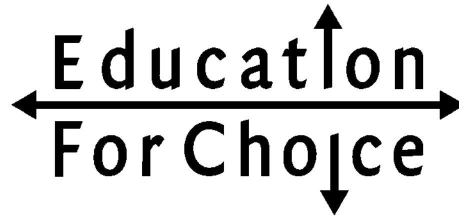

REDUCING REPEAT TEENAGE CONCEPTIONS: A REVIEW OF PRACTICE

By Lisa Hallgarten and Natalie Misaljevich
2007

Commissioned by the Teenage Pregnancy Partnership in Hackney and the City

www.efc.org.uk

REDUCING REPEAT CONCEPTIONS:
A REVIEW OF PRACTICE

CONTENTS

CHAPTER 1: REPORT SNAPSHOT
Aims 1
Executive Summary 1
Summary of Recommendations 2
Method 3

CHAPTER 2: TEENAGE CONCEPTIONS AND MATERNITIES 4
Reducing teenage conceptions 4
Maternity and repeat maternity 4
Looked After Children and Care Leavers 5
Case Study: Community personal advisor, Connexions, South West England 5

CHAPTER 3: ABORTION 7
Repeat abortion 7
Circumstances in which repeat abortion takes place 7
Physical risks of abortion 8
Psychological risks of abortion 8
Political context

CHAPTER 4: DECISION MAKING AND COUNSELLING 10
Pregnancy decision-making 10
Abortion counselling 10
Maternity counselling 11
Recommendations: counselling and support 12

CHAPTER 5: CONTRACEPTION 13
Contraception at time of abortion/maternity 13
Long Acting Reversible Contraception 13
– Problems initiating its use 14
– Problems maintaining its use 15
– Case study: youth worker, Connexions, Leeds 15
– Some possible approaches to overcoming obstacles to uptake and maintenance of LARC 15
Case Study: South Tyneside 16

CHAPTER 6: EMERGENCY CONTRACEPTION 19
Emergency Hormonal Contraception 19
Emergency contraception: use of the intrauterine device 21
Emergency contraception and sexually transmitted infections 21
Recommendations: contraceptive provision (inc. EC and LARC) 22

CHAPTER 7: SERVICES 23
Information and audits 23
NHS/Independent sector abortion provision and central booking arrangements 23
Recommendations: Commisioning and monitoring: a borough-wide approach 24
Having a key worker and champion 24
Recommendations: Champion 25

CHAPTER 8: INFORMATION AND EDUCATION 26
Information and Sex and Relationships Education (SRE) issues 26
Recommendations: SRE 28
Information and education about parenting 28
Recommendations: Parenting education 29
General information 29

CHAPTER 9: CULTURE AND ETHNICITY 30
Menstruation 30
Contraception 30
Maternity 30
Abortion 30
Asylum seekers 31
Female Genital Mutilation 31

FURTHER INFORMATION 34
Questions arising from the report for further investigation 34

ACKNOWLEDGMENTS 34

FOOTNOTES 35

APPENDICES

Aims

This report looks at some of the practical strategies currently being employed around the country to address repeat conceptions amongst young women following maternity and abortion. It also explores the assumption that repeat conceptions are mainly caused by shortfalls in contraceptive provision; and the scientific evidence, in addition to the political context for the efforts of health professionals to reduce the repeat abortion rate. A series of recommendations for local teenage pregnancy partnerships to consider are also provided. Funding for this report was provided to Education For Choice by the Teenage Pregnancy Partnership in Hackney and the City from the local implementation grant for teenage pregnancy. The report was commissioned to inform work undertaken as part of the Teenage Health Demonstration Site programme funded by the Department of Health.

Executive Summary

Providing intensive support can help young women to decide and implement a contraceptive plan in advance of, and following, maternity and abortion. It can help them to maintain consistent use of a reliable contraceptive method and so avoid unintended conceptions and repeat abortions. Those areas which have one key worker championing this work report success in reducing second and subsequent conceptions.

However, for the most vulnerable young women, the availability of contraception is not always enough. There are many reasons that women of all ages struggle to control their fertility. Some of these are beyond the remit or capacity of those working in sexual and reproductive health services. A young woman experiencing serial unwanted pregnancies should indicate to sexual health workers that there may be problems in other areas of her life. It is an opportunity to identify those vulnerable to multiple risks and there need to be clear referral pathways to other specialist services where the young person can access expert support and advice.

Long Acting Reversible Contraception (LARC) is not a panacea. It is not acceptable to all women. It is important for health professionals to understand young women's resistance to choosing long acting methods or, having chosen them, to maintaining their use over a long period of time. Better information about all contraceptive methods delivered as part of Sex and Relationships Education (SRE), and better counselling of possible side-effects and remedies before implementing LARC use, increases acceptability and maintenance of methods.

Good quality SRE has a key role to play in preventing unintended pregnancy by developing decision making and negotiation skills, providing accurate information, and dispelling myths around contraception, fertility and pregnancy. These myths can prevent young women from choosing and using reliable contraceptive methods in general, and following maternity and abortion specifically. Most professionals would like to see provision of contraceptive advice and supplies on-site in schools and colleges to ensure easier access to contraceptive services for young people.

The provision of education, support and contraceptive services which are identified as necessary to prevent second and subsequent unintended conceptions, are relevant to all young women. In a context in which self-reporting, rather than medical records is the main source of information for health professionals about a woman's previous abortion history, it may not be useful to assume that a young women is presenting with her first pregnancy.

Some women do not perceive having a second or higher order abortion as a problem. Those providing education, information and abortion services need to consider the most effective way to work with these women to promote consistent contraceptive use generally, without stigmatising their choice to have an abortion in the case of a particular pregnancy.

Strategies aimed at reducing repeat abortions do not aim to reduce the proportion of teenage conceptions ending in abortion and should not be implemented at the expense of efforts to reduce teenage maternities. Their aim should be to develop the skills and the remit of those working in a range of health and youth settings to create every possible opportunity to help young women to prevent all unintended conceptions and to initiate and maintain effective contraceptive use immediately following abortion and delivery.

Summary of Recommendations

Strategic & commissioning level:

- Implement a borough-wide strategy including coherent referral pathways with good local buy-in from relevant agencies.
- Identify a local champion to promote comprehensive contraceptive counselling for young people in maternity and abortion services.
- Commission NHS and independent abortion providers to work to consistent protocols on: the provision of contraception, record keeping and reporting.

Education level:

- Provide good quality SRE including evidence-based information, tailored for young people and covering all forms of contraception and pregnancy choices including abortion.
- Develop young people's skills to predict outcomes and consequences in order to enable decision-making.
- Address anxieties about fertility generally and after maternity/abortion specifically within SRE
- Include practical interventions such as the use of peer educators to promote the use of LARC and video footage of implant fittings to familiarise young people with the treatment.

Service level—support:

- Provide workforce training to ensure support for pregnancy decision-making in health and non-health settings.
- Include contraceptive planning within pregnancy decision-making support and ensure that a decision to abort, or go to term, is informed, not ambivalent and made without pressure or coercion.
- Include strategies to address the specific needs of looked after children in relation to decision-making about their sexual and reproductive health.

Service level—contraception:

- Provide intensive one-to-one contraceptive support to all young women pre and post maternity and abortion (provided in clinic, outreach and domiciliary settings).
- Develop Patient Group Directives to allow community midwives, gynaecology nurses and other nurses working with young people to prescribe and fit all contraceptive methods.
- Provide Emergency Hormonal Contraception in advance for those young women who rely primarily on the oral contraceptive pill or condoms for contraception.
- Make all methods of contraception available specifically at the time of abortion or maternity; and in all sexual and reproductive healthcare settings (including GUM clinics, family planning clinics etc.)
- Provide workforce training on how to counsel effectively on the side-effects of Long Acting Reversible Contraception (addressing concerns about weight gain and changes in menstrual patterns in particular).
- Provide and promote treatment for the side-effects of LARC.

METHOD
In order to look at the causes of and approaches to repeat conceptions and repeat abortions we sent questionnaires to a sample of professionals from health, youth work, social work and education who had participated in Education For Choice (EFC) training courses in the previous year.

We held in-depth interviews with 15 people working strategically in the planning and commissioning of services and on the ground with young people, in sexual health, maternity and abortion services.

We spoke to workers from several geographical areas that have achieved large overall reductions in teenage conceptions over the years of the Teenage Pregnancy strategy including South Tyneside, Gateshead, Darlington, Walsall, Wandsworth, and Nottinghamshire. They were able to talk about their successes, the obstacles they have overcome and the obstacles remaining, and the role of addressing second and subsequent conceptions and abortion in bringing down overall figures. We also spoke to several workers in Lambeth and Southwark, areas closer to City and Hackney demographically than the others in the study. They were able to tell us about the many challenges they face, and their ideas for improving services and increasing the impact of their work to try to reduce unintended conceptions. Finally, we spoke to several workers from City and Hackney who were able to talk about existing provision as well as ideas for development and improvement.

