Social Return on Investment

Evaluation of the Leicestershire and Rutland Community Safer Sex Project

Joëlle Bradly

December 2010 – *Revised for SROI assurance in August 2011*

This evaluation has piloted the process of using Social Return on Investment (SROI) to evaluate public services within Leicestershire County Council. The process has been led by the Research and Insight Team with initial support from CFE consultancy. A draft version of this report was peer reviewed by a member of the Young People Economic Team at the Department for Education (DfE).

Assurance Statement

"This report has been submitted to an independent assurance assessment carried out by The SROI Network. The report shows a good understanding of the SROI process and complies with SROI principles. Assurance here does not include verification of stakeholder engagement, data and calculations. It is a principles-based assessment of the final report."

For more information contact

Joëlle Bradly
Research and Insight Manager
Research and Insight Team
Chief Executives Department
Leicestershire County Council
Tel: 0116 305 5883
Email: joelle.bradly@leics.gov.uk
Websites: www.leics.gov.uk/statistics and www.lsr-online.org

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Executive Summary

This report uses the Social Return on Investment (SROI) methodology to explore the value of the Community Safer Sex Project (CSSP) in terms of who is affected by the project and what changes for them. It brings together softer intelligence from those using the services with hard data on outcomes. The stakeholder consultations initially provide an understanding of what matters most to those affected. This then informs the process of identifying indicators and measuring outcomes to understand the social value that can be attributed to the project.

This SROI evaluation of the Leicestershire and Rutland Community Safer Sex Project (CSSP) found that, for each £1 invested in CSSP supporting Connexions Leicester Shire to deliver sexual health services between approximately £7 and £9 is returned in social value. This is based on analysis of outcomes for young people visiting CSSP sites at Connexions between June 2009 and June 2010. Various sources of data were analysed to understand the nature and scale of need for the young people whom CSSP is designed to support. Examples of some of the findings were:

Approximately

- One in ten 14-16 year olds in Leicestershire have had unsafe sex
- One in ten females in the county become pregnant before they reach 20[1]
- One in ten pregnancy tests taken at Connexions are positive
- One in ten young people with a negative test on their initial visit then go on to become pregnant within 12 months

Research also suggested that risks associated with becoming a teenage parent can have significant impacts on future outcomes, regardless of whether a birth occurs. Understanding more about young people's attitudes to risk-taking has identified areas that are important to address such as supporting young people to make more informed choices, promoting healthy relationships and building confidence and autonomy.

The Leicestershire and Rutland Community Safe Sex Project (CSSP) supports the delivery of sexual health services for young people in community settings that they would typically access e.g. school, youth services, Connexions centres. Each year, approximately 500 staff working

[1] Based on Connexions data that 1 in 20 females aged 19 are parents and ONS data that approximately half of pregnancies under 20 end in a termination

with young people are trained by CSSP. Sexual health services are then accessed through these sites by around 10,000 young people each year. By consulting with stakeholders, it was found that benefits of CSSP extended beyond contraception information and provision. Increased confidence in young people to engage with health services and improved emotional health, as a result of the one-to-one support, were felt to also be direct benefits of providing sexual health services for young people. The service was also found to contribute towards reducing risk-taking and increasing engagement for more vulnerable young people.

Analysis of the data suggests that females under-18 using Connexions for sexual health support were less likely to become pregnant a year after their first visit than would be expected if the service did not exist[2], although the difference was not large enough to be statistically significant. However, around 12% of females who initially used the service for a pregnancy test were estimated to then continue to use the service proactively for advice or contraception without any further pregnancy tests, or becoming pregnant, that year. Such changes in behaviour, as evidenced by case studies, can significantly benefit young people, their families and public services. This suggests that benefits of the service extend further than simply preventing pregnancies by also addressing the behaviours associated with becoming a teenage parent, such as lack of autonomy and risk-taking.

The SROI process identified that addressing these behaviours has a significant benefit to both young people and public services. However, it was also recognised that a number of different factors, outside the scope of CSSP, contribute to such risk-taking and a number of different agencies may need to be involved in supporting young people to feel more in control of their lives.

Through calculating the social benefits of CSSP, the following outcomes were found to create the largest value:

Primary benefits

- Reduction in teenage pregnancy for young people (variable)

Secondary Benefits

- Young people make more informed proactive choices

[2] Compared to the 1998 baseline under-18 conception rate

- Reduced cost to public services of a teenage pregnancy (variable)
- Better support for young people taking risks reduces the number of disengaged young people

Tertiary benefits

- Improved access to emotional support for young people

Based on these findings, and the value of social return, it is recommended that CSSP continues to support the delivery of sexual health services for young people. The following recommendations can also be made with regards to ensuring efficient service delivery in the future:

Continue to provide dedicated young people friendly, community-based sexual health services across the county, particularly in areas of high need in relation to teenage pregnancy

Ensure service providers target services to meet the needs of vulnerable young people and those taking risks

Ensure high quality and diverse targeted training continues by developing a core training set which includes early intervention, taking into account the findings from the Coventry University research on risk-taking

Communicate teenage pregnancy risk factors, and links to other outcomes, to ensure partners work holistically to address young people's needs

Embed multi-agency practice at an operational level to inform service planning and delivery

Embed the indicators from this report to inform and review the value of sexual health work, e.g. increased confidence in young people

Continue to use data and soft intelligence, e.g. users' feedback, to inform service provision

Introduction

> Aims and objectives of the report

The aim of this report is to use the principles of Social Return on Investment (SROI) to evaluate Leicestershire and Rutland's Community Safer Sex Project (CSSP) in terms of its support to Connexions to deliver sexual health services to young people in Leicestershire. Social Return on Investment is an evaluation tool that demonstrates the value of investment by considering a range of outcomes for all stakeholders affected by the project. It attempts to put a monetary value on a range of social outcomes, both intended and unintended, so they can be included in measuring the impact of a project, while also taking into account who else may have contributed towards outcomes and what would have happened without the activity.

SROI is based on seven principles:

1. Involve stakeholders
2. Understand what changes
3. Value the things that matter
4. Only include what is material
5. Do not over-claim
6. Be transparent
7. Verify the result

The report will first consider how CSSP fits into the wider Teenager Pregnancy Strategy, the actual cost of teenage pregnancy and the current needs for young people in the county regarding sexual health. This information, and consultation with those affected, can be used to understand how CSSP currently addresses needs to promote better outcomes for young people and reduce financial pressures on public services. The evaluation will focus on one strand of CSSP to estimate the social return on investment of supporting the Connexions service to deliver sexual health services to young people over a 12-month period.

Limitations of the SROI process will be considered throughout the report to ensure that conclusions are not overstated and any judgements are transparent.

> Overview of the Teenage Pregnancy Strategy

The poor outcomes for teenage parents and their children have been well documented over the past twenty years. The Government's Teenage

Pregnancy Strategy, launched in 1999, represented the first co-ordinated attempt to address both the causes and consequences of teenage pregnancy. The strategy's targets included halving the under-18 conception rates by 2010 from the 1998 baseline and increasing the proportion of young parents in education, employment and training to 60% (to reduce social exclusion). Since the launch of the strategy, there has been steady progress towards these targets and in 2008 the under-18 conception rates in England were the lowest they have been for over 20 years. This represented a fall of 13.3% from 1998.

The Leicestershire Teenage Pregnancy Partnership supports local work towards both reducing teenage pregnancies and supporting young parents. The Community Safer Sex Project (CSSP) team train practitioners working with young people in their community to deliver sexual heath services, namely information, advice and support alongside condom distribution and pregnancy testing services

> Scope and context

Previous evaluations of CSSP have relied on the high numbers of users to demonstrate the popularity and accessibility of the service and high satisfaction rates of users, trained practitioners and partner agencies to evidence the quality of service. However, since community safer sex sites were first established in 2000, under-18 conception rates in the county have fluctuated, questioning the actual impact that the service is having on the lives of young people and costs of public services.

Of the 123 CSSP sites, 6 are based at Connexions centres in the county. Visits to Connexions sites represent 13% of all CSSP visits. Connexions Leicester Shire record their sexual health interventions on a centralised client database which can be analysed, along with other information on outcomes, over a specified period. This allows for a better understanding of actual *impacts*. Therefore, this SROI evaluation will focus on the return on the investment of CSSP supporting Connexions Leicester Shire to deliver sexual health services in the county.

Consistent recording of sexual health interventions at Connexions sites began in June 2009. This enables analysis of a full twelve months of sexual health activities, between June 2009 and June 2010.

Chapter 1: The context of delivery of CSSP

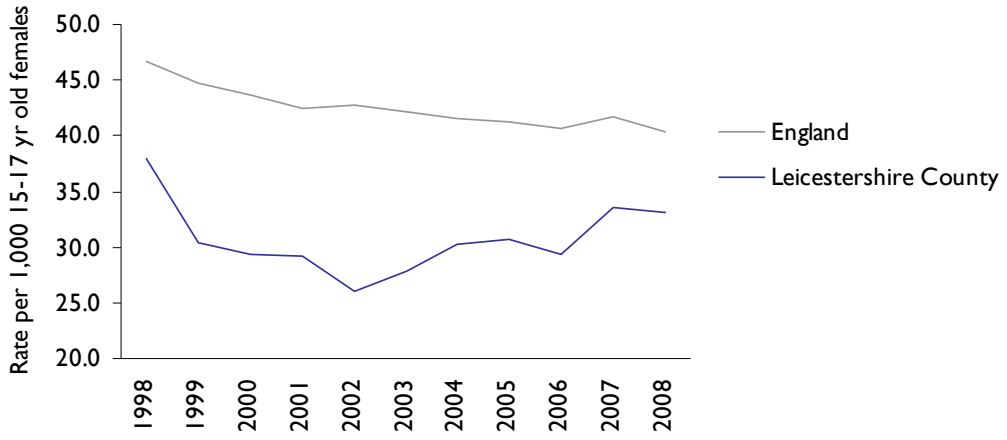
> Policy, political and economic context within which the strategy sits

Funding of the Teenage Pregnancy Strategy is based on the view that the costs of teenage pregnancies outweigh the cost of interventions to support their reduction. The Teenage Pregnancy Strategy Evaluation[3] in 2005 found that 9,350 pregnancies were averted between 1999 and 2002. The cost of the strategy over this period was £63.17 million. This equates to £6,753 spent per conception averted. Taking into account the saving to the NHS through reduction in births/terminations (19.95 million) the public sector cost was £4,623 per conception averted. The actual cost benefit of reducing teenage pregnancies will be discussed later in this report.

In 2008, there were 401 conceptions to females aged between 15 and 17 in Leicestershire. This equated to a rate of 33.1 per 1,000 females aged 15 to 17. This is lower than regional (39.6) and national rates (40.4).

In Leicestershire there has been a 12.9% reduction in the under-18 conceptions rate between 1998 and 2008. However, this compares to a reduction of 13.3% nationally[4]. Current rates are also slightly higher than expected, given the low levels of deprivation in the county. Based on current population estimates, there would need to be fewer than 250 conceptions to under-18's over a year in Leicestershire to meet the local 2010 target rate of 20.9.

Fig 1. Under 18 Conception rate



[3] *Teenage Pregnancy Strategy Evaluation: Final Report Synthesis* (2005) Department for Children, Schools and Families http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/research/strategyresearch/

[4] Office for National Statistics http://www.statistics.gov.uk/statbase/ssdataset.asp?vlnk=8903

Connexions data suggests that 4.91% of 19 year old females living in the county, *known* to Connexions, are currently parents or soon-to-be parents. It can therefore be estimated that around 1 in 20 females in Leicestershire become parents before they turn 20[5]. Moreover, given that an estimated 50% of under-20 conceptions end in terminations in the county, approximately 1 in 10 females in the county may be expected to become *pregnant* by age 20[6].

> Review of existing evidence

Outcomes for teenage parents

The outcomes for teenage mothers are well documented. Teenage parenthood is commonly associated with poor health and wellbeing outcomes including: increased risk of low birth-weight babies, a 60% higher infant mortality rate, poor mental health status of teenage mothers, and poor economic wellbeing[7].

Compared to peers from similar backgrounds, teenage mothers are more likely to have lower qualifications, lower incomes and be more likely to rely on benefits at the age of 33 than those who do not become teenage parents[8].

Locally, Connexions are required to work with, or offer support to, young mothers until they reach age 20. Connexions Leicester Shire reported that 62.7% of teenage mothers (age 16-19) in the county were not in education, employment or training (NEET) in September 2010. This compares to 5.3% of all 16-18 year olds in the county. However, further exploration of data shows that 31.4% of current pregnant young women in the county were NEET just *before* they became pregnant (and a further 10% were still in school). This suggests that, even before becoming parents, a significant proportion were disengaged from EET. Connexions data also shows that engagement in EET increases as time passes after giving birth, and that those who became parents before leaving school

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[5] Additionally, models using the 1970 BCS estimate that 9.8% of women in areas of average employment, and in families of average income, become teenage mothers http://sticerd.lse.ac.uk/dps/case/cp/CASEpaper141.pdf

[6] This is likely to be an under estimation given that Connexions do not routinely follow up those over 18 so some pregnancies at 19 will be unknown.

[7] *Teenage Pregnancy: Accelerating the Strategy to 2010* (2006) Department for Education and Skills http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/ig00156/

[8] *A League Table of Teenage Births in Rich Nations* (2001) UNICEF, Innocenti Research Centre http://www.unicef-irc.org/publications/328

(under 16) are more likely to re-engage in EET as young parents (16-19) compared to teenage parents who become parents post-16.

Between July and October 2010, a childcare sufficiency survey was completed by parents (97% of whom were mothers) of 4,208 children in the county, around their childcare needs. Parents and children's ages were included in the survey, as well as a number of questions around family composition and income. This allows for a breakdown by whether the parent was aged over 20 when the child was born or not.

It was calculated that 2.5% of children (107) whom surveys were completed on behalf of had parents who were aged 20 or under when they were born. The average age of the younger parents when they completed the survey was 24, compared to 37 for older parents. However, the average age of children was 5 for children born to both younger parents and older parents. In terms of children's age-related needs, therefore, samples are broadly comparable.

Of children born to a parent aged 20 or under, figure 2 shows that 36% lived in a household which had an income of under £10,000 (including benefits but before tax) compared to only 5% of children born to older parents. Assuming that the lowest annual household income is £10,000 and the highest is £60,000, the difference in average annual household income is approximately £19,500[9]. For 41% of children born to younger parents that parent was employed, compared to 71% for children of older parents. For a further 6% of children of younger parents, the parent was in full-time education (figure 3).

[9] This is likely to be an under estimatation of the difference as it does not take into account older parents with household incomes much higher than £60,000

Fig 2. Annual household income by age became a parent

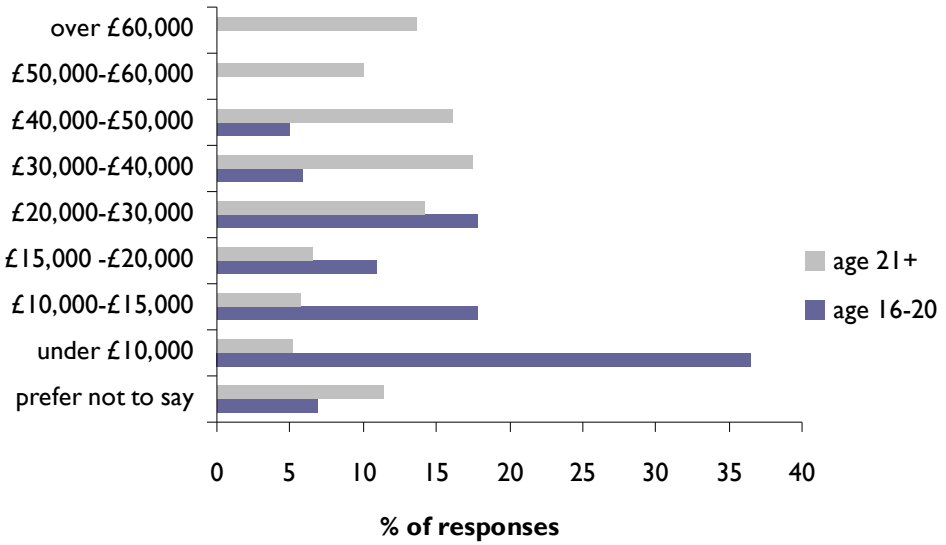
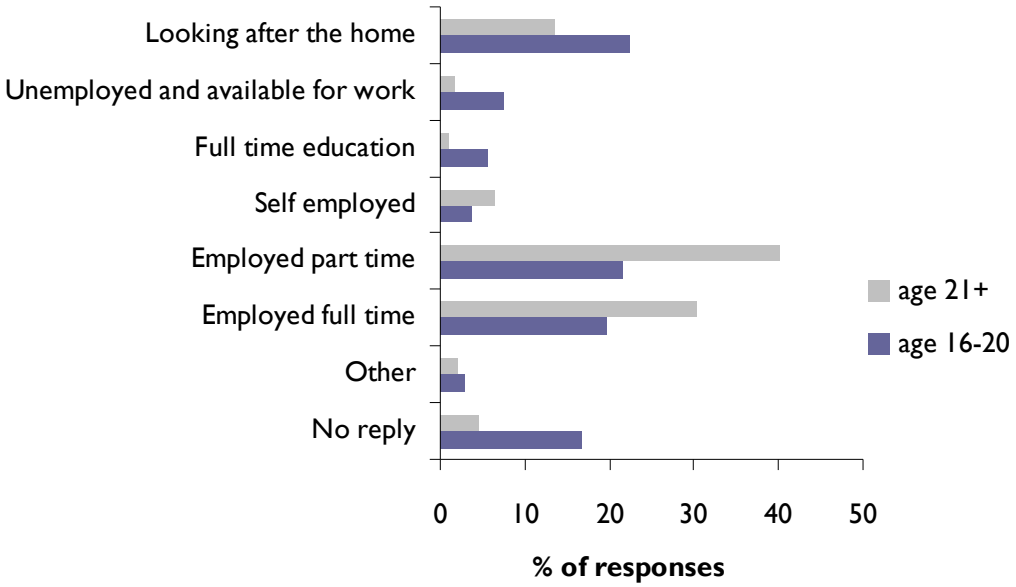


Fig 3. Economic status by age became a parent



For children born to younger parents, 40% were in lone-parent families compared to only 11% of children born to older parents. When asked about a partner's economic status, for 78% of children born to younger

parents whose parent had a partner, that partner worked full-time, compared to 93% for children of older parents. For 11% with partners, that partner was unemployed, compared to only 1% of children born to older parents, and for 4% the partner was permanently sick or disabled compared to less than 0.5% born to older parents. This suggests that less than half of children born to a teenage parent are supported financially by that parent's partner compared to over 80% of children to older parents.

