

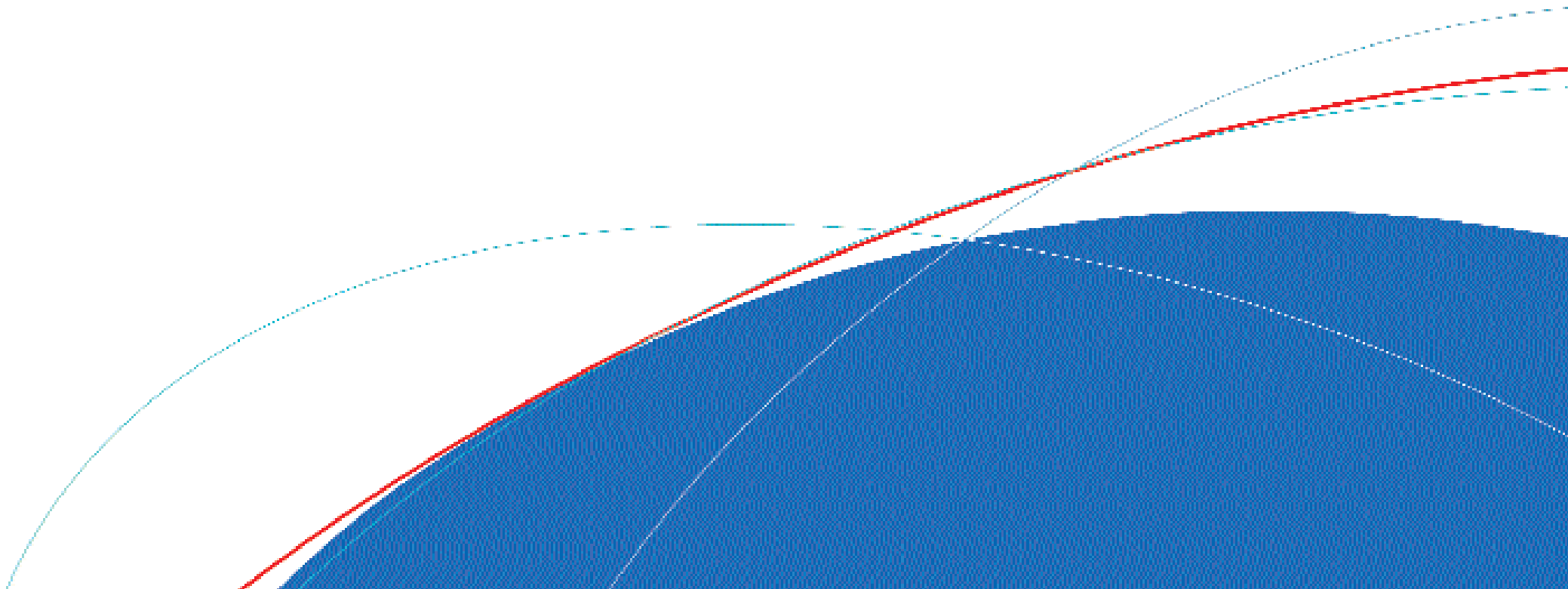


# Young Women, Sex and Choices:

A study of young motherhood in Haringey

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# Introduction

## Project summary and objectives

This project was set up to look at the sexual behaviour and decision-making processes of young women in Haringey. 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 decisions. 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 women (predominantly mothers) and service providers locally. 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 of these 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 inform the future development of the local Teenage Pregnancy strategy.

This report focuses on the experiences and views of the young women interviewed. It is organised into three chapters. Chapter one provides the background to the project including a brief overview of the policy context and a discussion of the research design. Chapter two presents the research findings thematically. It draws upon all the individual interviews and the focus groups. Chapter three draws these themes together and presents policy recommendations.



## Policy background and research design

### Background to the project.

New Labour 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 1998 and 2003 the under-18 conception rate in England fell from 46.6 to 42.1 (per thousand population aged 13-17). This is

a decline of 8.66% (ONS 2005). This downward trend needs to accelerate rapidly in order to achieve the government's targets. In Haringey, 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) 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).

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. Whilst this research investigated all three decision-points, particular attention was paid to abortion decision-making. The focus was on the relationship between social contexts and young people's individual decisions.

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 (Barna *et al* 2002). This project therefore sought to access the views and attitudes of young people on policy and services concerned with sex education and all aspects of sexual health.

## The local context

The research was conducted in the London Borough of Haringey. This has a diverse population with the eastern part of the borough having significant levels of social deprivation, whilst the western portion is relatively affluent. The borough also has a wide range of minority ethnic groups which taken together make up over 50% of the population (2001 census). It has a high number of refugees and asylum seekers. All these factors impact upon the sexual health services in the area.

