

Confidential Access to Family Planning and Teenage Pregnancy

**Submission to the Law Reform Commission Consultation Paper on: Children and the
Law: Medical Treatment**

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1. Introduction

The Law Reform Commission Consultation Paper “Children and Law: medical treatment”, henceforward LRC (2009), sets out proposed criteria under which health professionals could provide children of different ages with health care and medical treatment defined to include contraception. Children aged 16 or 17 would be presumed to have capacity to consent to such treatment. Children aged 14 or 15 would be regarded as capable of giving consent under certain conditions including that the medical professional should encourage the child to inform his or her parents (or guardians). Finally treatment could also be provided to children aged 12 or 13 under the condition that the parents (or guardians) are notified and their views taken into account.

The Commission notes that young people aged 16 or older can already “consent to medical treatment with presumably covers prescriptive contraceptives” (LRC, 2009, sections 3.60; 3.77) although they report anecdotal evidence that some doctors may be reluctant to prescribe under the age of 17 (LRC, 2009, section 3.78).

If adopted, the Commission’s proposals would place Irish law on the provision of contraception to minors in a similar position to that in England. Indeed, the Commission draws extensively on the so-called *Gillick* case which clarified that contraception in England and Wales could be provided to minors in England subject to the well-known *Fraser* guidelines (LRC, 2009, sections 3.82-3.94).

There are some important differences between The Commission’s proposals and the *Fraser* guidelines. In the first place, the Commission proposes that for children aged 12 or 13, parents would have to be informed whereas the Fraser guidelines do not require informing parents at any age. Note, however, that the Commission’s proposals would not require parental consent even at this age, only that parents’ views must be taken into account. In at least one other key respect, the guidelines suggested by the Commission make it much easier to provide contraception to children without parental involvement. Specifically, they propose

no counterpart to the *Fraser* guideline that the child must be “very likely to begin or to continue having sexual intercourse with or without contraceptive treatment.”

Underpinning the Commission’s proposals are the assumptions that (i) lack of confidentiality is a key barrier to minors accessing contraception services (LRC, 2009, sections 3.72; 3.75) and that (ii) access to contraception for minors plays an important role in reducing pregnancy rates amongst that group (LRC, 2009, section 3.58). In this submission, I will examine whether the academic evidence supports these assumptions. In summary there is indeed support for assumption (i) but little or no support for assumption (ii). Furthermore the experience in England & Wales suggests that the Commission’s proposals will not have the desired effect of reducing pregnancy rates amongst minors and may have the unintended consequence of contributing to an increased rate of sexual activity.

The submission is structured as follows. In the next section I outline the current state of sexual health amongst minors in Ireland relative to other countries, in particular England and Wales. Where possible, I concentrate on those aged under-16. In Section 2, I discuss the academic evidence relating to access to contraception and confidentiality. In section 3 I present an overview of recent experience of the English Teenage Pregnancy Strategy in which confidential access to contraception has been given high priority. Section 4 contains some concluding statements.

2. Teenage Pregnancy in Ireland

Data on pregnancy rates amongst Irish teenagers is limited by the lack of comprehensive data on abortion. However, on the reasonable assumption that the vast majority of abortions on take place in the UK, publicly available figures on the number of abortions (by age) on Irish residents in England and Wales allow us to arrive at reasonable estimates of pregnancy data. I focus here on rates to those aged under 16 as these are the group most affected by the Commission’s proposals.

Table 1 reports number and rates of pregnancy (including abortion and birth) and diagnoses of STIs for various age groups in both Ireland and, as a point of comparison, England & Wales where parental consent for contraception is not required. In 2008 (the latest available year), there were an estimated 73 pregnancies to Irish girls below the age of 16, a rate of 0.91 per thousand girls aged 13-15. These comprised 27 abortions conducted in England and

Wales and 46 births. The comparable rate for England & Wales was 5.51 per thousand, over 6 times higher than in Ireland. Indeed, the estimated pregnancy rate for under-16s in Ireland is about the same as the rate in the Netherlands, a country which is often highlighted as having one of the best records on teenage pregnancy in the world¹. Furthermore, as Figure 1 demonstrates, there is no evidence that the pregnancy rate amongst minors has been getting significantly worse over the past few years.

Clearly, it is possible that more abortions took place on Irish residents than those recorded in the official UK statistics. However, even if the actual abortion rate was five times higher than that reported (and there is no evidence of such significant under-reporting), the pregnancy rate in Ireland would still be less than 40% of the British rate.