These findings would suggest that, for children of younger parents, household incomes are significantly lower and this is partly accounted for by the finding that significantly fewer young parents live with a partner who is working. Moreover, for the children of younger parents, approximately half of the young parents were in employment or full-time education when completing the survey which does challenge assumptions about 'lifetime welfare dependency' generally associated with teenage parenthood.

It is often difficult to predict what outcomes would have been for young parents had they not become teenage parents. Teenage pregnancy is associated with deprivation, lack of qualifications and low educational expectations[10], which are all likely to contribute to poorer outcomes. Longitudinal research on the 1970's birth cohort by Ermisch and Pevalin (2003)[11] looked into the *causal* effects of a teenage birth and found that at age 30 there was little adverse impact, in terms of employment, income and qualifications, for those who were teenage mothers compared to those who became pregnant as a teenager but miscarried. This is a more reliable method of using a control group for comparison as it takes into account all factors, rather than just those that are commonly measured, which may lead young people towards teenage parenthood. It also takes into account differences between young people who choose a termination rather than a birth[12]. This research suggests that having a teenage birth is not the factor that 'causes' poor outcomes, but rather the path being followed leading up to it. Addressing the factors *leading* to teenage parenthood may be more likely to result in more positive outcomes or stronger protective factors against disadvantage for the young woman. Indeed, a recent review of long-term consequences of teenage parenthood by the University of Sheffield[13] suggests that 'even if all

[10] *NHS Leicestershire County and Rutland Sexual Heath Needs Assessment* (2010) LLR PCT
[11] *Does A 'Teen-Birth' Have Longer-Term Impacts On The Mother: Evidence from the 1970 British Cohort Study,* (2003) Ermisch, J. and Pevalin D. Institute for Social and Economic Research http://www.iser.essex.ac.uk/publications/working-papers/iser/2003-28
[12] *Teenage Pregnancy and Choice* (2000) Joseph Rowntree Foundation http://www.jrf.org.uk/publications/teenage-pregnancy-and-choice-abortion-or-motherhood-influences-decision
[13] *Systematic review of the long term outcomes associated with teenage pregnancy within the UK* (2010) Unpublished, University of Sheffield, Unpublished

teenage pregnancies could be prevented, this would not eradicate the poorer long-term outcomes experienced by these people.'

Moreover, there is a wealth of qualitative research with young parents on the increased motivation and aspiration that having a child has brought them, often providing them with opportunities to 'turn their lives around'[14][15]. This may suggest that, for some young people, taking similar risks and not becoming a parent may effectively lead them to be worse off if such aspirations and increased motivation are not realized.

Ermisch and Pevalin did find, however, for those young parents who did give birth, if they lived with a partner at age 30 that partner was less likely to have post-16 education and more likely to be unemployed. It is this that results in a reduced 'household' income. This suggests that, even without improving other factors, simply preventing a teen birth *does* reduce the likelihood of bringing up a child on a lower family income due to the lack of partners earnings.

In addition to economic outcomes, the longitudinal research on the 1970's birth cohort found that those who gave birth as a teenager were more likely to suffer from mental health problems in the first three years of being a parent, with higher levels of mental illness 2 years after the birth. This is important to consider in terms of the emotional costs of being a young parent.

Public costs of teenage parenthood

The public costs of supporting young parents have been estimated in a variety of documents. In a recent policy report by Straight Talking[16], the Teenage Pregnancy Unit estimated that it costs £14,000 in public services to support the first year of a birth for a parent under 18. This includes health and social costs as well as benefits. In terms of longer-term costs, the Teenage Pregnancy Strategy Evaluation[17] in 2005 calculated that a 17 year old giving birth will receive an estimated £94,063 in benefits (assuming the parent remains on benefits for 16 years of bringing up a

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[14] *Planned Teenage Pregnancy*, (2006) Cater, S. and Coleman, L. Joseph Rowntree Foundation http://www.jrf.org.uk/publications/planned-teenage-pregnancy-views-and-experiences-young-people-poor-and-disadvantaged-bac

[15] *Teenage Parenthood: What's the Problem?* (2010) Alexander, C., Duncan, S. and Edwards, R. http://www2.lse.ac.uk/newsAndMedia/publications/books/2010/TeenageParenthood.aspx

[16] *Taking Responsibility for Young Lives* (2010) Straight Talking Charity http://www.straighttalking.org/takingresponsibility/ST_Government_Report_2010%20Vweb.pdf

[17] *Teenage Pregnancy Strategy Evaluation: Final Report Synthesis* (2005) Department for Children, Schools and Families http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/research/strategyresearch/

child). Other reports have attempted to include the additional public costs associated with poorer social outcomes. A recent study by York University into estimating the life-time cost of NEET[18] estimates that the public finance cost of supporting teenage parents up to the age of 25 are between £67,592 (with support) and £193,734 (without support). This includes costs of benefits, social services and the criminal justice system.

This review of the recent research literature, however, has identified that assumptions about a 'lifetime on benefits' and social problems *caused* by a teenage birth should be challenged. Poor outcomes are not necessarily reduced without a change in factors associated with a risk of teen parenthood. It is therefore important to understand the factors associated with 'risk' of pregnancy and teenage parenthood.

Understanding risk-taking

The national teenage pregnancy guidance[19] identified 'risk factors' associated with increased likelihood of becoming pregnant or becoming a teenager parent. The most significant factor was having a mother who was a teenage parent. Other associated factors include poor mental health, involvement with police, drug and alcohol misuse, low educational attainment, low school attendance, disengagement from (and dislike of) school, being in care and low parental aspirations. The policy report from Straight Talking[20] identified typologies of teenage parents, based on the charity's experience, including 'accidental', 'risk-takers', 'career choice', and 'coerced', with issues ranging from contraception failure, alcohol misuse, low self-esteem and domestic violence. This highlights the complexity around addressing issues associated with teenage pregnancy.

Local research, carried out by Coventry University and commissioned by Leicestershire's Teenager Pregnancy Partnership in 2010[21], surveyed 576 young people aged 14 to 16 around attitudes to sex, sexual health and teenage pregnancy. Three schools in the county were selected that represented different levels of deprivation.

The most common 'main reason' young people gave for having sex was because they were in a relationship (83%). The most common reason for *not* having sex was because 'a pregnancy would get in the way of future

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[18] *Estimating the Lifetime Costs of NEET* (2010) University of York http://www.york.ac.uk/depts/spsw/research/neet/

[19] *Teenage Pregnancy: Accelerating the Strategy to 2010* (2006) Department for Education and Skills http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/ig00156/

[20] *Taking Responsibility for Young Lives* (2010) Straight Talking Charity http://www.straighttalking.org/takingresponsibility/ST_Government_Report_2010%20Vweb.pdf

[21] *Understanding young peoples' behaviour, attitudes, perceptions and influences in relation to sex, sexual health and teenage pregnancy* (2010) Coventry University, *for* Leicestershire Teenage Pregnancy Partnership

plans'. None of the 576 young people stated that they wanted to start a family when they left school. Around half of all the young people stated that they would consider abortion if they had an unplanned pregnancy. The most common 'ideal age' to start a family was 25, and 83% thought that being a teenage parent would be hard.

Half of the young people stated that they had not had any sexual experience, 18% had had a sexual 'experience' and 27% stated that they had had sex. Those young people who stated that they had had sex were significantly less likely to want to go to university, significantly less likely to state that they want to do what their parents want them to, significantly more likely to know someone who has been a pregnant teenager, more likely to say that they are similar to those who get pregnant, aware that they are more likely than their peers to get pregnant and less likely to regret unprotected sex. However, they were just as likely to regret a pregnancy and no more likely to want to be a parent one day.

Of those who had had sex, 37% stated that they were 'not always' safe. This represents 11% of the overall sample. Those who claimed they were not always safe were asked for reasons why they did not use contraception. Of the reasons given, some were due to not thinking (e.g. being drunk or caught up in the moment) while others were due to choosing not to (e.g. being too embarrassed or thinking they didn't need to).

> *"Sometimes you just get caught up in the moment and forget to use protection. Or if you're drunk and don't know what you're doing then protection wont be used"*
>
> *"After a long time I never got pregnant and myself and partner think one of us may not be able to have children"*
>
> *"Because I didn't have any at the time and it feels better without."*
>
> *"It's embarrassing to ask the other person to buy it, or buy it yourself"*
>
> *"It wrecks the moment having to worry about contraception"*
>
> *"Can't be bothered"*

While there were some significant differences between those stating that they had had sex and those who hadn't, there were less statistically significant differences between those taking risk and those always safe. This is partly due to smaller sample sizes. However, it is worth highlighting some of the differences between groups to try to identify factors associated with not always being safe.

Those who had had unsafe sex were even less likely to want to go to university, even less likely to want to do what their parents think they should, less likely to regret unprotected sex, less likely to use the Emergency Hormonal Contraceptive (EHC) after unprotected sex (37% said that they definitely would compared to 59% who were always safe) and more likely to have a family member who was a pregnant teenager. However, these differences were not statistically significant

There were some statistically significant differences; those who were not always safe were significantly more likely to be aware that they were more likely than their peers to get pregnant, but less likely to state that they want to be a parent one day. They were also significantly more likely to say that using a condom makes sex awkward, that using condoms interrupts the flow of sex and that using a condom would mean less pleasure.

There were also many similarities between those who were always safe and those who weren't. For example, those who were not always safe were no more likely to think they are *similar* to girls who do get pregnant, no more likely to be happy to be pregnant, no less likely to regret getting pregnant, no more likely to know someone who was a pregnant teenager, no less likely to consider abortion if they had an unplanned pregnancy, no less likely to think you should own your home or have a steady income before you have a child and no less likely to be able to afford condoms or say that buying them is embarrassing.

Reasons for having sex tended to be similar for those taking risks and those not, in terms of 'being in a relationship' (around 80%), and 'for the experience' (around 40%). However, of those who were not always safe, 27% said one of the main reasons for having sex was because a partner wanted to, compared to 16% who were always safe. Moreover, 66% of those who were not always safe stated that one of the main reasons was for pleasure, compared to 49% of those who were always safe.

Overall, the research found that most young people (89% in this sample) do appear to be acting responsibly regarding their sexual health and attitude to contraception. However, the small proportion of young people who do take risks did not always appear to relate unsafe sex to being pregnant or a teenage parent. In general, those who have had sex may have less preferences for higher education but they are not more likely to want to be a parent or less likely to regret a pregnancy. Furthermore, those who are taking risks are even less likely to want to be a parent one day. Rather than pregnancy being seen as a rational choice for those with little alternative, these findings suggest that young people can be aware of the risks they are taking without necessarily *wanting* to be 'teenage parent'.

Summary of evidence

These findings highlight the importance of CSSP in terms of providing young people with information and support, particularly with regards to the range of contraceptive methods available, and encouraging young people to consider the consequences of risk-taking and to feel that they can make safer choices. The young people taking risks appear to make decisions based on the *immediate* consequence. These immediate consequences can include factors such as less pleasure, 'interruption' or awkwardness for either themselves or their partner.

Despite not wanting to be parents yet, a small number of young people do not take sufficient action to avoid it, suggesting that some may feel that they have little control of their future and what happens to them. Being proactive and taking precautions to avoid unwanted situations can be a complex and unfamiliar change in behaviour. The research into outcomes of being a younger parent, and the similar outcomes for those who, by chance, do not become a parent, suggests that this may be a factor associated with poorer long-term outcomes. Raising aspirations, and improving decision-making skills, can, therefore, be important in improving the poor outcomes associated with teenage parenthood.

While there have been a number of evaluations of initiatives aiming to reduce teenage pregnancy, data regarding impacts remains limited in the UK. A recent review of targeted youth work[22] suggested that strategies that encourage sex education and contraceptive services, while remaining important, might not lower the rate of teenage pregnancy compared to youth development programmes that promote healthy relationships and engagement with learning. However, literature demonstrates that there are often other positive outcomes for young people involved in pregnancy prevention initiatives that are not identified as key outcome measures of an intervention. For example, interventions aimed at promoting behaviour changes also tended to increase confidence, motivation or emotional wellbeing in participants; and interventions aimed at reducing teenage pregnancy tended to increase autonomy and confidence, whether or not reduction in teenage pregnancy was achieved[23].

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[22] *Improving outcomes for young people by spreading and deepening the impact of targeted youth support and development* (2010) C4EO http://www.c4eo.org.uk/themes/youth/supportanddevelopment/files/research_review_targeted_youth_support.pdf

[23] *Young people, pregnancy and social exclusion: a systematic synthesis of research evidence to identify effective, appropriate and promising approaches for prevention and support*, (2006) Harden, A., Brunton, G., Fletcher, A., Oakley, A., Burchett, H. and Backhans, M. Institute of Education, Social Science Research Unit, EPPI-Centre http://eppi.ioe.ac.uk/cms/LinkClick.aspx?fileticket=N5UCW7SBFiw%3d&tabid=674&mid=1568&language=en-US

Chapter 2: The delivery of CSSP

> Summary of the overall delivery strategy

The Community Safer Sex Project (CSSP) was established in 2001 to support the emerging Teenage Pregnancy Strategy. Its core aim was to support and facilitate the development of local community-based pregnancy testing services. Twenty sites were set up in the first year. Through commitment from key partners and increased involvement of young people, the sites developed and delivery expanded. There are now over 120 sites within the County and Rutland supported by CSSP to deliver community-based sexual health services for young people, providing both preventative and reactive approaches to improving sexual health and reducing unplanned pregnancies as well as enabling and encouraging access to clinical services. The CSSP team also deliver sexual health training accessed by partner agencies, including clinical staff. The training covers areas around delay, legal issues, confidentiality and developing positive relationships.

The CSSP is led by a co-ordinator and supprted by two development workers employed by Voluntary Action Charnwood and based in Loughborough. The team delivers a face-to-face service from John Storer House and train and support other providers to deliver services from a range of community sites. Approximately 500 practitioners are trained each year to deliver a range of sexual health services and the sites are accessed by around 10,000 young people a year.

The CSSP has to date received funding on an annual basis. Of the total 2009/2010 budget for Leicestershire's Teenage Pregnancy Strategy, approximately a quarter was dedicated towards CSSP. This totalled £98,000.

Fig 4. Location of CSSP sites and teenage pregnancy hot spots

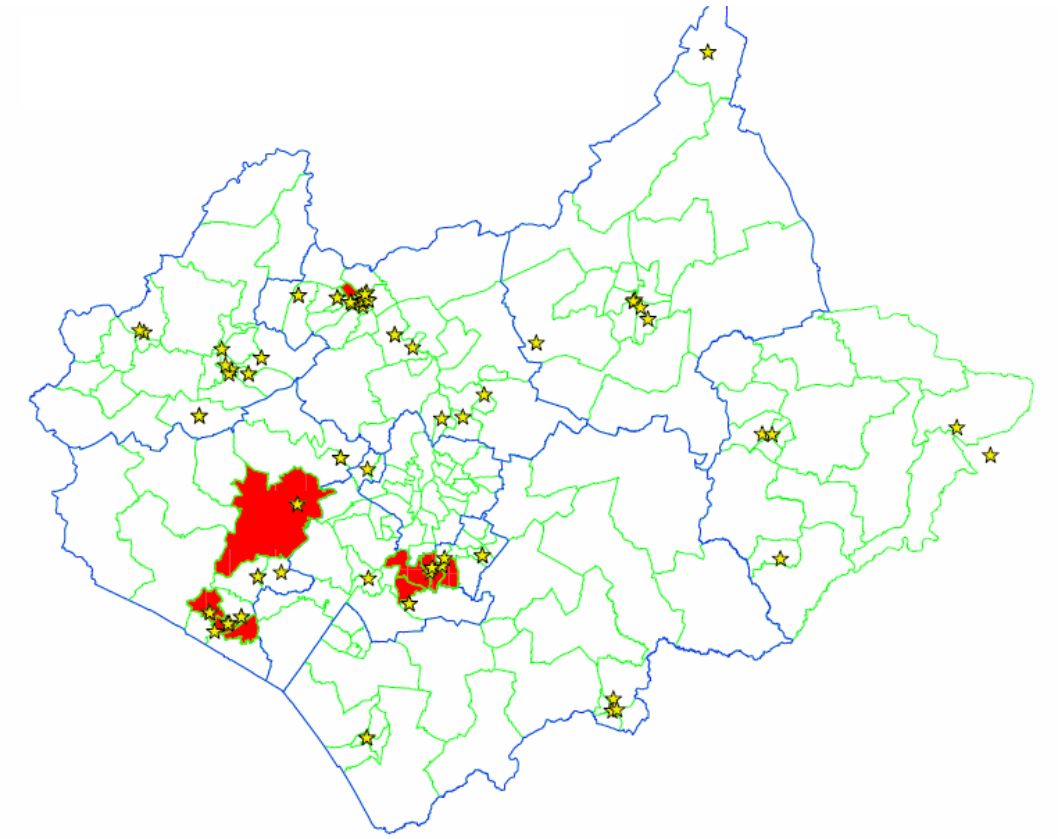


Figure 4 shows the locations of all Community Safer Sex sites and the locally identified 'hot spots'[24] for under-18 conceptions. These hot spots wards are:

- Loughborough Storer
- Newbold Verdon with Desford and Peckleton
- Hinckley Trinity
- Hinckley Castle
- Burbage St.Catherines and Lash Hill
- Saxondale
- South Wigston
- Wigston All Saints
- Blaby South

The objectives of CSSP are:

- Practitioners in community settings are equipped to offer on-site sexual health information, condom services and pregnancy testing

[24] Leicestershire Teenage Pregnancy Executive report (15.04.10)