We drew on the lessons we have learned from listening to the experiences of the 2,000 professionals we have trained and the 15,000 young people we have worked with in the past four years.

We reviewed some of the literature on repeat abortion, sexual behaviour and contraception following abortion and maternity from the UK, Europe and North America and identified key points from relevant guidance on aspects of contraceptive provision.

This study was not designed to provide quantitative evidence, but to identify common themes, to share good practice and offer practical solutions.

TEENAGE CONCEPTIONS AND MATERNITIES

REDUCING TEENAGE CONCEPTIONS

The Teenage Pregnancy Strategy was initiated because of evidence that there are health, social and economic benefits to delaying motherhood until beyond the teenage years.[1] Part of the strategy, therefore, focuses on preventing teenage conceptions. The teenage pregnancy unit calculates that 17% of under-18 conceptions are repeat conceptions, so addressing these is vital to bringing down overall conception rates. The strategy also supports teenage parents in order to address some of the risks of teenage parenthood e.g. isolation, lower educational attainment, poorer housing, poorer employment prospects, poorer health for mother and child…etc. There is concern that second and subsequent maternities can provide particular obstacles to participation by young mothers in those projects aimed at minimising these risks such as schemes to get them back into education, training and employment.

MATERNITY AND REPEAT MATERNITY

As with first conceptions, subsequent conceptions can be accidental – experienced by those using or intending to use contraception consistently and effectively and by those who don't positively plan to be pregnant, but take no action to prevent it. It is likely that many second or subsequent pregnancies are unplanned – a result of no change in behaviour, rather than an indication that a choice has been made. Ambivalence about maternity and/or resistance to abortion if accompanied by inaction will usually lead to maternity, and professionals express concern that some teenage maternities are the result of the lack of a decision, rather than a positive choice to become a mother or have another child. There is a common perception amongst young women that the impact of a second baby will be less because initial problems of housing and finance that a first pregnancy might raise are more likely to be partly resolved and the attitude of the young women is often one of 'why not?' When young women become pregnant many leave it to time to make the decision for them – i.e. the decision is taken out of their hands because they leave it too late for abortion to be an option.

For those positively intending to become pregnant, some of the reasons given for a positive attitude to pregnancy including repeat maternities are: a belief that it will help maintain the relationship with their partner and keep him from 'straying'; a desire to complete their family with the same partner, irrespective of whether or not the father actively parents their children (this is often due to the stigma associated with having children with more than one father); a desire to have a small age-gap between children; a belief that it will ensure better housing; wanting to do their parenting in one go so that it does not subsequently hinder efforts to gain training/employment…etc

There is widespread research evidence that young women's socio-economic status plays a part in the positive motivation to become pregnant or their choice to continue with an unintended pregnancy. This is especially true where lack of education and low aspiration are experienced in a social context within which maternity is the default for those experiencing unintended pregnancy and in which young motherhood is acceptable, expected or celebrated.[2] This is compounded by a real lack of opportunities for young people to make decisions as they grow up, such that when they need to make a life changing decision, they do not have the skills or experience to do so. This means that young women will often follow the expectations that others set for them – whether about education, a job, or pregnancy.

LOOKED AFTER CHILDREN AND CARE LEAVERS

In the majority of interviews and questionnaires, the particular vulnerability of those in care and leaving care to both unwanted and wanted conceptions was raised. For these young women managing and negotiating contraception within relationships on which they are reliant for affection and support can be extremely difficult. A fatalistic attitude of 'live life for the moment' and 'shit happens' can present an additional disincentive for contraceptive use.

Having a baby may also represent a perceived solution to many problems: an opportunity to have control over a decision and independence, something that may have been lacking in her life to date; potential prioritisation for housing; having 'someone to love' and to be loved by; an opportunity for reconciliation with an estranged parent; a way of guaranteeing the long term closeness and affection of the child's father; a way to recreate a healthy family life not experienced by the young woman in her own childhood…etc.

Several of our interviewees expressed concern at the sometimes unrealistic expectations these vulnerable young women were putting on the capacity of a baby to solve their problems. Furthermore, there is anxiety that when social workers try to help young women to try and look forward and predict the range of outcomes, positive and negative, if they were to continue with the pregnancy, the young women can experience this as, or perceive it to be, pressure to have an abortion. Better information and training for foster carers and social workers to provide non-directive pregnancy decision-making support was recommended by one interviewee. In Gateshead there is a written Looked After Children sexual health policy which includes mandatory training for Foster Carers and Social Workers which includes discussion of abortion. In another area social workers are encouraged, but not required, to attend sex and relationships training, and their take-up is patchy.

Case Study

Community personal advisor, Connexions, South West England

"Many young people I work with are in or leaving the 'care of the local authority'. Despite intense discussions and advice to make them aware and raise their aspirations they totally believe they can give this child the love and security that they themselves have not enjoyed. They may for numerous reasons have not felt allowed or it has been strongly suggested that they do not go through with a first conception, but this often only makes them more determined in subsequent pregnancies. This for some young people in care is their ultimate choice.

There is also the issue where young people are estranged from home and 'sofa surf' they are aware that to gain a home and some security that the council has a duty of care to provide accommodation for them and they become a priority case. Many look no further than this to the future when making decisions regarding conception.

J is a young person currently leaving care. She is involved with a much older man (early 40's) and has already experienced one abortion. She has told me she has also had a miscarriage. During our interviews she has revealed she has been actively trying to get pregnant for 18 months and even sought advice on the 'best ways' of ensuring conception.

J believes when eventually pregnant that Social Services will allow her to continue seeing this man and that he will want to live with her. The accommodation she is currently in means Social Services can dictate who stays over night. She also, as do many girls, believes that her mother will want to be involved in the baby's upbringing and the family will be reunited. She is desperately, in my opinion,

trying to get some control into her own life and make some of her own choices which she has in the past been unable to do."

REPEAT ABORTION

Given the difficulty of consistent, successful contraceptive use, the years in which a woman is sexually active, and small ideal family size, it is statistically likely that many women will experience multiple unintended pregnancies and choose to end one or more than one in abortion.[3] A woman's decision to end a pregnancy can be considered to be a reasonable and responsible decision in each case. Many health professionals accept that a woman might experience contraceptive failure several times in her reproductive life, resulting in having an abortion twice or more before reaching the menopause.

However, the professionals we spoke to specifically expressed concern about young women presenting for abortion twice or more in a short space of time. There was no consensus in those we spoke to on exactly what constitutes a problematic repeat abortion, with some basing their view on the period of time between each abortion, some by the age of the young woman, and others by the emotional or psychological state of the presenting woman. In general, though, incidents of repeat abortion can make health professionals feel anxious that they or the system have in some way failed the individual woman. This concern takes place in a context in which the social and medical consensus is that consistent contraceptive use is preferable to abortion as a primary method of family planning.

CIRCUMSTANCES IN WHICH REPEAT ABORTION TAKES PLACE

Most women requesting abortion report contraceptive failure as the cause of their pregnancy. 'Regardless of whether they were obtaining a first or repeat abortion, just over one-half of women had been using contraceptives when they became pregnant, and this lack of an association holds up after controlling for other factors. Adolescent women obtaining repeat abortion are, in fact, slightly more likely than first-time abortion patients to have become pregnant while using a hormonal method'. [4]

There is a reported prevalence of repeat abortion in some new immigrant communities e.g. Eastern European and Chinese, which has been attributed not only to contraceptive failure, a lack of knowledge about contraceptive methods or failure to access local contraceptive services, but also to a cultural acceptance of abortion as a primary means of birth control. However, in general, women in the UK are not consciously choosing to have unprotected sex with the intention of having an abortion in the event of pregnancy.

In addition to knowledge of contraception, contraceptive intention and ability to access contraceptive services, other factors can also impact on consistent and successful use of contraception by teenagers. The use of alcohol or drugs; a context of violence or sexual coercion; lack of support or cooperation from the partner for using contraception; lack of confidence and skills to negotiate condom use; a large age-gap or other inequality within the relationship such as economic dependence; a lack of self-esteem and self-care; a sense of fatalism; ambivalence about pregnancy; a desire to 'test-out' fertility…and more. Strategies for education and health provision are successfully addressing some of these issues and are promoting practical ways to encourage consistent contraceptive use within the context of 'chaotic' lifestyles. However, those most at risk of unintended pregnancy may have multiple problems in their lives and pregnancy may be considered by the young woman to be the least of her problems, as one interviewee put it, 'the symptom, not the cause, of the problem'.

PHYSICAL RISKS OF ABORTION

The Royal College of Obstetricians and Gynaecologists (RCOG) are clear that 'for most women an abortion is safer than carrying the pregnancy and having a baby. All medical and surgical procedures have risk, but the earlier in pregnancy you have an abortion, the safer it is.'[5] They go on to state that the risks associated with early abortion are small, though they increase steadily as the pregnancy progresses.[6] The greatest risks in early surgical abortion are those

associated with general anaesthesia which is commonly used – especially in NHS settings. However, the surgical procedure itself carries a small risk of infection, uterine perforation, cervical damage and excessive bleeding. The risks associated with early medical abortion are smaller still though a small proportion of medical abortions will be incomplete and will need to be completed surgically with the attendant risks. The risk of infection is addressed in most abortion services through the prescription of prophylactic antibiotics.[7]

Small as the risks are they are sufficient to support the medical consensus that a reliable contraceptive method used correctly and consistently (backed up by emergency contraception) is preferable to abortion or repeated use of abortion as a primary method of birth control.