## Research design

The project aimed to capture the diversity and complexity of the young women's experiences through listening to their accounts and explanations of their own decision-making about contraception, pregnancy and abortion. The focus on exploring how young women understand their own decision-making called for a qualitative methodology. This is particularly appropriate for in-depth investigation into people's perceptions, views and experiences (Silverman 2000). We also asked participants to talk to us about their knowledge and use of sexual health services. Combining this information with an examination of their decision-making processes has enabled us to reach some conclusions and general lessons about how their needs can best be met. We also interviewed a number of service providers (key informants) in order to understand further the context within which young women are making sexual health choices.

The following research methods were used:

- 4 focus groups with young women in local schools (years 9 and 10)
- Individual in-depth interviews with 13 young women
- Individual in-depth interviews with 25 key informants

A number of measures were taken to ensure data reliability and validity when analysing the material gathered. All interviews were fully transcribed and analysis was undertaken both individually and as a team, in order to check and cross-reference findings. The data were analysed in two stages utilising a thematic approach. In the first stage many of these themes corresponded closely to topics covered in the interview schedule, but others emerged as key themes during the process of analysing the findings. The second stage then involved the search for patterns within the data, including the identification of similarities and differences.

## Focus groups

Four 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 that 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 their participation in 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 and the discussion could remain confidential.

## Individual interviews with young women

Individual interviews were carried out with young women who had become pregnant whilst a teenager. 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. We were only able to recruit one young woman specifically for the abortion sample, and this is a weakness of the study. However, of the twelve young mothers interviewed, five also told us that they had terminated another pregnancy. The age range at time of giving birth was 14 to 18; at least four had first become pregnant under the age of 16. The majority were from minority ethnic backgrounds, principally Caribbean. The interviews provided valuable information on these young women's decision-making processes. We were able to focus on the different decisions made at different points in their lives.

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 many of these professionals to interview them, to talk to them about the project and also to ask for help with recruitment. Some of the participants were recruited through such personal contact. Others were recruited through mothers' groups and family planning service community clinics. All participants were

provided with information leaflets some time before the interviews.

The interviews explored their 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 had made.

## Interviews with key informants

We also spoke to twenty-five key professionals from different agency backgrounds. 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 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, however, 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) was obtained; and 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 projects etc). Approval was gained from the local Medical Ethics Committee. 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.

## Chapter two

# Research findings

### Research findings I: Key informants

**T**wenty-five key informants were interviewed. There were three main purposes to these interviews: first, to contribute to an understanding of the context within which individual young women make choices; second, in order to supplement and validate the findings from the focus groups and individual interviews with young women; third, to explore connections between the teenage pregnancy strategy and the regeneration/social inclusion policy of the borough. This report concentrates on the first two of these. Most of the key informants that we interviewed had worked with young mothers and/or with young people for a number of years. They were therefore able to contribute substantially to the information gathered from the other research participants. The pertinent issues raised in these interviews are summarised here and are intended to inform the second, and main, part of this chapter. A general point is noted first and then the comments are separated into those on prevention work and those on work around supporting young parents.

- **The teenage pregnancy strategy:** we found some evidence of tensions between the two strands of the strategy. In our interviews with key informants many had trouble reconciling the need to work positively with young mothers with the drive to discourage teenage pregnancy.

### Prevention work

- **SRE:** we found a great deal of unevenness in the content and delivery of sex and relationships education. One of the main issues for those responsible for the delivery of SRE was ensuring adequate time was available. We found variations in schools' policies on confidentiality and disclosure.
- **Diversity of population:** key informants recognised the need for targeted work amongst some ethnic minority communities. They were, however, very worried about the danger of labelling particular communities as problematic.
- **Refugees and asylum-seekers.** The needs of refugees and asylum-seekers for outreach sexual health generally (Barnett 1995) has been recognised at a local level. Many service providers, however, feel that they are struggling to reach this hard-to-reach group. In parallel, teenage pregnancy (and also sexual exploitation) is emerging as an area of concern amongst those who work with refugees and asylum-seekers.
- **4YP:** key informants were very positive about the work of 4YP, especially the 4YP bus. Particular strengths are the confidentiality policy and their ability to help young teenagers (and pre-teenagers) with their questions.

## Supporting young parents

- **Supporting young mothers:**

key informants were positive about the work with school-age mothers but felt that there was not enough support for teenage mothers over the age of sixteen.

- **Multi-agency and partnership work:**

there is evidence of strong partnership working around teenage pregnancy in Haringey, especially in terms of communication. Examples of good practice, mentioned by many informants, included the work of Surestart and the Leaving Care Team. There are, however, a number of difficult issues to be addressed:

- Limited resources that agencies are able to draw upon. E.g. Housing and childcare
- Difficulties in establishing the boundaries of the different agencies involved in this work. The clearest example is the support of under-16 teenage mothers where Social Services and the Education Service are both involved but in some cases may feel that the other agency is not pulling its weight
- Problems with initiatives being geographically limited e.g. SureStart

- **Regeneration:** teenage parenthood has been addressed in Northumberland Park (a deprived part of the borough). This seems to be the only scheme, however, that has made a serious attempt to look at teenage parenthood as an issue connected to regeneration. Some key informants felt that there was inadequate connection between social services, education services and the regeneration schemes in developing an integrated strategy.

