



Middlesex
University

Young Women, Sex and Choices:

a study of young motherhood in Shropshire

Rachel Hek and Lesley Hoggart

Middlesex University

**Social Policy Research Centre
Working Paper No. 1**

July 2004

INTRODUCTION

Project Summary and Objectives

This project, commissioned by the Teenage Pregnancy Co-ordinator for Telford and Wrekin Primary Care Trust, examined the sexual behaviour and decision-making processes of young women in Shropshire, predominantly in Telford. We asked young women about their sexual experiences, concerns and needs; their views on the sexual health services available locally, and their opinions on what might influence their own sexual behaviour and decision-making. The project also examined the support services for young mothers currently available and young women's views of these. Individual interviews were undertaken with young mothers and service providers. Focus groups were held in a number of schools.

The study had three main objectives. First, to improve understanding of what makes some young women engage in unprotected sexual intercourse; second, what then influences some young women to access emergency contraception; third, what

influences decisions about whether or not to terminate confirmed pregnancies. Our focus was on the relationship between social and cultural contexts and young women's individual decisions. The results of this project should help to determine which types of services and interventions might be prioritised by the local Teenage Pregnancy Unit.

This Report is organised into four chapters. Chapter one provides the background to the project including a brief discussion of the policy context and a discussion of the research design. Chapter two begins our discussion of the research findings by presenting the major themes/issues that emerged from the project. It draws upon all the individual interviews and the focus groups. Chapter three focuses on the individual decision-making processes of those young mothers interviewed. Chapter four draws these strands together and presents policy recommendations.

Policy Background, Local Context & Research Design

Background to the project

The present government first prioritised teenage sexual health in Our Healthier Nation, (Department of Health 1998). This was closely followed by the Social Exclusion Unit's Teenage Pregnancy Report (SEU 1999). The SEU Report highlighted what it considered to be the negative consequences of the consistently high rates of teenage pregnancy in the UK. In response, the Government allocated £60million to support the report's recommendations for local and national co-ordination, improvements in sex education and contraceptive services, and support for pregnant teenagers and teenage parents. The Teenage Pregnancy Unit was launched to co-ordinate these efforts. The two main aims were:

1. To halve the rate of conception among under 18s in England by 2010 (and also to set a downward trend in the conception rate for under 16s)
2. To reduce the risk of teenage parents and their children suffering long term social exclusion (SEU 1999)

Teenage conception rates remain high in the UK with more teenage young women becoming pregnant than anywhere else in Europe (UNICEF 2001). This is still the case even though the rate has fallen over the last couple of years. The most recent confirmed figures show that between 1999 and 2001 the under-18 conception rate in

England fell from 45.3 to 42.3 per thousand population aged 13-17, whilst the under-16 rate fell from 8.2 to 7.9 per thousand female population aged 13-15 (ONS 2001). It is clearly too early to judge whether this is the start of a downward trend. In contrast, in Telford and Wrekin, the site for this research, the rates have actually increased.

A number of different factors contribute towards the relatively high rates of teenage conception in the UK. The Acheson Report concentrated on the social, economic and cultural inequalities affecting health and claimed that disadvantaged young people are more likely to become unintentionally pregnant (Acheson 1998). This assessment is supported in the Teenage Pregnancy Report, which also considers other factors. It endorses explanations based upon: young people's poor knowledge of contraception; an accompanying lack of understanding about forming relationships and parenting; mixed messages about sexuality from the media and society in general; and low expectations amongst a significant number of young people (SEU 1999). The latest National Survey of Sexual Attitudes and Lifestyles (NATSAL) also shows that the likelihood of not using contraception increases as the age at which sexual intercourse begins go down (Wellings et al 2001). Unprotected sexual intercourse means that young people may also be at risk of contracting sexually transmitted infections (STIs). Effective use of contraception amongst young people is associated with good quality information and education about sexual matters including school-based sex education, and

with community sexual health services (Chambers et al 2001, Swann et al 2003). These are two important areas that the Government's Teenage Pregnancy Strategy has targeted for improvements (SEU 1999). They are clearly more amenable to local intervention than attempts to change patterns of deprivation. The SEU Report has been criticised for not addressing issues of deprivation and poor job prospects for many young people (FPSC 1999).

This project sought to access the views and attitudes of young people on policy and services concerned with sex education and sexual health. It is widely recognised that, to be effective, policy for tackling teenage pregnancy should be informed by the knowledge, views and attitudes of teenagers themselves (Chambers et al 2001; Counterpoint 2001; Jewell et al 2000). Indeed, it has been shown that when young people are involved in the planning, delivery and evaluation of sexual health services, such services are more likely to be used by young people (Save the Children 2002). Research that has concentrated upon decision-making in relation to engaging in 'risky' sexual activity has shown that, lacking adequate knowledge and/or self-confidence, young people struggle to negotiate 'safe' sexual encounters (Counterpoint 2001; Holland et al 1992; Thomson and Scott 1991; SEU 1999; West 1999). Two further points of decision, predominantly involving young women, can be distinguished. The first is whether to access emergency contraception following unprotected sexual intercourse. The second, following confirmation of pregnancy, is whether to terminate the pregnancy. This research investigated all three decision-points, and the focus was on the relationship between social contexts and young people's individual decisions.

The Local Context

The research took place in Telford, a New Town built around the old mining villages and market towns of North-East Shropshire. The population of Telford has grown to approximately 154,000, and has a forecast growth over the next ten years of 17% (IMD 2000). The town developed as the mining and coal industries declined and provided housing for people moving from Wolverhampton and Birmingham. Housing tenure is mixed between owner-occupier, privately rented, housing association and local authority. Many of the estates are located at a distance from facilities, public transport is irregular and journey times are considerable from areas of housing to the town centre. Some parts of Telford feature as amongst the most deprived in the country (IMD 2000). Overall Telford is the 96th most deprived local authority of 354 in England. Three of the wards in Telford are amongst the 10% most deprived, and a further seven amongst the 10 - 20 % most deprived. Over 50% of the population live in these most deprived wards. 20% of children live in households with no wage earner. Overall the area has a small (3.5%) minority ethnic population, although in two wards this is 17%. A significant Pakistani Muslim community is located in one of the most deprived wards. 25% of households in Telford and Wrekin are in debt, the third highest incidence of debt in the country. Educational achievement is below average, with only 34% gaining any GCSE's or / NVQ level 3, compared with 43% nationally. The area is therefore, struggling with low wages, poverty, debt, and high employment.

Telford and Wrekin has a higher birth rate than many other areas of the country, with women 10% more likely to have children. According to the most up to date national figures, teenage pregnancy rates are significantly higher than the national

average. Between 1999 and 2001: under-18 conception rate in Telford and Wrekin rose from 55.4 to 60.2 per thousand, whilst the under-16 conception rate rose from 8.2 to 12.7 per thousand. Abortion rates in Telford and Wrekin are amongst the lowest in England. Nationally, the proportion of conceptions leading to abortion rose between 1999 and 2001 from 43.5% to 46%. By way of contrast, in the same period proportion of conceptions leading to abortion in Telford and Wrekin fell from 37% to 33.7%.

Local Services

The area has many general practitioners and health centres. All GP's provide sexual health services, and due to an initiative by the local Teenage Pregnancy Unit, many of these are now 'young person friendly'. This means they will supply advice and contraception in confidence to young people. The sexual health advice service Risq, based in Telford with an outpost in Shrewsbury, offers a range of confidential services for young people. These include contraceptive provision and advice, emergency contraception, counselling around pregnancy and referral on to other relevant services.

A number of services for pregnant young women have been developed. Work is concentrated on helping pregnant young women and young mothers access education, health and other support services (Teenage Pregnancy Unit Annual Report 2002). A Teenage Pregnancy Support Officer (TPSO) provides support to young mothers under the age of sixteen throughout their pregnancy and beyond. A midwifery service for under-16s has been launched at Wrekin Maternity Unit and teenage dedicated midwives care for teenagers throughout their pregnancies. After the age of sixteen young mothers are referred to Connexions. There is also an

educational unit and specific youth service based projects for both pregnant young women and young mothers.