PSYCHOLOGICAL RISKS OF ABORTION

A review of existing literature was carried out by Dagg (2007), in relation to both the psychological sequelae of abortion and the sequelae for the mother and the child when abortion was denied. He concluded: "Adverse sequelae occur in a minority of women, and when such symptoms occur, they usually seem to be the continuation of symptoms that appeared before the abortion and are on the wane immediately after the abortion. Many women denied abortion show ongoing resentment that may last for years".[8]

'For the small minority of women who experience long-term post-abortion distress… risk factors are ambivalence before the abortion, lack of a supportive partner, a psychiatric history or membership of a cultural group that considers abortion to be wrong.'[9]

Several professionals reported that regret following an abortion, about which there was ambivalence at the time, can precipitate a speedy subsequent conception. This underlines the need for adequate pregnancy decision-making support to ensure that the individual woman is clear and confident that the decision she is making is the right one for her.

POLITICAL CONTEXT

A common anxiety of society is that women might 'use abortion as contraception'. This reflects not only legitimate medical concerns relating to relative risks, but also the moral and political consensus on abortion. Though the vast majority of people in the UK support the right of a woman to choose abortion, people's individual views and values around the issue vary widely. As a result those who actively support the provision of a full range of reproductive health care options are eager to maintain this loose consensus by reassuring those who are less certain of their position, that abortion is 'always a last resort', 'a difficult, but necessary decision', 'something most women would rather avoid at all costs', 'something that no one takes lightly'.

While abortion is not a taboo subject amongst those providing health services it is still taboo to talk about abortion in the kinds of positive terms in which most health interventions are discussed. If abortion is undesirable, it follows that more abortions are even more undesirable. This has sometimes led those running or working in abortion services to provide a lower standard of care than in other areas of medicine. The rationale for making abortion hard to access, unpleasant to experience or experienced as something that is offered grudgingly, is that women should not feel that this is an 'easy' solution and should be deterred from seeking abortion in the future. Some practitioners remain anxious that making a service user-friendly makes abortion 'too easy' and disincentivises consistent contraceptive use. As one Personal Advisor put it, 'if the experience of abortion previously has been satisfactory (they) are not worried about subsequent conceptions.'

Practitioners we speak to who are involved at various points in their local abortion care pathways work hard to provide a good quality service, to support young women in their decision and to avoid stigmatising those seeking repeat abortions. User-friendly services with

integrated contraception provision within a comprehensive pre and post-abortion care pathway is the ideal towards which they are working. This is a constructive approach, supported by the RCOG in their evidence-based guidelines.

DECISION MAKING AND COUNSELLING

PREGNANCY DECISION-MAKING

It is important for a young woman to know about all her pregnancy choices and to have considered the implications for herself of continuing with a pregnancy at this point in her life. She needs to know about all three options: continuing with the pregnancy and parenting; continuing with the pregnancy and putting the baby up for adoption; or having an abortion.

Some workers report taking a lead from the young woman when the pregnancy is confirmed about whether or not discussion of abortion is relevant. As a result abortion isn't always mentioned or discussed. It can be easy to assume that the young woman understands all three options and has chosen maternity especially if she reports the pregnancy as having been planned or intended. However, for many, pregnancy is a default rather than a positive choice and counsellors often have to spend some time working with a young woman to help her recognize that not making a decision or doing anything to address the pregnancy is a decision in itself. It is not safe to assume that a client has had all the necessary information or considered all her options unless the professional in question has explicitly offered to provide this information and explore these options with her.

A young woman may feel that maternity is expected of her or that there is no support in her family/community for abortion. Many young people assume that no one else in their community has ever had or would ever have an abortion. Statistics from the Office of National Statistics indicate that women of all ethnicities in this country access abortion services. It is essential that health and youth work professionals do not reinforce the silence around abortion by assuming that someone of a particular community, ethnicity or national origin would not consider abortion and consequently fail to offer them sufficient information or opportunities to discuss their options.

Sometimes young women present too late for abortion to be an option. In these cases it is useful to acknowledge the young woman's feelings about the pregnancy, to explore the option of adoption and to make explicit the timeframes for abortion so that she is well-informed (about the need to seek help early) in advance of future unintended conceptions.

ABORTION COUNSELLING

Most women do not need formal 'counselling', but find it helps to talk to someone who can give them accurate information, create the space for them to explore their options and who has the skills to help them consider the pros and cons of continuing with the pregnancy. This can help women both to make a decision when they feel unsure about what to do, and give women greater confidence that the decision they make is the right one for them. A best practice toolkit for professionals supporting this process is available from www.efc.org.uk.

Ambivalence about the abortion decision increases the risk of regret following abortion and has been reported by several interviewees as the motivation for young women deliberately conceiving or positively choosing to continue with a subsequent pregnancy. Where there is coercion or family pressure the young woman may need help specifically with identifying what she wants. It is important that she owns her decision. Several interviewees alluded to young women's 'sense' that they had been pressured to have an abortion. Whether this was their perception at the time or a way of attributing responsibility for the decision after the event, it indicates the importance of providing a space in which a young woman can articulate her own feelings and desires and in which her responsibility for her decision is acknowledged explicitly.

Young women can be worried about what happens when an abortion takes place whether she'll see the baby, or know what sex it is, what happens to it afterwards etc. Once a young woman has indicated that she might decide to have an abortion it is important that she understands fully the timetable of consultations and is aware of what to expect when she

attends for the abortion procedure and can have her detailed questions answered. However, this discussion should not take precedence over the decision itself - it is essential to ensure that sufficient focus is given to the decision of whether maternity or abortion is right for this client at this time.

This discussion (or series of discussions) can be a useful opportunity to consider the other things that are happening in the young woman's life and to identify other sources of support for her if appropriate. Recent research from Canada found that women seeking second and higher order abortions were more likely to have experienced partner violence and calls for abortion services to provide screening which 'could result in offers for referral and counselling that might prove helpful to the woman and could potentially help avert a future abortion.'[10]

A discussion about the future, most specifically about her contraceptive intentions is essential at some time before she attends for an abortion. It is helpful if all professionals who are involved in pregnancy decision-making work are familiar not only with the route into abortion services, but also what contraceptive methods will be available at the time of the abortion that will be appropriate to her depending on the abortion method chosen. It is essential that she is able to enact her chosen contraceptive method as soon as possible following abortion. If the professional knows that her chosen method is not available at the abortion clinic she will attend, it is important to find out the easiest way to access her chosen method and help to ensure that she does access it.

The incorrect, but widely held, belief that abortion will compromise a woman's fertility was acknowledged by interviewees to contribute to further unwanted conceptions following abortion – either because women choose deliberately to 'test' their fertility or because they don't see the need for contraception if they assume they are no longer fertile. This issue was addressed by the Teenage Pregnancy Independent Advisory Group (TPIAG): 'Many myths prevail, including the fact that abortion may lead to infertility, which TPIAG is concerned may be a contributory factor to repeat abortions'.[11] Anyone supporting a care pathway to abortion needs to ensure that the young woman is clear about the need to initiate contraception immediately following abortion, given that, according to the RCOG guidelines, 'it has been shown that ovulation occurs within a month of first-trimester abortion in over 90% of women'[12]. A survey on sexual behaviour following abortion found that in women aged 18-24 coitus recommenced within 2 weeks following abortion and that 86.9% of women of all ages had recommenced coitus by 8 weeks follow-up.[13]

It is useful for young women to be provided with written information on contraception and abortion that is tailored to them. All information needs to be given a number of times because when a young woman is pregnant, it can take time for it all to sink in.

MATERNITY COUNSELLING

For those choosing to continue with a pregnancy, contraceptive planning in the lead up to delivery, and implementation of the plan immediately after delivery when the young woman is highly motivated to use contraception is vital.

Some interviewees describe a scenario in which young mothers assume that since they will be at home anyway that it won't make much difference if they just have another child. Others do not accept that they will want to be sexually active following maternity, especially when they are not in a stable relationship. It can be helpful for professionals to provide an opportunity, in advance of delivery, to consider their future plans, and the benefits and disadvantages of different age gaps between children in relation to providing the best care to their children and the best opportunities (educational/career etc) for themselves.

RECOMMENDATIONS

Counselling and support

- Workforce training to ensure widespread provision of good quality pregnancy decision-making support in health and non-health settings. Support should include contraceptive planning and ensure that the decision to abort or go to term is informed, not ambivalent and made without pressure or coercion.
- Better information and training for foster carers and social workers around pregnancy decision-making support and abortion issues.
- Workforce training to ensure that there is widespread provision of support and information post-abortion for those who do not attend follow up appointments at clinics.
- Clear referral pathways to expert agencies in the event that repeat conceptions flag up to professionals other problems such as domestic violence, sexual abuse, substance misuse, relationship problems...etc
- Availability of long-term counselling for young women to help them resolve some of these issues and identify where starting a family fits in with their lives.