- **Young fathers:** there was a great deal of concern expressed at the lack of work with young fathers in the borough.

## Findings II.

### The experiences and views of the young women

This section concentrates on information provided by the one-to-one interviews with the young women and from the focus groups. We have used codes for individual quotations in order to protect the anonymity of our informants<sup>1</sup>. In total, a diverse group of between fifty and sixty 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).

Eleven of the young women interviewed were teenage mothers. Another gave birth at twenty-one but was included in the sample because she had terminated two pregnancies whilst a teenager (at fifteen and nineteen). The youngest age of motherhood was fourteen. They were from working-class backgrounds and less than half the group had educational qualifications at the time of interview. There was a variety of minority ethnic groups represented: they described themselves as white British (3), black British (1), African Caribbean (7) and black African (2). The focus groups were also mixed but with a higher representation of white British.

The findings that follow move from a general picture of how young women gain information from which they form their views and base decisions, through a discussion of their sexual behaviour, onto an analysis of their personal decision-making for or against motherhood. The more immediate personal factors (such as personal backgrounds and the attitudes of the fathers of the babies) are also discussed in the section on personal decision-making. The issues discussed were: sex and relationships education,

<sup>1</sup>M refers to mother; TOP to termination of pregnancy; and MTOP to those who have experienced both. KI stands for Key Informant.

sexual behaviour, contraception and abortion. All these issues are considered in relation to the prevention strand of the teenage pregnancy strategy. We also look at the work to support young mothers. Unless otherwise stated, quotations are selected to indicate broader opinions, and patterns of behaviour, amongst the group rather than those of any one respondent.

## Preventing teenage pregnancy

### 1. Sex and relationships education

Many of the young mothers claimed that, for them, the content and delivery of sex education had been inadequate. One concern, frequently expressed in the individual interviews and the focus groups was that sex and relationships education did not deal with their real concerns and experiences. These might include how boys can behave sexually, discussion on withdrawal and on 'myths'. One young mother described how she was not at all worried about having sex without a condom and had been surprised to find herself pregnant because she *'believed he would pull it out'*, as indeed she thought he had. (M3) Amongst the 'myths' that were mentioned were not getting pregnant the first time you have sex or if you have sex standing up.

There was also a strong sense that, for the young mothers at least, sex education on 'safe sex' and negotiating sexual encounters had not started early enough: *'they don't teach us a lot about that and when they do that's like it's too late'* (M3). Many of those interviewed had already begun sexual activity when they were taught about contraception. One was already pregnant when she was being told how to use a condom. Another said they didn't get taught much at school and the first written information she was given was when she was pregnant but *'it was already too late so I just threw them in*

*the bin'* (M5). Yet another said she started having sex in her first year at secondary school (aged 11 to 12), and thought that a lot of girls were sexually active from the next year (year 8). Many focus group participants argued that sex education needed to take place at an earlier, younger, stage, before the possibility of having sex had actually arisen. This was also a message from some professionals who were involved in the design and delivery of sex and relationships education.

The view that teachers might not be the best people to deliver SRE was also expressed by a number of participants in the focus groups (in one of the schools), many of the young women and also by some of the key informants. This was often connected to a criticism of the sex education as having too much of a biological focus:

*'We had quite poor sex education at school, it wasn't by an outside educator it was by our science teacher and ... nobody really paid much attention to him. And I just remember it being much more kind of biological than emotional.'* (TOP1)

These observations indicate that some sex educators are having difficulty relating to the concerns and culture of contemporary teenagers. Staff/student barriers may be impacting upon the delivery and content of some sex education and adversely affecting young people's engagement with the issues discussed. Focus group participants explained what had been unhelpful, and ventured ideas for improving sex education in school. The suggestions 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 also raised.

One of the most important issues in sex and relationships education is that of confidentiality. A recent paper from Childline

(Keep 2000) emphasised young people's need for non-judgemental and confidential advice. Sexual health professionals we interviewed confirmed that this desire for confidentiality is well known within the sexual health profession. One important concern raised by many professionals, and also in the focus groups, was uncertainties as to whether young women under sixteen were being treated confidentially by GPs.<sup>2</sup> 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. In many cases, they felt they would not be able to confide in a teacher because the conversation would get back to their family. It should be mentioned, however, that there was a contrast between the schools with the girls in one of the schools feeling much more comfortable with the idea of discussing sexual matters with selected teachers.