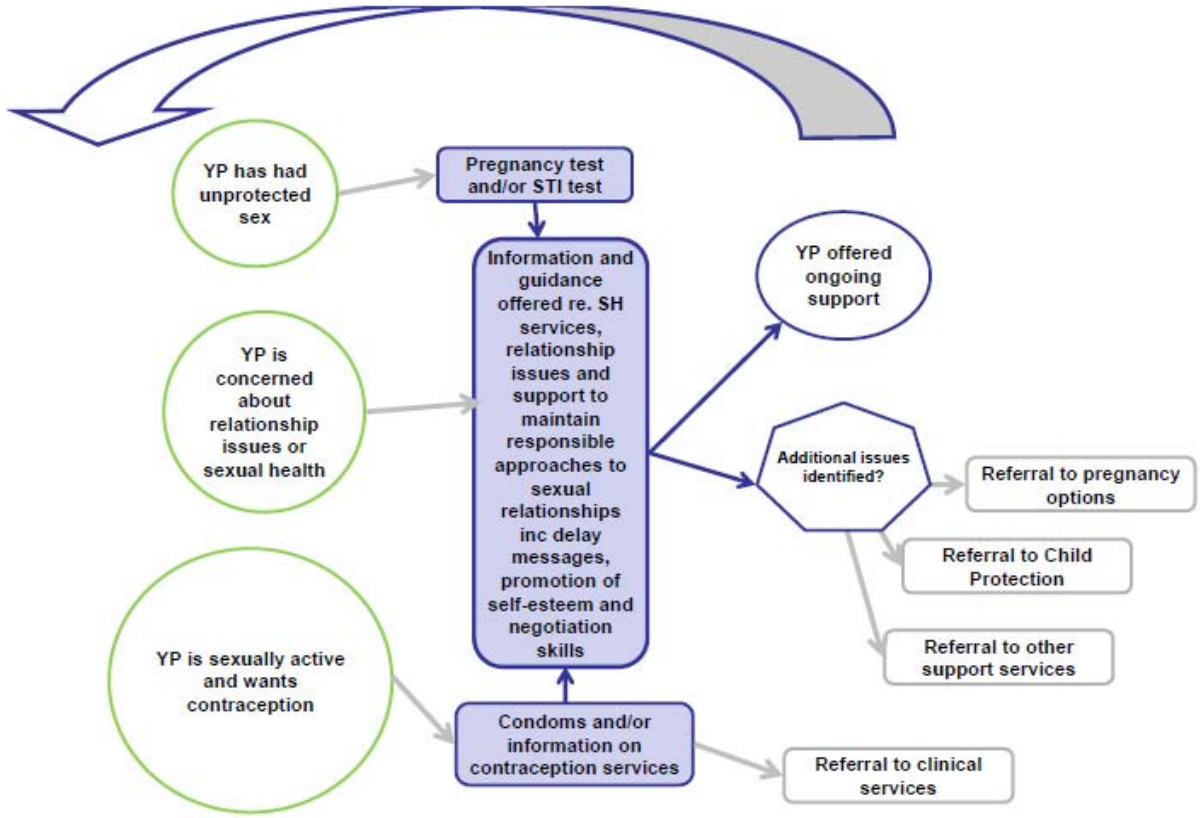
to young people, and to signpost or make referrals to more specialist services as appropriate

- The Children's Workforce are supported to actively engage in the implementation of the local teenage pregnancy strategy
- Improved access to sexual health information and services in familiar surroundings for young men and women from all communities
- Service providers are trained to encourage discussion around sexual health and relationships in line with national guidance, including talking with young people about delaying early sex
- Service providers are trained to promote safer sex awareness and the avoidance of unplanned teenage pregnancy in line with the Teenage Pregnancy Strategy and national drivers such as Every Child Matters
- Contribute to delivery of the target to reduce teenage conceptions by 45% from 1998 baseline by 2010
- Young people have access to the information and support they need to make informed choices about their lives and relationships
- Joined up and consistent messages about relationships and sex reach young people, practitioners and the wider community
- Children and young people have access to, and engage readily with, information about local services in their areas and know how and when to access them
- Young people demonstrate a responsible, informed and consistent approach to sex and relationships as a result of their engagement with CSSP sites

> Customer journey

A customer journey map provides a clear picture of how young people use CSSP sexual health services. Young people can access the service at a range of community based settings. This map shows how young people are provided with a service, but also provided with information and guidance to maintain responsible approaches to sexual relations, signposted to other services if required and offered ongoing support. This additional support may not always be offered at alternative services such as chemists or family planning clinics.

Fig 5. Young People's Journey Map



Chapter 3: The effectiveness of CSSP Delivery

> Case studies

To understand how young people use the service effectively, a selection of case studies can be reviewed to identify how the service can have a positive impact on users and promote or support more proactive behaviour. The three case studies below, provided by CSSP staff, show how the service can address particular issues associated with unsafe sex.

Case study 1

"A young man texted me to ask if he could come and talk to us about when was the right time to have sex. His texts indicated that he was clearly very nervous as a total of 15 texts were received enquiring about confidentiality, service times, etc, etc. Reassurances were offered (given normal limitations to confidentiality) and he visited later that day. He was a 15 year old boy who confided that he was under pressure from a 16 year old female friend to have sex, but he didn't feel ready. He had not spoken to anyone about this before – understandably, he felt his friends would tease him as there was a huge sense of male bravado at his school. I spent half an hour with him discussing how he felt and the implications of having sex. We also explored the implications of not having sex and how he could manage any difficulties that arose from this decision. The young man texted me the next day and said:

> *"Thank you for the chat. You really opened my eyes to how unready I am for sex"*

A year later the young man visited our service again and has continued to do so monthly. He has a steady girlfriend and they access us for condoms which they use conscientiously. The young woman is keen to use the pill and we have been able to give her the information about this that she needs, including correcting her mis-information, and we have signposted her to contraceptive services."

Case study 2

"A young woman (15) texted to say she was going to have sex with her boyfriend but he had already said he refused to use a condom and she wanted advice. We responded to stress the risks that would be involved in unsafe sex and that it was important that she felt confident in the relationship to assert her own wishes.

Two weeks later, the young woman texted to say she had just done a positive pregnancy test, having had unsafe sex on the evening in question. She was distraught and visited our service later that day. During the course of this and two other visits, we offered support to her and, with her consent and knowledge, to her mother, also. The young woman decided that a termination was her best option although she was very anxious about the procedure and we supported her through this time. Post-termination, she said to us:

> *"Thank you so much; I don't know what I would have done without you guys. I know I made the right decision"*

A year later she has been back to the service for information about long-acting contraception and, as a direct result of our reassurance, has had an implant fitted."

Case study 3

"(We) had a request to see a 14 year old with her foster mother as she had been consistently expressing her wish to have a baby. The foster mother was becoming increasingly concerned as this wish had been expressed from the age of 12 and had progressed from a wish to a plan of how to make it happen.

She had started a new school and attendance was improving but she didn't feel she had many close friends and felt that many of the other girls were 'immature' and this often frustrated her. Apart from sport and creative subjects, she didn't really enjoy school and didn't have an idea of a future career. Initially, she refused to come along to a pre-arranged appointment with her foster mum but did turn up at the last minute.

At first, she was reluctant to talk, thinking that I would be telling her she couldn't have a baby and spoke only to reiterate her plan to have a baby as soon as possible. During the session, I encouraged her to imagine life in the future, i.e. how life would be once pregnant, what life would be like with a baby and how it would be in five years time.

We looked at the practical, emotional, social and economic needs in order for her and a baby to thrive. She then acknowledged that at 14 she didn't have all the things in place in order for her to independently bring up a baby. As her own childhood had been difficult, she wanted a better life for her baby and recognised that, at such a young age, she would be supported by the services (something she felt would be intrusive and negative)

We then went on to talk about her aspirations and how she could plan her future to enable her to gain the independence she craved. I linked all the above with work on friendships and activity to raise self-esteem and we ended the session by her declaring that she still wanted a baby – just not now, and would now want to stay on at school and have a relationship with someone before considering having a baby."

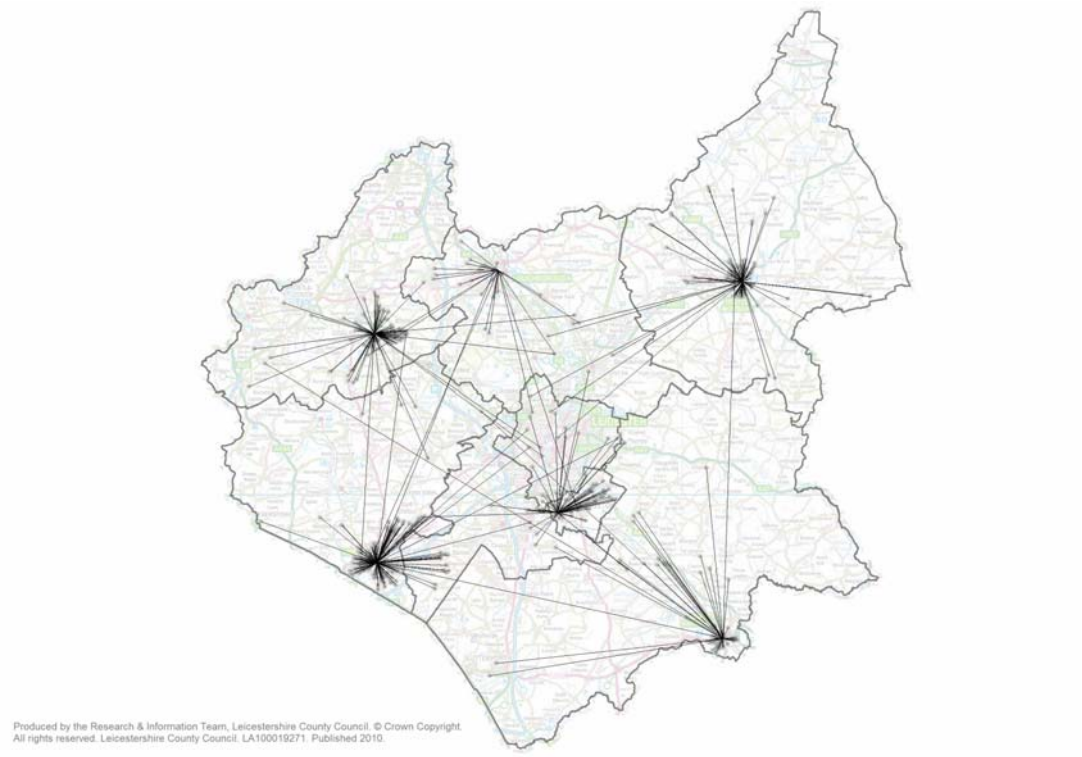
> Analysis of CSSP data

Of the 123 CSSP sites in the county, 6 are delivered at Connexions centres. A selection of Connexions staff are trained, offered on-going support and provided with resources by CSSP. Between June 2009 and June 2010, 13% of CSSP visits took place at Connexions sites

Connexions visits

Between 1st June 2009 and 30th June 2010 733 young people visited Connexions sites in the county and received a sexual health intervention. A valid home postcode was associated with 673 users. Figure 6 shows to patterns of travel to Connexions CSSP sites.

Fig 6. Map of Connexions CSSP users' postcodes and sites used



Output Area Classification (OAC) is used to categorise neighbourhoods according to the social and economic characteristics of those living within them[25]. Figure 7 shows that, compared to the 15-18 population of the county[26], a higher proportion CSSP users live in 'blue collar communities' or 'constrained by circumstances' and a lower proportion live in 'countryside' neighbourhoods or 'prospering suburbs'.

Fig 7. Table of Connexions CSSP users by OAC neighbourhood type

Supergroup	Name	Total CSSP users	Percentage of CSSP users	Percentage of 15-18 yr olds in Leics (2007)
1	Blue Collar Communities	168	**25.0**	11.9
2	City Living	2	**0.3**	0.9
3	Countryside	86	**12.8**	18.3
4	Prospering Suburbs	225	**33.4**	42.5
5	Constrained by Circumstances	53	**7.9**	5.5
6	Typical Traits	136	**20.2**	19.5
7	Multicultural	3	**0.4**	1.4
Total		**673**	**100**	**100**

Over half of CSSP users lived within neighbourhoods that are in the 3 most deprived county deciles for education and skills and 19% lived in the most deprived county decile for employment. There was a relatively even split between males and females with 47% of users male and 53% female. Figure 8 shows that the majority of users were between ages 15-18 when they first accessed the service. This broadly reflects the age group of Connexions users.

Fig 8. Table of age first accessed Connexions CSSP

Age first accessed	%
13	1.0
14	8.5
15	17.3
16	25.2
17	22.9
18	15.1
19	8.6
over 19	1.4

Additional characterises of service users can provide further information on levels of needs. 16% of users had a learning difficulty or disability, 4%

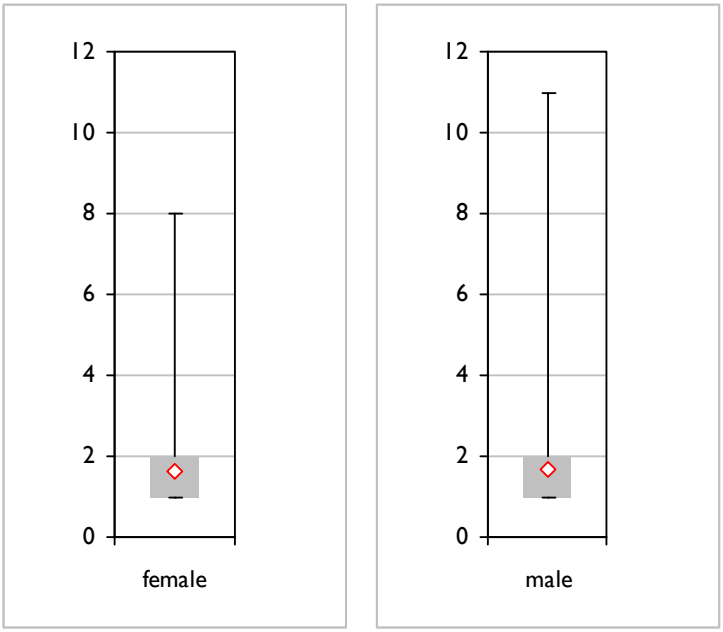
[25] *Leicestershire Output Ares Classifications* (2001) Leicestershire County Council http://www.lsr-online.org/reports/2001_census_output_area_classifcations

[26] Office for National Statistics, Mid-2007 Output Area Population Estimates (unpublished)

were supervised by the youth offending service (YOS) and 3% were in care or had left care.

The average number of visits per young person between 1st June 2009 and 30th June 2010, was 1.6, with a median of 1. The maximum was 11. Figure 9 shows that there was little difference in the number of visits between males and females although a small proportion males (1%) used the service more than 8 times over the 13 month period.

Fig 9. Box plots to show number of Connexions CSSP visits per user by gender



In total, there were 1,208 interventions between 1st June 2009 and 31st June 2010. Figure 10 shows that users were most likely to attend the Hinckley Connexions site. This may be due to the level or promotion of service here, or the lack of alternative services locally.

Fig 10.Table of Connexions CSSP sites accessed

Location	Total number of interventions	% of total interventions
Blaby Oadby Wigston	114	9.4
Coalville	204	16.9
Hinckley	477	39.5
Loughborough	41	3.4
Market Harborough	129	10.7
Melton	243	20.1
Total	**1208**	

In 70% of interventions, condoms were given out. Pregnancy tests were taken in 14% of interventions and Chlamydia tests were given out in 9% of interventions. In 3% of interventions, young people were referred on to another service. Only 1% of interventions resulted in a positive pregnancy test. Figure 11 shows that, compared to all CSSP users, those who had a pregnancy test between June 2009 and June 2010 tended to be more likely to live in 'blue collar communities' and 'constrained by circumstances' neighbourhoods and less likely to live in 'countryside' neighbourhoods.

Fig 11. Table of Connexions CSSP users who visited for a pregnancy test by OAC neighbourhood type

Supergroup	Name	Total taking tests	Percentage of those taking tests	Percentage of CSSP users
1	Blue Collar Communities	34	**28.3**	25.0
2	City Living	0	**0.0**	0.3
3	Countryside	9	**7.5**	12.8
4	Prospering Suburbs	38	**31.7**	33.4
5	Constrained by Circumstances	12	**10.0**	7.9
6	Typical Traits	26	**21.7**	20.2
7	Multicultural	1	**0.8**	0.4
Total		**120**	**100**	**100**

This data on tests taken can be compared to data on areas where young people do become pregnant. Analysis of postcodes from Connexions of *all* current teenage pregnancies (not just CSSP users) in the county[27] shows that neighbourhoods of those taking tests at Connexions CSSP sites are similar to those who do become pregnant (figure 12) although there is an under-representation of service users living in multi-cultural neighbourhoods.

Fig 12. Table of all current teenage pregnancies in the county by OAC neighbourhood type

Supergroup	Name	Total pregnant teenagers	Percentage of pregnant teenagers	Percentage of those taking tests
1	Blue Collar Communities	23	**28.8**	28.3
2	City Living	1	**1.3**	0.2
3	Countryside	7	**8.8**	7.5
4	Prospering Suburbs	20	**25.0**	31.7
5	Constrained by Circumstances	8	**10.0**	10.0
6	Typical Traits	16	**20**	21.7
7	Multicultural	5	**6.3**	0.8
Total		**80**	**100**	**100**

[27] As of October 2010 according to Connexions Leicester Shire

Outcomes

In understanding outcomes, it is important to identify the initial reason for using the service. Applying a hierarchy of need and assigning each visit to the most 'immediate' need can provide a picture of why young people first visit CSSP. In 14% of initial visits between June 2009 and June 2010, a pregnancy test was taken (9% of which were positive). In a further 7% of visits, Chlamydia tests given. This suggests that approximately 1 in 5 users are initially using the service after taking risks. 58% of initial visits resulted in just condoms being given out and 2% resulted in a referral to another service. The remaining 18% of initially visits resulted in 'sexual health' interventions without any of the above. Those who initial visited for sexual health interventions only or Chlamydia screening were most likely to use the service again.

Figure 13 shows that 12.4% (48) of female CSSP users became pregnant within 12 months of a visit. This was lowest for those living in Hinckley and Bosworth, Harborough and Melton and highest for those living in the city or Oadby and Wigston.

Fig 13. Table to show the % of all female Connexions CSSP users who became pregnant within 12 months of their initial visit

District	% of female users who became pregnant within 12 months
Blaby	11.1
Charnwood	13.6
City*	33.3
Harborough	8.9
Hinckley and Bosworth	9.7
Melton	10.2
NW Leicestershire	15.3
Oadby and Wigston	20.8
(blank)	8.3
Grand Total	**12.4**

* only 15 YP visited from the City

However, some of these will include females whose first visit was a positive pregnancy test, therefore this could not have been affected by the service. In total, 8% of all females become pregnant 'after' a sexual health intervention. This is higher for those females who initially came in for a pregnancy test (which was negative) and lowest for those who came in and received condoms, as shown in figure 14.

Fig 14. Table to show the % of all female Connexions CSSP users who became pregnant *after* a visit

Initial visit	% later became pregnant
Condoms	4.8
Sexual health service only	5.3
Chlamydia test	7.1
Pregnancy test (negative)	9.1

Of those *under 18* visiting in the first 6 months, 7% became pregnant within the following 12 months. Assuming that the majority were already sexually active, this can be compared to the 1998 baseline of 7.6% of sexually active 15 to 17 year olds[28]. Of those who visited proactively (to receive sexual health service only or condoms) only 6% became pregnant in the following 12 months.

Comparison to all CSSP sites

According to CSSP data, Connexions interventions represented 13% of all CSSP interventions between June 2009 and June 2010. 33% of CSSP interventions took place in schools and 29% in youth centres. The remaining visits took place at FE colleges (14%) and 'other' sites (11%), mainly the CSSP service in Loughborough.