CONTRACEPTION AT TIME OF ABORTION/MATERNITY

'Before she is discharged following abortion, future contraception should have been discussed with each woman and contraceptive supplies should have been offered if required. The chosen method of contraception should be initiated immediately following abortion'.[14]

Most contraceptive methods can be provided at the time of abortion. Where contraceptive choices cannot be implemented immediately, ward staff should take the opportunity to discuss where, when and how a young woman's chosen contraceptive method can be accessed. In Darlington – where medical abortion is the most commonly used method – enhanced counselling skills training is provided for nurses on gynaecology wards to help them facilitate conversations with young women having medical abortions. As a result they can use the time they are on the ward to discuss with young women any perceived obstacles to using a reliable contraceptive method, and help inform and support her contraceptive plan.

In areas where there are teenage pregnancy midwives involved in maternity and abortion services it makes sense for them to have the training and remit to provide contraception too. They have often built trusted relationships with the young woman over several weeks, have helped her to agree a contraceptive plan and are present at a point where motivation to use contraception is high. Where they are not able to provide contraception it is felt to be a missing link in the chain of care provided. Where midwives are limited to phoning to check that the young person has made the appointment, it can be perceived as nagging or checking up and it is not always practical to do so.

Use of uniform paperwork to record contraceptive planning can be useful to those providing follow up contraceptive support and help audit contraceptive choices and implementation and maintenance of chosen method (an example of such a form is included at Appendix 1).

LONG ACTING REVERSIBLE CONTRACEPTION

Problems initiating its use

There is a great deal of misunderstanding about long-acting reversible contraception (LARC) amongst both young people and some professionals, including GPs, family planning and school nurses. The most common misconception is that IUDs and IUSs are not suitable for nulliparous women (i.e. women who have not had children). Cost implications are also a factor in the reluctance by professionals to initiate LARC in young women, particularly where there is an anxiety that the method may not be maintained.

Young people are resistant to LARC for a number of reasons. The length of time for which IUDs, IUSs and implants are effective is often perceived negatively. For a teenager, a method of contraception that offers protection from pregnancy for a number of years (and will therefore represent a significant proportion of their life so far) can seem daunting or too permanent. A senior counsellor commented "if someone is 16 and you tell them that contraception can last for five years, you might as well tell them it lasts for 20 – it's huge for them."

Young women are anxious about the use of hormonal methods of contraception and are particularly fearful about their safety and long-term effects. A sexual health nurse in Lambeth has found that young women are particularly resistant to the long-term use of hormones. Her experience is echoed by a termination of pregnancy nurse in Southwark, who said that young women often switch back to using condoms because they "don't like drugs", despite the fact that some smoke, drink and/or use recreational drugs.

A resistance to LARC often centres on their perceived side-effects – most notably weight gain. This is despite a lack of evidence to support weight gain as a side effect with most LARC methods (see Appendix 4 – features of LARC to discuss with women). Weight gain was mentioned as a chief concern by almost every professional we spoke with whilst conducting this research and its impact should not be underestimated. A practitioner in Hackney described the problem thus: "if young people feel that they are gaining weight or getting spotty with ordinary contraception, they can stop it straight away. But with LARC they feel they have much less control and worry that they will just get bigger and bigger until the use of the method is ended."

This is noted as being all the more problematic for young mums, who experience a great deal of anxiety about body image following pregnancy and birth anyway, and have a strong sense of loss for the body they had pre-pregnancy. A negative self-image may be exacerbated by financial hardship which makes it difficult to maintain physical appearance through for example buying new clothes or make-up. In this context, LARC, with its perceived power to cause weight-gain, is simply not an option.

Problems maintaining its use

Some practitioners report a good uptake of LARC by young women, but find that a significant proportion of young women opt not to continue with their chosen method, usually because of the impact of unwanted side-effects on menstrual bleeding. A professional in Hackney said that no matter how thoroughly a method is explained so that young women understand fully what to expect from their chosen method and the likelihood of any side-effects, when the side-effects arise it causes them to discontinue the method's use.

One counsellor observes that there is huge issue amongst women of all ages about things that alter menstrual pattern. Her views echoed a number of other practitioners who said that anything that disrupts bleeding is perceived negatively, because women largely want their menstrual patterns to be maintained. A difference in the heaviness or regularity of bleeding is therefore unlikely to be tolerated. It may be that a change in menstrual bleeding provokes anxiety about the impact of contraception on health and fertility.

A common theme from practitioners was that some young women experiencing a change in bleeding may find it hard to conceal LARC use from their mother or carer. This is particularly likely where the young women's carer is the person who normally purchases their sanitary protection and is familiar with their menstrual patterns. Amenorrhoea due to the IUS or increased/more frequent bleeding with IUDs and implants can alert a carer to likely contraceptive use and thus the likelihood that the young woman is sexually active. Buying their own additional sanitary protection can be very expensive for many young women.

A lack of ability to organise themselves to return for subsequent contraceptive injections can also prove too difficult for some young women, and hinder their ability to maintain use of this contraceptive method.

Discontinued use of LARC in young women is seen by some practitioners as symptomatic of an inability to commit to a decision – about the contraceptive method chosen and the desire to delay pregnancy itself (for a first, second or subsequent time). Practitioners differ about whether this reflects a lack of opportunity – or a lack of will and ability - to plan long-term and think about the likelihood of future sexual activity and consequences.

Case Study

Youth Worker, Connexions, Leeds

A number of young people we have gone with to get the implant have already explained that they don't really use condoms or take the pill, hence their reason for going for the implant. While there they were given the pill and told to use condoms until it was a suitable time to fit the implant. At least two of the young people then became pregnant whilst waiting for the implant to be fitted.

One of the young women (aged 19) has one child and had just had a miscarriage from a second pregnancy when we went for the implant. She just didn't think about contraception when she got pregnant. After long discussions she decided the implant was the best method for her but was given the pill and told to use it until they could be sure she wasn't pregnant again. She didn't take the pills, had unprotected sex and became pregnant again.

When I discussed this with the clinic they explained that they wouldn't be covered if they fitted the implant if they weren't completely sure that the young woman wasn't pregnant and it also costs too much to fit and then take it out straight away if the young woman finds out she's pregnant.

Some possible approaches to overcoming obstacles to uptake and maintenance of LARC

- The experience of many practitioners indicates that word of mouth and personal recommendation influence the uptake of LARC. In Walsall a significant uptake in the use of implants by young women has happened because their friends have used this method and recommended it, indicating a high level of user satisfaction. Given that misinformation and suspicion about LARC is prevalent in the adult population, it will be interesting to see whether programmes to increase LARC use in older women increase take-up across the board (and/or vice versa).
- Training/awareness-raising of health care professionals about the suitability of LARC for young women.
- Injectable contraceptives may lessen anxieties about the length of time that LARC works for.
- The use of phoning and text messaging to remind those using injectables to return for repeat shots can help to avoid gaps in which there is no contraceptive cover.
- Dedicated teenage family planning sessions with access to all methods of contraception.
- Patient Group Direction (PGD) to enable community midwives (particularly within the Children's Service) to prescribe contraception, including LARC.
- More thorough contraceptive counselling which gives proper consideration of the likelihood of side-effects, and information about how these can be managed should they be experienced, to help young women feel more confident about choosing and maintaining LARC.
- Accessible adjuvant treatment for side effects e.g. Mifepristone – as outlined in National Institute for Health and Clinical Excellence (NICE) guidelines.
- Sex and Relationships Education which includes information on LARC and addresses issues of fertility and side effects such as weight gain.

South Tyneside – A case study

South Tyneside is a local authority area that has shown a substantial decrease in teenage conceptions between 1998 and 2005. Reducing repeat conceptions following maternity and abortion has been central to the local teenage pregnancy strategy, and success in this has been the major reason for the overall success. Contraceptive and abortion services for women of all ages are designed around the recommendations of the National Institute for Health and Clinical Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG).

When a young woman in South Tyneside is pregnant she is automatically referred to the Options Advisor, Elaine Doherty, employed by the PCT to see all pregnant women under 25 years old. Elaine finds out what contraception they were using, what the circumstances were for the pregnancy, and provides information and support to enable young women to make a decision about their pregnancy and to access appropriate services. Those opting to continue with their pregnancy are directed to a dedicated under-20s maternity service (accessed by 90% of pregnant teenagers). This supports them right from a first booking appointment, through the pregnancy and to considering and enacting a post-natal contraceptive plan. 28 days post-delivery, Elaine follows up with each young woman to ensure that she has initiated contraceptive use.

For those opting for abortion, post-abortion contraception is an integral part of their conversation with Elaine. All those having abortions can be provided with a long-acting or other method at the time of the abortion. In the case of medical abortion, implants can be fitted if the doctors can confirm the abortion is completed while the young woman is still on the ward. All medical abortion patients return 10-14 days later for a scan to confirm completion of the abortion. At this point an implant can be fitted if it wasn't before and an IUD/IUS can be fitted. Any Options clients who do not return for post-medical abortion scan are followed up by Elaine.