Focus Groups

Three focus groups, with 8-12 participants, were held in two schools. As far as we were aware none of the participants were pregnant. The focus groups explored levels of knowledge and attitudes towards contraception, pregnancy, abortion, and discussed factors the participants thought affected sexual decision-making. Previous research has found focus groups particularly valuable for accessing shared cultures and understanding the value frameworks within which sexual behaviour and decision-making takes place (Tabberer et al. 2000), and we found this to be the case in this research.

All participants were provided with leaflets explaining the purpose of the project and what to expect if they agreed to take part. A teacher discussed the process with them and participation was entirely voluntary. Children and parents were provided with relevant information leaflets and then gave written consent to the research. Participants were told they could withdraw at any time and that the data would remain anonymous and confidential. They were taped with participants' written permission. The focus groups lasted an hour, and took place in the schools, in rooms where there were no disturbances.

Individual interviews

Individual interviews were carried out with young women who had either had their babies, or who were expecting a baby. We had hoped to recruit twenty young women, half of whom had gone ahead with pregnancy and half who had decided on abortion but this proved to be very difficult. There seemed to be reluctance amongst health professionals to contact young women they knew of who had terminated a pregnancy. We were not able to recruit any young women specifically for the abortion sample, and this is a weakness of the study. One young mother we spoke had also had an abortion and was happy to discuss her experience with us.

The young women were recruited in a variety of ways. Initially the local Teenage Pregnancy Unit put us in contact with sexual health professionals and schools. We met with these professionals in groups and on a one-to-one basis, to inform them about the project and ask for help with recruitment. Professionals then agreed to talk to their clients about the project and to ask any interested in taking part to contact the researchers. This was done in order to preserve anonymity and to ensure that young women did not feel under pressure from the researchers to take part. The majority of volunteers we did speak to were recruited with the help of the education and youth services in Telford and Wrekin. They were provided with information leaflets some time before the interviews. Parents of those under 16 were also asked for their permission in writing for their children to participate, and were provided with relevant information leaflets. The interviews explored the young women's experiences and assessments of their own present and future lives; their explanations of decisions they had made; their attitudes towards sexual activity, motherhood generally and teenage motherhood specifically; their attitudes towards

abortion, and sources of information (and advice) on sexual health (including abortion); their access to sexual health services; their assessment of the value and usefulness of these sources; their assessment of the influence of other people on the choices they make.

Interviews with key professionals

We spoke to ten key professionals from different agency backgrounds (health, education, voluntary sector). These interviews focused on their views of the work of sexual health and other service providers with young people and young mothers. The interviews also explored their views and attitudes towards sexual health issues facing young people, in particular in relation to sex education, contraception, abortion and teenage pregnancy. We also sought their views on what services are needed and how existing services could be improved.

Research Access and Ethics

This is a sensitive area of research, in terms of the subject matter and the demographic characteristics of the main participants. Doing research with young people raises specific ethical issues as well as problems of access (Greig and Taylor 1999; Lewis and Lindsay 2000). Previous research indicates that young people are often not as inhibited as researchers and service providers expect them to be (Holland et al. 1992; Tabberer et al. 2000), and that they often welcome the chance to discuss their stories and experiences. This was also our experience. Allowing participants to reflect on their experiences and to speak about issues of importance to them can provide acknowledgement and validation of young people's stories, which may be beneficial in itself.

As researchers we were experienced in discussing sensitive areas with young people. The informed consent of participants (and parents where necessary), confidentiality and anonymity were stressed. The interviews were taped, with participants' permission, names were deleted from the transcripts, and the tapes were destroyed. The interviews took place wherever the young woman felt most comfortable (at home, at education project etc). Approval was gained from the local Ethics Committee in August 2002. Access, and facilitation of the research, was organised in consultation with the Teenage Pregnancy Co-ordinator. The research was designed in order to maximise the possibility of accessing the views of young people.

Access to the research participants in this research project, however, proved extremely difficult. Some of the conditions set by the local Ethics Committee made us very reliant upon service providers facilitating the project and referring young women on to us. Whilst the young women whom we interviewed appeared pleased to take part in the research this was outweighed by a marked reluctance (with some notable exceptions) on the part of several professionals to help us recruit participants. This was undoubtedly compounded by a number of key staff leaving their posts during the course of the project. This difficulty meant that the research took longer than we had anticipated and that we were unable to interview ten young women who had experienced an abortion.

Chapter 2:

Research Findings

This section concentrates on information provided by the one-to-one interviews with the young women. This data is supplemented by information from the focus groups and also the interviews with professionals. In total, a diverse group of forty-two young women took part in the study. Those we spoke to in individual interviews were aged between 14 and 20 years old (focus group participants were 14-16). Those interviewed individually were all teenage mothers (or about to become teenage mothers), the youngest giving birth at 14 and the eldest at 18. The majority, although not all, were from white UK backgrounds (as was the case with the

focus groups). Eleven of the young women's own mothers had been teenage mothers, and only three had fathers at home throughout their own childhoods. They were from working-class backgrounds and less than half the group had educational qualifications at the time of interview. However some of the remaining young women were in educational projects and were hoping to take GCSE's. All had aspirations for the future: eight said that they would like to attend college to train for the jobs that they wanted, and approximately half hoped to go into 'caring' types of work.

Themes and Issues

The data from the different research sources have been merged in order to preserve the anonymity of the people who spoke to us. The themes move from a general picture of how young women gain information from which they form their views and base decisions, to more personal factors affecting individual decisions. We begin by discussing the local social and cultural context of sexual decision-making. This covers attitudes and views on: sex and relationships education, sexual behaviour, contraception and abortion. The more

immediate personal factors (such as personal backgrounds and the attitudes of the fathers of the babies) are then discussed. We also look at the role of the services in this picture. Quotations are selected to indicate broader opinion in the group rather than that of one respondent. The next chapter searches for patterns in decision-making and provides a more specific picture of the paths that different young women chose to take and factors influencing these choices.

1. Sex and Relationships Education and information sources

The research participants claimed that the content and delivery of sex education was inadequate.

Oh them videos, what they show like the cartoon sex videos on how to put condoms on. I think it was that anyway and we had about two, two lessons probably at the most in sex education. Nothing really, nothing that made a difference to be honest when I was there.

I remember doing it in Year 7 I think (laughs) that's it. Just about male parts and female parts and stuff like that.... I remember the teacher talking to us and like all the immature boys giggling and laughing and it's not really useful.

This sense that the education they received was failing to connect with young people's current experiences and expectations was also indicated by complaints about material being 'out of date'.

The videos they use are really, they're like really old, they look really, really old. Like the 70s. These people are wearing, and this man's got really horrible clothing, this man has got a humungous moustache and this woman is wearing enormous glasses, black rimmed. The difference is like it was recorded before we were born and like things happened then more different.

The widespread use of unclear and irrelevant language and terminology was commented upon. Some drew connections between the use of such language and the obvious personal embarrassment of those delivering the lessons. A related concern was that sex and relationships education was superficial and did not deal with their real concerns and experiences. These might include how boys can behave sexually, and discussion on withdrawal.

They don't tell you that, they tell you the one way yeah, you have sex but they don't tell you the others ways and a man's mind goes wild.

They do sex education but it's not real. They don't tell you that if your boyfriend pulls out you can get pregnant off, you know, the ejaculation. And they don't actually show you what it looks like. It's worrying isn't it; they don't show you people doing it so you don't actually see anything properly do you. They say, 'This is how it's done and that, but you don't really know until it happens and the rubber splits in two.

Taken together, these observations indicate that sex educators are having difficulty relating to the language and culture of contemporary teenagers. Generational barriers are evidently impacting upon the delivery and content of sex education and adversely affecting young people's engagement with the issues discussed. On a positive note, many research participants were keen to engage with the issues. They explained what had been unhelpful, and ventured ideas for improving sex education in school. The suggestions followed logically from the criticisms mentioned above and focused upon the need to spend more time discussing the reality of negotiating sexual activity and what can go wrong. The value of having someone other than a teacher to talk to was raised. One focus group participant argued that sex education needed to take place at an earlier, younger, stage, before the possibility of having sex had actually arisen.

They should, they should have a counsellor there for one. Say you were being pressured or if you wanted to take the next step and they could talk about it.