Schools-based lessons are the main source of information about sexual matters for young people (Wellings *et al* 2001). It may well be that improvements made over the last couple of years might not have been experienced by the majority of the young mothers 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 most significant of these gaps were: availability of emergency contraception; 'safety' of withdrawal as a method; the legal time limit for abortion. According to the latest guidance on Sex and Relationships Education available at the time of the research, abortion should be part of the SRE curriculum (DfEE 2000). The young women, however, had received very little information about abortion and seemed to be reduced to guess work when asked about the legal time limit for abortion. Some of them said that it was not covered in school at all. We also heard about a number of instances of

'date rape' in the focus groups. This would indicate a need for more discussion on negotiating sexual encounters generally, and rape specifically. We thus found a confirmation of previous research indicating that improvements can be made in sex and relationships education (Tabberer *et al* 2000, SEU 1999).

There was very positive feedback on SexFM in all the focus groups. Participants felt that it had facilitated good discussion on negotiating sexual encounters and practising 'safe sex'.

One major problem was that many of the young mothers had dropped out of school, or had attended for limited periods. They therefore, often had no, or extremely limited, experience of sex education:

*'They taught you bits and pieces but as I told you I hated school so I tried my best not to go as much as possible.'* (MTO5)

## 2. Negotiating sexual encounters and contraceptive use

The young women interviewed individually for this study had a wide variety of views and experiences in relation to sexual behaviour. Many had had more than one sexual partner. Most had their first sexual experience at around 13-14 years old. The sexual health professionals interviewed also believe that most girls start having sex around this age but a substantial minority begin earlier. At least two girls in our sample had become sexually active at a younger age (11-12). Many of the young women became pregnant shortly after their first sexual encounter.

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

<sup>2</sup>This finding supports the local audit of sexual health provision for young people in general practice (Enfield and Haringey Teenage Pregnancy Team 2003).

them to start having sex. This contrasts with views expressed in the focus groups where the participants 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 young mothers use of contraception was often random, despite the risks of pregnancy and STIs. Most were more worried about STIs than becoming pregnant, and some had had themselves and their partners tested for HIV/AIDS and after that saw no need to use condoms.

Some said that they had limited and often inadequate information about contraception. Several told us that they became pregnant because the contraceptive they had been using had not worked (contraceptive failure).

*'Well I was on the pill and then what happened, I got an infection and I took antibiotics and didn't use any other protection. So that was that really the pill didn't work and I was pregnant'. (MTP3)*

Of the young mothers interviewed a high proportion seem to have become pregnant during the gap between injections. One had been using injections but became pregnant when there was a delay in getting the next injection:

*'I was taking the injection and then I come off it then and I was due my injection and it was a weeks space and then I was going to go and get it and then I found out that I was pregnant so because you have to have, normally, you have to have a pregnancy test before you get the injection. So I had the pregnancy test before I had the injection and I found out I was pregnant'. (M2)*

One told us she was on the pill and could not understand how she became pregnant:

*'Well they say that I didn't take it properly but I know I did so I just see it as one of them things'. (MTP5).* This comment also illustrates the fatalism of many of these young mothers.

One said that they had been using condoms and that she now knew that her partner was not using condoms every time - she wished she had also been on the pill. She did not seem in control in their sexual encounters:

*'when I first got pregnant I asked him what had happened, he goes "the condom burst", I was like "condoms don't burst" ... when I had the baby I was "so what happened?, he was like "Oh I didn't use a condom". I said "why" and he goes "because I wanted to have a baby". (M5).*

This particular young mother felt, from her talk with friends, that boys always wanted sex without a condom because it is better: *'I don't think they force them but they persuade them. They can be very persuasive'.*

Others knew that they were not using the contraception properly but decided to go ahead with sex anyway. Some 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. For many of the young mothers, their acknowledgement that they were careless regarding contraceptive use and often engaged in 'unsafe' sex does not seem to be because they lacked knowledge about contraception, but rather that they were not overly concerned to avoid pregnancy. Some had wanted to become pregnant: *'I was on the pill but I missed my pill because it was on purpose, it wasn't because it was a mistake. No, it wasn't a mistake' (M6).* Others told us that they were using contraception around the time they became pregnant, but were often unable to specify what contraception they

were using and why it failed. Within the space of about five minutes, M1 told us that she had been on the injection at the time but then explained that they had not been using condoms because she was taking the pill every day. Another had become pregnant three times within the space of approximately four years, the first time at 13. She had not been using contraception.

*'To tell you truthfully, even after I got pregnant the first time I didn't think I would get pregnant again. I didn't think of contraception. I was just a normal teenager and I didn't really think of pregnancy and having a baby or going to the clinic or anything like that'. (M/TOP1).*

She had not known she was pregnant the first time because she was so young her periods were irregular: *'I had no idea at all that I was pregnant'*.

