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Sorhaindo, AM (2017) Exploring young people's lived experience of a targeted positive youth development programme: A phenomenological investigation of the Teens and Toddlers teenage pregnancy prevention programme. PhD (research paper style) thesis, London School of Hygiene & Tropical Medicine. DOI: <https://doi.org/10.17037/PUBS.04645411>

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Exploring young people's lived experience of a targeted positive youth development programme: A phenomenological investigation of the Teens & Toddlers teenage pregnancy prevention programme

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Thesis submitted in accordance with the requirements for the degree of  
Doctor of Philosophy of the University of London

AUGUST 2016

Department of Social and Environmental Health Research

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No funding received

Research group affiliation(s): None

I, Annik Mahalia Sorhaindo, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

A handwritten signature in black ink, reading "Annik Mahalia Sorhaindo". The signature is written in a cursive style with a large initial 'A'.

## **Abstract**

The high rate of teenage pregnancy in the UK has been a source of concern for decades. In 2014, the under-18 conception rate for England and Wales arrived at its lowest since 1969. Many advocates owe this to the success of the Teenage Pregnancy Strategy (TPS).

The TPS aimed to halve the under-18 conception rate by 2010. The Strategy drew on evidence from research linking youthful fertility and social disadvantage and recommended targeting individuals and groups with these characteristics. One approach suggested by the TPS was Positive Youth Development (PYD). PYD programmes build upon young people's assets to prevent risk behaviours. Effectiveness of PYD interventions has not been replicated consistently.

PYD programmes are often designed to target high-risk individuals or groups. Some evidence suggests that targeting may lead to unintended consequences and do not to address the structural factors that increase risk.

The aim of this research was to explore whether and how young people's lived experience of being targeted for and participating in a PYD programme may be related to programme effectiveness.

I analysed qualitative data from the process evaluation of the Teens & Toddlers PYD pregnancy prevention programme (T&T). My analysis suggests that T&T provided some opportunities for PYD, but that this was not consistent. School staff's lack of transparency regarding the targeting strategy and criteria led to feelings of confusion and mistrust among some participants. They responded by adopting strategies to manage their risk reputations. School staff selected young women for intervention based on individual-level factors, suggesting that individualised notions of risk are being reproduced in schools.

The development of preventative programmes should include young people's voices in all aspects, use targeting sparingly, openly and as part of universal

programmes to minimise further marginalising young people who already experience multiple disadvantage and disconnection from school.

## **Acknowledgements**

I am deeply grateful to the many people who in various ways lent their support to the completion of this thesis. First, I thank my supervisor, Dr. Kirstin Mitchell for her scholarly guidance, gentle encouragement, unending patience and overall kindness during this process. I would not, could not, have completed this thesis without you, Kirsti.

Thank you to Professor Chris Bonell for setting me off on this journey and remaining a touchstone throughout, but particularly for being available at the end to see me through to completion.

I am also indebted to Dr. Adam Fletcher for encouragement and support early on in the process. I'll definitely miss having my drafts described as "immense!" You were a joy to work with.

Dr. Nicki Thorogood even before you took on the role of supervisor at the end, I could always count on you for pep talks, tea and red velvet cake in the East. Thank you for everything.

Dr. Peter Keogh, thank you for helping me turn early rants into research questions and for all your support toward this thereafter. Tricia Jessiman, our initial conversations during data collection were invaluable to the development of this thesis.

To my loving parents and sister, Marieange, Benoit and Ria Sorhaindo, thank you for enduring the numerous tearful phone calls and conversations that were a predominant feature of this process. You gave me the strength to get up and dive back in the many times I wanted to give up.

To my eternal cheerleaders Anitha, Carla, Christina, Cynthia, Debi, Emily, Gerardo, Graham, Karen, Kate, Luca, Mariana, Paolo, Ricardo, Tahilin, and Tom: Thank you for your unconditional friendship.

Dr. Sandy Garcia, you have believed in me since the very beginning and it is heart warming to have you here still cheering me on 20 years later. Professor Leon Feinstein, thank you for pulling my confidence back up on the many occasions it slipped frighteningly low. You are both mentors and dear friends.

Finally, I am grateful to the young women, school staff and programme facilitators who participated in the Teens & Toddlers process evaluation for the time and effort they invested in this study. I truly hope this thesis does justice to your voices.

“One of the lessons that I grew up with was to always stay true to yourself and never let what somebody else says distract you from your goals. And so when I hear about negative and false attacks, I really don't invest any energy in them, because I know who I am” - **Michelle Obama**, *Marie Claire*, 28 October 2008

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## Acronyms and abbreviations

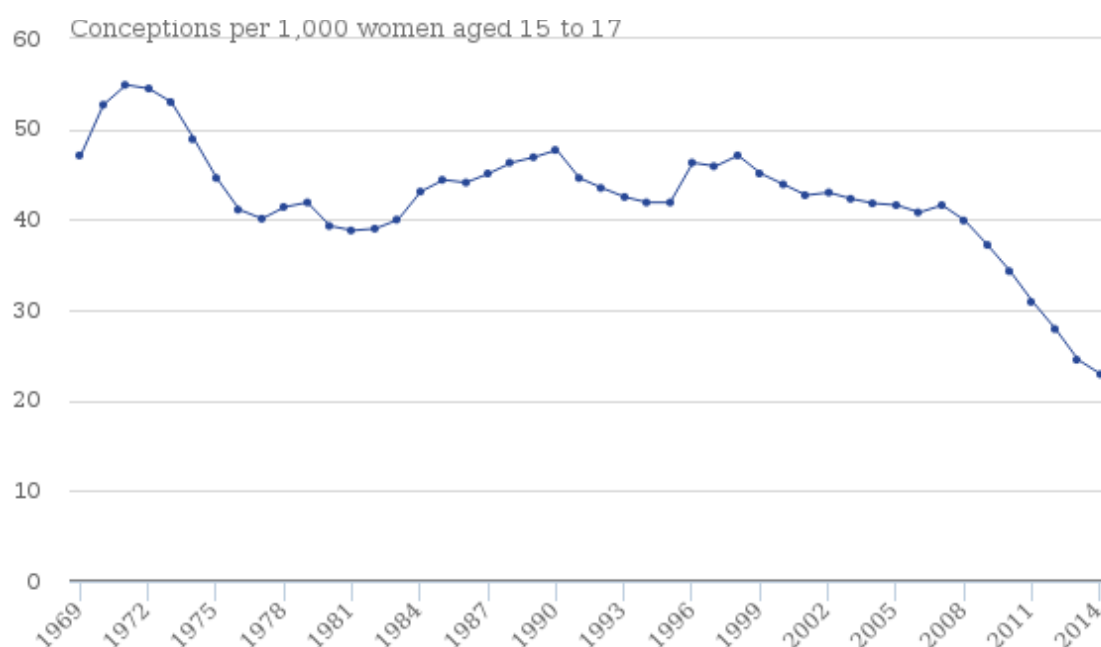
<b>5Cs</b>	5 Competencies
<b>BCS70</b>	1970 British Cohort Study
<b>BME</b>	Black or Minority Ethnic
<b>BHPS</b>	British Household Panel Survey
<b>DfE</b>	Department for Education
<b>DfES</b>	Department for Education and Skills
<b>DH</b>	Department for Health
<b>EU</b>	European Union
<b>FSM</b>	Free School Meals
<b>GCSE</b>	General Certificate of Secondary Education
<b>HIV</b>	Human Immunodeficiency Virus
<b>LSHTM</b>	London School of Hygiene and Tropical Medicine
<b>NatCen</b>	National Centre for Social Research
<b>NCDS</b>	National Child Development Study
<b>NPD</b>	National Pupil Database
<b>Natsal</b>	National Survey of Sexual Attitudes and Lifestyles
<b>NEET</b>	Not in Education, Employment or Training
<b>ONS</b>	Office of National Statistics
<b>Ofsted</b>	Office for Standards in Education, Children's Services and Skills
<b>PYD</b>	Positive Youth Development
<b>PI</b>	Principal Investigator
<b>RCT</b>	Randomised Controlled Trial
<b>SEU</b>	Social Exclusion Unit
<b>STI</b>	Sexually Transmitted Infection
<b>TPS</b>	Teenage Pregnancy Strategy
<b>T&amp;T</b>	Teens & Toddlers targeted teenage pregnancy prevention and youth development programme
<b>TPU</b>	Teenage Pregnancy Unit
<b>UK</b>	United Kingdom of Great Britain and Northern Ireland
<b>US</b>	United States of America
<b>UN</b>	United Nations
<b>UNICEF</b>	United Nations International Children's Emergency Fund
<b>YPDP</b>	Young People's Development Programme

## Chapter I. Introduction

England's Teenage Pregnancy Strategy: "*The success story of our time*"

In 2013, well-known columnist for *The Guardian*, Polly Toynbee, referred to the significant reduction in conceptions among young people under age 18 in England and Wales as the "success story of our time" (Toynbee, 2013). Indeed, the latest figures from the UK Office of National Statistics (ONS) report that, at 22.9 in 2014, the under-18 conception rate for England and Wales was at its lowest since 1969 when the rate was 47.1 conceptions per 1000 women aged 15 to 17 (Figure 1) (ONS, 2016a). Advocates and researchers alike ascribe much of this success to England's Teenage Pregnancy Strategy (1999-2010) (Gulland, 2016; Wellings et al., 2016; Hadley et al., 2016a; Skinner and Marino, 2016).

**Figure 1.** Under-18 conception rate per thousand women aged 15 to 17, England and Wales.



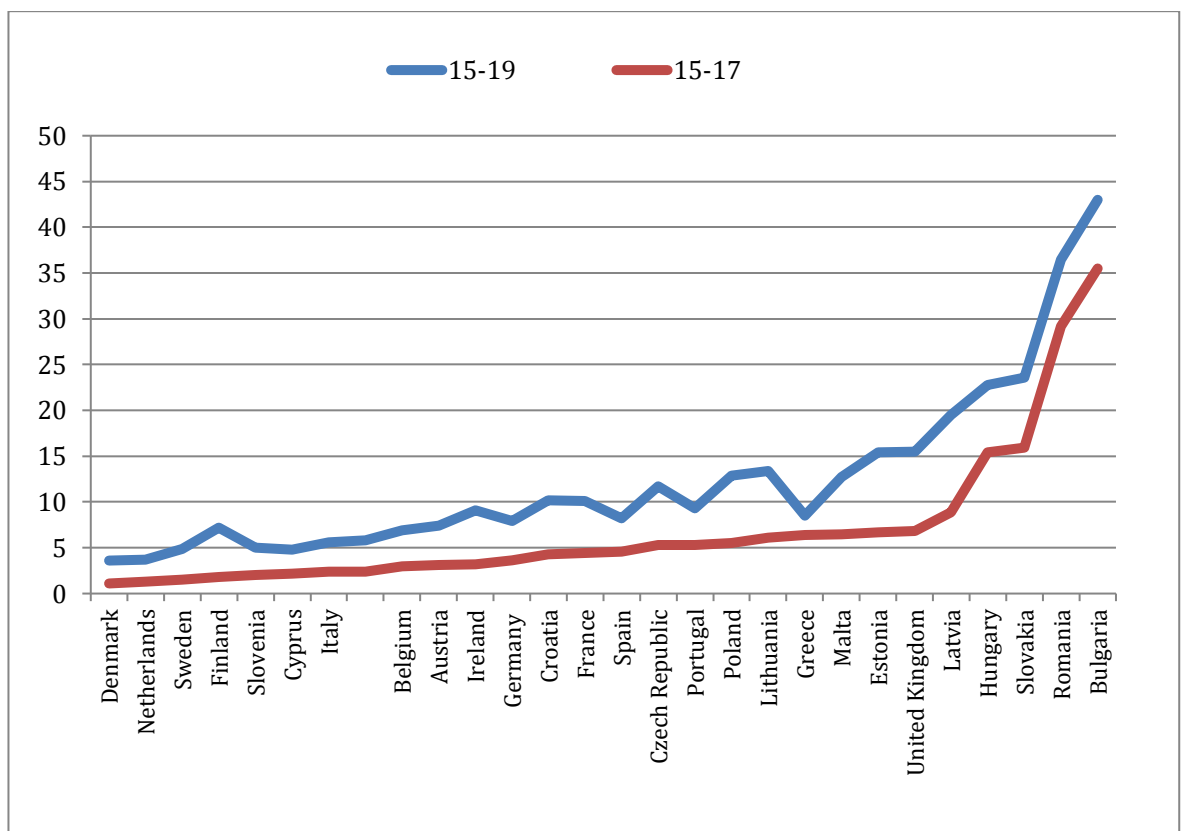
Source: Office of National Statistics (ONS), 6 March 2016, [www.ons.gov.uk](http://www.ons.gov.uk)

For over 40 years, the high rate of teenage pregnancy has placed the UK near the top of league tables among countries in Europe (Figure 2); and among high-income countries surpassed only by Romania and the US (Sedgh et al., 2015; UNICEF,

2013). The historically high rate of teenage pregnancy in the UK compared to other socially and economically similar contexts has been a source of social and political concern for several decades (Gulland, 2016; Arai, 2009; UNICEF, 2007).

In 1997, when the Labour government was elected into power, they broke with traditional patterns and policies for addressing the problem of teenage pregnancy. Moving away from the historical rhetoric about the rates of teenage pregnancy signifying social and moral decay (Duncan, 2007), Labour’s approach centred on tackling social exclusion (Arai, 2009; SEU, 1999).

**Figure 2.** *Live births per 1000 women aged 15 to 17 and 15-19 in EU28 countries, 2014*



Source: Eurostat data, compiled by the Office of National Statistics. [www.ons.gov.uk](http://www.ons.gov.uk)

In 1999, the sitting Labour government launched the Teenage Pregnancy Strategy (TPS) under the auspices of the Social Exclusion Unit (SEU), a cross-departmental government division made up of civil servants and experts seconded from external organisations to address issues related to social exclusion<sup>1</sup>. Cognisant of the multi-

<sup>1</sup> “Social exclusion is what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, poor health and family breakdown” England’s Social Exclusion Unit (2007)

dimensionality and the inter-connectedness of contemporary social problems, the Unit aimed to work across specific issues and government departments to produce “joined-up solutions to joined-up problems” (Skinner and Marino, 2016; Hadley et al., 2016b; SEU, 1999). Furthermore, changes in policy were to have “clear follow-up action, targets and evaluation plans”.

Strategically housed within the SEU, the Teenage Pregnancy Unit (TPU) was responsible for implementing efforts towards reducing teenage pregnancy in England. A policy document, *Teenage Pregnancy* (SEU, 1999), outlined Labour’s strategy for halving the under-18 conception rate by 2010 and reducing the risk of social exclusion for teenage parents by increasing their participation in education, training and employment by 60 per cent. The Teenage Pregnancy Strategy aimed to achieve these goals via four specific actions (SEU, 1999):

- A cross-sector national campaign to improve information, understanding and change behaviour;
- Coordination of activities at the national and local level;
- Prevention of the causes of teenage pregnancy via improved education approaches – in and out of school – access to contraception and targeting of at-risk groups, and a new focus on working with young men who had traditionally been left out.
- Supporting pregnant teenagers and teenage parents by facilitating a return to education, help finding employment and appropriate housing, and other intensive supports for the parents and the children.

In keeping with the ethos of the newly established SEU, teenage pregnancy was positioned as a cause and consequence of social exclusion and linked to poverty, disadvantage and poor educational attainment.

*Teenage Pregnancy* drew on evidence from public health and social science research linking youthful fertility to economic, social and educational disadvantage and suggested that focusing resources towards individuals and groups with these characteristics might reduce this risk. The policy document explicitly referenced UK and international research outlining risk factors for teenage pregnancy:

poverty, being a child in care, being a child of a teenage mother, poor academic and behavioural experiences in education or not being in education, sexual abuse, mental health problems, and involvement in or experience of crime. Furthermore, the document underscored that possessing “multiple risk factors” increased young people’s likelihood of experiencing early pregnancy and social exclusion. A longitudinal analysis published two-thirds of the way through 10-year Strategy, but based on data collected in 1997 provided support for the link between many of the risk factors outlined in the Strategy and teenage pregnancy among young women, and added new insight into risk factors among young men for causing a pregnancy. The study also found further evidence for the importance of multiple risk factors or the “clustering of risky behaviours” in increasing the likelihood of teenage pregnancy (Allen et al., 2007).

An important feature of the Strategy was its reliance upon on-going monitoring and evaluation to allow for adjustments and improvements in concepts and approaches to ensure the best outcomes. In a 2012 commentary on adolescent health and development published in *The Lancet*, of four suggestions for how to invest in the future of young people, one called for the continuing review and monitoring of the impact of preventative interventions for young people and addressing gaps and obstacles directly (The Lancet, 2012). In addition to the government’s SEU, multi-disciplinary social science research departments in the UK and elsewhere played an important role in providing the evidence to support political decisions and opinions, laid the basis for the design of Strategy, including effective approaches and target groups, and “increase[d] the confidence that enables [the Strategy] to be implemented in the face of shrill opposition” (Ingham, 2013).

Initially, to discover mechanisms for reducing teenage pregnancy, designers of the Strategy consulted with 70 projects in the UK and abroad to locate “promising approaches” for: sex and relationships education; improving access to contraception; supporting teenage parents and their children; and developing local and national initiatives. They then translated these approaches to suit the UK context. The TPU was charged with implementing a combination of activities, including a focus on interventions that target areas with high prevalence of teenage pregnancy and young people at high-risk of early parenthood. Midway

through the Strategy, in 2005, the TPU undertook an evaluation to compare areas where rates of teenage pregnancy were declining with areas experiencing less success. The purpose was to understand the features of the Strategy and its implementation that were leading to desired outcomes (Hadley et al., 2016; DH, 2005). As a result, new national guidance and a self-assessment tool were established and published to reduce the variation in local implementation. In particular, this new guidance called for targeted prevention for young people at most risk (Hadley, 2016b; DfES, 2006). In 2010, further national guidance reporting effective local practice was published based on the results of an updated evaluation (DCSF/DH, 2010).

The Strategy made significant strides, but ultimately did not reach its goal of halving the teenage pregnancy rate by 2010. Though the succeeding coalition government decided against continuing the Strategy in 2010, they maintained that reducing teenage pregnancy would remain a priority, would be included in other relevant policies and programmes, and would take into account evidence developed over the years of the Strategy on the most effective ways to reduce the teenage fertility rate (Hadley, 2014; Public Health England, 2012). Recently published data from 2014 suggest that since 1999 the rate of conceptions for under-18 year olds has decreased by 51 per cent, ultimately achieving the Strategy's aim four years later (ONS, 2016a). The UK ONS reported that a "number of factors" could possibly explain this reduction, including programmes instituted by successive governments, increased educational aspirations among young women, and a decrease in the social acceptance of teenage parenthood (ONS, 2015a).

In 2016, an observational study by Wellings and colleagues explored whether there was an association between the change in conception rates from 1994-98 to 2009-13 in local authorities in England, and TPS-related expenditure per head, socioeconomic deprivation and region. They found that following the peak in the rate of conceptions among women under the age of 18 in 1998, routinely collected national data demonstrated a steady decline until 2007, after which the decline continued at an accelerated pace. The decline was experienced in all areas, but was greater in the most deprived areas. Tests of the relationship between the decline in conception rates among women younger than 18 years by local authority and TPS



funding suggested an association amounting to a reduction of 8.2 conceptions per 1000 women for every £100 spent per head, after accounting for socioeconomic status and region (Wellings et al., 2016). The authors conclude that the TPS policy intervention, among other social and education changes, likely contributed to the decline in the rate of teenage conceptions in England and Wales. Others contest the role of policies, such as the TPS, in the decline. They argue that rates began to drop before the implementation of the Strategy and that the timing of shifts in conception rates did not appear to relate to periods of changes in government funding (Paton, 2012). These researchers emphasise improvements in educational outcomes and demographic change (increased immigration) in areas of high deprivation, and changes in young people's engagement in risk behaviours, as relatively more important than policies, such as the TPS (Girma and Paton, 2015).

Notwithstanding the remarkable success in England and Wales, there remains much to learn and understand about the features of efforts to reduce teenage fertility that are effective and those that are not. The Strategy is to become a model for the rest of the world (Hadley et al., 2016b). Improving on its components can benefit others hoping to replicate the success experienced in the UK. This thesis is written in the spirit of the constant evolution of evidence and interventions to address teenage pregnancy (and other risk behaviours among young people). It aims to assist policymakers, educators, practitioners, researchers and advocates in refining their approaches to improve outcomes for young people.

One of the "promising approaches" offered by the Teenage Pregnancy Strategy was Positive Youth Development (PYD). The concept of PYD rests on the notion of the flexibility of human development and the mutual influential relationship between the individual and their changing ecology (Lerner et al., 2011). During human development, the individual adjusts to their environment. So, there are perpetual opportunities for growth and change. There is the greatest potential for these opportunities during adolescence. PYD suggests that if the strengths of adolescents are purposefully aligned with positive resources in their environment (ecology), this can foster developmental assets that support positive transitions through adolescence into adulthood (Lerner et al., 2011). PYD programmes provide young people with opportunities to garner developmental assets to support them in confronting modern life challenges as they transition to adulthood. In contrast to

deficit-focussed interventions, PYD seeks to enhance young people's existing qualities, viewing youth as having "resources to be developed, rather than problems to be managed". PYD programmes support young people in avoiding health-compromising behaviours by encouraging pro-social actions and attitudes (Roth and Brooks-Gunn, 2003; Roth et al., 1998). Interventions employing this approach have been designed to address violence, substance misuse, risky sex and other potentially deleterious behaviours among youth (Melendez-Torres et al., 2016; Bonell et al., 2016b).

As was advocated in the TPS, PYD programmes, and other interventions designed to reduce risk behaviours, are often targeted at high-risk individuals or groups; the rationale being that the greatest resources be directed to those presumed to have the most need. Mid-way through the 10-year strategy, the *Teenage Pregnancy Strategy Evaluation* (DH, 2005) reported possible benefits of the PYD approach and made suggestions for future interventions. Of several recommendations, one encouraged a greater focus on targeted interventions that "selectively advantage" young people from poorer backgrounds and areas (pg. 76).

Despite considerable investments in the development and evaluation of PYD interventions, effects have not consistently been replicated across settings, with interventions that have been effective in one context showing no effects in others (Wiggins et al., 2009; Kirby, 2007). Furthermore, notwithstanding the implicit youth-centeredness of PYD, few evaluations have explicitly focussed on the perspectives of young people in seeking to understand the potential barriers to and facilitators of successful interventions (Fletcher et al., 2007; Krenichyn et al., 2007; Harden et al., 2006;). Understanding how young people experience the features of PYD interventions, including the process of being targeted as high-risk, is important for explaining the inconsistency of the results of programmes employing a targeted PYD design (Moore and Rosenthal, 2006).

### *The origins of this doctoral thesis*

This thesis is an analysis of qualitative data collected from young people and school staff as part of the evaluation of the Teens & Toddlers targeted teenage

pregnancy prevention and youth development programme (T&T). The aim of this research is to explore whether and how young people's lived experience of being targeted for and participating in PYD programmes designed to reduce risk-taking behaviour may be related to programme effectiveness. Lessons drawn from this research will inform the development of future programmes to prevent teenage pregnancy and other risk behaviours among youth and support on-going efforts (Crawford et al., 2013) to continue to reduce the prevalence of teenage pregnancy in the UK.

Across its administration, the Labour government emphasised the design of policy and support of activities and interventions that were based on evidence of effectiveness. Programmes sanctioned by the government, including those designed to reduce teenage pregnancy, were increasingly required to undergo evaluation. One such programme, the Teens & Toddlers youth development and teenage pregnancy prevention programme aimed to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (T&T, 2008). Before fully endorsing the programme as a viable intervention to help address the aims of the TPS, the UK Department for Education (DfE) called for an evaluation.

In 2009, as a result of a successful tender, researchers at the London School of Hygiene and Tropical Medicine (LSHTM) collaborated with colleagues at the National Centre for Social Research (NatCen) to evaluate the T&T programme. The NatCen/LSHTM evaluation team intended to assess the programme's effectiveness at reducing susceptibility to teenage pregnancy among high-risk young women living in areas of high prevalence of teenage pregnancy in England. To do so, the NatCen/LSHTM evaluation team proposed a randomised controlled trial (RCT) including an evaluation of process (Bonell et al., 2013). As a full-time Research Fellow at LSHTM working closely with one of the Principal Investigators (PI) of the study, I became an integral part of the research team and responsible for key aspects of the fieldwork and data collection. It was as a result of this experience that I became interested in exploring particular aspects of the T&T intervention in greater depth - beyond the aims of the DfE commissioned evaluation - for my doctoral research.

Prior to undertaking the full trial, the NatGen/LSHTM evaluation team conducted a formative evaluation with the aim of describing the concepts underlying the intervention and its logic model, including the programme components, causal pathways and intended outcomes (Appendix A). As a result of this experience, I decided to focus my doctoral thesis on some of the issues emerging for me while engaging with the T&T programme.

At each stage of the data collection process for the formative evaluation of T&T, I became increasingly concerned about how selection for and participation in the T&T programme may be affecting the young women in ways we were not planning to measure; some of which could have deleterious effects. First, I was interested in further understanding whether and how key features of the intervention, such as mentoring a young child, would influence positive development and prevent sexual risk behaviour. Second, observing initial T&T briefing meetings with the formative evaluation pre-RCT cohort, I noticed that the young women recommended for the programme were not told explicitly *why* they were selected for T&T or what the programme was *for*. The school staff and programme providers explained that they were deliberately vague about particular details of the programme so as not to stigmatise or deter the young women from participating. I wondered what consequences would result from this strategy. Also, as other students and school staff could easily identify the young women recommended for the programme, I was concerned that the young women selected, and those who ultimately participated in T&T, could be stigmatised and potentially even discriminated against. Finally, school staff tasked with selection were provided with a tool listing characteristics thought to be associated with teenage pregnancy to guide them in selecting young women to participate in the programme. I also had doubts about whether the school staff would make these selections fairly, and without introducing conscious or unconscious bias.

I discussed my concerns with both of the study's PIs, one being my PhD co-supervisor, and we agreed that I would collect additional data to explore these concerns in more detail. I gained approval from the DfE to include additional items to address my research questions into the instruments that would be used in the

RCT's integrated process evaluation so, the data for my PhD was simultaneously collected with the data for the process evaluation – but they are separately described, analysed and discussed here as a distinct piece of research.

The following chapters describe the rationale, methods and results of this study in detail. In Chapter II, I present a review of the literature that informed my understanding of the problem of teenage pregnancy in the UK, the determinants and consequences of early pregnancy, and the theoretical underpinning some of the approaches designed to address the problem. Chapter III outlines the specific aims of this thesis and the methodology employed to collect and analyse the qualitative data, with an emphasis on a phenomenological perspective. Chapter IV reflects upon my role as a researcher in this investigation and how my personal characteristics and the lens through which I observe the world was implicated in the formulation of the research questions posed, the process of data collection and, ultimately, the analysis and interpretation of the results.

This thesis is written in the “research-paper style” option offered by LSHTM, as such the results are comprised of three evidence chapters; each presented as a stand-alone academic paper. Evidence Chapter V examines the lived experiences of young women participating in the T&T programme to contribute to a clearer understanding of PYD intervention process and potential mechanisms. Evidence Chapter VI focuses on how young women experienced being identified as at risk for teenage pregnancy to understand the processes via which unintended consequences may occur. Evidence Chapter VII is an exploration of the process of selecting “at risk” young women in schools for targeted prevention intervention, and considers how school staff defined risk for teenage pregnancy and how they operationalised this definition to select young women for participation in T&T. I took this approach to the presentation of the results of this thesis for three reasons. Firstly, as described above, I aimed to investigate three discreet questions related to the T&T intervention. The research-paper style thesis approach provided each of these questions a distinct platform from which to present and thoroughly discuss the results, while highlighting the relevant context for the specific question. Second, as a full-time researcher, I was familiar with writing for scientific journals and perceived an advantage to receiving additional critique and

feedback on my research from external expert reviewers to ensure that my research met peer-review standards. Finally, although this thesis draws on theory and evidence from a range of disciplines, I aimed to focus my results to a public health audience. Directing the results to specific journals supported this aim.

To close this thesis, in the synthesis and conclusions, I draw together of all three Evidence Chapters and their implications for the development of interventions to reduce teenage pregnancy.

Through my analysis, I sought to make an evidence-based contribution to the development of a deeper understanding of the conceptual model underpinning PYD and to the debate on whether targeting high-risk individuals is appropriate. Furthermore, my analysis of how school staff define risk for teenage pregnancy and how they determine which young people fall within this definition, provides insight into how (and whether) social policy and evidence is interpreted and operationalised in the implementation of preventative interventions. Increased attention to these issues can improve the efficacy of such programmes, allow for more young people to benefit, increase the likelihood of a positive experience for all those involved and strengthen the effectiveness of approaches to address teenage pregnancy.

## **Chapter II. Review of existing evidence and theory**

Health and wellbeing in youth and adolescence is the foundation of positive outcomes in adulthood (Resnick et al., 2012; Sawyer et al., 2012; Public Health England, 2012). In high-income countries, such as the UK, priority health concerns for adolescents have shifted from infectious disease, malnutrition, and infant and childhood mortality to a focus on the impact of behaviours on outcomes in substance use, mental health, injury and sexual and reproductive health (Resnick et al., 2012; Sawyer et al., 2012). A central challenge to addressing risk behaviours among adolescents is their propensity for stimulating experiences. This stems largely from increased hormonal development during puberty, and lacking decision-making in exciting or stressful situations (Sawyer et al., 2012). Adolescence is also a period with a marked upsurge in sexual drive, the shaping of sexual values and, for many (Mercer et al., 2013), the start of sexual activity (Moore and Rosenthal, 2009). Many effective policies act to mitigate young people's exposure to risk by restricting access (*e.g.* age limits for access to alcohol and cigarettes) or offering education and skills to enable young people to self-manage their own exposure (*e.g.* sex and relationships education). A canon of research evidence has identified many of the determinants of health compromising and health promoting behaviours among adolescents and offers a solid basis for the development of effective policies and programmes to protect and improve the health and wellbeing of young people (Resnick et al., 2012).

In this chapter, I outline the existing evidence and theory underpinning the design of policies and interventions to address deleterious outcomes among youth, with a specific focus on teenage pregnancy. First, I briefly discuss why teenage pregnancy is considered an undesirable outcome for youth in the UK context. Following this, I outline the epidemiological research evidence identifying risk factors for teenage pregnancy. Later, I draw upon the sociological literature's discussion of notions of risk and uncertain transitions to adulthood as a feature of the social context of late modernity, and the relationship of this concept to teenage pregnancy. This section is followed by an explanation of the evidence and theory underpinning the TPS, and the origins of and theory supporting interventions with a targeted PYD design. To close the chapter, I discuss the literature on stigma, identity, and risk, informing

this thesis and the intersection and manifestation of these in the school environment.

### *Why is teenage pregnancy considered a problem in the UK?*

Despite the fact the teenage pregnancy has long been a feature of UK society (Duncan, 2007), its conceptualisation as a public health and social problem is relatively recent (Arai, 2009; Furstenberg, 2007; Duncan, 2007; Moore and Rosenthal, 2006). In fact, though rates of teenage pregnancy had begun to decline in the 1960s and 1970s in the UK and the US, (Arai, 2009; Furstenberg, 2007; Duncan, 2007; Moore and Rosenthal, 2006) this was precisely the time period when it began to emerge as a problem in the public discourse (Furstenberg, 2007). Teenage pregnancy during this period was perceived in both countries as having dramatically increased (Furstenberg, 2007), signalling a decline in morality, family life, and civic values, and increasing the demand for support from the welfare state (Breheny et al., 2010; Selman, 2001). However, youthful childbearing was common prior to industrialisation (Arai, 2009; Furstenberg, 2007), particularly among agricultural families; and changes in prevalence typically ebbed and flowed in line with the robustness of the economy (Furstenberg, 2007).

Prior to the 1960s, child birth and marriage were closely linked, such that if a woman became pregnant before marriage, there was a general expectation that she would marry and be socially and financially supported by the father (Arai, 2009; Furstenberg, 2007). Social stigma and shame were used as mechanisms for sanctioning childbirth outside marriage and managing the risks associated with premarital sexual activity (Furstenberg, 2007; Luker, 2000). However, as the stigma of cohabitation waned in the 1970s, childbearing outside of marriage became more common (Arai, 2009; Furstenberg, 2007). By the 1980s, in the UK, teenagers became the largest group of women who were not married when they gave birth (Moore and Rosenthal, 2006), which reflects a starker contrast in behaviour since the 1950s than youthful pregnancy.

The roots of the conceptualisation of teenage pregnancy as a problem are largely found in the moral and economic concerns for out-of-wedlock pregnancy (Arai,



2009; Furstenberg, 2007). Though childbirth outside of marriage was increasing overtime among all adults it was more frequent among young people and caused greater concern (Arai, 2009; Furstenberg, 2007). Teenage pregnancy was viewed as a “marker of marginality and inequality” (Luker 2000; Furstenberg, 2007) and concern centred upon the social and economic costs and consequences for the young women, the child and wider society (Moore and Rosenthal, 2006).

Contemporary research demonstrated, however, that modern decisions around pregnancy under the age of 18 are more likely related to socio-economic condition than to moral deficits in the young woman (Lee et. al., 2004). Lisa Arai (2009) acknowledged that arguments about the problem of teenage pregnancy as socially constructed have been presented for several decades. In 2004, Chris Bonell published a review of quantitative research that sought to explain why teenage pregnancy was conceptualised as a problem in the US and the UK (Bonell, 2004). In contrast to the UK, in the US the problem of teenage pregnancy was often framed as an issue related to the costs to the State of supporting teenage young parents and their children (Bonell, 2004), whereas teenage pregnancy in the UK was framed as a problem of social exclusion. Bonell highlighted that the consequences of teenage pregnancy related to poverty may not be inevitable, rather these consequences reflect the ways in which society responds to teenage pregnancy (Bonell, 2004).

Given the history and the evidence, whether teenage pregnancy should be considered a problem is debateable. Nevertheless, teenage pregnancy is framed as a problem in the UK and most industrialised countries primarily because of its association with socio-economic disadvantage and social exclusion for both young mothers and their children (Harden et al., 2009; Paranjothy et al., 2009; Harden et al., 2006; Bonell, 2004; Robson and Berthoud, 2003; Hobcraft and Kiernan, 2001) that can endure into adulthood (Kneale 2010; Ermisch and Pevalin, 2003). Though some UK studies have attempted to characterise teenage pregnancy as a problem because of health consequences to the mother and child, the evidence for this is weak for older adolescents (Paranjothy et al., 2009; Shaw et al., 2006; Lawlor and Shaw, 2002). Indeed, negative health outcomes appear mostly related to the mismanagement of pregnancy and birth rather than maternal age. This is

particularly true if the young mother is over the age of 16 (Arai, 2009; Shaw et al., 2006; Bailey 2005).

Evidence suggests that the social and economic consequences of teenage pregnancy are mediated by life conditions existing before pregnancy (Nettle et al., 2011). Both public health and sociology offer theories and evidence for the determinants of teenage pregnancy, which shape both the focus of research and interventions designed to address it.

### *Evidence on the social determinants of teenage pregnancy*

Public health orientated research links the propensity to becoming a teenage parent to a range of structural, demographic and psychosocial factors (Arai, 2009). Across this literature, a number of specific characteristics repeatedly emerge as key determinants, including poverty and disadvantage; educational achievement and aspirations; and parental support and expectations. For instance, in a systematic review of evidence from countries in the EU, socioeconomic disadvantage, disrupted family structure and low education levels were most consistently associated with early pregnancy and child-bearing across all countries (Imamura et al., 2007). I discuss the evidence, with a focus on data from the UK, below.

#### Poverty and disadvantage

For UK youth, adverse health outcomes are more commonly found among those from the poorest households (Public Health England 2012). Evidence from developed countries suggests that compared to young women from more affluent backgrounds, young women from poor circumstances are more likely to become pregnant and to carry their pregnancy to birth (Arai, 2009). For example, in analyses of the 1970 British Cohort Study (BCS70) mother's education was closely linked to women's likelihood of becoming a teenage parent. A woman whose mother had no qualifications was twice as likely to have given birth as a teenager (Ermisch and Pevalin, 2003).

Some evidence suggests that the likelihood of early motherhood is also influenced by poverty experienced in childhood. The greater the level of childhood poverty, the more likely a young woman is to become a parent in her teenage years. In analyses of UK data, 7.9 per cent of young women who did not experience childhood poverty became teenage mothers compared with 31 per cent who had experienced poverty in childhood (Hobcraft and Kiernan, 2001). Analysis of the National Child Development Study (NCDS), a longitudinal database of all people born in the UK between the 3<sup>rd</sup> and 9<sup>th</sup> of March 1958, suggests after controlling for other factors, childhood socioeconomic position was significantly related to age at first pregnancy – every standard deviation of the measure of childhood socioeconomic position was associated with a 0.89 years' delay in age at first pregnancy (Nettle et al., 2011). Eligibility for Free School Meals (FSMs), a measure commonly used as a proxy for deprivation, is also associated with teenage conception and continuing the pregnancy to birth (Crawford et al., 2013), even more strongly than findings related to educational attainment.

The association between poverty and early pregnancy also emerges in area-level studies. In England, teenage pregnancy is most prevalent in the poorest communities and among the most vulnerable young people (Bailey 2005). In contexts where young people have limited economic resources and labour market prospects, the perceived opportunity cost to having a child is reduced and becoming a parent as a teenager may become a more attractive alternative to education and employment (Ermisch and Pevalin, 2003). Data from 1991 for England, Scotland and Wales highlighted a near linear association between childbearing between the ages of 15-19 and social deprivation by local authority (McCulloch, 2001). Living in a deprived area is a risk factor associated with conceiving and birth as a teenager over and above the risk associated with individual deprivation)(Crawford et al., 2013). For example, in the 1992 waves of the British Household Panel Survey (BHPS) and the BCS70, lower family social class and increased local area unemployment were associated with a higher risk of becoming a teenage mother (Ermisch and Pevalin, 2003).

Although approximately half of conceptions under the age 18 end in abortion, there are vast differences by geographic location and level of disparity (Lee et al., 2004). The rate of teenage fertility also varies by local authority ward deprivation;

conception rates are higher in deprived areas and the proportion of conceptions ending in abortion is higher in less deprived areas (Lee et al., 2004; Teenage Pregnancy Unit, 2006), even after accounting for individual characteristics and the school they attend (Crawford et al., 2013). In 2012, Conrad examined the relationship between area-based deprivation and under-18 conception rates, and whether these changed between the period 1998 and 2010 – the years of the TPS. Data from 1998 suggested a strong inverse association between area-level deprivation and the under-18 conception rate (Conrad 2012). The analysis showed that young women living in areas with lower deprivation were more likely to end their pregnancies via abortion (Conrad 2012). However, by 2012 this relationship had weakened significantly, as more young women from deprived areas terminated their pregnancies (Wellings et al., 2016).

Inequity also appears to be a driver of teenage conception. Individual level deprivation is a stronger risk factor for teenage conception and pregnancy outcomes among young women from deprived households living in affluent areas, than for young women living in deprived households in deprived areas (Crawford et al., 2013). Similarly, young women performing poorly in high achieving schools are at higher risk of teenage pregnancy than young women performing poorly in low achieving schools (Crawford et al., 2013). In line with the “Spirit Level” theory, it is not simply material conditions that influence the prevalence of social problems, but rather the stress, anxiety and insecurity (emotional and otherwise) resulting from the experience of living in unequal societies that have implications for such outcomes (Wilkinson and Pickett, 2009).

#### Educational achievement and aspirations

Longitudinal evidence has linked educational disadvantage and school experience to teenage pregnancy. A study with 13-14 year olds found evidence supporting the link between dislike of school and teenage pregnancy (Bonell et al., 2005). Young people who disliked school because of bullying, loneliness or a sense of a lack of relevance of education on their lives were more likely to have sex (protected or unprotected) (Harden et al., 2006; Bonell et al, 2005).

Analysis of National Survey of Sexual Attitudes and Lifestyles (Natsal-3) also found an association between low educational attainment (having no qualifications

beyond those associated with the minimum school leaving age) and unplanned pregnancy (Wellings et al., 2013). Evidence from the third wave of the Natsal-3 conducted over two years between 2010-2012 measured the prevalence of unplanned pregnancy among a sample of the general population in Britain (England, Scotland and Wales). The proportion of women in the sample describing their pregnancy in the previous year as unplanned was highest among 16-19 year olds. Though pregnancies among this age group only accounted for 7.5% of the total number of pregnancies for women of all ages in the study, they represented 21.2% of unplanned pregnancies (Wellings et al., 2013).

In an analysis of the National Pupil Database (NPD) published in 2015, constant absence from school was associated with conception and the decision to carry the pregnancy to term (Crawford et al., 2015). Poor educational attainment is associated with teenage pregnancy and birth; however, deterioration of school performance between the ages of 11 and 14, and making slow academic progress in the early years of secondary school, is strongly related to becoming pregnant and having a child (Crawford et al., 2015). After controlling for other factors, young women attending higher performing schools are less likely to conceive, and more likely to have an abortion if they do conceive (Crawford et al., 2015).

Alongside this, evidence from accounts of young mothers and sexual health practitioners in some English communities suggest that low expectations for their education and employment may provide a better explanation for the prevalence of teenage pregnancy than knowledge of contraceptive methods or the availability of sexual health services (for example, Arai 2003).

#### Family factors, and parental support and expectations

There is an on-going and lengthy debate on the relationship between family structure and young people's sexual risk taking behaviour. Nearly two decades ago, Kiernan and Hobcraft (1997) found evidence to suggest that children of divorced parents began having sex earlier than children from families who remained intact. However, a 2003 analysis of the BCS70 found that having lived with one parent was not a risk factor for teenage pregnancy (Ermisch and Pevalin, 2003). Another, later, longitudinal study of UK data found that boys from single parent families were more likely to report sexual debut by age 15-16 and young

people of both sexes from lone parent families reported more conceptions by 15-16 (Bonell et al., 2006). However, other analyses of UK cohort data suggested that the importance of growing up in lone parent families has declined over time. The authors hypothesise that as non-traditional family formations become more common, the effect of this family structure on risk of teenage pregnancy has become less significant (Kneale et al., 2013).

In recent research on the relationship between family factors and teenage pregnancy among young people from disadvantaged backgrounds in an English population, Bonell and colleagues (2014) revisited the question on whether family structure, parent-child communication and parental interest are an important influence on outcomes. Their findings resonated with previous research suggesting that among disadvantaged young women, family factors, such as living with both parents, good communication with their mother and parents caring about school performance were respectively associated with reduced prevalence of teenage pregnancy, the expectation of becoming a teenage parent and risk of not using contraception (Bonell et al., 2014). However, parent-child communication and parental interest in education was not consistently associated with adverse sexual health outcomes. Furthermore, similar to findings from Kneale and colleagues (2010), there appeared to be limited influence of family structure; again suggesting that non-traditional family structures have become normalised in disadvantaged populations and, as such, no longer represent a risk factor for sexual health outcomes (Bonell et al., 2014).

In a 2006 analysis of longitudinal data, Wight and colleagues assessed the relationship between parental monitoring and communication and sexual behaviour. Low parental monitoring was associated with early sexual activity for boys and girls. For girls, low parental monitoring was also associated with more sexual partners and not using condoms or contraceptives. In terms of parental communication, boys who felt uncomfortable talking to their fathers about sex were more likely to regularly use condoms and girls' comfort talking to their fathers predicted condom use (Wight et al., 2006).

In addition to actual experiences in school and education discussed above, the experience of economic hardship on parents' educational expectations for their

child appears to be associated with age at first birth (Schoon et al., 2007). In households with limited economic resources, parents are less likely to expect their child to continue in education than parents in more affluent families. The teenagers of parents with lower educational expectations for their children tend to disengage from education and enter into parenthood earlier than their more socially and economically supported peers. More recent analyses of the BCS70 and the NCDS support the above evidence and centre on three main predictors of early fertility: dislike of school, favourable attitudes to motherhood, and lack of high parental expectation of progression to higher education (Kneale 2010).

Teenage childbearing is also more common among young people whose parents had children in their teens themselves. In an analysis of longitudinal data collected from women born in 1970, women born to teenage or young adult mothers were twice as likely to experience a birth before the age of 20 (Ermisch and Pevalin, 2003). In interviews with young mothers and non-teenage parents, the parents of many of the women who became mothers as teenagers also had children in their teens. The research highlighted the complexity of this relationship and the difficulty distinguishing the comparative influence of parents versus peers in communities with positive social norms around teenage parenting and suggests that young women from such communities had been socialised in their childhood and youth to view parenting as a viable option in the transition to adulthood (Whitehead, 2009).

#### *Societal perspectives: Young people's complex, uncertain transitions to adulthood*

The span between 'childhood' and 'adulthood' – typically defined as the ages between 12 and 18 (but increasingly considered from as young as 10 up to the age of 22) (Sawyer et al., 2012) – has lengthened and the transition between these two periods has become more challenging (Viner et al., 2012). The period of time youth spend in education has extended and they tend to marry and have children later. In an increasingly complex society, contemporary youth struggle to cope with the surge of physical, psychological and emotional development and changes that are typical of this period and, in tandem, strive to achieve the appropriate social, educational and economic dynamic to prepare them for adulthood. As transitions to adulthood have become less delineated and predictable, anxieties about adequately preparing for a successful adulthood during youth have increased.