Leaflets produced locally in straightforward language, describing the contraceptive methods most commonly chosen by young women, are supplemented by detailed fpa leaflets. There are dedicated contraceptive and sexual health services for young people and if doctors cannot offer all contraceptive methods they know where to refer to.

There is a high take up of LARC in South Tyneside. Good take-up is encouraged by ensuring that all contraceptive methods are available in the area and that wherever possible those providing advice can help young women to enact their choice of method at a point where their motivation to do so is high (immediately post-abortion and post-maternity). So successful has the policy been that the PCT have now mainstreamed this service, providing LARC at abortion and elsewhere for women of all ages. TOP consultants can put in implants in line with NICE guidance and of 400 TOPs in 2005 nearly 50% chose to use LARC.

Maintenance of LARC at one year is also good in South Tyneside, something that Elaine attributes to thorough contraceptive counselling. A description of the process indicates that there are no short-cuts here. Honesty and a commitment to facilitating truly informed choice ensure that all young women are able to consider the best possible option for them. They are given complete information about the possible best and worst case scenarios with a given type of contraception and asked to consider how they would cope if they experienced the worst case (e.g. in the case of implants, irregular bleeding). They are asked, in advance, to consider whether, if it didn't feel right, they would be prepared to try some kind of adjuvant treatment to alleviate the side effects and, if

that still didn't work, whether they would be open to thinking about a different method. Giving this kind of accurate and detailed information builds trust so that in the event that the method is inappropriate, the young woman doesn't simply give up, but is prepared to return to discuss alternative methods. Adjuvant treatment is given at 3-6 months for those finding bleeding patterns too burdensome. (See NICE guidance). If this does not help to improve the situation, other forms of contraception are considered.

Though myths, misinformation and negative personal anecdotes do provide obstacles to promoting LARC use, word of mouth can be used positively. Elaine has identified a few young women to be contraceptive 'buddies', prepared to talk to someone considering a contraceptive method, about their own positive experience of it. In fact a large part of the widespread take-up of implants has been as a result of word of mouth.

Emergency contraception is available 7 days a week and recognition of this and other local services was high amongst young people, according to an Exeter University study.

It is clear that a great part of the success in South Tyneside can be attributed to Elaine's 'passion for informed choice', and her commitment to providing the best possible service directed by evidence-based guidance such as the RCOG and NICE guidelines. As in many areas having a) a champion and b) worker(s) dedicated to providing one-to-one support for all young women experiencing pregnancy seems to be a successful formula. In addition, South Tyneside has the benefit of great collaboration between the PCT and hospital trust. GPs, youth workers and others in the area are engaged in supporting a strategy to ensure that there is access to good support at many points and that the full range of contraceptive methods are widely available. Since almost all abortions take place in the local hospital and are provided by just two consultants who are extremely engaged in the strategy to prevent unintended repeat conceptions, communication and co-operation are highly successful.

15 years working on the ward as a gynae nurse means that Elaine is trusted and welcomed on the ward. This is in contrast to other areas where it has been reported that there is a certain reluctance to let non-ward staff have access to young women on gynae wards for abortion whereas access to maternity wards is considerably easier.

Consistent record keeping enables thorough audits of services which provide ideas for developing and improving the service and the evidence required to make the case for adequate funding (in South Tyneside only 4 GPs provide implants, so the PCT chose to top-slice GP funds to subsidise contraceptive provision elsewhere).

Everything that can be done is being done to provide comprehensive contraceptive support. However, as the Teenage Pregnancy Co-ordinator for the area, Alice Wiseman, points out, those still experiencing repeat conceptions are often the most vulnerable and are presenting with the most difficult issues of which pregnancy is only one. The reduced numbers of conceptions are not reflected in a reduced workload for health and youth workers. This sentiment was reflected from local authorities around the country where looked after children are consistently identified as a high risk group for repeat conceptions leading to both maternity and abortion.

In October 2005 NICE produced a Quick Reference Guide on LARC, which notes that

"increasing the uptake of LARC methods will reduce the number of unintended pregnancies". Healthcare professionals may find its guidance useful, and key elements of it are included here, alongside information from the Royal College of Obstetricians and Gynaecologists 2004 evidence based guidance on the Care of Women Requesting Induced Abortion. Appendix 2

Links to a care pathway for LARC and a document outlining features of LARC methods to discuss with women are included at Appendix 3 and 4.

EMERGENCY CONTRACEPTION

In EFC's experience there is a good level of awareness about emergency hormonal contraception (EHC) amongst young people, and a significant proportion understand that it can be taken for up to 72 hours after unprotected sexual intercourse. Most young people and a significant proportion of professionals, however, are unaware that the IUD is a suitable method of emergency contraception for young women. In its guidance on emergency contraception, the Faculty of Family Planning is clear that "there is no medical reason why a young person need be restricted in her contraceptive choices on the basis of age alone".

The Faculty of Family Planning in its guidelines for professionals on the provision of emergency contraception[15] recommend that patient group directions (PGDs) be developed to allow nurses and other health care professionals to supply and administer contraceptives. This would be helpful in enabling young people to obtain contraception, including emergency contraception, from a wider range of health professionals, with whom they may already have built trusted relationships, such as community midwives.

Guideline (GL) 28: PGDs can be developed to allow nurses and other health care professionals to supply and administer contraceptives. PGDs may include use outside the terms of the product license provided such use is justified by current best practice; the PGD clearly describes the status of use outside the licence; and the documentation includes the reason why such use is necessary. (Grade C).

After EC use clinicians and women should discuss initiating a regular method of contraception. They advise that this can be started at any time in the woman's menstrual cycle if it is reasonably certain that the woman is not pregnant. They also advise that it is appropriate to initiate a regular method of contraception immediately if abstinence, or condom use, is unlikely.

EMERGENCY HORMONAL CONTRACEPTION

Although there is a high level of awareness about EHC amongst young people, their ability or motivation to use it may be less. This could be because of difficulty in accessing it, though pharmacy schemes which enable its provision free of charge to young people may be helpful in addressing this point. A lack of motivation to use it could be due to myths about its safety and efficacy, or simply the belief that "it won't happen to me". Where there is a risk of failure to use contraception effectively, such as forgetting to take the oral contraceptive pill (OCP), or inconsistent and incorrect condom use, there is a role for the advance provision of EHC. Advance provision of EHC may increase both young people's understanding of the way in which EHC works, and their motivation to use it when needed.

A small scale study carried out by Garg, Singh and Mansour in Newcastle in 2000[16] found that 98% of women attending for repeat abortion reported using contraception at the time of conception; 57% said they had used condoms, and 37% the OCP. The report does acknowledge the likelihood of over reporting of contraceptive use at the time of conception, however, it concludes that 68% of all repeat abortions in the study were attributable to user error with condoms and the OCP, and nausea and vomiting were associated with the latter.

The study notes that use of EHC was "very poor" and attributes this to a "lack of motivation to use it". 69% of women undergoing repeat abortion did not think about emergency contraception at the time, 88% did not use it at all, and 34% did not think that pregnancy would occur. Less than half were counselled about the use of EHC in the event that regular contraception failed.

The study concludes that LARC is the solution to reducing the likelihood of the need for

abortion. However, as we have seen LARC is not a panacea for unintended pregnancy. EFC believes that the advance provision of EHC has a role to play in helping young women to avoid unintended pregnancy in the event of contraceptive failure, or inconsistent use.

This view is echoed by a professional in Hackney who provides young women that switch from LARC to condoms with EHC in advance of need. This is accompanied by detailed information about where it can be obtained from again locally and free of charge, should it be required.

It is also a view endorsed by the Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit[17]. Recommendation 28 in their 2006 guidance on Emergency Contraception (EC) states that:

"Advance provision of Levonorgestrol (LNG) [i.e. emergency hormonal contraception] can be offered to women to increase early use when required."

This is a grade A recommendation which means that the evidence supporting it comes from randomised controlled trials. The guidance says:

"Clinicians may consider advance provision for any women who may be at risk (e.g. for women relying on barrier methods). Randomised trials have shown that advance supply of LNG to selected women is safe and effective. Increasing the uptake of EC may reduce the rate of unintended pregnancies without increasing the number of women having UPSI. In a trial, women who had advance supplies at home were more likely to use EC when required, without compromising regular contraceptive use or sexual behaviour. Interviews with women who had received EC in advance highlighted that while advance supplies were seen as useful, they were not considered an alternative to other forms of contraception. A population based study did not show that providing sexually active women with EC in advance of need had any impact on abortion rates."

The Faculty guidance is applicable to all professionals providing contraceptive services in primary and secondary care in the UK.

Guideline 4: LNG EC [i.e. EHC] may be considered between 73 and 120 hours after UPSI, but women should be informed of the limited evidence of efficacy, that such use is outside product license, and the alternative of an IUD" (Good practice point – i.e. no evidence exists but the best practice is based on the clinical experience of the expert group).