An obvious question in the light of the fact that abortion is illegal in Ireland, is whether the difference in pregnancy rates is solely due to lower abortion rates in the two countries. In fact this is not the case. As reported in Table 1, the under-16 birth rate in Ireland in 2008 was less than half the rate in England & Wales (0.58 per 1000 compared to 1.26 per thousand).

Some of those aged under-16 at the age of conception will have been 16 at the time of birth (or abortion). Unfortunately, Irish data are not available based on age at conception. However, as Table 1 reports, the difference in pregnancy rates amongst under-17s (i.e. including those aged 16 at the time of birth or abortion) between Ireland and England & Wales is just as striking as for under 16s.

A notable feature of the data is that the gap between England and Ireland is much smaller for older teenagers (for whom parental consent is not required in either country). For example, the estimated birth rate in 2008 to 18-19 year olds in Ireland was just 28% lower than that in England and Wales.

In justifying its proposals, the Commission refers to increasing rates of diagnoses of sexually transmitted infections (STIs) amongst teenagers in Ireland (LRC, 2009, section 3.71).

However, it is important to remember that the vast majority of these cases will be older

¹ The pregnancy rate (births plus abortion) for under-16s in the Netherlands was 1.14 per 1000 in 2007 (the latest year for which abortion data are broken down for this age group). The 2007 rate for under-17s in the Netherlands was 3.28 per 1000. Sources for these figures are Statistics Netherlands for births and population and Rutgers (2008) for abortions.

teenagers who would be unaffected by the confidentiality proposals. In fact, the Commission reports no data at all on STI diagnoses specifically amongst minors and so we simply do not know whether we have no idea whether the situation is getting worse for this group. In any case, rates of STI diagnoses (amongst both all teenagers and under-16s) have increased dramatically in England (where there exists extensive information, advice and access to contraception) over the same period. Further, at least some of the increase in both countries is due to greater awareness of asymptomatic infections such as Chlamydia. Finally, as reported in Table 1, the rate of STI diagnoses amongst Irish teenagers in 2007 (the latest available year) was just one quarter of the rate in England. Given that the English data include diagnosis only at specialised Genito-urinary Medicine (GUM) clinics, whereas the Irish data also include diagnoses at GP surgeries, the true position is almost certainly even more favourable to Ireland.

The limitations on STI data mean we should be cautious in making inferences and we have no information on STIs amongst minors in Ireland. However, the available data are clearly suggestive that STI infections amongst teenagers in Ireland are of an order of magnitude lower than in England.

In summary, teenage birth and pregnancy rates in Ireland are extremely low in comparison to countries such as England and Wales. There is little evidence of the situation worsening. Further, the superior record in Ireland on pregnancy rates most pronounced amongst younger teenagers, i.e. those most likely to be affected by the Commission's proposals.

The low pregnancy rate amongst minors in Ireland is so striking that caution is surely warranted before making significant changes to the legal position surrounding access to contraception for minors. However, it might be suggested the Commission's proposals are necessary in the context of a rapidly changing cultural context in Ireland. For example, it may be that pregnancy rates are low in Ireland due to restraint caused by strong religious affiliation. If that that affiliation becomes weaker, it could be argued that the proposals will play a role in limiting an inevitable rise in pregnancy rates. In fact, as we have seen there is little evidence of an increase in pregnancy rates amongst minors over recent years. However, we can assess the strength of this argument by examining academic evidence on the impact of confidential access to contraception from other countries such as the UK where the cultural

influence of religion has historically been much lower. I undertake this task in the next section of the submission.

3. Evidence on Access to Family Planning and Confidentiality

3.1 Assessing Academic Evidence

Paton (2009) discusses different types of evidence relating to interventions on teenage sexual health. At least three different types of studies can be identified – randomised controlled trials (RCTs), population studies and mathematical modelling, each of which carries both advantages and disadvantages.