In their discussion of youth transitions, Furlong and Cartmel (2007) drew on Beck and Giddens to illustrate how, for adolescents in late modern society, the movement to adulthood is shaped by risk. Giddens described the “risk society” as one, “...increasingly preoccupied with the future (and also with safety), which generates the notion of risk” (Giddens and Pierson, 1998). In his book, *Youth Lifestyles in a Changing World*, Steven Miles (2000) references Mary Douglas (1992) who argued that risk pervades and is shaped by the pressures of modern life. Furthermore, as we move towards a global society, she contended that we are liberated from the constraints of local communities, but in tandem, traditional sources of protection, security and support are absent, increasing a sense of vulnerability. The world is no longer predictable and dependable; rather it is characterised by uncertainty, both at the global environmental level but also at the everyday personal level. In this context, contemporary transitions to adulthood are less certain and young people do not have access, as before, to secure trajectories determined by, for instance, local communities and class structures (Furlong and Cartmel 2007; Miles 2000). For example, where in previous generations, communities of young people could rely upon anticipated trajectories from education to employment (e.g. well-paid, low-skill factory jobs in working class communities), contemporary transitions are longer and more variable.

Although there appears to be more choice for young people in post-industrial societies, opportunities continue to be stratified and unequal. Young people's life chances are still very much determined by class constraints. Not dissimilar to traditional societies, young people who are from poor, working class and/or disadvantaged backgrounds are more likely to encounter challenges in their transition to adulthood (MacDonald and Marsh, 2005). In essence, the development of life trajectories in late modern societies is not entirely unlike that of traditional societies; rather the pathways are just less transparent (MacDonald and Marsh, 2005). Because of the supposition that choice, equality and opportunity are increasingly available, lifestyles are assumed to be self-determined (Miles 2000). On the one hand, this represents the perception of an increase in independence, autonomy and agency. Alternatively, this increased choice requires that individuals undertake more strategic approaches to navigating the new risks and opportunities presented, rather than follow paths traditionally set by their



class, ethnicity or gender; albeit with limited autonomy, but clear prescribed destinations. In the context of late modernity, the individual assumes more responsibility for their life outcomes, the successes and the failures (MacDonald and Marsh, 2005). As such, the management of risks encountered by individuals are viewed as personal and the individual's responsibility rather than a result of factors outside of an individual's control (Furlong and Cartmel, 2007).

Theoretically, situations that in the past may have provoked calls for political action are now to be resolved at the individual level. Circumstances that before would have been considered fateful or random are now considered to have occurred as a result of personal failure. Negative outcomes, such as unemployment or poor health, are viewed as evidence of lacking within the individual rather than due to external forces further exacerbating inequality as individuals blame themselves when confronted with challenging situations and may view themselves (and may be viewed by others) as deficient if they struggle to succeed. Aligned with this, in place of the traditional policy discourse focussing on social class and social welfare, individualised dialogues of poverty and social exclusion are more prevalent and shape policy that focuses less attention on how agency may be constrained by the social and institutional environment in which young people transition to adulthood (Giddens, 1991; Furlong and Cartmel, 2007).

In this context, young people from disadvantaged backgrounds and with access to fewer resources may perceive fewer obvious sources of identity and belonging than previously seemed available to them based on their background. Considering the high rates of teenage pregnancy in the UK, Furlong and Cartmel (2007) drew attention to the association between high levels of unemployment and high levels of teenage birth and suggest that for young women, particularly those from disadvantaged backgrounds, facing a transition to adulthood with limited sources of "status and independence", parenthood may offer a viable option for developing a positive adult identity. They conclude,

“...it is hard to avoid the conclusion that we can best learn about why young women from less advantaged families tend to have children early by understanding why middle class young women don't – a difference that relates to resources and opportunities.” (p.69)

A number of studies have sought to understand whether and how young people residing in poor communities with limited economic and education opportunities

come to view parenthood as viable option in their transition to adulthood. Qualitative investigations of teenagers from disadvantaged communities lived experience of parenthood describe how young people in such contexts respond to unplanned pregnancy. In the context of insecure employment, inconsistent education and movement in and out of an informal economy, the lives of individuals living in socially and economically disadvantaged contexts tend to be erratic, unpredictable and unreliable. Furthermore, though it is implicit that the source and responsibility for this situation sits with them, they are also aware of the narrowness of their ability to change it. It is within the confines of this sense of “bounded agency” that young people determine the extent of and limits to their future possibilities. Young people living in such contexts, having grown accustomed to a sense of limited personal power and agency over their lives, interpret an unplanned pregnancy as yet another unexpected event for which they could not prepare and over which they have little control (MacDonald and Marsh, 2005). Where young people residing in other (more affluent) contexts may act to either prevent or seek a solution to unplanned and unwanted pregnancy (Lee et al., 2004) to allow them to pursue futures with greater possibilities, in disadvantaged contexts responses are more fatalistic (Harden et al. 2006; MacDonald and Marsh, 2005). In such circumstances, early parenthood initially viewed as another setback is often recast as an opportunity, among few, for young people to transform their lives for the better (Larkins et al., 2011). I discuss some of this literature below.

#### *Young women’s positive experience of teenage pregnancy*

Lisa Arai, in her volume *Teenage Pregnancy: The making and unmaking of the problem* (2009), highlights the growing body of evidence, mostly qualitative, that contests the view that teenage pregnancy is largely a negative experience. One of these studies is a qualitative investigation of the experiences of young women who became mothers in their teenage years. In interviews with 17 young women, Seamark and Lings (2004) unpack the complexity of the experience of young motherhood among teenage mothers in England. Many of the accounts of these women reflect the challenges evidenced in quantitative research – an early end to education, on-going poverty and the influence of intergenerational youthful pregnancy - on their experience. However, the interviews with women also suggested more positive aspects to young parenthood. For some young women,

despite initial doubts and fears, they enjoyed becoming a mother and described immediate love bonds with their child soon after their birth. Others, upon reflection, expressed happy emotions about becoming a mother and negated some of the common perceptions about the consequences of teenage parenthood, such as “growing up too quickly”. Parenthood offered emotional and relationship benefits to young women who described themselves as “lonely” and “seeking love” before becoming a mother. For young women, who had antagonistic relationships with their parents, motherhood elevated them to the status of adult and frequently improved family dynamics (Arai, 2009).

Moreover, for some young women, motherhood was not viewed as a limitation to continuing their education or the development of a career, but rather as source of motivation. A more recent study, conducted with ten young mothers from a deprived area of northwest England also challenges the view that teenage motherhood is largely a negative experience (Anwar and Stanistreet, 2015). Although the young women in this study did describe suffering from economic hardship, overall they viewed motherhood as a positive experience and one that afforded them a respected social role in their communities, in contrast to discouraging school experiences similar to that described above. As many of the young women who end up carrying pregnancies to term had poor educational attainment, motherhood was an alternative identity within which they could have higher expectations for success. In fact, in other research evidence, becoming a mother drove the young women to be more mature and to aspire to return to education and employment to improve their future and the future of their children (O’Brien Cherry, 2015; Duncan, 2007). Many of these young women professed that becoming a mother had, in fact, improved their lives (Middleton, 2011). So, for at least some young mothers, teenage pregnancy does not result in calamity, rather it served as an impetus for subsequently becoming involved in education, training and employment (Duncan, 2007). This research offers a less commonly reported but equally important perspective on motherhood as a positive experience for some teenage parents. However, it is worth bearing in mind the possibility that experiences are re-cast positively in the context of limited alternative educational or economic opportunities in the transition to adulthood.

*Theoretical underpinnings of the Teenage Pregnancy Strategy (1999-2010) and targeted interventions for young people*

The Teenage Pregnancy Strategy was strongly informed by US evaluations of programmes aiming to reduce teenage pregnancy and the transmission of sexually transmitted infections (STIs) (Philliber et al., 2002; Allen et al., 2001; Hahn et al., 1995). A report, *Emerging Answers*, a follow-up to a 1997 review, evaluated 73 studies measuring the impact of a range of programmes designed to improve the reproductive and sexual health of young people and summarised the characteristics of programmes demonstrating effectiveness at reducing sexual risk taking or pregnancy into five main categories:

- curriculum-based sex and STI/HIV education,
- mother-adolescent programmes,
- clinic protocols and one-on-one programmes,
- multi-component community programmes,
- service learning and multi-component positive youth development programmes

(Kirby 2007, pg. 23; Kirby 2001).

To be included in the non-systematic review, the study must have been conducted in the United States, been published between the years 1990-2007, included young people between the ages of 12-18, had an experimental or quasi-experimental evaluation design and a minimum sample size of 100. *Emerging Answers* divided the 73 programmes included in the review into three categories: programmes that focus on sexual factors; programmes that focus on social (nonsexual) factors and programmes that focus on both and summarised the effectiveness of each approach, and theories for why the approach might be successful, separately. PYD programmes were grouped with other programmes that focused on social factors and were considered one of the intervention designs to have demonstrated effectiveness in rigorous evaluations. The review concluded that there is strong evidence to suggest that PYD programmes have the capacity to delay the initiation of sex and reduce pregnancy rates (Kirby 2007; Kirby et al., 2003).

### *Positive youth development (PYD)*

As briefly mentioned in the Introduction, the roots of the concept of positive youth development lie in a debate starting in the 1970s and 1980s among comparative psychologists and biologists about the plasticity of developmental processes using the adolescent developmental period as a test case (Benson, 2015; Lerner et al., 2011). The PYD perspective emerged as a result of developmental scientists' research on human beings' adaptive relationship with their contexts and environments (Silbereisen and Lerner, 2007). In examining an individual's potential for change, the adolescent period was viewed as ideal for testing theories. From this work emerged a new language for the discussion of the nature of adolescent development centring on the need for diversity of experience, connection with adults and a focus on strengths and capacity (Silbereisen and Lerner, 2007). PYD's focus on individual capabilities also fits within the overall trend toward individualised interventions rather than societal interventions to increase employability and life changes. The concept of PYD gained traction and interest as a mechanism for supporting healthy youth transitions to adulthood in the 1990s (Benson 2015; Lerner et al., 2011).

The central goal of the approach is to equip young people with skills, opportunities and support to build upon some of the basic tools, such as peaceful management of conflict, problem-solving, and technical and analytic abilities among others, thought to be necessary for healthy growth (Bonell et al., 2016a; Kirby et al. 2003; Lerner and Thompson, 2002). The PYD philosophy emphasises that focussing on the strengths of youth and aligning these with resources for healthy growth present within the home, the school and the community, results in on-going positive development as a young person matures into adulthood (Silbereisen and Lerner, 2007; Lerner, 2005).

PYD programmes are holistic in nature and do not only focus on problems or deficits; rather they acknowledge young people's strengths and assets (Benson, 2007; Benson et al., 2004; Catalano et al., 2002; Pittman, et al., 2000; Roth et al. 1998). PYD suggests that increases in wellbeing are available to all young people by aligning developmental opportunities with the existing strengths of the young people themselves. This focus on building, developing and reinforcing strengths

grows attributes that optimise the potential of lives of young people and facilitate healthy transitions to adulthood (Lerner and Thompson, 2002). The appeal of this approach has intensified in a contemporary context where the challenges facing youth are perceived as great and pervasive (Silbereisen and Lerner, 2007; Furlong and Cartmel, 2005; Miles 2000). The strengths fostered via the PYD approach serve to build protective factors, including self-esteem, knowledge, skills and motivation, which are considered key assets for healthy development and the avoidance of risk behaviours (Gavin et al., 2010; Harden et al., 2006; Lerner and Thompson, 2002).

There are plenty of out-of-school programmes and activities for young people that provide a sense of community, an opportunity for socialising, and fun that would not be considered PYD because they are not based on its central philosophy (Kirby et al., 2003). True PYD programmes are underpinned by the theory of 'developmental intentionality' (Walker et al., 2005). Three central principles guide the theory of developmental intentionality: *intentionality, engagement and goodness of fit*. The theory stipulates that it should be the deliberate intention of PYD programmes to create opportunities that maximise the long-term developmental outcomes of young people. This does not necessarily refer to a particular programme structure or curriculum; it is rather concerned with the "mind-set" of the programme designers and providers and the rationale around the aim and purpose of the programme. Moreover, this perspective should pervade all aspects of the programme.

Young people are more likely to achieve developmental goals when they are engaged in their own learning and development. PYD approaches offer young people opportunities to become actively engaged in and to shape their own learning. Such contexts engender intrinsic motivation and concentration and generate initiative in ways often not found in young people's daily experience of schoolwork and unstructured leisure time (Larson, 2000). PYD theory asserts that the longer a young person is engaged in a programme, the more likely they are to achieve positive developmental outcomes (Kirby, 2003; Roth and Brooke-Gunn, 2000); though the "dose" or length of time or engagement in the activity necessary for achieving this is largely unknown.

Finally, PYD programmes should aim to achieve a good fit or match between the young person's needs and the learning opportunities available. The three tenets of this theory work together to optimise positive development. For example, a programme with a clear positive development intention creates an environment with a range of opportunities which collectively enhance the likelihood of a good fit for participants, and this good fit means that young people are more likely to be engaged in activities that are an appropriate match for their needs and interests (Bonell et al., 2016a; Walker et al., 2005).

Several models of PYD have been constructed over the past two decades representing the numerous perspectives on the theory (Brooks-Gunn and Roth, 2014). A recent systematic review (Bonell et al., 2016a) synthesising the theoretical literature on the PYD approach identified some reoccurring themes across the various models: thriving and positive assets, affective relationships with adults, and diverse activities and settings. Much of the literature appeared to support this notion of the 5 Competencies, or the 5Cs, as forming the basis for the strength-based approach:

- Competence in academic, social, emotional and vocational areas;
- Confidence is who one is becoming (identity)
- Character that comes from positive values, integrity, and a strong sense of morals;
- Caring and compassion

(Bonell et al., 2016a; Benson, 2015; Silbereisen and Lerner, 2007; Roth and Brooks-Gun, 2003)

In Bonell and colleagues' (2016a) synthesis of the theoretical literature on PYD, they identified growth in the capacity for "intentional self-regulation" as the causal mechanism through which young people achieve positive development. Intentional self-regulation involves the ability to choose goals that reflect an individual's life purpose, using cognitive skills to increase the likelihood of achieving such goals, and the facility to re-adjust when attempts fail or are limited in order to compensate effectively (Bonell et al., 2016a). The authors pointed out that though the existing theoretical literature discussed that intentional self-regulation works to develop the 5Cs, there is limited information on how to promote intentional self-

regulation. However, they offered three suggestions based on their synthesis: 1) by providing young people with resources (i.e. relationships and training in skills) to perform intervention-related activities that require intentional self-regulation, 2) offer young people a range of activities and opportunities to improve their ability to intentionally self-regulate, and 3) redirect young people's existing capacity to self-regulate toward more positive social goals (Bonell et al., 2016a).

In 2002, Lerner and Thompson delineated the key features of effective youth programmes. Such programmes should be:

1. grounded in the notion of PYD or the 5Cs and have clear aims;
2. focused on the assets of youth and on their involvement in all aspects on the programme, including design, conduct and evaluation;
3. cognisant of the diversity of youth both in terms of their unique abilities and in terms of their specific needs;
4. considered a safe and accessible space for young people, where they can use their time constructively;
5. collaborative and take an integrated approach to understanding the complexity of young people's lives and their relationships with the families, peers and schools;
6. "seamless" in their provision of integrated services to young people and the wider community;
7. mindful of the importance of caring adult-youth relationships, and provide training for adult leaders;
8. centred upon the development of the 5Cs of PYD - life skills, competency, caring, civic responsibility, and community service;
9. committed to programme evaluation and research in order to strengthen the design and delivery of the intervention;
10. an advocate for youth with all relevant parties, but particularly a voice to policymakers on behalf of young people.

(Lerner and Thompson, 2002)

The above list illustrates the range of characteristics of the individual and their context that, if effectively combined in PYD programmes, help young people to avoid risk behaviour (Lerner and Thompson, 2002).



As mentioned above, one important domain that is thought to generate some of the assets gained from the participation in youth activities is the development of caring relationships with adults. It is argued that these relationships offer young people opportunities to build social capital – potential access to information about other activities, employment opportunities, and other key information that can assist them with their development (Walker et al., 2005). Furthermore, these relationships can serve as a protective factor for at-risk youth, particularly when those relationships are characterised by “trust, attention, empathy, availability, respect and virtue” (Laursen, 2003). Effective PYD programmes emphasise warm and caring relationships with adults, rather than the adults simply serving instrumental roles in the delivery of youth service (Bonell et al., 2016a)

Some evidence and experience in practice suggests that the most effective pedagogical approach to PYD is through experiential learning. It is common for PYD programmes to include an aspect of service learning, a form of experiential learning. This approach emphasises “active exploration” followed by “critical reflection”. It consists of hands on activities that “build on processes of discovery, experimentation, trial and error, generalisation and application”. There is evidence that identity formation in adolescence is linked to participation in community service and service learning activities. As identity formation in adolescence is concerned with “looking beyond” their personal experience, experiential or service learning is thought to enhance identity formation in three developmental areas: 1) agency 2) social relatedness and 3) moral and political awareness. Participation in such community service has been shown to impact upon later activity well into adulthood (McIntosh et al., 2005).

It remains unclear which specific types of youth activities provide the greatest opportunity for PYD (Lerner, 2005). The settings in which PYD takes place are wide ranging, but typically fall under four main categories: specifically designed independent programmes, organisations, socialising systems and communities (Benson and Saito, 2001). PYD programmes range from informal to semi-structured to fully structured regularly meeting activities for young people. Schools, national youth organisations and community-based organisations often deliver these programmes but there are other systems that also design and deliver PYD programmes, for example private entities.

There are some challenges to the PYD approach. Firstly, despite the positive rhetoric, the general thrust of PYD programmes has been towards a focus on prevention of risk behaviours so that there are few existing programmes that actually focus on enhancing positive development and a plethora of programmes designed to address risk-taking behaviours (Roth et al., 1998). In hand with the type of programmes that tend to dominate the field, professionals delivering the programmes tend not to be trained in techniques that are in line with the central values of PYD (Mahoney and Lafferty, 2003).

There is evidence to suggest that PYD and development of the 5Cs may be protective against adverse sexual health outcomes. For example, academic attainment and good relationships with teachers and parents are associated with improved sexual health (Crawford et al., 2013; Arai, 2009; Allen et al., 2007; Kirby, 2007). Furthermore, some PYD interventions have been shown to reduce sexual risk (Gavin et al., 2010). More current reviews continue to indicate the effectiveness of PYD programmes that address the determinants of risky sexual behaviour and target high-risk young people. A recent systematic review suggests that PYD programmes designed to address the social and environmental determinants of teenage pregnancy can significantly reduce teenage pregnancy rates (Harden et al., 2009). A 2010 review by Gavin and colleagues included the results of evaluations of 30 programmes. Fifteen of these demonstrated proficiency in improving at least one sexual and reproductive health outcome, including delaying sexual initiation, decreasing the frequency of sex and acts of recent sex, increasing the use of contraception, decreasing the number of sexual partners, and resulting in fewer pregnancies or births, and fewer reported STIs. All but three of these programmes were targeted to young people who were identified as being at high-risk for negative social and economic outcomes. However, there was little evidence to explain *why* these programmes were effective (Kirby, 2007). Furthermore, to understand whether the PYD approach itself is effective, the theory of change for the approach must be clear. But currently, the conceptual framework defining what PYD programmes involve and via which causal mechanisms they work to effect change is limited.

Among the PYD programmes that have been evaluated one is frequently cited when professionals seek to exalt the benefits to the approach. The evaluation of the Children's Aid Society – Carrera Program (CAS-Carrera) has been important in drawing attention to the potential for PYD programmes (Philliber et al., 2002). CAS-Carrera included five activities and two service components. The programme activities consisted of a work-related intervention called Job Club, an academic component supporting participants with homework and preparation for standardised exams, comprehensive family life and sexuality education, an arts component focussed on developing talent in activities such as music and dance, and a sports component that focussed on activities requiring impulse control. The additional service components were mental health and medical care. In evaluation, the intervention was effective at reducing pregnancy by over 50% compared to the comparison group over three years.

The success of the programme prompted others to replicate the multi-component intervention, although those that were evaluated demonstrated fewer positive effects on behaviour. These programmes included components similar to that of the CAS-Carrera Program, but in some cases struggled with recruitment and retention of young people and staff, offered limited training, targeted slightly older teens and were generally less intensive regarding both sexuality education and youth development (Kirby, 2009; Kirby, 2007).

PYD is a promising approach for reducing risk behaviours and undesirable outcomes among young people, including teenage pregnancy. Although there has been movement towards a better understanding of the theoretical model for PYD, this remains limited. Furthermore, the evidence on successful preventative interventions based upon a clear theory of PYD, including measures of achieving the 5Cs and intentional self-regulation is thin.

### *Targeting*

Many approaches for addressing teenage pregnancy and other undesirable outcomes in health and wellbeing among youth, including the TPS and PYD programmes in general, use targeting. Targeting is the process of identifying a

population sub-group for whom an intervention, policy or programme is to be developed and directed towards. The approach and language of targeting is apparent across a number of fields, including education, social policy, economics, medicine, and health promotion. The idea is to provide specific resources to those identified as being at "high-risk" and are most likely benefit from intervention. For example, in social policy, policymakers have developed strategies to target individuals or groups that meet presubscribed indicators of poverty for social welfare and benefit programmes. Marketing has also long designed messaging to target and be used and understood by specific groups. In medicine, individuals or groups deemed most at risk of negative outcomes are targeted for further tests, treatment or preventative medication or therapy (e.g. screening)(Grimes and Schultz, 2002; Rose, 1985). The targeted or high-risk approach has advantages and limitations.

Targeting interventions toward individuals or groups with increased risk of an adverse outcome is thought to improve equity, enable more efficient use of resources (Carey and Crammond, 2014; Cerdá et al., 2014; Kreuter et al., 2014; Kreuter and Wray, 2003; Rose, 1992) and focus on the specific problem or individual/group at risk rather than those unlikely to be affected. Targeting can make cost-effective use of limited resources by prioritising the intervention toward those at most risk of developing negative outcomes and those who are most likely to benefit from support. Targeting individuals at high-risk also improves benefit-risk ratio whereby there is potential for costs of other interventions to exceed its benefits. Further, matching the intervention to the specific problem or individual at risk has the advantage of not involving people who are less likely to develop the problem.

A key challenge to targeting is determining the population in need (Culyer, 1995). The approach also assumes a clear distinction between those at high-risk and the rest of the population and the ability to properly identify or 'screen for' these individuals.

Geoffrey Rose (1981) famously recognised that, at the population level, risk to health is more often distributed across a continuum, than confined to a high-risk

sub group. Because of this, interventions targeted at high-risk groups, if successful, only result in reducing a fraction of the potential for negative outcomes across the whole population. On the other hand, universal approaches require that a bulk of individuals at low risk in the population experience the intervention, but do not benefit directly. This is known as the prevention paradox (Rose 1992). Targeted approaches have a greater impact on population level effects where risk is not normally distributed (Rose, 1992). But, where risk is normally distributed, universal, rather than targeted, approaches tend to have larger population-level effects (Rose, 1992).

In 2006, the UK government published interim reports on the TPS and advocated for interventions that targeted disadvantaged or at-risk individuals or areas. They argued for this on the basis that local authorities that successfully reduced under-18 conceptions had employed this approach (DfES 2006; TPU 2006).

Some PYD programmes have employed targeted approaches whereby they aim to identify 'at risk' young people that would potentially benefit most from the additional support. Though each intervention that uses a high-risk approach has a distinct method for selecting young people, in general, the process involves locating individuals possessing particular characteristics thought to demonstrate risk for negative behaviours and outcomes. For example, as described above, truancy (Zhou et al., 2015) and school exclusions (Bonell 2005; Bonell et al., 2003) are well-known 'risk factors' that can inform the process of targeting. The premise is that averting negative outcomes among these high-risk young people could substantially reduce overall prevalence of the outcome.

There is conflicting evidence on whether PYD programmes actually benefit from a targeted approach. Some evidence suggests that impacting on PYD does not require targeting specific youth, subgroups or particular behaviours. Elsewhere, studies of broadly targeted interventions (i.e. areas and not individuals) have shown that such programmes are most effective for young people with greatest initial risk of problem behaviours (Allen and Philliber, 2001).

In 2009, Douglas Kirby, the author of *Emerging Answers*, wrote an editorial piece in the *British Medical Journal*, reminding the public health community that "Youth

development programmes don't always work" (Kirby 2009). The editorial was prompted by the results of the evaluation of the Young People's Development Programme (YPDP), a three-year PYD initiative funded by England's Department of Health. The programme targeted young people aged 13-15 who were perceived by teachers as being at risk for teenage conception, substance misuse or exclusion from school and was informed by the design of other youth development programmes, in particular CAS-Carrera. In contrast to CAS-Carrera, however, young people were targeted for participation in YPDP based on their perceived behavioural risk. Additionally, programme provision was less defined and young people were involved in the programme for a shorter amount of time; 6-10 hours per week for one year versus 15 hours a week for three years.

The evaluation of YPDP produced troubling results. The findings of the quasi-experimental evaluation suggested that YPDP not only had no effect, but in fact appeared to increase risk taking behaviour among participants. For example, after 18 months in the programme, the evaluation reported significant increases in pregnancy rates and in the proportion of female participants in the intervention group expecting to be a parent by the age of 20 (9 months post-baseline), having heterosexual sex and having been temporarily excluded from school in the previous 3 months. Eighteen months post-baseline, all young people in the YPDP group significantly increased truanting behaviour in the previous 3 months. The programme seemed to have no effect on the likelihood of having multiple sexual partners, substance use or social-psychological factors such as, self-esteem and anger (Wiggins et al., 2009).

In Kirby's editorial, he summarised the complete findings of the CAS-Carrera evaluation and pointed out that despite the noted successes of the approach, not all the results had been positive. None of the further evaluations of CAS-Carrera found positive effects on the sexual behaviour of young men and three out of four studies did not find any improvements to the sexual behaviour or contraceptive use among young women. He concluded that the CAS-Carrera approach may not have an effect on male sexual behaviour in general and that in order to have any positive impact, similar multi-component interventions must be implemented fully by enthusiastic and engaged staff – a feature of CAS-Carrera that may be challenging to replicate.

The authors of the evaluation of YPDP drew on evidence from previous studies to attempt to explain the unanticipated negative effects of the programme. They hypothesised that programmes targeting and bringing together young people at risk may prompt a peer influence that reinforces rather than diminishes acceptance of risk behaviour. They also suggested that the young people targeted for YPDP might have felt labelled as a result of being recommended to the programme. That is, being identified as 'at risk' may have stigmatised and inadvertently lowered participants' aspirations. This may have also been exacerbated by the fact that some participants attended YPDP in place of normal schooling. However, the evaluation was not specifically designed to explore the validity of these explanations (Wiggins et al., 2009).

### *Targeted approaches and labelling*

Theorists in the field of criminology have long debated the potential social and psychological consequences for individuals labelled as deviant or as engaging in socially unsanctioned behaviour. Labelling theory suggests that society's response to the control of criminal activity through identifying, segregating, punishing and stigmatising offenders may in fact incite further deviance (Plummer 2001). Sociologists Howard S. Becker and Edwin Lemert introduced labelling theory in the early 1960s and the late 1970s; first asserting that definitions of deviant behaviour are socially constructed and highlighting that though it is the behaviour that is considered socially unacceptable, it is the offender that typically receives the label. In 1963, Becker stated:

"Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders... Deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an "offender". The deviant is one to whom that label has successfully been applied: deviant behaviour is behaviour that people so label." (Plumber 2001)

Lemert argued that there were two types of deviance: primary deviance may arise from social, cultural and psychological sources but had minimal implications for the person's status or psychic structure; secondary deviance concerns the ways in which the experience of stigma and punishment for deviance can alter one's

identity such that it leads to further deviance (Plummer 2001; Sampson and Laub, 1997). Lemert believed that agencies charged with controlling crime actually generated it as a result of the methods used to identify and discipline criminals. As appropriate behaviour is socially constructed, labelling was viewed as a political act designed to exclude those who do not abide by social rules. Secondary deviation is the adoption of a social role created by the social reaction to the primary deviation but is also regarded as resistance, rebellion, rejection and/or rationalisation of the labels placed upon an individual or group (Plummer 2001; Sampson and Laub, 1997).

Theorists in other disciplines have borrowed and built upon Labelling Theory. For example, in mental health, Link and colleagues modified the theory and developed a model for understanding the developmental and psychological processes that produce the consequences of official labelling. They argued that individuals internalise social perceptions and beliefs about mental health (or other undesirable characteristics) and thus anticipate rejection and discrimination leading to withdrawal from “normal” society and the development of poor self-esteem (Link and Phelan, 2001). This response to being labelled then increases vulnerability to future disorder (or deviance) (Sampson and Laub, 1997).

### *Stigma and self-presentation*

Goffman described stigma as the possession of an attribute that is considered by society to be undesirable and that the individual or groups possessing this attribute are thought of differently and discredited. He said that individuals are then reduced, in the minds of others, from a whole, normal and acceptable person, to a “tainted and discounted one”. This undesirable attribute is a stigma. Stigma creates boundaries between those who are considered “normal” and “others” in society. Not all undesirable attributes are stigmatising; the ones that are, tend to be those that run contrary to what the particular society believes that specific type of person should be (Goffman, 1963).

There is increasing awareness of the impact of stigma on public health interventions. Fear of stigma and discrimination can have an impact on the



effectiveness of interventions and treatments, including willingness to attend services, poor treatment adherence and further risk of disability (Heijnders and van der Meij, 2006).

The topic of teenage pregnancy in the UK has traditionally raised social concern because of societies' values about young people engaging in sex, which is considered an adult activity, and sex outside of marriage unacceptable. More recently, as described above, there has been increasing understanding that teenage pregnancy is linked with the undesirable experience of disadvantage. Early motherhood is not an acceptable part of middle class culture as it challenges norms that expect young women to delay parenthood while they secure the economic advantages of employment and career building, and avoid state dependence (McRobbie, 2007). Teenage pregnancy itself is considered a stigmatising event (SmithBattle, 2013; Whitley and Kimayer 2008; Weimann et al., 2005). As such, it follows that being identified as having attributes that suggest that an individual is at risk of teenage pregnancy is not value-less, but is in fact potentially stigmatising and can have undesirable consequences.

### *Deviancy training*

In addition to the possible consequences of labelling, Kirby (2009) and Wiggins and colleagues (2009) also draw attention to other potentially iatrogenic effects of targeted approaches. Other research has considered how interventions that bring together groups of deviant peers might lead to an increase in risk taking behaviour (Bonell and Fletcher 2008). Dishon and colleagues (1999) observed that as adolescence is the developmental period most influenced by peers, young people exhibiting problem behaviour tend to respond positively to reinforcement of such behaviour from similar or more deviant peers. The authors termed this phenomenon "deviancy training". They found it was most evident among vulnerable male youth with moderate to high levels of problem behaviours. In their experimental research, they found that younger boys (age 13-14) increased deviant behaviour, such as tobacco, alcohol and cannabis use, after engaging socially with slightly older (age 15-16) deviant boys. Dishon and colleagues suggested that for these young men, attending peer-group interventions can have

negative, rather than positive, effects on their risk-taking behaviour. More recent research presents a more nuanced view of this phenomenon. In a 2011 study of after school programmes, Rorie and colleagues considered whether young people's propensity to positively reinforce peer deviance was related to the level of structure or the extent to which activities included clear expectations for how young people spend their time. They observed that though, overall, peers tend to emulate deviance, peer group leaders tended not to respond to deviant behaviour. Further, deviance was less common during more structured activities, for example academic activities, and more positive during less structured recreational activities. Peer group leaders also responded more positively to deviance during unstructured recreational time.

The evidence available on targeted approaches demonstrates both their strengths and weaknesses, and potential for harms as well benefits. On the one hand, targeted PYD programmes address major precursors to teenage pregnancy and when executed properly can have lasting effects (Harden et al., 2009; Philliber et al., 2002). However, on the other hand, particular characteristics inherent to the approach, namely the labelling of young people as 'at risk' and aggregating together young people with similar problems and behavioural patterns may inadvertently reinforce the norms and behaviours that the programme is designed to reduce (Rorie et al., 2011; Wiggins et al., 2009; Bonell and Fletcher 2008; Dishon et al., 1999). Finally, identifying high-risk young people may not, on its own, completely address negative outcomes at a population-level (Kneale et al., 2013; Rose 1992; Rose 1981; Rose 1985).

YPDP and other programmes have struggled to explain iatrogenic effects of their interventions. Previous research has provided preliminary signposts to potential explanations for how these interventions produce their benefits and consequences, including iatrogenic effects. Some researchers have posited hypotheses for how the process of identifying young people for PYD interventions and programmes and the experience of participating in the programme may partly explain the equivocal findings but these are under-theorised. Furthermore, there is limited information from the perspective of the programme participants about how these effects arise and are experienced in the context of a targeted PYD programme. In

this chapter, I outline the theoretical frameworks underpinning my perspectives on targeting.

### *School performance and achievement, identity and the presentation of risk*

As I discussed earlier in this chapter, negative school experience is consistently linked to risk of teenage pregnancy in longitudinal research. Further, in qualitative analyses young parents themselves often describe their previous educational experiences as discouraging.

Researchers have described how in a competitive academic and school performance climate some contemporary UK schools appear to place higher value on students who achieve standards that would improve the status of the school. In these contexts, students who are not predicted to achieve are often left by the wayside (Bonell et al., 2011; Benjamin, 2002; Gillborn and Youdell, 2000). The pressure placed upon schools to focus efforts on those students most likely to achieve creates a context where lower achievers are less inclined to invest in education and search for alternative markers of identity, including those that include risk behaviours (Bonell et al., 2011; Fletcher et al., 2009). Though, in some schools where this approach is taken, faculty responsible for pastoral care or the overall wellbeing of students offer students whose strengths are not in their academic ability alternative opportunities in non-academic areas, value is still implicitly based on academic achievement. Where academic achievers are separated from other students in this way, students who are weaker academically are susceptible labelling and stigma (Goffman 1963; Goffman 1959).

Within school contexts that prioritise performance and standards, ethnographic research by Shereen Benjamin (2002) offered an example of how students with special educational needs at an all girls' school constructed their identities based on alternative markers of success as a survival resource in an environment where their abilities and academic performance were not valued. Benjamin illustrated how young people work to negotiate and define their sense of self within the personal, social and political school context where their agency is constrained by the labels placed upon them by the school and their teachers based upon their academic performance. In such school contexts, a "tug-of-war" may ensue whereby

marginalised youth struggle to regain power in an institution where their power is limited. Similar to the findings in other research (Fletcher et al, 2009), these young women resist relenting to the schools' control and categorisations of them and construct anti-school identities to create and preserve their sense of self. Some of these self-characterisations, such as bad girls resisting academic work and lazy girls lacking effort – which may actually be reactions to the school environment – can resemble the behavioural characteristics identified as risk factors for outcomes, such as teenage pregnancy (Benjamin, 2002).

The education literature has also underscored the increasingly gendered and racialised notions of risk in modern youth in general, but also how this can potentially manifest in US and UK schools. In another piece of research focused on the experience of young women with special needs, this time in the US, Ferri and Conner (2010) point out that the increasingly alarmist discourse about the youth crisis can tend to miss taking into account how key structural factors, such as the decreasing availability of economic and employment opportunities, regressive welfare reforms and disadvantaged urban environments manifest and contribute to the difficulties young people experience particularly in urban schools. Furthermore, in local communities, the presence of traditional networks of family, church, neighbourhood organisations and clubs that once guided and supported young people as they navigated adolescence are declining, placing increased pressure on schools and educators to provide social and emotional support to students.

Ferri and Conner (2010) argue that in wider society black and urban youth are “pathologised” and deemed to be at least a source of, if not themselves directly, social problems. These young people are not considered victims of social inequality but rather a threat to white middle class values. The pathologising of urban youth of colour in particular has become so prominent such that they are “equated with failure and risk”. As young white women co-opt the culture of urban youth of colour they are also similarly pathologised as bullying and hypersexualised “problem girls”. In their analysis of young black and Latina girls in special education, they considered how in schools in the US these young women worked to subvert normative expectations surrounding race, gender, ability and social class. The authors highlighted that despite a policy of confidentiality,

teachers and other students via direct and indirect information, easily identified the special needs status of particular students. According to the girls' accounts, once teachers and students were aware of their special needs status they were treated differently and stigmatised as "less able" (Ferri and Conner, 2010).

As described above, although young women who are disengaging from school typically identified by the school and their peers as such, they are comparatively less visible to teachers and other professionals than boys who are disengaging from school. Their disengagement tends to be hidden, go unrecognised or be falsely interpreted. In a 2007 study of young women in London secondary schools, Archer and colleagues (2007) found that girls with low levels of achievement suffered from more severe lack of confidence than their disengaging male counterparts. Many of these girls used strategies that included poor behaviour and acting out in the classroom, which they described as "being loud" and "speaking their mind" to generate capital and challenge the quiet and passive feminine norms that are typically rewarded at school. Where such behaviour fitted within normative expectations for boys, it often put girls in conflict with the school and they were interpreted as deviant. Furthermore, such behaviour from black minority ethnic (BME) groups reinforced stereotypes about black students as aggressive and challenged beliefs about the passivity of Asian women, but led to severe consequences from the school for both groups (Archer et al., 2007).

In an exploration of teachers' and students' perception of the "ladette" culture among young women in the UK, Jackson (2006) points out how this modern departure from traditional and "acceptable" forms of middle-class and largely White femininity signifies risk or risky behaviour. Teachers and students described "ladettes" as "excessive" in their manner of dress and use of make-up, "overtly" heterosexual, and "shameless" and "brash". Additionally, they were believed to engage in risky behaviours, such as excessive use of alcohol, smoking, and violence, and also described as being disruptive to classrooms and lessons. From the perspective of the young people engaging in the culture these behaviours were in part about protecting their self-image; in particular, to avoid being considered a "swot" or as being interested in studying and school. To protect themselves from stigma and discrimination, Goffman described the intricate performances that

individuals undertake to construct their public identities and present themselves in a way that protects their sense of self and in a favourable light (Goffman, 1959).

From the above literature, we learn that in some contexts, schools that are pressured to focus on a narrow definition of achievement can be hostile for young people, but particularly those from disadvantaged backgrounds and those with educational difficulties. Such schools may marginalise and label young people who do not easily conform to the standards of high academic achievement and White middle class values. In an act of “symbolic violence”, the school as a social institution validates or invalidates students (Weininger, 2005). The young people who experience this struggle and “push back”, albeit within the constrained school environment, by constructing anti-school identities and employing a range of performances to resist the undesirable identities pressed upon them by the school. Adults may interpret behaviours and “performances” as signifying risk. Some of these young people may indeed engage in activities that put their wellbeing at risk, but this literature suggests that the sources are more likely found within the school structure and academic policies, and the young people’s position in wider society than inherent to the individuals themselves.

Evidence from England and Spain suggests that there is a positive association between teacher connectedness, defined as supportive teacher-student relationships, and subjective well-being, irrespective of age, gender, country and perceived performance at school. The authors argue that teacher connectedness can serve as a health asset for young people, implying that efforts to improve and protect PYD may benefit from prioritising this relationship in school-based interventions (García-Moya et al., 2015). Recent policy recognises the importance of relationships for young people’s health and wellbeing, including those with trusted adults (Public Health England, 2012)

It is against this background that I explore young people’s lived experience of a targeted PYD teenage pregnancy prevention programme, including the overall experience of the intervention, the perception of being targeted and the processes underlying the selection and recruitment of young people centres upon, is informed by, and builds upon the above concepts.

### **Chapter III. Research design, data and methods<sup>2</sup>.**

#### *Research aim and questions*

The psychosocial literature on PYD programmes suggests that the approach can result in benefits to the health and wellbeing of the young people who participate. However, this contrasts with evidence from evaluation studies that have struggled to consistently demonstrate effectiveness. Despite the repeated endorsement of targeted PYD approaches to address or prevent risk behaviours, little is understood about how such interventions are experienced by the young people themselves. Researchers hypothesise that being targeted for programmes to prevent or address risky behaviours may produce some unintended deleterious consequences, such as labelling and stigma among young people considered “at risk”. Further, previous research has suggested that drawing together groups of high-risk young people may provoke deviance training where peers encourage rather than discourage risky behaviours. However, to my knowledge, no previous study has explicitly investigated young people’s lived experience of these interventions to explore whether such phenomena actually occur in the context of PYD programmes and whether this is related to programme effectiveness. Furthermore, few evaluation studies have fully addressed how PYD intervention processes may be related to young people’s experience of the programme and its outcomes.

Researchers, such as Kneale and colleagues (2013), question the actual feasibility of identifying high-risk young people for the targeting of policies and programmes, specifically with regard to teenage pregnancy. This doctoral research contributes to the debate about the overall utility of the approach. Such evidence could help elucidate the features of programmes that result in programme success and those that are less useful.

First, to understand how features of a PYD programme’s design may shape young people’s experience of the programme, Evidence Chapter VI addresses the following research questions:

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<sup>2</sup> Some tables and figures presented in this chapter are also presented in evidence chapters.

- How was the Teens & Toddlers programme experienced by the young women who participated?
- How did the lived experience of the programme relate, if at all, to positive youth development?

Second, to explore how the experience of being targeted for participation in a teenage pregnancy prevention programme may relate to unintended consequences of high-risk approaches, Evidence Chapter VII addresses the following:

- How did it feel to be deemed at risk of teenage pregnancy, from the perspective of young women selected for participation in the T&T programme?
- How did the context of the selection process influence the meaning of the experience?

Finally, in Evidence Chapter VIII, to understand how the construction of an “at risk” identity is related to both evidence of the risk factors for teenage pregnancy and targeting for PYD programmes, I will explore the process of selection and recruitment of young women into the Teens & Toddlers programme with respect to the following two research questions:

- How did the school staff responsible for the recruitment and selection of young women conceptualise risk in terms of its source (individual or structural) and its distribution (broad or discrete)?
- How did school staff operationalise these conceptualisations of risk in their selection of young women to participate in T&T?

To achieve the above aim and attempt to answer the related research questions, I analysed data from four in-depth case studies that formed part of the process evaluation of the Teens & Toddlers programme. In the remainder of this chapter, I will describe the methods used in this thesis in full. Shortened versions of this chapter have been included in each of the subsequent stand-alone evidence chapters.



*The intervention: Teens & Toddlers youth development and teenage pregnancy prevention programme*

T&T is a 18-20 week youth development teenage pregnancy prevention programme that aims to “decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant” and targets geographical areas with high rates of teenage pregnancy (T&T 2008) ([www.teensandtoddlers.org](http://www.teensandtoddlers.org)). The intervention is comprised of three specific components: mentorship of young children ages 3-5 in a nursery or primary school setting; a classroom curriculum delivered in small group sessions by trained facilitators; and mandatory one-to-one counselling sessions with trainee counsellors (Table 1). Intervention participants leave school around midday once or twice a week for the duration of the programme and either walk or take a bus to a nearby nursery or primary school participating in the programme. Participants are paired with a 3-5 year old child identified by the nursery staff as potentially benefitting from additional attention, learning or emotional support. The intervention participants work closely with and provide mentorship to the child they are paired with for 90 minutes each session over the course of the 18-20 weeks of the programme. The intervention participants and the young children are supervised by the nursery staff and up to two T&T facilitators. T&T believes that pairing vulnerable teenagers and young children under the supervision of skilled adults offers benefits for each, such as improvements in personal, social and communication skills. Further, working with young children is thought to reduce risk of teenage pregnancy by developing the intervention participants’ awareness of the responsibility and challenge involved in parenting, as well as self-awareness and confidence.

Following the 90 minutes of “nursery time”, the participants spend an additional 90 minutes in small group sessions with one or two trained facilitators who deliver the T&T youth development classroom curriculum. These group sessions focus on self-esteem and sense of control; emotional literacy and social skills (self-reflection, self-management, awareness of others); options, aspirations and goal-setting for future education/employment; teenage sex, sexual health and the

consequences of unplanned pregnancy; sources of health advice and support including sexual health; and understanding the responsibility involved in parenting. Each session focusses on one of the above topics and during each session the participants discuss their experiences working with the young children. The T&T programme theorises that this classroom curriculum may reduce risk of teenage pregnancy by supporting participants to be clear about their goals and possess the skills to achieve them; be aware of the responsibility of parenting; and possess self-esteem, sense of control, knowledge and skills to make informed decisions about sexual behaviour and conception. As part of these sessions, the intervention participants were encouraged to write their thoughts and feelings, in general and about the mentoring experience, in a journal.

Finally, participants also receive mandatory one-to-one sessions with a trainee counsellor 2-3 times during the programme. Counsellors working with the T&T programme generally contributed their time in partial fulfilment of requirements for a counselling qualification.