This was also a message from the other focus groups and from some professionals who were involved in the design and delivery of sex and relationships education.

Why don't we do something about it this year [year 9] anyway? I think my opinion is you do it really early, I mean just early enough so you know, because if you don't know it's too late, it's too late to know. I think they should do it every year but more advanced every year.

Information and discussion on contraception is generally introduced towards the end of year nine, or year ten, when most girls are already fourteen, and some may be sexually active or under pressure to become so. Teachers were concerned that this was too late. One school that introduces contraception into sex and relationships education in year nine recently had a pregnant year seven pupil (by her boyfriend).

One important issue is that of confidentiality. The girls in some of the focus groups talked about not having anywhere to go for confidential advice or information, or anyone to talk to if they were worried about being pregnant. One exception was a school in which there was a counsellor who offered a confidential service. This was welcomed by the girls. Her rules of confidentiality differed significantly from those practised by most teachers and it is likely that she is able to offer important help and advice to girls and boys who would not feel happy about confiding in teachers. A recent paper from Childline (Keep 2000) emphasised young people's need for non-judgemental and confidential advice. Other professionals we interviewed confirmed that this desire for confidentiality (which includes taking pupils for pregnancy tests) is well known within the sexual health profession.

A further problem was that many of the young women had dropped out of school, or had attended for limited periods. They had no experience of sex education at all; they lacked information and were disillusioned with the education system. Young women talked about relying on information from a variety of media sources. Television (soaps, chat shows and discussion programmes) were the most commonly mentioned. Some young women also referred to magazines, such as *Cosmopolitan*, as a source of information. Others said that the majority of their information came from discussions with friends, mothers and sisters. There was a general sense of embarrassment about discussing sexual matters with fathers.

They probably did sex education but I probably weren't there (laughs)

We thus found a strong confirmation of previous research indicating that substantial improvements can be made in sex and relationships education (Tabberer et al 2000, SEU 1999). It may well be that improvements made over the last couple of years might not have been experienced by many of the young women we interviewed. Many of the young women in the focus groups, however, also displayed a lack of knowledge about some aspects of contraception and abortion and felt that what they were taught was 'too little, too late'. The limited, and value-laden, delivery of education on the issue of abortion will be discussed in Section 4 below.

2. Negotiating sexual encounters

The young women in this study had a wide variety of views and experiences in relation to sexual behaviour. About half had had more than one sexual partner, and half had become pregnant by their first sexual partner. Most had their first sexual experience at around 14–15 years old. They often became pregnant quite quickly after this. The majority indicated that they had not particularly enjoyed their first sexual encounter.

In terms of peer pressure, our findings supported previous qualitative research (Counterpoint 2001) that found that young women seem to have just as much, if not more, influence on whether other young women have sex, than young men. Our interviewees indicated that there is a lot of talk about sex, but that often those who are doing the talking have not actually 'done the deed'. We were presented with conflicting messages about the desirability of under-age sexual activity. In some respects they were telling us that there is a certain kudos attached to having sex, but they were also aware that young women who do have sex may be the subject of gossip, and often get little peer support if they become pregnant.

It's funny though because I was one of the last girls to lose my virginity because they were all ragging us and stuff like that so I went and done it and I was the first to get pregnant and the first one to like lose my friends. It wasn't peer pressure or nothing but I thought there must be something wrong with me because I was one of the last few girls. And obviously now I know I wasn't one of the last few girls because they were all just bragging or whatever.

By way of contrast, young men's relationship to sexual activity is seen as relatively trouble-free: they are seen as liking sex, bragging about sex and not thinking much beyond this. Some of the young women said that their sexual partners were willing to use contraception, although they did not always give this as much thought as the young women. Others indicated that they felt that there would be situations when young men could pressurise them into not using contraception.

I don't think, that boys they just do it for the sake of it to, boys to show off – 'I've slept with this many people', and girls because they don't want to feel left out or because they feel they have to because everybody else is doing it. So no I don't think they do enjoy it. Well boys might do I don't know but I don't think girls do.

Oh boys are a bit more into it than girls, they're a bit more into bragging. It was more like they wanted sex but not a baby. I don't think they minded using something, I think some of them were really like I'll do anything. I think some of the boys were really like not even thinking about contraception. Most of them are thinking about other things, some of them were just so intent on sex, that it was all they thought about.

The overall picture that emerges from the individual interviews is one in which young women are not necessarily making a conscious decision about the best time for them to start having sex. This contrasts with views expressed in the focus groups where the young women talked about starting sex when they 'were ready for it', about 'not allowing boys to take advantage', and about how a boyfriend who is only interested in sex is not worth having. It is clear, however, that

negotiating sexual encounters on this basis is easier said than done. The context within which sexual activity is instigated is one in which there is a lot of talk about sex, in which most young people seem to believe it starts at the age of fourteen to fifteen but in which they often claim at a

later stage that they had been misled. There is also not much confidence about their ability to practice 'safe sex'. The professionals interviewed also believe that most girls start having sex around this age but a substantial minority begin earlier.

3. Taking 'risks' and becoming a mother

The young women told us their use of contraception was often random, despite the risks of pregnancy and disease. This was despite the fact that many who told us this also said they were fully aware of these risks and knew how to use contraception effectively. Others said that they had limited and often inadequate information about contraception. When contraception was used there was a definite preference for the use of condoms, and many indicated that they saw this as protection against disease, particularly chlamydia. Health professionals told us that there had been a high profile campaign in the area about the risk to young women of leaving this infection untreated. This seemed to have had an impact. Young women also said that the method of contraception they choose depended on safety from infections and pregnancy. The choice was also clearly influenced by immediate factors such as who had advised them about contraception, and the ease with which they could access alternative methods.

Oh yeah sexual diseases you can catch like Aids or Chlamydia or something. I don't want to catch nothing because I know my boyfriend has slept with other people but I haven't, so I wanted to use them.

My Mum come to me and told me that I was going to go on the pill, one because I didn't have very nice periods she thought it might calm them down a bit. And then she just took me to the doctors and put me on the pill. I didn't ask for it she come to me.

Previous research has shown that alcohol and drugs often contribute towards 'getting out of it' and engaging in unprotected sex (Counterpoint 2001: 10). In our research, the focus group participants recognised that using alcohol and/or drugs made it more difficult for anyone to practice 'safe sex'. One young mother indicated that alcohol played a part in whether she used contraceptives or not.

The first time I did use a condom, and that after that it was just when I had them with me, or he had them with him. After that I often didn't, I drank a lot, started drinking a lot.

A number of the professionals we interviewed also talked about drugs and alcohol in relation to poor contraceptive use and to the decision to have sex at all. One told us that when they talked to young women about when they started having sex a common response is 'Oh I was drunk, I can't remember'. Another, who had run workshops with young people felt, 'I think alcohol has a massive impact you know, they'd go out Thursday, Friday, Saturday and be absolutely hammered and not actually know who they've been with'. On such occasions condom use is obviously difficult.

Becoming pregnant

Most of the young mothers (and mothers-to-be) told us that when they became pregnant they had either not been using

any contraception or had been using contraception inefficiently. Several told us that the time they became pregnant was the only time they had not used contraception. Others knew that they were not using the contraception properly but decided to go ahead with sex anyway. Many of these said that this would not be the case again. Often the messages were confusing and difficult to interpret. This seems to indicate confusion about (or an unwillingness to discuss fully) their own intentions and the possible consequences of their action.

It was just one time when I never, I knew, one time when you don't use it and you don't think it will happen to you and that's when it did.

It was an accident but I was stupid as well. I didn't use anything.

I was on the pill but I didn't take it properly (laughs) so I got caught on the pill. Well I knew to be honest yeah I knew it's just that I guess I was stupid to be honest, I didn't know how to take it, I wasn't as careful as I should have been. I am now though (laughs).

When young women who do not want to be pregnant know they have had unsafe sex an obvious thing to turn to is emergency contraception.

Emergency contraception

There was a noticeable lack of knowledge regarding emergency contraception. Almost all of the young women had received little information on emergency contraception, and some were misinformed about its effects. Only one had used emergency contraception. Others who had tried to get it had not been able to.