RCTs attempt to estimate the difference in an outcome between a treatment and control group before and after an intervention such as exposure to a particular sex education curriculum. The use of a control group allows for the impact of factors that may have affected the outcome of both groups over the time period. As such, well-designed RCTs hope to identify the causal effect of the intervention. On the other hand, a potential problem with RCTs is the possibility that knowledge of being observed may alter the behaviour of participants in either control or intervention groups. Further, RCTs tend to be focused on a very specific group of subjects and, hence, it may be difficult to use them to predict the impact of a policy aimed at the wider population. A good example of this problem occurs with RCTs (e.g. Raine *et al*, 2005; Raymond *et al*, 2006) that have studied the impact of interventions to increase access to emergency birth control (EBC). Such studies typically select both control and intervention groups from amongst women attending family planning clinics. The results are informative about the effect of easier access to EBC on those who are already sexually active, but it is harder to draw conclusions about the impact of such a policy on the general population.

Population-level studies tend to use secondary data either on individuals or on regional areas such as local authorities or States. The best such studies exploit the advantages of panel data (i.e. data on several observations over several periods of time) to estimate the impact of an intervention. In terms of policy application, this type of approach has the advantage of testing directly for an aggregate impact, i.e. at the level at which the policy is targeted.

A third class of research uses mathematical modelling to try to identify the impact of behavioural changes over time. For example, some recent work combines survey data on sexual activity amongst young people with estimates of contraceptive failure to identify the

extent to which observed decreases in teenage pregnancy rates in the USA can be attributed to abstinence or contraceptive use. These studies tend to be very sensitive to the assumptions employed. Further, although these studies examine the direct mechanism by which pregnancy rates go down, they are not able to provide evidence on the impact of a policy intervention on, for example, family planning access or confidentiality. For this reason, I do not consider such studies further here.

3.2 Access to Family Planning

The evidence from the peer-reviewed literature on the impact of increased access to family planning on conception rates amongst minors is not encouraging. Wilkinson *et al* (2006) provide a statistical analysis of the impact of measures implemented as part of the English Teenage Pregnancy Strategy. In the first place, they find that those local authorities that have been allocated more money to the strategy have experienced larger reductions in under-18 conception rates (albeit their study focused on the early years of the Strategy). However, looking at specific factors within this overall finding, they find that those areas with higher quality contraceptive services and with better access to services experienced *lower* reductions in conception rates than other areas.² Although such an association should not necessarily be interpreted as a causal effect, the finding is in line with a range of population-level studies and evaluations of RCTs from both the U.S. and the U.K. (Evans, Oates and Schwab, 1992; Clements *et al.*, 1998; Paton, 2002, 2006; DiCenso *et al*, 2002) which all fail to find evidence that access to family planning reduces pregnancy rates amongst minors.

Looking at outcomes once pregnancy has occurred, there is some evidence that access to family planning may be associated with fewer teenage births (Wolfe, Wilson and Haverman, 2001; Kearney and Levine, 2009) but more abortions (Wilkinson *et al*, 2006) and these findings are consistent with the increase in the *proportion* of abortions in England since the start of the Strategy there.

The evidence-base is perhaps strongest on the issue of the impact of increased access to emergency birth control (EBC). An exhaustive review of RCT evidence on this question concludes that “to date, no study has shown that increased access to [EBC] reduces unintended pregnancy or abortion rates on a population level” (Raymond, Trussell and Polis,

² Wilkinson *et al* (2008) also find that areas judged to be providing better quality sex education had also not seen bigger reductions in teenage conception rates than other areas.

2007, p.184). This is complemented by population-level studies from the U.K. (Glasier *et al*, 2004; Girma and Paton, 2006; Paton, 2006) which also all find that access to EBC does not lead to reductions in teenage pregnancy rates.

That increasing access to family planning services does not appear to reduce teenage conception rates may seem counter-intuitive at first sight. In fact, there are a number of reasons why such interventions might be ineffective. One possibility is that the findings simply reflect the high failure rates experienced in practice with most forms of family planning. For example, the latest evidence from the U.S. suggests that over 8% of pill users and 17.4% of condom users will experience pregnancy over a 12 month period (Kost et al, 2008, p. 14). These percentages are likely to be even higher amongst adolescents. Stanford, (2008) presents evidence the effectiveness of emergency birth control is much lower than previously thought.

A further possible explanation put forward primarily by economists such as Levine (2003, 2004) is that greater access to family planning (or abortion) reduces the perceived risks associated with early sexual activity and, as a result, leads some young people increase risk-taking behaviour, for example, through greater sexual activity. Combined with the high failure rates of contraception noted above, fewer pregnancies from greater use of birth control are counterbalanced by more pregnancies arising from more sexual activity.