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, both focus group participants, and some of the young mothers, felt that using alcohol and/or drugs made it more difficult for anyone to practice 'safe sex'. A young sex educator (not a teacher) talked about running sessions at schools and youth clubs in which she heard many stories about the impact of alcohol and drugs on young people's sexual behaviour. In some cases this will be of young people getting drunk *'as an excuse to be able to have sex with people'*, and in other cases it may be a case of young men taking advantage of women on drugs. She was clear that drugs lead to less responsible sex so

*'if they're on drugs they'll be kind of iffy about who they're doing it with and also totally unaware of their safety. And then because they're unaware of that and they are on drugs, they wouldn't remember whether they used a condom and they wouldn't remember to go and get the morning after pill and may not even be aware of the fact that they could be pregnant'. (K11)*

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. There was, however, a noticeable reluctance amongst this group of young mothers to discuss emergency contraception. This is connected to the difficulty in judging their intentions with regard to sexual behaviour. Those who explained their pregnancies through unknown contraceptive failure, felt that a discussion on the possible use of emergency contraception was irrelevant. Equally, for those who were not especially concerned to avoid pregnancy (which could also include some of the contraceptive failures) emergency contraception was not considered. The young mothers were aware of the availability of emergency contraception, and some had used it in the past, but for one reason or another, most of them had not considered using it at the time they became pregnant. As mentioned above, emergency contraception was one of the gaps in knowledge identified in the focus groups.

### 3. Abortion or motherhood: personal decision-making

Previous research has shown that young women's choices on abortion or motherhood are strongly influenced by their personal circumstances at the time of becoming pregnant (Lee *et al* 2004). We looked at the context of individual abortion decision-making and searched for patterns emerging in the individual interviews.

For the context we concentrated on their descriptions of their family background, their attitudes towards school and what they told us about their partners (at the time of pregnancy). We then analysed their descriptions of making the decision to continue or terminate a pregnancy and finally what they felt about the consequences of those decisions.

## Context of the choice.

Many of the young mothers described unhappy personal circumstances. This included troubled home lives, sometimes with 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:

*'I had a hard life when I was young, full of domestic violence and everything in my family. Its like I've been through a lot of emotional things'* (M0P4).

Nearly all the young mothers described 'non-traditional' family relationships. It was highly unusual for them to have been living at home with their mother and father prior to becoming pregnant. Some of these young mothers were unhappy at home and had been pleased when they found out they were pregnant:

*'I didn't want to have an abortion because I got pregnant and when I got pregnant I wasn't really bothered, I wasn't bothered that I was pregnant, I was just kind of glad in a way. Because of the things I was going through with my family I felt lonely. I felt lonely because my dad used to be there for me all the time until he left'*. (M6)

In turn, for many, their own relationships with the fathers of their babies was also 'non-traditional'. Another of the young

mothers, for example, said that she had grown up without a father and didn't want the same thing for her baby. She was, however, struggling with her own relationships:

*'I kind of have a boyfriend but he's planning on getting married to someone else so I'm like thinking of just letting it go. But I think I might get married to my baby father because we still have that connection of talking to each other and telling him how his baby is doing, sending pictures to each other, even though he's living with his girlfriend in America. But he's talking to me about settling down and I'm thinking about it. But I doubt it will happen though [laughs]'* (M5)

In general, the young women downplayed what might be described as social, or personal, 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.

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). The most recent national study of teenage abortion decision-making found that teenagers who saw their lives as insecure were more likely to decide in favour of motherhood, whereas those who had a personal focus on education and employment were more likely to decide in favour of a termination (Lee *et al* 2004). Some years ago Elphis Christopher drew

upon work in Haringey to argue that for some young mothers there seems to be a 'need for a baby' (Christopher 1987). 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. In this research, most of the young mothers had been disillusioned with school and many had stopped attending before they became pregnant. They often talked about 'hating' school:

*'I hated the pupils, I hated the teachers, I hated every single thing about it. That's why I left and I decided to go to college and that didn't last very long because I got pregnant and I left.'* (MTOP5)

*'I hated school, hated it, didn't go'* (MTOP3)

Most of these had just 'dropped out', and one had been suspended. Other girls stopped attending when they became pregnant. After becoming a mother, however, some of these were determined to finish school and were helped by the Education Reintegration Officer.

Their partners were generally much older than the mothers interviewed. The biggest age gap was twelve years with a 15 year old mother and 27 year old father. Some of the mothers felt that maintaining a relationship with the fathers of their babies and forming a traditional family unit was very important. 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. Others were more ambivalent and seemed to come and go. Many of the young women described partners as having their own problems (drink, drugs, criminality, prison), with some being violent.

Whilst some of the young women interviewed seemed concerned to build a family life, it was clear that this was very difficult. The practical difficulties faced by young couples who want to stay together after the birth of their baby are immense. Many of the professionals commented that a young mother's parents will try and keep her away from her baby's father. Some of the professionals we interviewed were concerned that young fathers were generally discouraged from parenting responsibilities and maintaining a relationship with the mother of their children.

### Abortion decision-making

In most cases, the young women had been involved in some discussion and thought about whether or not to terminate confirmed pregnancies. Their comments indicate a lack of hostility towards abortion and contrast with other local studies in which a high level of opposition to abortion on the basis that it is morally 'wrong' effectively excluded this as a possible option for many young women (Hek and Hoggart 2004; Tabberer *et al* 2000).

