

Teenage pregnancy and access to contraception: what does the evidence show?

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Since the Government launched its Teenage Pregnancy Strategy in 1999, millions of pounds have been spent on access to “confidential sexual health services” for young people. Many nurses are uncomfortable with providing such services to children under 16, especially without parental knowledge, but do so believing that they are helping to reduce the risks of early pregnancy.

Unfortunately, the latest data shows that pregnancy and abortion rates for under-sixteens are higher now than when the Strategy started. Given this, nurses may be questioning whether they have been right to go along with this policy and it will be helpful to understand what the academic evidence says on the issue.

We have a wealth of evidence, from both randomised trials and population-level studies, indicating that access to birth control has little if any impact on teenage pregnancy rates. To take one example, a 2007 Obstetrics and Gynecology review of the evidence relating to emergency birth control (EBC) concluded, “to date, no study has shown that increased access to [EBC] reduces unintended pregnancy or abortion rates”.

When policy interventions have unexpected impacts which subvert the aim of the policy, economists often refer to the ‘Law of Unintended Consequences’. In this case, by lowering the pregnancy risk, easier access to birth control may encourage more young people to engage in sexual activity. If so, numbers of pregnancies decrease amongst those who would have had sex anyway, but increase amongst those who have sex when they otherwise would not have done. Overall, we end up with a similar number of pregnancies but with more underage youngsters being sexually active. Even worse, many birth control methods offer no protection against sexually transmitted infections (STIs). Indeed, research in the *Sex Education* journal suggests that increased access to EBC may be associated with higher teenage STI rates.

On the positive side, the academic evidence is clear that involving parents in decision-making is crucial. When the Gillick ruling was in effect in England and Wales during most of 1985, contraception could not be provided to underage girls without parental involvement. Take-up at family planning clinics dropped by about 30%, yet underage pregnancy rates actually decreased slightly relative to older teenagers. Even more encouragingly, work in the *Journal of Health Economics* and elsewhere reveals that laws requiring parental consent before an abortion is performed on a minor lead to significant decreases in teenage abortions, pregnancies and even sexually transmitted infections.

It is unclear why it has taken so long for these findings to filter down to nurses working in the field. Whatever the reason, nurses might remember that although the Frazer guidelines permit nurses to provide minors with access to abortion and contraception without parental knowledge, they do not require nurses to do so. Further, all health professionals (and indeed taxpayers) should question the wisdom of PCTs spending scarce resources on measures such as school-based provision of EBC that, at best, are ineffective and, at worst, may actually be contributing to poor sexual health amongst teenagers.

References

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