The question of whether access to family planning increases risky sexual behaviour is by no means resolved in the academic literature. For example, the meta-analysis of DiCenso *et al*. (2002) does not find evidence that contraceptive access affects sexual behaviour. In contrast, Raymond and Weaver (2008) report that access to EBC is associated with a significant increase in risky behaviour. Further, other research (Richens, Imrie and Copas, 2000; Paton, 2006; Klick and Stratmann, 2008) uses diagnoses of STIs as a proxy for sexual risk taking and finds evidence that such legal changes can indeed have the unintended consequence of increasing sexual risk taking.

Irrespective of the reasons behind the findings, the academic research to date provides no evidence that greater access to contraception for minors will contribute to lower pregnancy rates amongst that group.

3.3 Impact of Confidentiality

As the Consultation Paper notes, many observers and lobbyists around the world argue that confidentiality is crucial when providing family planning services to young people, especially those below the age of consent. It is commonly suggested that by assuring young people that parents do not have to be informed, uptake of services will increase and this will in turn contribute to lower underage pregnancy rates. However, if access to such services does not in fact reduce conception rates, then the case for guaranteeing confidentiality is considerably weakened.

In fact, very few studies have actually examined the impact of removing (or enforcing) confidentiality for contraception on pregnancy rates (rather than just on the uptake of services). Those that have (Paton, 2002; Zavodny, 2004, 2005) have failed to find a significant impact on underage conception rates, although there is some evidence of an impact on births relative to abortions.

The Consultation Paper contains a long discussion of the 1985 *Gillick* ruling which affected which meant that for most of 1985, family planning could not be provided to underage girls without parental consent in England and Wales. The Commission states that “[T]his caused a striking reduction in the number of young women under the age of 16 who sought advice on contraception” (LRC, 2009, section 3.100). This is indeed true – as Figure 2 shows, take-up at family planning clinics amongst this age group in England dropped by about 30% in 1985 relative to the previous year.

What Commission fails to mention is that the underage conception rate in 1985 decreased slightly relative to the rate amongst older teenagers. Similarly, Paton (2002) shows that the rate also did not increase relative to the underage conception rate in Scotland where the Fraser ruling did not apply. Given that we had fewer under-16s accessing family planning yet no increase (and possibly a slight decrease) in pregnancies, a natural inference is that the rate of underage sexual activity decreased. The Commission relies on the experience following the *Gillick* ruling as justification for ending parental consent for under-16s in Ireland. In fact, the experience in England suggests that the Commission’s proposals would not reduce underage pregnancy rates in Ireland but may increase underage sexual activity.

Further evidence on the beneficial impacts of parental involvement come from research that has examined the impact of laws in the U.S. which mandate parental involvement (including consent in some cases) before abortions are performed on minors. Methodological difficulties, such as controlling adequately for abortions carried out in neighbouring States without such a law, mean the issue is by no means settled, but the majority of studies to date find that parental involvement laws lead to significant decreases both in underage abortion rates (Joyce, Kaestner and Colman, 2006; Levine, 2003) in overall conception rates (Levine, 2003) and, even more encouragingly, to decreases in teenage STIs (Klick & Stratmann, 2008). Such findings stand in stark contrast to the Commission's stance that imposing confidentiality will contribute to improved sexual health amongst minors.

4. The English Teenage Pregnancy Strategy

In June 1999, the Labour Government in England launched a Teenage Pregnancy Strategy with specific targets to achieve a 15% reduction in the under-18 conception rate by 2004, a 50% reduction by 2010 and to establish a long run downward trend in the under-16 conception rate (Social Exclusion Unit, 1999). In a parallel development in 2004, the Government also adopted a target of reducing the rate of new diagnoses of sexually transmitted infections among under-16s and 16-19 year olds.

Responsibility for implementing the Teenage Pregnancy Strategy was given to a new body, the Teenage Pregnancy Unit (TPU) which has now been subsumed within the Department of Children, Schools and Families *Every Child Matters* (ECM) programme. Each local authority in England was provided with a specific target for reducing under-18 pregnancy rates in their area and given resources to help them achieve this target. The TPU/ECM remains responsible for national initiatives and for advising on and monitoring policy delivery at the local level. Funds started being allocated to the Strategy from the end of 1999 and increased to about £40 million per year from 2003/4 onwards. About 85% of expenditure is allocated for local implementation with the remainder being taken by central costs.

From the start, improving young people's knowledge of and access to confidential contraception services has been at the heart of this strategy in the belief that this will contribute to lower teenage conception and STI rates.