Guideline 5: Women can be advised that LNG EC [i.e. EHC] can be used more than once in a cycle if clinically indicated". Good practice point – see above for definition.

With regard to the use of EHC more than once per cycle, the Clinical Effectiveness Unit "support the use of EC more than once in a cycle". They note that the Summary Product of Characteristics states that repeated administration of LNG is not recommended because of disturbances to the cycle, however, the Clinical Effectiveness Unit (CEU) state that "giving repeat doses of LNG prior to the luteinising hormone surge (i.e. prior to ovulation) may be effective and further unprotected sexual intercourse may be an indication for repeat LNG use". They clearly state that "repeated use will not induce abortion if the woman is already pregnant". No data were identified regarding a minimum time interval between successive EC treatments. The consensus view of the CEU Expert Group was that "unprotected sexual intercourse within 12 hours of a dose of EC does not require further treatment with EC".

EMERGENCY CONTRACEPTION: USE OF THE INTRAUTERINE DEVICE (IUD)

As noted above the IUD also acts as a safe and effective method of emergency contraception. When fitted at any time up to five days after unprotected sex it is 99% effective at preventing

pregnancy. This compares favourably to EHC which has an overall rate of effectiveness of 84% when used within 72 hours after unprotected sex.

One practitioner in Hackney noted that some young women are happy to have the IUD fitted as a method of emergency contraception, but then ask to have it removed shortly afterwards. Given its efficacy as a long term method of contraception and the cost of fitting and removing the device, it would be useful to consider what information and support young women could be given to help them to continue IUD use in the long term.

Encouraging the use of the IUD as a method of emergency contraception, alongside a strategy to encourage long-term maintenance of the method, would be another route to increasing LARC use.

The Faculty of Family Planning offer the following recommendations about the IUD's use as emergency contraception, which are based on good practice (unless otherwise indicated):

Guideline 6: "An IUD (or advice on how to obtain one) should be offered to all women attending for EC even if presenting within 72 hours of unprotected sexual intercourse"

In some areas the small number or poor distribution of practitioners able to fit the IUD means that women may not be able to access this method at the clinic they attend. In this instance women should be given LNG EC and referred as soon as possible to someone who is able to do so.

Guideline 10: "A copper IUD can be inserted up to 5 days after the first episode of unprotected sexual intercourse. If the timing of ovulation can be estimated, insertion can be beyond 5 days of unprotected sexual intercourse, as long as it does not occur beyond 5 days after ovulation." This is a Grade C recommendation where the evidence supporting it is limited but the advice relies on expert opinion and has the endorsement of respected authorities.

The Faculty guidance goes on to state that "Use of an IUD for EC carries the same contraindications as does routine IUD insertion. For most women, benefits of IUD use outweigh risks (World Health Organisation [WHO] category 1 unrestricted use, or WHO category 2, benefits generally outweigh risks). A risk of STIs, previous ectopic pregnancy, young age and nulliparity are not contraindications to IUD use".

EMERGENCY CONTRACEPTION AND SEXUALLY TRANSMITTED INFECTIONS

Young women at risk of unintended pregnancy are also likely to be at risk of sexually transmitted infection (STI). The Faculty of Family Planning offer the following guidelines in relation to STIs and the use of the IUD as a method of emergency contraception:

Guideline 17: "A sexual history should be taken from all women attending for EC to assess risk of STIs (Grade C).

Guideline 18: Prior to emergency IUD insertion, women at higher risk of STIs (those under the age of 25, who have changed sexual partner, or had more than one partner in the last year) should be offered testing for Chlamydia trachomatis (as a minimum) (Grade C). Where other STIs are prevalent in area, these should also be tested for, as should any other sexually transmitted infection if the woman is anxious about the risk of STIs.

Guideline 19: For women assessed as being at higher risk of STIs, if results of testing are not available at the time of emergency IUD insertion, the use of prophylactic antibiotics may be considered. (GP Point). Emergency IUD insertion should not be delayed."

RECOMMENDATIONS

Contraceptive provision

- One to one contraceptive support should be available for all young women pre and post maternity and abortion (provided through a teenage pregnancy service, through domiciliary nurses or through youth services to include central clinics and outreach).
- Patient Group Direction (PGD) and training should be developed to allow community midwives, gynae. nurses and others working with young people to prescribe and fit all contraceptive methods.
- Availability of advance provision of Emergency Hormonal Contraception for those using condoms or the oral contraceptive pill as their primary contraceptive method should be ensured.
- Contraception provision allowing young women to enact their choice of contraception without delay, at any reproductive health care setting including abortion services, maternity services, GUM clinics, family planning clinics…etc, should be implemented.
- All methods of contraception should be made available specifically at the time of abortion and maternity where medically appropriate.
- Workforce training on how to counsel effectively on the side effects of LARC, particularly to address concerns around weight gain and change in menstrual patterns, should be made available.
- Provision and promotion of adjuvant treatment for the side effects of LARC should be available.
- Awareness should be raised amongst GPs and family planning staff of suitability of IUD/IUS for nulliparous women.
- IUDs should be made available as a form of emergency as well as long term contraception.
- Strategies should be developed to address the specific needs of looked after children to make decisions concerning their sexual and reproductive health.
- Strategies to address the specific needs of looked after children to make decisions concerning their sexual and reproductive health.
- Strategies should be developed to engage the wider adult population with accurate information about contraception in order a) to encourage men to use and promote contraception and b) to encourage family and carers to support young women to choose and consistently use a reliable contraceptive method.

SERVICES

INFORMATION AND AUDITS
Accurate information on the young women who are requesting abortions can support targeted education and information and tailored contraceptive provision. There may be a prevalence of repeat abortions in a particular postcode, amongst young women from a particular school or college, from a particular ethnic group or nationality.

Nationally, statistics on repeat abortion are calculations rather than actual numbers, an issue that is currently being addressed by the Department of Health. Even where systems have been put in place locally there are many obstacles to collecting accurate figures. Women might have had their abortions at two or more different clinics or even in different PCT areas. At the request of the woman, the GP may not be notified. Where information on previous abortions relies on self-reporting, under-reporting is likely, except in specific communities in which repeat abortion is widely accepted.

Those areas which have been most successful in gathering accurate information are those in which there is one referral route for all young women accessing abortion through the same (for example pregnancy counselling) service and in which all or most abortions take place in one clinic or hospital.

Accurate information on the uptake and maintenance of different contraceptive methods by age group, by place of delivery or abortion etc can help to identify gaps in provision, workforce training and development needs, support the development of age-appropriate literature, and find out about the best times, places and ways in which to deliver services to maximise their impact.

In her article Postnatal Contraception Planning for Young Women (included at Appendix 5), Elaine Doherty provides an example of a contraceptive plan proforma and contraceptive review proforma which are used to record contraceptive choices and maintenance post-delivery.

NHS/INDEPENDENT SECTOR ABORTION PROVISION AND CENTRAL BOOKING ARRANGEMENTS
Central booking systems that allow direct booking into an abortion service can lead to some young women bypassing important processes and discussions that could help them to agree and implement a post-abortion contraceptive plan. This can be avoided if all abortion providers are working to an agreed protocol whether the abortion takes place in an NHS or independent sector setting. This might take the form of a contractual agreement that all pre-abortion counselling for young women will include explicit discussion of post-abortion contraceptive options and (ideally) all abortion providers will be able to fit or provide the chosen contraceptive method at time of abortion, where medically appropriate. Contracts between PCTs and independent clinics should be explicit about what contraceptive services must be available to young women who access an abortion.

Abortions are sometimes provided at several NHS sites, or at a combination of NHS and independent clinics. In any case reporting mechanisms need to be in place to ensure that the health professional or team with the remit for post-abortion support are notified of all young women accessing abortion. This can ensure more widespread initiation and maintenance of post-abortion contraception.

Some professionals commented that the opportunities to ensure consistent practice in terms of post-abortion contraceptive provision and record keeping and reporting are greater with independent providers (than with NHS departments) where clear contractual agreements can

set out the methods that will be made available. However, some professionals reported inconsistent provision of contraceptive methods by independent providers, even where there was an agreement to provide specific methods at time of abortion.

RECOMMENDATIONS

Commissioning and monitoring: a borough-wide approach

Policies should be in place to ensure:

- that all NHS and independent abortion providers are working to consistent protocols on the provision of contraception, record keeping and reporting.
- that PCTs, hospital trust(s), independent abortion providers, young people's sexual health services, GPs and family planning clinics are aware of and working to support the overall strategy.
- that all young peoples' and sexual and reproductive health services are able to signpost young people to the most appropriate services in the event that they are not able to support a young person's contraceptive or pregnancy choice.