Participants successfully completing the T&T programme could achieve a National Award in Interpersonal Skills, Level 1 (NCFE). (See Appendix A for the Teens & Toddlers intervention logic model.)

**Table 1.** *The Teens & Toddlers multicomponent positive youth development programme for the prevention of teenage pregnancy*

<b>Intervention length</b>	18-20 weeks, 1 day a week, 3-4 hours a day
<b>Recruitment (2 phases)</b>	1. Schools are recruited from areas (boroughs, districts) with high rates of teenage pregnancy. 2. Teachers and other school staff responsible for inclusion, discipline and/or pastoral care identify students
<b>Participants</b>	Students between the ages of 13-15 considered to be at high risk of teenage pregnancy
<b>Activities</b>	Classroom curriculum focused on child development, effective parenting skills, anger management, sexuality and relationships Mentoring young children between the ages of 3-5 who are thought to be in need of additional learning or emotional support in a nursery or primary school setting Meetings with a trained counsellor for hour-long one-to-one sessions.
<b>Award</b>	National Award in Interpersonal Skills, Level 1 (NCFE)

### *The Targeting Strategy*

The T&T programme identified participants by targeting at two levels: First, schools were recruited from areas (boroughs or districts) with high rates of teenage pregnancy. Second, teachers and other school staff responsible for inclusion, welfare, discipline and/or pastoral care at these schools were asked to identify and select, typically female, students between the ages of 13-15 considered to be at high-risk of teenage pregnancy to participate in the intervention. To assist with the targeting process, the T&T programme provided schools with a “selection tool” or checklist of risk factors that the intervention designers believed were associated with teenage pregnancy, such as disengagement with school, engagement in sexual behaviour and low self-esteem (Appendix B).

Young women who were identified by the school staff as at risk for teenage pregnancy were invited to attend an informational meeting where a representative from the T&T programme described the intervention. The potential programme participants were asked to complete a brief survey and were given personal and parental consent forms for the purposes of the intervention. The young women were not told how or why they had been selected or about the programme’s focus on teenage pregnancy. The personal and parental consent forms mentioned that the programme included information on sexual health, but did not state why the young woman had been selected. Limited provision of information about the purpose of the programme and how participants were selected was a conscious effort by the T&T programme and school staff to avoid stigma and to encourage young women to participate (Jessiman et al., 2011, pgs. 22-23).

### *Data sources*

The data used for this research were collected as part of a DfE-funded evaluation of the T&T programme (Jessiman et al. 2011). Researchers at NatCen and LSHTM undertook an RCT, including a formative component and integral process evaluation, to examine the success of the T&T programme at reducing risk factors for teenage pregnancy, including timing of first sex, use of contraceptive methods

and levels of self-esteem. The individual-level RCT, including 493 young women, was conducted in 22 schools, starting in September 2009. Half of these schools (N=11) were in the greater London area; three were in Middlesex; three in Lincolnshire; one in north Yorkshire; two in Lancashire; and two in Greater Manchester. Each participating school was linked to a local nursery or primary school as stipulated by the T&T intervention.

The T&T programme offered in the 22 schools that participated in the RCT was 17 weeks in length and delivered between September 2009 and August 2010. Normally, outside of the RCT, the first 6-8 students submitting signed personal and parental consent forms would be accepted onto the programme. In the RCT, young women who were selected and returned the consent forms were then randomised to either participate in the T&T intervention, or to serve as comparisons or as replacements in the event of participant drop-out. Comparisons and replacements were not offered any additional intervention. Data for the RCT were collected at three points in time via self-completion questionnaires: prior to random allocation (baseline), immediately following the intervention, and one year later. The specific measures, analysis and results of the RCT are published elsewhere (Bonell et al., 2013).

During the RCT, the programme evaluators also offered schools a list of evidence-based risk factors for teenage pregnancy to assist school staff with the selection of appropriate programme participants (Appendix C).

Process evaluations assess the implementation, receipt and setting of an intervention (Oakley et al., 2006). Integration of outcome and process evaluation data can facilitate the exploration of, particularly multi-component and multi-site, interventions to assess any variation in intervention delivery across contexts, determine the pathways through which the intervention may impact upon outcomes, and explore how different sub-groups respond to the intervention (Strange et al, 2006; Harden et al., 2006). These studies also help to establish whether there are faults in the intervention itself or whether the delivery inhibits its effectiveness. Process evaluations have been found to be crucial to understanding the mechanisms through which an intervention or programme is

implemented and are fundamental to its success or failure (Brackett-Milburn and Wilson, 2000).

The process evaluation was conducted simultaneously to the RCT (Figure 4) and aimed to explore the feasibility, fidelity, accessibility and acceptability of the intervention. Additionally, the process evaluation aimed to review the method by which young women were selected by school staff to participate. The integral process evaluation for the evaluation of the T&T programme focused on qualitative data collected from four case-study schools participating in the RCT. The case-study schools were all based in London, as this was more convenient for the London-based evaluation team. From the sample of 11 London schools, the four schools chosen for participation as case-study sites were purposively selected based on: (1) their level of experience of the T&T programme (for some schools the RCT was their first time delivering the programme but other schools had previous experience); and, (2) their Ofsted<sup>3</sup>-ratings ('good' versus 'satisfactory'). The rationale being that it was important to include schools with different levels of experience working with the T&T programme and academic performance, as these characteristics may influence the delivery of the intervention. Table 2 provides a selection of socio-demographic characteristics for each of the boroughs included in the case study for the first year of the evaluation.

**Table 2.** *Selection of socio-demographic characteristics of London Boroughs where case studies were conducted*

<i>% non-UK born, 2009</i>	
School 1	53.0
School 2	38.8
School 3	33.3
School 4	28.2
Greater London	33.8
United Kingdom	11.4
<i>% of population who are Black, Asian or Minority Ethnic (BAME), 2013</i>	
School 1	64.9
School 2	50.2
School 3	46.9
School 4	39.6
Greater London	41.8
England	14.6

<sup>3</sup> Ofsted (Office for Standards in Education, Children's Services and Skills) inspects and regulates services for children and young people, and those providing education and skills for learners of all ages in the UK.

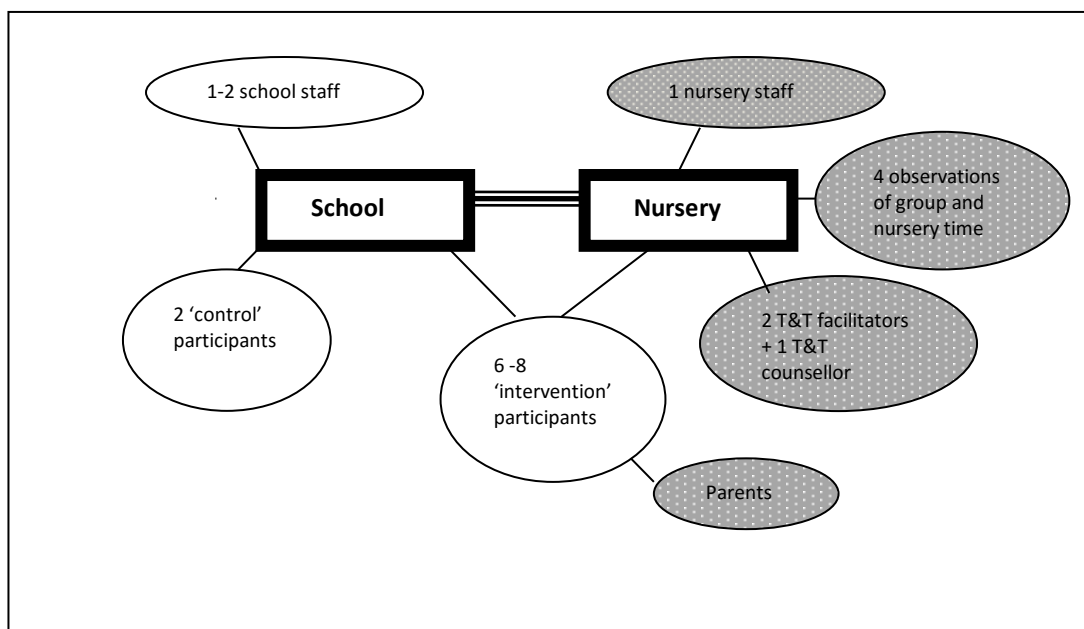
<i>Teenage conception rate, 2009 (per 1000 young people under 18)</i>	
School 1	38
School 2	37
School 3	63
School 4	59
Greater London	41
England	38
<i>% of 16-18 year olds who are NEET*, 2009</i>	
School 1	4.6
School 2	4.7
School 3	8.7
School 4	6.6
Greater London	5.3
England	<i>not available</i>


\* NEET = Not in Education, Employment or Training.

Source: London Data Store: <http://www.data.london.gov.uk/dataset/London-borough-profiles>

In each case study school, for the purposes of the process evaluation, data were collected from the young women in both the intervention and comparison arms of the RCT, school staff responsible for implementing the programme, T&T facilitators and counsellors and nursery staff (Figure 3).

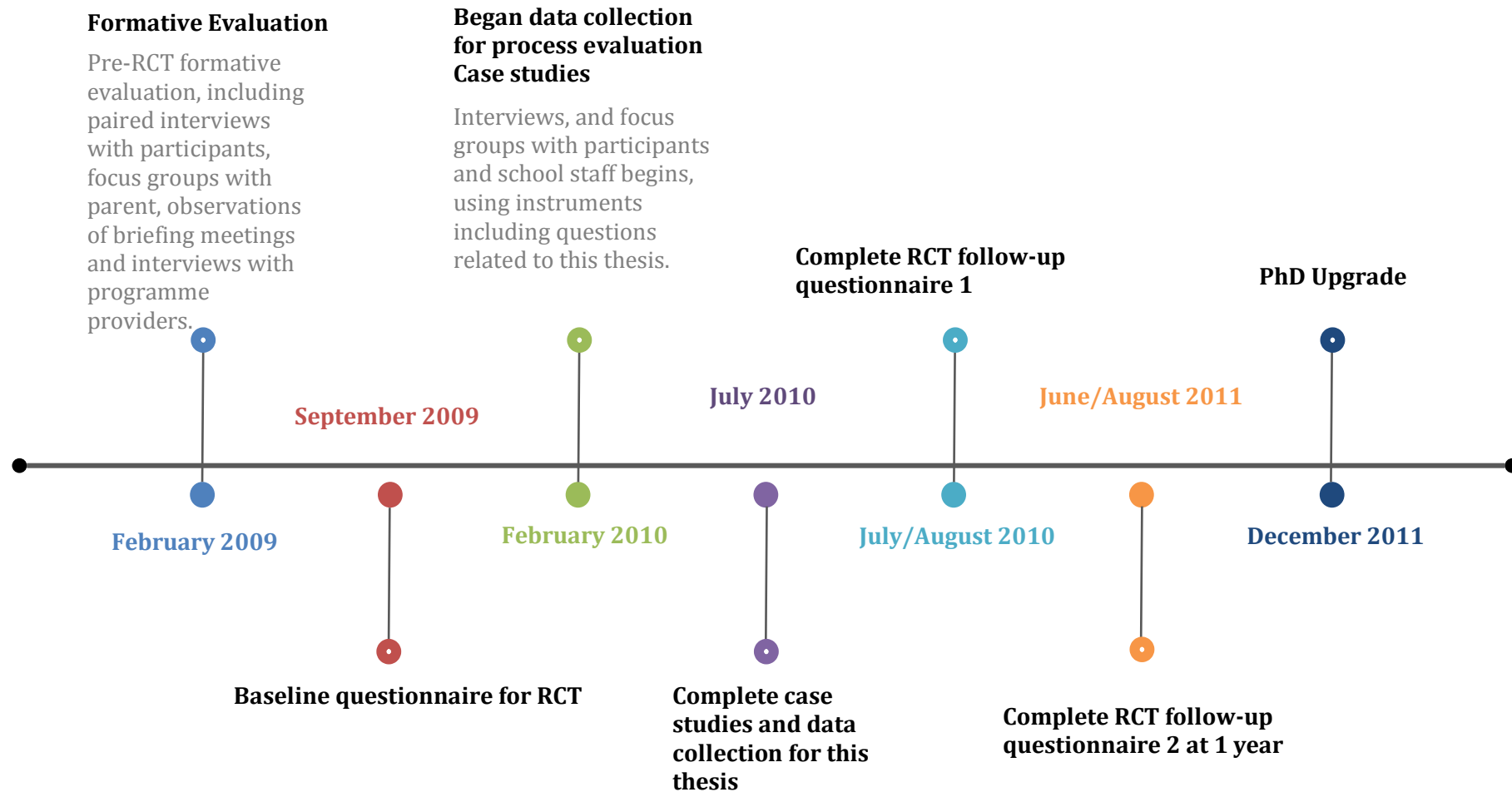
**Figure 3.** Case study plan for the process evaluation of T&T intervention (2010)



 Data was not included in this research.

Adapted from: Jessiman et al. 2011.

**Figure 4.** Overall project and data collection timeline



Following the formative phase of the evaluation of T&T, I included additional questions to the semi-structured topic guides to be used in the integral process evaluation to address the research questions I posed as part of this doctoral research (Appendix D). During the field work phase, data for the process evaluation and this thesis were collected simultaneously by a NatCen Researcher and me.

### *Data collection methods*

Throughout the 17 weeks of the programme, as part of the process evaluation, we conducted semi-structured participant observations of different aspects of programme provision: initial information sessions, classroom sessions, mentoring in the primary and nursery schools, and awards ceremonies. As these data were collected inconsistently and as my focus was on the perspectives of young people and school staff, I did not include the observations in my analysis for this thesis. However, I kept field notes in a diary to document my experience collecting data. Field notes can serve a number of purposes in research. My notes were mostly a record of what I observed during the field work, but I also used the diary as a personal journal where I documented my feelings and reactions to what I experienced while collecting data (Neuman and Robson 2009).

This thesis comprises data collected from the young women who participated in the intervention and comparison arms of the trial and school staff responsible for the selection of students for this thesis, as these data were most appropriate for answering my research questions. In addition to excluding the data from the observations, I also excluded data from nursery staff, counsellors and parents.

In research with the young women, a sequence of qualitative data collection methods were used as part of the evaluation to build mutual respect, trust and rapport with the young women and encourage them to speak openly about their experience of the intervention (Alderson and Morrow, 2004). Furthermore, this process allowed space for young women who were reluctant to participate in the larger focus group setting to more comfortably share their thoughts in paired and/or one-to-one interviews.



Together with a researcher from NatCen, I conducted two focus groups (4 total) with approximately 5 participants in each group (n=20); paired or triad interviews (8) with 12 participants overall; and 15 interviews with individual participants (Table 3). All participants who were available on the day of data collection participated. In the focus groups, we engaged with participants using a range of interactive methods, including vignettes and flash cards. The focus groups and interviews focussed largely on the participants' experience of and perceptions of recruitment, the acceptability, fidelity and impact of the programme, and possible causal explanations of the impact of the programme. The interviews conducted with the comparison participants (n=8) in the study took place towards the end of the programme and focused on issues important for the RCT, such as the potential for contamination and confounding, but also about their perceptions of the programme, the selection process and the young women who were selected to participate in T&T (Table 3).

**Table 3.** Summary of data collected from young women at each case study school and used in this research

	School 1	School 2	School 3	School 4	TOTAL
<b>Young people</b>					
Focus groups with participants (each including 5 young women)	1	1	1	1	4
Paired/Triad interviews with participants	1 x paired 1 x triad	1 x triad	2 x paired	3 x paired	8 (18)*
In depth interviews with participants	5	3	3	4	15*
In depth interviews with comparison participants	2	2	2	2	8

\*Some students who participated in the focus group dropped out of the programme by the time the interviews were conducted.

Though the evaluation team did not collect information beyond name and year of study during the focus groups and paired interviews, we collected information on age, ethnicity and information about with whom the young women in one-to-one interviews with the same young women (Table 4).

As part of the process evaluation, we also interviewed 17 school staff responsible for the selection of young women in 12 of the 22 schools included in the RCT. These were typically one or two staff from each school responsible for the

selection of participants for the intervention. An initial 9 school staff participants were conveniently drawn based on their availability from London-based schools participating in the RCT and a further 8 from schools in the north of England. These interviews covered: the criteria used to select young people for the programme, the use of the guidance provided by T&T and by the evaluation team, confidence in the selection of participants and the anticipated impact of the programme on the young women.

All the interviews and focus groups were conducted in private spaces on-site either at the school or the primary school/nursery where the intervention was taking place. At each data collection moment, the participant was provided with an information sheet about the study and asked for verbal consent to participate. Focus groups with young people typically lasted between 90 minutes and 2 hours, and interviews with young people lasted between 60-90 minutes. The interviews with school staff were conducted in private spaces at the school, or by telephone, and were also recorded and transcribed. Each of these interviews lasted between 30 and 45 minutes. The interviews were recorded using hand held tape recorders and later fully transcribed by staff at NatCen for the purposes of the evaluation. Throughout the study, NatCen stored these files under password protection on their premises. I was provided with the relevant transcripts to analyse for my doctoral research. Once I had access to the relevant transcripts, I also stored these under password protection on my desktop computer. The research ethics committees of NatCen and LSHTM granted approval for the overall study.

**Table 4.** *Characteristics of young women interview participants*

	<b>Age at the time of interview</b>	<b>School year</b>	<b>Ethnicity**</b>	<b>Family life</b>
<b>SCHOOL 1*</b>				
Interview 1	14	9/10	Black or Black British	Lives with both parents; four brothers and two sisters
Interview 2	14	9/10	Black or Black British	Lives with mother; two brothers and one sister
Interview 3	14	9/10	Black Caribbean	Lives with mother; young brother and younger sister
Interview 4	14	9/10	Black or Black British	Live with mum; has an older sister no longer at home; father has stepdaughter with girlfriend
Interview 5	14	9/10	<i>No response<sup>†</sup></i>	Lives with both parents and has four brothers and one sister
Comparison 1	14	9/10	Black British	Lives with mother and six siblings
Comparison 2	14	9/10	Black British	Lives with mother, father, sister and brother.
<b>SCHOOL 2</b>				
Interview 1	14	9	Mixed English	Has one sister [No information on parents]
Interview 2	14	9	Asian	Lives with mother, two sisters, cousin and nephew.

Comparison 1	14	10	Black British	Lives with mother, father, sister and brother; is the youngest child
Comparison 2	14	9	Data not collected	Lives with mother and father and has 2 brothers and 2 sisters; only one brother and one sister live with them
SCHOOL 3				
Interview 1	14	9	Black Caribbean	Lives with mother, sister and two nieces; and occasionally another niece comes to stay
Interview 2	14	9	Polish	Only child and lives with mother and father. Emigrated from Poland to UK when she was 11.
Interview 3	14	10	Black	Lives at home with 5 brothers and sisters, mother and stepfather
Comparison 1	14	9	<i>Data not collected</i>	Lives with mother, grandmother and sister
Comparison 2	14	9	Mixed Caribbean	Lives with mother, father and sister and brother two brothers
SCHOOL 4				
Interview 1	14	<i>Data not collected</i>	White	Lives with mother, father,
Interview 2	13	<i>Data not collected</i>	White	Lives with mother, two younger brothers, mother is expecting
Interview 3	14	<i>Data not collected</i>	White	Lives with mother and stepfather; has two brothers
Interview 4	14	<i>Data not collected</i>	White	One brother and one sister [No information on parents]
Comparison 1	14	9	Data not collected	Lives with father and two sisters

Comparison 2	14	9	Data not collected	Has an older brother and a younger brother <i>[No information on parents]</i>
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\* Students moved from year 9 to year 10 within the same school year

\*\* Students identified their ethnicity

† Respondent chose not to respond

**Table 5. Roles of school staff participating in interviews**

SCHOOL 1	
Teacher 1	Lead Learning Mentor
Teacher 2	Lead Learning Mentor
SCHOOL 2	
Teacher 1	Director of Learning for Year 10; Lead teacher and advisor for extended learning program; Sports science teacher
Teacher 2	Director of Health Sciences
Teacher 3	Director of Learning for Key Stage 4, Year 10
SCHOOL 3	
Teacher 1	Pastoral mentor for year 9
Teacher 2	Year 9 classroom mentor
SCHOOL 4	
Teacher 1	Pastoral liaison worker for year 9
Teacher 2	House support officer; Pastoral support
SCHOOL 5	
Teacher 1	Assistant head teacher
SCHOOL 6	
Teacher 1	Learning support unit manager and extended services person
SCHOOL 7	
Teacher 1	Teacher, Key Stage 3/4 Science; Deputy Head for year 9; Pastoral manager
SCHOOL 8	
Teacher 1	Leader of professional behaviour
SCHOOL 9	
Teacher 1	Inclusion manager
SCHOOL 10	
Teacher 1	n/a
SCHOOL 11	
Teacher 1	Assistant principal in charge of inclusion
SCHOOL 12	
Teacher 1	Assistant head teacher in charge of child protection care and guidance

*The analytical approach*

For my doctoral research, I adopted techniques associated with phenomenology and thematic analysis (Creswell, 2007). Phenomenology is the study of experience. It involves “distilling experiences into essences” or the core meaning of a dynamic structure, experience or other phenomenon – that is, the essential features of a phenomenon for which the phenomenon would cease to exist if withdrawn - to achieve new and deeper patterns of understanding (Creswell 2007). The aim of the approach is to determine the meaning of an experience for the individuals having the experience. Through considering this experience from the perspective of several people undergoing it, a researcher can draw general understandings of the essence of the experience (Moustakas, 1994).

I felt a phenomenological approach was appropriate to achieve the aims of this research as it allows for the description of the “meaning” of the experience of a particular phenomenon – in this case, participation in a targeted PYD programme for teenage pregnancy prevention - from the perspective of several individuals who have experienced the same phenomenon. I chose to develop this thesis around the principles of phenomenology because I was interested in understanding the experience of the intervention and the process and experience of targeting and was not interested in specific cultures, social groups, or other aspects of the experience (Van Manen 1990).

Husserl believed that experience should be examined in the way that it occurs; on its own terms (Smith et al., 2012). Human beings connect with the world through being in it. Human knowledge arrives through our interactions with the world – and not only in the mind (Husserl, 1999). Phenomenology asserts that individuals tend to go through life without reflecting upon their experiences – without delving deeper into their meaning and rather rely on culturally induced assumptions as a means of interpreting life experiences at a superficial, surface level. Thus, the experience of being and connecting with the world is largely unconscious, unless one intentionally brings the experience into conscious awareness by turning toward and reflecting upon it (Turner, 2009).

Phenomenological research is focused on taking a researcher into an unknown life event “such that the knowledge gained adds significantly to the body of knowledge about the phenomenon” and leads to new research to help learn more about the phenomenon. The focus is on “intentionality or turning toward the phenomenon and bringing it into conscious awareness”. However, turning toward intentionality reframes the phenomenon in the researcher’s mind such that the experience becomes new and fresh – this approach allows the “manifold” to emerge, or the variations on perceptions of the various subjects’ recollections that when taken together present something new about the lived experience that had not been before considered (Moustakas, 1994). As new structures and textures are found, the phenomenon can be reduced down to its essential themes. The idea is that reflection, through the perceptions of the researcher experiencing the event and eliciting the perceptions of others who have experienced the phenomenon, will yield deeper understanding.

Phenomenology assumes that the importance or key features of the experience actually lie “behind it” and that this is only likely to be discovered through phenomenological reflection. To approach an understanding of the true nature of a phenomenon, an exploration of a lived experience should be multi-dimensional and investigate different perspectives on the experience (Turner 2009). Through this process, the researcher locates commonalities across the experiences, identifies clues to the essential nature of the phenomenon and discovers leads to new research that further facilitates understanding (Turner, 2009). The method takes the experiences of individuals and reduces them to a description of its “universal essence” and illustrates what all participants have in common as they experience a phenomenon to understand what, but also how, it was experienced. This description allows those who have not undergone the experience themselves to gain some insight (Creswell 2007).

Phenomenological reflection and reduction, employed after data collection, suggests that through description, the hidden meaning of a phenomenon will emerge and eventually lead to deeper knowledge (Creswell, 2007). It aims to address two central questions:

- What was experienced in terms of the phenomenon?
- What contexts or situations have typically influenced or affected the experience of this phenomenon?

(Creswell, 2007)

The researcher aims to come to “epoche” where one suspends or “brackets out” previous assumptions about a phenomenon observe it as if for the first time (Englander 2016; Creswell 2007; Moustakas, 1994). In reading the literature on epoche in preparation for this work, there is a lot written about what it is but very little on how to do it. In order to attempt to suspend my judgements, I had to be initially clear on what they were. During the formative evaluation and the process evaluation, I often took field notes to document my thoughts at the time. Furthermore, I was very cognisant of the reasons why I wanted to undertake this research and made further note of these. Later, in the chapter Role of the Researcher, I discuss how I used these notes to attempt to “bracket out” my



preconceived notions about the T&T programme, the study participants and the process of targeting employed by the school staff.

Central to the phenomenological approach is the presence of empathy when engaging with the stories of the experience of the phenomenon under investigation. To achieve an empathetic position with the young women, I sought to do the following during data collection and in analysis:

- See the world as the young people see it;
- Understand their feelings;
- Be non-judgmental;
- Communicate my understanding

(Brown, 2007; Wiseman, 1996)

I based my analysis on the principles of the Giorgi 5 step approach (1979). The approach appealed to me because of its emphasis on immersion and iterative engagement with the data, as I believed that such an approach would facilitate my goal to understand the experience from the perspective of the study participants:

1. Immersion in the data to get an intuitive sense on the whole phenomenon;
2. The process is repeated but now the researcher is concerned with the analysis of the data to try and locate units of meaning or statements;
3. When all the units of meaning are defined, the researcher searches for relationships and essences with the explicit aim of identifying meaning and psychological insight.
4. In the last step, the researcher synthesises the “transformed meaning units” into a consistent statement, called a “situated structural description” regarding the subjects’ experience and focused on the phenomenon.

(Moustakas 1994)

For each of the research questions, I analysed the data first by using a process of horizontilisation whereby I first highlighted significant statements, sentences or quotes that provided an understanding of how participants or school staff experienced the phenomenon – the T&T PYD intervention. This information was then reduced to notes or sections of text and printed onto small pieces of paper.

These statements or quotes were then reviewed, refined into a final set of meaning units and clusters of interconnected meaning units (Smith et al, 2009), including superordinate and subordinate units (Appendix E for examples) (Table 6). I recognise that I probably conducted the fourth step less than typical phenomenological papers because I wanted to appeal to a public health and sociological audience.

All of the transcripts were then entered into NVivo. After having engaged with the data several times using pen and paper, I wanted to formally code the transcripts using the meaning units emerging from the data to understand how accounts varied across actors and contexts. Using the established meaning units, I returned to the transcripts in NVivo and coded the texts line by line using the meaning units as a coding frame. I undertook constant comparison analysis of the coding frame refining the meaning units and the codes during this process. When the text was coded in NVivo, I crosschecked the data by collection method (focus groups, paired interviews and single interviews with young women and interviews with school staff) and noted any significant inconsistencies or deviant cases. The intention was not to confirm veracity of the accounts, rather, triangulation provided alternative perspectives on the same phenomenon to potentially reveal its other dimensions that may not have presented themselves in the interviews and/or shed additional light on weaknesses in the interview data (Creswell, 2007; Green and Thorogood, 2004; Mason, 2002). This process provided me with a description of the essence of the experience of participating in the T&T intervention that helped to respond to my research questions.

**Table 6.** Example meaning units, themes clusters and codes generated to understand young people’s experience of the PYD programme [Evidence Chapter VI].

<b>Theme cluster 1</b>			<b>Theme Cluster 2</b>				<b>Theme cluster 3</b>		
Building confidence			Connecting and engaging with adults in the programme				Learning about yourself		
<b>Meaning unit 1a</b>	<b>Meaning unit 1b</b>	<b>Meaning unit 1c</b>	<b>Meaning unit 2a</b>	<b>Meaning unit 2b</b>	<b>Meaning unit 2c</b>	<b>Meaning unit 2d</b>	<b>Meaning unit 3a</b>	<b>Meaning unit 3b</b>	<b>Meaning unit 3c</b>
“A boost”	Overcoming a challenge	Purpose, accomplishment and growth	Making connection	Learning to build intimacy	Discomfort/ invasion of privacy	Not respected by adults in the programme	Being vulnerable	Learning life lessons	“I’m changed”
<b>1a codes</b>	<b>1b codes</b>	<b>1c codes</b>	<b>2a codes</b>	<b>2b codes</b>	<b>2c codes</b>	<b>2d codes</b>	<b>3a codes</b>	<b>3b codes</b>	<b>3c codes</b>
Creating options	Working with children challenging and fun/ Frustrating	Building confidence	An adult you trust to talk to	Enjoy making toddler happy	Facilitators are repetitive	Cannot understand the teachers	Expressing my feelings	Taking responsibility with regard to risk	Adults treat me with more respect now
Increased concentration in school	Children unpredictable and difficult to control	Freedom and creativity	Appreciate real life experience	Improving my relationships	Pushy and prying	No mutual respect	Help with believing in myself	Self-worth	Empathise with parents
Desire to further education	Exhausting activity	Fun and accomplishment	Awkward moments with facilitators					Choice and independence	Change what people think of you
Trying out a potential career	Facilitators coach us	Proud of skills in working with children	Building relationships with children					Encourages self-reflection and self-realization	
	Facilitators create a safe environment for children	Learning new things	New respect for adults					Getting a “reality” check	

	and young women								
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## **Chapter IV. The Role of the Researcher**

I believe that all investigation is shaped by the investigator's perspective and experience (Thoresen and Öhlén 2015; Creswell, 2007). As a qualitative researcher, I am aware that my thoughts, feelings, experiences, expectations and presentation shaped the process and result of this research. As the researcher telling this particular story, I am cognisant that my participation in this study influenced the meaning of the findings to the extent that another researcher investigating similar themes may have approached the investigation differently, constructed distinct relationships with the study participants and the data, and produced an alternative story.

Indeed, my mere engagement with study participants may have influenced how they responded to my inquiries. Their presumptions about my ideas, beliefs and expectations influenced their reactions to me (Cooley, 1902). I agree with Finlay when she stated: "Research is thus regarded as a joint product of the participants, the researcher, and their relationship: It is co-constituted" (Finlay 2002). Van Manen (1997) took a step further and described the role of the researcher in phenomenology as active. The interaction is not simply one akin to viewing phenomena through a particular lens; the researcher mediates between the different meanings of a lived experience.

This thesis is a reflection of my interpretation of the phenomenon of PYD and the targeting strategy used in the T&T programme. This interpretation, in turn, is based on my culture, social class, nationality, gender and personal politics (Creswell, 2007). Therefore, articulating how my involvement, my "role as the researcher", and the subjective and intersubjective features of this study may have shaped its development provides additional illustration of the social context within which this investigation took place and thus a deeper understanding of the perspective it represents and interpretation of the findings (Moustakas, 1994). Furthermore, such a reflexive exploration bolsters the integrity and trustworthiness of this work (Green and Thorogood, 2009; Finlay, 2002). In this chapter, I explore how my perspective, position, and presence manifest in this thesis.

### *My perspective*

My epistemological perspective is interpretive. I believe that experience is socially constructed and varies depending upon the cultural, social and historical context within which that experience resides. I believe that the interpretation of experience is furthermore mediated by the subjectivities of the actor(s) involved (Creswell, 2007). Reality is thus shaped by what individuals believe to be real, rather than some objective, measurable truth (Neuman and Robson, 2009; Green and Thorogood, 2009). This perspective can be contrasted with positivism, the view that social science research should be approached similarly to the natural sciences. A positivist approach to research suggests that social reality is comprised of a set of value-free and objective facts. The intention with such research is to develop a logical and causal law, which can be replicated in subsequent research (Neuman and Robson, 2009). Though I have borrowed from positivist techniques to organise my thinking and interpretation in this analysis, as I describe below, my emphasis is on the importance of the interaction and the acknowledgement of the influence of a variety of social forces on human experience (Creswell 2007). Although it was not my intention with this work to determine whether the T&T intervention was successful at preventing teenage pregnancy (this objective was addressed elsewhere), I believe that through interaction with the young women and school staff who were involved in the intervention, I learned and was able to induce the meaning of the experience to provide insight into how such interventions may lead to certain outcomes in sexual health and other risk behaviours among young people.

It is important in contextualising this thesis for me to present my perspective on young people's sexuality, sexual health and teenage pregnancy. Sex, sexual health, sexuality and sexual rights are topics that evoke strong sensibilities, and generate a number of viewpoints and agendas, particularly when applied to the lives and behaviours of young people. I take a public health perspective on young people's sexual health in accordance with the WHO's holistic definition of sexual health and sexual rights; excerpts of which are found below, respectively (WHO 2010):

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2010)

“Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination
  - the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
  - the right to privacy
  - the rights to the highest attainable standard of health (including sexual health) and social security
  - the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
  - the right to decide the number and spacing of one's children
  - the rights to information, as well as education
  - the rights to freedom of opinion and expression, and
  - the right to an effective remedy for violations of fundamental rights.”
- (WHO 2010)

In my view, the principles above pertain equally to young people as to adults. In line with my interpretive epistemological perspective, for me sexuality is socially constructed, context and culture dependent and shaped by local and temporal cultural norms and values (Moore and Rosenthal, 2006). I believe that young people should be free to enjoy and explore their sexuality while also maintaining their social, physical, psychological and emotional health and wellbeing. I also trust that in some contexts preventing early pregnancy and parenthood potentially increases the likelihood of positive opportunities, outcomes and life chances for young people; and, that for some young people becoming a parent in their teenage years is an uplifting and rewarding experience (Anwar and Stanistreet 2015; O'Brien Cherry 2015; Middleton 2011; Arai 2009; Duncan 2007; Seamark and Lings 2004).

My perspective is intertwined with my position or place in my social world. Though I discuss them separately in this chapter, the distinction is somewhat artificial. In reality, my beliefs are product of my position and my perspective shapes how I interpret and experience my position.

### *My position*

My first awareness of the importance of my position to this work was my initial engagement with the T&T programme as part of the formative evaluation. As previously indicated, my initial engagement with T&T via the formative evaluation prompted curiosities about PYD and targeting, and ultimately formed the origins of this study. Though my colleagues shared my interest in these issues, I believe that my position – my gender, race/ethnicity, nationality and social class, and the interconnection of these – added a further dimension to my conceptualisation of these as important issues to be explored in research.

I believe that my identity influences my observations, characterisations of problems and my formulation of potential solutions. As a woman, I was troubled by the notion implicit in the design of the T&T programme that young women were tacitly being made responsible for addressing the issue of teenage pregnancy as it was emerging in the communities in which they lived and the schools that they attended. Teenage pregnancy has long been characterised as a problem of women (Luker, 2000). Though policies and interventions increasingly focus on and include young men in efforts to increase safe sexual behaviours, and decrease unwanted pregnancies and the transmission of STIs, including in the TPS (SEU, 1999), there remains a latent belief, exemplified in the design of the T&T programme among others, that the greatest responsibility for prevention lies with women (Barcelos, 2014). This programme's design potentially served as perpetuation of the pathologising of women's bodies (Greer, 1970) in general, and a further exertion of biopower and regulation of the teen female body (Barcelos, 2014). I did not directly explore these issues in my research, but this concern served as part of the root of my problematisation of aspects of the T&T programme approach.

I can also be described as Afro-Caribbean, West Indian American and/or African American depending upon my location and the vantage point of the observer. This aspect of my identity is ever-present for me, and potentially for others. In fact, it is commonly more present for me than my gender (Hooks, 1982). During the formative evaluation, I was not surprised when I entered the informational sessions for the T&T programme and found the room filled with young people



from disadvantaged and/or BME backgrounds; I had seen it before. In my personal experience, particularly for individuals in positions of authority, my race and ethnicity indicated poverty, unstable family situation, academic struggle and under-employment, overt sexuality and promiscuity, early and out-of-wedlock pregnancy, and aggressive and argumentative “attitude”, in line with common stereotypes of people from the African diaspora, or some “lite” version of these. I wondered if this was happening in the T&T programme and, more importantly for me, whether the young women participating in the programme perceived this as I did, and if so, how it felt. However, I was also aware that the young women might not have shared my viewpoint. Particularly as issues of race, ethnicity and social class are produced from a different social history in the UK, but also because my socio-economic background and level of education was different from the young women I engaged with in this research. Combined with my position as a woman, I felt the need to ensure that these young women’s voices were heard, but I was also conscious that their voices might be different from mine.

How the study participants interpret my position with regard to my race, ethnicity, nationality and gender is not inevitable (Fryer et al., 2015). The reading of these dimensions of my persona depends upon the particular social, cultural, political and economic context in which they manifest. Furthermore, the subjectivities of the study participants represent an additional layer through which they interpret my position in their social worlds. This is true for the adults and the young people included in this study (Connelly, 2008). In this thesis, I accept that dialogues on race, gender and social status are context-specific and that it would be remiss to make assumptions. Furthermore, I understand how responses to me may be influenced by my position; there are things that the participants would have been willing to say or not in my presence (Connelly, 2008). I contemplated whether themes around race would have been so openly discussed had I been white (Connelly 2008), and indeed no conversations about race emerged in discussions with my colleague.

For the school staff, I did not fit into a mould of the UK so they may not have known how to pitch the arguments they were making. However, as they were aware that I am a researcher, they may have assumed that education was

important to me and that I believed that it was positive to avoid teenage pregnancy.

As an adult researcher working with young people, a dynamic, most likely that of power differential (Alderson and Morrow, 2004) is introduced into the interaction that is beyond the expected imbalance between the researcher and the “researched” (McLaughlin 2015). The unequal power relationship represents intergenerational inequalities and the “power dynamics of age” (Mayall 2000; Morrow and Richards 1996). This power differential is magnified in a school. In fact, in the early stages of data collection, some of the young women participating found it challenging to call me “Annik” instead of “Miss”. Though some researchers working in schools may not choose to present themselves in this way (Mauthner 1997), I believed that calling me by my first name made an important distinction between myself, as the researcher, and the teachers and school staff as the authority in the school context. Furthermore, it minimised my role as an adult.

As I explained in the methodology, the evaluation team took additional steps to build rapport and ensure the authenticity of the study participants’ accounts of their experiences (Jessimen et al., 2011), including providing ample opportunity for the participants to voice their views, and using group interviews (Kirk, 2007). Furthermore, the evaluation team explained the study and what we were hoping to learn from speaking with them (Mauthner, 1997). However, though the power differential may have diminished it could not have been eliminated.

As much as my position brought a fresh perspective to this research, it could also have influenced the objectivity that is essential for its integrity. I decided to employ a phenomenological approach to this research as it offered specific techniques for prioritising and maintaining objectivity and allowing the research subjects and data to present the phenomenon under investigation with little to no preconceived notions about the story to be told. The researcher aims to “bracket out” their experiences and existing beliefs and view the phenomenon as it is, as it presents itself and without including other information or perceptions or presumptions the researcher may have about it. The intention is to arrive at “epoche” where the researcher suspends all pre-understandings, pre-judgments and theories and

comes to terms with their assumptions (Moustakas, 1994; Creswell, 2007; Englander, 2016). Englander (2016) states:

“Utilizing the epoche does not mean that one forgets everything one previously knew to arrive at a kind of blank state, but rather that one brackets one’s natural attitude; that is, one invites a shift in attitude in order to look at the subject matter” (pg. 4)

For Moustakas (1994), in phenomenology, a phenomenon is “perceived freshly, as though for the first time...” though, he believed that this was rarely achieved. I do not believe that I successfully attained a sustained state of epoche during this research process, nor do I believe that this is likely for any researcher, as through the development of the research project and collecting data they will have formed opinions and potentially biases about the phenomenon. For me, my curiosity about the T&T programme and development of instruments to investigate this phenomenon occurred before the explicit development of this research, so I was already influenced and could not “suspend” this. However, I used the principles of phenomenological epoche to draw explicit awareness to this influence. Though I was unable to entirely “bracket” out my preconceived notions, in acknowledging them I was continuously cognisant of how my perceptions may be shaping my research.

### *My presence*

As I describe above, I was aware of my “position” relative to the study participants during data collection and throughout the development of this thesis. I was also cognisant of how this and my “presence” as a researcher may have implications for the intervention experience and for the research. An excerpt from my field notes below illustrates my awareness of the effect of my presence during my first observation of one the T&T programme’s group time activities with two T&T programme facilitators and a group of participants (Appendix F):

“My feelings at the time: Obviously I stick out a bit because I am an adult with a funny accent that they have never met before, but sitting in the circle helped. My first impression of the girls is that they were respectful and obedient. All Afro-Caribbean Black and probably from low-income homes.”  
*Fieldwork notes, School 1, 17 March 2010*

My notes indicate my awareness of how my presence impacted upon the environment; I “stuck out”. Not only because I was new to the group, but also because I was different in many ways, including the way that I spoke. Later in the same fieldwork notes entry, I state “The facilitators thought they [the young women] were quieter than normal because I was present” (Appendix F); indicating that the impact of my presence was noticeable to the other adults in the room and that they also noted a difference in the behaviour of the young women which they owed to my presence. Such altering of behaviour, or reactivity, is unsurprising in the context of research (Neuman and Robson, 2009), particularly at the early stages of interaction with study participants. As described in the methods chapter, the step-wise approach the evaluation team took to engaging with the young people and building rapport was precisely to guard against this type of reactivity. I took additional steps, by sitting in a circle with the facilitator and the young people to reduce the distance between adult and young person, but also to begin to facilitate familiarity and rapport.

I similarly felt uncomfortable and awkward in some of my interactions with school staff, though the reason for this was different. I often sensed that the school staff resented the evaluation and the evaluation team’s presence. An excerpt from my field notes below illustrates a particularly frustrating day (Appendix G):

“It is clear that the staff do not want me here. I don’t want to be here either. They are the ones who want to be evaluated and I am just doing my job. I have no vested interest in the result of the evaluation. I wish they would [not] make the experience so difficult for me.”

*Field work notes, School 1, 23 June 2010*

My field notes were an important tool for formulating my understanding of the context and circumstances of the research. Further, as exemplified here, I was able to document my feelings, emotions, hunches and mood regarding the overall experience and release my stress (Neuman and Robson, 2009; Mason 2003). The field notes also enabled an acute awareness of factors that impacted upon my interaction with study participants and overall data collection.

As a result of my awareness of the school staff’s discomfort with the evaluation and presence of the researchers, I began every interview by explaining my role in the evaluation and that I had no vested interest in the outcome of the research; I only

wanted to hear their opinions and views about the T&T programme and the evaluation, whatever they may be. This approach appeared to “open the door” to candid discussions. Staff were generally happy to offer their honest views of the evaluation:

“Erm well the research has just made things a bit more difficult because it’s, you know talking [to] a bigger number of kids, more people to have liaise with you know more people you’re upsetting because you’ve removed them from a lesson to have a meeting, you know more emails because you have to tell people, you communicate more things to, it’s that really, that, that’s the difference, it’s just made it a little bit more complicated.”

*School 11, Teacher 1*

The introduction of my research may have altered the meaning of the experience of participation of T&T for the young women in the programme. There are places in the interview transcripts where it becomes clear that the questioning of the experience made the participant aware of aspects of their involvement in the programme to which they had been oblivious prior to the interview:

**Do you have any idea what the programme is trying to achieve?**

YW: To stop teenage pregnancy. [Chuckles]

**You think that’s what it is now?**

Yeah.

**You weren’t sure before you had this interview?**

Yeah.

**But now you think it is?**

Yeah.

**Okay. Yeah, all right. What do you think about that?**

Erm, [slight pause] I don’t like it.

*School 1, Comparison 1*

Further, the evaluation was very present for the study participants. In subsequent chapters, I will describe how, the young women particularly, confused the intervention with the evaluation. The T&T programme was a complex, multicomponent intervention that aimed to influence a number of features of young people’s experience in an effort to prevent teenage pregnancy. In order to evaluate the outcomes and processes of the intervention, the evaluation teams at LSHTM and NatCen devised an equally complex trial, including a complicated recruitment procedure and many phases and types of data collection. From my perspective as an evaluator and a researcher, the intervention and the trial were distinct. However, the young women and the school staff participants experienced both phenomena simultaneously and it was frequently unclear to them where the

intervention began and the research ended. Although in my analysis I interpreted their accounts as referring to the intervention, their perspectives may also have been influenced by their “experience” of the evaluation. In particular, the additional, but essential, step of randomising the young women the school staff put forward for the programme for participation in the trial was confusing for the young women (and possibly the school staff) and potentially obscured or further complicated both the experience of being targeted and the assessment of young people’s risk. This is common among trial participants who may develop strong opinions about the non-intervention of aspects of the trial such as randomisation or struggle to fully understand key concepts related to trials (Featherstone and Donovan, 1998; Bird et al., 2011).

The below excerpt from a focus group interview illustrates how some of the young women conflated the purpose of the intervention with the evaluation. In a focus group discussion, I asked the young women to complete a sentence written on a card with what they believed to be the purpose of the T&T programme and read out their responses to the group:

**And you guys? What did you, what did you say? Can you read it out?**

YW1: To help teens as they learn how to react to toddlers.

YW2: To help toddlers, to teach them discipline and social skills.

**Okay.**

YW3: And researchers, innit, understand the relationship and bond that is made and why.