Annual data, from April 2009 to March 2010[29], shows that pregnancy tests taken at Connexions make up 17% of all pregnancy tests at CSSP sites. 34% are taken in schools and 15% are taken in youth service settings. 25% are taken in 'other' sites and 9% are taken in FE colleges. This suggests that 'other' CSSP sites see a higher proportion of young people who are taking risks[30] than other services and the youth services may see a lower proportion. However, it is also worth noting that 60% of pregnancy tests taken in youth service settings and 65% of those taken in schools were for under-16s, compared to 30% at Connexions sites.

[28] Approximately 50% of 15-17 year olds are sexually active
[29] *NHS Leicestershire County and Rutland Sexual Heath Needs Assessment* (2010) LLR PCT
[30] Or give this reason for initially presenting at a service

Chapter 4: The Social Return on Investment of CSSP supporting Connexions to deliver sexual health services

'Social Return on Investment (SROI) is a tool that helps organisations in measuring social impact and economic value they are creating. It can be thought of as a broad approach to cost-benefit analysis which is primarily used by public sector organisations in deciding whether or not the benefits resulting from an intervention justify its costs'[31].

The SROI process is made up of the following stages

- Talking to stakeholders to identify what social value means to them
- Understanding how that value is created through a set of activities
- Finding appropriate indicators, or 'ways of knowing' that change has taken place
- Putting financial proxies on those indicators that do not lend themselves to monetisation
- Comparing the financial value of the social change created to the financial cost of producing these changes[32]

CSSP provide the Connexions service with training, resources and support to deliver sexual health interventions. However, the amount of training fluctuates depending on need (e.g. staff turnover) and funding available. This evaluation will only consider the amount that was spent between June 2009 to June 2010. Some staff would also have been trained before this date.

> Stakeholders' consultation

In order to analyse the impact of CSSP, it was necessary to identify all the possible stakeholders that are affected by the project. Young people, heath and social care, DWP, parents and CSSP trained Connexions staff were identified as being affected. A selection of stakeholders were contacted and asked to describe the impact of CSSP in terms of what

[31] *The Green Book* (2003) HM Treasury http://www.hm-treasury.gov.uk/data_greenbook_index.htm

[32] *Measuring Real Value: A DIY Guide to Social Return On Investment* (2007) New Economics Foundation

difference the project makes to *them*. The following stakeholders were consulted[33].

- 51 young people (44 in initial consultation and 7 to verify values)
- 13 parents of teenagers (2 in initial consultation and 11 to verify results)
- 18 Connexion staff trained by CSSP (7 in initial consultation and 11 to verify results and attribution)

This represented 7% of the young people who were service users and 36% of the trained Connexions staff. However, when outcomes, indicators and values had been established a database of *all* service users was analysed to calculate actual impact (696 young people over 12 months). Consultation material is available in the Appendix

Young People

The sexual health service, by its nature, considers confidentiality key to providing an effective and popular service. This confidentiality, and the sensitive or personal issues often discussed, meant that it was considered unethical to carry out a comprehensive follow up of users through questionnaires (as the personal nature of visit meant that it would be inappropriate to ask for contact details and re-contact users.) It was possible, however, to involve a sample of CSSP service users in the initial stakeholder consultation by carrying out face to face interviews with young people at the point of service delivery. The consultation was then opened out to other young people in the county who may have used the service. This was done through posting a discussion on the county's youth website and engaging with young people on peer mentoring training. These young people were given the option to state whether they had used the service or not, and answer questions accordingly about the difference the service made to them. It was ensured that these young people consulted represented a range of ages, included both males and females, and included those using the service both proactively and reactively. In total 44 young people were engaged within this initial consultation stage

The following questions were asked to young people to understand the range of possible outcomes of the service, and how any impact can be measured:

[33] The stakeholders do not need to be statistically representative but ideally enough should be included so that all the benefits are covered.

1. Why have you used this service?
2. What difference has the service made to you?
3. Do you think you will do anything differently as a result of using the service?
4. Do you think you will think any differently as a result of using the service?
5. What are the negative impacts of the service?
6. What would you do if the service did not exist?
7. Are there any other benefits of the service?

These interviews were then used to inform both the outcomes and indicators. Seven young people, aged between 15-18, involved in peer research training, were later consulted to verify the values.

Young people were asked **why they used the service**, to gain an understanding of their needs, and how the service addressed them. They mainly cited the need for a confidential service that offered support.

> *"I visited with my girlfriend because we wanted condoms plus my girlfriend is thinking about going on the pill but she's scared of seeing her doctor because she's under 16." Male CSSP user (15)*

> *"(We) can use them to gain access to protection and be able to talk to someone on a one-to-one basis so that things you ask can be confidential." Jitty user*

> *"This is the only place I know about, I didn't want to go to my doctor because I might be seen, or they might tell my parents." Female CSSP user (14)*

> *"Just to talk and discuss personal issues. I used this service because I felt comfortable." CSSP user*

> *"I didn't know what to do after not being able to get the morning after pill so I came back here because I trust them." Female CSSP user (14)*

> *"For help and advice if they are in trouble, and it's a simple place to go"*

When young people were asked **what difference the service made to them** they often said that the service helped them to sort their problems out.

> *"This service has given my friends and me a place to go for friendly but essential advice and help, without it we would not have the confidence to go and get problems sorted." Female CSSP user (16)*

Young people stated that they were often initially nervous about using the service but tended to be more confident after visiting. They felt that the non-judgmental and supportive staff contributed to their willingness to return.

> *"My friends said don't be nervous because they are really nice." Male CSSP user (15)*

The one-to-one contact also provided the opportunity for young people to discuss sexual health concerns or worries and then either receive appropriate support or be referred on to relevant services. It was felt that often such worries are difficult to discuss with other adults.

> *"This has been a very valuable and informative service, which has helped me understand issues which I would feel uncomfortable discussing with a parent or teacher." Female CSSP user (16)*

> *"They help with issues that you can't talk to your parents about."*

Young people also cited the impact of feeling able to talk through sexual health issues. This included being able to think about the consequences of risk taking, realising the importance of talking to parents and seeking further advice without fear of being 'told off'. Young People felt that this impacted on how they made decisions in terms of being able to think ahead and discuss issues before acting.

> *"It made us think about what it would be like if my girlfriend got pregnant because it does happen." Male CSSP user (15)*

> *"I've learnt that maybe I should have waited a bit longer before I started having sex and that I should have got contraception sorted first." Female CSSP user (14)*

When young people were asked about whether they would do or think any differently as a result of the service they talked about being more likely to use services in the future, acting more responsibly, and feeling more supported

> *"The lady was great and talked to us for a while about our relationship and we learnt stuff about the different types of condoms and how to use them. She talked to us about the pill and where to get it and I think my girlfriend will go to the family planning in*

Loughborough soon. She said we could come and see her again and she gave us information to take away." Male CSSP user (15)

"I'll take more responsibility next time, or come for help sooner." Female CSSP user (14)

"It's made me realise that maybe we should try and talk to our parents soon but the main thing is we aren't worried any more about being judged or told off and I am really pleased my girlfriend is going on the pill probably because that's extra safe too." Male CSSP user (15)

"It gives people confidence to make the right choices."

"By giving them information they may not feel as pressured to do things just because they feel it's popular."

"I think it will help them make decisions and make them fully informed, it will also help them choose what is best for them"

"They can think and talk through their decisions to make a better educated decision"

"It helps people make decisions more conscientiously."

"I was really worried before I came today but I knew we would get support here." Female CSSP user (14)

Connexions and CSSP staff re-iterated that in aiming to increasing young people's confidence and supporting them to feel more informed, young people would then take fewer risks in terms of their sexual health.

Young people were also asked what they would do if the service didn't exist. Again, they stressed the importance of a place where young people felt comfortable that was confidential and easily accessible. There was a lack of knowledge or awareness about other services they would use.

"I think many young people may be lost on where to go to seek any information and advice they may want. Young people may feel embarrassed about going to anyone else about sexual health." Jitty user

"I wouldn't do anything – which is bad, as if I do end up being pregnant I wouldn't tell my mum – she would kill me. I wouldn't want my mum to know or my doctor. I wouldn't want it on my records." Female CSSP user (14)

"Often people don't have anyone else to ask or don't know where to go for information." CSSP user

"More students would feel confused and alone"

Young people also commented on the importance of better access to contraception such as the morning after pill. Some had had distressing experiences of trying to obtain the morning after pill through clinical services (where they felt they were not treated with respect) and, therefore, CSSP was viewed as the only friendly place for young people to go to for confidential support.

In addition to the young people's comments, the case studies identify how building trust between staff and young people can address a number of issues and contribute to a range of outcomes, such as raising aspirations, and supporting better relationships and more responsible approaches to sexual health.

No negative impacts of CSSP were mentioned by young people and it was generally felt that the universal *availability* of the service was important to young people, regardless of whether they currently needed it themselves.

The State

The state is included as a stakeholder due to the public funding that is allocated towards the teenage pregnancy strategy. The benefits are, therefore, that through investment there is a reduction in teenage conceptions, and a saving in associated health and welfare costs. A general improvement in health and wellbeing can also reduce longer-term welfare costs. The benefits to the state can later be split by DWP and health and social care as these are the agencies or departments most affected by resource savings, or demand on services, although it was not possible to consult with them directly.

Parents / carers

Although not directly affected by the service, parents are considered important stakeholders due to the impact that a teenage pregnancy or risky behaviour would have on them. The Coventry University research found that young people taking risks were significantly less likely to state that they did what their parents think they should than those who had not had sex. The parents were consulted through identifying CSSP trained staff who were parents, as they had an understanding of the service, but also an understanding of being a parent. Two parents of teenagers were interviewed on the phone and then 11 parents were later involved, at a CSSP training update session, in verifying or challenging any assumptions through voting on how much they agreed with a selection of statements, prompting further discussions. The parents initially interviewed stated that CSSP enabled them to feel confident and have 'peace of mind' that

their son or daughter could access sexual health services easily. This made them feel supported in their role as they had confidence that the service could deliver impartial advice and guidance on sensitive issues that they may find difficult to discuss. One parent discussed the benefits of the service being able to normalise the use of contraception with sex, particularly benefiting boys, who are more likely to access CSSP than family planning clinics. The CSSP case studies also highlighted the support to parents and the encouragement they gave to young people to discuss important issues with parents. All of the parents felt that the CSSP support given to young people resulted in a better family life at home either to some extent, or to a great extent. However, parents also identified that there was a perception that the service could encourage their children to have sex without thinking about the consequences. Although the parents interviewed (because they understood the service) felt that this fear was unfounded, they still understood that this worry was very real to some parents who were less informed. Ideally, more parents would have been consulted as stakeholders to include those who were not involved in the service. However, the confidential nature of the service meant that often parents were not aware that it had been accessed by their son/daughter and therefore it was difficult to contact parents about the difference CSSP made to them. Outcomes were therefore considered based on the assumption that improved behaviour of young people would have some impact on family life for the parents and a reduction in pregnancies would potentially reduce the chance of them becoming a grandparent early.

Connexions staff

CSSP-trained Connexions staff were considered as stakeholders because of the affect that the training may have on them personally. Seven staff responded to an initial questionnaire asking what difference the CSSP training made. 11 staff were then consulted later at a CSSP update training session to vote on their agreement on a number of assumptions, and also vote on their attribution to outcomes. In the initial questionnaire staff noted that the main benefit to them was having the confidence to provide sexual health information and support. They also found that, by offering pregnancy tests and condoms, they were able to maintain contact or have initial contact with young people who may not otherwise use the service.

> *"Enables us to catch up with the young people who would not come in if not for the sexual health service available – can update contact details and destinations" Connexions PA*

> *"It enables us to deliver sexual health services to young people in Hinckley and Bosworth. This may sometimes mean that we have contact with young people who may not otherwise use the service but would actually rather benefit from what we can offer." Connexions PA*

The training enabled Connexions staff to provide sexual health services themselves, there and then, rather than referring them on to another service that young people still might not use. Many of the benefits that staff talked about were around providing a better service for young people

> *"Being part of the CSSP allows me to offer a greater depth of service to the young people I work with. I feel this makes me a better advisor and increases my ability to be of benefit to young people – this is ultimately the most rewarding aspect of my job. The training I am given in order to do this is useful and necessarily up-to-date. This allows me to feel secure in offering sexual health advice to young people." Connexions PA*

This was further evidenced through the CSSP training feedback forms:

> *"Brilliant trainer, excellent, engaging delivery as ever; I now feel ready and confident to work with young people in our condom service."*
>
> *"The training exceeded my expectations; it helped me see things from a young person's point of view."*
>
> *"I learnt so much about contraception and new ways to discuss it effectively with young people."*

In terms of direct benefits to the Connexions staff themselves, 80% felt that they had *personally* benefited 'a great extent' from the training, above the improved service they offered young people. This included being able to progress in their job, feeling more confident and being in a better position to avoid job cuts by adding to their skills.

> *"Extra training which adds knowledge to my skill base."* Connexion PA

Excluded stakeholders and outcomes

Stakeholders that were also considered but excluded from the SROI included the school, and the local community. It was felt that any impacts

to these stakeholders were not significant enough to include as most outcomes for young people were on an individual, personal level, so larger settings are unlikely to be aware of any changes.

The following changes, as a result of CSSP training, were also considered

- A negative impact on the Connexions service of delivering a sexual health service

55% of staff felt there were no negative impacts to the Connexions service at all, and 36% felt that there were 'not very much'. Generally it was felt that the service helped provide more support to people that needed it, rather than being a distraction away from helping NEET

- A negative impact on the Connexions staff of delivering a sexual health service

46% of staff felt there was no negative impact on them at all, and 46% felt that was 'not very much', Issues discussed included having to question their own morals and sometimes having difficult conversations with young people. However, generally staff felt happy to deliver the service and that the support was important and valued.

- The negative impact on parents of providing sexual health services for their children

While 55% of parents felt that they were 'to some extent' negative impacts to them, when prompted to discuss this most parents felt that this was around other parents' perceptions of what the service did, rather than the actual support offered which they felt had a positive impact on family life. To avoid speaking on behalf of 'other parents', this outcome has been excluded. However, the issue of how to communicate key messages to parents has been fed back to the project.

- The negative impact of increased number of referrals through CSSP identifying issues

3% of visits resulted in a referral to another service. While this may cost more in resources for the referral agency the number was felt to be relatively low. Connexions staff also felt that one of the main benefits of the CSSP training was that they were able to deliver support to young people at the time it was needed, rather than have to refer them on.

While there was not enough evidence from stakeholders to include these outcomes, the latter two, due to their potential significance, can be tested in the sensitivity analysis.

> Theory of change

Through these stakeholder consultations 4 logic chains, explaining the theory of change, were developed. The chain provides details of the intended and unintended changes, the activities that contribute towards the changes, followed by the short-term, medium-term and long-term outcomes.

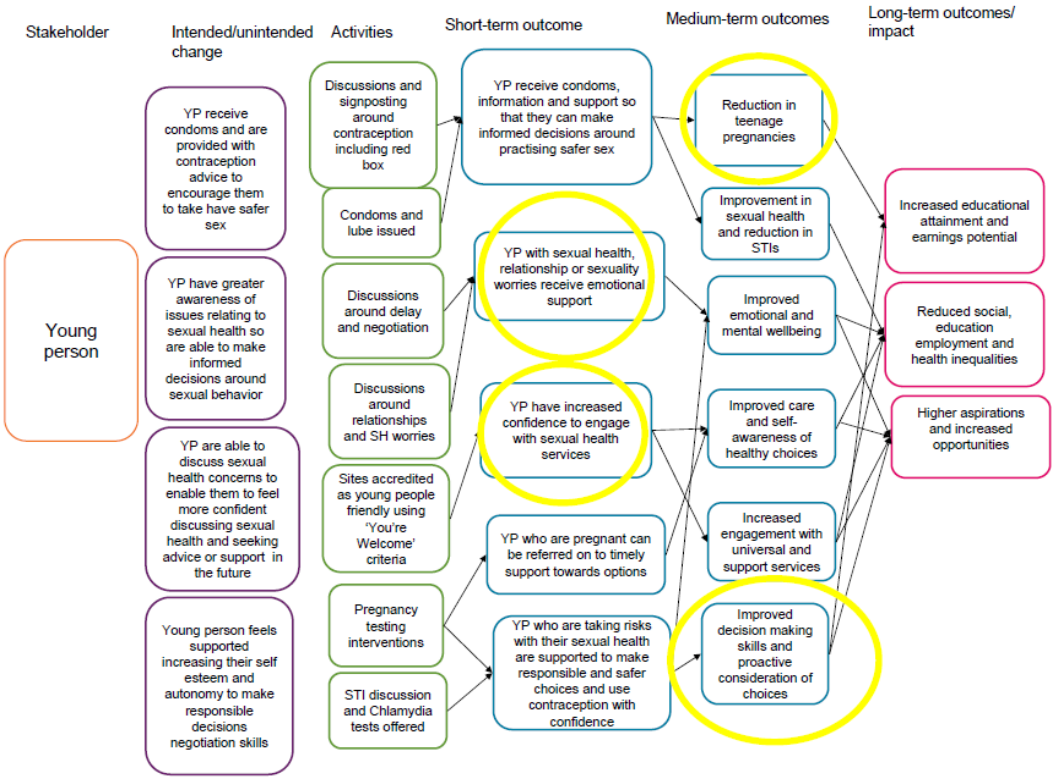
For young people, the short-term outcomes involve support to make informed decisions, increased confidence, access to support and increased awareness. The medium-term outcomes are that these short-term outcomes would result in a reduction of unplanned pregnancies, improved general health and well being, raised aspirations and increased opportunities. The long-term outcome is a reduction in social, education and employment inequalities.