I did actually try and get the morning after pill but it was around Christmas time yes, it was around Christmas time, I think it was like Bank Holiday and they weren't opening, I couldn't get it anywhere.

Most of the professionals we spoke to were concerned about young women's access to emergency contraception. This was particularly the case for those working in schools who felt they were unable to respond adequately to pupils who had told them they had recently had unsafe sex and were worried about becoming pregnant. We heard of one case in which someone in a school had taken a young woman to a local hospital, for emergency contraception and she had been turned away:

She came to me, it wasn't a day when there was one of the clinics on, it was before the time when we had as much information about the clinics who were pupil friendly and they refused, flatly refused to give her any advice, any form of morning after contraception. They told her that the only help they would give her is to, that she'd got to go to her own doctor. Now she went there, I sent her there in all good faith, she was treated quite badly and made to feel cheap and her needs were not catered for, she was told she had to go to her doctor which she did. She hadn't got any money on her, I had simply got her to the xxxxx, she hadn't got any money on her, her nearest doctor was, her doctor was a bus ride away... That was appalling and you know similar situations have happened as well

Although the interviewee above did note that they are now able to refer to pupil friendly clinics for emergency contraception she remained concerned about the availability of emergency contraception at weekends, when it is most needed.

4. Abortion

The young women we spoke to presented us with complex views on abortion. Their first reaction was invariably to state that they disagreed with abortion. This is not altogether surprising as all those interviewed individually had made the decision to continue their pregnancies rather than terminate them. The way that they talked about abortion, however, is revealing. Many used terms like ‘killing babies’, were highly moralistic and talked about ‘innocence’ (of the baby) and ‘blame’ (of someone becoming pregnant). This use of language bears a strong resemblance to the terminology of the ‘pro-life’ movement. However, most of the young women developed this later in interviews and expressed the view that although it would not be ‘okay’ for them, it would be acceptable for others. They talked of other young women they knew who had gone ahead with abortions, and many expressed the view that it is each woman’s right to decide whether or not to terminate a confirmed pregnancy. Of the young mothers, only one, as far as we know, had also experienced an abortion. This was with a second pregnancy. She was comfortable with this choice and indicated that she had received a good service.

Only two of those interviewed who expressed clear anti-abortion views were also well informed about abortion policy and procedures. Three others had either no information or incorrect information about the effects of abortion, and their views had been formed on this basis.

I watched a talk show, if you know what I mean, I don't know what it was, on abortion pills and I thought oh God they've brought out a pill now that you can take. But I looked at the dangers of it as well that you can take it and then like it doesn't, you won't know when you're going to lose it if you know what I mean, it could be a fully grown baby. I remember

one young woman on this talk show and five months later she lost her baby, so it was fully grown.

I mean if you had an abortion you could just have the chance of never having children again and I thought sod that, I'll have a baby now because if I had an abortion I could never have children.

The largest group of young women were those who felt that abortion wasn't for them, but that it was an individual choice and that others should be able to decide for themselves. They often moved from saying they didn't agree with abortion to talking about exceptions, such as rape, or failed contraception. There were strong references to ideas of blame and innocence. Many knew of others who had had an abortion.

I don't like the killing, I think you know the baby hasn't done anything wrong at all and it hasn't got a chance do you know what I mean, I think it's really cruel, I just don't like it. I hadn't liked it for ages, I just don't agree with it. You know it's up to other people if they want to do it but personally I wouldn't do it.

I don't agree with that unless you've been attacked or like if they did use contraception and they did get pregnant well may be it is acceptable then but other than, if they didn't use contraception and they did get pregnant then I think it's their fault they shouldn't have an abortion, it's their responsibility. It's their own fault. Like I say not unless I was attacked or anything.

Some of the young women indicated that people close to them were opposed to abortion and described how this had played a part in their decision-making.

Well I mean when I was with my ex he said if I ever get rid of it, the baby, there'd be trouble so that kind of put me off the idea. And I don't really agree with them, I'm not religious but I don't believe in abortions. I mean it's like how I think of it is it's killing a part of you; you're not giving it a chance.

These views fit with previous research findings that indicate that views on pregnancy and abortion are largely culturally defined (Tabberer et al 2000). Many young women spoke of partners and parents disagreeing with abortion. Many professionals also expressed anti-abortion attitudes. They invariably expressed the view that their personal opinion of abortion as morally wrong did not impact upon their work with young people. However, it seems highly likely that such professionals would find it difficult to present abortion as a positive choice.

One professional who had been involved in young people's workshops told us that young women are 'very moralistic' about abortion, that 'most of them actually think that abortion is wrong' and that she has been told 'time and time again if you have a termination you're killing life, you're killing a baby'. The professionals also talked about a climate in which young women who have an abortion generally feel terrible guilt after the event. This is what would be expected given the way that abortion is discussed in the area. These young women can be seen to be under immense cultural pressure to feel that having an abortion is morally wrong and not the right decision for them.

According to the latest guidance on Sex and Relationships Education, abortion should be part of the SRE curriculum (DfEE 2000). The young women, however, had received very little information about abortion. Some of them said that it was not covered in school at all.

No I didn't know anything about abortion, nothing at all.

They've got these little, they were like pods they were and they showed like the belly and then a baby inside and all this stuff.

We were also told about some cases in which abortion is dealt with in sex and relationships education. The way in which it is dealt with, in some cases, however is not balanced and is cause for concern: 'we do show how quickly a foetus develops you know, from embryo to foetus ... not that long a period of time'.

I just give them the facts. We've got some plastic foetuses from four weeks I think to twenty-four weeks so we look at the development of the foetus, we look at what they think would be the cut off point for an abortion and that usually surprises them when they hear that the biggest foetus we've got the abortion is still legal ... Their attitude to abortion is always hundred percent against, always one hundred percent against. Which is quite amazing because you tell them the statistics then for how many women will probably end up having an abortion and they're just horrified [Interviewer asks 'why do you think that is?'] ... I think probably because if you have an abortion you don't necessarily think what it entails, it's an operation, but when you see the foetuses I think that's what shocks them most

This is a questionable way of dealing with abortion in sex and relationships education and is likely to contribute towards young people's negative feelings towards abortion. This use of model foetuses is reminiscent of some of the political campaigning activity of openly anti-abortion organisations such as LIFE. Such a strategy aims to assert foetal-personhood by making the foetus a public, visual presence separate from (and usually opposed to) the potential mother (Petchesky 1987).

5. Personal backgrounds

Many of the young women talked about troubled home lives describing direct and indirect experience of violence within their own families, from boyfriends or in the community in general. They referred to sexual and physical abuse, as well as witnessing domestic violence. These experiences seemed to be part of a picture that led to certain decisions being taken. All the young women who told us they had planned to become pregnant, as well as many of those who had not made this claim, had some experience of the type of difficulties mentioned above.

I don't think my Dad should hit me. It really did hurt honestly, it really did hurt. All my life, all my life, once my brother was born....they've took more interest in him than me and they thought I was just some kind of reject. So I just never paid no attention because my Dad thought by hitting me he'd learn me, you know.

It's difficult living at home because my Mum and Dad they go to the pub every night. My Mum... basically she drinks like two bottles of wine a night and she's always out of her face basically and so we usually argue when she's been drinking.

My sister is home occasionally but she's sort of a tearaway. She's really horrible to my Mum. Really horrible, she used to hit my Mum. So my Mum had enough and put her into a children's home. She [sister] was just really nasty to her, she used to call her a fat bitch and everything ... And my sister threatened her with a knife and everything.

All of the young mothers who told us that they had planned their pregnancy had been bullied at school, and had not been attending due to this.

The same things, pushing me around and hitting me and things like that and the school didn't do anything about it. Yeah that's what started it all off [depression] I

think. My Mum just said don't go back to school because it made me suicidal so she didn't want me going back to school, I didn't go back. And then about two weeks after I stopped going I was fine.

I was always tired and that and I was having a lot of problems with a lad in school. We nearly always ended up fighting. One day my Nan was in hospital, he turned round and said 'Oh you can't go and see her today she's already dead'. So I was always fighting with him.