Figure 3 illustrates trends in teenage conception and STI diagnosis rates in England since 1995. The under-16 conception rate in 2008 (the latest available year) was about 5% higher than when the Strategy was launched in 1999, whilst the under-18 rate was about 10% lower. However, a large part of the decrease came between 1999 and 2001 when relatively little had been spent on the Strategy. Since then, the downward trend in both rates has slowed down considerably and there appears to be no prospect of the Government meeting its target of a 50% reduction by 2010. Further, as noted above, studies which try to isolate the impact of access to contraceptive services over the period of the Strategy (e.g. Girma and Paton, 2006; Wilkinson et al, 2006) have been unable to find any link between greater access to confidential contraception and lower conception rates.

Although the national data provide little evidence that the Strategy has had any impact in reducing conception rates, there is more evidence that the Strategy may have affected the outcome of teenage conceptions. For example, the percentage of under-18 conceptions ending in abortion increased from 53% in 1999 to about 62% in 2008.

Finally, new diagnoses of STIs amongst teenagers have continued to increase throughout the period (see Figure 3). Although, as noted above, some of this increase may be due to greater awareness and diagnosis of STIs, there are few signs that teenage sexual health is improving.

In summary there is little evidence from the experience of the English Teenage Pregnancy Strategy to suggest that the Commission's proposals to permit access to contraception for minors without parental consent will have beneficial impacts on sexual health in Ireland.

5. Summary and Recommendations

Despite the illegality of abortion in Ireland, birth rates for under-16s are also very significantly lower in Ireland than in England. Indeed, on the basis of data on abortions carried out in the UK on Irish residents, pregnancy rates for under-16s in Ireland are amongst the lowest in Western Europe. There is no evidence of an upward trend in birth or pregnancy rates amongst minors in Ireland.

The academic evidence as well as recent experience from England suggests that the Law Commission proposals to allow the provision of contraception to children between the ages of 12 and 15 without parental consent would not have the intended effect of reducing

pregnancy rates amongst that group. Further, there is a serious risk that the proposals would have the unintended consequence of *contributing* to an increase in the rate of underage sexual activity.

Implementing the Commission's proposals to allow the provision of contraception to minors as young as 12 without parent consent would place Ireland's relatively superior position in terms of sexual health amongst minors at serious risk.

As a result of these considerations, I recommend that the provision of contraception services to children under the legal age of consent to sexual activity be excluded from any guidelines relating the provision of healthcare without parental information and or consent.

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Table 1: Teenage Pregnancies (2008) and STI diagnoses (2007), Ireland and England

		Ireland		England	
		Number	Rate	Number	Rate
Under-16	Abortions	27	0.34	4,113	4.25
	Births	46	0.58	1,215	1.26
	Pregnancies	73	0.91	5,328	5.51
Under-17	Abortions	56	0.69	10,223	10.3
	Births	228	2.79	4,475	4.51
	Pregnancies	284	3.48	14,698	14.8
18-19	Abortions	344	6.20	23,303	33.2
	Births	1816	32.7	32,047	45.7
	Pregnancies	2160	38.9	55,350	78.9
Under-20	STI diagnoses	1082	3.78	52,930	15.8

Notes:

(i) Pregnancy, abortion and birth rates are per 1000 females. STI rates are diagnoses per 1000 population. Under-16 rates are based on 13-15 year olds, under-17 on 14-16 year olds and under-20 on 15-19 year olds. Ages are the time of birth or the abortion.