*School 1, Focus group*

The influence of the evaluation team and the researchers was evident. In fact, in at least one instance, young women participating in a focus group compared (and appeared to prefer) the research process with the T&T intervention. The below interaction between two young women was recorded during a small group activity in a focus group session.

YW1: Don’t you think this is better than Teens and Toddlers, ‘cause we talk more here than...

YW2: ...And it’s not full on.

YW1: They talk about it, like, literally...

*School 4, Focus group*

This represents one of the numerous challenges associated with developing a trial to evaluate a complex intervention (Bird et al., 2011). During data collection, I

often had to take the time to explain to the young women and the school staff which parts of what they were experiencing were the intervention and which were the evaluation and I regularly asked for clarification on their responses.

Finally, as I mention above, as part of the evaluation, data collection with the young women and the school staff was shared with a colleague on the evaluation team. I have limited ability to be reflexive about how her perspective, position and presence may have influenced the data collection process. Some of the issues raised for me here, namely gender and researcher status, potentially manifested in similar ways in her interviews. However, her race, ethnicity, nationality and the intersection of these are distinct from mine and I cannot reflect upon them here.

**Evidence Chapter V. Young women’s lived experience of participating in a positive youth development programme: The “Teens & Toddlers” pregnancy prevention intervention**

The stand-alone research paper that forms this chapter is published as indicated below:

Sorhaindo, A., Mitchell, K., Fletcher, A., Jessiman, P., Keogh, P. and Bonell, C. (2016) Young women’s lived experience of participating in a positive youth development programme: The “Teens & Toddlers” pregnancy prevention intervention. *Health Education*, 116(4): 356-371.

The publication and permissions can be found in Appendix H.



**Young women’s lived experience of participating in a positive youth development programme: The “Teens & Toddlers” pregnancy prevention intervention**

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*Accepted for publication in Health Education: 9 August 2015*

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## **Abstract**

**Purpose** – Evaluation of the Teens & Toddlers (T&T) positive youth development (PYD) and teenage pregnancy prevention programme suggested that the intervention had minimal effectiveness partly due to its unclear theory of change. This study examines the lived experiences of young women participating in the programme to contribute to a clearer understanding of intervention process and potential mechanisms.

**Design/methodology/approach** – We conducted four focus groups (n=20), eight paired or triad interviews (n=12) and 15 interviews with young women participating in an RCT of the T&T programme in England, analysing these data using a phenomenological approach.

**Findings** – T&T provided some opportunities to experience the ‘five Cs’ that underpin PYD programme theory: competence, confidence, connection, character and caring. However, the young women did not experience the programme in a way that would consistently develop these characteristics. The lack of opportunities for skill-building and challenge in the activities constrained their ability to build competence and confidence. Some programme facilitators and counselors were able to achieve connections and caring relationships with the young women, though other adults involved in the programme were sometimes perceived by the participants as overly critical. The character development activities undertaken in the programme addressed attitudes towards sexual risk-taking.

**Originality/value** – Few studies of the PYD approach examine young people’s perspectives. This research suggests that the young women were not consistently provided with opportunities to achieve youth development within the T&T programme. In refining the programme, more thought is needed regarding how delivery of particular components may facilitate or impede a PYD experience.

**Paper type:** Research paper

**Word count:** 5998/6000

**Acknowledgements:** We would like to thank the English Department of Education for funding the larger study from which this work was developed, the Teens & Toddlers programme and all the young women who participated in this research.

## Introduction

Teenage pregnancy has been a major concern in the UK for decades. The UK government's Teenage Pregnancy Strategy (TPS) (1999-2010) (Social Exclusion Unit, 1999; DCSF, 2010) was associated with a decline in the conception rate for under-18s in England and Wales but did not meet the strategy's target of a 50% reduction. The current rate of 27.9 per 1000 women aged 15-17 remains the highest in Western Europe (Public Health England, 2014; Office of National Statistics, 2014; UNICEF Office of Research, 2013). The strategy included a focus on positive youth development (PYD) interventions as a means of prevention (Philliber et al., 2002; Kirby 2007).

PYD views young people as resources to be developed, rather than as problems to be solved (Pittman, Irby and Ferber, 2000). It seeks to promote social and emotional development by supporting young people to gain skills, knowledge and competencies (Roth et al. 1998; Catalano et al., 2002; Benson et al., 2004; Benson 2007). PYD stands in contrast to deficit models of treatment or prevention in that it focuses not merely on preventing problem behaviours but also on developing positive assets. Proponents argue that PYD should aim to develop five positive attributes: competence (including academic and social skills); confidence; connection (close relationships to family, peers and community); character (positive values and integrity); and caring (Roth and Brooks-Gunn, 2000). Similarly, the Development Asset Model identifies 40 features of young people's ecologies and resources that when enhanced contribute to healthy development (Benson, 1997; Benson and Scales, 2009; Lerner et al., 2011).

The argument that PYD and development of the five "C"s may be protective against adverse sexual health outcomes is supported by empirical evidence demonstrating that some of these assets, such as academic attainment and good relationships with teachers and parents, are associated with improved sexual health (Arai 2009; Allen *et al* 2007; Kirby 2007; Crawford *et al* 2013) as well as evidence that PYD interventions can reduce sexual risk (Gavin *et al* 2010). There is less consistent evidence that self-esteem is associated with reduced risk of teenage pregnancy (Goodson *et al*, 2006; Arai 2009).

While the broad aims of PYD are generally agreed, the conceptual basis for how PYD might reduce sexual risk behaviours is under-developed and there is a lack of consensus about which ingredients of programmes contribute most to effectiveness (Roth and Brooks-Gunn, 2003; Kirby, 2007; Spencer and Spencer, 2014). However, particular programmatic features tend to recur across the various models: emphasis on young people's positive attributes and potential; an atmosphere of "hope"; the sense of being part of a "caring family"; and opportunities for young people to cultivate their interests, develop skills and gain exposure to new experiences (Roth and Brooks-Gunn, 2003). Which of these is most important, and whether all must be present to achieve PYD remains unclear (Roth and Brooks-Gunn 2003). Given the lack of an over-arching conceptual framework and variability in implementation, it is not surprising that evaluations of PYD interventions report mixed results (Wiggins et al., 2009; Kirby 2009; Bonell et al. 2013).

In a randomized controlled trial (RCT) of the Teens & Toddlers teenage pregnancy prevention programme, Bonell and colleagues (2013) examined the success of the intervention in reducing unprotected sex and expectations of teenage parenthood, and increasing a measure of youth development, as well as various secondary outcomes. The programme providers did not have an explicit theory of change for the intervention though the evaluators developed one as part of a formative evaluation conducted prior to the RCT (Jessiman et al. 2012). The RCT reported that T&T had no impact on its primary outcomes, but intervention participants were less likely to experience a decrease in their self-esteem than the control group (Bonell et al. 2013). The authors concluded that the lack of a prior, explicit theory of change linking intervention components and outcomes might have contributed to its limited impact.

Process evaluations examine intervention delivery but less often examine the mechanisms underlying intervention effectiveness or lack thereof (Oakley et al., 2006). The complexity of the mechanisms by which PYD aims to improve sexual health underlines the importance of such in-depth process evaluation in this field, though this is rarely done (Roth and Brooks-Gunn 2003). For example, although the evaluation of the Young People's Development Programme (YPDP), a UK based PYD initiative targeting at-risk 13-15 years olds, did have a process evaluation, it

was insufficiently focused on intervention mechanisms to be able to explain the unexpected findings of intervention harm suggested by the outcome evaluation (Wiggins et al., 2009).

Process evaluations of implementation and intervention mechanisms must attend to the perspectives of intervention participants (Oakley et al, 2006; Spencer 2013). However, despite the avowed youth-centeredness of PYD, few evaluations have included the perspectives of young people in seeking to understand the potential barriers and facilitators to success (Krenichyn et al., 2007; Fletcher et al., 2008). Understanding how young people experience particular elements of PYD programmes can generate new insights into how potential, empowerment and hope are engendered and contribute to the development of a sounder conceptualization of the approach.

In this paper, using qualitative data collected during the process evaluation of T&T, we aimed to examine how young women participating in T&T experienced it; and what this suggests about the mechanisms underlying the programme. In doing so, we aimed to generate hypotheses about why the programme had limited impact.

## **Methods**

### *Intervention*

The data for this study were collected as part of an independent evaluation of the T&T programme funded by the UK's Department for Education led by NatCen and the London School of Hygiene and Tropical Medicine (LSHTM). T&T aims to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (Teens & Toddlers 2008) (Table 1). Over the course of the 18-20 week programme, young women are identified by their teachers as potentially benefiting from participation in T&T on the basis of being perceived as at risk of teenage pregnancy. Those who consent to participate spend one afternoon per week in a pre-school nursery, each mentoring a child aged 3-5 years old in need of additional attention for approximately 90 minutes, supervised by the nursery staff and up to two T&T facilitators. T&T believes that pairing

vulnerable teenagers and young children under the supervision of skilled adults offers benefits for each, such as improvements in personal, social and communication skills ([www.teensandtoddlers.org](http://www.teensandtoddlers.org)). The young women also spend 90 minutes in facilitated group sessions focused on child development, effective parenting skills, and sex and relationships education. These sessions are intended to develop skills to be applied when mentoring children. Sessions at the start of the programme provide a foundation for the mentoring work by introducing the young women to the nursery and developing skills needed for mentoring the child. Participants also receive mandatory one-to-one sessions with a trainee counsellor (who generally contribute their time in partial fulfillment of requirements for a counselling qualification) 2-3 times during the programme. Upon completion of T&T, participants receive a National Award in Interpersonal Skills, Level 1 (National Council for Further Education).

### *Sample*

The process evaluation collected qualitative data from four case-study schools in London, selected to encompass different levels of experience in delivering T&T (first time versus previous experience); and ratings of school quality as judged by government inspectors<sup>4</sup> ('good' versus 'satisfactory'). In each case-study school, data were collected from young women in year 9 (age 13/14 years) randomised to participate in the programme or serve as controls, as well as teachers, T&T facilitators and counsellors, and nursery staff, through participant observations, focus groups, and paired and individual interviews. Here, we present only data from programme participants in order to examine our research question concerning participants' experience of the programme. The overall process evaluation is reported elsewhere (Jessiman et al., 2012).

### *Data collection methods and tools*

The researchers designed a sequence of qualitative data collection methods in order to build mutual respect, trust and rapport with the young women and

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<sup>4</sup> Ofsted (Office for Standards in Education, Children's Services and Skills) inspects and regulates services for children and young people, and those providing education and skills for learners of all ages in the UK.



encourage them to speak openly about their experience of the intervention (Alderson and Morrow, 2004). We began with focus groups at the start of the intervention, moving to paired/triad interviews and then to one-to-one in-depth interviews. AS and TJ each conducted two focus groups (4 total) with participants using a range of interactive methods, including vignettes and flash cards, (n=20) with approximately 5 participants in each group; paired or triad interviews (8) with 12 participants overall; and 15 interviews with individual participants. Topic guides addressed various issues including those related to the research questions explored in this paper.

All the interviews and focus groups were conducted with participants' informed consent in private spaces at the pre-school nursery, and were recorded and fully transcribed. Each interview lasted between 60-90 minutes and focus groups between 90-120 minutes. The research ethics committees of NatGen Social Research and LSHTM granted ethical approval for the study.

#### *The analytical approach*

We adopted a phenomenological analytic approach (Creswell, 2007) to describe the meaning of the experience of participation in a PYD programme from the perspective of young women. Transcripts were read through several times by AS and preliminary meaning units identified. AS and KM reviewed, refined and agreed upon a final set of meaning units and worked together to develop clusters of interconnected meaning units (Smith *et. al*, 2009). AS, in consultation with KM, then undertook line-by-line coding of data in NVivo using the clusters of meaning units as a coding frame (Table 2). During this process, the researchers attempted to 'bracket out' their personal experience and/or opinions of the intervention and observe the data as if for the first time. This was challenging for AS because of her involvement in the T&T evaluation, but KM had not been involved in the data collection and was able to offer a novel perspective.

## Results

Data from 28 young women were analysed for this paper (Table 3). We identified three cross-cutting themes regarding participants' experiences of the programme and how this was experienced as impacting upon their development of social and emotional competencies. We report our findings, by theme, below.

### *Being challenged*

Young women selected to participate in T&T were enthusiastic about the programme, viewing it as an opportunity to gain a qualification, "boost" their educational and employment prospects, and gain experience working with young children.

**"So when you were first told about Teens & Toddlers what did you think about it?"**

It was exciting.

**Exciting?**

Yeah.

**Why?**

Because the way they were describing it, like working with the toddlers and that."

*Paired interview 1, School 3*

PYD programmes seek to offer an 'engaging experience' (Vandell et al., 2005), that allows for intrinsic motivation, effort and concentration. Engagement is reflected in the extent to which young people are focused and excited about the activities in which they are participating (Walker et al., 2005; Larson 2000). This high level of pre-programme enthusiasm potentially sets the stage for an atmosphere conducive to PYD. However, this was put to the test immediately, as participants began to engage with the children:

**"What was it like for you the first time you visited the nursery?"**

Annoying. [Laughs.]

**Annoying? Why?**

'Cos the little kids were rude to me.

**They were rude? What they say?**

When I'd talk to them they would spit and didn't answer me back, and when you told them to stop doing something, they would just walk off."

*Focus group, School 1*

Contrasting with their anticipated friendly welcome, the initial rejection from the children resulted in feelings of hurt and disenchantment with the programme.

“Yeah, I don’t actually like it [the programme] ‘cause it’s just sometimes you don’t get along with the child and you just can’t ...

**Do you get along with your child?**

Not that much.

**No?**

He hates me.

**He hates you?**

Yeah. He tells me to go away.”

*Paired interview, School 1*

Further challenges emerged: the children were difficult to predict and often did not follow instructions. Some of the children exhibited disruptive behaviours, such as crying, being aggressive or “throwing strops”, and the young women found it difficult to respond effectively. On occasions where their attempt to work with the children failed, some young women felt “anxious”, “scared” and overwhelmed.

“Cos sometimes, yeah, it’s nice to hang round Jessica, but then the thing that happened was, after she threw the scissors [...] she got sent away, and she was crying, and I thought that because she was crying and she looked angry, I thought she would be angry with me and she wouldn’t want to talk to me, so I was kind of scared that I might lose my toddler. And then she went and she came back and she wasn’t talking to me so I was scared...”

*Focus group, School 3*

Exposure to such challenges was an intended element of the programme, both to introduce participants to the realities of raising children, but also to allow them to overcome challenges. Confronting such challenges required many young women to reassess their expectations about the work; it was going to require more effort than anticipated. At this point, about a quarter of young women dropped out (Bonell et al., 2013).

The intensity of the immediate challenge of working with the children may have lessened the sense of hope and motivation that is essential for PYD. Larson (2000) has argued that for the ‘development of initiative’ three elements must co-occur: intrinsic motivation to participate in an activity; concerted attention and engagement in the activity; and engagement with the experience over time. This is similar to the notion of ‘flow’ (Csikszentmihalyi 1990; Rich 2003) *i.e.* a balance between challenge and skill so that negative consequences such as anxiety or

boredom are minimised. For some young women, T&T may have failed to create a “flow” experience by presenting immediate challenges that they did not feel equipped to overcome.

There was variation in the amount of supervision and support the facilitators provided to the young women while they were working with the children. Some closely accompanied the young women while they worked with the children and others only offered light guidance and observed from afar (Jessiman et al. 2012).

**“Has the facilitator helped you to work with her, at all?**

Sometimes...they told me to like, if I felt ill they said, oh, just keep playing with her and then you’re going in in a minute.

**Anything else they did to try and make it easier for you or...?**

[No response heard]

**No? Okay.”**

*Interview 1, School 4*

The young women described how some facilitators provided positive reinforcement and actively coached them to continue with T&T. For these young women, the experience became less daunting and more enjoyable and most persevered.

“Yeah sometimes when I was really like I wanted to give up they were like just keep trying, don’t worry, it takes a long time but it will work.”

*Interview 3, School 3*

Those who were able to forge relationships with the child felt a sense of achievement and were also sometimes able to make connections with meeting other challenges in their lives.

“Maybe it makes you feel a bit more confident because once you get over an obstacle with your toddler then it’s like I helped him through it so maybe I could again or maybe I can do that.”

*Triad interview, School 1*

PYD theorists suggest that without support young people have limited ability to overcome challenges on their own, and may stall, become stuck and lose initiative (Larson et al. 2005). PYD practitioners should therefore assign appropriately challenging tasks to encourage young people to grow, but provide the correct support to avoid negative experiences.

### *Connecting and engaging with adults in the programme*

Evidence suggests that caring relationships with at least one non-parental adult helps to build self-esteem and self-efficacy, and protects against risk (Eccles and Gootman, 2002; Laursen & Birmingham, 2003; Bowers et al., 2014). For successful PYD, young people need to view non-parental adults as a problem-solving resource and an 'open ear' (Bowers et al. 2014). The T&T programme counsellor, in particular, became a trusted source of support and advice about managing difficult emotions for many participants.

"She asks and she knows what to say. And it never gets silent.

Never gets silent.

Like, the only time it gets silent is if you've told her something sad and she'll sit there and be like 'oh', and then she'll know what to say as quick as...

...It's the comeback, isn't it?

It's like, boom, and then she knows exactly how you feel."

*Focus group, School 4*

The counselling sessions were an opportunity for a confidential conversation with a trusted adult. However, attending the sessions was mandatory and for the young women who did not want counselling, the sessions sometimes felt uncomfortable as they felt obliged to share more information than they would have liked.

It was weird because I haven't done it before, and it's like, just there, talking, and just quite. It's weird. [Laughs.]

**Ok. So it's a bit awkward. Would you do it again?**

You have to, but I wouldn't want to.

[...]

...we thought, "We'll go in there, she'll ask us questions," but she only asked us a few, and we'd just have to talk and talk about anything, and then, like, sometimes we wouldn't know what to say. And then, like, 'cos, yeah, it's awkward, the silence, you just end up telling her everything, and you don't want to.

*Focus group, School 1*

Children and adolescents with concerns about confidentiality, judgement and stigma, and who are uncomfortable with expressing their emotions are often reluctant to seek professional help. Adolescents in particular, tend to prefer self-reliance or speaking to friends and family when dealing with problems (Del Mauro and Jackson Williams, 2013). For most of the young women participating in T&T,

this was the first time they had spoken to a counsellor and they may have experienced some uneasiness as a result.

In group sessions, some facilitators shared personal experiences to help illustrate particular issues. These 'real life' experiences appeared to be valued by participants and engendered a sense of connection and mutual understanding.

"Like [the facilitator] and us, we're close 'cause she uses her experiences and tells us...if we ask questions she won't just read it from a book, she'll talk of her experience and what she thinks and then give us, and then just elaborate on what she's saying basically. [...] It's better because, instead of talking from a book you know, oh well the book says that, but once you get an, when she gets someone's experience you can say well they've been through it so they should know about it, and they're telling you from what they know [...]."

*Interview, School 1*

However, not all of the facilitators managed to create a trusting atmosphere, resulting in awkward and uncomfortable moments.

**"What does working with [facilitators] what is that like?"**

YW1: They don't really know what to say.

YW2: Like they'll go silent and then smile at us and we don't know where to look.

YW3: That's when we start laughing in the class. "

*Paired interview 2, School 4*

The discomfort of some facilitators may have been due to lack of training (Jessiman et al., 2012), underscoring the importance of investment in the development of relevant skills among adults expected to fulfil the role of 'caring adult' (Bowers et al., 2014). However, in most cases participants felt that the T&T facilitators treated them with more respect than the teachers at school:

"YW1: They teachers like kinda belittle you, [...]

YW3: Like if they're talking, they don't expect you to say nuffink, yeah, you're just basically something little to them, you're just, 'nuffin', they just talk to you like anyhow they like, they don't care.

YW2: And it's like they have to act like they're above you, it's like they can't come down and talk to you properly.

*Paired interview (with 3 participants), School 1*

In contrast, the young women sometimes felt the pre-school nursery staff were less supportive. For example, one young woman felt that a member of staff at the nursery was "having a go at" or criticising her.

“That teacher, I was running around in the playground and just running around, wasn’t I, just running around with the kids and she had a go at me and I was like ‘what?’ She was like ‘don’t run around with the kids, I don’t want you running round with the kids’ and when I asked why, she was like ‘because I don’t want you doing it, you could fall over’ I thought to myself ‘I’ve been doing this for ages and now you’re telling me I can’t do it.’”

*Focus group, School 4*

In effective PYD, adults help young people to feel secure, cared for and valued (Nitzberg 2005). Though not the main programme providers, difficult relationships between the nursery teachers and the young women may have adversely influenced their experience of the programme and their likelihood of achieving positive development.

From the perspective of the young women, some adults involved in T&T were skilful in making connections, building trust, and warmth, and treating the young women with respect but this was not consistent across the programme.

#### *Learning about yourself*

PYD models vary in terms of what they identify as personal and social assets that comprise positive development, but they all tend to focus on building confidence, emotional self-regulation, moral character and self-esteem. During group sessions, the facilitators introduced activities, such as participants reflecting upon their work and relationships with the children, as well as role-playing, and journaling to encourage the young women to develop empathy, improve their behaviour and value themselves (Jessiman et al., 2012).

“In one session, we had to look at our toddler and see if there was any, like, anger about and, where they would show it. And then we had to come back into the classroom time and say what we found out about their anger, and then where we show our anger from....”

*Interview 4, School 1*

The process of reflection on their experience in the nursery and in the counselling helped some young women to ‘discover’ their abilities and qualities, and understand how their behaviour might affect others:

“The counselling session and also the part in the nursery when I watched the children. [...]from the toddlers I saw how, I don’t know how to say it, like I reflected it to see how I act and I just like saw myself from a different view

and looked how I act and everything like that, so I guess I just changed a little bit....”

*Interview 2, School 3*

Through journaling, they were able to chart their progress and improvement over time:

“...when you’re writing in your journal and you think back, you realise, “Well, yeah, I have done a good job today, and I’ll try and do a little bit better and a little bit better,” and then it’s like, when you’re writing in your journals you realise that you have done better and better.”

*Focus group, School 3*

Though the relationship between self-esteem and teenage pregnancy is unclear (Goodson et al., 2006), many interventions, including T&T, aim to increase self-esteem to reduce sexual risk behaviours. Across the various components of the T&T intervention, the young women had opportunities to build self-esteem through overcoming the challenge of working with a child, sharing with and seeking advice from a trusted adult, and reflecting upon their strengths and weaknesses via specific activities in the group sessions. This entire process appeared to have an impact on the young women’s self-esteem.

**“Has Teens & Toddlers changed how you feel about yourself in any other way that we haven’t talked about yet?”**

Just like understanding that I’m important...”

*Interview 4, School 4*

T&T also deliberately sought to enhance participants’ understanding of their risk of early pregnancy. Despite not initially seeing themselves as at risk, some participants began to discuss delaying sex, using condoms, and putting their wellbeing at the centre of any decision to have sex. Some young women also began to express the view that it was important to develop a stronger connection with someone before having sex. The programme appeared to influence the young women’s attitudes, although this does not necessarily indicate an imminent change in behaviour.

“[...] like everything we spoke about on relationships, like that you should only like have sex with someone if you really wanna be with them sort of thing, and that’s sort of changed like... Not that I would go and sleep around sort of thing, but I know that it’s not just about them, it’s about me as well...”

*Interview, School 4*



## **Discussion**

The nature of PYD is 'top-down' in that it defines what constitutes healthy development for young people, but it also aims to empower young people to make choices and contribute to their communities. However, little previous research on PYD has examined participants' views about the programmes and how these might impact upon them. This study aimed to contribute to filling this gap.

A number of key themes and findings emerge from our analysis. The initial excitement about participation in T&T set the stage for an engaging experience (Vandell et al., 2005). However, for many, the challenge of working with young children did not provide the right balance of challenge and skill (Larson, 2000) to support building competence and a sense of achievement. However, with coaching from facilitators others persevered and overcame these challenges. These findings suggest that activities that offer a stimulating but achievable challenge for young people are more likely to result in feelings of accomplishment and engender confidence. Furthermore, it is important that adults working with young people actively support young people to meet the challenge, rather than merely monitor progress.

In many cases, the adults who were involved in T&T played a special role in creating a caring environment. T&T providers became trusted sources of guidance and support. However, some nursery staff were perceived as critical and perhaps introduced a negative aspect to the non-parental adult relationship building that is central to PYD (Bowers et al., 2014). Interactions with adults that appeared to produce trust and connection were based on honest communication and mutual respect.

Reflecting upon their experience helped some participants to develop self-esteem and moral character. Furthermore, the programme aimed to link participants' sense of personal development with their attitudes to risk of pregnancy and sexual behaviour. Though these interviews may have been susceptible to social desirability bias, the young women expressed feeling differently about their sexual

lives as a result of participation in T&T, particularly because of the moral character they built while participating in the programme.

Our study had a number of limitations. Our qualitative research aimed to produce a rich account of experiences and processes rather than to develop statistically representative findings. However, the relevance of our findings to other participants in T&T or other PYD programmes is uncertain. Given that approximately a quarter of participants dropped out of the programme within the first eight weeks (Bonell et al., 2013), our study is liable to selection bias whereby the most satisfied participants remained in the programme.

Our study has a number of implications for policy and research. PYD interventions continue to be developed and delivered to improve sexual health and there is some evidence that such approaches are effective (Gavin *et al* 2010). Our research on young women's experiences of a PYD programme offers a number of useful insights, which should help inform further refinements to PYD interventions and theories of change. PYD interventions would benefit from: ensuring a good balance between challenge and support; ensuring participants develop trusting relationships with all adults involved in programmes through the provision of advice and support, and the exchanging of experiences and the development of self-awareness, not only in terms of self-esteem but also in terms of developing empathy and a realistic assessment of vulnerability to adverse sexual health. Existing empirical evidence suggests that assets, such as the 5 "C"s are associated with better sexual health. More attention to engendering such positive development is likely to result in improved effects in sexual health outcomes.

## References

Alderson P and Morrow V (2004) *Ethics, social research and consulting with children and young people*. Ilford, Essex: Barnardo's.

Allen E, Bonell C, Strange V, Copas A, Stephenson J, Johnson AM and Oakley A (2007) Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomized trial of sex education. *Journal of Epidemiology and Community Health* 61: 20-27, doi:10.1136/jech.2005.

Allen JP and Philliber S (2001) "Who benefits most from a broadly targeted prevention program? Differential efficacy across populations in the teen outreach program". *Journal of Community Psychology* 29(6): 637-655.

Arai L (2009) *Teenage Pregnancy: The making and unmaking of a problem*. Bristol: The Policy Press.

Arie S (2014) "Has Britain solved its teenage pregnancy problem?" *British Medical Journal* 348: g2561.

Benson PL (1997) *All kids are our kids: What communities must do to raise caring and responsible children and adolescents*. San Francisco: Jossey-Bass.

Benson PL, Mannes M, Pittman K, Ferber T (2004) "Youth development, developmental assets, and public policy". In, Lerner Richard M and Steinberg L (eds) *Handbook of adolescent psychology (2nd ed.)*. Hoboken, NJ US: John Wiley & Sons Inc, pp 781-814.

Benson PL (2007) Developmental assets: an overview of theory, research and practice. In: *Approaches to positive youth development*. London: Sage

Benson PL and Scales PC (2009) Positive youth development and the prevention of youth aggression and violence. *European Journal of Developmental Science* 3(3): 218-234.

Bonell C, Maisey R, Speight A, Purdon A, Keogh P, Wollny I, Sorhaindo A and Wellings K (2013) Randomized controlled trial of 'teens and toddlers': A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery. *Journal of Adolescence* 36: 859-870.

Bowers E, Johnson S, Buckingham M, Santiago G and Warren D (2014), Youth development across mid- to late- adolescence: The moderating effect of parenting profiles, *Journal of Youth and Adolescence* 43(6): 897-918.

Catalano RF, Hawkins DJ, Berglund L, Pollard JA, Arthur MW (2002) Prevention science and positive youth development: Competitive or cooperative frameworks? *Journal of Adolescent Health* 31: 230-239.

Crawford C, Cribb J and Kelly E. (2013) Teenage pregnancy in England. Report, Centre for Analysis of Youth Transitions (CAYT). Report No. 6. London: Institute for Fiscal Studies.

Creswell JW.(2007) *Qualitative Inquiry and Research Design* (2nd Ed). Thousand Oaks, London and New Dehli: Sage Publications.

Csikszentmihalyi M (1990) *Flow*. New York: Harper and Row.

Del Mauro J and Jackson Williams D (2013) Children and Adolescents' attitudes towards seeking help from professional mental health providers. *International Journal for the Advancement of Counselling* 35(2): 120-138.

Department for Children, School and Families (DCSF) (2010) *Teenage Pregnancy Strategy: Beyond 2010*. Report, DCSF-00224-2010.

Eccles J and Gootman J (2002) *Community programs to promote youth development*. Washington, D.C: National Academy Press.

Fletcher A, Harden A, Brunton G, Oakley A, Bonell C (2008) Interventions addressing the social determinants of teenage pregnancy. *Health Education* 108 (1): 29-39.

Gavin LE, Catalano RF, Davis Ferdon C, Gloppen KM and Markham CM (2010) A review of positive youth development programs that promote sexual and reproductive health. *Journal of Adolescent Health* 46: S75-S91.

Goodson P, Buhi ER and Dunsmore SC. (2006) Self-esteem and adolescent sexual behaviors, attitudes and intentions: a systematic review. *Journal of Adolescent Health* 38(3): 310-319

Jessiman T, Keogh P, Scott S, Wollny I, Sorhaindo A and Bonell C (2012) Teens and Toddlers integrated process evaluation. Report DFE-RR212.

Kirby D, Lezin N, Afriye RA and Gallucci G (2003) *Preventing Teen Pregnancy: Youth development and after-school programs*. Scotts Valley, California: ETR Associates.

Kirby D. (2007) *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

Kirby D. (2009) Reducing pregnancy and risky behaviours in teenagers. Youth development programmes don't always work. *British Medical Journal* 339: b2054 doi: 10.1136/bmj.b2054.

Krenichyn K, Schaefer-McDaniel N, Clark H and Zeller-Berkman S (2007) Where are young people in youth program evaluation and research? *Children, Youth and Environments*, 17(2): 594-615.

Laursen and Birmingham (2003) Caring relationships as a protective factor for at-risk youth: An ethnographic study” *Families in Society: The Journal of Contemporary Human Services* 84(2): 240-246.

Larson RW. (2000) Towards a psychology of positive youth development. *American Psychologist* 55(1):170-183.

Larson R, Hansen D and Walker K. (2005) Everybody’s gotta give: Development of initiative and teamwork within a youth program. In: Mahoney JL, Larson RW and Eccles JS (eds) *Organized Activities as Contexts of Development: Extracurricular activities, after-school and community programs*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc.

Lerner RM, Lerner JV, von Eye A, and Bowers EP (2011) Individual and contextual bases of thriving in adolescence: A view of the issues. *Journal of Adolescence* 34: 1107-1114.

Nitzberg J (2005) The meshing of youth development and community building. *New Directions for Youth Development* 106: 7-16.

Oakley A, Strange V, Bonell C, Allen E, Stephenson J and RIPPLE Study Team (2006) Process evaluation in randomised controlled trials of complex interventions. *British Medical Journal* 18; 332(7538): 413-416.

Office of National Statistics (2014) Conceptions in England and Wales, 2012. Statistical Bulletin, Office National Statistics, 25 February.

Philliber S, Williams Kaye J, Herring S and West E (2002) Preventing pregnancy and improving health care access among teenagers: An evaluation of the Children’s Aid Society – Carrera Program. *Perspectives on Sexual and Reproductive Health* 34(5): 244-251.

Pittman K, Irby M, and Ferber T (2000) Unfinished Business: Further Reflections on a Decade of Promoting Youth Development, International Youth Foundation. In:

Public/Private Ventures (eds) *Youth Development: Issues, Challenges and Directions*. Philadelphia: Public/Private Ventures.

Public Health England (2014) Sexual and Reproductive Health Profiles. Available at: <http://fingertips.phe.org.uk/profile/sexualhealth/data>.

Rich GJ (2003) The positive psychology of youth and adolescence. *Journal of Youth and Adolescence* 32(1): 1-3.

Roth J, Brooks-Gunn J, Murray L and Foster W (1998) Promoting healthy adolescents: Synthesis of youth development program evaluations. *Journal of Research on Adolescence* 8(4): 423-459.

Roth J and Brooks-Gunn J (2000) What do adolescents need for healthy development? Implications for youth policy. *Social Policy Report*, 14(2). Ann Arbor, MI: The Society for Research in Child Development.

Roth JL and Brooks-Gunn J (2003) Youth Development Programs: Risk, Prevention and Policy. *Journal of Adolescent Health* 32: 170-182.

Smith JA, Flowers P and Larkin M (2009) *Interpretive Phenomenological Analysis: Theory, Methods and Research*. London: Sage Publications.

Social Exclusion Unit (SEU). (1999) *Teenage pregnancy*. London: HMSO.

Spencer G (2013) Young people's perspectives on health: empowerment, or risk? *Health Education* 113(2): 115-131.

Spencer MB and Spencer TR (2014) Invited commentary: Exploring the promises, intricacies, and challenges to positive youth development. *Journal of Youth and Adolescence* 43: 1027-1035.

Teens & Toddlers (2008) *Teens & Toddlers Intensive Implementation Programme*.

Haringey. Internal document.

UNICEF Office of Research (2013) Child Well-being in Rich Countries: A comparative overview. *Innocenti Report Card 11*, Florence: UNICEF Office of Research.

Vandell, DL, Shernoff DJ, Pierce KM, Bolt DM, Dadidman K and Brown BB (2005) Activities, engagement and emotion in after-school programs (and elsewhere). *New Directions for Youth Development* 105: 121-129.

Walker J, Marczack M, Blyth D, and Borden L (2005) Designing youth development programs: Toward a theory of developmental intentionality. In: Mahoney J.L., Larson R.W. and Eccles J.S. (eds) *Organized Activities as Contexts of Development: Extracurricular activities, after-school and community programs*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc.

Wiggins M, Bonell C, Sawtell M, Austerberry H, Burchett H, Allen E and Strange V (2009) Health outcomes of youth development programme in England: prospective matched comparison study. *British Medical Journal* 339: b2534  
doi:10.1136/bmj.b2534.



**Table 1.** The Teens & Toddlers multicomponent positive youth development programme for the prevention of teenage pregnancy

<b>Intervention length</b>	18-20 weeks, 1 day a week, 3-4 hours a day
<b>Recruitment (2 phases)</b>	1. Schools are recruited from areas (boroughs, districts) with high rates of teenage pregnancy. 2. Teachers and other school staff responsible for inclusion, discipline and/or pastoral care identify students
<b>Participants</b>	Students between the ages of 13-15 considered to be at high risk of teenage pregnancy
<b>Activities</b>	Classroom curriculum focused on child development, effective parenting skills, anger management, sexuality and relationships
	Mentoring young children between the ages of 3-5 who are thought to be in need of additional learning or emotional support in a nursery or primary school setting
	Meetings with a trained counsellor for hour-long one-to-one sessions.
<b>Award</b>	National Award in Interpersonal Skills, Level 1 (NCFE)

**Table 2.** Meaning units, themes clusters and examples of codes generated from phenomenological analysis.

Theme cluster 1			Theme Cluster 2				Theme cluster 3		
Building confidence			Connecting and engaging with adults in the programme				Learning about yourself		
Meaning unit 1a	Meaning unit 1b	Meaning unit 1c	Meaning unit 2a	Meaning unit 2b	Meaning unit 2c	Meaning unit 2d	Meaning unit 3a	Meaning unit 3b	Meaning unit 3c
“A boost”	Overcoming a challenge	Purpose, accomplishment and growth	Making connection	Learning to build intimacy	Discomfort/ invasion of privacy	Not respected by adults in the programme	Being vulnerable	Learning life lessons	“I’m changed”
1a codes	1b codes	1c codes	2a codes	2b codes	2c codes	2d codes	3a codes	3b codes	3c codes
Creating options	Working with children challenging and fun/ Frustrating	Building confidence	An adult you trust to talk to	Enjoy making toddler happy	Facilitators are repetitive	Cannot understand the teachers	Expressing my feelings	Taking responsibility with regard to risk	Adults treat me with more respect now
Increased concentration in school	Children unpredictable and difficult to control	Freedom and creativity	Appreciate real life experience	Improving my relationships	Pushy and prying	No mutual respect	Help with believing in myself	Self-worth	Empathise with parents
Desire to further education	Exhausting activity	Fun and accomplishment	Awkward moments with facilitators					Choice and independence	Change what people think of you
Trying out a potential career	Facilitators coach us	Proud of skills in working with children	Building relationships with children					Encourages self-reflection and self-realization	
	Facilitators create a safe environment for children and young women	Learning new things	New respect for adults					Getting a “reality” check	

## **Evidence Chapter VI. Being targeted: young women's experience of being identified for a teenage pregnancy prevention programme**

The stand-alone research paper that forms this chapter is published as indicated below:

Sorhaindo, A., Bonell, C., Fletcher, A., Jessiman, P., Keogh, P. and Mitchell, K. (2016). Being targeted: Young women's experience of being identified for a teenage pregnancy prevention programme. *Journal of Adolescence*, 49: 181-190.

The publication and permissions can be found in Appendix I.

Being targeted: young women's experience of being identified for a teenage pregnancy prevention programme

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**Acknowledgements:** We would like to thank the young women who participated in this research, the Teens & Toddlers programme and the English Department of Education for funding the larger study from which this work was developed.

## Abstract

Research on the unintended consequences of targeting 'high-risk' young people for health interventions is limited. Using qualitative data from an evaluation of the Teens & Toddlers Pregnancy Prevention programme, we explored how young women experienced being identified as at risk for teenage pregnancy to understand the processes via which unintended consequences may occur. Schools' lack of transparency regarding the targeting strategy and criteria led to feelings of confusion and mistrust among some young women. Black and minority ethnic young women perceived that the assessment of their risk was based on stereotyping. Others felt their outgoing character was misinterpreted as signifying risk. To manage these imposed labels, stigma and reputational risks, young women responded to being targeted by adopting strategies, such as distancing, silence and refusal. To limit harmful consequences, programmes could involve prospective participants in determining their need for intervention or introduce programmes for young people at all levels of risk.

*Key words:* High-risk; prevention; risk management; targeting; teenage pregnancy; school

## Introduction

The UK Teenage Pregnancy Strategy (1999-2010) (Social Exclusion Unit, 1999; Department for Children Schools and Families (DCSF), 2010) recommended targeting preventative programmes to high-risk individuals and areas. Although the strategy coincided with a decline in the conception rate for under-18s in England and Wales (Arie, 2014; Institute for Fiscal Studies, 2013), the rationale and benefits of targeting remain contested (Bonell & Fletcher, 2008; Institute for Fiscal Studies, 2013; Fletcher, Gardner, McKee, & Bonell, 2012).

Targeting interventions toward individuals or groups with increased risk of an adverse outcome is thought to improve equity, enable more efficient use of resources (Carey & Crammond, 2014; Cerdá, Tracy, Ahem, & Galea, 2014; Kreuter, et al., 2014; Kreuter & Wray, 2003) and focus on the specific problem or individual/group at risk rather than those unlikely to be affected. The approach is, however, criticised for its limited potential impact on incidence at the population-level, and limited recognition of the wider social determinants (Fletcher et al., 2012). Considering teenage pregnancy for example, risk is normally distributed and most pregnancies will arise from the larger group of young women at low or medium risk rather than the smaller group at high risk (Kneale, Fletcher, Wiggins, & Bonell, 2013; Rose, 1992). High-risk strategies, if successful, only result in reducing a fraction of the potential cases in the overall population and require continued intervention with new cases, as overall susceptibility in the population remains unaddressed (Grimes & Schultz, 2002; Rose, 1992).

Targeting also assumes an ability to identify those at high-risk and to distinguish between these individuals and the rest of the population (Grimes & Schultz, 2002; Rose, 1992). Kneale et al. (2013) tested the capacity of targeting, based on indicators of risk, to locate future teenage mothers in three UK cohort study databases and found that this group is difficult to identify thus targeted interventions would not reach the majority of young women who would become teenage parents.

There may be unintended consequences for individuals who are targeted. For example, interventions that identify young people as 'at risk' may lead to negative self-perception or 'labelling' (e.g., naughty, problematic) and the associated stigma attributed to the label (Goffman, 1959, 1963). The approach may also inadvertently lower young people's expectations and engender poor behaviour and outcomes (Evans, Scourfield, & Murphy, 2014; Rorie, Gottfredson, Cross, Wilson & Connell, 2011; Wiggins et al., 2009; Bonell & Fletcher, 2008; Weiss et al., 2005; McCord, 2003; Dishion, McCord, & Poulin, 1999). A qualitative exploration of a social and emotional learning intervention with students aged 12-14 in secondary schools in Wales identified four unintended effects related to targeting criteria and composition of the intervention groups: negative labelling, elevation of status among targeted (poorly behaved) students, marginalisation of unknown peers in mixed groups, and amplification of deviancy within friendship groups (Evans et al., 2014). This experience of targeting, labelling and stigma, particularly in formal systems of intervention, may have long-term repercussions rooted in a young person's inability to overcome having been categorised, and having internalised, a negative label (Creaney, 2012).

Stigma is associated with sexual health outcomes, such as sexually transmitted infections (STIs) (Foster & Byers, 2013; Balfe et al., 2010) and teenage pregnancy (SmithBattle, 2013; Weimann, Rickert, Berenson, & Volk, 2005) leading to worries about judgment, guilt, shame and rejection among those who experience it. Being considered at high-risk for teenage pregnancy or to be singled out for a teen-pregnancy intervention may provoke similar sentiments among young women identified. While previous studies provide important evidence on the unintended consequences of targeting, none capture the nature of the experience from the perspective of the young people considered at risk. Examination of the meaning of the experience of being targeted may facilitate an understanding of why the approach results in unintended effects. Interpretive phenomenological analysis seeks to illuminate the lived experience of a phenomenon by interrogating the perceptions of individuals who experienced the same phenomenon. In general, a phenomenological approach aims to address two central questions: What was experienced? and What contexts or situations have influenced or affected the experience? In doing so, the approach investigates the significance of an

experience, in contrast to examining the consequences (Smith, Flowers, & Larkin, 2012; Moustakas, 1994; van Manen, 1990). In this research, we explore via a phenomenological approach, the experience of being targeted for the Teens & Toddlers teenage pregnancy prevention programme (T&T): What it felt like to be deemed at risk of teenage pregnancy; and, how the process of selection influenced the meaning of the experience, from the perspective of the young women who were selected to participate in the T&T programme.

## **Methods**

To explore young women's lived experience of being targeted, we drew on qualitative data from the evaluation the T&T intervention.

### **The intervention**

Teens & Toddlers is a teenage pregnancy prevention programme that aimed to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (Teens & Toddlers, 2008). The programme had three components: a classroom-based curriculum focussed on the development of interpersonal skills, healthy parenting and sexual health, and including weekly journaling; mentoring a child between the ages of 3-5 years old in need of extra attention in a nursery or primary school setting for one to two afternoons a week; and one-to-one hour-long sessions with a trained counsellor over the course of 18-20 weeks (Sorhaindo et al., 2009).

### **The Targeting Strategy**

Schools were recruited from areas with high rates of teenage pregnancy. To identify potential participants for the intervention, school staff responsible for pastoral care or inclusion compiled a list of year 9 or 10 (aged 13-14) students whom they believed were at risk of teenage pregnancy. To assist with this process, T&T provided school staff with a 'selection tool' or checklist of factors related to a young person's personality, behaviours, and background, which the



T&T programme believed indicated risk of teenage pregnancy (Sorhaindo et al., 2009). At the time of this study, T&T was undergoing evaluation via Randomized Controlled Trial (RCT) and the evaluators also offered a list of evidence-based risk factors for teenage pregnancy to assist school staff with the selection of appropriate programme participants. Later during the evaluation, we discovered that staff responsible for selection rarely used either of these tools (Jessiman et al., 2011), but rather based their selection of potential programme participants on their documented and anecdotal knowledge of the student and/or their intuitive sense of the students' risk for teenage pregnancy (Sorhaindo et al., 2016; Jessiman et al. 2011, pg. 29).

Young women who were identified as at risk for teenage pregnancy were invited to attend an informational meeting where a representative from T&T described the programme. The potential programme participants were asked to complete a brief survey and were given personal and parental consent forms for the purposes of the intervention. T&T was described to the young women as an opportunity to gain expertise in working with young children and a National Award in Interpersonal Skills, Level 1 (NCFE). The young women were not told how or why they had been selected or about the programme's focus on teenage pregnancy. The personal and parental consent forms mentioned that the programme included information on sexual health, but did not state why they had been selected. Limited provision of information about the purpose of the programme and how participants were selected was a conscious effort by T&T and school staff to avoid stigma and to encourage young women to participate (Jessiman et al., 2011, pgs. 22-23).