In general, the young women downplayed what might be described as social problems. They preferred to talk about positive choices they had made in their lives, rather than dwelling upon negative experiences. The professionals that we spoke to were more concerned to talk about the social problems of their client group than the young women we actually spoke to. This indicates differing perceptions, and definitions, of 'unsettled backgrounds' and 'social problems'. The professionals talked about abuse in the home, bullying, poor school attendance, drink, drugs and the wider issue of social deprivation. Some of these issues were also prominent in the focus groups. One of the most striking was the focus group's acceptance of domestic violence as part of many people's lives. The two comments below did not cause surprise amongst the group:

My sister's got a boyfriend she doesn't go out with any more and he keeps beating her up and he's just had another child with her and she finished with him and he keeps bringing up the excuse that he comes round to see his kids but he comes round to wind her up and beat her up and everything.

My dad left four years ago and my mum got a boyfriend and he used to strangle her when we were round my dad's, she never used to tell me. She only tell me like before last Christmas and she left him then but he nearly killed her the once.

6. The dads

The fathers were generally much older than the mothers interviewed, from 21 to 29 years. The biggest age gap was 15 and 29. Ten of the mothers felt that maintaining a relationship with the fathers of their babies and forming a traditional family unit was very important. They are striving to create a stable family unit, and are by no means just exploited by older men. Many see relationships with older men as more stable, and offering them and their child greater support than those with younger partners. The majority were with the father's of the babies (7) whilst a further two fathers were around and offered support. Only three mothers were not in contact with their baby's father.

The young women told us about the fathers' varying reactions to the pregnancy, babies and their role as fathers. Some were pleased, and were supportive and wanted to be involved.

Fine, he loves the baby. He's staying for the last week so wherever he's been he's always come to my house at night. I like sort out the shopping and get his tea on, the baby's tea on and that, he goes upstairs and baths him and changes him and if he comes in the morning he likes to change him. So we've doing a lot of the looking after together.

Yeah he looks after him all the time (laughs). He does changing, getting him ready and all that and since like he's been born I've only like made his bottle three times at the most. He does it all, he just gets up and washes the bottles, sterilises them, makes them and if I ask him to get the baby ready he'll get him nappy and feed him and do all sorts.

Others were more ambivalent and seemed to come and go. Some of the dads were described as having their own problems (drink, drugs, criminality, prison) and some are violent.

Oh yeah. I mean I'm glad I've got away because I've found out so much about him when I was with him. I mean he was in prison for six years and, which I never knew before, and he's been, he had to go in one of them like hospital things, like a mental hospital.

My boyfriend was on heavy drugs and I got him off it. When I went out, when I went out with him I got him off it. I just, I couldn't have it, I couldn't have it because he was ignoring me and I slowly had to get him off it and I said 'You're going to put our relationship on the line'. And you know he's stopped doing it, he's stopped doing you know all the drugs ... and he also got sent to prison when he was with me because crimes he committed ages ago.

Whilst most of the young women interviewed seemed concerned to build a family life, it was clear that this was very difficult. We were told by midwives that many pregnant teenagers begin their antenatal appointments with their own parents but then at some stage they move away from their parental home to try to stay with their boyfriends. However, the practical difficulties faced by young couples who want to stay together after the birth of their baby are immense. Although fathers are able to stay with the family unit in the sheltered housing projects, it became clear that housing was a problem in keeping the family together. It seems as though the professionals working with the young mothers focus very much on the mothers and do not necessarily encourage the potential family unit to stay together. Only three of the young mothers and fathers

were living together in their own place, whilst eight young women were living at home or with other relatives. Some of the dads were living with them in this situation, but this proved difficult for everyone concerned. One professional who delivers sex and relationships education in schools told us that 'the Dads usually have nothing to do with the girl and her baby although they have agreed in sex and relationships education that this is not what they want'. This may indicate that the reality of fatherhood leads to a change of heart or that what they want is not easily achievable and they retreat. Many of the professionals commented that a young mother's parents will try and keep her away from her baby's father. One of the professionals we interviewed felt that

young fathers were generally discouraged from parenting responsibilities and maintaining a relationship with the mother of their children.

There's very few parents who would actually even if they acknowledge their children are sexually active at 14 and 15 would actually let a partner stay. You can't get housing between 16 and 18 very easily, you can't, certainly get a tenancy so even if you want to be together where do you live? You know how do you see each other and especially as the pregnancy progresses if you're not wanted at her home and your parents don't care anyway, I mean that's being a bit flippant but you know where are these, where are they supposed to meet, how are they supposed to build a relationship?

7. The Services

All the interviewees felt that most of the services they had received were excellent. They discussed the pre-birth and after birth services, and felt in general that Telford was a good place for teenage mothers. All the young women mentioned the Teenage Pregnancy Support Officer, and particularly felt that her non-judgemental attitudes and the time she gave had helped enormously.

The policy of having midwives dedicated to working with teenagers has also had positive feedback in this research. The young women were very happy with the support received from this unit. Health visitors and Surestart project workers were also referred to as being particularly helpful. One place that was consistently mentioned by the young women (including in the focus groups) as a place where they would be happy to go for advice and information was Risq.

Loads of people have been there like loads of people know someone who's gone there and then all the teachers and that they tell you about it and there's like loads of leaflets just saying if you want to like go there you know they'll talk to you.

Not all comments on the services were positive, however. A number of the young mothers did express the view that they were treated poorly by some medical staff simply because they were young. This was especially evident when a particular local hospital was involved. Almost all the young women who had given birth there were unhappy with their experiences.

The midwives when they come round, they first come round she turned her nose up at me until I said something to her. And at xxxxx Hospital when I had him you know the midwives said, 'Oh she's 14'. They were really horrible. I felt inadequate.

It is noticeable that the young women were much more positive about the care and services they had received after making the decision to becoming a mother, than those at earlier points in their lives. This was most obvious around education. Young women, for example, who had dropped out of school were positive about the educational projects they were later involved in as young mothers.

When providers were asked about services they expressed concerns about time, finance and sustainability. Whilst they agreed that the teenage pregnancy strategy had improved many sexual health services for young people they also pointed out that they were unable to do as much for their client group as they felt was needed. It is clear that the strategy is heavily dependent upon a small group of highly committed people. Providers were also worried that improvements in services might be dependent on the Teenage Pregnancy Unit and were not embedded enough in mainstream services. Others felt that the teenage pregnancy strategy had opened up a source of income that was not being fed through to services that dealt with young people that were 'underfunded'. It was clear, for example, that Risq was stretched to the limit with young people often having to wait over an hour to be seen, and not having enough funds to ensure an adequate supply of condoms.

One important concern raised by many professionals was uncertainties as to whether young women under sixteen were being treated confidentially by GPs. We were told a number of 'anecdotal' stories in which a young person's confidentiality had clearly been breached and parents had been informed of previous visits to GP surgeries for 'confidential' contraceptive advice.

Chapter 3:

Teenage Motherhood and Choice

In this chapter we focus on the choices made by the young women that we interviewed. Many of the themes outlined in the previous chapter will be revisited as we discuss to what extent the pregnancies were planned. It is important to emphasise firstly, that it is of course very difficult to establish how far any pregnancy is planned, and secondly, that unplanned pregnancies are not automatically unwanted pregnancies. This second point is particularly relevant for those that we interviewed, many of whom had made a positive decision to go ahead with pregnancies they described as unplanned.

The young women's determination to make their own decisions, at all times, is very striking. This desire to control their own lives was, in most cases, not tempered by a consideration of the possible consequences of having a child on the probability of realising this ambition. Those with older children were able to reflect back and generally talked about how they had not expected their lives to change so dramatically following the birth of their child.

Making Decisions

The young women experienced a variety of reactions, from those close to them, to news of their pregnancy. The degrees and sources of support were also varied. These factors did affect the decisions they made. Some had experienced adverse reactions to their news, but the majority, although they had been nervous about saying anything, received a supportive reaction. Unfortunately, because we were unable to interview a comparable group of young women who had chosen to terminate their pregnancies we are not able to draw firm conclusions regarding family support or disapproval and decision-making processes in relation to abortion. The young women who spoke about their decision-making process regarding abortion or motherhood nevertheless gave a clear picture of this being a difficult process especially if their own views clashed with those close to them. Some spoke of feelings of confusion and being left to make the decision alone. Others talked of

conflict between their own wishes and those of their family members or boyfriends.