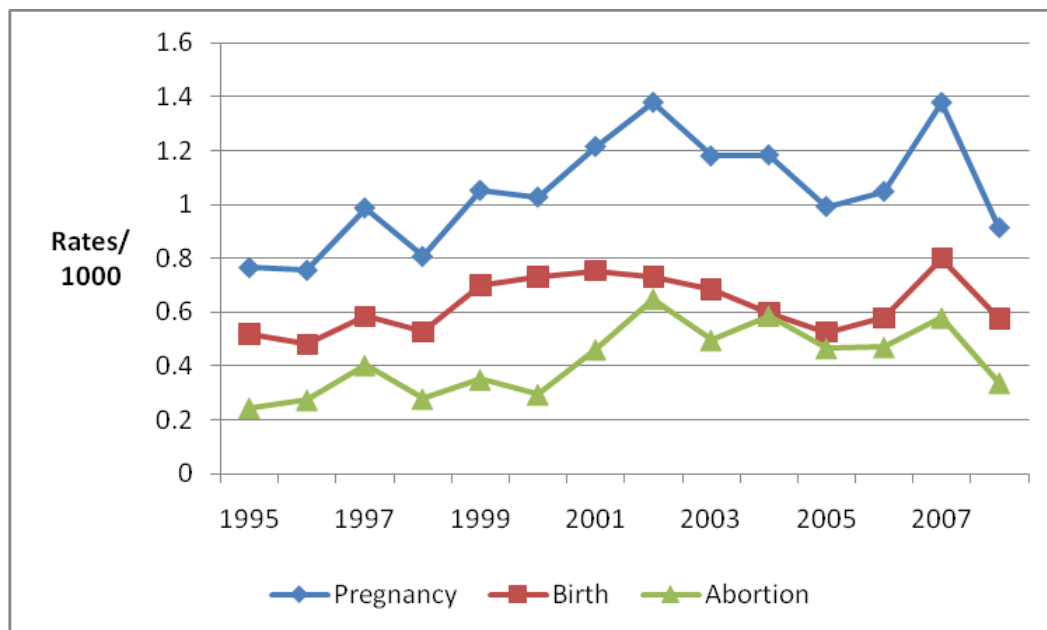
(ii) STI figures relate to diagnoses of 5 key infections: Chlamydia, HPV, Gonorrhoea, Genital Herpes and Syphilis. English data are restricted to diagnoses at GUM clinics.

(iii) Pregnancies are the total of abortions and births.

(iv) Abortion numbers in Ireland are abortions carried out on Irish residents in England and Wales. A combined total is given for 16 and 17 year olds. The number for 16 year olds (used in the under-17 rows) is estimated on the basis that 40% of the total are on 16 year olds, this being the proportion for English residents.

(v) Sources for English data are Office of National Statistics (births and population), Department of Health (abortions) and the Health Protection Agency (STIs). Sources for Irish data are Irish Statistics (births and population), Department for Health (abortions) and the Health Protection Surveillance Centre (STIs). The Irish population figures are the single year of age estimates using the MIF1 method.

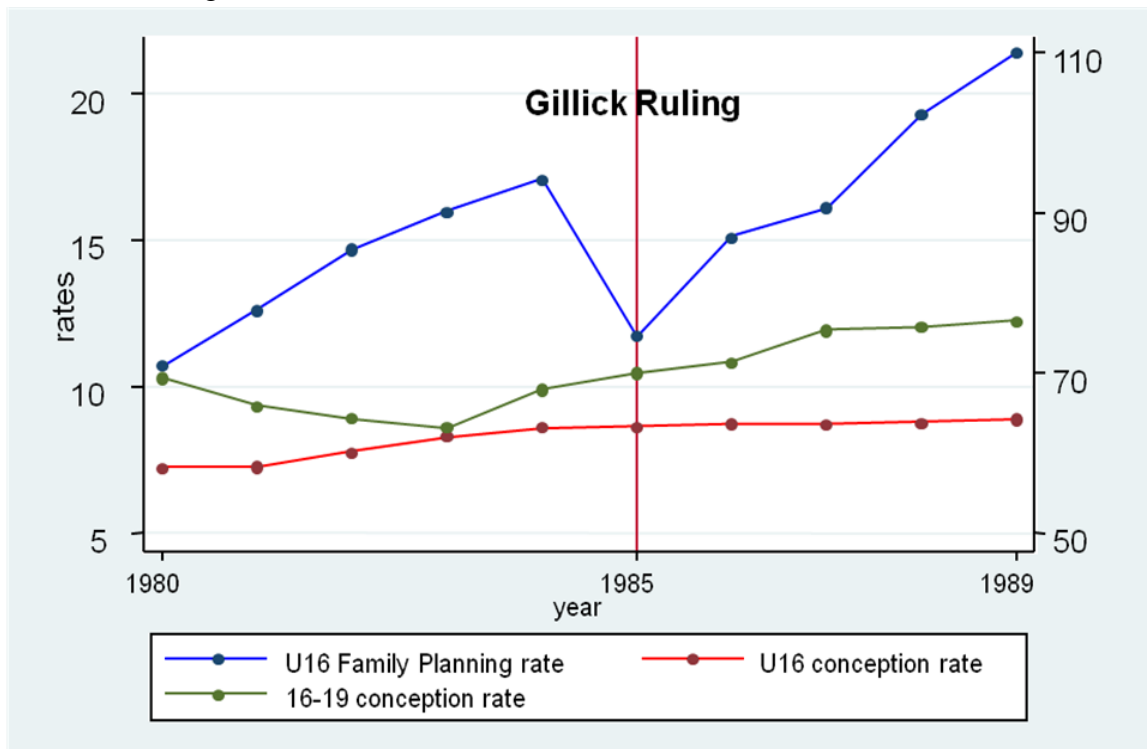
Figure 1: U16 birth, pregnancy & abortion rates Ireland 1995-2008



