Complete Summary

GUIDELINE TITLE

Contraceptive choices for young people.

BIBLIOGRAPHIC SOURCE(S)

Contraceptive choices for young people. J Fam Plann Reprod Health Care 2004 Oct;30(4):237-50; quiz 251. [189 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology

Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations that cover medical, legal, and other issues facing young people and clinicians in relation to contraceptive advice and treatment, and to sexual and reproductive health

TARGET POPULATION

Young people aged less than 18 years considering the use of contraception

INTERVENTIONS AND PRACTICES CONSIDERED

1. Assessing and documenting of young person's competence (ability to understand advice, weigh up the risks and benefits, and express wishes) using the Fraser criteria
2. Being alert to the possibility of maltreatment, coercion, or exploitation
3. Addressing confidentiality and disclosure
4. Assessing medical eligibility for contraceptive use
5. Contraception:
    - Combined oral contraception
    - Progesteron–only pill
    - Progesteron-only implant
    - Progesteron-only injectable (depot medroxyprogesterone acetate [DMPA])
    - Condoms
6. Counseling young women regarding risks and benefits of contraception use
7. Follow-up 3 months after the initiation of hormonal contraception
8. Ensuring access to and appropriate information on contraception and treatment

MAJOR OUTCOMES CONSIDERED

- Rate of teenage pregnancy
- Incidence of sexual activity in young people aged less than 18 years
- Risks and benefits of hormonal contraception use

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches were performed for: MEDLINE (CD Ovid version) (1990-2004); EMBASE (1990-2004); PubMed (1990-2004); the Cochrane Library (to April 2004), and the US National Guideline Clearing House. The searches were performed using relevant medical subject headings (MeSH), terms, and text words. The Cochrane Library was searched for systematic reviews, meta-analyses and controlled trials relevant to contraception for young people. Previously existing guidelines from the Faculty of Family Planning and Reproductive Health Care (FFPRHC), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO), and reference lists of identified publications were also searched. Similar search strategies have been used in the development of other national guidelines.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications were appraised according to standard methodological checklists before conclusions were considered as evidence. Evidence was graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organizations.

Evidence tables (available on the Faculty Web site [www.ffprhc.org.uk]) summarise relevant published evidence on contraception in young people, which was identified and appraised in the development of this Guidance.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of recommendation are based on levels of evidence as follows:

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

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

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

COST ANALYSIS

The guideline developers reviewed a published cost analysis.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the grades of recommendation, based on levels of evidence (A-C, Good Practice Point), are provided at the end of the "Major Recommendations" field.

How can a clinician assess a young person's capacity to consent to contraceptive use?

1. A clinician should assess a young person's competence to consent to treatment by her ability to understand information provided, to weigh up the risks and benefits, and to express her own wishes (**Grade C**).
2. If a young person is assessed competent this should be documented in case notes as her being "Fraser ruling competent" (advice understood, will have or continue to have sex, advised to inform her parents, in her best interest) (**Grade C**).

3. A clinician can provide contraceptive advice or treatment to a competent young person (aged less than 16 years) without parental consent or knowledge using the Fraser criteria (refer to table 1 in the original guideline document) (**Grade C**).

How can a clinician be alert to the possibility of maltreatment, coercion, or exploitation of a young person?

4. A clinician may wish to inform a young person of the law in relation to sexual activity (**Good Practice Point**).
5. All staff involved in services for young people should receive appropriate training to alert them to the possibility of exploitation or coercion and should be aware of local mechanisms for reporting in line with child protection policy and procedures (**Grade C**).
6. All services should have a named clinician identified as the local lead on child protection policy and procedure (**Grade C**).

How can a clinician address confidentiality and disclosure with a young person?

7. Each young person should be made aware of the confidentiality to be expected from all members of the health care team (**Grade C**).
8. Each young person may be advised that other professionals, such as teachers and youth workers, may not have the same duty of confidentiality (**Good Practice Point**).
9. A young person aged less than 16 years should be made aware, in advance, that confidentiality might be broken if current maltreatment, exploitation, or coercion is suspected (**Grade C**).
10. A young person should be made aware that her consent would be sought if information is to be shared or confidentiality breached. However, consent is not essential if the disclosure is justified (**Grade C**).
11. The timing of reporting or breach of confidentiality should be carefully considered and made jointly with the professional lead (**Good Practice Point**).