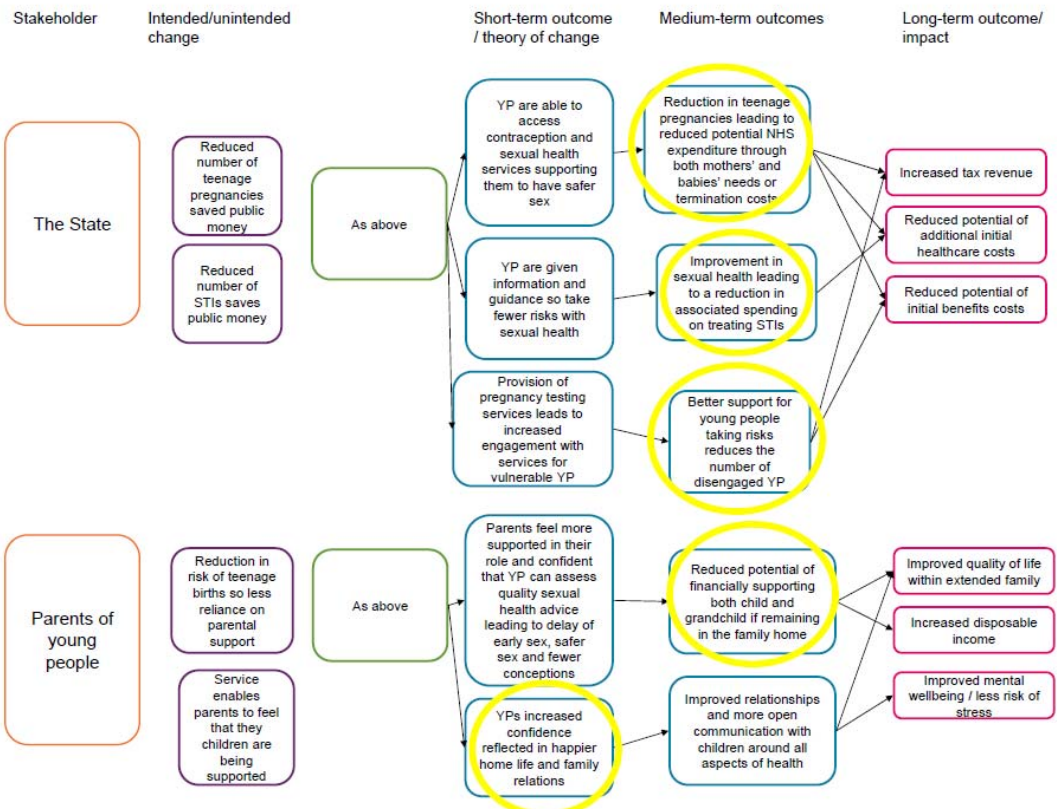
For the state, the short-term outcomes, similar to those for young people, are around supporting young people to access appropriate support and take fewer risks. However, the medium-term and long-term outcomes are more associated with reduced costs of public spending. The medium-term outcomes are around reducing the costs associated with pregnancies, terminations and treating STI's. The long-term outcomes include increased tax revenue as a result of increased responsibility and opportunities and reductions in additional health care and potential benefit costs.

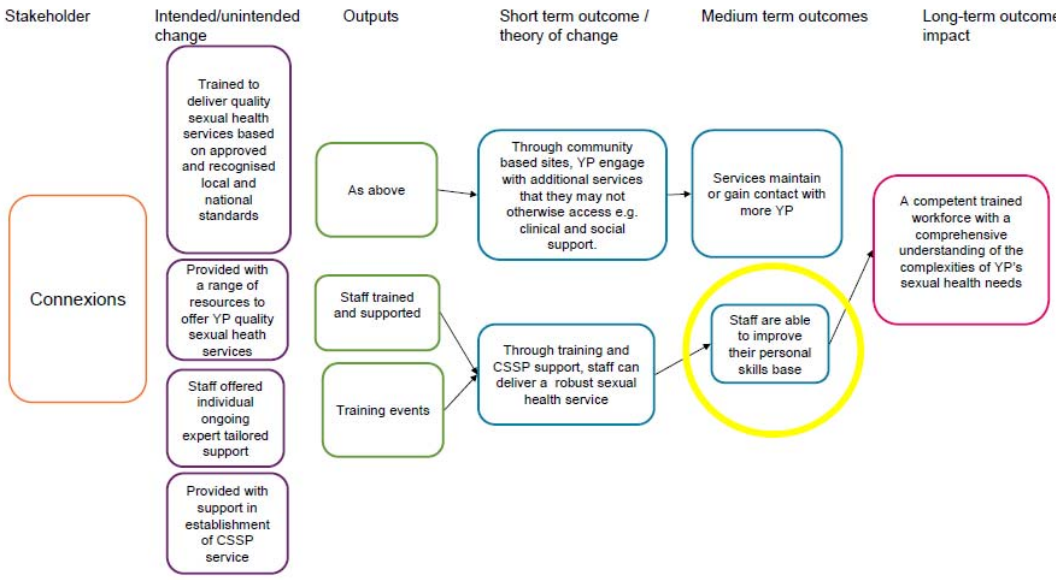
For parents the short-term outcomes are improved family relations and assurance that their son or daughter can access sexual health advice. Medium-term outcomes are around more open communications and reductions in the likelihood of contributing to the upbringing of a grandchild. Long-term impacts are improvements in quality of life and mental wellbeing through higher disposable income in the event of a reduced pregnancy or reduced stress through avoidance of a son or daughter's risk-taking behaviour.

Short-term outcomes for Connexions staff receiving CSSP training include the ability to deliver a service, and to provide support to more young people. Medium-term outcomes involve improving the skills of staff The long-term outcome is a trained workforce with a comprehensive understanding of young people's sexual health needs.

Fig 15. Theory of change map







One of the principles of SROI is to only include what is material. The principle states: 'Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact'.

Materiality is defined as *"Information is material if its omission has the potential to affect the readers' or stakeholders' decisions".*

The first filter is relevance. According to SROI Guidance on Materiality, testing for relevance involves identifying whether the outcome is relevant because there are:

- policies that require it or perversely block it and the intervention can deliver it;
- stakeholders who express need for it and the intervention can deliver it;
- peers who do it already and have demonstrated the value of it and the intervention can deliver it;
- social norms that demand it and the intervention can deliver it; and
- financial impacts that make it desirable and the intervention can deliver it.

The outcomes in the theory of change can be tested for relevance by judging each outcome against the criteria above.

Fig 16. Relevance test for outcomes

Stakeholder	Outcomes	Relevance	Relevant?	Why not longer/shorter term outcomes
Young People	Reduction in unplanned pregnancies	Funding for CSSP is based on the overall aim to reduce under-18 conceptions	Y	It was felt that the outcomes did go further than simply practicing safe sex to a reduction in pregnancies, as without this reduction there would not be the benefit to YP. However, longer term outcomes in terms of increased earning potential were unknown as long term data was unavailable and research suggested little impact on long term earnings without wider support.
	Improved sexual health and reduction in STIs	Although this is an aim of the service, this outcome was not mentioned by YP suggesting that they are personally more concerned with avoiding pregnancy than STIs	N	
	YP with relationship needs or worries receive emotional support	While this may not always be needed for a sexual health service, it was felt that this was how CSSP differed from chemists etc and contributed towards better satisfaction from YP.	Y	As many YP only visited once, it was difficult to know whether this support would lead to longer term outcomes of improved emotional/mental wellbeing unless continued support was provided.

	YP have increased confidence to engage with health services on SRE	YP spoke about how feeling uncomfortable speaking about sexual health was a barrier to using other Sexual Health services	Y	While YP may be more confident to use this service again, they may still have reservations about using universal/adult services. There is less evidence on the transition to universal services through CSSP
	YP who are pregnant can be referred on to timely support towards options	This was not a specific aim of CSSP, and CSSP felt that although they could make referrals they were often unaware of how they were followed up.	N	
	Young people who are taking risks are given guidance and then improve their decision making skills leading to proactive consideration of options	YP often mentioned that after using CSSP they were more likely to think about what they were doing and the consequences of taking risks. Research suggests that many poor outcomes for young people (and young parents) are associated with poor decision making and feeling a lack of control over life choices	Y	While it may be reasonable to assume there are long term benefits of better decision making, there is a lack of longitudinal research on the impacts of such changing behavior through CSSP

Health and Social care	Reduction in teenage pregnancies leading to reduced potential NHS expenditure through both mothers' and babies' needs or termination costs	Funding for CSSP is based on the overall aim to reduce under-18 conceptions	Y	Longer term outcomes in terms of reduced benefit costs were unknown as long term data was unavailable and research suggested that in reducing teenage pregnancies there is little impact on long term outcomes without wider support
	Improvement in sexual health leading to a reduction in associated spending on treating STIs	Much of the CSSP training covers safety against STIs as well as pregnancy with an aim to reduce public costs	Y	There is a lack of research that STI testing would result in longer term health cost savings
DWP	Better support for young people taking risks reduces the number of disengaged YP	Connexions staff stated that the service helped make contact vulnerable YP and offer a range of support. YP taking risks are some of the most vulnerable and live in the most deprived areas, costing more to the state.	Y	Data not available on longer term impacts
Parents	Reduced potential of financially supporting both child and grandchild if remaining in the family home	Research suggests that parents often feel more affected or worried about a child's teen pregnancy than the YP	Y	There is a lack of reliable research that longer term happiness or well being is affected.

	YPs increased confidence reflected in happier home life and family relations	Research suggests that many parents of teen mothers feel problems started before pregnancy when child was taking risks – However, the affect on parents of changing behavior is difficult to quantify	Y	Although young people are likely to be happier at home if they feel they can access support, some of the benefit to parents in terms of more open relationships may possibly be offset by some parents' perceptions of the service that it has a negative impact on communication (e.g. parents may prefer YP to talk to them, rather than Connexions staff). Therefore, although it is encouraged by the service, there is a lack of evidence of the longer term outcomes of better communication between child and parent.
Connexions staff	Staff are confident and motivated to deliver up-to-date, consistent and accurate sexual health advice	Staff valued the training and rated it highly. They felt that benefits exceeded the outcomes associated in delivering a better service to YP and included being able to progress in their job, avoid job cuts and feel more confident	Y	This was the outcome that staff felt most able to identify with personally. Other outcomes were not felt to directly benefit Connexions staff
	Services maintain or gain contact with more YP	While this was mentioned by Connexions staff it was felt this was reflected in benefits to YP and to the state, rather than the staff themselves	N	

The following outcomes were identified as relevant:

Young People

- Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies
- Young people feel more confident in discussing sexual health and consequently continue to engage with sexual health services
- Young people who are taking risks are given guidance and then improve their decision making skills leading to more *considered* proactive choices
- Young people who have concerns around sexual health, relationships or sexuality are provided with emotional support

Health and Social care

- Better sexual heath services reduces the number of teenage pregnancies
- Better sexual heath services reduces the spreading of STIs

DWP

- Better support for young people taking risks reduces the number of disengaged young people

Parents

- Greater peace of mind because of better sexual health support resulting in reducing the likelihood of them becoming a grandparent early
- Improved family life because of better sexual health support resulting in reducing the likelihood their child taking risks

Connexions Staff

- Staff are trained to deliver approved sexual health support for young people, improving their skills base

As these outcomes have been judged to be relevant at this stage, significance will now need to be considered at each of the next stages. Significance means that the real or potential scale of the outcome has passed a threshold that means it influences decisions and actions.

Where quantities of change or values are low the outcome may not be significant. If deadweight or attribution are high then the outcomes may not be significant *to CSSP*. Significance can be considered after quantities of change, values, deadweight and attribution have been determined.

> Measuring impact

An indicator is a piece of information that helps determine whether or not change has taken place – it allows performance to be measured. The indicators are the *ways of knowing* something has happened or changed. There are often different ways of knowing a change has taken place. However, due to the confidentiality of the service it was difficult to follow up service users to ask them directly what had changed for them. Based on the stakeholder interviews with young people about what they did differently, indicators were chosen and the database of all 696 service users and 1,134 visits was used to measure where a change had taken place, e.g. evidence of a change from reactive to pro-active types of visits. This chapter will list the outcomes identified from the logic chains and the indicators chosen to measure whether that change has happened.

Young People

- Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in **fewer teenage pregnancies**

The high proportion of young people surveyed in the Coventry University research who stated that they would regret a pregnancy, and the fact that no young people stated that they wanted to start a family when they left school, supports using the measure of a reduction in young people becoming parents under-18 as an indicator in terms of the benefits to young people.

This outcome can be measured by calculating the number of pregnancies averted (or reduced) through the service. No current control group is available due to the absence of data on who has, and who has not, used any of the CSSP sites. Due to the high number of CSSP sites, it cannot be assumed that those not using sexual health services at one CSSP site are not receiving a similar service elsewhere (e.g. school, youth service). Therefore, 1998 is used as a baseline as this represents a period before the co-ordinated Teenage Pregnancy Strategy.

Conception rates of CSSP users under-18 can be compared to the 1998 under-18 conception rates. Research suggests that first sex often

initiates a first visit to sexual health service[34]. Therefore, those using CSSP are likely to be sexually active. The proportion of 15-17 year olds who have had sex is approximately 50%[35]. It can, therefore, be estimated that 7.6% of sexually active 15-17 year old became pregnant in 1998 (38 per 1000 15 -17 year olds or 38 per 500 15 -17 year olds who were *sexually activ*e, i.e. 7.6%). The percentage of females under-18 using the Connexions CSSP service and becoming pregnant within the following 12 months can therefore be compared to the baseline of 7.6%. Data showed that for females under 18 when first visiting, 7% became pregnant within the following 12 months. In real numbers, 26 out of 372 under-18s using CSSP become pregnant within 12 months compared to an expected 28.28. This difference suggests that 2.28 pregnancies were averted through using the Connexions CSSP services. However, by excluding young females who initially visited for a pregnancy tests (as the nature of visit dictates a higher risk of future pregnancy), only 6% later became pregnant (14 out of 236), suggesting approximately 14 fewer pregnancies over the 12 months. Alternatively, if the average rate between 1998 and 2000 was used as a baseline (6.5%) no pregnancies would appear to have been reduced over the year, when considering the full cohort. In the sensitivity analysis a range of values can be considered.

Figure 17. Comparison of conception rates

Calculated conception rate for sexually active 15-17 year olds	%
1998 rate	7.6%
Average 1998-2000 rate	6.5%
All CSSP users	7%
Pro-active CSSP users	6%

Additional conceptions for young people 18 and over may also be reduced through the service but as this is not a target of the strategy, and less is known about the proportion of older teenagers who make rational choices to enter motherhood, this is not included in the indicator.

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[34] *An Evaluation of Brook Sexual Health Outreach in Schools* (2008) Centre for Public Health Research http://hsc.uwe.ac.uk/net/research/Data/Sites/1/GalleryImages/Research/BrookSH%20Report_Bookprint2.pdf

[35] Based on the Coventry University research and wider review of evidence

- Young people feel more confident in discussing sexual health **and consequently continue to engage with sexual health services**

Many of the young people talked about increased confidence through using the service and feeling more comfortable talking to someone about their sexual health and not being judged. Practitioners also described how nervous young people were when first accessing the service and said that increased confidence was often observed upon repeat visits.

"I came back here because I trust them." Female CSSP user (14)

The majority of users consulted stated that they would definitely use a sexual health services again if they needed to. However the indicator used here is the number of young people who return to the service after their first visit as this is considered to be evidence of feeling comfortable enough to return to a service.

- Young people who are taking risks are given guidance and then make more ***considered*** **proactive choices**

National research suggests that teenage pregnancy is associated with a number of other risk-taking behaviours such as alcohol misuse, involvement with police and not attending school. The Coventry University research, and the case studies provided, identified that, for some young people, risk-taking is associated with low aspirations, low confidence and other social issues. Such behaviour can have long-term impacts. The interviews with young people identified that many felt the services encouraged them to make more conscientious choices, be more responsible and to think things though more.

"I'll take more responsibility next time, or come for help sooner." Female CSSP user (14)

Changing such risk-taking behaviours can also have positive effects on future outcomes as suggested by the evidence reviewed.

A review of CSSP information suggests that they support a number of young people in areas associated with disengagement and low aspirations. However, it is unrealistic to assume that all those who do not become pregnant have raised aspirations. Therefore, counting those young people who changed from reactive to proactive service use was felt to be a fair indication of a change in behaviour. The indicator used as a proxy measure for change is the number of young people who initially present themselves for a pregnancy test and then go on to use the service

proactively for either condoms or sexual health advice with no repeat pregnancy test or pregnancy. By using the service proactively rather than reactively, they are taking more control and responsibility over their lives.

- Young people who have concerns around sexual health, relationships or sexuality **are provided with emotional support**

Many young people use the service if they are concerned about sexual health issues and want to talk about them confidentially. This is also highlighted in the case studies and consultation with young people.

> *"I was really worried before I came today but I knew we would get support here." Female CSSP user (14)*

Without CSSP, many young people stated that they do not know where they would go for this support. The indicator used here is the number of interventions recorded as 'sexual health service' as this is an indication that a discussion or meaningful intervention took place, rather than simply a referral, pregnancy test, or condoms given.

Health and Social care

- Better sexual heath services **reduces the number of teenage pregnancies**

As previously discussed, funding of the Teenage Pregnancy Strategy is based on the view that the public costs of teenage pregnancies outweigh the cost of interventions to support their reduction. The indicator used here is the reduction in under-18 pregnancies (as used for the young people indicator) for those using the service, compared to the 1998 baseline.

- Better sexual heath services **reduces the spreading of STIs**

The National Chlamydia Screening Programme (NCSP) is a Department of Health Initiative to tackle the increase in Chlamydia in the under 25's. The programme is based around raising awareness of Chlamydia to young people and to provide opportunistic screening. Therefore, the number of screening tests is used as an indicator as this allows for infections to be picked up and treated.

DWP

- Better support for young people taking risks **reduces the number of disengaged young people**

Risk-taking in young people is often associated with disengagement. Public costs involved in re-engaging young people can be particularly high. The indicator used here is the number of young people who are NEET and taking risks (as evidenced by an initial visit for pregnancy test) when they first use the service who then re-engage with education, employment or training.

Parents

- Greater peace of mind because of better sexual health support resulting in **reducing the likelihood of them becoming a grandparent early**

Interviews with parents found that the service was able to provide the parents with confidence that their child was receiving information and guidance on contraception to act safely. Parents hoped that this would result in a reduced likelihood of their child becoming a parent at an early age. Research suggests that grandparents often play a key role in supporting teenage parents. The indicator used here is the reduction in under-18 *parents*.

- **Improved family life** because of better sexual health support resulting in reducing the likelihood their child taking risks

Young people taking risks can affect the whole family. Improvements in behaviour can, therefore, lead to improvements for family relations and home life in general. Many parents state that the teenage years are the most turbulent. Therefore, additional support to encourage responsibility in young people can make a significant difference to parents. The indicator used here is the number of young people who initially present themselves for a pregnancy test and then go on to use the service for either condoms or sexual health advice with no repeat pregnancy test or pregnancy (as above), and the proportion of parents who believe that such change in behaviour would result in better family life 'to a great extent'

Staff

- Staff are trained to deliver approved sexual health support for young people**, improving their skills base**

It was important to staff that training from CSSP was suited to their needs and improved their knowledge and skills to deliver sexual health advice to young people. The indicator used here is from the number of staff had been trained, the proportion who believed that they benefited personally to 'a great extent' through better job prospects.

