National Teenage Pregnancy Midwifery Network

Working to improve outcomes for teenage parents and their children by developing maternity services to meet their needs.

Preventing unplanned second pregnancies – models of service delivery

This paper describes four different models of service delivery, drawn from members of the National Teenage Pregnancy Midwifery Network, that contribute effectively to preventing unplanned second pregnancies among young women by providing access to contraceptive advice, support and follow-up as part of their maternity care.

The common features of these models are:

- Contraceptive planning begins early in pregnancy, and continues throughout.
- Young women are encouraged to make a contraceptive choice before delivery or very shortly afterwards.
- Midwives or family planning nurses give practical support e.g. with transport to appointments, or ensuring young women leave hospital with a supply of contraceptives.
- Either midwives have additional family planning training or qualifications, or family planning nurses are involved in delivering the service.

1. Family planning services integrated into maternity care

In **South Tyneside** a family planning nurse works as an integral part of the team caring for pregnant teenagers. She meets teenagers at their booking appointment and starts the process of making a contraceptive plan. She sees them again at 28, 34 and 38 weeks, and visits them on the postnatal ward, and at home if necessary. The vast majority of teenagers have chosen contraception before they give birth. If they choose a long-acting method the nurse arranges fast track appointments for implanon or IUDs, and liases with the Sure Start Plus adviser to assist the young women with attending appointments. If they do not keep the appointment, the dedicated health visitor follows it up. Young women who choose oral contraceptives leave hospital with a 3 month supply as part of their discharge plan. The nurse calls and texts the young women at home to remind them to start taking the pills on the 21st day. In her antenatal sessions she does a formal "pill teach". The dedicated health visitor follows up on contraception at 6 weeks, as do the mainstream health visitors later in the first year.

The highly visible service ensures that choosing not to use contraception has to be an active decision, not a default position. The nurse's approach is to find the most suitable contraception for each individual, by focussing on what the young woman wants the contraception to do for her, and how she would feel about body image issues such as having no periods or slight weight gain. All the girls are given condoms during their antenatal care, and the nurse does implanon counselling.

Last year's figures show only 25 re-conceptions within 2 years of delivery (a handful of which were planned, and the rest either declined to choose a method or defaulted on oral contraception).

2. Midwife takes the lead in family planning

In **Wigan** teenagers receive normal midwifery care with extra support from the 0.4 FTE teenage pregnancy midwife who is also a family planning nurse. At her first contact (when the young woman attends her 16 or 18 week scan) the midwife explores previous contraception used (if any) and ensures that the young woman understands why the method may have failed. She then discusses future contraception, with a general explanation of all methods and, if the young woman has already made a choice, a detailed discussion of that method and how to access it locally. She discusses STIs, demonstrates condom use and gives the young woman a supply of condoms. Contraception is raised again whenever the midwife sees the young woman (usually at 30 weeks). She does one postnatal home visit to under 16s and again discusses contraception and supplies condoms.

The midwife also runs teenage parentcraft classes at which she gives out condoms, passes around samples of different contraceptive methods, and uses "beer goggles" to advise on how alcohol and drugs can lead to contraceptive failure (eg faulty condom technique). The contraception session has been incorporated into a tour of delivery suite to maximise attendance.

There is good uptake of contraception, but the teenage pregnancy midwife role may in the future be extended to enable the midwife to issue contraception and fit implanon herself (she is currently undertaking training for this), possibly under Patient Group Directions, to reduce the risk of young women defaulting on their appointments.

The South Tyneside model has been adapted in **Newcastle**, where the teenage pregnancy midwife herself offers implanon counselling and discusses contraception antenatally at 12, 20 and 30 weeks, so that the young women have made a contraceptive choice before birth. If implanon is required she arranges the appointment for 21 days and personally takes more vulnerable young women to the appointment.

In **West Hertfordshire**, the two teenage pregnancy midwives start contraceptive advice at their first contact with a young woman, and continue to discuss it throughout pregnancy. A family planning nurse comes to the antenatal classes. The teenage pregnancy midwives visit the young women within the first week postnatally to arrange contraception, and if they choose the implant or injection the midwives take them by car to the appointment at the local GUM clinic. Only two out of 130 teenagers have had a repeat unplanned pregnancy.

3. Building familiarity with family planning services during pregnancy

In **Leeds** the teenage pregnancy midwife has a one-to-one caseload of under 17s, with care delivered at school or home. She also runs parentcraft groups for 17-19 year olds. She schedules some appointments (and soon, groups) at a midwifery room in the Contraception and Sexual Health / Connexions building, so that young women are familiar with the building and confident about using the co-located services. The midwife discusses contraception throughout the pregnancy, in the context of the trusting relationship she builds up with the young women.

In **Birmingham** the teenage pregnancy midwife makes contraceptive advice a priority, and has arranged regular visits from family planning and sexual health

workers to the teenage pregnancy drop-in group. She also gives out condoms in fun packages when young women who have delivered come back to the group for a reunion party.

4. Referral to family planning services

In **Oxford**, as part of a new care pathway for teenagers, community midwives offer pregnant teenagers referral, at 20 weeks, to specialist family planning outreach clinics based in local communities and Sure Start. These clinics discuss family planning options and document a postnatal plan, which they follow up postnatally.

In **Gateshead**, a family planning nurse offers a dedicated postnatal service to teenagers. She gets to know the young women during pregnancy by attending their drop-in groups. She visits within 21 days after birth to discuss contraception, issues oral contraceptives and revisits women who choose Depo-Provera (as most do) every 11 weeks to re-issue. At present the midwifery service is a very limited source of referrals, but it is potentially an excellent model, with 100% continuation rate of contraception, and teenage conceptions overall down 22%.

Published comparison of two different models of support in Hertfordshire:
Mead M et al (2005). *Evaluation of a midwifery support service for pregnant teenagers*. British Journal of Midwifery, 13(12): 762-766.

This paper describes the outcomes for pregnant teenagers supported in one of two ways. One midwife delivered an "interface model", where in a part time post she had responsibility for all pregnant teenagers and supplemented the care provided by the community midwives by networking across the health service and with other agencies, but did not deliver normal antenatal, intrapartum and postnatal midwifery care. The second midwife delivered a "caseload model" providing full antenatal and postnatal care for teenagers up to 28 days, and intrapartum care for about a third.

The young women looked after by the "interface model" midwife were significantly more likely to have selected a method of contraception (95% vs 67%) and were more likely to use long term methods such as Depo-Provera or Implanon (36% vs 24%). The authors caution that the findings were limited by the fact that only one midwife's performance in each model of care was evaluated, and that personality, and the ethos of the particular local Trust, may have had an important impact on the care they provided.

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