### **Evaluation Design**

Normally, outside of the RCT, the first 6-8 students submitting signed parental consent forms would be accepted onto the programme, but to enable the RCT, young women who were selected and returned the consent forms were randomised to either participate in the T&T intervention or to serve as comparisons. Comparisons were not offered any additional intervention. Data for the RCT were collected at three points in time via self-completion questionnaires: prior to random allocation (baseline), immediately following the intervention, and

one year later. The specific measures, analysis and results of the RCT are published elsewhere (Bonell et al., 2013).

## **Data Sources**

The qualitative data used in this analysis were collected during the RCT's integrated process evaluation conducted in four case-study schools based in four different boroughs of London with high rates of teenage pregnancy (Bonell et al., 2013; Jessiman et al., 2011). Table 1 provides a selection of socio-demographic characteristics for each of the boroughs included in the case study for the first year of the evaluation. In each case study school, data were collected from young women randomised to participate in the programme (intervention arm) and randomised to serve as controls (comparison arm), through focus groups, and paired and individual interviews. The first and fourth authors conducted four interactive focus groups with 20 participants overall, 8 paired or triad interviews with 18 young women overall, interviews with 15 programme participants and 8 interviews with comparison participants, two from each case study school (Table 2). Researchers used a step-wise process of increasingly more in-depth data collection techniques to build trust and rapport with the young women before conducting one-to-one interviews (Alderson & Morrow, 2004). Furthermore, this process allowed space for young women who were reluctant to participate in the larger group setting to more comfortably share their thoughts. The focus groups and interviews focussed largely on the participants' experience of and perceptions of recruitment, the acceptability, fidelity and impact of the programme, and possible causal pathways. The interviews conducted with the control participants (n=8) focused on the potential for contamination and confounding, perceptions of the programme, the selection process and experience of and views on recruitment.

All the interviews and focus groups were conducted in private spaces on-site either at the school or at the nursery or primary school where the intervention was taking place. Semi-structured topic guides were developed to lead the discussions, which were conducted and recorded with permission, and later transcribed verbatim. Each interview lasted between 60-90 minutes and focus groups between 90 minutes and 2 hours. The research ethics committees of

NatCen Social Research and the London School of Hygiene and Tropical Medicine (LSHTM) granted approval for the study.

## **Analysis**

We adopted techniques associated with phenomenological and thematic analysis (Creswell, 2007). The first author read through the transcripts several times and took notes or highlighted sections of texts that appeared to represent some aspect of the young women's accounts of the experience of being targeted. These notes and sections of texts were written or printed onto small pieces of paper, reviewed separately from the transcripts and organised into emergent themes.

The first and final authors then worked together to develop connections between the themes and grouped them into 'meaning units', including creating super-ordinate and sub-ordinate units. Finally, the first author coded the data line-by-line in NVivo using the previously created meaning units as a coding frame (Smith et al., 2009; Creswell, 2007), but undertook constant comparison analysis of the coding frame refining the meaning units and the codes during this process. When the text was coded in NVivo, the first author crosschecked the data by collection method (focus groups, paired interviews and single interviews) and noted any significant inconsistencies or deviant cases.

## **Results**

### **Characteristics of study participants**

We only collected year of study from the participants during focus groups and paired interviews. However, in one-to-one interviews with the same young women, researchers asked their age, ethnicity and information about whom they lived with. All were 14 years old, apart from one in School 4, and in either year 9 or 10. Most were from Black or mixed ethnicities (Table 3).

## Exploring experiences

We present four aspects of participants' lived experiences of being selected for the T&T programme emerging from our data; two themes influenced by the targeting strategy: 'Confusion about why they were selected' and 'Increased resentment and mistrust of teachers' and two themes related to being categorised as at high-risk: 'Labelling and reinforcing stereotypes' and 'Managing risk reputations'.

### **Confusion about reason for selection.**

As the school and programme providers avoided informing the young women of the reason they were targeted for T&T, the majority of participants began the programme without knowing: that they had been identified as at risk for teenage pregnancy; and that the aim of the intervention was pregnancy prevention. Furthermore, almost all of the young women interviewed expressed confusion about how they were selected for T&T:

**Do you have any idea why you were selected?**

I don't know!

**You have no... do you care?**

What that I got picked?

**Yeah, I mean about why, yeah. Coz not everybody went right, so...**

No. I think coz I have older brothers and sisters, and... I don't know. I think maybe! And they have younger kids and then, yeah, I think so. But I'm not sure!

*Interview 3, School 4*

In three of the focus group discussions and several of the interviews, the young women discussed their theories for how and why they were selected the programme, including choosing the most misbehaved students, teachers' choosing, having younger siblings, and their responses to the RCT baseline questionnaire. However, other young women believed that they had been selected randomly; and were happy about this: "Yeah, I was happy that I got chosen, 'cause it was random and not everyone got chosen so the fact that I did, yeah, I was happy about it." [Interview 3, School 1] These students did not understand that they were initially selected by their teachers to enter a pool of young women that were randomised for the RCT.

During the focus groups discussions, many of the young women expressed their existing doubt of teachers' trustworthiness.

YW1: We think that they read the forms. They chose people according to the forms....But they said, like, everyone has an equal chance [but decided that] we're just going to pick out the names.

YW2: Yeah, they said they were going to pick it out of a hat, but, like, they changed – I think, I think they did read them and decide for themselves.

*Focus group, School 1*

"After my friend told me, then I was kind of thinking that... I think a teacher *would* kind of do that, but I don't know." [Focus group, School 3]

### **Increased resentment towards and mistrust of teachers.**

Following this period of confusion, the purpose of the programme and the reason the young women were selected for the study became known to some young women via passing comments, rumours and gossip at their school. For example:

**Do you know why or how you got chosen to go to that room [where the informational meeting was held]?**

Nope.

**Do you have any ideas?**

There were just rumours and whatnot.

**What were the rumours?**

Erm, they picked the girls that are most likely to get pregnant.

*Comparison interview 1, School 1*

Learning about the targeting strategy in this manner appeared to exacerbate negative feelings about their teachers:

I didn't really like it, for teachers to think that [...], you're going to get pregnant, they don't really know me outside of school, so I don't think like they have the right to actually say to me you're going to get pregnant, you have to go to this programme, you have to work with kids. [...] So it's a bit like sad to hear that teachers think something like that about you. It's scary actually.

*Comparison interview 1, School*

Some young women described feeling "insulted", "annoyed" and "angry" that their teachers believed them to be at risk for teenage pregnancy:

They [other students] were like, 'Oh, you only got picked because you put you had sex [on the RCT baseline questionnaire]', and I was, 'No, I didn't' ...

**Did you believe them at all?**

Yeah.

**How did that make you feel when you were believing them?**

Annoyed and angry at the teachers that picked us.  
*Interview 2, School 4*

For a few women, their latent mistrust of teachers was simply confirmed and perhaps strengthened through this experience.

### **Labelling and reinforcing stereotypes.**

For some study participants, particularly in one school, their perception of a predominance of young Black and Minority Ethnic (BME) women identified for the programme signalled T&T's focus on risk.

**Okay, so what about the girls that you saw [at the informational meeting] made you think [the programme was about teenage pregnancy]?**

Because they were all, like, black girls. So I just thought that it was, that it was that.

**Okay, does anybody else think that?**

Yeah

**In the school or in the group?**

In the group. At first we all did, but then, not now we don't.

**Okay, did it bother you at all?**

Not really.

*Interview 4, School 1*

The young BME women in this study not only appeared to be aware of this perception, but may have also internalised or accepted it.

For the participants in two of the schools, a preponderance of peers who had a reputation of being "loud" was another clue to the purpose of T&T: "[The informational meeting] was like most of the loud girls, but it's like most of the black girls, like a few Somali girls, and one Asian girl, but she hangs around with the loud group." [Comparison interview 1, School 1]

When discussing why they may have been selected for T&T, the young women quoted below characterised their behaviours positively, yet at the same time appeared conscious of the incongruence of such behaviour with the expectations of their teachers and the school: "Because us lot are more outgoing, isn't it?" "Yeah". "If that make sense, we're really, like, straightforward about things". [Focus group, School 4]

In the focus groups, voices regarding dissatisfaction with being considered at risk were dominant. Only later, in more intimate settings, were opposing voices heard. For example, in a triad interview, it emerged that other young women in this study were indifferent about being considered by their teachers to be at risk of teenage pregnancy.

**How do you feel that somebody might put you in a group of people that [...] they think might have children when they're a teenager? How does that feel?**

YW1: That feels insulting.

YW2: I don't really mind. *You don't mind.*

YW1: I would be insulted by that.

*Triad interview, School 1*

A couple of the young women felt that labelling could encourage young people to participate in risky behaviour and that in fact information about sexual health and parenting would be useful for all young people.

Putting tags on girls, 'cause they don't really know us outside of school, [...] so they can't just tell us, you're going to be pregnant, we're trying to stop you from being pregnant. That's gonna make the girls want to go and get pregnant.

*Comparison interview 1, School 1*

"I think it should be for, good for all peoples, [...], so then like they can all understand, because it could be anyone that, like needs, [...], doesn't know what to expect or how to understand little kids". [Comparison interview 1, School 4]

Another young woman thought it would be hard to determine, based on assumptions about particular background characteristics, who would experience a teenage pregnancy:

... some people say like, 'Oh, children with bad families and that might get in that predic...' I think they can be the most quietest person and you would never know they get into that predicament, but I don't think it's any sort of person, I think anyone could really do it.

*Comparison interview 2, School 3*

**Managing risk reputations: distancing, silence and refusal.**

Young women targeted for T&T appeared to employ three risk reputation management mechanisms in reaction to being identified as at risk for teenage

pregnancy: distancing, silence and refusal. For example, one young woman in the control arm described feeling relief when she discovered that she had not been picked to participate in the T&T programme.

I was actually relieved.

**Relieved that you didn't get picked?**

Yeah, 'cause I thought they picked the girls that were like proper most likely to get pregnant, that's what I thought, ain't it, so, [...] like wow they don't think that about me anymore.

*Comparison interview 1, School 1*

She was not aware that she had been randomly allocated to the control group. Albeit erroneous, she interpreted her *not* being selected to participate in T&T as a welcome indication that she was not in the same category as her *riskier* peers; she had avoided a potential loss of status by not being chosen, thus distancing herself from the associated stigma (Link & Phelan, 2001; Goffman 1959, 1963).

Though the young women were typically excited about participating in the T&T programme, (Sorhaindo et al., *in press*), some described how they managed the stigma associated with being labelled as at risk of teenage pregnancy by remaining silent about the programme's aim when talking about it with others, including their parents.

*...what do you think your mum would think about that?*

Mum would get angry.

My mum would be really upset. Yeah, she'd be like, "What...?"

*...so do you tell her?*

And my dad would be upset...

No, I didn't tell her, because then I don't really want my mum to be like, "Oh, well, you can't go there any more," 'cos my mum is that kind of person...

I really want to do this.

Yeah. So I just didn't tell my mum.

*Focus group, School 3*

Some young women simply refused to accept that they were at risk of teenage pregnancy:

I think the one where you got picked because you're more likely to have children soon, I think that's rude. 'Cause I know I'm not one of those people and I know like all of us that are there would not [...]

**So why would you think it's rude?**

Because that means I'd be seen as a person that is most likely to have sexual intercourse at a young age, and I'm not.

*Single interview 2, School 1*



Others exhibited refusal by recasting the meaning of participation in line with their, less negative, self-perception. In an interactive activity where the young women were asked to fill-in-the-blank of a statement written on a card provided by the study researchers, one group changed their response:

At first we wrote, what's it? [reading card] 'Girls that are vulnerable and gullible to get pregnant at a young age.' But then we realised that we're in the programme so this was talking about ourselves, and I'm not vulnerable. [Laughter.] So then we changed it to 'Girls that are mature enough to know when it's right to have children'.

*Focus group, School 3*

## **Discussion**

Existing literature on targeting high-risk young people suggests that the approach can have unintended consequences (Evans et al., 2014; Wiggins et al., 2009; Bonell & Fletcher, 2008; Dishion et al., 1999). This study contributes to this literature by highlighting aspects of the experience of being targeted: feelings of confusion and resentment, the experience of labelling and reinforcement of stereotypes, and the need for additional identity work to manage risk reputations.

This study is limited by small sample size, as is common in qualitative research, and focussed only on London schools. Furthermore, though the lack of demographic information on the focus groups and paired/triad interviews participants somewhat limits our ability to contextualise the findings this information was collected from in-depth interviews with the same young women. The study was also imbedded in a larger evaluation with a different aim and a complicated recruitment strategy. In fact, the RCT could have been responsible for some of the students' (and teachers') confusion about the targeting criteria and strategy. Finally, as about one-quarter of the young women who participated in T&T eventually dropped out mostly due to conflict with lessons or because they disliked the programme (Bonell et al., 2013), this study could have suffered from selection bias whereby the students with potentially less interest in school and more satisfaction with the programme remained. Despite these shortcomings, it provides insight into the experience of being targeted.

Many of the young women began the programme with lack of clarity regarding what the programme was for and why they had been selected to participate. They speculated about a number of potential reasons, and several expressed doubt regarding their teachers' honesty about the selection process. Learning that their teachers believed that they were at risk for teenage pregnancy and needed intervention left many young women feeling angry and mistrustful. Previous research by Evans et al. (2014) also found that inadvertent discovery of the targeting criteria led to negative labelling and bitterness among the intervention participants. Research on student disruption and teacher discipline in schools found an association between teachers who focussed on respect, personal regard and trust in their approach to discipline, and low student defiance; the relationship was mediated by students' perception of teacher trustworthiness (Schneider, Judy, Ebmey, & Broda, 2014; Gregory & Ripski, 2008). As positive relationships with teachers are important for learning, behaviour and overall wellbeing (Holfve- Sabel, 2014; Gorard & See, 2011; Gregory & Ripski, 2008), this experience could have wider implications.

Some study participants believed that the assessment of their risk for teenage pregnancy was based on prejudices related to their BME status and a negative interpretation of their outspoken character; and the characteristics of the women selected for the programme seemed to reinforce these existing stereotypes (Ferri & Conner, 2010; Archer, Halsall, & Hollingworth, 2007; Jackson 2006; Ali 2003). Half of the young women selected by their teachers and included in the RCT were from non-White ethnicities (Bonell et al., 2013). However, in only one of the four case-study schools was the overall proportion of students from non-White ethnicities close to this (45%). Only one-quarter of the students in two of the schools and 18% in the fourth school were non-White. Therefore, it is not surprising that the study participants observed that the proportion of young women from BME groups put forward by their teachers for participation in the intervention did not reflect the actual distribution of BME at their school.

The stereotyping of BME youth is pervasive in modern schools and young people's BME status is often "equated with failure and risk". As young white women co-opt this culture they are also similarly pathologised as hypersexualised 'problem girls'

(Ferri & Conner, 2010; Ali, 2003). In an exploration of the 'ladette' culture among young women in the UK, Jackson (2006) points out how this modern departure from traditional and 'acceptable' forms of middle-class, and largely White femininity, signifies risk. From the perspective of the young people engaging in the culture, their posturing and behaviours were, in part, about protecting their self-image and presenting themselves more favourably (Goffman, 1959, 1963). However, in the school context, this further identified them as deviant and needing intervention (Jackson, 2006). Previous research suggests that young women in London secondary schools with low levels of achievement use strategies, including poor behaviour in the classroom, which they described as "being loud" and "speaking their mind", to challenge the quiet and passive feminine norms that are typically rewarded at school. Such behaviour often put the young women at odds with the school and was interpreted as deviant (Archer et al., 2007). Furthermore, "loud" behaviour from BME groups may reinforce stereotypes about Black students as belligerent (Archer et al., 2007; Fordham, 1993).

Young people may adopt a range of strategies to manage and control being considered 'at risk' (Mitchell et al., 2001). Several young women in this study felt it necessary to distance themselves from or reject risk identities. Silence is a common feature of stigma and risk management strategies (van Brakel, 2006). The young women's concern about their parents' possible negative reaction to them being targeted for the T&T programme may have been warranted. In a focus group with parents (not related to young people participating in T&T), conducted during the formative evaluation phase of the larger project, some parents expressed concern that their children could be selected based on stereotypes, specifically related to ethnicity, and that there would be consequences associated with the 'at risk' label. Further, despite an awareness of the written guidance provided to teachers, they were skeptical about whether teachers would be objective and about teachers' competency for making sexual health risk assessments (Sorhaindo et al., 2009).

Some young women were indifferent to being targeted for intervention. Though it is difficult to interpret this, some possible explanations could be that, in the context of schools where categorisation and labelling are common, perhaps young women targeted for T&T were accustomed to being perceived as problematic and

had come to accept this characterisation. Alternatively, this response could indicate the effects of labelling taking hold. Link and Phelan (2001) argued that individuals internalise social perceptions and beliefs about undesirable characteristics and thus anticipate rejection and discrimination (Sampson & Laub, 1997).

### **Conclusion**

Targeting as a strategy for allocating resources towards prevention and treatment has its merits, potentially both in terms of equity and impact, if risk is not normally distributed. However, the approach may carry consequences that prevent interventions achieving their full benefit. The process of selecting young people for T&T led to negative emotion, potentially reinforced existing stereotypes and forced the participants to conduct additional identity work to manage the label imposed upon them. An alternative approach would be to include prospective participants in the process by informing them of the targeting strategy and/or inviting them to opt in based upon open discussions and mutual assessments about their sexual health needs. Not only could this potentially prevent some of the negative experiences found here, but also, consciously engaging in an intervention to prevent risk behaviour may lead to increased adherence and intervention effectiveness, which may outweigh the costs of any reduction in participation. Otherwise, schools may introduce programmes that operate on the population-level, including all students, regardless of their risk. This approach would limit the unintended consequences of targeting and reduce incidence of teenage pregnancy, by lowering risk in the overall population

## References

- Alderson, P., & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. Ilford, Essex: Barnardo's.
- Ali, S. (2003). 'To be a girl': culture and class in schools. *Gender and Education, 15*, 269-283. doi: <http://10.1080/09540250303859>.
- Archer, L., Halsall, A., & Hollingworth, S. (2007). Inner-city femininities and education: 'race', class, gender and schooling in young women's lives. *Gender and Education, 19*, 549-568. doi: <http://10.1080/09540250701535568>.
- Arie, S. (2014). Has Britain solved its teenage pregnancy problem? *British Medical Journal, 348*. doi: <http://dx.doi.org/10.1136/bmj.g2561>.
- Balfe, M., Brugha, R., O'Connell, E., McGee, H., O'Donovan, D., & Vaughan, D. (2010). Why don't young women go for chlamydia testing? A qualitative study employing Goffman's stigma framework. *Health, Risk and Society, 12*, 131-148. doi: <http://10.1080/13698571003632437>.
- Bonell, C., & Fletcher, A. (2008). Addressing the wider determinants of problematic drug use: advantages of whole-population over targeted interventions. *International Journal of Drug Policy, 19*, 267-269.
- Bonell, C., Maisey, R., Speight, A., Purdon, A., Keogh, P., Wollny, I., Sorhaindo, A., & Wellings, K. (2013). Randomized controlled trial of 'teens and toddlers': A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery. *Journal of Adolescence, 36*, 859-870. doi: <http://10.1016/j.adolescence.2013.07.005>.
- Carey, G., & Crammond, B. (2014). A glossary of policy frameworks: the many forms of 'universalism' and policy 'targeting'. *Journal of Epidemiology and Community Health, 68*. doi: [10.1136/jech-2014-204311](https://doi.org/10.1136/jech-2014-204311).
- Cerdá, M., Tracy, M., Ahem, J., & Galea, S. (2014). Addressing population health and health inequalities: The role of fundamental causes. *American Journal of Public Health, 104*, S609-619. doi: <http://10.2105/AJPH.2014.302055>.
- Creaney, S. (2012). Targeting, labelling and stigma: challenging the criminalisation of children and young people. *Criminal Justice Matters, 89*, 16-17. doi: <http://10.1080/09627251.2012.721967>.

- Creswell, J.W. (2007). *Qualitative Inquiry and Research Design* (2nd Ed). Thousand Oaks, London and New Dehli: Sage Publications.
- Department for Children, School and Families (DCSF). (2010). *Teenage Pregnancy Strategy: Beyond 2010*. (DCSF-00224-2010). London: Department for Children Schools and Families.
- Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm. *The American Psychologist*, *54*(9), 755-764.
- Evans,R., Scourfield, J., & Murphy, S. (2014). The unintended consequences of targeting: young people's lived experiences of social and emotional learning interventions. *British Educational Research Journal*, *41*, 381-397. doi: <http://10.1002/berj.3155>.
- Ferri, B.A., & Connor, D.J. (2010). 'I was the special ed. girl': urban working-class young women of colour. *Gender and Education*, *22*, 105-121. doi: <http://10.1080/09540250802612688>.
- Fletcher, A., Gardner, F., McKee, M., & Bonell, C. (2012). The British government's Troubled Families Programme: a flawed response to riots and youth offending. *British Medical Journal* *344*, e3403. doi: <http://dx.doi.org/10.1136/bmj.e3403>
- Fordham, S. (1993). "Those loud Black girls": (Black) women, silence and gender "passing" in the academy. *Anthropology and Education Quarterly*, *24*, 3-32.
- Foster, L.R., & Byers, E.S. (2013). Stigmatization of individuals with sexually transmitted infections: effects of illness and observer characteristics. *Journal of Applied Social Psychology*, *43*, E141-E152. doi: [10.1111/jasp.12036](http://10.1111/jasp.12036)
- Gregory, A., & Ripski, M.B. (2008). Adolescent trust in teachers: Implications for behavior in the high school classroom. *School Psychology Review*, *37*, 337-353.
- Goffman, E. (1959). *The presentation of self in everyday life*. London: Penguin Books Ltd. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon & Schuster, Inc.
- Gorard, S., & See, B.H. (2011). How can we enhance enjoyment of secondary school? The student view. *British Educational Research Journal*, *37*, 671-690.
- Grimes, D.A., & Schulz, K.F. (2002). Uses and abuses of screening tests. *The Lancet*, *359*, 881-84.

- Holfve-Sabel, M.A. (2014). Learning, interaction and relationships as components of student well-being: Difference between classes from student and teacher perspective. *Social Indicators Research*, *119*, 1535-1555.
- Institute for Fiscal Studies. (2013). *Teenage Pregnancy in England Center for Analysis of Youth Transitions Impact Study* (Report No. 6). London: Crawford, C., Cribb J., & Kelly E.
- Jackson, C. (2006). 'Wild' girls? An exploration of 'ladette' cultures in secondary schools. *Gender and Education*, *18*, 339-360. doi: 10.1080/09540250600804966.
- Jessiman, T., Keogh, P., Scott, S., Wollny, I., Sorhaindo, A., & Bonell, C. (2012). Teens and Toddlers integrated process evaluation. (Department for Education Research Report DFE- RR212).
- Kneale, D., Fletcher, A., Wiggins, R., & Bonell, C. (2013). Distribution and determinants of risk of teenage motherhood in three British longitudinal studies: implications for targeted prevention interventions. *Journal of Epidemiology and Community Health*, *67*, 48-55. doi:10.1136/jech-2011-200867.
- Kreuter, M.W., & Wray, R.J. (2003). Tailored and targeted health communication: Strategies for enhancing information relevance. *American Journal of Health Behavior*, *27*, S227-S232.
- Kreuter, M.W., Hovmand, P., Pfeiffer, D.J., Fairchild, M., Rath, S., Golla, B., & Casey, C. (2014). The 'long tail' and public health: New thinking for addressing health disparities. *American Journal of Public Health*, *104*, 2271-2278. doi: 10.2105/AJPH.2014.302039.
- Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363-85.
- McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *The ANNALS of the American Academy of Political and Social Science*, *587*(1), 16-30. doi: 10.1177/0002716202250781.
- Mitchell, W.A., Crawshaw, P., Bunton, R., & Green, E.E. (2001). Situating young people's experience of risk and identity. *Health, Risk & Society*, *3*, 217-233. doi:10.1080/13698570124548
- Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage Publications.

- Rorie, M., Gottfredson, D.C., Cross, A., Wilson, D., & Connell, N.M. (2011). Structure and deviancy training in after-school programs. *Journal of Adolescence*, 34(1), 105-117. doi: 10.1016/j.adolescence.2010.01.007
- Rose, G. (1992). *Rose's Strategy of Preventive Medicine*. Oxford: Oxford University Press.
- Sampson, R.J., & Laub, J.H. (1997). A life-course theory of cumulative disadvantage and the stability of delinquency. In T. Thorberry (Ed.), *Developmental Theories of Crime and Delinquency*. (pp.1-29). New Brunswick, NJ: Transactions Publishers.
- Schneider, B., Judy, J., Ebmey, C.M., & Broda, M. (2014). Trust in elementary and secondary urban schools: A pathway for student success and college ambition. In, D. Van Maele, PB Forsyth, and M. Van Houtte (Eds.) *Trust and School Life: The Role of Trust for Learning, Teaching, Leading and Bridging*. Dordrecht, the Netherlands: Springer Science+Business Media.
- Smith, J.A., Flowers, P., & Larkin, M. (2009) *Interpretive Phenomenological Analysis: Theory, Methods and Research*. London: Sage Publications.
- SmithBattle, L.I. (2013). Reducing the stigmatization of teen mothers. *MCN. The American Journal of Maternal Child Nursing*, 38, 235-241. doi: <http://10.1097/NMC.0b013e3182836bd4>.
- Social Exclusion Unit (SEU). (1999). *Teenage pregnancy*. London: Her Majesty's Stationary Office.
- Sorhaindo, A., Keogh, P., Bonell, C, Jessimen, P., Smith, R., & Wollny, I. (2009). Findings from pre-RCT formative evaluation of the Teens & Toddlers programme: Interim report for DCSF. Unpublished document.
- Sorhaindo, A.M., Bonell, C, Fletcher, A., Jessimen, T., Keogh, P., & Mitchell, K. (2016) How do teachers conceptualise risk for teenage pregnancy?: An exploration of the process of selecting "at risk" young women in schools for targeted prevention intervention. Unpublished manuscript, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.
- Sorhaindo, A.M., Mitchell, K., Fletcher, A., Jessimen, T., Keogh, P., & Bonell, C. (in press). Young women's lived experience of participating in a positive youth development programme: The "Teens & Toddlers" pregnancy prevention intervention. *Health Education*.
- Teens & Toddlers (2008). Teens & Toddlers Intensive Implementation Programme. Haringey. Unpublished internal document.



- Van Brakel, W.H. (2006). Measuring health-related stigma – A literature review. *Psychology, Health & Medicine, 11*, 307-334. doi: 10.1080/13548500600595160.
- van Manen, M. (1990). *Researching Lived Experience*. Albany, NY: The State University of NY (SUNY).
- Weimann, C.M., Rickert, V.I., Berenson, A.B., & Volk. (2005) Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health, 36*, 352.e1-352.e.7.
- Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., & Weisz, J.R. (2005) Iatrogenic effects of group treatment for antisocial youth. *Journal of Consulting and Clinical Psychology, 73*, 1036-1044.
- Wiggins, M., Bonell, C., Sawtell, M., Austerberry, H., Burchett, H., Allen, E., & Strange, V. (2009). Health outcomes of youth development programme in England: prospective matched comparison study. *British Medical Journal, 339*, b2534. doi:10.1136/bmj.b2534

**Table 1.** Selection of socio-demographic characteristics of London Boroughs where case studies were conducted

<i>% non-UK born, 2009</i>	
School 1	53.0
School 2	38.8
School 3	33.3
School 4	28.2
Greater London	33.8
United Kingdom	11.4
<i>% of population who are Black, Asian or Minority Ethnic (BAME), 2013</i>	
School 1	64.9
School 2	50.2
School 3	46.9
School 4	39.6
Greater London	41.8
England	14.6
<i>Teenage conception rate, 2009 (per 1000 young people under 18)</i>	
School 1	38
School 2	37
School 3	63
School 4	59
Greater London	41
England	38
<i>% of 16-18 year olds who are NEET** , 2009</i>	
School 1	4.6
School 2	4.7
School 3	8.7
School 4	6.6
Greater London	5.3
England	<i>not available</i>

Source: London Data Store: <http://www.data.london.gov.uk/dataset/London-borough-profiles>

\*\* \* A NEET is a young person who is "Not in Education, Employment, or Training".

**Table 2.** Summary of qualitative data collected

	<b>School 1</b>	<b>School 2</b>	<b>School 3</b>	<b>School 4</b>	<b>TOTAL</b>
<b>Young people</b>					
Focus groups with participants (each including 5 young women)	1	1	1	1	4 (n=20)
Paired/Triad interviews with participants	1 x paired 1 x triad	1 x triad	2 x paired	3 x paired	8 (n=18)
In depth interviews with participants	5	3	3	4	15
In depth interviews with comparison participants	2	2	2	2	8

**Table 3. Characteristics of study schools and interview participant**

	Age at the time of interview	School year	Ethnicity**	Family life
<b>SCHOOL 1*</b>				
Interview 1	14	9/10	Black or Black British	Lives with both parents; four brothers and two sisters
Interview 2	14	9/10	Black or Black British	Lives with mother; two brothers and one sister
Interview 3	14	9/10	Black Caribbean	Lives with mother; young brother and younger sister
Interview 4	14	9/10	Black or Black British	Live with mum; has an older sister no longer at home; father has
Interview 5	14	9/10	<i>No response<sup>†</sup></i>	Lives with both parents and has four brothers and
Comparison 1	14	9/10	Black British	Lives with mother and six siblings
Comparison 2	14	9/10	Black British	Lives with mother, father, sister and brother.
<b>SCHOOL 2</b>				
Interview 1	14	9	Mixed English	Has one sister [No information on
Interview 2	14	9	Asian	Lives with mother, two sisters, cousin and nephew.
Comparison 1	14	10	Black British	Lives with mother, father, sister and brother; is the youngest
Comparison 2	14	9	Data not collected	Lives with mother and father and has 2 brothers and 2 sisters; only one brother and one sister
<b>SCHOOL 3</b>				
Interview 1	14	9	Black Caribbean	Lives with mother, sister and two nieces; and occasionally another
Interview 2	14	9	Polish	Only child and lives with mother and father.
Interview 3	14	10	Black	Lives at home with 5 brothers and sisters,
Comparison 1	14	9	<i>Data not collected</i>	Lives with mother, grandmother and sister
Comparison 2	14	9	Mixed Caribbean	Lives with mother, father and sister and brother
<b>SCHOOL 4</b>				
Interview 1	14	<i>Data not collected</i>	White	Lives with mother, father,
Interview 2	13	<i>Data not collected</i>	White	Lives with mother, two younger brothers,

Interview 3	14	<i>Data not collected</i>	White	Lives with mother and stepfather; has two brothers
Interview 4	14	<i>Data not collected</i>	White	One brother and one sister [No information on parents]
Comparison 1	14	9	Data not collected	Lives with father and two sisters
Comparison 2	14	9	Data not collected	Has an older brother and a younger brother [No information on parents]

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\* Students moved from year 9 to year 10 within the same school year  
† Respondent chose not to respond

**Evidence Chapter VII. How do teachers understand risk of teenage pregnancy?: An exploration of the process of selecting “at risk” young women in schools for targeted prevention intervention**

**How do teachers understand risk of teenage pregnancy?:  
An exploration of the process of selecting “at risk” young women in schools  
for targeted prevention intervention**

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*1 May 2016*

Word length: 6745/7000

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## **Abstract**

Disease prevention and public health often employ “high-risk” approaches, where professionals screen for and identify individuals at increased risk to offer preventive intervention. In addition to universal approaches, the UK Teenage Pregnancy Strategies (1999-2010) recommended the use of targeted interventions for “at risk” individuals. Professionals including those working in schools were tasked with identifying individuals to target. But it is not clear how school staff conceptualised risk for teenage pregnancy and thus identified students.

Data collected via the process evaluation of the Teens & Toddlers (T&T) pregnancy prevention programme were used to explore school staff’s views about risk and targeting. Interviews were conducted with 16 school staff responsible for the selection of participants in 12 of the 22 schools included in the evaluation.

School staff selected young women based primarily on individual-level factors and via three processes: application of the T&T programme selection tool; personal and institutional information about students, and “gut feeling” about overall “vulnerability”. Even when provided with guidance, school staff generally relied on their own understanding of risk of teenage pregnancy and strategies for identifying young people for intervention.

Our study suggests that individualised notions of risk and responsibility for health are being reproduced in schools by health interventions and the school staff who are responsible for managing risk. In practice, the approach relies on an incomplete picture of what is known about influences on health and illness. Universal approaches are more likely to have a population-level impact and avoid many of the challenges encountered with targeting.

**Key words:** schools; universalism; teenage pregnancy; targeted intervention; risk

## **Acknowledgements:**

We would like to thank the English Department of Education for funding the larger study from which this work was developed, the Teens & Toddlers programme and



all the teachers and other faculty at the schools that participated in this research. We are also grateful to Leon Feinstein for his helpful comments on early drafts of this manuscript.

## Introduction

“High-risk” strategies, whereby professionals screen for and identify particular individuals with increased risk within a population to offer them protective or preventive intervention, are common in disease prevention and public health. The high-risk strategy has intuitive appeal; the approach aims to target those most likely to be affected, and as such, might present a favorable cost-benefit ratio and effective use of limited resources (Rose, 1985; 1992). However, among other challenges with the high-risk approach, it is difficult to screen for and identify precisely which individuals are at greater risk (Rose, 1985; 1992). Though there have been improvements in detecting risk factors that, when applied to a high-risk approach, may increase the impact of prevention efforts (Frohlich and Potvin, 2008; McLaren et al., 2010), practitioners continue to struggle with the strategy.

A further criticism of the high-risk approach is the potential negative effects of “labelling” that may result from the screening process, particularly for outcomes that are viewed as deviant or stigmatising (Rose, 1992; Marmot, 2014). There may be social and psychological consequences for individuals deemed to be deviant or to be engaging in socially unacceptable behaviour (Plummer, 2001). In fact, having been labelled can promote further deviance (Lemert 1967). Individuals may internalise social perceptions and beliefs about undesirable characteristics and anticipate rejection and discrimination leading to withdrawal from “normal” society and the development of poor-self esteem (Link et al., 1989). This response to being labelled can increase vulnerability to future disorder (or deviance) (Sampson and Laub, 1997).

These problems of identifying who is at risk and potential inadvertent harms befalling those thus targeted do not occur with universal approaches, which instead aim to reduce the overall risk of entire populations, often by addressing more ‘upstream’ determinants. Universal approaches take action with the underlying causes, or social determinants (*e.g.* economic inequality), of deleterious outcomes at the level of the population, where successful intervention would shift the distribution of risk “to the left”, effectively reducing risk for all, particularly where risk is normally distributed. Ultimately, universal approaches are thought to

avoid a greater proportion of poor outcomes, as incidence is more likely to emerge from a large group at low or moderate risk, than from a small group at high risk (Rose 1981, 1985, 1992; Marmot 2014).

Nonetheless, targeted approaches continue to be deployed, particularly where there are concerns that risk may be concentrated in certain sub-populations and where there are fears that universal approaches may fail to address or even add to health inequalities (Frohlich and Potvin 2008). Nonetheless, a recent rapid overview of systematic reviews concluded that “downstream” preventative interventions that focus on individual-level factors, such as education, are more likely to increase health inequalities than upstream interventions that focus on social or policy level determinants (Lorenc et al., 2013).

Indeed, many policies in the UK targeting children and young people have been characterized by a “risk-focused prevention paradigm” (Brown et al., 2013; Turnbull and Spence, 2011; Shoveller and Johnson, 2006). In 1999, the UK Teenage Pregnancy Strategy (TPS) (1999-2010) was initiated under the auspices of the Social Exclusion Unit as an evidence-based approach to reducing under-18 fertility rates. Among a battery of interventions, including universal approaches, such as comprehensive sex education, the Strategy included a focus on targeting at-risk groups (Social Exclusion Unit, 1999). A key feature of the Strategy was the identification of risk factors for teenage pregnancy and the promotion of interventions targeted to populations at risk. The focus on high-risk was further strengthened in a mid-way analysis of the Strategy (BMRB International, 2005).

A range of professionals, including clinicians, social workers, public health practitioners, programme providers and others, working with youth are frequently positioned as authorities who define and regulate risk and have undertaken the role of “expert” in classifying young people into risk categories and introducing corrective interventions (Alaszewski and Coxon, 2008; Brown 2013). Under the TPS, local governments in areas with high rates of teenage pregnancy were provided with earmarked funding to implement “integrated and innovative” prevention programs. As part of this, local Teenage Pregnancy Coordinators and school staff were responsible for commissioning and implementing appropriate

interventions for their communities (Social Exclusion Unit, 1999). However, this role of “expert” may be problematic. In the context of an abundance of data and information, and corresponding interpretations of these, experts often struggle to reach consensus about the classification of risk, or about appropriate risk management strategies.

Risk discourse and the related expert use of scientific data analysis approaches has also facilitated the (re)framing of social problems, such as teenage pregnancy, once considered largely a moral dilemma related to parenthood out-of-wedlock, into non-moral terms (Macvarish, 2010). In particular, the framing of teenage pregnancy as important within a public health model allows for the “borrowing” of the credibility, legitimacy and authority of the health professional trusted to have the correct information and objectivity, and lessens the moral tone (Macvarish, 2010), despite the fact that health ceases to be a primary concern in pregnancies beyond very early adolescence (Kneale et al., 2013). Even so, morality continues to be a tacit source of concern:

“...a new form of moralising, which still has the regulation of individual behaviour in its sights, but which evades the direct engagement with arguments about right and wrong. The authority to which policy-makers appeal to identify social problems worthy of attention and to justify State intervention is of medical experts, epidemiologists, social psychologists and neuro-scientists.” (Macvarish J. 2010 p. 320)

When specifically considering children and youth, Turnbull and Spence (2011) argue that the assessment of risk has been used as a “tool of blame” to justify preventative intervention, surveillance and control, in some cases, even before the young person has presented a problem. Policies focused on risk have served as an impetus for practitioners and parents to become “risk managers” or to help young people to handle and respond to risks and challenges as they emerge, and to “be resilient to the things that can throw them off course and have the confidence and ability to manage the risks they encounter” (DCSF, 2008; Turnbull and Spence, 2011). Brown (2013) argues that this risk discourse promotes and justifies the practice of socially dividing young people into groups – risky vs. safe; acceptable vs. unacceptable – and that this sorting exercise may actually exacerbate hardship among already disadvantaged groups of young people.

The manner in which risk is conceptualised and then operationalised as a mechanism for prevention among youth may have important implications for health and wellbeing. Given schools' role in serving as "experts" in the identification of "at risk" young people and for selecting appropriate interventions, their understanding of what constitutes risk for outcomes such as early pregnancy and the process by which they select programmes and participants is likely to influence the effectiveness and acceptability of interventions.

The Teens and Toddlers Positive Youth Development and Teenage Pregnancy Prevention Programme (T&T) targeted schools from areas with high rates of teenage pregnancy and required that school staff responsible for inclusion, pastoral care, or Personal and Social Health Education (PSHE) select students between the ages of 13-15 considered to be at high risk of teenage pregnancy to participate (Teens & Toddlers 2008). However, little is understood about how schools and teachers conceptualise risk for teenage pregnancy. Using qualitative data from the T&T process evaluation, we addressed the following research questions: how did the school staff responsible for the recruitment and selection of young women conceptualise risk in terms of its source (individual or structural) and its distribution (broad or discrete)? and, how did school staff operationalise these conceptualisations of risk in their selection of young women to participate in T&T?

## **Methods**

T&T is an 18-20 week programme, designed for young people deemed by their teachers to be at risk of teenage pregnancy, that combines a classroom curriculum with mentorship of young children between the ages of 3-5 who are in need of additional support in a nursery or primary school setting (T&T, 2008). The T&T classroom curriculum focuses on child development, effective parenting skills, anger management, sexuality, and relationships. Participants also meet with a trainee counsellor for mandatory one-to-one sessions.

To guide school staff in selecting young women for the programme, T&T programme providers gave participating schools a one-page checklist of factors

associated with risk for teenage pregnancy, such as disengagement with school, engagement in sexual behaviour, and low self-esteem (Table 1). As part of a pre-RCT formative evaluation, the research team reviewed the checklist and suggested that some of the criteria were not based on evidence and were excessively subjective and offered them an improved alternative. However, later in the evaluation, the research team discovered that staff responsible for selection did not use the revised tool provided by the research team (Jessiman et al., 2012).

Students deemed by school staff to be at risk of teenage pregnancy were invited to an information session led by a T&T programme facilitator during school hours. Interested students and their parents signed a consent form in order to participate. A group of 6-8 students from each school, who were accepted onto the programme, attended 3-4 hour sessions based at a local nursery or primary school, typically, one afternoon a week. Participants successfully completing the programme achieved a National Award in Interpersonal Skills, Level 1.

We draw on data collected as part of a UK Department for Education-funded evaluation of the T&T programme from 2009 to 2011 (Bonell et al. 2013; Jessiman et al. 2012). Researchers at the National Centre for Social Research (NatCen) and the London School of Hygiene and Tropical Medicine (LSHTM) undertook a randomized controlled trial (RCT) including process evaluation to examine the success of the T&T programme at reducing risk factors to teenage pregnancy and to explore the feasibility, fidelity, accessibility and acceptability of the intervention. The RCT was conducted in 22 schools in England. Most of these schools (N=12) were in the greater London area and the remaining 10 were in the north of England (Bonell et al. 2013). As part of the process evaluation, the evaluators interviewed 16 school staff responsible for the selection of student participants in 12 of the 22 schools. These were typically one or two staff from each school responsible for the selection of participants for the intervention. An initial 11 school staff participants were conveniently sampled from London-based schools participating in the RCT based on their availability and a further five from schools in the north of England. These interviews covered: the criteria used to select young people for the programme, the use of the guidance provided by T&T, confidence in the selection and the anticipated impact of the programme on the young women

who participated. All the interviews were conducted in private spaces at the school, or by telephone, and were recorded (with permission) and transcribed. Each interview lasted between 30 and 45 minutes. The research ethics committees of NatGen Social Research and LSHTM granted ethical approval for the study.

The results of the RCT and process evaluation are reported elsewhere (Bonell et al. 2013; Jessimen et al., 2012). To explore the research questions posed here, the transcripts from the 16 school staff responsible for selecting young women to participate in T&T were re-analysed using techniques borrowed from phenomenological and thematic analytic approaches (Glaser and Strauss 1967; Creswell 2007). AS read through the interview transcripts several times and took notes or highlighted sections of texts that appeared to represent school staff's conceptualisations of risk for teenage pregnancy. These notes and sections of texts were written or printed onto small pieces of paper, reviewed separately from the transcripts and organised into emergent themes. AS and KM reviewed, refined and agreed upon a set of meaning units and worked together to develop clusters of interconnected meaning units (Smith *et. al*, 2009). AS, in consultation with KM, undertook line-by-line coding of data in NVivo using the clusters of meaning units as a coding frame (Smith et al., 2009; Creswell, 2007), undertaking constant comparison analysis of the coding frame refining the meaning units and the codes during the process.

## **Results**

### ***School staff attitudes towards teenage pregnancy and the intervention***

School staff were interested in T&T because they believed that aspects of the intervention approach would reduce teenage pregnancy. For example, they believed that “raising awareness” about the difficulty and responsibility involved with raising a child and about the consequences of early pregnancy would be effective in reducing fertility rates among young people in their school and their community. The focus on providing young women with information on sexual health also attracted teachers to the programme:

“...although they seem quite kind of streetwise, you kind of assume they know certain things and just stuff about sexual health, and stuff about how

to protect themselves and all that, like it's just nice to know that they've been given that information and have that knowledge, and whether they choose to use it, or not, is really it's kind of like a choice they have to make themselves, but at least we have kind of helped equip them with some kind of knowledge in those areas."

*School 1, Teacher 1*

The notion that young people have a "choice" about their risk for teenage pregnancy arose in many of the conversations with school staff. The T&T intervention was viewed as a tool to "equip" young people to make "better choices" or "good decisions" about their sexual health and other problem behaviours, and increase their cognisance of the lifestyle "options" that are available to them.

"Ok, personally my understanding is to better equip young people to make good choices, or the right choices, whether they are good or not [laughs] just so they've got all the knowledge they need before they make a decision. [...] and again just that they are better informed of the options that they have, whether that is involving sex, drink, drugs, you know, just a better knowledge of things."

*School 3, Teacher 1*

The school staff member below discusses how raising young people's awareness of the alternative lifestyle options available to them can increase students' aspirations and encourage them to break generational cycles of early child bearing and worklessness:

"[...] just because their elder sister did it, doesn't mean they've got to, or just because their mum did, or, you know, we're now into the third generation of parents who've never worked and so, you know, it's I want you to raise your aspirations. I don't just want you to think, 'I'm going to have a baby', you know, what else can you get out of school?"

*School 5, Teacher 1*

To address our research questions, we explored how school staff discussed their views on and involvement in the selection of young people believed to be at risk for teenage pregnancy for the T&T intervention. Figure 1 summarises the responses of the 16 interviewees and we discuss these in more depth below.