How can a clinician assess medical eligibility for contraceptive use?

12. A young person should be assisted in making contraceptive choices by considering her individual contraceptive needs and wishes as well as other factors relating to lifestyle and risk of pregnancy or sexually transmitted infection (STI) (**Good Practice Point**).

Puberty and Menarche

13. Young women should be advised against the use of regular hormonal contraception before menarche. If they are sexually active, condoms should be advocated (**Good Practice Point**).

Bone Mineral Density

14. Young women should be informed that normal pubertal development, exercise, diet, and smoking influence bone mineral density (BMD) (**Grade B**).
15. Young women should be informed about the effects of hormonal contraception on BMD (**Grade B**).
16. A young woman may choose a progestogen-only injectable over other contraceptive methods despite uncertainty about the long-term effect on BMD (**Good Practice Point**).

Sexually Transmitted Infection

17. Young people should be advised that, when correctly used, condoms are effective in the prevention of human immunodeficiency virus (HIV) (**Grade B**).
18. Although evidence for a protective effect of condoms against STIs other than HIV is limited, young people should be advised on the consistent and correct use of condoms in the promotion of safer sex (**Good Practice Point**).

How can a clinician optimise a young person's compliance with contraception?

Contraceptive Choices

19. Age alone should not limit contraceptive choices for young people (**Grade C**).
20. A young person should be enabled to use her chosen method of contraception as long as there are no medical contraindications (**Good Practice Point**).

Gynaecological Cancers

21. Young women may be advised that combined oral contraception (COC) reduces the risk of ovarian and endometrial cancer and, with less than 5 years use, does not increase cervical cancer risk (**Grade B**).
22. Young women may be advised that depot medroxyprogesterone acetate (DMPA) does not appear to have any effect on ovarian, endometrial, or cervical cancer risk (**Grade B**).

Breast Cancer

23. Young women should be advised that any increase in risk of breast cancer associated with hormonal contraception is small and there is no effect of duration of use (**Grade B**).

Venous Thromboembolism

24. Young women should be advised that although the risk of venous thromboembolism (VTE) increases with COC use the absolute risk is very low (**Grade B**).
25. Young women may be advised that progestogen only contraceptives do not appear to increase the risk of VTE (**Grade B**).

Weight Gain

26. Young women may be advised that there is no evidence of weight gain with COC use (**Grade B**).
27. Young women may be advised that weight gain can occur with some progestogen-only methods, but may simply reflect the normal increase in weight expected during the early reproductive years (**Grade C**).

Acne Vulgaris

28. Young women can be advised that COCs may improve acne vulgaris (**Grade B**).
29. Young women should be advised that the occurrence of acne can be a reason for discontinuation of progestogen-only implants and injectables (**Grade B**).
30. Dianette® is indicated to treat severe acne which has not responded to oral antibiotics. It should be withdrawn 3 to 4 months after the treated condition has resolved or if there is no improvement (**Grade C**).

Mood Changes and Depression

31. Young women should be advised that it is unclear whether hormonal contraception has an adverse effect on mood (**Grade B**).

Appropriate Follow-up

32. Young people should be encouraged to return at any time if they develop problems with contraception (**Grade C**).
33. A young woman should be advised to return for follow-up in the 3 months after the initiation of hormonal contraception. This allows side effects or other concerns to be addressed and helps ensure correct use of the method (**Good Practice Point**).

How can clinicians ensure access to contraception for young people?

34. Sexual health providers should adapt services to meet the needs of young people (**Grade C**).
35. Services for vulnerable young people may be delivered within mainstream services with outreach facilities provided where appropriate (**Grade C**).
36. Young people attending any reproductive health care setting (e.g., postnatal wards, abortion services, or genitourinary medicine [GUM] clinics) should have access to contraceptive advice and/or treatment (**Grade C**).
37. Reproductive health providers should engage in multi-agency working to promote services for young people (**Good Practice Point**).
38. Sexual and reproductive health services should support school nurses in their development and training (**Good Practice Point**).