Fig 18. Full list of outcomes, indicators and quantities

Who will we have an effect on? Who will have an effect on us?	Description How would we describe the change?	Indicator How would we measure it?	Source Where did we get the information from?	Quantity How much change will there be?
Young People	Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies	Number of females under 18 who use the service and become pregnant within 12 months, compared to the 1998 basline rate for sexually active 15-17 year olds	Connexions CSSP data	2.28
	Young people feel more confident in discussing sexual health and continue to engage with sexual health services	Number of YP who visit and return to the service within the year	Connexions CSSP data	248
	Young people who are taking risks are given guidance and then make considered proactive choices	Number of YP who initially use the service for a pregnancy test and then continue to use the service proactively within the year (with no pregnancy)	Connexions CSSP data	11
	Young people who have concerns around sexual health, relationships or sexuality are provided with emotional support	Number of visits recorded as 'Sexual Health Interventions'	Connexions CSSP data	504
Health and Social Care	Better sexual heath services reduces the number of teenage pregnancies	Reduced pregnancy as above	Connexions CSSP data	2.28
	Better sexual heath services reduces the spreading of STIs	No of Clamydia test given out	Connexions CSSP data	100
DWP	Better support for young people taking risks reduces the number of disengaged young people	Number of young people who initially use the service for pregnancy test who move from NEET to EET	Connexions CSSP data	5
Parents	Greater peace of mind because of better sexual health support resulting in reducing the likelihood of them becoming a grandparent early	Reduction in pregnancies as above and proportion that would redult in a birth	Connexions CSSP data	0.98
	Improved family life because of better sexual health support resulting in reducing the likelihood their child taking risks	For the YP who reduced risk (as above), multipled by the % of parents who felt reduced risk taking would result in better family life 'a great deal'	Connexions CSSP data and voting handsets	2.97
Connexions staff	Staff are trained to deliver approved sexual health support for young people, improving their skills base	Percentage of staff reporting that they personally benefited from the increased skills 'a great deal' (73%) multiplied by the number of staff trained	Voting handsets	36.5

Considering significance

The quantity of change involved in reduced pregnancies (particularly births) is low compared to other outcomes. However, if these outcomes were judged to be insignificant at this stage, then the main aim of CSSP would be excluded from the SROI. Rather, a judgement can be made to leave the outcome in at this stage and then explore how its exclusion may affect the SROI in the sensitivity analysis. Similarly, numbers involved in changing behaviour are comparably low so the exclusion of these outcomes can be tested later.

> Valuing benefits

To assess the value of each outcome, all of the outcomes need to be monetised, or expressed in financial terms. When financial data is unavailable or difficult to obtain, proxies can be used. A proxy is a value that is deemed to be close to the desired outcome, for which data may be unavailable. Proxies should not be seen as conveying a hard and fast value on that outcome but as a way of expressing it in financial terms that ensures it can be included in the analysis. The value of the outcome is the value that it represents to that stakeholder. Since CSSP is a confidential service, in some cases it can be difficult to understand how those young people using it value the outcomes. Where reliable research into outcome costs are available (e.g. costs of a teenage birth) such figures can be used. However, in the absence of robust research, or in order to validate any assumptions, other ways of measuring value can be used, such as market value costs, willingness to pay costs or analysis of family spending surveys, to estimate the value that stakeholders currently place on such outcomes. Where proxies are used, the values can be checked with stakeholders to ensure reliability of judgements. This section will list the material outcomes identified from the logic chains and the values attached.

Young People

- Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in **fewer teenage pregnancies**

The research identified that, for some young people, becoming a parent can have a positive impact on their lives. The cost of a pregnancy to *young people,* therefore, will only use those costs known to be *caused* by

a *teenage* birth (e.g. increased post-natal depression, lower family income).[36]

1. Longitudinal research that explores long-term outcomes *caused* by a teenage birth suggests that, although there is little impact on the mothers' long term income, employment and qualifications, there is in increased chance of having an unemployed partner or a partner without post-16 qualifications. The childcare survey in Leicestershire found that approximately 9% of all younger mothers lived with an unemployed partner compared to approximately 1.5% of older mothers.[37] Therefore, if 7.5% more younger mothers than older mothers are suffering from a reduced family income due to lack of partner earnings, it can be estimated that approximately £18,000 a year[38] (average pay for a male low skilled worker) is lost for 7.5% of mothers. As this is a long-term outcome it can be multiplied by 14 for the years of being a parent up to around age 30[39]. This totals an average of £18,900 per teenage mother.[40]

2. Research also suggests that there is an emotional cost of becoming a young mother, as well as a financial cost. The longitudinal research found that young mothers are more likely to suffer from mental health issues. The above research identified that younger mothers scored 30% higher in mental health test scores two years after the birth. The cost of one hour a weeks counseling over a year is £2,085[41]. It is estimated that approximately 40% of teenage mothers experience post natal depression, three times higher than older mothers. The value of treating a mental illness can be used as the cost of poorer mental health/increased stress for 27% of mothers to give an average cost of £563 per teenage mother[42].

These two costs can be combined to give a total negative value of becoming a teenage mother for the young person. The emotional cost is only small and could potentially be omitted from the calculation. However, this would ignore a key finding from the longitudinal research, therefore

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[36] Cost to young people of conceptions that are terminated are not included as we know less about the impact on young people and whether long-term outcomes are affected. Further research into post-abortion counseling services may provide insight to include this in future evaluations.
[37] This is similar to additional analysis on the 1970 Birth Cohort Study which found that at age 30 12% of teenage mothers lived with an unemployed partner, compared to 0% of those who had a miscarriage in their teens. Further analysis also found that earnings for partners of teenage mothers were approximately 30% less than partners of those who had had a miscarriage in their teens.
[38] Annual Population Survey www.nomisweb.co.uk (average wages for a machine operator in East Midlands)
[39] As there is little evidence available on impacts past age 30 for the parent, or after the child reaches 14
[40] Additionally, partner earnings are likely to be lower due to lack of partners' post-16 qualifications.
[41] Department of Health unit costs
[42] Mental health is also likely to affect overall quality of life for both the young parent and child although there is less research available on this.

its inclusion represents a component of the SROI 'story' that could prompt further investigation. The total value of a teen birth is therefore £19,463 per teenage birth. If 43% of under-18 conceptions result in a birth this equates to **£8,369** per under-18 conception. This was checked with young people through ordering the event of an unplanned pregnancy against other scenarios with a financial implication. (See Stakeholder Activity Exercise in Appendix)

- Young people feel more confident in discussing sexual health **and consequently continue to engage with sexual health services**

While there may be long-term benefits of engaging with health services, there is little research available on the longer-term outcomes. Many young people feel embarrassed speaking to someone about personal health issues. They would often rather send a text or search the internet. However, there is an increased value of seeing a health professional as they can identify further issues and ensure advice given is appropriate. Therefore, the value to an individual of a visit to a private GP can be used here to evidence the value of choosing to engage with health services at **£63** [43](Market value).

- Young people who are taking risks are given guidance to make more *considered* **proactive choices**

The value of changing behaviour

The value of changing behaviour from taking risks with sexual health to making more informed proactive choices is very complex and likely to differ depending on each individual's circumstance. However, it is possible to try and understands how young people view risks based on the local Coventry University research with young people, wider research on risk-taking, and the negative value placed on such risk.

For those who use the service for a pregnancy test, it is known that their chance of being pregnant is around 9% as this was the proportion of pregnancy tests taken at Connexions that were positive over the 12 months. Research into decision making[44] suggests that young people are aware of the risks they are taking but have rationally weighed up this risk against the benefits (or avoidance of negatives). Indeed, the Coventry

[43] http://www.bupa.co.uk/individuals/self-pay-treatments/gp-services
[44] *Risk and rationality in adolescent decision making: Implications for theory, practice, and public policy*. Psychological Science in the Public Interest (2006). Reyna, V. F., & Farley, F.

research found that young people taking risks were aware that they were more likely to become pregnant than their peers, but suggested that the evidence from the focus groups supported that idea that for these young people they had rationalized that the benefits (or avoidance of negatives) were worth the risk.

> *"You get to the point of having sex and realise you haven't got a condom and think,'what's the worst that can happen?'"*

> *"I think one thing I find bad at school is they say, 'don't have sex or else you will get Chlamydia or you will get pregnant' but that is still variable and it is not a definite thing. You should say if you do this it might, it can ……."*

Past research[45] on risk taking and teenage pregnancy has found that many young mothers fell into a category called 'fatalists'.[46] Rather than planning or not planning their pregnancy (which was deemed too simplistic) the young mothers took a view that they were aware of risks but 'if it happened it happened'. This resonates with the young mother's focus group comments from the Coventry University research:

> *"I didn't get pregnant on purpose. [But] if I'd wanted to go to Uni, get a degree, and do something specific, I'd have either been more sensible or probably had an abortion"*

> *"The thing is contraception is not 100% and if you drink or smoke it brings down the effectiveness of the patch, and you're doing that at your own risk, like I was told when I went for this patch if you drink, smoke, you're going to put ten years on your life and bring down the effectiveness of the patch. Fair enough, so if I fall pregnant that is my fault"*

Changing behaviour would result in taking away this risk and the associated negative value of this risk for the young person, as they are choosing to no longer engaging in such activity. CSSP aim to achieve this through increased awareness of alternative options, supporting young people to feel more in control over situations, and encouraging young people to be prepared for when they are more likely to be at risk of being unsafe. By addressing the inconvenience or embarrassment of accessing and using contraception they aim to reduce the negative value young people associate with being safe, to ensure that they no longer take risks.

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[45] *Risk: young women and sexual decision-making*, Hoggart, L. Policy Studies Institure

[46] Other categories include accidental *(where there is a not a rational decision around risk made)* and planned *(where there is no perceived negative value at the time)*. However, Hoggert's research suggests that young people did not often fit confidently into these groups.

The perceived risk of having unsafe sex to young people is therefore estimated to be equivalent to the 9% chance of becoming pregnant. As a negative value of an abortion has not been identified, it may be reasonable to use the negative value of becoming a young parent to calculate the perceived negative value of the risk taken. Applying the negative value of a teen birth used in this report (£19,463) the value of the risk for those who end up taking pregnancy tests was £1,771. This value was checked with young people through ordering the event of having unprotected sex against other scenarios with a financial implication. (See Stakeholder Activity Exercise in Appendix)

- Young people who have concerns around sexual health, relationships or sexuality **are provided with emotional support**

The value of being able to see someone to discuss concerns can be varied depending on the issue and potential longer-term benefits. Due to lack of information here the value is estimated to be equivalent to the value of visit to a counsellor of **£40 per young person**[47]. This can be checked with young people through ordering importance of having someone to talk to compared to alternatives with a financial cost. (See Stakeholder Activity Exercise in Appendix)

Health and Social care

- Better sexual heath services **reduces the number of teenage pregnancies**

1. Any long-term public costs of teenage parenthood above the initial year of support are excluded from this analysis due to lack of robust evidence on costs *caused* by a teenage birth rather the wider social problems. However, the public costs of supporting teenage parents in the first year are common given that few parents age 18 and under are able to support themselves financially at this time in their life, particularly when the pregnancy is unplanned. Therefore, this 'additional' year on benefits per young parent is considered realistic. The Teenage Pregnancy Unit estimate the costs of benefits, health and social care in the first year as £13,905 for each teenage mother under 18 and £17,208 for each teenage mother 18 or over[48] [49] (See Appendix Tables 1 and 2). By

[47] Internet search-cost of one visit to a counsellor
[48] *Estimating the cost of being "not in education, employment or training" at age 16-18,* Godfrey et al (2002) Research Report 346, Social Policy Research Unit, University of York
[49] *Evaluation of the Teenage Pregnancy Strategy: annual synthesis report No. 2: 2002,* Wellings et al, (2003) London School of Hygiene and Tropical Medicine

calculating the proportion of under-18 conceptions nationally that result in a teenage birth at 18, a figure is gained of £15,504.80 per teenage birth.

2. The cost of a termination varies according to whether it is a medical or surgical termination, and the fee is graded according to the number of weeks gestation. The DH Abortion statistics provides a breakdown of the number of abortions per year by gestation, provider and method. These proportions have been used to derive an indicative cost associated with each procedure type. Based on an analysis of 2009 data this would suggest that the average cost of an abortion is £623 per conception terminated[50]. This cost also includes the initial consultation fee (See Appendix Table 3).

Based on previous proportions of births (43%) and terminations (57%) the average public cost of an under-18 conception is **£7,022.** Although this is a potential cost-saving to the public purse, it is unlikely to lead to a decrease in budget for the public body. However, what it does allow the state to do is to spend the money allocated to 'under-18 conception' on other services. Therefore this outcome is likely to result in resource re-allocation rather than a cost saving.

- Better sexual heath services **reduces the spreading of STIs**

Approximately 4.1% of Chlamydia tests taken in Leicestershire are positive[51]. The NHS cost of a visit to a GUM clinic for treatment is approximately £400. However, it is estimated that for each person treated, this saves/prevents Chlamydia being spread on to three further people. This therefore saves further treatment costs of £1,200[52]. The overall saving is £800 per person *treated* (£1,200 minus £400). Therefore, for each test, this saves approximately **£33.** Again, this outcome is likely to result in resource re-allocation rather than a cost saving.

DWP

- Better support for young people taking risks **reduces the number of disengaged young people**

[50] British Pregnancy Advisory Service
[51] *NHS Leicestershire County and Rutland Sexual Heath Needs Assessment* (2010) LLR PCT
[52] Youthnet SROI (2009) www.slideshare.net/luc_b/youthnet-sroi-presentation

Increased engagement of young people has significant public cost savings. The Audit Commission cites research by York University's study of costs on being NEET. The cost of 16-18 year olds who are NEET is estimated to be **£5,760 per young person**[53].

Parents

- Greater peace of mind because of better sexual health support resulting in **reducing the likelihood of them becoming a grandparent early**

The cost for a parent of becoming a grandparent early takes into account the fact that an estimated 80% of lone mothers under 18 live at other people's homes, usually the parents', compared to 9% of older lone mothers[54]. Therefore, it is more likely that the parents will contribute to the grandchild's upbringing, either financially or in terms of childcare. There is little data available on grandparent's experiences although a recent qualitative study[55] found that they were often more apprehensive about the pregnancy than the young person is. Grandparents often continue to be very involved in the young mother's life after the baby is born and issues such as overcrowding, sibling rivalry or jealousy and financial strain were mentioned. The study suggests that teenage mothers may be less aware of the stress that their pregnancy and the birth of their baby has on the family and especially the grandmother. Some grandmothers may provide care on a daily basis while others may be more infrequent. In Leicestershire around 40% of teenage mothers are in EET and 20% of teenage mothers access Care to Learn (free childcare for parents under 20's)[56], therefore around a fifth may be relying on grandparents for regular childcare. This can impact of a grandparent's ability to take up work paid themselves. Taking the National Minimum Wage (£5.93 in 2010) for 16 hours a week wages lost over two years for 20% of teenage parents' parents, a value of **£1,973** is calculated per teenage birth.[57]

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[53] *Estimating the Lifetime Costs of NEET* (2010) University of York, http://www.york.ac.uk/depts/spsw/research/neet/

[54] *Teenage mothers and the health of their children*, (1998) Botting, B., Rosato, M. & Wood, R. *Population Trends* 93: 19-28

[55] *Parents of teenage parents. Research, Issues and Practice (2011)* Young People in Focus

[56] According to LSC figures, August 2009

[57] Parents of Teenage Parents, Research, Issues and Practice, Shepherd, J. Ludvigsen A. Hamilton W. (2011) *Parents of teenage parents: research, issues and practice, summary report*. Young People in Focus. Brighton

- **Improved family life** because of better sexual health support resulting in reducing the likelihood their child taking risks

It is likely that risk taking behavior will result in increased stress for the parent. Reducing such behavior can therefore can a positive impact on the parents and family life. This reduction in stress is estimated to be equivalent to the cost of a stress management course at **£630**[58].

Staff

- Staff are trained to deliver approved sexual health support for young people, **improving their skills base**

Staff trained by CSSP could go elsewhere for training available nationally. The most cost effective alternative is a one-day session from a trainer for 12 staff costing £1,000[59]. This is equivalent to **£83 per staff member**.[60] (Market Value)

[58] From SROI database: http://www.psychotherapy.org.uk/
[59] CSSP staff also provide ongoing support after training events
[60] Leicestershire Teenage Pregnancy Partnership costs

Fig 19. List of all outcomes and financial proxies

Stakeholders	The Outcomes (what changes)			
Who will we have an effect on? Who will have an effect on us?	Description	Financial Proxy	Value £	Source
	How would we describe the change?	What proxy did we use to value the change?	What is the value of the change? (1)	Where did we get the information from?
Young People	Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies	Long term impact of being more likely to live with an unemployed partner = 7.5% * loss of approx £18,000 (average wage for low skilled employee) * 14 years (£18,900) * liklihood of a birth	£8,369	1970's birth Cohort Study, APS, ASHE (see report)
		Emotional cost = one hour a weeks counseling over a year (£2,085) for 27% of teen mothers (40% suffer PND, compared to 13% of older mothers) (£563) * liklihood of a birth		Department of Health (see report)
	Young people feel more confident in discussing sexual health and continue to engage with sexual health services	Private cost of GP visit (Market Value)	£63	BUPA
	Young people who are taking risks are given guidance and then make considered proactive choices	Value of risk for those taking pregnancy test = 9.1% (chance of positive tests) * value of becoming a teen mother (above)	£1,771	1970's birth Cohort Study, APS, ASHE,Department of Health, Connexions CSSP data
	Young people who have concerns around sexual health, relationships or sexuality are provided with emotional support	Market value of one meeting with a counsellor	£40	Website search
Health and Social Care	Better sexual heath services reduces the number of teenage pregnancies	Public spending on supporting a teen birth for the first year = £15,305 *liklihood of a birth (43%)	£16, 128	Teenage Pregnancy Unit (see report)
		NHS unit cost of termination = £623 * liklihood of a termination (57%)		NHS unit costs
	Better sexual heath services reduces the spreading of STIs	Cost of additional Chlamydia treatment (£800) for 4.1% of tests	£33	NHS / Youthnet
DWP	Better support for young people taking risks reduces the number of disengaged young people	Cost of supporting a young person who is NEET	£5,760	Audit Commission/York University (see report)
Parents	Greater peace of mind because of better sexual health support resulting in reducing the likelihood of them becoming a grandparent early	Cost of providing childcare for parents for teenage parents	£1,973	National Minimum Wage (see report)
	Improved family life because of better sexual health support resulting in reducing the likelihood their child taking risks	Cost of stress management course	£630	UK Council for Psychotherapy
Connexions staff	Staff are trained to deliver approved sexual health support for young people, improving their skills base	Cost of personal trainer for 12 people (£1,000) per person	£83	CSSP info (see report)

Considering significance

The value for reduced spreading of STIs and provision of emotional support are low in comparison to other values. However, the numbers involved indicate that they could potentially prove material. By determining the actual impact the significance of these outcomes can be re-considered.