I didn't want my Mum and Dad to be upset with me, because I was still talking to them by then, and was a bit bothered what they were going to say. My boyfriend wasn't here. He was in jail. I thought oh God I'd best get rid of this. So I went to the clinic and they gave me all these leaflets about abortion, what kind of abortion you can have like, stuff about those clinics, you know to get rid of it and that. And deep down it wasn't really what I wanted, I didn't want to get rid of it, it was just I wanted to make everyone else happy.

This young woman went as far as the clinic in Birmingham before deciding that she would not have an abortion. Some of the others talked about their own mothers having experienced 'forced' abortions, and said that this had affected the way they

thought about abortion. Another young woman talked about a relative who tried to take the decision away from her.

My granddad was really mad with me, but his reaction made me sick. He offered me £1,000 to have an abortion; I think that's disgusting. I couldn't believe it. It was like 'You are joking, it's like putting a price on my baby'.

The overwhelming message from the discussion on decision-making and abortion was the importance attached to making their own decisions.

I think if you get pregnant and things it's up to you, don't listen to anyone. It's entirely up to you, it's your baby, it's your body. If you want to have an abortion you have it, if you want the baby you have it. It's entirely up to you, don't let anybody, anybody at all tell you what to do. Don't let anybody tell you, it's your baby.

Planned or unplanned pregnancies

We have divided the mothers into three groups based on the issue of intentionality, and whether their pregnancies were intended/planned or otherwise. In Group A the mothers seemed to have planned their pregnancies; in Group C the pregnancies seem clearly unplanned whilst in Group B the intentions are not clear. This grouping is useful for the purposes of policy recommendations and for beginning to understand the cultural and social factors influencing decisions made. The grouping acknowledges that factors underlying young motherhood are complex. There cannot be a 'one brush fits all' approach. The recommendations would therefore apply to young women who might fall into one of these groups, rather than the specific young women interviewed.

The groups, however, shade into each other. Indeed it might be better to think of this as a continuum from completely planned to completely unplanned with a large space in between for those for whom the intention is not at all clear. Our intention is not to stereotype, or impose fixed categories. This would deny the individuality of the young women, the complexity of their situations and the personal choices each has made.

Group A: Planned Pregnancies

We judged that five young women had made a positive choice to start a family. This was for a variety of reasons, although it is interesting to note that all those who planned the baby told us that they had been unsettled or unhappy in their lives in some way prior to becoming pregnant. In this group contraception was either not used in full knowledge that this might result in a potential pregnancy, or was not used because an active decision had been made to have baby.

I don't know I just, I know it sounds stupid but I just kept seeing programmes with people's babies and that and I just said I wanted a baby and all that. He just agreed to it really, just agreed to stop using any contraception and we went from there.

I've wanted a baby for ages. Since I was about 12. I don't know it just popped into my head.

We moved two of the young women from Group B to Group A during the course of the analysis. This was an indication of the difficulty of being sure about intention. The first talked about careless contraceptive use, feelings of disillusion

with school and how she wanted to create a family. With previous boyfriends they sometimes used a condom but sometimes they didn't have one. She seemed to be telling us that because she had not fallen pregnant in the past she thought she was not going to get pregnant, and later says that

We did talk about we wanted a baby. So we were kind of trying but we weren't. I mean we weren't using anything...we were trying all the time and when it came to it I did a pregnancy test and I wasn't and I thought oh well there's something wrong with me.

The second had used contraception with other boyfriends but said she had not with her current boyfriend. When she was asked whether she was worried about becoming pregnant she replied:

Well this time, when I started going out with him this time we didn't use contraception but we talked about having a baby and we said if it happens it happens, if not then it doesn't happen, but if it happens then we're ready to go along with it. And so we thought there's no point in using contraception because we don't mind having a baby.

What the young women in this group have in common is their apparent intention to become mothers. Apart from this, the most striking similarity is that they all had unsettled backgrounds, as mentioned above. The young women talked about experiencing bullying in some way, either at school, at home or in their neighbourhood. Two of them described themselves as being depressed before they became pregnant because of the bullying they were suffering. The two young women who were being bullied at school had virtually dropped out of school. They were all, however, involved in education projects at the time of the interview. All the young women's own mothers had also been teenage mothers.

Unsurprisingly, given their desire to have a baby, all held negative attitudes towards abortion. They talked about how it was not right to be forced to have an abortion and about the moral issues surrounding the decision to terminate a pregnancy.

Group B: neither planned nor totally unplanned

Four of the young women fall into this category, and within this group there is a wide variation in the attitude of the mothers towards their pregnancies. This ranged from one who told us that she knew she was not using the pill properly and that she had wanted a baby but a little later, to someone who talked about using condoms except on one occasion, who concealed her pregnancy for 6 months and whose parents were furious when they discovered she was pregnant. We discussed the possibility of putting the first young woman in Group A and the second young woman in Group C. What is noticeable about the mothers in this group is their ambivalence about their intentions, and what connects them is our inability (and their unwillingness) to say with any degree of certainty that the pregnancy was either completely planned or completely unplanned.

There is a wide age range here (14-19), and most (3 out of 4) had left school with no qualifications. They had either dropped out or been expelled. Only one had left school with her GCSEs. She had also finished college before falling pregnant at the age of 19.

What connects these young women is random contraceptive use, and limited sex education (a characteristic shared with most of the young women interviewed). All 4 respondents said that the sex education they received was very limited and did not seem relevant to them. It seems likely that they had not intended to become pregnant. One describes her pregnancy as an accident and told us that she was using

contraception except for the one occasion on which she became pregnant. One was on the pill but was not taking it properly – she described herself as careless but also said that she did want a baby sometime. Another indicated that when she did use contraception she used condoms, but that this was random. The fourth said that she generally used condoms, but had not on a few occasions, one of which was when she became pregnant. All four said that they had little knowledge of emergency contraception, and did not know where to go or how to access it.

The four young women in this group seemed to have mixed experiences in terms of their own backgrounds. Two indicated that their own family life had been stressful and unsettled. They also said that their own families were not supportive when they found themselves pregnant. The other two said that their own families were supportive both before and after pregnancy, and that their mothers had themselves been teenage mothers at the time of their own first pregnancy. They had all decided that abortion was not for them personally. Most of them expressed mixed feelings about abortion saying things like ‘I don’t think its right’, but also talked about abortion being okay if that is what someone decides for themselves.

Three of this group were still with their babies’ fathers in stable relationships. Of these, two had already given birth and said that the father was involved in and enjoyed caring for a baby. The one who was still pregnant indicated that the father (whom she was living with) would remain involved. These young women had clear plans to remain in these relationships and build a family life together.

Group C: Unintended pregnancies

Three young women were in this group and they all spoke of their pregnancies as

accidents. They said that they had been using contraception, and that they been completely surprised when they found themselves pregnant. One said that she generally used condoms but on one occasion had relied on withdrawal and described her reactions to the knowledge that she was pregnant as ‘shock’ and ‘horror’. Another said that she had been ‘stupid’ because she had not been using anything and that she had (unsuccessfully) tried to get emergency contraception. She was upset to find herself pregnant because by then she had split up with her boyfriend. The third young woman told us that she and her boyfriend had been using condoms. She went on to say that on the occasion they didn’t she became pregnant. She had travelled to Birmingham for an abortion but decided not to go ahead when she was given a scan.

The age range in this group is slightly narrower than group B (15 -17). Two had left school with GCSEs, and one had started college, but left in the middle of her course because she became pregnant. The third young woman was continuing her education at an education project.

It seems that no one in this group had chosen to become pregnant. They all felt that sex education had not prepared them for sexual decision-making; indeed they were vague about what they had been taught. However, they had all made the choice to continue with the pregnancy rather than have an abortion and they all expressed positive views on motherhood.

All these young women said that when they had recovered from the initial shock, they were pleased. In addition, their own mothers and families were quite supportive when they had discovered that they were pregnant. Everyone in this group had mothers who had themselves been teenage mothers at the time of first pregnancy.