### ***How do teachers conceptualise risk for teenage pregnancy?***

When asked to describe the characteristics they looked for to determine a young woman's risk of teenage pregnancy, over half of school staff interviewed reported that a sense of overall "vulnerability" was a key risk factor for teenage pregnancy and that it was one of the criteria they used for selection into the T&T programme



(Figure 1). As one interviewee noted, this term could comprise “anything”, and this latitude in thinking was reflected in other interviewee definitions:

“We looked through it and decided who we felt was vulnerable, and that could be anything. To be honest it could be that they come from quite a large family, they may have had issues in school, they may have been excluded, there may be issues at home, they may [be] sexually active...”

*School 3, Teacher 1*

“Vulnerable in the sense of [pause] it could be a child protection issue... or it could be, as I said before, a social issue where there’s either single parents or young parents, or there are other problems that are faced at home. Then those could be the ones that are chosen for the particular programme.”

*School 2, Teacher 1*

In general, young women described as vulnerable by school staff were struggling (academically, socially, emotionally) or were thought to be involved in behaviours or activities that the teachers believed to be harmful to their wellbeing. For one teacher, these activities included disruptive behaviour and spending too much time with boys:

“Like behaviour issues. Disruption. Finding them too much with the boys. You know, vulnerability in that sense”.

*School 7, Teacher 1*

Another teacher described the emotional challenge and frustration some young women appeared to experience as they struggled to perform academically:

“A lot of girls who are angry, for whatever reason, because they’re not academic and they’ve been hammering a square peg into a round hole and they just get really cheesed off with it, sometimes they get very short with people and they have a lot of squabbles and fights and that, you know?”

*School 6, Teacher 1*

This teacher actively sought alternative interventions for her challenging students and believed they would benefit, both in terms of pregnancy prevention and with regard to their emotions, attitudes and social relationships, from a less formal approach to intervention.

“[...] just doing something a bit different that’s not mainstream education I think is refreshing for them.

*School 6, Teacher 1*

In addition to information and observations of behaviours specific to school performance, school staff also considered a number of aspects of young women’s self-concept to be indicators of risk factors for teenage pregnancy. For example, nearly every school staff member interviewed considered “lack of self-esteem” or “lack of self-worth” as risk factors for teenage pregnancy (Figure 1).

“...they lacked self-esteem, they lacked real self-worth ... we have a couple of kids every year who end up pregnant because they don't know a lot, they're just incredibly naïve.”

*School 5, Teacher 1*

“[...]some of the girls that are identified, their self-esteem's quite low and that's probably why they are at high risk maybe of kind of getting into kind of underage relationships and things like that.”

*School 1, Teacher 2*

School staff described how they believed self-esteem to be related to teenage pregnancy. For example, one member of school staff argued that low self-esteem led to premature sexual relationships and an inability to resist male sexual advances, therefore risking early pregnancy:

“[...] it's interesting, how their self-esteem gets knocked. [...] giving them confidence to say no to boys and things.”

*School 2, Teacher 2*

Similarly, high self-esteem was perceived by another member of school staff as promoting good decision-making that would avoid teenage pregnancy by increasing knowledge and self-worth:

“I think for all of them a raised self-esteem I think is the biggest thing. Again, about making good decisions being equipped to make good decisions, valuing themselves [...] and hopefully in valuing themselves and understanding situations better, you know, won't be faced with teenage pregnancies, because at the end of the day that's the thing we're trying to avoid [laughs].”

*School 3, Teacher 2*

A handful of school staff also mentioned personality traits, such as being “quiet” or “withdrawn”, as risk factors for teenage pregnancy. Terms such as “shy”, “naïve”, and “lonely” were also used. Some school staff explained that such young women are often overlooked for intervention, as the more disruptive and loud students receive much of the attention.

“[...] those who are withdrawn or shy or somehow haven't got good social skills, maybe something like that, so that was the sort of cohort we were looking at.”

*School 12, Teacher 1*

Using these conceptualisations of risk for teenage pregnancy as a framework, school staff employed a number of strategies to locate and select potential participants for T&T.

### ***How did school staff operationalise these concepts to select and recruit “at risk” young women to participate in T&T?***

Although most school staff were able to name several different factors that they considered to be indicators of risk of teenage pregnancy, a couple found it difficult to narrow down the criteria, as they believed that a diverse group of young women possessing a range of characteristics could potentially be at risk for teenage pregnancy. For example:

“Well here we haven’t got a main type of girl that we aim it at, it is a varied selection...”  
*School 5, Teacher 1*

“...so there was not a particular girl or boy we were looking for. It was just a broad sort of, you know...”  
*School 3, Teacher 1*

Additionally, some school staff described the difficulty they experienced with finding a system or process for selecting students for the programme that would not potentially stigmatise or label the young women. One teacher explained:

“[Sighs lightly]. I don’t know [how we select them]. That’s why I’m saying it’s very difficult to actually say ‘how do you do this’, because if you ask for, say, the Year 9 team’s input, if I was to put an email out saying ‘we’ve got a Teens and Toddlers programme that aims to, its aim is this, can you think of any students?’ Are you going to give them more information than they need? You know, sometimes it’s difficult. You shouldn’t sort of judge students, but some people will and you don’t want them to do that either...”  
*School 4, Teacher 1*

Other school staff found it challenging to make fair assessments about students’ eligibility for T&T. As one teacher reviewed indicators listed in the assessment tool (Table 1) with the researcher they realised that they did not have access to the relevant data and information required:

“Well, it’s difficult, you know? We have a year group of 240 students. I’ve only been in this role since September. I can’t say I could tell you about every student. The fact that I do attendance every week, I have to see who’s under a certain bit, would tell me who the bad attenders are. The rest of it, you know, some of it I’ll know. Disruptive behaviour I’ll know because they come through my office. In care, I’ll know. Parent or sibling was a teenage, no, I wouldn’t automatically know that...”  
*School 4, Teacher 1*

Our analysis identified three specific strategies used by school staff to locate young people at risk for teenage pregnancy: use of the original T&T intervention selection

tool; assessment of key student and school data; and their “gut feeling”. These are described below.

*Strategy one: Using the T&T selection tool*

A minority of school staff used the original tool for selection provided by the T&T programme to identify possible participants (Jessimen et al., 2011); six of 16 school staff interviewed (none used the one provided by the research team). Among those who did use the tool, it was applied in a variety of ways.

About half of these school staff first made a broad selection of young women based on their knowledge of the students and then used the criteria in the T&T selection tool to determine, among this sub-set, who was at the highest risk for teenage pregnancy. This process was sometimes documented and other times conducted *ad hoc*. Given the small number of spaces available on the programme, school staff reported that the checklist helped them to narrow down the larger group of potential participants to those they believed would most benefit:

“[...] because we fill in a sheet when we select anyway to see actually, although we think they’d be good for it, do they sort of match the criteria because on the original programme we had a huge number of students that we wanted to send out and then we had to break them down by going through this checklist.”

*School 3, Teacher 2*

One staff member described how she read the tool and bore the suggested criteria in mind when considering which students to recommend for the programme. A minority of school staff appeared to value the guidance from the T&T programme in helping them use specific criteria for selection and to choose the “right” young women for the intervention, but still struggled to find a discrete group at high-risk to put forward.

In two schools, the school staff distributed the T&T selection tool to the students and asked them to respond to the questions. Later, the school staff scored each young woman’s level of risk based on their responses:

“No, what we did was we got the girls in; they filled in their questionnaire, then the teachers helped to rate them, you know, a special questionnaire was given and the teachers were asked to fill in certain things about the girls.

[...] [The checklist] is good because it gives additional information here, which you may not be aware of. And it also helps us, helps you, for example

with attendance, with family background you may not know about..."

*School 7, Teacher 1*

Some school staff reported that they did not have sufficient information about the young women's personal lives to help them to determine their risk for teenage pregnancy. Allowing the potential participants to complete the selection tool themselves helped these school staff to acquire additional information about the young women's personal and family life to aid in the assessment of risk and need for intervention.

*Strategy two: Assessment of key student and school data*

Some staff did not use the tool (n=10) but nonetheless followed a fairly systematic procedure using the data they had to hand. Given their role in pastoral care and student welfare, some school staff responsible for selection had access to documentation regarding their students' school performance (academic and behaviour) and often also used this information to determine whether their students were at risk and would benefit from intervention.

"[...] we looked at their attendance, we have a thing at school, records of concern, and [...] we sat together and we also spoke to heads of houses and sort of just identified girls that were having these problems here, in different shapes or forms even with attendance or even with their emotions."

*School 4, Teacher 2*

Some school staff described how they used 'local evidence' - a combination of school staff experience with the students and school data - to decide, collectively, which young people would benefit from intervention. A staff member responsible for selection described how she worked together with her colleagues, pooling their experience and expertise, to draw up a list of potential T&T intervention participants grounded in school-level student data:

"...it's mainly Year 9/Year 10 so that head of year would have a feeling for her year group, but also the learning mentor works with one or other of those year groups so they would have an input, the counsellor might work with some of those year group and so on and so forth and so it's about sort of making a decision together based on our, you know, the knowledge we have of them, plus also the data we have on them, their behaviour logs, their conduct logs, their attendance figures, if we know of any issues with social services, whether they're looked after, that sort of thing might come into play as well.

*School 11, Teacher 1*

Given their positions in pastoral care, several school staff had privileged information on the young women's personal lives that helped them to determine the need for intervention. One member of school staff explained:

“Because of my work with the Head, the students in the year, we talk about kind of quite confidential things so I know quite a lot about personal, what is going on, like in their personal lives so I know that I would know like for a fact that some of them have been sexually active, or some of them may have even had pregnancies previously...”

*School 1, Teacher 1*

### *Strategy three: Gut feeling*

Despite access to data and information about their students, some school staff described how they based their decisions on a “gut feeling” or an intuitive sense of particular young women's need for intervention, and on hearsay regarding sexualised behaviour or drug and alcohol use. Some school staff explained that their experience working closely with students in schools for many years afforded them a familiarity with the characteristics of “at risk” young people such that they were able to rely on their instincts. For example:

“I mean this sounds very woolly but a lot of it is, especially when you're quite experienced and you've been, I've working with these girls for a long time. You get a sort of innate feeling that this girl is going that way, partly because of the way they present, the things they say, whether they're, you know sort of interacting with boys when they shouldn't [...] so a lot of it is a, you know, maybe a gut feeling I suppose to put it, in loose terms, so we'd look at all those issues and then we'd make some judgments on whether we thought that was the right student.”

*School 11, Teacher 1*

Further, in lieu of more objective information school staff reported using visual cues, such as the way a young woman dressed or whether she spent leisure time with boys, as indicators for selection:

“I mean we make assumptions based on, we hear things, whether they are going around with a boy, whether they are talking about boyfriends, but also how they dress, you know it is, it's very sort of circumstantial, we're guessing, we don't ask them for sure.”

*School 12, Teacher 1*

## **Discussion**

As schools and school staff often serve as ‘risk managers’ or ‘experts’ responsible for commissioning risk reduction interventions and selecting students for

participation in these, how they conceptualise risk and operationalise targeting can influence the approaches they support, who they select, and thus whether any particular programme has a reasonable likelihood of success. To contextualise school staff's notions of risk for teenage pregnancy we presented data on their general views on factors that protect against early fertility and why T&T was considered a useful approach. School staff reported believing that factors such as sexual health education, empowerment to make good choices with regard to their sexual behaviour, and raising educational and employment aspirations were salient protective factors. Moreover, they viewed the T&T intervention as appropriate, as it consisted of components that aimed to develop these factors among young women at risk.

Most school staff included in this study characterised risk for teenage pregnancy as vulnerability and lack of self-esteem. They described vulnerable young people as those experiencing difficulty or challenge in an area of their lives. In making their case for targeted intervention, Frohlich and Potvin (2008) define vulnerable populations as "a sub-group or subpopulation who, because of shared social characteristics, is at a higher risk of risks" (p. 218). Our data suggest that many school staff shared this view that vulnerable young people were more susceptible to poor outcomes than other students in the school, and that a number of personal, social and school-level factors indicate this. Despite clear indications that school staff were motivated and well-intentioned in their attempt to support young women whom they felt needed guidance, there were problems with their conceptualisations of risk for teenage pregnancy that may thwart them from effectively fulfilling their role as risk managers. School staff's characterisation of particular young women as vulnerable reflected their concern with the students' wellbeing and desire to offer help. However, their notions of vulnerability were vague and variable. Though nearly all school staff believed self-esteem to be a risk factor for teenage pregnancy, the evidence is much more mixed (Goodson et al., 2006). Similar to their characterisation of vulnerability, their definition of self-esteem was also ambiguous.

In their 2011 research on the use of risk factor analysis in UK child and youth social policy, Turnbull and Spence documented the routine use of ambiguous

phrases referring to various perceived risks in social policy discourse, such as “negative” or “disadvantage”, and “problem behaviours”, to encompass a wide range risk factors and characteristics. The school staff definitions of vulnerability resembled such popular social policy discourse. Although school staff could, and did, name specific factors that, for them, signified vulnerability and thus risk for teenage pregnancy, they also admitted that vulnerability “*could be anything*”. This vague, catch-all term appeared to provide teachers with authoritative language with which to describe young women whom they perceived to be problematic and with whom the school staff wished to intervene or engage; and sufficient ambiguity to allow for flexibility in determining who fell into this category. Previous research has highlighted how school cultures dominated by middle-class values may reproduce inequalities by viewing counter cultures that resist schools’ focus on academic achievement and discipline as inappropriate or deviant (Fletcher et al., 2009; Archer et al., 2007; Jackson 2006). The power that school staff in the study held to open opportunities for intervention granted them an additional authority over defining what was acceptable school culture and the ability to apply this definition to specific sub-groups of the student body that manifested values that were in conflict with the school. However, this flexibility also offered a helpful advantage to school staff needing to be creative in how they divvied out alternative opportunities for young people they believed needed additional support with their overall social development in a context with limited resources.

School staff struggled to operationalise their conceptualisations of risk for teenage pregnancy. They found it difficult to determine a set of discreet criteria that would indicate that a young woman was at risk. Rather, they were able to list a range of factors that could raise their concern. Further, as they were cognisant of the potential stigma and labelling that the young women could experience as part of the selection process, they had to be creative in their data gathering strategies to attempt to protect their students. In other cases, they did not have access to relevant information, such as attendance, family life, drug alcohol use and sexual risk behaviours in order to make a reasonable assessment of risk. Despite these obstacles and challenges, they drew upon the resources available to them to help with selection: the T&T selection tool, student and school data and their “gut



feeling”. Each of these approaches was an attempt to determine which young women were at most risk and in need of intervention, given limited places in the programme.

Castel argued that professionals evaluate risk through practices of assessment and classification of information (Stanley, 2013; Castel, 1991), and that the process followed is as important as who is conducting the assessment (Stanley, 2013). Staff in the schools implementing T&T employed various mechanisms to determine which of their students would benefit from the intervention. Less than half of school staff used the guidance provided by the programme to determine risk; the others selected young women based upon their personal perceptions or definitions of risk, and the student information and school data available to them. In Stanley’s (2013) research with social workers in New Zealand, information on clients and knowledge of the client’s situation was interpreted by social workers through the lens of their experiences. Based on this combination of facts and intuition, social workers determined their clients’ need for intervention. An *a priori* understanding about what features of an individual’s experience should indicate cause for concern preceded any official classification of risk and influenced social worker’s determination of this. Similarly, in this research, both information stemming from policies and discourses on risk for teenage pregnancy and school staff’s internal understandings of what signifies potential for poor outcomes shaped their choices about the information used to make the assessment. The T&T selection tool may have prompted school staff’s focus on primarily individual-level factors, but few actually used this. The routine information collected in the school environment, school staff’s familiarity with students, their responsibility for students’ welfare and their experience engaging with a wide range of young people afford school staff a unique sense of students’ life; a potentially invaluable resource for anticipating problems and achieving prevention. Despite this, the knowledge and expertise needed to function as experts may need to be more precise than what is available. In particular, although school staff tend to be well-acquainted with their students and over time may develop an ability to detect patterns in behaviour and attitudes that signify risk, the practices and processes used to select young people for intervention in most of the schools included in the study is susceptible to the influence of prejudices, misunderstandings and errors in judgment; they

themselves acknowledged this. Furthermore, the ability to make good assessments is heavily dependent on the specific skills and intuition of school staff, which will vary in any context.

The assessment and management of risk has been ubiquitous in UK health and social policy since the late 1990s. Its emergence is thought to reflect a weakening, in late modernity, of the influence of traditional constructs, such as class culture, and gender and family roles, in predetermining life chances. Concomitantly, there has been an increasing focus on individual agency in the navigation of life trajectories (Beck, 1992). As such, solutions for social and health problems are increasingly sought at the level of the individual, rather than on a collective basis (Beck 1992; Parton 2010; Turnbull and Spence, 2011; Brown et al., 2013).

Our study suggests that, aligned with the social exclusion ideology, school staff aiming to reduce teenage pregnancy in their schools and communities adopt interventions that focus on targeting a separate and discrete group of young people believed to possess characteristics that place them at greater risk of early fertility than their peers. As such, they reproduce neoliberal notions of risk and responsibility for health in schools by the programmes introduced to address health behaviours and via the school staff who are responsible for managing risk. However, this approach represents an incomplete picture of what is known about influences on health and illness (Glasgow and Schrecker 2015). Although, providing interventions, such as T&T, suggests an acknowledgement that some young people may need additional support to avoid undesirable outcomes, it ignores the fact that many young people experience structural constraints that inhibit their ability to make choices that protect their health and wellbeing and suffer from inequalities in access to “protection, exposure to risk, and access to care” (or services) (Glasgow and Schrecker 2015).

In 2014, Brown and colleagues argued that “...structural inequalities are rewritten as a set of factors that put young people at risk and individualism means people are responsible for their own fate: thus neoliberal governments construct young people as ‘at risk’ not because of their class or circumstance, but as a result of their own behavior” (Brown et al. 2014).

The high-risk approach used in the T&T intervention reinforces the notion that prevention of teenage pregnancy is largely an individual matter, when much of the evidence suggests that it is not. The approach may result in improvements in the short-term but without removing the causes of the causes, and changing social norms, the problem will persist (Rose 1981, 1985, 1992; Cerdá et al., 2014). Furthermore, the high-risk approach's potential for resulting in stigma and labelling runs the risk of further marginalising already disadvantaged young people (Riele, 2006).

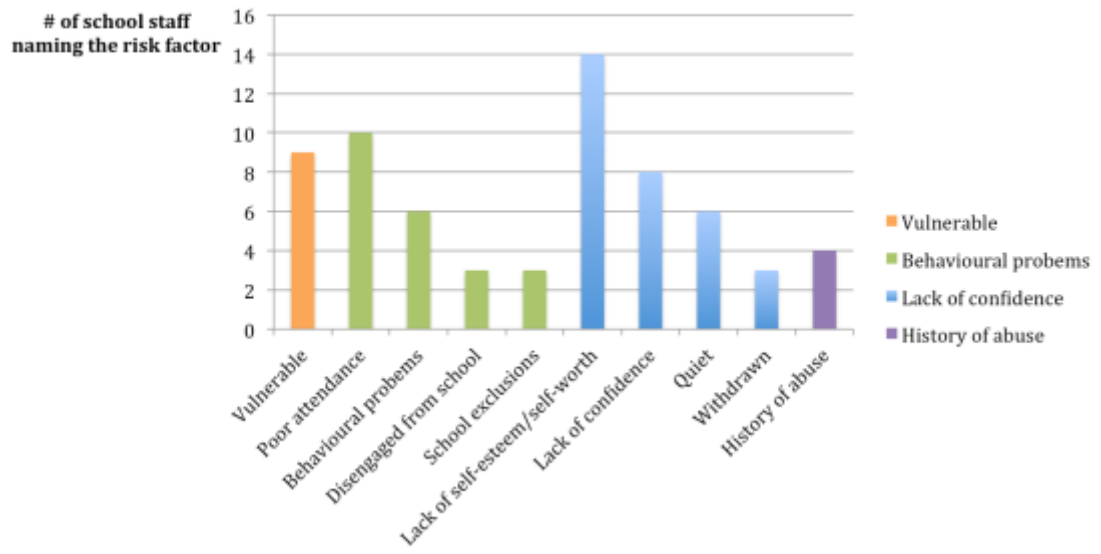
In the main, policy and professionals take a targeted high-risk approach to reducing rates of teenage pregnancy, despite evidence that universal approaches may be more effective in addressing health and social outcomes, and avoiding unintended consequences, such as stigma and labelling. This paper cannot explore the specific significance of this, but our data indicates a number of problems with accurately identifying those at risk, both with regard to school staff's conceptualisations and the processes employed to operationalise these in selecting young women for intervention. Indeed, the young women who were ultimately recruited for the RCT evaluation were found to be not as engaged in risk behaviours as the school staff presumed, limiting the evaluation team's ability to detect behavioural effects (Bonell et al., 2013). A targeting strategy based largely on subjective assessments is clearly imperfect.

Nearly all of the teachers believed that the intervention could have been beneficial to *all* their students. Some struggled to choose potential participants because they felt they could make an argument for including almost any student. That said, some individuals at greater risk of poor outcomes do require special or additional attention (Marmot, 2014; Hadley, 2014). Proportionate universalism, which combines population-level intervention with complimentary targeting proportionate to need, may potentially mediate the challenges and potential harms encountered with targeting, but continue to acknowledge the additional needs of high-risk populations (Carey et al., 2015; Marmot 2014).

**Table 1.** Criteria included in T&T “Teenager Selection Tool”

- Shyness (or withdrawn-ness)
- Negativity and lack of self-belief
- General sadness (or depression)
- Nervousness (or anxiety)
- Anger (or aggressiveness)
- Disengagement from others
- Frequently use alcohol and/or drugs
- Are not interested in thinking about their future
- Are disengaged from and uninterested in school
- Are sexually active
- Believe it is acceptable to have a child as a teenager
- Has poor school attendance record (truancy)
- Experienced puberty earlier than their peers
- Has a history of sexually transmitted infections
- Has previously been pregnant (or caused a pregnancy)
- Has a family member who is/was pregnant as a teen
- Has a history of abuse (physical, sexual or emotional)
- Is currently in care, or has been in care in the past
- Has a history of family instability & lacks positive role model
- Generally does not perform well at school

**Figure 1. Risk factors for teenage pregnancy, as named by school staff selecting young women to participate in T&T (n=16)**



## References

- Alaszewski A and Coxon K. (2008) The everyday experience of living with risk and uncertainty. *Health, Risk & Society*, 10(5): 413-420.
- Arie, S. (2014) Has Britain solved its teenage pregnancy problem? *BMJ*, 348, g2561.
- Beck U (1992) *Risk society: towards a new modernity*. London: Sage.
- Bonell C., Maisey R., Speight A., Purdon A., Keogh P., Wollny I., Sorhaindo A. and Wellings K. (2013), "Randomized controlled trial of 'teens and toddlers': A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery". *Journal of Adolescence*, 36, 859-870.
- Brown S, Shoveller J, Chabot C and Montagne AD. (2013) Risk, resistance and the neoliberal agenda: young people, health and well-being in the UK, Canada and Australia. *Health, Risk & Society*, 15(4), 333-346.
- Carey G, Crammond B, and Leeuw (2015) Towards health equity: a framework for the application of proportionate universalism. *International Journal for Equity in Health*, 14: 81doi 10.1186/s12939-015-0207-6.
- Castel R. (1991) From dangerousness to risk. In: G. Burchell, C. Gordon and P. Miller eds. *The Foucault Effect: studies in governmentality*. Hemel Hempstead: Harvester Wheatsheaf, 281-298.
- Catalano RF, Fagan AA, Gavin LE, Greenberg MT, Irwin CE, Ross DA, Shek DTL. Worldwide application of prevention science in adolescent health. *The Lancet*, 379: 1653-1664.
- Cerdá M, Tracy M, Ahem J and Galea S. (2014) Addressing population health and health inequalities: The role of fundamental causes. *American Journal of Public Health*, 104 (S4): S609-S619.
- Creswell, J.W. (2007), *Qualitative Inquiry and Research Design* (2nd Ed). Thousand Oaks, London and New Dehli: Sage Publications.
- Department for Children, School and Families (DCSF) (2010), *Teenage Pregnancy Strategy: Beyond 2010*. DCSF-00224-2010.
- Duff C. (2003) The importance of culture and context: rethinking risk and risk management in young drug using populations. *Health, Risk and Society*, 5(3): 285-299.

Frohlich KL and Potvin L. (2008) The inequality paradox: The population approach and vulnerable populations. *American Journal of Public Health*, 98(2), 216-221.

Fletcher A, Bonell C, Rhodes T (2009) New counter-school cultures: female students' drug use at a high-achieving secondary school. *British Journal of Sociology of Education* 30(5): 549-562.

Furlong A and Cartmel F (2007) *Young People and Social Change*. New Perspectives. (2<sup>nd</sup> edition). London: Open University Press.

Geronimus AT. (2003) Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Social Science and Medicine*, 57: 881-893.

Giddens A (1991) *Modernity and Self-identity: Self and Society in the Late Modern Age*. Cambridge, Polity Press.

Glaser, BG. and Strauss A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine Publishing Co.

Glasgow S and Schrecker T (2015) The double burden of neoliberalism? Noncommunicable disease policies and the global political economy of risk. *Health & Place*, 34: 279-286.

Hadley A. (2014) Teenage pregnancy: huge progress... but more to do. *Community Practitioner*, 87(6): 44-47.

Jessiman T, Keogh P, Scott S, Wollny I, Sorhaindo A and Bonell C. (2012) *Teens and Toddlers integrated process evaluation*. DFE Research Report DFE-RR212.

Kneale D, Fletcher A, Wiggins R, Bonell C (2013) Distribution and determinants of risk of teenage motherhood in three British cohorts: implications for targeting prevention interventions. *Journal of Epidemiology and Community Health* 67(1): 48-55.

Lorenc T, Petticrew M, Welch V and Tugwell P. (2013) What types of interventions generate inequalities? Evidence from systematic reviews. *Journal of Epidemiology and Community Health*, 67: 190-193.

Office of the Deputy Prime Minister (2004) *The Social Exclusion Unit*. London: Office of Deputy Prime Minister.

Office of National Statistics (ONS) *Conceptions in England and Wales, 2013*. 24 February 2015.

Macvarish J. (2010) The effect of 'risk-thinking' on the contemporary construction of teenage motherhood. *Health, Risk & Society*, 12(4), 313-322.

Marmot M. (2014) Commentary: Mental health and public health. *International Journal of Epidemiology*, 43(2): 293-296, doi: 10.1093/ije/dyu054

McLaren L, McIntyre L and Kirkpatrick S. (2010) Rose's population strategy of prevention need not increase social inequalities in health. *International Journal of Epidemiology*, 39: 372-377.

Parton N. (2010) 'From dangerousness to risk': The growing importance of screening and surveillance systems for safeguarding and promoting the well-being of children in England. *Health, Risk and Society* 12(1): 51-64.

Rose G. (1981) Strategy of prevention: lessons from cardiovascular disease. *British Medical Journal*, 282: 1847-1851.

Rose G. (1985) Sick individuals and sick populations. *International Journal of Epidemiology*, 14(1): 32-38.

Rose G (1992) *Rose's Strategy of Preventive Medicine*. Oxford: Oxford University Press.

Rose G, Khaw KT, Marmot M (2008) *Rose's Strategy of Preventive Medicine*. Oxford, UK: Oxford University Press.

Shoveller JA and Johnson JL (2006) Risky groups, risky behaviour, and risky persons: Dominating discourses on youth sexual health.

Smith JA, Flowers P and Larkin M. (2009) *Interpretive Phenomenological Analysis: Theory, Methods and Research*. London: Sage Publications.

Social Exclusion Unit (SEU). (1999) *Teenage pregnancy*. London: HMSO.

Sorhaindo, A., Keogh, P., Bonell, C., Jessimen, P., Smith, R., Wollny, I (2009) Findings from pre-RCT formative evaluation of the Teens & Toddlers programme: Interim report for DCSF. Unpublished document.

Stanley T. (2013) 'Our tariff will rise?: Risk, probabilities and child protection. *Health, Risk and Society*, 15(1): 67-83.

Teens & Toddlers (2008) *Teens & Toddlers Intensive Implementation Programme*. Haringey. Internal document.

Turnbull G and Spence J. (2011) What's at risk? The proliferation of risk across child and youth policy in England. *Journal of Youth Studies*. 14(8), 939-959



Viner RM, Ozer EM, Denny S, Marmot M, Resnick M, Fatusi A and Currie C. (2012) Adolescence and the social determinants of health. *The Lancet*, 379: 1641-1652.

Wilkinson P, French R, Kane R, Lachowycz K, Stephenson J, Grundy C, Jacklin P, Kingori P, Stevens M and Wellings K. (2006) Teenage conceptions, abortions, and births in England, 1994-2003, and the national teenage pregnancy strategy. *The Lancet*, 368: 1879-86

## **Chapter VIII. Synthesis and conclusions**

This thesis sought to fill gaps in what is understood with regard to factors that may mediate the effectiveness of interventions to prevent teenage pregnancy. In particular, this thesis examined aspects of a promising and championed approach to preventing teenage pregnancy: targeted PYD interventions.

Using case study data from the process evaluation of the T&T youth development and teenage pregnancy prevention programme, I examined, via qualitative analysis informed by phenomenology, the experience of participating in a targeted PYD intervention, with a primary focus on the perspectives of the young women who participated, and school staff responsible selecting “at risk” young women for the programme. The findings of this analysis were discussed in three stand-alone research papers, presented here as evidence chapters. Chapter VI aimed to understand how features of the T&T programme may have shaped participants’ experience of PYD. In Chapter VII, I explored whether the experience of being targeted was associated with some of the unintended consequences found in other analyses of targeted programmes and high-risk prevention approaches. In the final evidence chapter, I characterised school staff’s understandings of risk for teenage pregnancy and how these were operationalised to identify participants for the T&T intervention. Here, I summarise the findings across the three papers, present the strengths and limitations of the overall thesis, and discuss the potential contribution of this research to debates and policy on youth sexual health and preventative interventions.

### *Summary of findings*

#### The experience of PYD programmes

Chapter VI contributes to a better understanding of the conceptual model of PYD by presenting findings from the analysis of young women’s accounts of their experience of the T&T programme. My research revealed three key programme features that were associated with experiencing the intervention positively: an offer of an achievable challenge; trusting connection with adults; and opportunity

for reflection and contemplation. Being challenged, but more importantly persevering and overcoming a challenge, is an important part of PYD, as it builds self-confidence. When individuals are motivated and engaged with an activity over time they experience “flow”, a learning experience that minimises anxiety and boredom and fosters skills-building (Rich, 2003; Csikszentmihalyi, 1990). However, in my research, when the challenge was too great, young women were left feeling disillusioned and this potentially hindered their opportunity to develop the 5Cs (competence in academic, social, emotional and vocational areas; confidence in who one is becoming (identity); character that comes from positive values, integrity, and a strong sense of morals; and caring and compassion). Achievement of the central challenge of the programme – mentoring a young child - appeared to be mediated by the quality of the support provided by the programme facilitators.

Warm and caring connection with non-parental adults builds self-esteem and self-efficacy, protects against risk and is important for PYD (Bowers et al., 2014; Silbereisen and Lerner, 2007; Roth and Brooks-Gun, 2003; Laursen & Birmingham, 2003; Eccles and Gootman, 2002). The facilitators, counsellors and nursery/pre-school teachers involved in the T&T programme potentially served as trusted sources of support and advice for the young women in the programme. However, the successful development of such relationships was mixed. When facilitators shared real-life personal experiences during group discussions, they fostered a sense of trust, connection and mutual understanding with the young women participating in the programme. When the young women described the counselling sessions as a positive experience, they also tended to view the counsellors as a trusted source for advice and support. In some cases, interactions with the adults on the programme did not generate connection and potentially thwarted positive development. Some facilitators were not skilled in constructing safe spaces for comfortable conversations about sexual health, leaving the group sessions feeling awkward and some young women recalled feeling criticised by members of the nursery staff. Moreover, as the counselling sessions were mandatory, some young women felt uneasy and obliged to share more information than they would have liked.

## Unintended consequences of targeting

The phenomenological approach taken in this thesis allowed for an exploration of the meaning of being targeted from the perspective of individuals who experienced the phenomenon in evidence Chapter VII. To avoid stigma, the school staff and T&T programme providers offered minimal information to the young women about the purpose of T&T and how they were selected for the programme. However, as found in previous research on targeting for youth intervention (Evans et al., 2014), the participants inadvertently discovered the programme's aim and targeting strategy and this led to, among some young women, confusion, and exacerbation of an existing mistrust of school staff. Both prior to becoming privy to the purpose of the programme and after the focus on prevention of teenage pregnancy became clear, the young women began to reflect upon the characteristics of their peers in the programme. Some noted that the other young women participating in T&T tended to be from BME backgrounds and/or had a reputation for being "loud", outspoken or belligerent among the school community. The dawning realisation that mostly BME students and the "loud" students were selected for T&T indicated to others that the programme was likely focussed on addressing risk behaviour and possibly teenage pregnancy. The fact that they came to this conclusion suggested an existing awareness of how the behaviours of such young women are characterised or stereotyped by the school community. Affirmation that these young women were indeed targets of preventative intervention further deepened these. To manage these imposed labels, stigma and reputational risks, young women responded to being targeted by adopting strategies, such as *distancing* themselves from other targeted young women, *silence* about the purpose of the programme and *refusal* to accept that they are at risk of pregnancy.

The findings of evidence Chapter VII suggest three potential undesirable outcomes related to the targeting strategy employed by the T&T programme. One, being considered at risk for teenage pregnancy by school staff reinforced existing negative tensions between students and their teachers, potentially leading to further conflict at school. Secondly, bringing together groups of young women from stereotyped groups further instilled notions about the types of individuals who engage in risk behaviour. Finally, being targeted for a stigmatised health

outcome required that some young women undertake additional identity work to manage their risk reputations.

#### School staff's conceptualisation of risk for teenage pregnancy

A key feature of the T&T programme was the process of selection of participants. As described earlier, school staff were charged with determining which young women from their year 9 or year 10 groups were potentially at risk for teenage pregnancy and would benefit from preventative intervention. Evidence Chapter VIII summarises the experiences of school staff in selecting young women to participate in the teenage pregnancy prevention intervention. In a broader sense, this chapter was a critical look at expert risk management in practice.

In my analysis of interviews with school staff, I found that those responsible for selecting young women for the T&T programme had varied understandings of risk of teenage pregnancy, but that in general their perceptions focused on individual-level factors, including a generalised sense of vulnerability. School staff, in their role as risk experts, used a combination of school level data, formally and/or informally acquired information about the causes and consequences of teenage pregnancy, and experience accumulated over long periods of time working with young people in schools and communities to formulate a conceptualisation of risk for teenage pregnancy. They applied these conceptualisations in varying ways, often haphazardly, to select young women for the programme. In contrast to evidence suggesting wide ranging risk factors across the socio-ecological framework (see my review in introduction), the decisions of school staff were based on individual and proximate considerations.

Increasing awareness of choice and responsibility among the young women was frequently described as an advantage of the T&T programme. Many school staff believed that the programme would empower young people to make “good decisions” with regard to their sexual and reproductive health and prevent unwanted pregnancy. The perspectives of many school staff are consistent with a neo-liberal discourse that underscores individual behaviours as leading to risk and

in young people's responsibility for making rational choices that fit within desirable social norms (Brown, 2013).

### *Strengths and limitations*

A strength of this thesis is that it offers a perspective uncommonly featured in research on youth sexual health interventions: young people's experience of the intervention themselves. Numerous evaluations of preventative interventions for young people have determined effectiveness based on the change in specific health and behavioural outcomes. Process evaluations have assessed whether the intervention was implemented as it should and measured acceptability among participants, but few previous studies have sought to understand whether the intervention was *experienced* as intended or documented other, previously unanticipated experiences, that occur as a result of the intervention.

In engaging with the young women participating in T&T, the evaluation team worked diligently to establish rapport (Kirk, 2007) with participants to encourage open and honest accounts of their experience on the programme. I believe that this thesis benefited from these efforts and from employing techniques that would allow for the triangulation of data, including collecting data at various points across the development of the evaluation, from different contexts (case studies) and using different data collection approaches – focus groups, paired interviews and in-depth discussions (Green and Thorogood, 2009; Patton, 1999). It is argued that methodological triangulation serves to offset the weaknesses of any one approach with the strengths of another (Green and Thorogood, 2004; Nueman and Robson, 2009). In addition to promoting the development of rapport between the researchers and the study participants, this methodological triangulation (Mason, 2002) allowed me to approach my research questions for this thesis from different angles. The case study approach and the availability of data from different London schools also supported a multifaceted account of the phenomenon of a PYD programme, which is aligned with the central principles of the phenomenological approach outlined in Chapter IV (Smith, Flowers and Larkin, 2009).

In my study, I found that focus groups were an advantageous approach in that the young women were able to work together to discuss and understand how they felt about aspects of the programme (Creswell, 2007). Furthermore, the young women appeared to feel empowered (Neuman and Robson 2009) and comfortable speaking with the researchers in this context. For example, my discussions with the young women helped them to consider and form their opinions about the programme. The techniques used in the focus groups – vignettes and fill-in-the-blank statements - helped the young women to reflect on the meaning of the experience for them. The focus group participants also had the opportunity to consider whether their peers held the same views and interpretations of the experience. However, the data collected potentially could have suffered from important drawbacks (Neuman and Robson, 2009). For instance, it was occasionally difficult to detect diversity in perspective; the young women tended to present “group think” or consensus opinions (Neuman and Robson, 2009). Despite active probing and encouragement, quieter and less dominant young women with dissenting views were heard infrequently and dimly, as the more vocal participants drowned out their voices. The consequence of this was that a limited quantity and quality of ideas were presented in this forum (Neuman and Robson, 2009). Had data collection ended here, I would have had a less rich understanding of the young women’s lived experience of T&T and PYD.

The subsequent paired and one-on-one interviews provided the young women with an additional space to explore the meaning of the experience, but this time from their individual perspectives and with limited influence from other participants. The approach shifted the focus of our discussions from perspectives on the meaning of the experience for “us” to a view on the meaning of the experience for “me” (Mason, 2003). It was during these one-on-one interactions that more nuanced accounts of aspects of the T&T intervention were discussed. The interviews were conducted toward the end of the intervention and the young women were also more familiar with the programme, their colleagues, the facilitators and nursery staff, and the researchers. For example, at the focus group stage, some young women discussed the experience of counselling generally; whether they liked it or not. Later, in paired and one-on-one interviews, I learned more about their feelings related to trust and support, but also their concerns

about over-sharing personal information. One-on-one interviewing can present a challenge where participants are shy or less willing to speak or share experiences (Creswell, 2009). Although, this did occur in some of the interviews in this study (particularly among the young women from the comparison group who were only interviewed once), the efforts described earlier to build rapport were helpful and most respondents were open and forthcoming with their thoughts and ideas, especially during the interviews.

While the perspectives captured via these distinct methodologies somewhat differed, rather than offer a diversity of opinion, this exercise in methodological triangulation afforded more understanding of the young women's personal experiences and opinions of the T&T PYD programme and the underlying reasons for these. Revisiting the research questions with the study participants at several points over time and using different data collection techniques to do so produced rich and layered data that allowed for a deeper and fuller understanding of the young women's experience (Green and Thorogood, 2004).

In each evidence chapter, I discussed some of the factors that presented limitations to the specific piece of research presented. Here, I discuss some overall limitations to this thesis.

On occasion, having conducted this study within the context of the evaluation and RCT proved to be problematic for data collection and the interpretation of the findings. In my chapter on the Role of the Researcher, I discussed how my presence and the presence of the T&T programme evaluators appeared to have influenced both the young women's and school staff's experience of the intervention, in terms of affecting reactivity, but also by causing the perception that the evaluation and the intervention were one in the same. In particular, the adults and the young women in this study struggled to fully grasp the concept of a trial and randomisation. This is not unique to the T&T programme evaluation. A plethora of evidence demonstrates that participants in clinical research routinely fail to adequately understand trials and the difference between research and treatment, including the concepts of randomisation and the role and purpose of comparison groups (Henderson et al., 2007; Dixon-Woods et al., 2007). In 1995, Peterson and



Leffert discussed how the context of pubertal, cognitive, psychosocial and moral development during the period of adolescence has implications for participation of young people in research. For example, their reactions to situations that are generally unproblematic for adults may increase emotion or anxiety in young people. Though many young people, particularly those over the age of 15 (Tait et al., 2007), can comprehend information as well as adults, because of their inexperience their expectations may be different or flawed (Petersen and Leffert, 1995). Blake and colleagues (2011) found that even after a detailed explanation of the key principles of clinical trials, young people only understood the concept of randomisation in the abstract. In this study, participants continued to believe that researchers would use a systematic approach, such as the results of tests or assessments, to determine who received the intervention. Similarly, in my analysis of targeting, many young women did not believe that they had been randomly selected for T&T. Some thought that the school staff had either read the results of the baseline questionnaire to determine who needed intervention, or simply chose the young people they wanted to participate in T&T. The data suggested that the young women came to this conclusion because of a tacit mistrust of the school staff. However, is it unclear how much of this perception may have resulted from their misconception or misunderstanding of trial processes and randomisation, as suggested by Blake et al., and others (Unguru et al., 2010; Tait et al., 2007).

When not under evaluation, young women are chosen directly by school staff for participation in the T&T programme. The need to randomise for the evaluation interfered with the normal process of selection for the programme. In the context of the RCT, the young women who believed they had been randomly selected for the programme may not have as intensely experienced or perceived the stigma and stereotyping reported by some of the young women on the programme. Further, school staff may have been more diligent or used an alternative strategy in their selection of participants for the programme if the young women were not to be later randomised to experience the intervention or not. Ideally, I would have collected data outside of the context of the trial, but that was not possible. Despite this drawback, the fact that the greater part of the experience of the T&T programme for both the young women and the school staff was not “tainted” by

the research provides assurance that the accounts reported here are relevant to the lived experience of the intervention and not the RCT.

Building on this evidence regarding the consequences of limited participant understanding of trials, my research highlights how the trial context can influence programme process issues, such as acceptability. This thesis also underscores the importance of ensuring that study participants, particularly young people, understand the trial processes; not only for compliance with ethical standards but for maintaining the integrity of research related to the experience of the intervention. The evaluation team made minimal effort to explain the principles of the RCT to the study participants and perhaps underestimated the consequences of not doing so.

The potential for bias related to participant preference for the intervention has been documented (McCambridge et al., 2014; Bird et al., 2011). As the data used in my analysis were collected in the context of an evaluation designed primarily to provide evidence on the implementation (process) and impact (outcome) of the T&T intervention, the evidence presented here is vulnerable to a form of social desirability bias (Nueman and Robson, 2009). For example, the school staff and the young women knew that the intervention was being evaluated and that the results of the RCT may have implications for the future of the T&T programme. The interview questions used to collect data for this thesis were included as part of the interview guide for the integrated process evaluation, and the respondents were not privy to which questions were for which study. Both the school staff and the young women were inclined to view the T&T intervention generally positively (Jessiman et al., 2011) and wanted the intervention to continue in their school. As such, respondents may have erred towards more favourable accounts of their experience in the hopes of affecting a positive result to the evaluation. Although as part of the larger study, we assured study participants of the confidentiality of their responses, the possibility that social desirability bias impacted on this research cannot be discounted.

London is socially, economically and culturally quite different from the rest of the UK. On average, Londoners tend to be younger than the population in other parts

of the UK and experience higher weekly earnings (ONS, 2013). In London, a smaller proportion of employees are paid less than the living wage and residents enjoy the highest Gross Disposable Household Income (GDHI) (the amount of money available for spending or saving after income distribution measures) (ONS, 2016b; ONS, 2015b). According to information from mid-2014, the capital city had the greatest growth in population in comparison to elsewhere in the UK and is the most densely populated (ONS, 2013). London is also the most ethnically diverse area in England and Wales (ONS, 2011). Over a third of international migrants into the UK head to London (ONS, 2016c). Though urban and deprived areas are typically associated with poor educational attainment, this is not the case in London. Academic performance, measured by GCSE points, among students in London is the highest in the UK. This “London Effect” is also strongest for poor students living in disadvantaged neighbourhoods and has been attributed to successful education policies in the capital (Greaves et al., 2014), particularly the London Challenge (2003-2011) (Hutchings, 2012) and the overall improvement in the quality of London schools (Blanden et al., 2015). Other analyses owe the “Effect” to the ethnic diversity of London, but especially, immigration (Burgess, 2014). Previous research had demonstrated that white British students were not progressing as well through school as their ethnic minority contemporaries. Burgess (2014) argues that the London Effect is a result of the “aspiration, ambition and engagement” characteristic of many new migrants to the UK and the successful multi-ethnic schools their communities engendered, prompting high performance even among the disadvantaged (Burgess, 2014).

It is likely that a combination of the determination of migrants to London and the innovative school policies instituted in the capital is responsible for the success of London schools. Regardless of the cause, the academic context and, relatedly, other aspects of the school and community experience of London are significantly different than that of the rest of the UK. Given that the case study data used in this thesis were collected from four London schools, this may have implications for the generalisability of my findings (Green and Thorogood, 2004). Not only was the ethnic make-up of my study sample likely to be different than I would have found elsewhere, but the lives and experiences of the young people I interviewed were probably also distinct in terms of culture, values, opportunities, resources and

perspective. Nevertheless, I believe that the principles emerging from my conclusions are potentially generalisable to other contexts, though caution should be taken in their application.