Only a few talked about being personally opposed to abortion:

*'Well I just decided because I don't agree with abortions because I feel even though the baby ain't out yet I still feel you're killing a newborn baby. That's the way I think.'* (M1)

In this case, the decision not to have an abortion was 'quite easy' but she did think about adoption. This young mother presented her position as a moral choice. For another it was connected to her family's religious beliefs.

*'It's against our religion to get rid of babies so we have to keep them. If we get pregnant we have to deal with it.'* (M2)

For others, who personally did not want an abortion there was no generalisation of this opinion. M4, for example, had opted against abortion but commented that other people could do it, it was up to them, and was quite clearly not opposed to abortion:

*'I always said if I got pregnant I'd abort my baby but when I got pregnant I was like I can't abort my baby, I was like I can't do it ... it's something that's a part of you'*

Although many of the young mothers told us that they had not intended to become pregnant, it was clear that it was not an outcome that they were very concerned to avoid. Most of the young mothers were very matter of fact about becoming pregnant and described how quickly they accepted their new status. It was not something to be feared but a possible 'accident'. For some it does appear as if they just wanted to have a baby. Then the decision was straightforward even though they might not have intended to become pregnant on this particular occasion. M3 told us that her boyfriend wanted her to have an abortion but she *'wanted to have my baby'*.

*'I've got four sisters and they've all had their babies and my brother and he's got his child as well and my brother is like if you ever do an abortion I'll finish with you for good. Look at my little baby anyway, look how cute she is man. She's my baby'.* (M3)

All the young women were asked who had influenced their decisions and the main picture is of young people wanting to make these decisions alone. All the young women interviewed (individual interviews and focus groups) stressed that they should make decisions themselves.

*'I have thought for myself and I did for myself. I see it as you know when every one had their opinion and said you know you shouldn't have have xxx or you should, I saw it as my decision because it's me that's got to look after him. And I don't ask anyone for anything'.* (M0P5)

*'no-one it was just myself'.* (M2)

Often parents were described as wanting their daughters to have an abortion and concentrate on their education. When they were asked about making the decision the young women often posed the decision as a choice between having the baby or continuing with their education. It was often their partner and/or their parent(s) who had felt they should have an abortion and concentrate on their education. But they had clearly disagreed. When asked why her boyfriend wanted her to have an abortion, M3 replies *'because he wanted me to finish college, finish uni, then he'd think about having a baby.'*

However, although they wanted to stress that the final decision had been their's, it was clear that for most of them these decisions were generally influenced, directly or indirectly, by those around them. Young mothers talked about the influences of their family and their partner of the time. Many, however found it difficult to talk to their families: *'..my family I couldn't talk to about it, they didn't know I was pregnant until I was about three months pregnant'* (M1). Her boyfriend had wanted her to have an abortion because he wanted to go to college before becoming a father.

In most cases, the greatest single influence on the young mothers' decision to continue with their pregnancies was their relationship with the father of their babies. In cases where they were no longer happy with their relationship they were more likely to terminate pregnancies than continue, whilst if they felt optimistic about the relationship they wanted to continue with the pregnancy.

M/TOP2 had planned her first pregnancy (15). When asked who influenced her decision she replied: *'Nobody, just me, it's my life, just me.'* Later, however, it became clear that her relationship with her partner was important:

*'I was fifteen when I had my first daughter and I was happy that I was pregnant because I had a family breakdown with my mum, and I had a good boyfriend so I was okay.'* Both times the decision was relatively easy. She was asked how easy the decision was to have the baby: *'It was very easy because I had someone to support me but the second time when I had a termination I didn't feel confident in no support so I didn't have it'*

One mother told us that the first time she became pregnant she was happy with her relationship and she decided to keep the baby. Shortly afterwards she became pregnant again and felt very differently:

*'I got pregnant basically nearly straight after him but it was with his dad, and I was in a bad relationship. It wasn't the best idea to have another child as I was trying my best to get out of the relationship with him in the first place'* (M/TOP5).

One counter-case, was that of M2 who was determined to keep the baby even though she was not happy with her partner. She was, however, strongly opposed to abortion on the grounds of religion.

Some talked about wanting to please their partner by having their baby. At other times they talked more generally about young men wanting to become 'baby fathers' and being hostile to the idea of abortion. One young mother described her ex-partner's response to her abortion:

*'He stopped talking to me completely, he was angry he stopped talking to me. He was proper excited because he told all his friends and then I went and killed it and aborted it yeah, it was like he looked an idiot because he went and told all his friends that I was having a baby and there was no baby so it made him look like a fool.'* (M/TOP4)

Some key informants felt that many young women are manipulated/coerced by their partners into having their babies.

