e.g. bullying or stress)? What are your preferences for contraception? What do your friends use? How good do you think you might be at remembering pills? Have you had any problems in the past with using a particular contraceptive? Do you use or know how to access condoms Have you ever had sex (oral, anal, vaginal) without condoms or any other method of contraception?
General Health	Enquire about prescription medications, drug use: smoking, alcohol use, non-prescription drugs, diet, and physical activity levels Do you have any health concerns? Do you have health concerns relating to contraceptive use? Have you had the human papillomavirus (HPV) vaccination? Are you aware of local health services for young people?
Family history	Enquire about any significant medical problems (e.g. heart disease, diabetes, venous thromboembolism)
Sexual and reproductive health	What age were you when you started your periods? When did you last have a period? Was it normal for you? Do you have any problems with your periods or irregular bleeding? Have you ever been pregnant? Have you previously had an abortion or miscarriage? Do you have a partner or partners at the moment? Is your relationship with your partner(s) casual/regular/long-term (steady)? What gender is/are your partner(s)? How old is (are) your partner(s)? How long have you been with your partner(s)? How well do you know your partner? Where did you meet your partner? Do you or your partner have other partners? Does your partner ever frighten you? Have you ever had vaginal, oral (mouth to genital contact) or anal sex (penetration of back passage) or are you thinking about it? Do you feel ready to have sex? Do you feel you would be able to say no if you did not feel it was the right time? Have you thought about the consequences of sexual activity: pregnancy, sexually transmitted infections (STIs)? Have you ever had an STI or been tested for STIs? Have you ever been forced to have sex? Have any of your partners ever rewarded you with items such as clothes, food, cigarettes, money, alcohol or drugs for having sex with them?

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APPENDIX 5: FAILURE RATES OF CONTRACEPTIVE METHODS

Percentage of women experiencing an unintended pregnancy within the first year of use with typical use and perfect use (modified from Trussell)[34]

Method	Typical use (%) (estimated)	Perfect use (%)
No method	85	85
Fertility awareness-based methods	24	0.4–5
Female diaphragm	12	6
Male condom	18	2
Combined hormonal contraception*	9	0.3
Progestogen-only pill	9	0.3
Progestogen-only injectable	6	0.2
Copper intrauterine device	**0.8**	**0.6**
Levonorgestrel intrauterine system	**0.2**	**0.2**
Progestogen-only implant	**0.05**	**0.05**
Female sterilisation	**0.5**	**0.5**
Vasectomy	0.15	0.1

Long-acting reversible contraception/contraceptive methods in bold type.
*Includes combined oral contraception, transdermal patch and vaginal ring.

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Discussion Points for Contraceptive Choices for Young People

The following discussion points have been developed by the FSRH Education Committee.

Discussion Points

1 A 13-year-old girl attends clinic asking for contraception advice. She is having consensual intercourse with her regular boyfriend also aged 13 years:
(a) What are the issues to consider?
(b) Would this differ if the girlfriend was 12 years old?
(c) Would this differ if the boyfriend was 16 years old?

2 How can we encourage increased uptake of long-acting reversible contraception (LARC) methods among young people?

3 Should emergency contraception be available in schools?

Questions for Contraceptive Choices for Young People

The following questions and answers have been developed by the FSRH Education Committee.

Indicate your answer by ticking the appropriate box for each question	***True***	***False***
1 By the age of 16 years approximately one in five young people have had sexual intercourse.	☐	☐
2 Condoms are not necessary if intercourse is pre-menarche.	☐	☐
3 Administration of progestogen-only emergency contraception (POEC) between 72 and 120 hours for emergency contraception (ED) is outside the terms of the product licence.	☐	☐
4 If a young person attends for EC within 72 hours of unprotected sexual intercourse (UPSI), it would be inappropriate to fit a copper-bearing intrauterine device.	☐	☐
5 Advanced provision of EC has not been shown to reduce the unintended pregnancy rate.	☐	☐
6 There is no clear evidence that combined oral contraception affects body weight.	☐	☐
7 If confidentiality is to be breached, the consent of the young person is required.	☐	☐
8 Use of depot medroxyprogesterone acetate is contraindicated in young people aged <18 years (UKMEC 3) due to concerns about bone mineral density.	☐	☐
9 Young people accounted for 65% of the chlamydia cases diagnosed in UK genitourinary medicine clinics in 2007.	☐	☐
10 Young people may be offered sexually transmitted infection screening immediately after UPSI or condom failure.	☐	☐

Answers

1 False
2 False
3 True
4 False
5 True
6 True
7 False
8 False
9 True
10 True

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STEPS INVOLVED IN THE DEVELOPMENT OF CEU GUIDANCE

STEP	TIME TAKEN
Formulation of **key clinical questions** by the Clinical Effectiveness Unit (CEU). **Systematic literature review** involving searching electronic, bibliographic databases by CEU researcher. **Obtaining and reviewing** copies of the full papers of all relevant publications identified through the searches. **Formal, critical appraisal** of key papers and development of short evidence tables.	This process must be completed in a maximum of 8 weeks.
Draft one guidance document is written providing recommendations and good practice points based on the literature review.	The CEU has overall responsibility for writing the guidance document. The multidisciplinary group and other peer reviewers should highlight inconsistencies, errors, omissions or lack of clarity.
Peer review by multidisciplinary group comprising stakeholders and including service user representation; representation from the Faculty of Sexual and Reproductive Healthcare (FSRH) Education Committee; and where possible representation from the FSRH Clinical Effectiveness Committee (CEC) and FSRH Council.	
Preparation of draft two guidance document based on written comments of peer reviewers.	
Multidisciplinary group meet to discuss draft two.	A one-day meeting of the multidisciplinary group is held to discuss draft two.
Preparation of draft three based on discussion at the multidisciplinary group meeting.	
Peer review of draft three by the multidisciplinary group, the FSRH CEC and two independent peer reviewers.	
Preparation of draft four based on written comments.	
Draft four is prepared and is sent to the multidisciplinary group, FSRH CEC and independent peer reviewers.	Minor comments can be accepted at this stage.
Final guidance document published by the FSRH.	Proofreading of guidance document by three members of the CEU team independently. Comments collated by the Unit Director. A pdf version of the guidance is available on the FSRH website.

COMMENTS AND FEEDBACK ON PUBLISHED GUIDANCE

All comments on published this guideline can be sent directly to the Clinical Effectiveness Unit (CEU) of the Faculty of Sexual & Reproductive Healthcare (FSRH) via the FSRH website (www.fsrh.org).

The CEU may not respond individually to all feedback. However, the CEU will review all comments and provide an anonymised summary of comments and responses, which are reviewed by the Clinical Effectiveness Committee (CEC) and any necessary amendments made subsequently.

www.fsrh.org