How can clinicians ensure young people receive appropriate information on contraception?

39. Young people should have adequate time during consultations to address contraceptive and broader health issues (**Grade C**).

40. Contraceptive and sexual health services may develop links with education authorities and schools to promote and provide the planning, delivery, and evaluation of sex and relationship education (**Good Practice Point**).
41. Sex and relationship education should be provided from childhood and within the context of emotional and social development (**Grade C**).
42. Any service providing contraception or sexual health advice should be able to provide young people with leaflets about contraception, sexual health, and other lifestyle issues, appropriate Web site addresses and highlight other relevant local services for young people (**Grade C**).

How can health professionals involve young people?

43. Young people should be involved in the development of contraceptive and sexual health services (**Good Practice Point**).

Definitions

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

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

General Potential Benefits

- Appropriate medical advice regarding contraceptive choice and use and sexual and reproductive health
- Prevention of unintended pregnancy

Specific Benefits

- Evidence suggests that *combined oral contraception (COC)* has no negative effect and may even have a positive effect on bone mineral density (BMD); *COC* reduces the risk of ovarian and endometrial cancer and may improve acne vulgaris.
- A prospective study found that *progesterone-only implant (levonorgestrel)* increased BMD by 2.5% after 1 year of use and by 9.3% after 2 years' use.
- When correctly used, *condoms* are effective in the prevention of sexually transmitted infection, especially human immunodeficiency virus (HIV).

POTENTIAL HARMS

- Studies in young *depot medroxyprogesterone acetate (DMPA)* users found bone mineral density (BMD) decreased by 1.5% after 1 year of use and by 3.1% after 2 years' use.
- *Combined oral contraception (COC)* is associated with a small increase in risk of breast cancer and venous thromboembolism.
- Weight gain can occur with some *progesterone-only methods*; occurrence of acne vulgaris may be associated with *progesterone-only implants and injectables*.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Contraceptive choices for young people. J Fam Plann Reprod Health Care 2004 Oct;30(4):237-50; quiz 251. [189 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Oct

GUIDELINE DEVELOPER(S)

Faculty of Sexual and Reproductive Healthcare - Professional Association

SOURCE(S) OF FUNDING

Faculty of Family Planning and Reproductive Health Care

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Clinical Effectiveness Unit (CEU): Dr Gillian Penney (Director), Dr Susan Brechin (Co-ordinator); Ms Alison de Souza, and Ms Gillian Stephen (Research Assistants)

Clinical Effectiveness Committee: Professor Anna Glasier (Chair); Dr Chris Wilkinson (ex-officio); Dr David Hicks; Dr Joanne Protheroe; Dr Jo Power; Ms Toni Belfield; Catronia Sutherland

Expert Group: Dr Audrey Brown (Consultant in Sexual and Reproductive Health, The Sandyford Initiative, Glasgow); Mr David Coulter (Education Policy Advisor, National Society for the Protection of Children); Ms Nan Cameron (Community School Nurse, NHS Grampian, Portlethen Academy, Aberdeen); Dr Ruth Howlett-Shipley (Specialist Registrar in Public Health Medicine, Dorset/Trainee Member of the CEU); Ms Margaret McArthur (Nurse Manager, Team Leader, Square 13 Family Planning and Reproductive Health Services, Aberdeen); Dr Louise Massey (Specialist Registrar in Public Health/FFPRHC Education Committee Member); Ms Louise McKay (Senior Health Promotion Specialist, Healthy Respect Project, Lothian); Dr Poornima Prabhu (Clinical Medical Officer, Family Planning, Cardiff); Ms Fiona Rennie (Community School Nurse, NHS Grampian, Aberdeenshire); and Ms Gillian Walker (Client Services Manager, Caledonian Youth, Scotland)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

Print copies: Available from the Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

Discussion points for contraceptive choices for young people and questions developed by the Faculty of Family Planning and Reproductive Health are available at the end of the original guideline document.

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

PATIENT RESOURCES

None available

NGC STATUS

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