Others felt pressured to terminate. Two of the young mothers described how either their mum or their dad 'beat them up' when they found out they were pregnant (the first time) and then forced them to have an abortion: *'And then my dad found out and he beat me up and forced me to have an abortion'* (M/TOP4). At first she had felt okay about this because she was not getting on well with the 'baby father', but she felt very upset following the abortion and had a baby one year later. The reasons she gave for the latter decision were that she had a new more supportive partner and also that she was nearly sixteen and would be able to claim benefits and housing and therefore provide for her baby. The second of these also felt that she had not made the decision to have an abortion:

*'I was fourteen at the time. I had had a lot of pressure from Mum, Aunties, every body. Mostly my Mum was pressuring me, pressuring my boyfriend to tell me to have the abortion and a lot of rowing and stuff .. I mean she really beat me up type of thing.'* (M/TOP1)

Apparently in this case the abortion had gone wrong and she had ended up having a miscarriage at home. She was pregnant again within a year and this time she continued the pregnancy. She felt that she had been pressured into having an abortion by her mother when she may well have reached the same decision herself had she

been allowed to do so. If this been the case she felt it would have been a lot easier. She had recently had a second abortion which she felt fine about because it was 'my decision'. This young mother is now studying at college and wants to work in social care.

### Consequences of decisions made.

There is a clear pattern with those who felt regret following an abortion. Either they had felt pressured into an abortion (ie. it had not been their decision) when they were likely to feel negative and quite likely to become pregnant again soon afterwards, or they had made the decision themselves but had noted a lack of support during and after the termination. In cases where young women had felt they had been pressurised into making a decision they were not happy with (e.g. to terminate a pregnancy) they had difficulty coming to terms with the outcome. In other words, they are looking to make the decision themselves, but also want to be supported in that decision. For the six young women we interviewed, if either of these factors were missing they regretted their decision. There is a need for further research in this area.

Many of those who had terminated pregnancies talked about being alone, about having no-one to talk to about their decision. M/TOP2: *'The second time nobody knew about my termination but church because that's the only place I went to to cry my eyes out'*. After having described the care she received whilst undergoing the termination as 'rubbish' she was asked what kind of improvements could be made:

*'A lot more support, a lot more advice and a lot more time to think, you know, about situations and whatever. Just a lot more counselling'*.

Another young woman talked about distressing physical symptoms after having an abortion. She was so worried about her

loss of blood that she wondered whether something was seriously wrong and that she might have become infertile. She was asked if she had spoken to anyone about her concerns:

*'No they never offered, nobody ever offered counselling. I speak to my friends about it but no, nothing was ever offered to me. If it was I would have taken it'*. (TOP)

There were also some regrets expressed by those who had chosen the path of motherhood. Although they stressed the importance of making their own decisions, they also commented upon how, as mothers, their autonomy was severely limited. They did not draw any connections between these two sets of observations themselves, although many of the young mothers did express regret that they had not waited until they were older before they became mothers. When asked if there was anything they would have liked to be different, the following represents a common sentiment:

*'Probably having the baby at a later age because I never thought it would be this hard. I always thought, oh a baby it would be so great and now it's hard work, real hard work. I wish I'd waited'*. (M2)

Several of the young mothers, however, saw their present lack of autonomy as positive for themselves. They connected it to what they viewed as growing up and becoming more responsible. Many commented that they had turned their lives around:

*'Well I can't you know put on my shoes and say I'm just going to do what I like today, you know, I've got to put my shoes on and put on XXXX's shoes and then say what we're going to do today. I prefer it this way because, you know, I don't know what I would be doing now if I didn't have XXXX', and later, 'I mean sixteen or not you know as soon as I had a child I'm now an adult'*. (M/TOP5).

*'The way I was before I was really bad, I was really bad, every now and then I would get in trouble with my parents. I was doing stupid things with all my friends on the roads. But like as soon as I had XXXX now its like I've calmed down' (M4)*

When asked how her life might have been different if she did not have a child, she replied:

*'I don't think I would have been so dedicated to doing my GCSEs or going on to college. I don't think I'd be more positive about it than I am now. I would've seen it as another let's just go and do whatever. But having XXXX has pushed me into doing this because its not only for me its for XXXX as well isn't it? So I've got to do better'.*

Many of these young mothers, therefore, had aspirations beyond motherhood for the future. They were generally positive about both the support they received as mothers, and the help available for them to pursue their education.

## 5. Supporting young mothers.

The focus in this research was on the process through which some teenage girls become teenage mothers. We did, however, also ask the young mothers about the help and support they had received from a number of services.

All the interviewees had positive comments about services for young mothers in Haringey. This was, however, especially the case for the school-age mothers. There was concern amongst those who were approaching school-leaving age that they would not continue to receive help and support, a view echoed by key informants. In particular, they mentioned the work of

the education team and the mentoring system.

Not all comments on the health services were positive. A number of the young mothers did express the view that they were treated poorly by some medical staff simply because they were young.

It is noticeable that the young women were much more positive about their education after they had become mothers than those at earlier points in their lives. Young women who had dropped out of school were positive about the help they were given to continue their education and expressed the wish to go on to college, and some to University. These aims, however, were counteracted by problems that many of them were facing with accessing suitable childcare.