Despite these limitations, I believe that the evidence presented in this thesis provide an important contribution to current debates on interventions to protect the health and wellbeing of young people. I discuss this in detail below.

### *Contribution to current debates*

Active participation of young people in research and evaluation regarding their health

Increasing the involvement of children and young people in matters and decisions that have implications for their lives is part of a historic effort to promote the inclusion of under-represented citizens in governance, and the sharing and redistribution of power (Arnstein, 1969). Proponents of the participation of children, adolescents and young adults have emphasised the benefits and sought to encourage the practice. For instance, in 2003, the UK Department for Education and Skills (now defunct) published a handbook, *Building a Culture of Participation*, to provide guidance for involving children and young people in policy, service planning and delivery, and evaluation (Kirby et al., 2003). The handbook emphasised that including young people had benefits for service development and for the social inclusion and wider social development of young people (Kirby et al., 2003). These sentiments were echoed in a report published by the Carnegie UK Trust in 2008 that underscored the many benefits to involving children and young people in decision-making, including drawing together different generations of citizens and communities to improve social cohesion (Carnegie UK Trust, 2008). More recently, the UK government reiterated their recognition of the importance of including young people's voices on issues related to their own health and wellbeing (Public Health England, 2012).

Head (2011) outlines three key motivations for the involvement of children and young people: 1) participation as a right and a demonstration of moral respect for

young people and their voices, perceptions and opinions; 2) more efficient and effective services and interventions, and 3) individual and societal level developmental benefits. Evidence suggests that involving youth actually promotes PYD through building developmental assets, such as critical thinking, a diverse social network, valuable skills, exposure to new opportunities, forming new relationships with adults, serving as role models and empowerment (Viner et al., 2012; Farthing, 2012; Head, 2011; Powers and Tiffany, 2006; Carnegie UK Trust, 2008; Kirby and Bryson, 2002). Participation offers young people “openings, opportunities and obligations” (Hart, 1992) that contribute to their growth and development. Considering young people’s perspectives is also in line with an ethos of youth centeredness and reflects the general move towards patient and public involvement encouraged by funders, such as the National Institute for Health Research (<http://www.invo.org.uk/>), and the Carnegie UK Trust (Carnegie UK Trust, 2008).

Drawing on the well-known model of citizen involvement theorised by Arnstein in 1969, Hart developed a similar schema for the participation of children and young people (Hart, 1993). Hart’s model, “The Ladder of Participation”, depicts eight levels at which children and young people may become involved in decision-making:

- Level 1: Manipulation
- Level 2: Decoration
- Level 3: Tokenism
- Level 4: Assigned but informed
- Level 5: Consulted and informed
- Level 6: Adult-initiated, shared decisions with children
- Level 7: Child-initiated and directed
- Level 8: Child-initiated, shared decisions with adults

According to Hart, Levels 1 to 3, do not represent genuine participation. Rather, at these levels, the children and young people are mostly unaware of their role, are involved to create the appearance of involvement and their participation is largely for the benefit of adults. In Level 1, children are used to express a message or action, but they are unaware of what it is. In Level 2, the presence of children is

used to bolster a cause but they are not involved in its purpose. In Level 3, children appear to have a voice, but are not truly given an opportunity to express their views. The higher levels of the Ladder, 4 to 8, represent increased degrees of true participation. Hart believes that there are four requirements for authentic participation:

1. The children understand the intentions of the project;
2. They know who made the decisions concerning their involvement and why;
3. They have a meaningful (rather than 'decorative') role;
4. They volunteer for the project after the project has been made clear to them.

(Hart, 1992).

Most of the developmental benefits described above occur when participation is characterised by involvement akin to the higher levels of The Ladder. A measure of the quality of participation is whether the young people involved have an effect on the development, direction and/or outcome of an activity and whether their involvement results in outcomes for themselves and the greater society. How participation manifests varies depending upon the context and the purpose of the activity, but should essentially involve real engagement and influence, not simply passive voices (Checkoway, 2011).

The range of domains within which children and young people can potentially participate is quite broad (Fleming, 2012; Checkoway, 2011). Of relevance to this thesis is their participation in the development of interventions and research that have bearing on their lives. Researchers in the UK have advocated for youth involvement in the design and implementation of interventions for their emotional health and wellbeing (Coombes et al., 2013; Percy-Smith, 2007) and reducing bullying and aggression in schools (Fletcher et al., 2015). Advocates believe that involving children and young people in research at the higher levels of Hart's Ladder, has numerous benefits. For example, the offer of an alternative perspective to adults', the ability to prioritise and identify relevant research questions, achieve better communication with and accessibility to their peers for the research process

and dissemination, and gain self-esteem and confidence that can benefit them in future endeavours (McLaughlin et al., 2015). Powers and Tiffany (2006) contend that the quality of research on young people benefits from their participation: “Participation by youth in the research process can improve the quality of research by generating more reliable data and improving data interpretation because it involved those closest to the issues under investigation in the formulation of research questions and the strategies to answer them”. There is evidence to suggest that young people from high-risk and disadvantaged backgrounds are able to meaningfully contribute to development of research projects and benefit (Harper and Carver, 1999).

Evidence suggests that involving young people in the process of intervention can result in increased adherence, and increased relevance of the issues being addressed and the manner in which they are addressed (Sawyer et al., 2012). Previous research has explicitly recommended involving young people in making decisions in the organisation of the school (Harden et al., 2006). Ensuring that young people share their views and are involved in shaping educational and developmental experiences encourages the development of, particularly marginalised, young people, and provides professionals with important information about how to support them. For example, data from a process evaluation of a randomised controlled pilot trial of an intervention to initiate local change in bullying and aggression in English secondary schools found that formally involving a diverse group of young people in school-level action groups to work with school staff to identify priorities and whole school change was feasible and acceptable to both students and staff (Fletcher et al., 2015).

In this doctoral research, it was self-evident that the participation of young people was essential for achieving valid answers to my research questions regarding their experiences of PYD and targeting. As adults, my and the evaluation team’s notions of what constitutes or creates a specific experience may not have been aligned with those of the young people (Carnegie UK Trust, 2008). Without including the direct perspectives of young people, we were potentially overlooking factors influencing the intervention and our research. Indeed, the findings of this research demonstrate how key lessons about the experiences of young people can be

uncovered when they are consulted. Moreover, the evidence produced here, exemplified by the confusion, frustration, and discomfort frequently expressed by the young women, both with regard to their experience with the intervention and targeting, suggest that greater involvement of the T&T programme participants in development of the intervention and the evaluation would have significantly improved the process and the outcomes.

The literature on participation largely discusses the benefits of youth involvement to organisations, institutions, society and the young people themselves, but few have considered whether participation is also a mechanism for reducing harms and preventing unintended consequences in preventative interventions. Across all three evidence chapters, a more collaborative and inclusive approach to the design, implementation and evaluation of the T&T programme may have helped to overcome many of the challenges experienced and the consequences resulting. Though the voices of young people were central to this research, their participation and involvement in the shaping of the overall evaluation and this thesis could have been much greater.

There are several instances in the T&T intervention and the evaluation where closer involvement with young people may have prevented some of the unintended consequences encountered. For example, with regard to the intervention, the young women could have been included in preliminary discussions of what was perceived as the problem of teenage pregnancy in the school and the community and perhaps they may have offered their views regarding if and why this was this case. School staff and programme providers could have worked with young women in the schools to consider the types of programmes and interventions, and the components of these, that they believed might address it. Alternatively, in the design of the T&T programme, providers may have worked with young people before the start of the intervention to adapt the programme to the needs of the youth involved.

My research demonstrated that school staff found the process of selecting young people for participation in the intervention challenging. Some school staff had already begun to involve young people in their selection of participants for the



T&T programme by asking the young women to determine their own risk. I believe this approach could have been used more extensively and explicitly, closely guided by school staff responsible for pastoral care. If the young women were more fully engaged with the risk assessment process, they may have also been more committed to the intervention and reducing their risk for teenage pregnancy. Furthermore, a well-designed collaborative approach may have been empowering.

I reported how the young women who participated in the obligatory counselling as part of the T&T programme had mixed experiences. Those who found the counselling uncomfortable tended to reject this intervention component, missing the opportunity to benefit. I hypothesised that this was related to the mandatory nature of this aspect of the intervention. In an analysis of young people's mental health help-seeking behaviour in three UK high schools, researchers concluded that young people assess the risks and benefits of seeking help before making a decision about whether to reach out for emotional support. In some schools, a "tough" public image was viewed as a mechanism for self-preservation (Coombes et al., 2013). Other research has highlighted the importance for some young people of constructing "safe identities" (tough/macho personas) in schools (Fletcher et al., 2009). The presentation of a "tough" or "safe identity" is at odds with help-seeking. Some young people saw the risk of disclosure as enough of a reason to avoid seeking help, though others viewed receiving help as a greater benefit than the risk of seeking it out. Much of these attitudes were mediated by concerns about trust, privacy and confidentiality, which is particularly important for individuals in this age group (Parsons et al., 2016; McDonagh and Bateman, 2012). A recent study on young people's preferences for emotional support in school also identified the importance of privacy and confidentiality. Though the students preferred support from adults than from peers, they needed assurances that their teachers were trustworthy (Kendal et al., 2011). The study found that self-referral afforded the young people the safety they felt they needed in order to seek out support. The authors concluded that one strategy for encouraging young people's help-seeking behaviour is to consult with young people to develop a mechanism for the design of pastoral care that fits within their needs and considers their concerns (Kendal et al., 2014). Undertaking a similar strategy in the T&T programme may have improved the experience of counselling for the participants.

Increased effort by the evaluation team to explain the process of the RCT and the process evaluation could have avoided the confusion around selection and randomisation. Moreover, some of the young women could have been integrated into the evaluation team taking on roles that would not have interfered with the integrity of the study but would have engendered more ownership over the evaluation. Existing examples of young people's involvement in health research demonstrate that they can effectively participate in study design, development of instruments, recruitment of participants, data collection, analysis, and dissemination (Powers and Tiffany, 2008; Percy-Smith, 2007). The extent to which young people can participate in research on themselves and their peers without compromising the integrity of the research depends upon the study context and the research question.

Despite the many years of pushing for the involvement of young people, achievement of participation, particularly at higher levels, has not been widely achieved (Fleming, 2012; Head, 2011; Kirby et al., 2003; Kirby and Bryson, 2002; Hart, 1992). Although private industries that stand to benefit from understanding the perspectives of under-represented groups have advanced further in the inclusion of young people, the public sector has been slower to develop a culture of participation in their institutions (Fleming, 2012; Head, 2011;). Part of the reason for this is that conducting research with young people requires increased time, support and resources to provide the young people with the necessary skills (Kim, 2016; MacLaughlin 2015; Percy-Smith, 2007; Kirby and Bryson, 2002). Farthing (2012) signals that another aspect of the concern about youth participation reflects uneasiness about the role of young people as active citizens in society.

The United Nations Convention on the Rights of the Child has formed the basis of most arguments regarding the rights of inclusion and participation of children and young people (Fleming, 2012; Hammersley, 2015). Among other factors related to the participation of children and youth, the Convention calls for research with children, in contrast to "on" children and the involvement of children in decision-making with regard to research that focuses on them. However, the ensuing debate on the actual competence, decision-making ability and capacity to consent at various stages of children and young people's development questions the

feasibility of the absolute and active participation of children and young people (Hart, 1992; Checkoway, 2011; Hammerley, 2015). Furthermore, some query the sincerity of the movement and heavily critique participation as just another form of controlling young people and persuading them to conform (Farthing 2012). In the end, most contemporary research including children and young people is initiated, supported and driven by adults (Kim, 2016; Fleming, 2012). Despite some of the existing tensions around the issue, there are surely gains to be made, and more importantly harms to be avoided, by increasing young people's participation. However, young people's involvement must extend beyond the tokenistic to be effective, and attitudes and systems must be changed to truly involve them where feasible and beneficial (Rose and Shevlin, 2004).

#### Further marginalising disadvantaged young people

The evidence presented in this thesis highlights the significant potential for further marginalising young people who are likely to already be materially, socially or academically disadvantaged in the design and implementation of the T&T PYD programme. This section discusses and suggests alternative strategies to mitigate this.

First, during their participation in the T&T programme, young women were challenged by the intervention activity to a point where some actually lost confidence and had experiences with nursery and preschool teachers that resembled their negative experiences with teachers and other staff in school. To the extent this occurred, these negative relationships may negate attempts to engender positive development. Programmes that worsen a young person's relationship with the school may not only thwart any potential gains made by the programme, but may also cause harm with regard to the future relationship to the school and, indirectly, young people's health and wellbeing (Markham et al., 2010; Grossman and Bulle, 2006). Moreover, young women deemed high-risk, vulnerable and suffering socially and academically are the least able to afford further deterioration of their relationships to school.

The targeting process may have further aggravated tense relationships between some of the young women and the school staff. It is difficult to determine whether the negative emotions towards the school staff after learning about the targeting strategy was, at least in part, due to or exacerbated by the school staff's lack of transparency about how the participants were selected. Regardless, we can learn from the failures of this process whether they are attributed to young women's *not knowing* about being considered at risk for teenage pregnancy or to *being considered* at risk.

In the introduction to this thesis, I presented arguments for targeting high-risk groups from the sociological, medical and public health literature. My own data suggests that targeting young people in schools can be difficult to operationalise, possibly inaccurate and may cause harm – through labelling, stigma, and lowering young people's expectations. As targeting relies upon knowledge of the risk factors associated with socially undesirable behaviours or situations *and* the ability to accurately detect these in order to anticipate and then target (Carey and Crammond, 2014; Brown et al., 2013; Turnbull and Spence, 2011; Parton, 2010; Duff 2003; Castel, 1991), in contexts such as schools where risk factors related to health outcomes may be difficult to know, the process becomes quite challenging. The imperfection of targeting approaches is well documented. To offer one example: in a study of an intervention in Wales that targeted communities of deprivation the authors concluded that: "...even successful targeting...excludes more than half of the high-risk children who could potentially benefit from intervention and a strategy is needed to ensure delivery of services to high-risk families living outside of high-risk post-codes" (Hutchings et al., 2013).

In T&T, the school staff wanted the ability to be creative and flexible about whom they offered additional resources. After working with young people for long periods of time they believed that they were sufficiently knowledgeable about their students' lives and were best placed in the school context to determine who was at risk and which interventions would be most appropriate and useful. A question remains, however, regarding how professionals who are given roles as risk managers best define and assess risk. What does risk look like in the school context? Previous research suggests that young people who develop "at risk"

school identities are grappling with developing and maintaining an acceptable self-concept within a larger institutional structure in which they do not fit and where they are labelled and stigmatised (Bonell et al. 2011; Fletcher et al., 2009; Benjamin, 2002). Disadvantaged young women are stigmatised and labelled in schools, because they challenge middle class values and because they do not add to the school academically (Bonell et al., 2010; Ali 2002; Jackson, 2002; Gillborn and Youdell 2000;). Such young women tend to take up behaviours to protect their image (Goffman, 1959); these are the same behaviours that identify them to staff and programme providers as being at risk of teenage pregnancy and possibly participating in other risky health behaviours (Archer et al., 2007). Although the intention may be to provide disadvantaged, vulnerable and struggling young people with an alternative opportunity to build positive personal and social identities, the process of being targeted for and participating in such programmes has the potential to further marginalise and, in effect, may be actually quite similar to the dynamics already underway at the school. As such, the same performances and mechanisms used to construct and protect their identities at school are likely to be at work within the PYD programme context – and have the same consequences including labelling and stigma. In this context, any improvement a PYD programme may provide would be off-set by the wider structural constraints on the identity of these disadvantaged youth. For these young women, as the school staff reported in Chapter IX, school is a challenge. Interventions that are not experienced positively, creating additional challenge, may lead to further marginalisation.

Even if the accuracy of targeting was improved (McLaren et al., 2010; Frohlich and Potvin, 2008), my research suggests that there are important consequences related to being identified as at risk for a stigmatised health outcome, such as teenage pregnancy. Being labelled as at risk of teenage pregnancy required the young women in my study to do additional identity work to mitigate the consequences of the related stigma. Stigma is a source of stress, is related a host of deleterious health and wellbeing outcomes and is a fundamental cause of health inequalities (Hatzenbuehler et al., 2013; Link and Phelan 2006; Van Brakel, 2006; Link and Phelan 2001; Crocker 1999). Furthermore, young people who are stigmatised because of their sexual and reproductive health behaviour may conceal sexual

activity from the supportive adults in their lives and avoid accessing quality resources and services for fear of discrimination (Wood and Aggleton, 2002). The consequences of stigma are exacerbated when the individual suffers from multiple stigmas, such as socio-economic deprivation, minority race/ethnicity and low academic attainment. Most of the young people who were selected for the T&T intervention had one or more of these stigmatised attributes, and may have experienced intensified consequences of the stigma of being targeted as a result. The potential harm associated with targeting, labelling and stigma may diminish or eliminate any gains achieved from effective intervention. This said, the experience of stigma varies depending upon the context and the shared meaning and representation of the phenomenon among the social group (Crocker, 1999). Some young people may not experience targeting on risk as a stigmatising experience, but it is difficult to know which young people will and which will not. In considering how to implement interventions to reduce risky sexual behaviour and outcomes with youth, programme providers should consider the potential for stigmatisation and other harms related to targeting for high-risk (Bonell et al., 2015; Weiss et al., 2006).

In 2012, Viner and colleagues published an analysis of the social determinants of health for adolescents. The World Health Organization describes the social determinants of health as, “the conditions in which people are born, grow, live, work and age”, referring to the circumstances that are shaped by families and communities and by the distribution of money, power and resources at global, national and local levels and affected by policy choices made at these levels. The authors demonstrate that the strongest determinants of health for adolescents and young people are factors such as national wealth, income inequality, and access to education. They suggest that the most effective interventions are probably more likely to realise change through structural changes to improve access to education and employment.

A number of studies emerging in the past decade demonstrate how universally deployed school-based interventions can reduce risk taking behaviours among young people (Shackleton et al., 2016). For example, multi-level whole-school interventions designed to improve the school climate, such as Aban Aya in the US

(Fagen and Flay 2009; Flay et al., 2004;), Gatehouse in Australia (Bond et al., 2004) and Healthy School Ethos in England (Bonell et al., 2011), have demonstrated potential in reducing risk behaviours and improving overall wellbeing. These interventions include components such as: a needs-assessment; the institution of social development curriculum; efforts to improve staff-student communication; teacher and staff training on how to model proactive classroom management; the institution of a school task force including students to review and revise school policies on issues such as bullying; and parent training workshops. In addition to being applied at the school-level, these interventions aimed to address the structural determinants of risk behaviours among young people, rather than individual-level risk factors.

Notwithstanding my findings, I believe that targeting still has a valuable place in the delivery of preventative interventions for young people. Targeting is a creditable attempt to direct additional resources to individuals in the greatest need. For many health and social outcomes and in certain situations and contexts, the absence of targeting may exacerbate inequalities (Capewell and Graham, 2010; Frolich and Potvin, 2008). Researchers searching for the best strategies for reducing rates of teenage pregnancy have recommended a focus on combining intervention components at the structural level with components at the individual-level (Harden et al., 2006). Carey and colleagues (2014, 2015) describe the range of mechanisms through which policy and intervention may combine targeted and universal approaches to avoid inequities and (further) marginalisation of particular social groups while maximising the advantages of each approach. The authors recognise the challenges with determining the point at which targeted approaches are warranted and how to determine need (Carey et al. 2015). Subsidiarity, as a principle of governance, devolves such decisions to the level closest to the social group of interest, for instance, local government, and non-governmental and community organisations, and encourages the empowerment of individuals and communities to shape the decisions that impact upon their lives (Carey et al., 2015). Based on my findings, it seems that a similar framework could be employed with young people. Interventions that involve a whole-school approach and include elements of targeting that are determined with the participation of young people may do more to mitigate unintended consequences

than one of these approaches alone.

#### Future of PYD interventions

In the introduction to this thesis, I set out with the analysis that followed to build upon evidence and fill gaps in what we know about why and how PYD programmes may or may not work. I outline below how, based upon the evidence presented in this thesis, I believe the development of PYD programmes can be advanced towards greater acceptability and effectiveness among young people.

The importance of “skills building” and novel experiences appear repeatedly in descriptions of PYD theory. A recent systematic review further emphasised the potential effectiveness of programmes similar to T&T – combining education, skills-building and contraception promotion – in reducing the risk of teenage pregnancy (Oringanje et al., 2016). Furthermore, recent reviews of the evidence on the conceptual model of PYD emphasise the importance of diverse activities and the salience of a young person’s ability to make progress through a programme to develop the benefits of PYD (Bonell et al., 2016a; Bonell et al., 2016b). In my research, the T&T programme designers intended for the experience of engaging with young children to be demanding to allow the participants to learn new skills and benefit from meeting a goal, but, in some cases, the challenge was too difficult and, rather than leading to a sense of empowerment, the experience was demotivating and disheartening for some young women. Activities included in PYD programmes should involve a balanced amount of challenge and support in order to create a positive environment conducive to development.

My data show that young people’s relationship with adults is important for interventions to work. Adults and young people need to communicate with one another to improve PYD approaches and targeting. Non-parental adult relationships with young people that are characterised by honest communication and mutual respect should feature centrally to any activities designed to promote PYD. Previous research has explicitly recommended that teachers receive training to help them to form positive relationships with young people (Harden et al., 2006). The group sessions on the T&T programme were spaces where the key



features of the programme – challenge of working with young children, relationships built with the adults on the programme, and journaling, role playing and other activities based on reflection – came together to allow the young women to consider themselves and potentially grow and change. These spaces for contemplation are critical for advancing the self-esteem and moral character thought to reduce risk behaviours among young people and protect their health, and are essential to any conceptual model of PYD. Programme providers and implementers should design and undergo training in pedagogy that focuses on how to build trusting and warm relationships with young people. This may prove to be more important than other aspects of programme delivery, as in my data these relationships appeared to underlie and drive the effectiveness of nearly all the programme components.

#### *Ethical issues regarding the Teens & Toddlers intervention*

The T&T intervention was initially designed in 1978 in California, US by the organization *Children: Our Ultimate Investment (COUI)*, founded by Laura Huxley, wife of the author Aldus Huxley, in 1977. The overall aim of the COUI organisation was to address, what Laura Huxley described as, the “unnecessary suffering” in the world (COUI, 2009). T&T was described by COUI as an approach to providing at-risk young people with life skills to prepare them for adulthood. Laura Huxley believed that children and young people experienced similar challenges as they grew and developed, and could learn life skills from each other via working closely together, and thus designed the T&T programme. COUI UK was founded in 2001 and began to deliver T&T in the UK under the same premise. T&T became one of an assortment of interventions in the UK working to prevent teenage pregnancy and other risk behaviours and contribute to the TPS (DfES, 2006).

As with many interventions, programmes and activities designed by individuals or small local organisations hoping to support or improve their communities or a specific population, T&T was not designed grounded in evidence; rather it was developed based upon what Laura Huxley perceived as a need and what she believed would serve as an effective solution. Although the organisation eventually added PYD to the T&T programme and were clear on the various

components, COUI UK did not have an explicit logic model until the evaluation team developed one for the intervention during the formative evaluation. Furthermore, though the T&T programme providers did seek consent for participation in the intervention from both from the young people and from parents, as described earlier in this thesis, the programme providers decided against explicitly describing the programme as aiming to prevent teenage pregnancy so as not to raise undue concern among parents and potential participants, and as a mechanism for avoiding stigma. As a result, the programme participants and their parents were not fully informed about the purpose of the programme.

While there are numerous ethical guidelines and standards for researchers wishing to work with children and young people (Bronte-Tinkew et al., 2008; Alderson, 2007; Alderson and Morrow, 2004) this is less common for, particularly private, organisations offering services or resources to their local communities. The *Community Tool Box* website ([ctb.ku.edu](http://ctb.ku.edu)) provides some suggestions for community-level programme organisers for learning how to improve ethical standards for their activities. In their section on consent, the website authors provide an example of participation in an intervention that is also a study to illustrate the importance and utility of consent; again, emphasising the importance of consent in research, and seemingly understating the salience of full informed consent for participation in any intervention or activity with young people.

As described in the introduction to this thesis, the evaluation of the T&T intervention was a result of a successful tender to the DfE. As part of the preparation evaluation, the research team's plans were scrutinised by the Institutional Review Boards (IRB) of both LSHTM and NatCen and the project was approved. However, although the evaluation team held several discussions about some of the ethical implications of the intervention, an evaluation of the intervention processes, including mechanisms of consent, and the intervention overall were not given priority in the evaluation nor were they apparently scrutinised by the IRB, which was likely focussed on the ethics related to the evaluation.

Small, privately instituted and organically developed programmes are commonly developed at the grassroots level and can offer benefits to the communities and individuals they serve. However, many of these programmes operating at this level are not often assessed for ethical standards. Typically, concern for effectiveness and adherence to standards only emerges after the programme solicits financial support or backing from larger public or private agencies.

The overall intervention approach, essentially at-risk young people working with young children needed addition support, was at no point formally scrutinised for its ethical implications. As part of the pre-RCT formative evaluation, the research team conducted a literature review and consulted with experts to locate information on programmes similar to T&T. At the time of the formative evaluation in 2009, there were no other interventions taking a similar approach. However, there were a handful of academic articles documenting interventions using virtual infant simulator dolls in the US and the UK to prevent teenage pregnancy and promote parenting skills. The evidence did not suggest any benefits to the intervention and some researchers expressed concern that the intervention could reinforce the desire to become a parent (Sorhaindo et al., 2009).

Ultimately, the evaluation team managed to persuade the T&T programme providers to add language to the consent forms indicating that the young people would be receiving sex education as part of the intervention. Although this did not fully describe the aim of the intervention, it introduced the notion that the young women would be discussing sex as part of T&T. The evaluation team should have gone farther and included adherence to ethical standards as part of the measures of the process evaluation. More generally, programme providers should be encouraged to aspire to ethical standards that resemble those required for research; as any level or type of intervention has the potential to cause harm.

#### *Directions for future research and practice*

This research provides insights that prompt future research towards the development of effective interventions to prevent and reduce teenage pregnancy and other risk behaviours and deleterious outcomes among youth. Firstly, analysis

of the experience of participating in a PYD programme suggests that specific aspects of PYD programmes, namely a balance between challenge and skill that builds confidence; appropriate support from caring adults; and an opportunity to develop character through reflection should be emphasised in conceptual models to promote positive development. Activities designed on the basis of a conceptual model including these features should be evaluated to determine whether this approach indeed increases intervention effectiveness. In addition to evaluating the outcomes of such interventions, it will be important for future research to document, via process evaluation, the actual implementation of activities characterised by the features suggested here. Also, in line with the ethos of the approach, determine whether the intended sentiments of hope, caring and connection and the 5Cs are truly generated via PYD activities from the perspective of the young people participating.

The qualitative research presented in Chapter VII of this thesis calls for the development of testable hypothesis around the effects and effectiveness of targeting and risk assessment. Questions remain about the impact of targeting strategies on the potential effectiveness of risk reduction interventions for young people. Further research building upon the findings presented here, may compare the outcomes of activities using different targeting strategies to locate intervention participants. In particular, compare the effectiveness of risk managers, such as school staff, in the selection of high-risk individuals with young people's self-assessment of risk. Further research may also explore the competency and the accuracy of risk managers, such as school staff, in making assessments. Moreover, future research might consider how school staff's roles as authorities influence their decisions about risk.

Evidence Chapter IX also highlights the importance of school staff being supported with evidence to make the most of their expertise and to not stretch themselves beyond what they are comfortable with and what they are trained to do in assessing young people's risk. Furthermore, additional investigation may aim to quantify the extent to which targeted groups' awareness of being considered at risk of a stigmatised health outcome impacts upon the effectiveness of preventative interventions. Future studies may also consider whether knowledge

of individual-level risk factors for outcomes such as teenage pregnancy further stigmatises targeted groups.

Practitioners and researchers should solicit and attempt to understand the perspective of young people on what is experienced as positive and helpful. Additionally, an appreciation of the diversity of youth and the distinct needs of different youth populations can help programme providers to come to the understanding that activities for youth should be as diverse and kaleidoscopic as youth themselves. Programmes should continue to check in with youth to determine if their experiences are continuing to be positive. Involving young people is not simply an issue of ensuring that they are enjoying the benefits of a programme. Practitioners must acknowledge that overlooking the needs and wants of youth may lead to unintended consequences and, in some cases, even harm. Furthermore, this involvement should occur at the highest possible levels of Hart's Ladder of Participation to reap the greatest benefits for all those involved (Hart, 1993).

Professionals should make use of the great advances in methodologies for involving young people in social research (Parsons et al., 2016; McDonagh and Bateman, 2012). Christensen (2004) suggests that researchers ask themselves, "Are practices employed in the research process in line with and reflective of children's experiences, interests, values and everyday routines; and what are the ways in which children routinely express and represent these in their everyday life?" (Christensen, 2004). Materials and efforts to describe the research process to young people should be designed with their developmental level in mind (Kirk 2007; Petersen and Leffert 1995). Tait and colleagues (2007) suggest using bullets, bolding and images to increase comprehension and processability of informational materials for young people. Future programme evaluators should seek to have a dedicated discussion with both the adults and the young people involved about the evaluation and its purpose, the features of RCTs, the intervention, and the roles of all the actors involved.

Finally, future research may pose these or similar research questions among populations residing outside of London and in other countries to determine

whether the lived experience of targeted PYD intervention is distinct in different contexts.

### *Conclusions*

The UK has experienced great successes in reducing the prevalence of teenage pregnancy, but the approaches used could potentially have greater positive impact and sustainability if refined. Going forward the community of public health policymakers, researchers and practitioners working towards reducing teenage pregnancy within their contexts should consider including young people's voices in all aspects of intervention development to benefit from their rich perspectives, and using targeting sparingly, openly and as part of universal programmes to minimise further marginalising young people who already experience multiple disadvantage and disconnection from their peers and adult mentors in school. Doing so may result in greater gains in the prevention of undesirable health and social outcomes, but more importantly, avoid causing unintended harm.

## **Additional references (not included in research papers)**

Alderson, P. & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. Ilford, Essex: Barnardo's.

Allen, E., Bonell, C., Strange, V., Copas, A., Stephenson, J., Johnson, A.M., Oakley, A. (2007). Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomised trial of sex education and their implications for policy. *Journal of Epidemiology and Community Health*, 61: 20-27.

Allen, J.P. and Philliber, S. (2001). Who benefits most from a broadly targeted prevention program? Differential efficacy across populations in the teen outreach program. *Journal of Community Psychology*, 29(6): 637-655.

Ali, S. (2003). 'To be a girl': culture and class in schools. *Gender and Education*, 15, 269-283. doi: <http://10.1080/09540250303859>.

Anwar, E. and Stanistreet, D. (2015). 'It has not ruined my life; it had made my life better?': a qualitative investigation of the experiences and future aspirations of young mothers from the North West of England. *Journal of Public Health*, 37(2): 269-276.

Arai, L. (2009). *Teenage Pregnancy: The making and unmaking of a problem*. Bristol: The Policy Press.

Arai, L. (2003). Low expectations, sexual attitudes and knowledge: explaining teenage pregnancy and fertility in English communities. Insights from qualitative research. *The Sociological Review*, 199-217.

Archer, L., Halsall, A. and Hollingworth, S. (2007). Inner-city femininities and education: 'race', class, gender and schooling in young women's lives. *Gender and Education*, 29(5): 549-568.

Arnstein, S.R. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*, 35 (4): 216-224

Bailey, P. (2005). Teenage pregnancies: is the high rate of teenage pregnancy and parenthood in the UK a public health problem? *Journal of Family Planning and Reproductive Health Care*, 31(4): 315-319.

Barcelos, C.A. (2014). Producing (potentially) pregnant teen bodies: biopower and adolescent pregnancy in the USA. *Critical Public Health*, 24(4): 476-488.

Benjamin, S. (2002). *The Micropolitics of Inclusive Education*. Buckingham and Philadelphia: Open University Press.

Benson, J.B. (Ed.) (2015). *Advances in Child Development and Behavior*. United States: Elsevier Science Publishing Co.

Benson, P.L. (2007). Developmental assets: an overview of theory, research and practice, in Silbereisen, R.K. and Lerner, R.M. (Eds), *Approaches to Positive Youth Development*, London: Sage.

Benson, P.L., Mannes, M., Pittman, K. and Ferber, T. (2004), Youth development, developmental assets, and public policy, in Lerner, R.M. and Steinberg, L. (Eds), *Handbook of Adolescent Psychology*, 2nd ed., Hoboken, NJ: John Wiley & Sons Inc., pp. 781-814.

Benson, P.L. and Saito R.N. (2001). The scientific foundations of youth development. In, P.L. Benson and K.J. Pittman (Eds.) *Trends in youth development: Visions, realities and challenges*. New York: Springer Science+Business Media LLC.

Bird, L., Arthur, A. and Cox, K. (2011) "Did the trial kill the intervention?" experiences from the development, implementation and evaluation of a complex intervention. *BMC Medical Research Methodology*, DOI: 10.1186/1471-2288-11-24.



Blake, D.R., Lemay, C.A., Kearney, M.H., Mazor, K.M. (2011). Adolescents' understanding of research concepts. A focus group study. *Archives of Pediatric Adolescent Medicine*. 165(6):533-539. doi:10.1001/archpediatrics.2011.87.

Blanden, J., Greaves, E., Gregg, P., Macmillan, L. and Sibieta, L. (2015) Understanding the improved performance of disadvantaged pupils in London. Centre for Analysis of Social Exclusion (CASE), London School of Economics and Political Science (LSE). Working Paper 21. September 2015.

Bond, L., Patton, G., Glover, S., Carlin, J.B., Butler, H., Thomas, L., Bowes, G. (2004) The Gatehouse Project: can a multilevel school intervention affect emotional wellbeing and health risk behaviours? *Journal of Epidemiology and Community Health*, 58: 997-1033.

Bonell, C., Hinds, K., Dickson, K., Thomas, J., Fletcher, A., Murphy, S., Melendez-Torres, G.J., Bonell, C., and Campbell, R. (2016a). What is positive youth development and how might it reduce substance use and violence? A systematic review and synthesis of theoretical literature. *BMC Public Health*, 16:135. DOI 10.1186/s12889-016-2817-3

Bonell, C., Dickson, K., Hinds, K., Melendez-Torres, G.J., Stansfield, C., Fletcher, A., Thomas, J., Lester, K., Oliver, E., Murphy, S., and Campbell, R. (2016b). The effects of Positive Youth Development interventions on substance use, violence and inequalities: systematic review of theories of change, processes and outcomes. *Public Health Research*, 4(5). DOI: 10.3310/phr04050

Bonell, C., Jamal, F., Melendez-Torres, G.J. and Cummins, S. (2015). 'Dark logic?': theorising the harmful consequences of public health interventions. *Journal of Epidemiology and Community Health*, 69: 95-98 doi:10.1136/jech-2014-204671

Bonell, C., Wiggins, M., Fletcher, A. and Allen, E. (2014). Do family factors protect against sexual risk behaviour and teenage pregnancy among multiply disadvantaged young people? Findings from an English longitudinal study. *Sexual Health*, 11: 265-273.

Bonell, C., Maisey, R., Speight, A., Purdon, A., Keogh, P., Wollny, I., Sorhaindo, A. and Wellings, K. (2013). Randomized controlled trial of 'teens and toddlers': A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery. *Journal of Adolescence*, 36, 859-870.

Bonell, C, Fletcher A, Sorhaindo A, Wells H and McKee M. (2011) How market-oriented education policies might influence young people's health: development of a logic model from qualitative case studies in English secondary schools. *Journal of Epidemiology and Community Health*, 66: e24 doi:10.1136/jech.2011.137539.

Bonell, C., Sorhaindo, A., Strange, V., Wiggins, M., Allen, E., Fletcher, A., Oakley, A., Bond, L., Flay, B., Patton, G., and Rhodes, T. (2010). A pilot whole-school intervention to improve school ethos and reduce substance use. *Health Education*, 110(4): 252-272.

Bonell, C. and Fletcher A. (2008) Addressing the wider determinants of problematic drug use: Advantages of whole-population over target interventions. *International Journal of Drug Policy*, 19: 267-269.

Bonell C, Allen E, Strange V, Oakley A, Copas A, Johnson A and Stephenson J. (2006) Influence of family type and parenting behaviours on teenage sexual behaviour and conceptions. *Journal of Epidemiology and Community Health*, 60: 502-506.

Bonell, C., Allen, E., Strange, V., Copas, A., Oakley, A., Stephenson, J. and Johnson, A. (2005) The effect of dislike of school on risk of teenage pregnancy: testing of hypotheses using longitudinal data from a randomised trial of sex education. *Journal of Epidemiology and Community Health*, 59: 223-230.

Bonell, C. (2004). Why is teenage pregnancy conceptualized as a social problem? A review of quantitative research from the USA and UK. *Culture, Health and Sexuality*, 6(3): 255-272.

Bonell, C., Strange, V., Stephenson, J.M., Oakley A.R., Copas, A.J., Forrest S.P.,

Johnson, A.M., and Black, S. (2003). Effect of social exclusion on the risk of teenage pregnancy: development of hypotheses using baseline data from a randomized trial of sex education. *Journal of Epidemiology and Community Health*, 57: 871-876.

Bowers E, Johnson S, Buckingham M, Santiago G and Warren D (2014), Youth development across mid- to late- adolescence: The moderating effect of parenting profiles, *Journal of Youth and Adolescence* 43(6): 897-918.

Brackett-Milburn K and Wilson S. (2000) Understanding peer education: insights from a process evaluation. *Health Education Research*, 15(1): 85-96.

Breheny M and Stephens C. (2010) Youth or disadvantage? The construction of teenage mothers in medical journals. *Culture, Health and Sexuality*, 12(3): 307-322.

Brooks-Gunn, J. and Roth, J. (2014), Invited commentary: Promotion and prevention in youth development: Two sides of the same coin? *Journal of Youth and Adolescence*, 43(6): 1004-1007.

Bronte-Tinkew J, Allen T and Joyner K. (2008) Institutional review boards (IRB): What are they, and why are they important? Part 7 in a Series on Practical Evaluation Tools. Child Trends.

Brown, B. (2007). I thought it was just me (but it isn't): Making the journey from "What will people think?" to "I am enough". New York, NY: Penguin Random House.

Brown, S., Shoveller, J., Chabot C, and Montagne, A.D. (2013). Risk, resistance and the neoliberal agenda: young people, health and well-being in the UK, Canada and Australia. *Health, Risk & Society*, 15(4), 333-346.

Burgess, S. (2014). Understanding the success of London's schools. Centre for Market and Public Organisation (CMPO) Working Paper No. 14/333. October 2014.

Capewell, S. and Graham, H. (2010). Will cardiovascular disease prevention widen health inequalities? *PLoS Medicine*, 7(8): e1000320.  
doi:10.1371/journal.pmed.1000320

Carey G, Crammond B and De Leeuw E (2015) Towards health equity: A framework for the application of proportionate universalism. *International Journal for Equity in Health*, 14:81 DOI 10.1186/s12939-015-0207-6.

Carey, G. and Crammond, B. (2014). A glossary of policy frameworks: the many forms of 'universalism' and policy 'targeting'. *Journal of Epidemiology and Community Health*, doi:10.1136/jech-2014-204311.

Carnegie UK Trust. (2008) *Empowering Young People*. Dunfermline, Fife: Carnegie UK Trust.

Castel, R. (1991) From dangerousness to risk. In: G. Burchell, C. Gordon and P. Miller eds. *The Foucault Effect: studies in governmentality*. Hemel Hempstead: Harvester Wheatsheaf, 281-298.

Catalano, R.F., Hawkins, D.J., Berglund, L., Hawkins, J.D., Berglund, M.L., Pollard, J.A. and Arthur, M.W. (2002). Prevention science and positive youth development: competitive or cooperative frameworks? *Journal of Adolescent Health*, 31: 230-239.

Cerdá, M., Tracy, T., Ahem, J. and Galea S. (2014) Addressing population health and health inequalities: The role of fundamental causes. *American Journal of Public Health*, 104(S4): S609-S619.

Checkoway, B. (2011). What is youth participation? *Children and Youth Services Review*, 33: 340-345.

Christensen, P.H. (2004). Children's participation in ethnographic research: Issues of power and representation. *Children & Society*, 18: 165-176.

Cooley, CH.. (1902). The social self the meaning of 'I?', *Human Nature and the Social Order*. New York: Scribner. pp. 136-178.

Coombes, L., Appleton, J.V., Allen, D. and Yerrell, P. (2013) Emotional health and well-being in schools: involving young people. *Children & Society*, 27: 230-232.

Connolly, P. (2008). Race, gender and critical reflexivity in research with young children. In, Christensen, P. and James, A. (eds.) *Research with Children: Perspectives and Practices*, Second Edition, London: Routledge.

Conrad, D. Deprivation-based inequalities in under-18 conception rates and the proportion of under-18 conceptions leading to abortion in England, 1998-2010. *Journal of Public Health*, 34(4): 609-614.

Crawford, C., Cribb, J., and Kelly, E. (2013). *Teenage Pregnancy in England*. Centre for Analysis of Youth Transitions (CAYT). CAYT Impact Study: Report No. 6. London: Institute of Fiscal Studies.

Creswell, JW. (2007). *Qualitative Inquiry and Research Design* (2nd Ed). Thousand Oaks, London and New Dehli: Sage Publications.

Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology*, 35: 89-107.

Csikszentmihalyi, M. (1990). *Flow*. New York: Harper and Row

Culyer, A.J. (1995). Need: the idea won't do - but we still need it. *Social Science and Medicine*, 40: 727-730.

Department for Health (DH)(2005). *Teenage Pregnancy Strategy Evaluation: Final Report Synthesis*. London: Department for Health.

Department for Children, Schools and Families (DCSF) and Department of Health (DH) (2010). *Teenage Pregnancy Strategy: Beyond 2010*. London: DCSF..

Department for Education and Skills (DfES). (2006). *Teenage pregnancy next steps: Guidance for local authorities and primary care trusts on effective delivery of local strategies*. London: DfES.

Dishon, T.J., McCord, J. and Poulin, F. (1999). When interventions harm. *American Psychologists*, 54(9): 755-764.

Dixon-Woods M, Ashcroft RE, Jackson CJ, Tobin MD, Kivits J, Burton PR, Samani N. (2007) Beyond “misunderstanding”: Written information and decisions about taking part in a genetic epidemiology study. *Social Science & Medicine*, 65: 2212-2222.

Duff, C. (2003). The importance of culture and context: rethinking risk and risk management in young drug using populations. *Health, Risk and Society*, 5(3): 285-299.

Duncan, S. (2007). What’s the problem with teenage parents? And what’s the problem with policy? *Critical Social Policy*, 27(3): 307-334.

Eccles, J. and Gootman, J. (2002). *Community programs to promote youth development*. Washington, D.C: National Academy Press.

Englander, M. (2016). The phenomenological method in qualitative psychology and psychiatry. *International Journal of Qualitative Studies on Health and Wellbeing*, 11: 30682 <http://dx.doi.org/10.3402/qhw.v11.30682>.

Ermisch, J. and Pevalin, D.J. (2003). Who has a child as a teenager? ISER Working Papers Number 2003-30.

Evans,R., Scourfield, J., & Murphy, S. (2014). The unintended consequences of targeting: young people’s lived experiences of social and emotional learning interventions. *British Educational Research Journal*, 41, 381-397. doi: <http://10.1002/berj.3155>.

Fagen, M.C. and Flay, B.R. (2009). Sustaining a school-based prevention program: Results from the Aban Aya sustainability project. *Health Education and Behavior*, 36(1): 9-23.

Farthing, R. (2012). Why youth participation? Some justifications and critiques for youth participation using New Labour's Youth Policies as a case study. *Youth & Policy*, 109: 71-97.

Featherstone, K. and Donovan J.L. (1998). Random allocation or allocation at random? Patients' perspectives of participation in a randomised controlled trial. *British Medical Journal*, 317: 1177-80.

Ferri, B.A. and Connor, D.J. (2010). 'I was the special ed. girl': urban working-class young women of colour. *Gender and Education*, 22(1): 105-121.

Finlay L. (2002) "Outing" the researcher: The provanance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4): 531-545.

Flay, B.R., Graumlich, S., Segawa, E., Burns, J.L., Holliday, M.Y., for the Aban Aya Investigators (2004). Effects of 2 prevention programs on high-risk behaviors among African American youth. A randomized Trial. *Archives of Pediatric Adolescent Medicine*, 158: 377-384.

Fleming J. (2012) Young people's participation – Where next? *Children & Society*, DOI:10.1111/j.1099-0860.2012.00442.x

Fletcher, A., Fitzgerald-Yau, N., Wiggins, M., Viner, R.M. and Bonell, C. (2015) Involving young people in changing their environment to make it safer. Findings from a process evaluation in English secondary schools. *Health Education*, 115(3/4): 322-338.