The SROI process also involves assessing the extent to which the outcomes result from the actual project, and any additional impacts. To do this, **deadweight, displacement, attribution and drop-off** rates and **duration** need to be taken into account. These were agreed with those working on the project, based on their experiences, the needs of young people and wider research.

Deadweight

Deadweight considers what would have happened anyway if the project did not exist. For indicators measuring a reduction in teenage pregnancy, deadweight is already taken into account by comparing to the 1998 under-18 conception rate, and then considering different baselines in the sensitivity analysis. There are a range of factors that can influence changes in rates, e.g. increased sexualisation in the media, therefore, to assume that rates would have remained constant is considered a fair assumption, given the complexity of understanding changes in teenage pregnancy rates.

For other outcomes there is a lack of baseline data and it is possible that young people would make changes for themselves, for examples a risk of pregnancy may be enough of a 'wake up call' to prompt future contraception use. However, the similarities between those taking test and those who become pregnant suggests that past behavior is a key predictor of future behavior and CSSP work to address this issues. This is highlighted through the case studies where young people are encouraged to consider the implications of their actions on their own lives. For 'making more pro-active choices', deadweight was estimated to be 10% as the project staff felt a tenth of young people who changed behavior would have done so anyway. Deadweight for 'increased confidence' and 'improved emotional' health was agreed at 25% because it was felt by staff that a quarter of the young people seen would have become more confidence regardless of the project, and a quarter of young people would have received emotional support for example from a friend or parent.

For 'increased engagement' in EET it was estimated by Connexions staff that 50% of NEET young people taking risks who moved into EET would have moved to EET regardless of the CSSP activity. This was agreed with

CSSP staff as the project does not directly aim to increase EET and there are a number of other agencies that work towards this. Some transitions, however, may be due to the project as young people may not have otherwise engaged with formal services, such as Connexions, if the CSSP project did not exist. The case studies also show how CSSP-trained staff can encourage young people to consider education in terms of future aspirations.

Reduction of STI's through CSSP was also given a deadweight of 50% as this focus of the service had been reduced and therefore given less promotion, so it was assumed that around half of those using the service for STD test would have got tested through other services if they did not exist. Not all sites were equipped with testing resources and therefore this outcome was not felt to be a key feature of CSSP by the practitioners. As the deadweight figures are mainly estimated through staff's own judgments these can all be tested in the sensitivity analysis.

It might be supposed that deadweight for outcomes to Connexions staff would be high and lead to the outcome not being material. However, staff felt strongly that they personally benefited from the training provided by CSSP and that such additional skills had enabled them to keep their jobs through recent cuts to the service. A deadweight of just 25% was therefore applied and consequently the outcome of improved skills is deemed material and retained in the impact map.

Displacement

Displacement occurs when the project benefits are at the expense of others (e.g. benefits are displaced from elsewhere). An example may be that young people would use clinical services instead of CSSP and achieve the same results. While this is plausible, a number of the young people stressed that they could not go to their family doctors, or had had bad experiences of using chemists. Many also did not know where else they could go. Connexions also felt that offering sexual health services did not take time away from seeing other NEET young people as many young people they saw were also NEET. It was therefore estimated that none of the outcomes have been displaced, although a displacement of 10% can be tested in the sensitivity analysis.

Attribution

Attribution considers what share of an outcome is attributable to, or results from, those outside of the project. To understand how much of each outcome can be attributed to the CSSP training and how much can be

attributed to the Connexions staff themselves a group of 11 Connexions staff who had been trained by CSSP and had been delivering sexual health services for over a year were asked to vote on the proportion of each outcome they felt could be attributed to them. These results are shown in the table below:

Fig 20. Attribution results

Outcome	Average Connexions Attribution (%)
Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies	43.5
Young people feel more confident in discussing sexual health and consequently continue to engage with sexual health services	65.9
Young people who were taking risks are given guidance and then improve their decision making skills leading to proactively considering choices	50.0
Young people who have concerns around sexual health relationships are provided with emotional support	63.2
Better sexual health services reduces the spreading of STIs	59.5
Better support for young people taking risks with sexual health reduces the number of disengaged young people	40.9

The main areas where Connexions felt that outcomes were more reliant on their own skills and experience, rather than the CSSP training, was in relation to increasing confidence of the young people, and providing emotional support. The outcomes that they felt were more dependent on the training were those around engaging those young people who were taking risks, and reducing pregnancies. Attribution for these outcomes was therefore lower, as seen in figure

Duration

The duration for each outcome was estimated to be to one year, as it was felt that the limited contact (i.e. most young people only visited CSSP service once during the 12 months) dictated that the outcome was not likely to last more than a year. However, this was also tested in the sensitivity analysis to understand the impact of more long term outcomes.

Drop-off

Drop off refers to the deterioration of an outcome objective over time, such as the number of participants each year who lose the confidence gained as a result of the project. This is not relevant if the duration is just one year, however, in the sensitively analysis a number of different durations are tested, which is when the drop off becomes important. While it is expected that outcomes such as better health can last a number of years, since most young people only visit CSSP sites once or twice in a year, a drop-off of 50% and 75% can be applied in the sensitivity analysis. It was felt that outcomes associated with changing risks-taking behaviors may be more difficult to sustain long-term, without wider support

Projecting future benefits

When projecting benefits into the future, it is standard SROI practice to discount the value of any future benefits. The HM Treasury discount rate of 3.5 per cent was applied to all future benefits in the model.

> Impact Map

All of this information can be collated, together with data on outcomes over a 12 month period, in an impact map to show how the value of each outcome is calculated.

Fig 21. Impact Map[61]

Stakeholders	The Outcomes (what changes)								Deadweight %	Displacement %	Attribution %	Drop off %	Impact
Who will we have an effect on? Who will have an effect on us?	Description	Indicator	Source	Quantity	Duration	Financial Proxy	Value £	Source	What would have happened without the activity?	What activity would we displace?	Who else would contribute to the change?	Will the outcome drop off in future years?	Quantity times financial proxy, less deadweight, displacement and attribution
	How would we describe the change?	How would we measure it?	Where did we get the information from?	How much change will there be?	How long will it last?	What proxy did we use to value the change?	What is the value of the change? (1)	Where did we get the information from?					
Young People	Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies	Number of females under 18 who use the service and become pregnant within 12 months, compared to the 1998 basline rate for sexually active 15-17 year olds	Connexions CSSP data	2.28	1	Long term impact of being more likely to live with an unemployed partner = 7.5% * loss of approx £18,000 (average wage for low skilled employee) * 14 years (£18,900) * liklihood of a birth Emotional cost = one hour a weeks counseling over a year (£2,085) for 27% of teen mothers (40% suffer PND, compared to 13% of older mothers) (£563) * liklihood of a birth	£8,369	1970's birth Cohort Study, APS, ASHE (see report) Department of Health (see report)	0%	0%	44%	75%	£10,780.95
	Young people feel more confident in discussing sexual health and continue to engage with sexual health services	Number of YP who visit and return to the service within the year	Connexions CSSP data	248	1	Private cost of GP visit (Market Value)	£63	BUPA	25%	0%	66%	75%	£3,995.84
	Young people who are taking risks are given guidance and then make considered proactive choices	Number of YP who initially use the service for a pregnancy test and then continue to use the service proactively within the year (with no pregnancy)	Connexions CSSP data	11	1	Value of risk for those taking pregnancy test = 9.1% (chance of positive tests) * value of becoming a teen mother (above)	£1,771	1970's birth Cohort Study, APS, ASHE,Department of Health, Connexions CSSP data	10%	0%	50%	75%	£8,766.45
	Young people who have concerns around sexual health, relationships or sexuality are provided with emotional support	Number of visits recorded as 'Sexual Health Interventions'	Connexions CSSP data	504	1	Market value of one meeting with a counsellor	£40	Website search	25%	0%	63%	75%	£5,564.16
Health and Social Care	Better sexual heath services reduces the number of teenage pregnancies	Reduced pregnancy as above	Connexions CSSP data	2.28	1 1	Public spending on supporting a teen birth for the first year = £15,305 *liklihood of a birth (43%) NHS unit cost of termination = £623 * liklihood of a termination (57%)	£16, 128	Teenage Pregnancy Unit (see report) NHS unit costs	0%	0%	44%	75%	£9,042.60
	Better sexual heath services reduces the spreading of STIs	No of Clamydia test given out	Connexions CSSP data	100	1	Cost of additional Chlamydia treatment (£800) for 4.1% of tests	£33	NHS / Youthnet	50%	0%	59%	75%	£676.50
DWP	Better support for young people taking risks reduces the number of disengaged young people	Number of young people who initially use the service for pregnancy test who move from NEET to EET	Connexions CSSP data	5	1	Cost of supporting a young person who is NEET	£5,760	Audit Commission/York University (see report)	50%	0%	41%	75%	£8,510.40
Parents	Greater peace of mind because of better sexual health support resulting in reducing the likelihood of them becoming a grandparent early	Reduction in pregnancies as above and proportion that would redult in a birth	Connexions CSSP data	0.98	1	Cost of providing childcare for parents for teenage parents	£1,973	National Minimum Wage (see report)	0%	0%	44%	75%	£1,092.45
	Improved family life because of better sexual health support resulting in reducing the likelihood their child taking risks	For the YP who reduced risk (as above), multipled by the % of parents who felt reduced risk taking would result in better family life 'a great deal'	Connexions CSSP data and voting handsets	2.97	1	Cost of stress management course	£630	UK Council for Psychotherapy	10%	0%	50%	75%	£842.00
Connexions staff	Staff are trained to deliver approved sexual health support for young people, improving their skills base	Percentage of staff reporting that they personally benefited from the increased skills 'a great deal' (73%) multiplied by the number of staff trained	Voting handsets	36.5	1	Cost of personal trainer for 12 people (£1,000) per person	£83	CSSP info (see report)	25%	0%	0%	75%	£2,272.13
Total							£18,722.00						£51,543.47

Considering Significance

The impact on improved family life, and reduced spreading of STI, are low compared to the impact of other outcomes. This is perhaps

[61] This map is based on 1,134 visits, 696 young people seen, and 50 staff trained at Connexions CSSP sites between 1st June 2009 and 1st June 2010

expected as CSSP is less developed in working with parents, and has reduced its focus on STI testing. However, the value of the impact is equivalent to 12% and 14% respectively of the total invested in CSSP supporting Connexions therefore it can be judged significant enough to be considered material. It may also point to areas that could be developed in the future to increase the social value of the return on investment. In most cases deadweight given to outcomes for staff is considered to be high enough for the outcome to not be material. Although this is not the case in this report the sensitivity analysis can test the impact of removing Connexions staff as stakeholder.

> Inputs

The cost of CSSP supporting Connexions to deliver sexual health services between 1st June 2009 and 1st June 2010 was calculated to be **£5,694**. This included resources (£3,000), delivery of training (£2,494), and staff support (£200).

> The Social Return on Investment ratio

Using the 1998 under-18 conception rate as a baseline, the SROI calculation found that after taking into account the discount rate of 3.5%, the *present value* of benefits of supporting Connexions over 12 months to deliver sexual health services in the county was:

£51,543

This gives a total *present* value of £49,800. After subtracting the investment of £5,694 this gives a net present value of £44,106

The social return on investment ratio is the total present value of the benefits divided by the investment = £8.75

The SROI ratio is therefore 8.75:1. That is, for every £1 invested in CSSP supporting Connexion between 1st June 2009 and 1st June 2010, **£8.75 worth of social value was created**.

Fig 22. Proportion of benefits to each stakeholder

Young people	£29,107
Health and Social care	£9,719
DWP	£8,510
Parents	£1,934
Connexions staff	£2,272

Figure 22 shows that young people are the primary beneficiaries of the project (56%), followed by savings to health (19%) and DWP (17%).

While the benefit to DWP may be real cost savings in terms of reduced state benefits, the savings to health and social care are likely to be in terms of resource savings rather than actual cost savings. While this may possibly allow for redirection of resources, if benefits are sustained, it is unlikely to lead to real cash benefits for health and social care.

The benefits can be split by outcome according to the level of value attached:

Primary benefits (>£10,000)

- Reduction in teenage pregnancy for young people (variable)

Secondary Benefits (£7,500 to £10,000)

- Young people make more informed proactive choices
- Reduced cost to public services of a teenage pregnancy (variable)
- Better support for young people taking risks reduces the number of disengaged young people

Tertiary benefits (£5,000 to £7,500)

- Improved access to emotional support for young people

The variation in conception rates before and after the establishment of CSSP sites does not show a clear positive impact of their activity. Therefore, there is only weak evidence that the rate of under-18 conceptions for those using the Connexions CSSP sites is lower than it

would have been if the service did not exist, questioning the significance of this outcome. The sensitivity analysis will also therefore test the return on investment if no reduction in conceptions was assumed.

> Sensitivity analysis

This SROI has identified that benefits also include raising aspirations, increasing engagement and improving emotional health for young people resulting in a return of around £9 for every pound spent. These benefits are likely to have a significant impact on young people's outcomes and long-term public costs. If the analysis on the reduction in pregnancies found that there were no reductions in pregnancies but other outcomes remained the same, the social return would still have been around £6 for every pound spent on supporting the Connexions service. Conversely, if the same number of pregnancies were averted, but there was no associated changes in risk-taking or re-engagement of those taking risks then the social return would have been reduced from £9 to £7. In other words, simply using the teenage pregnancy rate as an indictor for evaluating the service ignores the wider benefits of supporting young people to make proactive choices.

The public and personal costs of teenage parenthood used in this evaluation are significantly lower than figures used in other reports on long-term costs. This is based on research around the outcomes *caused* by teenage parenthood, rather than wider social factors. If the public costs (up to age 25) used in the audit commission report were applied then this would result in a ratio of either £14 (cost of teenage parenthood with additional support estimated at £67,529) or £26 (cost of teenage parenthood without additional support estimated at £193,734), per pound spent on supporting Connexions. This is before taking into account assumed additional loss of earnings for young people becoming young parents. Alternatively, this report suggests that such wider public costs associated with teenage parenthood can only be reduced if there is support available to address the factors associated with the risk of becoming a teenage parent. Moreover, relying only on costs associated with teenage *parenthood* can also ignore any negative impacts associated with young people having unsafe sex and risking pregnancy but not resulting in a birth.

A number of other assumptions in this report can be varied in the sensitivity analysis to test how this changes the overall SROI ratio. The following table shows how adjusting duration, drop off, the number of pregnancies avoided; displacement and deadweight may affect the calculation. It can also show how the inclusion of negative outcomes such

as increased demand on services or increased worry for parents can affect the SROI. The affect of adjusting deadweight was important as for most of the outcomes, apart from conception rates, there was a lack of baseline data so it was difficult to know what would have changed without the activity.

Fig 23. Sensitivity Analysis

Sensitivity	Social return per £
Original SROI with 2.28 pregnancies avoided (all users representative of all sexually active YP)	£8.75
Adjusting duration and drop off	
all outcomes 3 years and drop off 50%	£14.62
all outcomes 3 years and drop off 75%%	£11.37
Adjusting reduction figures	
if 14 conceptions were avoided (assuming that pro-active users only were representative of all sexually active YP)	£26.92
if no conceptions were avoided	£6.22
if no risk reduced	£7.12
Adjusting displacement and deadweight	
Adjusted all displacement to 10%	£7.87
Increasing all deadweight (where not already accounted for) to 50%	£7.67
Increasing all deadweight (where not already accounted for) to 75%	£5.45
Removing stakeholders	
Removing Connexions staff as material stakeholder	£8.36

With the exceptions of when the number of pregnancies reduced increased to 14, and when the duration of 3 years was considered, the SROI remains fairly close to £8. This suggests that a range of between £7 and £9 is likely to cover most of the possibly scenarios considered here. By collecting more evidence on the duration of outcomes then a higher SROI may be possible. However, it is likely that more intensive or on-going support would be required for outcomes to be sustained over a number of years.

Impact of negative outcomes

While some negative outcomes were considered in the report they were excluded due to lack of evidence of them being material. It is possible to include them in the sensitivity analysis to test the impact that they may have. It was found that the inclusion of increased referrals and parents' worries resulted in a SROI of around £8 and £6 respectively. This suggests that it may important to explore how messages about CSSP are communicated to parents and address any concerns or misconceptions.

Fig 24. Test for negative impacts

Stakeholders	The Outcomes (what changes)									
Who will we have an effect on? Who will have an effect on us?	Description	Indicator	Source	Quantity	Duration	Financial Proxy	Value £	Source	Impact	
	How would we describe the change?	How would we measure it?	Where did we get the information from?	How much change will there be?	How long will it last?	What proxy did we use to value the change?	What is the value of the change? (1)	Where did we get the information from?	Quantity times financial proxy	Change to SROI
Social Care	Increased referrals of those with additional needs identified	Number of referrals	Connexions database	34	1	30 mins with a social worker	-£58	Department for Children Schools and Families (DCSF) Think Family Toolkit (2009)	-£1,972	£8.41
Parents	Increased worry of child talking to some else about sexual health issues	Number of YP seen and % of parents who feel there is a negative impact of sexual health services	Connexions database and voting handsets	382	1	one session with counseller	-£40.00	Internet search- costs of one visit to a counseller	-£15,280	£6.15

Verification of findings

Draft finding were shared with CSSP trained Connexions staff and parents to check any assumptions. Values of outcomes to young people were also checked through the stakeholder exercise of ordering items of financial worth with the outcomes in this report. The final report was reviewed and agreed with CSSP staff and signed off by the Leicestershire Teenage Pregnancy Board. The report has also been independently peer reviewed by a member the Young People Economic Team at the Department for Education (DfE). A young person's summary has been made available to young people using the service with an opportunity to feedback comments.

Chapter 5: Conclusions and recommendations

> Implications of the findings for overall service and future delivery

This evaluation has identified how CSSP fits into the national teenage pregnancy strategy and the local and national evidence that supports the strategy, in terms of outcomes for teenage parents, associated public costs, and the current needs of young people. The stakeholder consultation attempts to understand all the possible impacts (or changes) due to the project. These outcomes were then given a financial value based on the value of the benefit or the costs saved through a reduction of negative outcomes to the stakeholder. Where financial costs were not applicable, proxies were used to measure the value, informed by the research and the stakeholder consultations. This process ensured that the most 'important' factors were measured and given the most weighting in the evaluation. Measurable indicators were developed to assess whether the change has happened and consideration was taken as to how much of the change could be accounted for by the project and how long the impact lasts.