When providers were asked about services that support young mothers 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. The young mothers seemed aware of this and often commented on specific help received from individuals that went 'beyond the call of duty'.

## Chapter three

# Recommendations

In general, this research supports the view that the local teenage pregnancy strategy needs to continue to be multi-dimensional in its approach. The recommendations, however, are not equally applicable to all. Teenagers become mothers for different reasons and there is no simple causal pattern. What also needs to be taken into account is the complex issue of intent. It is possible to view the young mothers into different groups organised around the issue of intentionality. Some may have planned their pregnancies whilst another group may have become pregnant entirely unintentionally. The largest group is likely to be somewhere in between these two positions. Factors underlying young motherhood are complex and there is, therefore, no simple approach to the prevention strategy. Improving teenagers' understanding of effective contraceptive use, for example, is of little value when it comes to preventing 'planned' pregnancies. We indicate below how the recommendations fit with our analysis of the decision-making processes of the young mothers interviewed.

We recommend that the Teenage Pregnancy strategy develops work in the following areas. We are aware that the Team is already prioritising some of these in Haringey and hope that these recommendations support that process.

### Prevention strategy:

#### **Sex and relationships education.**

Many of the young women interviewed felt that the current sex education programmes in school could be improved. 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). One of the most important issues raised was the need for informal confidential advice and support. Young women in the focus groups, in particular, indicated that having someone at school that they could talk to confidentially would be helpful. Confidentiality is a difficult issue because of child protection concerns and the issue of disclosure. There are, however, exceptions in the Sexual Offences Act 2003 that allow professionals working with young people to provide confidential sexual health advice and treatment (fpa 2004).

The following recommendations are particularly relevant for the efforts to reduce the number of accidental pregnancies. These may arise out of inadequate knowledge, poor contraceptive use (contraceptive failure) and difficulties negotiating sexual encounters.

1. Discuss the consistency of sex and relationships education (SRE) in schools, including
  - re-considering the age at which contraception is discussed
  - facilitating confidential question and answer sessions
  - defining 'at risk' within the teaching profession
  - discussing abortion in a non-judgemental way

- how to deal with complex, 'non-traditional' personal relationships
- how to facilitate more discussion on sexual pressure, including 'date rape'
- relate to young people's worries about STIs and connect to discussions on sex whilst under the influence of drugs and/or alcohol

2.The above could be facilitated by a borough-wide review of SRE in schools.

3.There is an urgent need for sex and relationships education to be developed in other settings. Many young people miss out on secondary school-based SRE, either because they have 'dropped out' of school, or because they have missed specific sessions.

The following two recommendations apply to work with young women who may become pregnant intentionally. This work could take place in all settings.

- 4.Explore ways in which work could be developed on the possible consequences of becoming a mother whilst still at school.
- 5.Discuss ways of connecting the prevention strategy to young women's desire for autonomy, and the implications of motherhood on this.

## Sexual health services: recommendations

- 6.Further work around the availability of emergency contraception with a strong emphasis on access and confidentiality issues.
- 7.A review of the abortion service available to young women locally, in particular the availability of post-termination counselling.
- 8.Sustained effort to introduce appropriate pre- and post-abortion counselling for those who request it, to normalise abortion and improve young women's experiences of the process.
- 9.Continue to support and expand the work of 4YP.

## Community based, partnership, work.

It has been established that effective sexual health services for young people are holistic and multi-agency in approach (Barna *et al* 2002). In terms of specific issues this research echoes national research findings that school excludees /persistent truants, and teenagers in families with high levels of conflict, are at higher risk of becoming teenage parents than those who do not face these difficulties (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 key informants 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. In such cases early intervention is clearly important. Thought could 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), the resulting *Children Act* and the development of local childrens' services.

- 10.Work with schools and other services to identify, and help, young women who are falling into a pattern of non-attendance.
- 11.Continue to work with other agencies to help provide young people with positive options for the future. A focus on work with the youth service could be beneficial.
- 12.Working around sexual health and fatherhood with young men.
- 13.Continue with multi-agency partnership working to improve sexual health services for young people, including abortion services.

## Further research

14. The local strategy would benefit from further research into the following areas:

- Rapid repeat pregnancies
- Sexual health of refugees and asylum-seekers
- Minority ethnic differences in attitudes towards young parenthood
- Sexual exploitation and sexual violence

## Supporting teenage parents:

This will remain an important area of work. Our analysis has shown that there is a strong likelihood that many young mothers have either 'planned' their pregnancies, or are not concerned to avoid pregnancies. Many young women will continue to resist the prevention message and choose to become young mothers. We recommend the following:

1. Maintain support for young mothers support groups, and continue with attempts to involve young fathers.
2. Expand peer mentoring.
3. Continue to work with other agencies (especially education and Connexions) to open up opportunities for young mothers.
4. Continue to support and extend support for young parents aged over 16.



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