HAVING A KEY WORKER AND CHAMPION

Several interviewees talked about the value of having one key worker responsible for providing contraceptive follow-up for every young woman in the area who gets pregnant. In Wandsworth a nurse visits all young women on the maternity wards and is able to provide them with domiciliary family planning for at least a year. Anne Patterson, Teenage Pregnancy Co-ordinator, believes it would be helpful to provide the same level of support for young women in the area having an abortion. Many interviewees agree that provision of contraception in accessible, young people friendly clinics needs to be supplemented by intense outreach work. In Lambeth, Southwark and Lewisham attempts to recruit a nurse to a one year post to provide this kind of care - as a pilot project – have failed. Perhaps the one-year contract is an obstacle. However it has also been suggested that it might be too overwhelming a post for one person, or it might be too isolating. The success of these kinds of posts rely on being part of an integrated strategy which is adopted by all local agencies including youth services, GP clinics, family planning clinics, and consultants and nursing staff in maternity and abortion services. In areas where this has happened, far from feeling isolated, the people in these roles feel they are central to a network of professionals all working towards the same end.

For this to happen a true champion is needed. This might be the person who provides or leads the contraceptive outreach or another professional. Someone needs responsibility for building relationships with all the key players; making links between PCT, hospital trust, independent providers etc; selling the strategy, auditing and evaluating services to provide evidence for ongoing funding…and more. It is clear from the interviews carried out by EFC that principled commitment to informed choice and to increasing contraceptive use, coupled with energy and enthusiasm for overcoming obstacles are key requirements for a champion.

RECOMMENDATIONS

Champion

- A champion who is passionate about informed reproductive choice is essential to promote comprehensive contraceptive counselling for young people.

  The champion should:
- have particular responsibility for ensuring that those accessing abortion and maternity services are supported to make and implement a contraceptive plan;
- ensure PCT-wide buy in to comprehensive contraceptive provision;
- make links between different agencies;
- and create coherent referral pathways and signposting.

INFORMATION AND SEX AND RELATIONSHIPS EDUCATION (SRE) ISSUES
SRE provision remains patchy. In the absence of a statutory SRE curriculum, more work needs to be carried out with school governors and parents to secure their commitment to a programme of good quality, comprehensive SRE for all children and young people.

Many schools schedule Personal and Social Health Education (PSHE) PSHE conference days in preference to regularly timetabled PSHE lessons throughout the academic year; this means that any pupil absent on a conference day risks missing out on a significant proportion of their sex and relationships education. A continued programme of PSHE is more likely to result in greater exposure to health promotion messages and gives young people the opportunity to revisit key issues.

Not all young people attend mainstream schools. Truancy, absenteeism and exclusion also play their part in denying young people the opportunity of good quality SRE. It is therefore important that the other places that young people attend offer sound SRE provision. These include independent schools, complementary education facilities, pupil referral units, youth clubs, young parents groups and care settings.

Good quality abortion education is an integral element of comprehensive SRE. It enables young people to consider the choices that lead to and result from unintended pregnancy and helps them to develop the understanding and motivation to use contraception when they are sexually active. As with all good quality SRE, it helps young people to reduce sexual risk-taking and to avoid both unplanned pregnancy and sexually transmitted infections.

Delivering abortion education in a way that neither promotes nor stigmatises early parenting, adoption or abortion also means that young people are more likely to feel confident in seeking help and support from family, carers and professionals if unintended pregnancy does occur. This is vital to ensuring optimum health and nutrition when a young woman chooses to continue with a pregnancy, and to accessing early abortion when she chooses to end it. A best practice toolkit on abortion education is available from www.efc.org.uk.

Whilst many schools see the value of including abortion education in their SRE curricula, a great proportion continue to utilise anti-choice agencies like Life, Care and the Society for the Protection of the Unborn Child (SPUC) to deliver this element. Anti-choice agencies are often responsible for the promotion of inaccurate messages about both contraception and abortion – which ironically can lead to greater sexual risk-taking and repeat abortion. The notion that abortion causes problems with fertility is commonly expounded by anti-choice agencies and is at the top of most young people's concerns about abortion. This can have a profound impact on young women in relation to sexual risk taking; professionals providing one-to-one support to pregnant young women frequently report that their clients sought to 'test' their fertility following an initial abortion, and subsequently find themselves pregnant again.

Poor SRE can stigmatise teenage pregnancy and abortion, contribute to feelings of guilt, shame and fear and fail to give young people the vocabulary or the skills they need to talk to parents, carers or professionals. This creates the risk that young people will delay seeking help and advice when they need it most. Some young women, fearful of admitting the possibility of pregnancy, may delay testing for pregnancy, or seek to cover up or deny pregnancy until they are several months into it. This can prevent them from actively engaging in informed decision-making about their pregnancy, excludes ante-natal care in the early months of pregnancy, and means that young women have little or no choice about abortion. The practice of utilising anti-choice agencies to deliver any aspect of SRE is therefore detrimental to young people's health and well being and should be ended. Teachers should be encouraged through continuing professional development to undertake the provision of good

quality abortion education themselves.

SRE needs to address all contraceptive methods, including LARC so that young people have a greater understanding of the options open to them. This could help to dispel the many myths that prevail, which often come from friends, sisters and mothers – e.g. about IUDs, IUSs and implants getting lost, – and about the safety and failure rates of other methods. Contraceptive toolkits may also help to dispel myths about what different contraceptive methods look like and how they are used.

Peer education may play a particularly useful role in education about LARC – so that young women can hear from other young women about what having an IUD, IUS or implant fitted is like. It may help to allay the anxieties of many young women that it's possible for others to see an implant under the skin, or that inserting one causes serious scarring. Where this is not possible a video showing how an implant is fitted might be appropriate, and could be adapted as a training tool for contraceptive nurses.

Both young men and young women have anxieties about fertility, which may be compounded by high profile media coverage about fertility issues and In Vitro Fertilisation (IVF). Some young people have used contraception inconsistently and when they or their partner have not become pregnant have assumed that either the risks of unintended pregnancy have been overstated, or else become worried that they may not be fertile. Both assumptions can lead to further sexual risk taking, inevitably leading to pregnancy and/or infection. SRE therefore needs to address fertility, risk-taking in relation to it, and give clarity about fertility following both maternity and abortion. The inter-play between sexually transmitted infections and fertility should also be addressed. Health promotion messages about Chlamydia have been interpreted by some young people such that they believe the impact of Chlamydia on fertility affords them protection from unplanned pregnancy; thereby further reducing their perceived need for safer sex and contraceptive use.

SRE needs to place a greater focus on helping young people to develop a range of skills, so that, for example, they are able to negotiate safer sex and contraceptive use, identify consequences and predict outcomes, and make and implement decisions. Practitioners often feel that young people have much of the information they need about sex and relationships, but that they lack the skills to apply that information to themselves and their own circumstances. By enabling young people to develop these skills, they will be better able to make, implement and maintain contraceptive plans, and in the event that pregnancy does occur, be better placed to make their own decisions about it.

Several interviewees called for more on-site (school) provision of sexual health services. Governors' committees are widely viewed as an obstacle both to provision of sufficient good quality SRE and to allowing school nurses to provide services on site.

RECOMMENDATIONS

Sex and Relationships Education

- Every school, youth, and care setting should provide good quality Sex and Relationships Education and information.
- This should be available over a period of time – a drip, drip approach not one-off conference days a few times in a school career.
- Word of mouth can be positive as well as negative – there is a role for peer education to dispel some myths and give information about what having LARC is like (especially for implants).
- A video showing the fitting of an implant could be a useful training and educational tool.
- Contraceptive toolkits that show what IUS/IUDs look like and what an implant looks like, could help to dispel common misconceptions and myths, including those about side effects.
- Contraception education should include all contraceptive methods.
- SRE should include good quality information about abortion, adoption and parenting.
- SRE should address anxieties about fertility, risk-taking in relation to fertility and 'testing' fertility, and provide an understanding of fertility following maternity and abortion.
- Schools should not utilize anti-choice agencies which can have a negative impact on healthy choices.
- Written information should be tailored to young people.
- SRE should seek to develop skills, especially predicting outcomes and consequences, making and implementing decisions, and relationship and negotiations skills.

INFORMATION AND EDUCATION ABOUT PARENTING

Some practitioners have identified the need for much more widely available parenting classes for young mums and dads. These practical courses should address a wide-range of issues but should crucially include information on planning a family; the factors that are relevant and how to make and implement decisions. These could incorporate visits from a range of professionals including for example family planning nurses, who would also be able to provide tailored one-to-one advice.

When run alongside courses that build confidence and develop basic skills including literacy, numeracy and budgeting, the hope is that planning for the future – and where a family fits into that – will have a positive impact on raising aspirations. This could be furthered through the provision of vocational training opportunities for young parents that provide work placements, aimed at enabling young parents to gain skills, qualifications, motivation and independence. The timing of these courses is crucial – they need to run continuously so that they are available when young people need them – not at set times of the year.

In Walsall there has been a huge uptake for Care to Learn which the Teenage Pregnancy Co-ordinator attributes to Further Education (FE) providers creating courses specifically for young mothers which allow them to 'achieve together', learning vocational and basic skills alongside issues directly relevant to them as parents.