Notes:

See Table 1 for data sources and definitions. Population deflators are interpolated from the single-year-of-age census figures for different years.

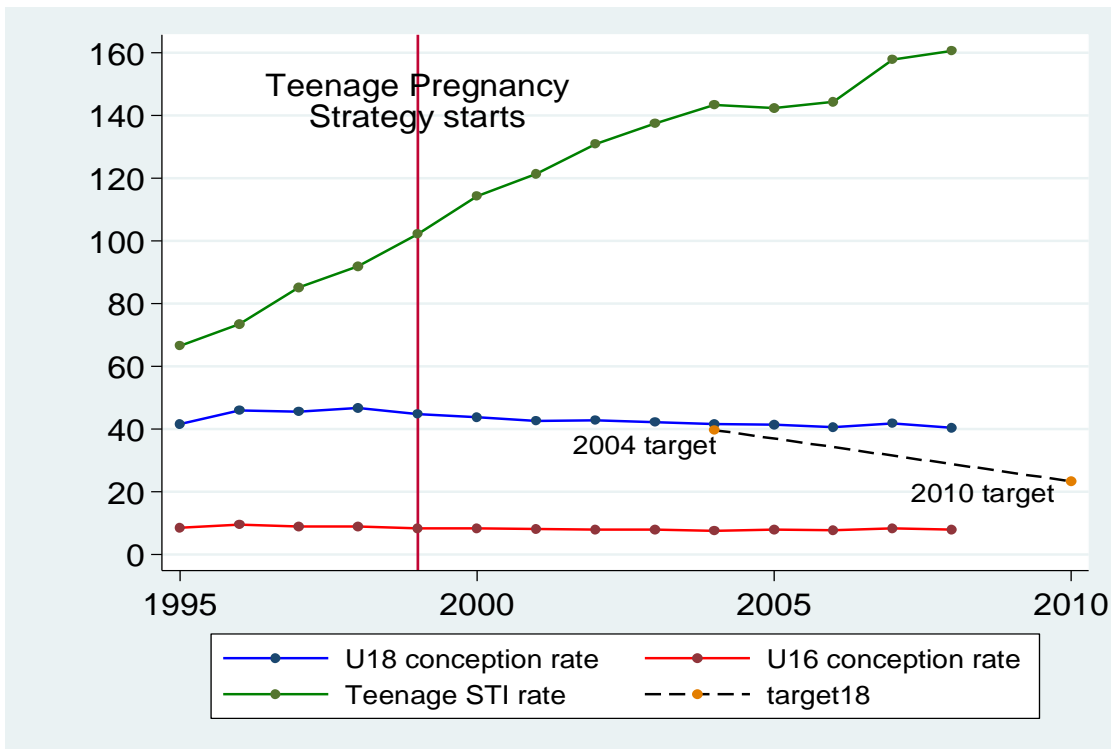
Figure 2: The Impact of the Gillick Ruling on family planning & conceptions amongst under-16s in England



Notes:

- (i) This graph is taken from Figure 2 in Paton (2009).
- (ii) U16 & 16-19 rates are per 1000 females aged 13-15 & aged 16-19 respectively. Sources are Department of Health for family planning & Office of National Statistics for conceptions.
- (iii) Rates for 16-19 year olds are scaled using the right hand side of the graph for ease of the comparison over time.

Figure 1: Progress of Teenage Pregnancy Strategy in England



Note:

- (i) This graph is updated from Figure 1 in Paton (2009).
- (ii) U16 & U18 Conception rates are per 1000 females aged 15-17 & 13-15. Teenage STI rates are diagnoses of main STIs among all teenagers at GUM clinics per 10,000 people aged 15-19. Sources are the Office of National Statistics for conceptions and the Health Protection Agency for STIs.