Conclusions and Policy Recommendations

This final chapter discusses policy recommendations. Firstly we refer back to the main themes outlined in chapter two and discuss their implications for policy and practice recommendations. This gives recommendations that might make general improvements. However, it is clear from our analysis of the three different groups of young women that these recommendations are not equally applicable to all young women. We therefore comment upon the relevance of these recommendations for each of the groups identified in chapter three. Finally, we offer some suggestions for the prioritisation of these recommendations.

1. Sex education and advice.

There are two dimensions to the recommendations on this issue: delivery of sex and relationships education to young women who are not in school, and improvement of sex and relationships education for those in school.

Delivery of sex and relationships education to young women who are not in school

There is clearly a need to target young women who fall into a pattern of non-attendance at secondary school. This can be done in many creative ways. Some suggestions are:

- starting sex education programmes at primary school
- outreach initiatives, such as a young person's sexual health information bus and work with the youth services

Policy Recommendations based on themes.

It is important to emphasise here that these themes, and recommendations, are based upon the interviews with young mothers, focus groups in the schools and interview with the professionals. They are thus firmly grounded in the attitudes, knowledge and experiences of service users and providers.

Improvement of sex and relationships education for those in school

Almost all the young women interviewed felt that the current sex education programmes in school was inadequate and only providing the most basic information. Many commented that the language used needs to be more 'real', and that those delivering these sessions should have up to date knowledge of issues important to young people. This needs to go beyond the basics and should dispel myths (such as if a boy 'pulls out' you can't get pregnant). Young women also indicated that having someone at school that they could talk to confidentially would be helpful.

Suggestions for improvement are:

- reviewing the delivery and content of sex and relationships education, ensuring language and materials used engage young people

- investigating how best to provide confidential information/services in schools. The positive comments about the drop-in centre at one of the schools needs to be considered together with the focus group's concerns about the confidentiality of the service
- **urgent attention needs to be given to input on the use and availability of emergency contraception, and abortion. Both these issues need to be covered in a non-judgemental balanced way, so young women have an impartial information base to inform their own decisions and choices.**

2. Sexual behaviour

Conclusions and recommendations following from the theme of sexual behaviour are closely related to the need to review sex and relationships education. Thought needs to be given to:

- the issue of peer group pressure
- young women's difficulties in negotiating safe sex
- how can young women be empowered to think about what might be in their own best interests

How can these issues best be dealt with in sex and relationships education? We did not find much evidence of systematic work around relationships in the curriculum. This could be connected to work around the possible consequences of becoming a mother whilst still at school. Many of the young mothers we interviewed told us that their advice to other young women would be to wait a while: could they make an input into a broad based sex and relationships initiative?

Suggestions for improved input in this area are:

- outreach work amongst teenagers
- more work on the relationships component in SRE

3. Use of contraception

The picture that emerged from the interviews with young women is one of poor contraceptive use. This is clearly for a number of different reasons, and it is likely that there will always be some young women who are unable to negotiate safe sex, and some who do not wish to do so. Improvements in sex and relationships education could help those who make a conscious decision in favour of 'unsafe sex' to think through the possible consequences of their choices.

Sex and relationships education could also help those young women who do not practice safe sex for other reasons. An important focus should be dispelling 'myths'. However, an important intervention here would be the promotion of information about contraception advice and condom availability through GPs who sign up to young people friendly initiatives. There also needs to be a campaign around the availability of emergency contraception. Given the difficulty that many young women seem to have in managing contraceptive use, sexual health workers might be encouraged to promote the use of dual contraceptive methods.

Suggestions are:

- dispelling contraceptive 'myths'
- promoting condom availability
- promoting contraceptive advice
- improving access to, and awareness of, emergency contraception

4. Abortion

One of the most striking findings in this project was the prevailing moral climate against abortion. This was expressed by the young women and also by some of the sexual health professionals. This helps explain why the proportion of under-18 conceptions leading to abortion is significantly lower in Telford and Wrekin than the national average.

- **Some serious thought needs to be given to de-stigmatising abortion, taking into account the local moral climate**

5. Personal Backgrounds

It has been established that school excludees/persistent truants, and teenagers in families with high levels of conflict, are consistently at risk of becoming teenage parents (Swann et al 2003). It is clear from our interviews with young mothers, from the focus groups interviews and also from the information we were given by professionals that, locally, young women who have some kind of troubled background (bullying, abusive relationships, persistent truancy etc) form a high proportion of teenage mothers. This research also indicates some correlation between such backgrounds and low educational attainment. At a national level, these factors are associated with teenage motherhood, and not associated with abortion: the NATSAL survey found that 29% of sexually active young women who had left school with no qualifications had a child at age 17 or younger (Wellings et al 2001). In such cases early intervention is clearly important. Thought should be given to how inter-agency work might be focused on the schools. This can be done in the light of the Green Paper Every Child Matters, (DfES 2003) and the resulting Children Bill (House of Lords 2004). We found that where a school counsellor was

available young people did take advantage of confidential advice and that problems could be picked up at an early stage.

- **Inter-agency work is needed to identify and help school children who are falling into patterns of non-attendance.**

6. The Dads

There is a noticeable shortage of research and policy interventions that focus on young fathers (Swann et al 2003). In this study, we found that services were focused on young mothers rather than young families. The young mothers, however, were telling us about their hopes of creating a family. They were trying to do this in the most difficult circumstances.

- **The teenage pregnancy unit could consider the value of establishing more young fathers groups and whether there could be more work around parenting skills for all young parents, not just the mothers.**

7. The Services

The following recommendations arise from the discussion on services:

- dedicate the same commitment to the prevention strategy as to the young parents strategy
- better resourcing for the successful services, and thought about sustainability
- initiate emergency contraception campaign and improve accessibility
- investigate the way that local hospitals deal with young mothers
- build upon the success of the teenage specific midwives strategy with more dedicated follow-up

Policy Recommendations based on groupings.

In this section, we will refer back to the three identified groups and comment upon the policy recommendations that are most appropriate for young women that might fall into each group.

Group A: planned pregnancies

These recommendations are applicable to young women who might plan pregnancies rather than specifically to the five young women within this group in our study.

The teenage pregnancy strategy's aim of cutting the number of teenage conceptions is hard to apply to this group of young mothers. It seems likely, although we cannot say certain, that in our study the young women's own unsettled lives had propelled them towards making a positive choice in favour of motherhood. In many respects such a context is beyond the remit of local teenage pregnancy units.

One thing that requires greater attention, however, is the issue of school attendance and bullying at school. The NATSAL survey found an association between low educational achievement and teenage motherhood, but argued that there is a strong potential for preventive intervention in this area (Wellings et al 2001). This is something that the local unit could look into further as per suggestions under 'personal backgrounds' above.

There might be some value in conducting some small-scale research into the implications of the tendency for pregnant school-girls to be taken out of school for their education. What impact does this have on the girls still at school who are already falling into a pattern of non-attendance?

The aim of preventing young mothers falling into social exclusion is much more appropriate for young women who might fall within this group. In Telford very good mechanisms have been established for teenage mothers. Many of the young women we interviewed were taking part in one or other of the education/training possibilities available and most had ideas about working in the future. Although this is not surprising as most of our participants were recruited via education projects, this was a marked contrast to their experiences at school.

One final policy area that needs some thought is housing and benefits. Mothers under the age of sixteen are not entitled to either. The teenage pregnancy report argued that these young women still require the support of their own family and that neither they nor their baby thrive if left to their own devices. This may be true for the majority of mothers under the age of sixteen but it is clear from this research that many of these mothers are not in a supportive family situation. In the cases supported housing might be a solution.

For young women who might fall in this group the following recommendations are applicable:

- early intervention strategies to support young women with unsettled backgrounds
- working with young fathers and giving thought to developing a strategy for supporting young families
- maintain the good services established for pregnant teenagers and young mothers

Group B: neither planned nor unplanned pregnancies

It should be clear that for group B the division between planned/intended pregnancy and unplanned/unintended is not at all straightforward. This means that some of the work around prevention of teenage pregnancy might not necessarily be effective with young women that would fall within this group. For such young women, the recommendations for group A (especially working with schools to identify young women who are falling into a pattern of non-attendance and/or are being bullied) are important.