RECOMMENDATIONS

Parenting Education

- Parenting classes for young mums and dads should incorporate decision-making skills and explore the factors relevant to planning a family. They should be integrated into courses that build confidence and basic skills.
- Courses need to run continuously in order to be available to parents when they need them.
- Basic skills work and vocational training with work placements should be provided through teenage parent projects and/or in collaboration with local FE colleges.

GENERAL INFORMATION

Provision of young people friendly information about maternity, abortion and contraception is important. Clear graphic representations of care pathways for contraception, maternity and abortion services should be available for all those working with young people in the area to ensure that information about contraceptive services is widely available.

CULTURE AND ETHNICITY
Culture and ethnicity can have an interesting bearing on the way in which young people perceive a range of issues relating to sex and relationships. Whilst of course it is important not to make assumptions that people of a particular ethnic group, faith or culture will think or act in a certain way, an awareness of the issues may help professionals to provide more appropriate information and support.

Young people who have not received the majority of their education in Western Europe are also less likely to have benefited from sex and relationships education and have lower levels of knowledge about contraception, pregnancy and STIs as a result.

MENSTRUATION
A lack of menstruation was noted by some practitioners as being perceived particularly negatively by some African and Turkish communities. Within these communities frequent and heavy periods are preferred because they are perceived as being much more effective at expelling 'bad' blood. IUDs, which can cause heavier bleeding, are therefore preferred by women in these communities, whilst contraceptives that shorten or stop periods or make them lighter are more likely to be avoided.

CONTRACEPTION
Young people that come from families which do not believe in sex before marriage may be reluctant to use contraception of any kind if it is likely to be found (in the case of oral contraceptive pills and condoms) or where a parent is likely to notice a change in menstrual patterns (in the case of LARC). In some practitioners' experience, the children of parents who are strongly religious – regardless of the religion – are the hardest of all to encourage to use contraception.

MATERNITY
In Hackney professionals identified a strong desire amongst young women to complete their families with the same partner, often due to the stigma associated with having children with a number of different partners. This seems to be irrespective of whether or not the father actively parents their children – some may, some may not (there is a wide diversity of experience), and some may also continue to have a number of children with other young women.

ABORTION
Some young people whose families are from Africa (where abortion is largely illegal and therefore unsafe) are well versed about the likely risks of unsafe abortion, and are likely to commonly associate all abortion with the same risks.

Young people who think or know that their parents strongly disapprove of abortion are more likely both to hide the fact that they are sexually active from their parents, and to seek to access abortion without their parent's involvement to cover up pregnancy (and sexual activity) when it does occur.

The stigma surrounding abortion is not prevalent in all cultures. One practitioner in Hackney has observed that amongst some Nigerian women abortion is experienced repeatedly and, in her experience, they are quite open to reporting this. Conversely she found that White and Asian women were more likely to deny or under-report repeat abortion, whose incidence often only comes to light when their GPs notes are obtained.

A high repeat abortion rate has been reported amongst Chinese students in Luton, and amongst women of Eastern European origin in Bradford and nationally. This has led both areas to consider what kind of information they need to provide – where, in what format and in what language(s) - to ensure that women in those communities are aware of contraceptive

services and of the benefits of using reliable contraceptive methods.

ASYLUM SEEKERS

A Black Health Agency worker reports a significant increase in the numbers of young asylum seekers presenting with unplanned pregnancies which lead to abortion. Young asylum seekers have little control over their lives; living life on a day-to-day basis makes asking questions like "where do you plan to be in five years time, and what impact will having a child have on that" meaningless. Being in a new environment and leading a turbulent life makes it difficult for people to identify what they want or to plan for their futures effectively. Young asylum seekers are often unaccompanied and in need of affection, which they may only be able to access through sex. In this context contraceptive use is often a low-priority issue, and the skills to negotiate its use can be lacking.

Young women that find themselves pregnant in these situations are devastated by the prospect that being pregnant will reflect on them badly, especially mid-asylum application. In addition some young women have reported that they have felt stigmatised by social services and blamed for their pregnancies, which in turn has caused them to request abortion.

FEMALE GENITAL MUTILATION

Some practitioners noted that Female Genital Mutilation (FGM) is very rarely asked about during consultations with young women. Consequently it often only becomes apparent when a young woman goes into labour, or presents for an abortion. FGM can cause complications during birth and in carrying out abortion. The non-governmental organisation FORWARD (www.forward.uk.org) can offer more information and support on this issue. The World Health Organization provides guidelines on managing labour and abortion for women who have experienced FGM. http://www.who.int/gender/other_health/en/Studentsmanual.pdf.

Questions that have arisen from the writing of this report which might call for further investigation:

What is the role of men in prevention of first and subsequent conceptions, maternities and abortions?

What is the role of miscarriage in young women's patterns of contraception use and perceptions of fertility?

In some areas a huge push to support young mum's back into education and to engage them with ambition and aspiration has been successful in reducing repeat maternities – is there anything in place to provide for young women having abortion if they are equally disengaged?

Is there a way to ensure that those having an abortion can access the same level of intense care provided by domiciliary nurses for those who continue with their pregnancy?

Is there a high level of abortion without parental involvement – if so, does this impact on contraceptive choices – especially LARC which affect menstrual patterns to a degree that might be noticeable to the young woman's parent or carer?

Is post-natal depression an issue for young women in relation to subsequent conceptions?

ACKNOWLEDGEMENTS
Thanks to the following people for spending so much of their valuable time talking to Education For Choice. I hope their commitment to supporting healthy decision-making, and their openness in talking to us about their successes and challenges is reflected in this report.

Sarah Bekaert	Advanced Nurse Health Practitioner, City and Hackney
Joanna Brien	Senior Counsellor - Brook London, London Borough of Lambeth
Vanessa Bridge	Development Worker – Black Health Agency, Manchester
Sue Bush	Termination of Pregnancy Nurse, London Borough of Southwark
Barbara Convery	Teenage Pregnancy Coordinator, Gateshead
Elaine Doherty	Young Women's Pregnancy Options Advisor, South Tyneside
Charlotte Engelnik	Teenage Pregnancy Sexual Health Nurse, Lambeth
Sue Jablonskas	Teenage Pregnancy Coordinator, Nottinghamshire
Diane Osborne	Teenage Pregnancy Coordinator, Walsall
Anne Patterson	Teenage Pregnancy Coordinator, London Borough of Wandsworth
Jennie Patterson	Senior Practitioner Young Family Support Service, City and Hackney
Tracey Samuels	Children's Centre Midwife, City and Hackney
Dr Lindy Stacey	Consultant in Community Gynaecology, City and Hackney
Donna Thorne	Teenage Pregnancy Coordinator, Darlington
Alice Wiseman	Teenage Pregnancy Coordinator, South Tyneside

[1] *Social Exclusion Unit report on Teenage Pregnancy*. HMSO 1999.
[2] *'Planned' teenage pregnancy: Views and experiences of young people from poor and disadvantaged backgrounds*. Cater S, Coleman L. Trust for the Study of Adolescence (TSA), Joseph Rowntree Foundation2006;
A matter of choice? Explaining national variation in teenage abortion and motherhood. Lee E, Clements S, et al. Centre for Sexual Health Research at the University of Southampton and Joseph Rowntree Foundation 2006;
Teenage pregnancy and Choice. Abortion or motherhood: influences on the decision. Tabberer S, Hall C, et al. Joseph Rowntree Foundation 2000.
[3] *Repeat Abortion in the United States.* Jones R, Singh S et al. Guttmacher Institute 2006. http://www.guttmacher.org/pubs/2006/11/21/or29.pdf
[4] ibid.
[5] *RCOG information for patient. About abortion care: what you need to know.*
[6] *The Care of Women Requesting Induced Abortion: evidence-based guideline* number 7.p.23 Royal College of Obstetricians and Gynaecologists, 2004.
http://www.rcog.org.uk/resources/Public/pdf/induced_abortionfull.pdf
[7] ibid.
[8] *The psychological sequelae of therapeutic abortion: denied and completed*. Dagg PK. American Journal of Psychiatry 1991;148:579–85.
[9] ibid.
[10] *Characteristics of women undergoing repeat induced abortion***.** Fisher WA, Sing SS et al. CMAJ 2005: 172 (5). http://www.cmaj.ca/cgi/content/full/172/5/637
[11] *Fourth Annual Report of the Independent Advisory Group on Teenage Pregnancy, September 2006.*
[12] *RCOG guidelines* op.cit.
[13] *Sexual behaviour during the first eight weeks after legal termination of pregnancy.* Boesen HC, RØrbye C et al. Acta Obstetricia et Gynecologica Scandinavica 2004;83(12):1189-92.
[14] RCOG guidelines op. cit.
[15] *FFRPHC Guidance(April 2006) Emergency contraception*. Journal of Family Planning and Reproductive Health Care 2006;32(2):121-128
[16] *Peri-abortion contraceptive care: Can we reduce the incidence of repeat abortions?* Garg M, Singh M, Mansour D. The Journal of Family Planning and Reproductive Health Care 2001; 27(2):77-80.
[17] *FFRPHC Guidance* op. cit.