The SROI analysis found that the social return of CSSP supporting Connexions to deliver a sexual health service to young people in the county was between £7 and £9 for each £1 invested. This finding supports the continuation of established CSSP sites where possible. However, the process has also contributed to a further understanding of where such benefits are delivered.

The SROI identified that the largest benefits of CSSP are associated with averting teenage births. Of females using the Connexions sites for sexual health services (who were under 18), 7% became pregnant within 12 months of a visit. This can be compared to a baseline comparison group of 7.6%.[62] This was estimated to equate to 2.3 under-18 conceptions averted through Connexions. It is predicted that averting such pregnancies that would result in a birth (43%) significantly reduces the likelihood of children being brought up on a lower income, primarily due to the increased chance of former teenage parents having a partner who is unemployed or on a low wage. The long-term reduced household income for children growing up with younger parents highlights a link to the current child poverty agenda and supports further work on understanding how poverty impacts on children's experiences and outcomes. However, simply averting a teenage birth may not necessarily

[62] Not a statistically significant reduction at 95% confidence level

have an impact on long-term outcomes for the mother, if other factors are not addressed.

An additional primary benefit of CSSP identified through the SROI is the costs saved by addressing risk-taking, disengagement and low aspirations in young people. Of young people visiting for a pregnancy test, 12% then used the service proactively for advice or contraception. Of those who were NEET and taking risks, 36% re-engaged in EET within a year. These factors were identified as having a significant impact individually on young people and public costs, and the service of providing pregnancy tests was felt to be an effective way to engage with such young people and offer a range of support. Indeed, research has identified that it can be difficult to affect teenage pregnancy rates without improving wider social factors such as deprivation, education, and aspirations. However, the case studies identified that in some cases sexual health services can be an essential part of addressing risks and improving a range of outcomes, by providing support to make proactive choices.

Providing emotional support for young people using sexual health services and increasing their confidence to use services again were also found to be important. However, Connexions staff felt that CSSP training and support attributed less towards these outcomes, and that such outcomes relied more on their own skills and experiences.

There are a number of limitations of this evaluation. Confidentiality of the service meant that a prescriptive follow-up of users was not possible so, often, indicators were calculated using the quantitative data from the database. The CSSP team and Connexions staff were relied on to fill any gaps based on their experiences of working with young people, e.g. estimating the proportion of young people who would have increased in confidence regardless of the project. The absence of a control group for such outcomes placed increased importance on making any assumptions transparent, and considering the sensitivity analysis.

While *changing* behaviour is shown to be a primary benefit of the service, it is important to note that *supporting* responsible behaviour is a key aim of the service and that young people do *want* to be responsible with their sexual health. Therefore, it is important that services respond to young people's needs. Moreover, taking a pregnancy test, or an incident of unsafe sex, may not always be symptomatic of wider risk-taking behaviour in young people. The social return on investment process would typically also include any negative impacts of the service. This was kept in mind during the stakeholder interviews. However, while, for some young people, the project did not appear to have a significant impact on *changing* behaviour, none of the young people consulted felt that there

were any negative changes due to the project. The only negative points cited were around 'lack of promotion', indicating that perhaps more young people could be benefiting from the services.

This evaluation has been able to measure the number of young people using the service who become pregnant within a year, providing a measure of impact in terms of reducing teenage pregnancies, against the 1998 baseline. However, an assumption was made that under-18's using CSSP were not significantly different to all sexually active 15-17 year olds. Alternatively, it could be considered that CSSP users may be more proactive (in seeking to use a service) and therefore less likely to become pregnant anyway. While representation could not be confirmed, analysis of the user data did indicate that Connexions CSSP users were more likely to live in more deprived areas than the general population and a significant proportion visited the service as a direct consequence of being at risk of a pregnancy.

The majority of costs used in this evaluation are based on proxies and assumptions that are made transparent in the report. While such costs are difficult to validate, the process of estimating the value of activities has added to the current understanding of benefits of the service in terms of the cost of the teenage parenthood as opposed to the cost of being at 'risk of teenage parenthood'. Research suggests that it is factors associated with the likelihood of becoming a teenage parent that impact on future outcomes, more than the *actual* teenage birth. However, understanding the process of avoiding risks, and the role that sexual health services have in addressing such risks, is highly complex. It also worth noting that analysis of the 1970's birth cohort found that long-term negative effects of early parenting were larger for those who became parents between 18 and 20 than for parents under 18[63]. This may be due to effects of early parenthood diminishing over time, better support for younger mothers (who are more likely to still be in school and living at home) or differences in the reason that younger and older teenagers become parents. Moreover, a number of studies find that outcomes associated with teenage parenthood can also be applied to parenthood in early to mid twenties, highlighting a need to consider the appropriate age targeting for sexual health services, depending on where concerns lie and the objectives of the service.

The case studies in this report highlight the complexity of working with young people within sexual health services. It can be argued that, as such, the service does not easily lend itself to the use of indicators as a

[63] *Understanding the effects of early motherhood in Britain: the Effects on Mothers,* (2004) Goodman, A., Kaplan, G. and Walker, I. http://www.ifs.org.uk/docs/teenage.pdf

measure of success. However, through this SROI process, the story behind the indicators has been explored to provide insight into who benefits from the service and the value that can be placed on that benefit.

An additional difficulty in measuring the impact of the service is the lack of information on outcomes for males, in terms of the reduced likelihood of becoming a young father, which has resulted in a clear gap in the evaluation. Approximately half of all CSSP users are male. However, much less is known about outcomes for males who take risks or become young fathers. Young fathers are often harder to identify from the data available. Indeed, 251 young mothers (16-19) in the county are currently engaged with Connexions, compared to 65 young fathers. This report has identified that fathers play a key role in addressing the lower household incomes that children of teenage parents grow up in. However, it is worth noting that national figures estimate that around a quarter of fathers to babies born to teenage mothers are aged over 25[64]. Further research into the role males play in outcomes associated with teenage pregnancy and the impact of sexual health services on them is needed to fully understand the benefits of CSSP.

The impact of a teenage pregnancy on the wider family, such as the parents of the teenager, should not be ignored, particularly where there are other family issues such as poverty, poor health or other caring responsibilities. Added pressure on families can compound difficulties for those with complex needs if holistic family support is not available.

In terms of cost effectiveness of the local teenage pregnancy strategy as a whole, findings from this report can also be used alongside the SROI of Leicestershire's EET strategy that estimates the social return on supporting young parents into education, employment and training[65]. Rather than comparing the SROI ratios, it is important that the ratios are understood in term of the wider stories of value uncovered during the SROI process. Considering the complexity in reducing teenage pregnancies and the difficulties in having a significant impact on conception rates, supporting young parents, understanding their ongoing needs and trying to remove both the short-term and long-term barriers, can be important in improving the quality of life and opportunities for them and their children. Bearing in mind the proportion of females who become mothers under 20, it is important that monitoring tools and local consultations are able to identify whether those who became parents at a

[64] *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents* (2008) Department for Children, Schools and Families www.dcsf.gov.uk
[65] *Evaluation of the Young Parents EET Strategy* (2010) CFE

younger age are accessing services differently, or exhibiting different levels of satisfaction, to ensure that services are meeting their needs.

Recommendations

Taking into account future cuts to public services, it is important to identify how services can be targeted or delivered more effectively. This report makes the following recommendations to ensure effective sexual health service delivery for young people in Leicestershire:

- Continue to provide dedicated young people friendly community-based sexual health services across the county, particularly in areas of high need in relation to teenage pregnancy
- Ensure service providers target services to meet the needs of vulnerable young people and those taking risks
- Ensure high quality and diverse targeted training continues by developing a core training set which includes early intervention, taking into account the findings from the Coventry University research on risk-taking
- Communicate teenage pregnancy risk factors, and links to other outcomes, to ensure partners work holistically to address young people's needs
- Embed multi-agency practice at an operational level to inform service planning and delivery
- Embed the indicators from this report to inform and review the value of sexual health work e.g. increased confidence in young people
- Continue to use data and soft intelligence, e.g. users' feedback to inform service provision

This report supports the continuation of sexual health training to staff at sites accessed by more vulnerable young people, e.g. where numbers of pregnancy tests or teenage pregnancy rates are high. In other areas, where young people are more proactive in using services, it may be appropriate to consider supporting young people to move on to adult / universal services e.g. GP's, family planning clinics, ensuring that there are local, young people friendly, services available. Working closer with the Leicester City services and establishing links or duplication may increase efficiency and effectiveness of the service, particularly given that a number of the county's 'teenage pregnancy hot spots' border the city and many young people travel between the city and county for school, college or socialising.

There is still more to understand about risk-taking. Better understanding of the different reasons why some young people get pregnant and how areas differ can help to influence local services. For many young people who present themselves for pregnancy tests, this may be the first time they engage with a formal support service. Of all those Connexions CSSP users who became pregnant since June 2009, 37% had previously been seen for a pregnancy test (which was negative) or a Chlamydia test. While this suggests that it is important to understand how those taking risks can be supported, it also identifies that, without the service, those at risk may not become known to support services.

To have an impact on local teenage pregnancy targets, partners working with young people, particularly vulnerable young people, should also take on board the findings and recommendations of this report and training should to be targeted towards those working with young people at risk. As services such as the youth service and Connexions restructure, it is important that, through appropriate training, services can identify young people early who may be at risk and ensure that they are encouraged to access sexual health or relationship support when needed. The CSSP, therefore, need to identify the core training areas to be delivered.

Embedding research and consultation in sexual health service developments can ensure that services meet the needs of young people and wider society. Best practice and case studies, as well as new research, can be shared to improve local knowledge and expertise. It is also important to consider how young people prefer to use sexual health services, e.g. the importance of confidentiality and trust, and continue to use this information to inform service provision. Increased emphasis on research, analysis and evaluation is recognised by the recent NHS white paper published in July 2010[66] as important in service redesign and decision making. A focus on measuring what is important locally, rather than prescribed targets, places additional responsibility on authorities to understand local priorities and impacts of services.

[66] *Liberating the NHS* (July 2010) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Appendix

Tables for cost calculations

Table 1: Annual unit costs for teenage mothers in year 1

Costs	*Under 18*	*18 years*
Contribution loss	£740	£1,260
Tax foregone – direct	£509	£1,058
Tax foregone – indirect	£2,045	£2,543
Benefits	£7,956	£9,708
Health costs	£2,455	£2,455
Social services	£200	£200
Total year 1	£13,905	£17,205

Source: Unit costs are derived from *Godfey et al (2002)*[67] and *Wellings et al (2003)*[68].

Table 2: Estimated age of mother at birth from under 18 conceptions

Age of mother at birth	*% of births*
< 14	0.1
14	0.9
15	4.1
16	13.8
17	32.1
18	48.9
Total	100

Source: Derived from ONS Birth Statistics, 2001

Table 3: Tariffs Related to Termination of Pregnancy

	Procedure Type	Tariff	Proportion of Total Abortions	Cost
PbR	HRG Elective*	£473	0.304	£143.79
	HRG Non Elective*	£679	0.076	£51.60

[67] *Estimating the cost of being "not in education, employment or training" at age 16–18* Godfey et al (2002) Research Report 346, Social Policy Research Unit, University of York

[68] *Evaluation of the Teenage Pregnancy Strategy: annual synthesis report No. 2: 2002* Wellings et al (2003) London School of Hygiene and Tropical Medicine

BPAS Medical	Under 9 weeks	£530	0.212	£112.39
	9 – 18 weeks	£850	0.044	£37.47
	19 – 24 weeks	£1,285	0.003	£3.88
BPAS Surgical	Up to 14 Weeks	£638	0.387	£247.19
	15 – 18 weeks	£855	0.016	£13.60
	19 – 24 weeks	£1,640	0.008	£13.12
Average Cost of TOP				**£623**

*Data on proportion breakdown is not routinely available. For the purposes of this calculation, it has been assumed that the majority (80%) of NHS (PbR) abortions are carried out on an elective basis.

Published by the British Pregnancy Advisory Service (BPAS)[69].

Young People's Stakeholder Activity Exercise

Based on responses from 7 young people age 15-17

Rank the following in terms of what makes you feel better?	Averge rank	approx value
going on a weeks holiday abroad	2.3	£1000
getting a new outfit	3.5	£100
getting a new x-box game	3.6	£40
having a private chat with someone understanding	3.8	
watching a film	4.4	£5

You wake up and can't remember what happened the day before. Rank the following in terms of what you would you regret the most?	Averge rank	approx value
you've been fined £1,000 for criminal damage	2.3	£1,000
you've been chucked out of college	3.2	£2,000
you've had unsafe sex	3.3	
you're in the middle of nowhere and the train back home is £120	3.7	£120
you've ruined your new shoes	4.6	£50

[69] BPAS price guide 2010. Last updated Dec 2009
www.bpas.org/js/filemanager/files/price_list_2010

Rank the following scenario's in terms of which would be worst in your life right now?	Averge rank	approx value
you can't use the internet for a year	2.8	£300
you find out you're pregnant/your girlfriend is pregnant	2.9	
your family become homeless	3.3	£10,000
your new car is written off before you get insurance sorted out	4.4	£3000
you lose your wallet (with £50 in)	5.1	£60

Consultation Material

Young people's initial consultations questions

1. Why have you used this service?
2. What difference has the service made to you?
3. Do you think you will *do* anything differently as a result of using the service?
4. Do you think you will *think* any differently as a result of using the service?
5. What are the negative impacts of the service?
6. What would you do if the service did not exist?
7. Are there any other benefits of the service?

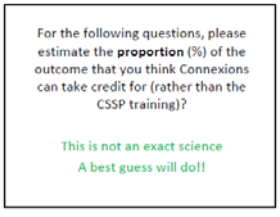
Connexions staff initial consultation questions

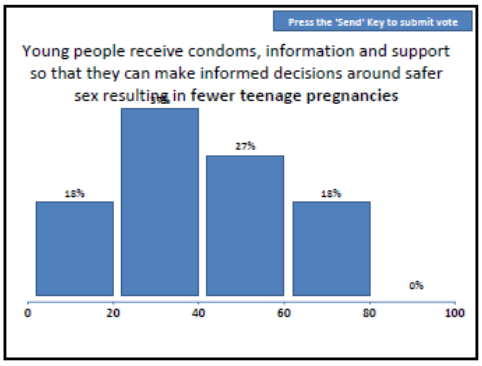
1. What do you see as the benefits of CSSP (e.g. resources, funding, training,) to you – what difference does this make?

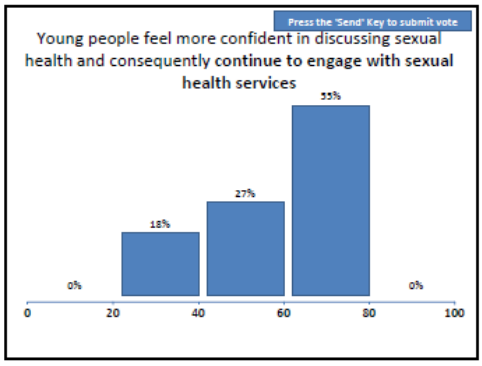
2. What do you see as the benefits of CSSP to young people – what difference does this make?

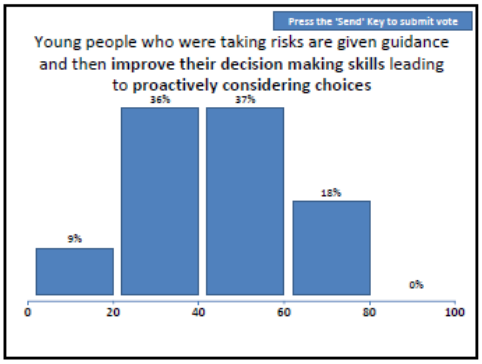
3. Who else may benefit from CSSP? Can you give examples of how?

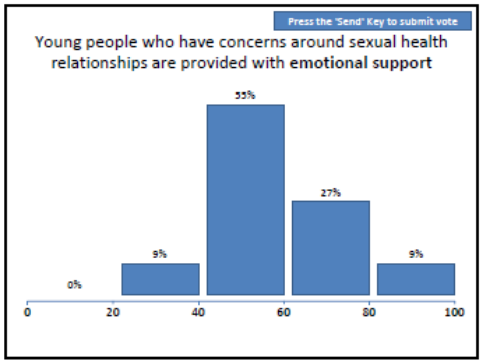
Follow up questions to Connexions staff and parents

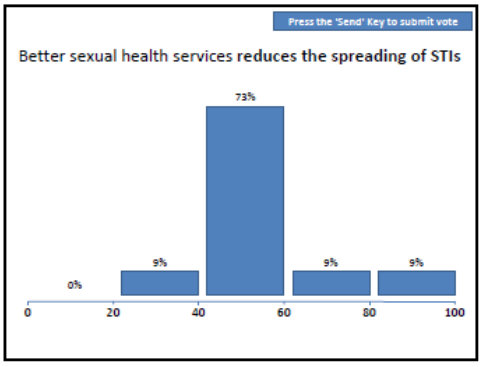


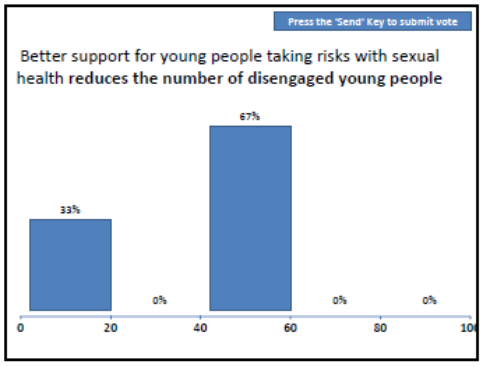

Press the 'Send' Key to submit vote
Young people receive condoms, information and support so that they can make informed decisions around safer sex resulting in fewer teenage pregnancies
18%
36%
27%
18%
0%
0
20
40
60
80
100


Press the 'Send' Key to submit vote
Young people feel more confident in discussing sexual health and consequently continue to engage with sexual health services
0%
18%
27%
55%
0%
0
20
40
60
80
100


Press the 'Send' Key to submit vote
Young people who were taking risks are given guidance and then improve their decision making skills leading to proactively considering choices
9%
36%
37%
18%
0%
0
20
40
60
80
100


Press the 'Send' Key to submit vote
Young people who have concerns around sexual health relationships are provided with emotional support
0%
9%
55%
27%
9%
0
20
40
60
80
100


Press the 'Send' Key to submit vote
Better sexual health services reduces the spreading of STIs
0%
9%
73%
9%
9%
0
20
40
60
80
100


Press the 'Send' Key to submit vote
Better support for young people taking risks with sexual health reduces the number of disengaged young people
33%
0%
67%
0%
0%
0
20
40
60
80

For the following questions, please think about how much you agree with the statements given