The other obvious policy intervention is to address the issue of inefficient contraceptive use. Accidents do happen but it is clear from the young women' accounts that they were all having unprotected sex occasionally or regularly. The policy areas that need improving for this group are:

- early intervention strategies to support young women with unsettled backgrounds
- improved sex education (especially emergency contraception and abortion)
- access to information about and supplies of a range of contraceptives
- availability and accessibility of emergency contraception
- de-stigmatising abortion
- promoting dual contraceptive methods

Group C: unplanned pregnancies

For young women that might fall into group C and become pregnant accidentally teenage pregnancy units should focus on the prevention strategy.

- improved sex education (especially emergency contraception and abortion)
- access to information about and supplies of a range of contraceptives
- availability and accessibility of emergency contraception
- de-stigmatise abortion
- promoting dual contraceptive methods

In cases of pure accident, the prevailing moral climate on abortion is especially important. An effort needs to be made to de-stigmatise abortion.

Priorities

In general, as Swann et al (2003) point out, there is some consensus about what works to reduce the teenage pregnancy rate. They highlight the importance of good quality school-based, and community-based, sex and relationships education linked to contraceptive services. This research supports this assessment and also concludes that the local teenage pregnancy strategy needs to continue to be multi-dimensional in its approach. It needs to recognise that young women become mothers for different reasons and there is no simple approach to the prevention strategy. However, if you consider the three decision points (engaging in unsafe sex, using emergency contraception, deciding for or against abortion) that lead towards teenage motherhood, it is clear that at all three stages improvements could be made. There is little doubt that improvements in sex and relationships education in schools, for example, could prevent many accidental pregnancies, and also some of those where the intention is unclear. It is, however, not the only change needed. We would recommend that the teenage pregnancy unit concentrate upon the following:

1. Improving sex and relationships education, including:
 - discussing abortion in a non-judgemental way
 - considering the age at which contraception is discussed
 - reaching young people out of school
2. A campaign around the availability of emergency contraception
3. Sustained effort to de-stigmatise abortion and make availability much easier
4. Promotion of dual contraceptive

methods

5. Working with schools and other services to identify, and help, young women who are falling into a pattern of non-attendance and/or are being bullied
6. Work around raising awareness of the importance of confidentiality to young people, particularly with GPs and schools.

References

- Acheson, D. [Chairman] (1998) *Independent Inquiry into Inequalities of Health Report*, London: Stationery Office.
- Chambers, R., Wakley, G. and Chambers, S. (2001) *Tackling Teenage Pregnancy: sex, culture and needs*, Abingdon: Radcliffe Medical Press.
- Counterpoint (2001) *Young People's Perception of Contraception and Seeking Contraceptive Advice*, London: Counterpoint (UK).
- Department of Health (1998) *Our Healthier Nation: a Contract for Health*, London: HMSO.
- DfEE (2000) *Sex and Relationship Education Guidance*, Department for Education and Employment.
- DfES (2003) *Every Child Matters Green Paper*, London: Stationery Office.
- FPSC (1999) *Teenage pregnancy and the family, Family Briefing Paper 9*, London: Family Policy Studies Centre.
- Greig, A. and Taylor, J. (1999) *Doing Research With Children*, London: Sage Publications.
- Holland, J., Ramazanoglu, C., Sharp, S. and Thomson, R. (1992) 'Pleasure, pressure and power: some contradictions of gendered sexuality' in *The Sociological Review*, 40 (4), pp 645-674.
- House of Lords (2004) *Children Bill*, HL Bill 35, London: Stationery Office.
- IMD (2000) *Index of Multiple Deprivation*, www.Neighbourhood.statistics.gov.uk/reports
- Jewell, D., Tacchi, J. and Donovan, J. (2000) 'Teenage Pregnancy: whose problem is it?', *Family Practice*, Vol. 17, No. 6, pp. 522-528.
- Keep, G. (2000) *I can't believe it's happened to me*, London: Childline.
- Lewis, A. and Lindsay, G. (eds.) (2000) *Researching Children's Perspectives*, Buckingham: Open University Press.
- ONS (2001) *Population Trends*, 103, London: Office for National Statistics.
- Save the Children (2002) *Get Real: dedicated sexual health services*, London: Save the Children.
- Silverman, D. (2000) *Doing Qualitative Research: a practical handbook*, London: Sage Publications.
- SEU (1999) *Teenage Pregnancy*, Cmd 4342. London: The Stationery Office.
- Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003) *Teenage Pregnancy and Parenthood: a review of reviews*, London: Health Development Agency.
- Tabberer, S., Hall, C., Prendergast, S. and Webster, A. (2000) *Teenage Pregnancy and Choice*, York: York Publishing Services (Joseph Rowntree Foundation).
- Teenage Pregnancy Unit Annual Report (2002), Telford and Wrekin.
- Thomson, R. and Scott, S. (1991) *Learning about Sex: Young Women and the Social Construction of Sexual Identity*, London: The Tufnell Press.
- UNICEF (2001) 'A league table of teenage births in rich nations', *Innocenti Report Card No.3*, July 2001. Florence: Innocenti Research Centre.
- Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, B., Mercer, C., Johnson, A., Copas, A., Korovessis, C., Fenton, K. and Field, J. (2001) 'Sexual behaviour in Britain: early heterosexual experience', in *The Lancet*, Vol 358, pp 1843-1850.
- West, J. (1999) '(not) talking about sex: youth, identity and sexuality', *Sociological Review*, Vol. 47, No. 3. pp. 525-547.

Abstract

This report presents the findings of a research project on the sexual behaviour and decision-making processes of young women in one area in the West Midlands. It is based upon interviews with young mothers, focus groups in schools and interviews with sexual health professionals. The project focused upon decisions around the use or non-use of contraception (including emergency contraception) and on whether or not to terminate confirmed pregnancies.

The research project found evidence of positive changes associated with the local teenage pregnancy strategy. These are predominantly around the support services for young mothers. There are signs, however, that significant improvements can be made with respect to the prevention part of the teenage pregnancy strategy. In particular, sex and relationships education does not seem to be reaching enough young people, especially those who are falling into a pattern of school non-attendance. The report also proposes that a sustained effort should be made to facilitate the presentation of abortion in a non-judgemental manner in an effort to destigmatise abortion locally. Improved access to abortion services is also necessary.

Keywords

Teenage Pregnancy; Sex Education; Contraception; Abortion; Sexual Behaviour

Biographical Notes

Lesley Hoggart Whilst undertaking this research project Lesley was a senior lecturer in social policy and research methods at Middlesex University. She is now a Senior Research Fellow at the Policy Studies Institute. Her research interests include feminist political action and the politics of reproductive choice; and young people's sexual behaviour and reproductive decision-making. She has written a number of articles on teenage pregnancy and young people's sexual decision-making. Her book, *Birth Control and Abortion Rights: political conflict and policy negotiation in Britain*, was published by The Edwin Mellen Press in 2002.

Rachel Hek works at the University of Birmingham as a researcher for the National Evaluation of the Children's Fund and as a lecturer and tutor in Social Work. She is a qualified social worker and psychodynamic counsellor and has worked both independently and for local authorities with children, young people and families. She continues to work with young people in the care system and in educational settings. Her research interests are in the views of looked after children and young people, particularly about the services they receive, and refugee children and young people's experiences of preventative services.

Acknowledgements

We would like to thank all those people who took part in this project, including the local service providers who helped with the planning and facilitation of the research. In particular, we thank all of the young women who gave so generously of their time and experience. All these young women, whatever their own personal situations, spoke to us about their positive feelings about being a mother and showed enormous commitment and love towards their babies.

I love it to be honest. The best thing about being a Mum is everything because the love that you feel for them is a very nice feeling. I don't know, I don't know what I'd say the best thing about being a mum is, unconditional love for, giving and taking. I just love everything about it.

It's not all doom and gloom. People think 'oh no once you have kids that's it'. I think it's better because I've had my child early, she's getting all grown up now so I'm still doing things anyway, I'm not missing out.

I just love being a Mum.

Everybody turns their nose up at you thinking 'oh teenage pregnancies', but it doesn't really matter do you know what I mean, because you love your baby like any normal Mum would and you'll protect him, you'll do anything for him. So it's just the same. And he's beautiful, he's the best thing in the world, I couldn't be without him.