Fletcher, A., Bonell, C., Sorhaindo, A. and Rhodes, T. (2009), Cannabis use and 'safe' identities in an inner-city school risk environment. *International Journal of Drug Policy*, 20(3): 244-50 doi: 10.1016/j.drugpo.2008.08.006.

Fletcher, A., Harden, A., Brunton, G., Oakley, A., and Bonell, C. (2007). Interventions addressing the social determinants of teenage pregnancy. *Health Education*, 108(1): 29-39.

Frolich, K.L. and Potvin, L. (2008). The inequality paradox: The population approach and vulnerable populations. *American Journal of Public Health*, 98(2): 216-221.

Fryer CS, Passmore SR, Maietta RC, Petruzzelli J, Casper E, Brown NA, Butler J, Garza MA, Thomas SB and Quinn SC. (2015). The symbolic value and limitations of racial concordance in minority research engagement. *Qualitative Health Research*, DOI: 10.1177/1049732315575708.

Furlong, A. and Cartmel, F. (2007). *Young people and social change*. 2nd Edn. Open University Press: Maidenhead.

Furstenberg FF. (2007) *Destinies of the disadvantaged: The politics of teen childbearing*. New York, New York: Russell Sage.

García-Moya, I., Brooks, F., Morgan, A .and Moreno, C. (2015). Subjective well-being in adolescence and teacher connectedness: A health asset analysis. *Health Education Journal*, 75(6): 641-654.

Gavin, L.E., Catalano, R.F., Davis Ferdon, C., Gloppen, K.M .and Markham, C.M. (2010). A review of positive youth development programs that promote sexual and reproductive health. *Journal of Adolescent Health*, 46: S75-S91.

Geronimus AT. (2003) Damned if you do: culture, identity, privilege and teen childbearing in the United States. *Social Science & Medicine*, 57: 881-893.



- Giddens, A. and Pierson, C. (1998). *Conversations with Anthony Giddens: Making Sense of Modernity*. Stanford, CA: Stanford University Press.
- Giddens, A. (1991). *Modernity and Self-identity: Self and Society in the Late Modern Age*. Cambridge, Polity Press.
- Gilborn, D. and Youdell, D. (2000) *Rationing Education: Policy, Practice, Reform and Equity*. Buckingham: Open University Press.
- Girma, S. and Paton, D. (2015). Is education the best contraception?: The case of teenage pregnancy in England. *Social Science & Medicine*, 131: 1-9.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon & Schuster, Inc.
- Goffman, E. (1959). *The presentation of self in everyday life*. London: Penguin Books Ltd.
- Greaves, E., Macmillan, L., and Sibieta, L. (2014). Lessons from London school for attainment gaps and social mobility. SMCP Research Report SMCP-RR363.
- Green, J. and Thorogood, N. (2004). *Qualitative Methods for Health Research*. London: Sage Publications.
- Greer, G. (1970). *The Female Eunuch*. London: Harper Collins.
- Grimes, D.A. and Schulz, K.F. (2002). Uses and abuses of screening tests. *The Lancet*, 359: 881-84.
- Grossman, J.B. and Bulle, M.J. (2006). Review of what youth programs do to increase the connectedness of youth with adults. *Journal of Adolescent Health*, 39: 788-799.

Gulland, A. (2016). Teenage pregnancy rate falls to record low. *British Medical Journal*, 352:i1484 doi: 10.1136/bmj.i1484.

Hadley, A. (2014). Teenage pregnancy: huge progress... but more to do. *Community Practitioner*, 87(6): 44-47.

Hadley, A., Ingham, R., and Chandra-Mouli, V. (2016a). Teenage Pregnancy Strategy for England. *The Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(16\)30619-5](http://dx.doi.org/10.1016/S0140-6736(16)30619-5).

Hadley, A., Chandra-Mouli, V., and Ingham, R. (2016b). Implementing the United Kingdom Government's 10-year Teenage Pregnancy Strategy for England (1999-2010): Applicable lessons for other countries. *Journal of Adolescent Health*, 59: 68-74.

Hahn, A., Leavitt, T. and Aaron, P. (1994). *Evaluation of the Quantum Opportunities Program*, Heller Graduate School, Brandeis University, Waltham, Massachusetts.

Hammersley, M. (2015). Research ethics and the concept of children's rights. *Children & Society*, 29: 569-582.

Harper, G.W. and Carver, L.J. (1999) "Out-of-the-Mainstream" Youth as partners in collaborative research: Exploring the benefits and the challenges. *Health Education & Behavior*, 26(2): 250-265.

Harden, A., Brunton, G., Fletcher, A. and Oakley, A. (2009) Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies. *British Medical Journal*, 339: b4254 doi:10.1136/bmj.b4254.

Harden, A., Brunton, G., Fletcher, A., Oakley, A., Burchett, H., Backhans, M. (2006). Young people, pregnancy and social exclusion: A systematic synthesis of research evidence to identify effective, appropriate and promising approaches for prevention and support. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Hart, R.A. (1992). *Children's Participation: From tokenism to citizenship*. Innocenti Essays, No. 4. Florence, Italy: UNICEF.

Hatzenbuehler, M.L., Phelan, J.C. and Link B.G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, 103(5): 813-821.

Head, B.W. (2011). Why not ask them? Mapping and promoting youth participation. *Children and Youth Services Review*, 33: 541-547.

Heijnders, M. and van der Meij, S. (2006). The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health and Medicine*, 11(3): 353-363.

Henderson, G.E., Churchill, L.R., Davis, A.M., Easter, M.M., Grady, C., Joffe, S., Kass, N., King, N.M.P., Lidz, C.W., Miller, F.G., Nelson, D.K, Peppercorn, J., Bluestone Rothchild, B., Sankar, P., Wilford, B.S. and Zimmer, C.R. (2007) Clinical trials and medical care: Defining the therapeutic misconception. *PLoS Med*, 4(11):e324.

Hobcraft, J. and Kiernan, K. (2001), Childhood poverty, early motherhood and adult social exclusion. *British Journal of Sociology*, 52(3): 495-517.

Hooks, B. (1982). *Ain't I a Woman. Black Women and Feminism*. London: Pluto Press.

Husserl, E. (1999). *The Idea of Phenomenology*. Dordrecht, The Netherlands: Kluwer Academic Publishers.

Hutchings, M., Greenwood, C., Hollingworth, S., Mansaray, A., Rose, A., Minty, S. and Glass, K. (2012) Evaluation of the City Challenge programme. Department for Education, Research Report DFE-RR215.

Ingham, R. (2013). Teen pregnancies, rhetoric and research. The Guardian. Available at: <https://www.theguardian.com/society/2013/dec/18/teen-pregnancies-rhetoric-research>. [Accessed 16 January 2016].

Imamura, M., Tucker, J., Hannaford, P., Oliveira da Silva, M., Astin, M., Wyness, L., Bloemenkamp, K.W.M., Jahn, A., Karro, H., Olsen, J., Temmerman, M. (2007). Factors associated with teenage pregnancy in the European Union countries: a systematic review. *European Journal of Public Health*, 1(6): 630-636.

Jackson, C. (2006). 'Wild' girls? An exploration of 'ladette' cultures in secondary schools. *Gender and Education*, 18(4): 339-360.

Jessiman, T., Keogh, P, Scott, S., Wollny, I, Sorhaindo, A. and Bonell. C. (2012) Teens and Toddlers integrated process evaluation. DFE Research Report DFE-RR212.

Kendal S, Keeley P and Callery P. (2014) Student help seeking from pastoral care in UK highschoools: a qualitative study. *Child and Adolescent Mental Health*, 19(3): 178-184.

Kiernan, K. and Hobcraft, J. (1997). Parental divorce during childhood: Age at first intercourse, partnership and parenthood. *Population Studies*, 51(1): 41-55 DOI: 10.1080/0032472031000149716.

Kim CY. (2016) Why research 'by' children? Rethinking the assumptions underlying the facilitation of children as researchers. *Children & Society*, 30: 230-240.

Kirby D. (2009) Reducing pregnancy and risky behaviours in teenagers. Youth development programmes don't always work. *British Medical Journal*, 339: b2054 doi: 10.1136/bmj.b2054.

Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

Kirby, D., Lezin, N., Afriye, R.A. and Gallucci, G. (2003). *Preventing Teen Pregnancy: Youth development and after-school programs*. Scotts Valley, California: ETR Associates.

Kirby, D. (2001). Understanding what works and what doesn't work in reducing adolescent sexual risk-taking. *Family Planning Perspectives*, 33(6); 276-281.

Kirby, P. and Bryson, S. (2002). *Measuring the Magic: Evaluating and researching young people's participation in public decision-making*. London: Carnegie Young People Initiative.

Kirby, P., Lanyon, C., Cronin and Sinclair R. (2003) *Building a Culture of Participation: Research Report*. London: Department for Education and Skills.

Kirk, S. (2007). Methodological and ethical issues in conducting qualitative research with children and young people: A literature review. *International Journal of Nursing Studies*, 44: 1250-1260.

Kneale, D., Fletcher, A., Wiggins, R., Bonell, C. (2013). Distribution and determinants of risk of teenage motherhood in three British longitudinal studies: implications for targeted prevention interventions. *Journal of Epidemiology and Community Health*, 67(1): 48-55 doi:10.1136/jech-2011-200867.

Kneale, D. (2010). *Pathways to Parenthood: Exploring context as a predictor of the time to first parenthood*. PhD. Institute of Education, University of London.

Krenichyn, K., Schaefer-McDaniel, N., Clark, H. and Zeller-Berkman, S. (2007) Where are young people in youth program evaluation and research? *Children, Youth and Environments*, 17(2): 594-615.

Kreuter, M.W., Hovmand, P., Pfeiffer D.J., Fairchild, M., Rath, S., Golla, B., and Casey, C. (2014) The "long tail" and public health: New thinking for addressing health disparities. *American Journal of Public Health*, 104: 2271-2278.

Kreuter, M.W. and Wray, R.J. (2003). Tailored and targeted health communication: Strategies for enhancing information relevance. *American Journal of Health Behavior*, 27(suppl 3): S227-S232.

The Lancet. (2012). Putting adolescents at the centre of health and development. *The Lancet*, 379(9826): 1561.

Lawlor, D. A. and Shaw, M. (2002), 'Too much too young? Teenage pregnancy is not a public health problem', *International Journal of Epidemiology*, 31(3): 552-3.

Larkins, S.L., Page, R.P., Panaretto, K.S., Mitchell, M., Alberts, V., McGinty, S. and Veitch, P.C. (2011). The transformative potential of young motherhood for disadvantaged Aboriginal and Torres Strait Islander women in Townsville, Australia. *Medical Journal of Australia*, 2011; 194(10): 551-555.

Larson, R.W. (2000). Toward a psychology of positive youth development. *American Psychologist*, 55(1): 170-183.

Laursen, E. (2003). Caring relationships as a protective factor at at-risk youth: A ethnographic study. *Families in Society: The Journal of Contemporary Social Services*, 84(2): 240-246.

Laursen, E. and Birmingham (2003) Caring relationships as a protective factor for at-risk youth: An ethnographic study" *Families in Society: The Journal of Contemporary Human Services* 84(2): 240-246.

Lee, E., Clements, S., Ingham, R. and Stone, N. (2004) *A matter of choice? Explaining national variations in teenage abortion and motherhood*. York: Joseph Roundtree Foundation.

Lerner, R.M. (2005). Promoting positive youth development through community and after-school programs. In, Mahoney JL, Larson RW and Eccles JS. (Eds)

*Organized activities as contexts of development.* Mahwah, New Jersey and London: Lawrence Erlbaum Associates, Publishers.

Lerner, R.M., Lerner, J.V., Benson, J.B. (2011). Positive youth development: research and applications for promoting thriving in adolescence. *Advances in Child Development Behavior*, 41: 1-17.

Lerner, R.M. and Thompson, L.S. (2002). Promoting healthy adolescent behavior and development: Issues in the design and evaluation of effective youth programs. *Journal of Pediatric Nursing*, 17(5): 338-343.

Link, B.G. and Phelan, J. (2006). Stigma and its public health implications. *Lancet*, 367: 528-29.

Link, B.G. and Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-85.

Luker, K. (2000). *Dubious Conceptions.* Cambridge, Massachusetts and London, England: Harvard University Press.

MacDonald R and Marsh J. (2005) *Disconnected Youth?* London: Palgrave MacMillan.

Mahoney, A.C. and Lafferty, C.K. (2003). Special issue: Positive youth development. *American Journal of Health Behavior*, 27(supplement 1): S3-S5.

Mason J. (2002) *Qualitative Researching.* London: Sage Publications.

Mauthner, M. (1997). Methodological aspects of collecting data from children: Lessons from three research projects. *Children & Society*, 11: 16-28.

Markham, C.M., Lormand, D., Gloppen KM., Peskin, M.F., Flores, B., Low, B., and House L.D. (2010) Connectedness as a predictor of sexual and reproductive health outcomes. *Journal of Adolescent Health*, 46(3): S23-S41.

Mayall, B. (2000). Conversations with children: working with generational issues. In, Christensen P, James A (eds) *Research with Children: Perspectives and Practices*. First edition, London: Falmer Press.

McCambridge, J., Witton, J. and Elbourne, D.R. (2014). Systematic review of the Hawthorne effect: New concepts are needed to study research participation effects. *Journal of Clinical Epidemiology*, 67: 267-277.

McCulloch A. (2001) Teenage childbearing in Great Britain and the special concentration of poverty households. *Journal of Epidemiology and Community Health*, 55: 16-23.

McDonagh JE and Bateman B. (2012) 'Nothing about us without us': considerations for research involving young people. *Arch Dis Child Educ Pract Ed*, 97: 55-60

McIntosh, H., Metz, E., and Youniss, J. (2005). Community service and identity formation in adolescents. In, J. L. Mahoney, R. W. Larson, & J. S. Eccles (Eds.). *Organized activities as contexts of development: Extracurricular activities, after-school and community programs*. Mahwah, NJ: Lawrence Erlbaum Associates.

McLaren, L., McIntyre, L. and Kirkpatrick S. (2010). Rose's population strategy of prevention need not increase social inequalities in health. *International Journal of Epidemiology*, 39: 372-377.

McLaughlin, H. (2015). *Involving Children and Young People in Policy, Practice and Research*. London: National Children's Bureau (NCB).

McRobbie, A. (2007). Top girls? Young women and the post-feminist sexual contract. *Cultural studies*, 21(4-5): 718-737.

Melendez-Torres, G.J., Dickson, K., Fletcher, A., Thomas, J., Hinds, K., Campbell, R., Murphy, S., and Bonell, C. (2016) Systematic review and meta-analysis of effects of community-delivered positive youth development interventions of violence



outcomes. *Journal of Epidemiology and Community Health*, doi:10.1136/jech-2015-206132.

Mercer, C.H., Tanton, C., Prah, P., Erens, B., Sonnenberg, P., Clifton, S., MacDowall, W., Lewis, R., Field, N., Datta, J., Copas, A.J., Phelps, A., Wellings, K. and Johnson, A.M. (2013) Change in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). *The Lancet*, 382:1781-94.

Middleton S. (2011) 'I wouldn't change having the children – not at all.' Young women's narratives of maternal timing: What the UK's Teenage Pregnancy Strategy hasn't heard. *Sexuality Research and Social Policy*, 8(3): 227-238.

Miles, S. (2000). *Youth lifestyles in a changing world*. Buckingham: Open University Press.

Moore, S. and Rosenthal, D. (2009) *Sexuality in Adolescence. Current Trends*. London and New York: Routledge.

Morrow, V. and Richards, M.P.M. (1996). The ethics of social research with children: an overview. *Children & Society*, 10: 90-105.

Moustakas C. (1994) *Phenomenological Research Methods*. Thousand Oaks, California: Sage Publications.

Nettle, D., Coall, D.A. and Dickins, T.E. (2011). Early-life conditions and age at first pregnancy in British women. *Proceedings of the Royal Society*, 278: 1721-1727. doi:10.1098/rspb.2010.1726.

Neuman, W.L. and Robson, K. (2009). *Basics of Social Research. Qualitative and quantitative approaches*. Toronto, Ontario: Pearson Canada Inc.

Oakley A, Strange V, Bonell C, Allen E, Stephenson J, and RIPPLE Study Team. (2006) Process evaluation in randomized controlled trials of complex interventions. *British Medical Journal*, 332: 413-416.

O'Brien Cherry, C., Chumbler, N., Bute, J., and Huff, A. (2015) Building a "Better Life": The transformative effects of adolescent pregnancy and parenting. *SAGE Open*, DOI: 10.1177/2158244015571638.

Office of National Statistics (ONS). (2016a). *Conceptions in England and Wales, 2014*. 9 March.

Office for National Statistics (ONS) (2016b). Regional gross disposable household income (GDHI): 1997 to 2014. Office for National Statistics.

Office for National Statistics (ONS) (2016c). Population estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2015. Office for National Statistics.

Office of National Statistics (ONS). (2015a). *Conceptions in England and Wales, 2013*. 24 February.

Office for National Statistics (ONS) (2015b) London Analysis: Estimate of employee jobs paid less than the living wage in London and other parts of the UK. Office of National Statistics.

Office of National Statistics (ONS) (2014).. International comparisons of teenage births, 2012. 15 October 2014

Office for National Statistics (ONS) (2013). *London's population was increasing fastest among the regions in 2012*. Office for National Statistics.

Office for National Statistics (ONS) (2011). Ethnicity and national identity in England and Wales: 2011. Office for National Statitcis.

Oringanje, C., Meremikwu, M.M., Eko, H., Esu, E., Meremikwu, A., Ehiri, J.E.

Interventions for preventing unintended pregnancies among adolescents.  
*Cochrane Database of Systematic Reviews* 2016, Issue 2. Art. No.: CD005215.  
DOI: 10.1002/14651858.CD005215.pub3.

Paranjothy, S., Broughton, H., Adappa R., and Fone, D. (2009). Teenage pregnancy: who suffers? *Archives of Disease in Childhood*, 94: 239-245.

Parton N. (2010) 'From dangerousness to risk': The growing importance of screening and surveillance systems for safeguarding and promoting the well-being of children in England. *Health, Risk and Society* 12(1): 51-64.

Paton, D. (2012) Underage conceptions and abortions in England and Wales 1969-2009: the role of public policy. *Education and Health*, 30(2): 22-24.

Patton MQ. (1999). Enhancing the quality and credibility of qualitative analysis. *HSR: Health Services Research*, 34(5): 1189-1208.

Percy-Smith, B. (2007) "You think you know? ... You have no idea": Youth participation in health policy development. *Health Education Research*, 22(6): 879-894.

Petersen AC, Leffert N. (1995) Developmental issues influencing guidelines for adolescent health research: A review. *Journal of Adolescent Health*, 17: 298-305.

Philliber, S., Williams Kaye, J., Herring, S. and West, E. (2002) Preventing pregnancy and improving health care access among teenagers: An evaluation of the Children's Aid Society – Carrera Program. *Perspectives on Sexual and Reproductive Health*, 34(5): 244-251.

Pittman, K., Irby, M. and Ferber, T. (2000). Unfinished business: further reflections on a decade of promoting youth development, international youth foundation", *Youth Development: Issues, Challenges and Directions*. Philadelphia, PA.: Public/Private Ventures.

Plummer, K. (2001). Labeling Theory. In, Bryant C (Ed) *Encyclopedia of Criminology and Deviant Behaviour, vol I*. Philadelphia, PA: Brunner-Routledge.

Powers, J.L. and Tiffany, J.S. (2006) Engaging youth in participatory research and evaluation. *Journal of Public Health Management and Practice*, November(Suppl): S79-S87.

Public Health England (2012). *Improving young people's health and wellbeing. A framework for public health*. London: Public Health England and Association for Young People's Health (AYPH).

Resnick, M.D., Catalano, R.F., Sawyer, S.M., Viner, R., Patton, G.C. (2012) Seizing the opportunities of adolescent health. *The Lancet*, 379: 1564-1566.

Rich, G.J. (2003) The positive psychology of youth and adolescence. *Journal of Youth and Adolescence* 32(1): 1-3.

Rorie, M., Gottfredson, D.C., Cross, A., Wilson, D. and Connell, N.M. (2011) Structure and deviancy training in after-school programs. *Journal of Adolescence*, 34:105-117.

Rose G. (1992). *Rose's Strategy of Preventive Medicine*. Oxford: Oxford University Press.

Rose, G. (1985). Sick individuals and sick populations. *International Journal of Epidemiology*, 14(1): 32-38.

Rose, G. (1981). Strategy of prevention: lessons from cardiovascular disease. *British Medical Journal*, 282: 1847-1851.

Rose R and Shevlin M. (2004) Encouraging voices: listening to young people who have been marginalised. *Support for Learning*, 19 (4): 155-161.

- Roth, J.L. and Brooks-Gunn, J. (2003). Youth Development Programs: Risk, Prevention and Policy. *Journal of Adolescent Health*, 32: 170-182.
- Roth, J. and Brooks-Gunn, J. (2000). What do adolescents need for healthy development? Implications for youth policy. *Social Policy Report*, XIV(1): 3-19.
- Roth, J., Brooks-Gunn, J., Murray, L. and Foster, W. (1998) Promoting healthy adolescents: Synthesis of youth development program evaluations. *Journal of Research on Adolescence*, 8(4): 423-459.
- Robson, K. and Berthoud, R. (2003). Teenage motherhood in Europe: A multi-country analysis of socioeconomic outcomes. *European Sociological Review*, 19(5): 451-466.
- Sampson, R.J. and Laub, J.H. (1997). A life-course theory of cumulative disadvantage and the stability of delinquency. In, Thorberry T (Ed) *Advances in Criminology Theory, Vol. 7*. Transactions.
- Sawyer, S.M., Afifi, R.A., Bearinger, L.H., Blakemore, S.J., Dick, B., Ezeh, A.C., Patton, G.C. (2012) Adolescence: a foundation of future health. *The Lancet*, 379:1630-1640.
- Seamark CJ and Lings P. (2004) Positive experiences of teenage motherhood: a qualitative study. *British Journal of General Practice*, 54: 813-818.
- Schoon, I., Martin, P. and Ross, A. (2007) Career transitions in times of social change. His and her story. *Journal of Vocational Behavior*, 70: 78-96.
- Sedgh, G., Finer, L.B., Bankole, A., Eilers, M.A., and Singh, S. (2015) Adolescent pregnancy, birth, and abortion rates across countries: Levels and recent trends. *Journal of Adolescent Health*, 56: 223-230.
- Shackleton, N., Jamal, F., Viner, R.M., Dickson, K., Patton, G., and Bonell, C. (2016). School-based interventions going beyond health education to promote adolescent health: Systematic review of reviews. *Journal of Adolescent Health*, 58: 382-396.

Shaw, M., Lawlor, D.A. and Najman, J.M. (2006) Teenage children of teenage mothers: Psychological, behavioural and health outcomes from an Australian prospective longitudinal study. *Social Science and Medicine*, 62: 2526-2539.

Silbereisen, R.K. and Lerner, R.M. (Eds) (2007). *Approaches to Positive Youth Development*. London: Sage Publications, Ltd.

Skinner, S.R. and Marino, J.L. (2016) England's Teenage Pregnancy Strategy: a hard-won success. *The Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(16\)30589-X](http://dx.doi.org/10.1016/S0140-6736(16)30589-X).

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, methods and research*. London: Sage Publications.

SmithBattle, L. I. (2013). Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal Child Nursing*, 38, 235e241. <http://10.1097/NMC.0b013e3182836bd4>.

Social Exclusion Unit (SEU). (1999). *Teenage pregnancy*. London: HMSO.

Strange, V., Allen, E., Oakley, A., Bonell, C., Johnson, A., Stephenson, J. and the RIPPLE Study Team. (2006) Integrating process with outcome data in a randomised controlled trial of sex education. *Evaluation*, 12(3): 330-352.

Tait, AR. (2007). Presenting research information to children: A tale of two methods. *Anesthesia & Analgesia*, 105: 358-64.

Teenage Pregnancy Unit (2006) *Teenage pregnancy: working towards 2010. Good practice and self-assessment toolkit*. UK Department for Education and Skills and UK Department of Health.

Teens & Toddlers (T&T) (2008). *Teens & Toddlers Intensive Implementation Programme*. Haringey. Internal document.

Thoresen, L. and Öhlén, J. (2015). Lived observations: Linking the researcher's personal experiences to knowledge development. *Qualitative Health Research*, DOI: 10.1177/1049732315573011

Toynbee, P. (2013). The drop in teenage pregnancies is the success story of our time. [online] The Guardian. Available at: <https://www.theguardian.com/commentisfree/2013/dec/13/drop-teenage-pregnancies-success-story-children>. [Accessed 16 January 2016].

Turnbull, G. and Spence, J. (2011). What's at risk? The proliferation of risk across child and youth policy in England. *Journal of Youth Studies*, 14(8), 939-959

Turner, B. (2009). The phenomenological research method as a valid human sciences research tool into the investigation of human behavior, In, Lentz CA (Ed.) *An Anthology of Higher Learning. Volume II: Research Methodology*. Las Vegas, Nevada: The Lentz Leadership Institute LLC.

Unguru, Y., Sill, A.M., Kamani, N. (2010) The experiences of children enrolled in pediatric oncology research: implications for assent. *Pediatrics*, 125(4): e876-83. doi: 10.1542/peds.2008-342.

UNESCO (2014) *Developing an education sector response to early and unintended pregnancy*. November ED-2014/WS/33.

UNICEF Office of Research (2013). *Child Well-being in Rich Countries: A comparative overview*. Innocenti Report Card 11, Florence, Italy: UNICEF Office of Research.

Van Brakel, W.H. (2006). Measuring health-related stigma – A literature review. *Psychology, Health & Medicine*, 11, 307-334. doi: 10.1080/13548500600595160

Van Manen, M. (1990). *Researching Lived Experience. Human Science for an Action Sensitive Pedagogy*. New York: State University of New York Press.

Viner, R.M., Ozer, E.M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. and Currie C. (2012). Adolescence and the social determinants of health. *The Lancet*, 379: 1641-52.

Walker, J., Marczak, M., Blyth, D. and Borden, L. (2005), Designing youth development programs: Toward a theory of developmental intentionality. In, Mahoney JL, Larson RW and Eccles JS (Eds). *Organized Activities as Contexts of Development: Extracurricular activities, after-school and community programs*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc.

Wiseman T. (1996) A concept analysis of empathy. *Journal of Advanced Nursing*, 23: 1162-1167.

Weininger, E.B. (2005). Chapter 4. Foundations of Pierre Bourdieu's class analysis. In, Wright EO (Ed.) *Approaches to Class Analysis*. Cambridge: Cambridge University Press.

Weiss, M.G., Ramakrishna, J. and Somma, D. (2006). Health-related stigma: Rethinking concepts and interventions. *Psychology, Health and Medicine*, 11(3): 277-287.

Wellings, K., Palmer, M.J., Geary, R.S., Gibson, L.J., Copas, A., Datta, J., Glasier, A., Scott, R.H., Mercer, C.H, Erens, B., Macdowall, W., French, R.S., Jones, K., Johnson, A.M., Tanton, C., and Wilkinson, P. (2016). Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000-12: an observational study. *The Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(16\)30449-4](http://dx.doi.org/10.1016/S0140-6736(16)30449-4).

Wellings, K., Jones, K.G., Mercer, C.H., Tanton, C., Clifton, A., Datta, J., Copas, A.J., Erens, B., Gibson, L.J., MacDowell, W., Sonnenberg, P., Phelps, A. and Johnson, A.M. (2013). The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet*, 382:1807-1816.



Whitehead E. (2009) Understanding the association between teenage pregnancy and inter-generational factors: A comparative and analytical study. *Midwifery*, 25:147-154.

Whitley R and Kimayer LJ. (2008) Perceived stigmatization of young mothers: An exploratory study of psychological and social experience. *Social Science and Medicine*, 66(2): 339-348.

Wiggins, M., Bonell, C., Sawtell, M., Austerberry, H., Burchett, H., Allen, E. and Strange, V. (2009) Health outcomes of youth development programme in England: prospective matched comparison study. *British Medical Journal*, 339: b2534.

Wight, D., Williamson, L., and Henderson, M. (2006). Parental influences on young people's sexual behaviour: A longitudinal analysis. *Journal of Adolescence*, 29: 473-483.  
Wilkinson and Pickett (2009) *The Spirit Level: Why equality is better for everyone*. New York: Bloomsbury Press.

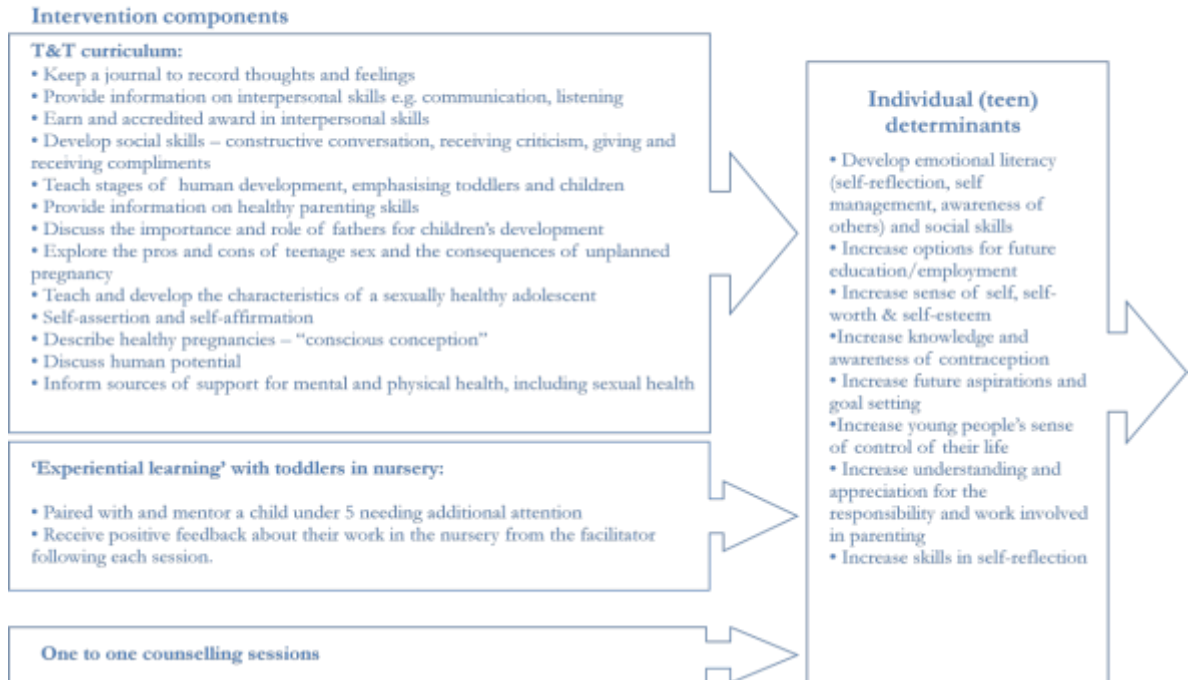
Wood, K. and Aggleton, P. (2002). *Promoting Young People's Sexual and Reproductive Health. Stigma, Discrimination and Human Rights*. Thomas Coram Research Unit. Institute of Education, University of London.

World Health Organization (WHO) (2010). *Developing sexual health programmes: A framework for action*. Geneva: WHO.

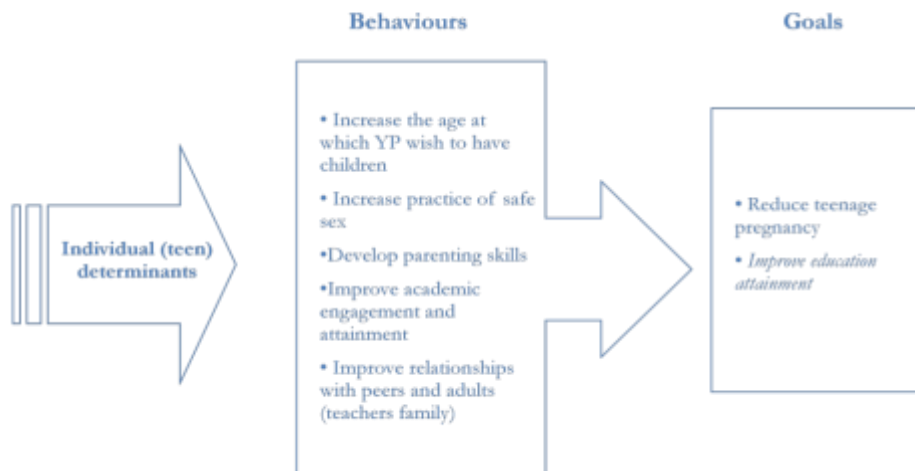
Zhou, Y., Ismajani Puradiredja, D., and Abel G. (2015). Truancy and teenage pregnancy in English adolescent girls: can we identify those at risk? *Journal of Public Health*, doi:10.1093/pubmed/fdv029

## Appendix A: Teens & Toddlers intervention logic model

### Logic model



### Logic model continued...



## Appendix B. Teens & Toddlers Selection Tool

### INFORMATION SHEET

#### Teenager Selection Tool for teachers

You may be aware that the Teens and Toddlers programme will be working with some of the young people from your school in the near future. If you have received this form, some of the students from your class or year group are being considered for the programme.

Our aim at Teens and Toddlers is to work with the young people who are considered to be most at risk of experiencing or causing early pregnancies. As you might imagine, selecting the right young people for the programme can be quite a complex process. However, through our research, we have identified a number of key criteria that have been shown to have an influence on whether a teenager is more or less likely to become a teenage parent.

We have also found that teachers are very good at predicting the behaviour of their students. Therefore we need your assistance to help us identify which young people are most in need of the Teens and Toddlers programme. On the following page is a 20 item questionnaire that asks you to rate the young person under consideration for the programme according to a number of personality characteristics, attitudes and behaviours, and background factors. All you need to do is tick one of the three boxes for each of the items listed. We estimate that each questionnaire will take no more than 5 minutes to complete.

Please understand that the purpose of this form is to identify which young people will benefit most from the programme, so that we can hopefully prevent some teenage pregnancies from occurring. Your responses will not be considered as judgemental or derogatory to the young people. None of the information you provide will ever be raised with the young people, and the Teens and Toddlers facilitators will not have access to this information. Teachers should be assured that the main aim of the questionnaire is to help us identify the right teenagers to include, and the data won't be used for anything other than research purposes.

It is very important to note that we are very careful in the way we store data. The questionnaire completed by you is only used to select young people, and then responses are quickly stored on a password-protected database which only very few members of staff have access to.

We recognise that some of the questions are entirely subjective and therefore your answers are not expected to be definitive in any way. You may or may not know the answers to the questions asked, but please use your judgement if you suspect the answer to be "yes" or "no".

Thank you very much for your help with this matter and for taking the time to complete the questionnaire.

Please note that the school will be responsible for identifying, and excluding from the project

- people on a list kept under s.1 Protection of Children Act 1000 (individuals considered unsuitable to work with children;
- people subject to a disqualification order under the Criminal Justice and court Services Act 2000 (having committed a sexual offence or an offence

of violence against a child or having been involved in the supply of drugs to a child).

**Student Number** \_\_\_\_\_ **Age:** \_\_\_\_\_ **School:** \_\_\_\_\_

### About the teenager's personality

*How does this teenager compare to his/her peers on the following personality characteristics?(tick one box per item)*

	Lower than peers	About the same as peers	Higher than peers
1. Shyness (or withdrawn-ness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Negativity and lack of self-belief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. General sadness (or depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Nervousness (or anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Anger (or aggressiveness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Disengagement from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### About the teenager's attitudes and behaviours

*How does this teenager compare to his/her peers on the following attitudes and behaviours? (tick one box per item)*

*This teenager says and does things that suggest they...*

	Less than peers	About the same as peers	More than peers
7. Frequently use alcohol and/or drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are not interested in thinking about their future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are disengaged from and uninterested in School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Believe it is acceptable to have a child as a teenager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### About the teenager's background

*The following background issues are well-documented 'risk factors' for teenage pregnancy. Please rate this teenager from your knowledge of their background.*

*This teenager:.....*

	No or "I suspect not"	Don't know ?	Yes or "I suspect so"
12. Has a poor school attendance record (truancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Experienced puberty earlier than their peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a history of sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has previously been pregnant (or caused a pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has a family member who is/was pregnant as teen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has a history of abuse (physical, sexual or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Is currently in care, or has been in care in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has a history of family instability & lacks positive role models	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Generally does not perform well at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Thank you very much for completing this questionnaire*

## Appendix C. Evaluation team risk factor checklist

### INFORMATION SHEET

#### Advice for Teachers on Teenager Selection

The Teens and Toddlers programme will be working with some of the young people from your school this year. If you have received this form, some of the students from your class or year group will be considered for the programme.

Teens and Toddlers works with young people who could be at risk of experiencing early pregnancies. The first step of the programme is to select students who might be at risk from your school. We have identified some criteria that have been shown to influence whether someone is more likely to become a teenage parent. We would appreciate your assistance in helping us identify which young people might benefit from the Teens and Toddlers programme.

At this stage, we would like you to invite girls in your class or year group who have some or all of the following characteristics to the Teens & Toddlers briefing meeting to be held at your school in the next couple of weeks.

**Please give students who have some or all of the below characteristics an invitation letter to the briefing meeting:**

- ▶ Are disengaged from or uninterested in school
- ▶ In general, do not perform well or underperform (*i.e.* do not work to their potential) in school
- ▶ Exhibit poor or disruptive behaviour in class
- ▶ Have a poor attendance record
- ▶ Parent rarely/never attends parents' evenings
- ▶ Parent or sibling was a teenage parent
- ▶ Currently/previously in care
- ▶ Exhibits withdrawn or shy behaviour in class. Has difficulty interacting with peers.

**It is very important that that you invite only those students to the briefing meeting who meet these criteria. This way we give the opportunity to the students in most need.**

**N.B. The school is responsible for ensuring that the following are not invited onto the project**

- those on a list kept under s.1 Protection of Children Act 2000 (individuals considered unsuitable to work with children;
- those subject to a disqualification order under the Criminal Justice and Court Services Act 2000 (having committed a sexual offence or an offence of violence against a child or having been involved in the supply of drugs to a child).

**Thank you very much for your help with this matter and for taking the time to help with the selection process.**

## Appendix D. Study instruments

### Topic Guide for focus groups

- The primary aim of these focus group interviews is to gain an understanding of respondents' understandings and experience of being on the Teens & Toddlers programme, to inform the integral process evaluation.
- The topic guide is designed for interviewing young people in groups.
- This is a *topic guide*, and wording and ordering of questions is subject to change depending on the circumstances of the interview. In all cases groups will be facilitated by researchers experienced in carrying out research with young people.

<u>Activity</u>	<u>Outcomes</u>	<u>Resources</u>	<u>Time</u>
<p><b><u>1a. Introductions</u></b></p> <ul style="list-style-type: none"> <li>• Introduce self &amp; NatCen</li> <li>• Introduce study:</li> <li>• Digital recording – check OK</li> <li>• Reassure re confidentiality; ensure understanding of the term and also no feedback to parents/teachers/ T&amp;T</li> <li>• How we'll report findings</li> <li>• Reminder of session length – (max 90 mins) check OK</li> <li>• Reiterate voluntary nature of session (also that can take a break and fine to refuse to answer any question)</li> <li>• Ask to try not to all talk at once</li> <li>• Any questions/concerns?</li> </ul> <p><b><u>1b. background</u></b> Participants to spend 2 mins finding out the following about the person sitting next to them, and then feedback to the group</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• No. of brothers and sisters (and older/younger)</li> <li>• Favourite thing to do after school</li> <li>• Plans for when they leave school</li> <li>• One thing about them that other people wouldn't guess</li> </ul>	<p>Everyone knows each other and understands the purpose of the discussion</p>	<p>- information sheet (provided previously)</p> <p>Resource sheet with questions written on it and space for answers, to be collected in</p>	<p><b><u>10 mins</u></b></p> <p><b><u>5 mins</u></b></p>
<p><b><u>2. Recruitment</u></b></p> <ul style="list-style-type: none"> <li>▪ How did you find out about Teens &amp; Toddlers?</li> <li>▪ What did the school/teachers tell</li> </ul>	<p>Explore participant's understanding of the programme before participation, and</p>	<p>None- general discussion</p>	<p><b><u>15-20 mins</u></b></p>

<p>you about Teens &amp; Toddlers?</p> <ul style="list-style-type: none"> <li>▪ Did you attend a presentation about the programme?</li> <li>▪ What did you understand about the programme when you were first told about it?</li> <li>▪ Does your parent or guardian know you are taking part in Teens and Toddlers?</li> <li>▪ How did they find out about the programme?</li> <li>▪ What does your family think about you taking part? Why</li> <li>▪ Did the research process influence you/your family’s decision in any way?</li> <li>▪ Do you know what the randomisation was?</li> <li>▪ How did you feel about that?</li> <li>▪ What do you think it has been like for those who were not selected to take part?</li> </ul>	<p>decision to take part</p>		
<p><b>3. Selection</b></p> <p>A. Participants split into two groups, given 2-3 minutes to write on flip chart answers to:</p> <ul style="list-style-type: none"> <li>▪ What do you think is the main point of Teens and Toddlers?</li> <li>▪ Who do you believe Teens &amp; Toddlers is for?</li> </ul> <p>Compare flip charts and use for discussion.</p> <ul style="list-style-type: none"> <li>▪ Why do you think you were selected?</li> <li>▪ How do you feel about being selected?</li> </ul> <p>B. Participants read (or are read out) three short biographies and asked to discuss a) whether the person would be selected for teens and toddlers b) what they might learn from the programme</p>	<p>Explore understanding of programme and feelings about why they were selected, and intended outcome of the programme</p>	<p>Flip chart paper and pens</p> <p>Copies of biographies</p>	<p><b><u>20-30 mins</u></b></p>
<p><b>4.</b></p> <p><b><u>4a. Experience of taking part – the curriculum</u></b></p> <p>Tell me more about what you actually</p>	<p>Understanding of participant experiences</p>	<p>None- general discussion</p>	<p><b><u>20 mins</u></b></p>

<p>do on the programme starting with group time – the curriculum part.</p> <ul style="list-style-type: none"> <li>▪ What do you do in group time (the curriculum)?</li> <li>▪ What did you do the first day?</li> <li>▪ What have you done since then?</li> <li>▪ What is the facilitator like?</li> <li>▪ What do you like and dislike about group time?</li> <li>▪ How does working with the facilitator make you feel?</li> <li>▪ Do you think having a facilitator is important? Why?</li> <li>▪ How do you feel/what do you think about the topics that are discussed during the group sessions?</li> <li>▪ What do you think about how they are presented?</li> <li>▪ Have you had one-to-one counselling? How was that?</li> <li>▪ What is the counsellor like?</li> <li>▪ Do you think having counselling is important? Why?</li> </ul> <p><b><u>4b. Experience of taking part – working with children</u></b></p> <p>And what about the work with the children?</p> <ul style="list-style-type: none"> <li>▪ What is the nursery like?</li> <li>▪ What are the nursery staff like?</li> <li>▪ Do you work with one child or more than one?</li> <li>▪ Do you just do observations or do work yourself?</li> <li>▪ What happened on your first day working with a child?</li> <li>▪ How did you feel?</li> <li>▪ What do you do when you are with the child?</li> <li>▪ Who decides what you do?</li> <li>▪ How long do you work with the child?</li> <li>▪ Was this enough time?</li> <li>▪ How does working with children make you feel?</li> <li>▪ Is working with the children what you expected? How and why?</li> <li>▪ Do you think working with the children is important? Why?</li> <li>▪ Does it make you think any differently about becoming a parent?</li> <li>▪ If so, how?</li> <li>▪ Do you have any brothers, sisters</li> </ul>			
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<p>or cousins that are younger than you?</p> <ul style="list-style-type: none"> <li>- Do you look after them?</li> <li>- Is that different from your work in the nursery at all?</li> </ul>			
<p><b><u>5. Impact</u></b></p> <p>Now we are going to start thinking about what might change as a result of taking part in Teens and Toddlers.</p> <p>Series of cards – respondents pick one, read it out, and begin discussion...</p> <p><b><u>5 Talk about next steps, consider pairings for interviews, thank and close</u></b></p>	<p>Begin to consider impact/potential impact</p>	<p>Question cards – see attached</p>	<p><b><u>10 mins</u></b></p>

## Topic Guide for paired interview with participants

- The primary aim of these paired interviews is to build on the earlier focus groups and explore T&T participants' experience of the programme to date, perceptions of its impact and anticipated outcomes, and possible causal pathways.
- The topic guide is designed for interviewing young people in groups.
- This is a *topic guide*, and wording and ordering of questions is subject to change depending on the circumstances of the interview. In all cases groups will be facilitated by researchers experienced in carrying out research with young people.

### 1. Introduction

- Introduce self & NatCen (reminder)
- Introduce study: (reminder)
- Digital recording – check OK
- Reassure re confidentiality
- How we'll report findings
- Reminder of interview length – (max 30-45 min) check OK
- Reiterate voluntary nature of interview (also that can take a break and fine to refuse to answer any question)
- Any questions/concerns?

### 2. Respondent backgrounds

- Tell me about yourselves
  - Age
  - Family members
  - Friends
  - Describe ethnicity?
- Do you like school?
- What is the thing you like most about school?
- What is the thing you like least about school?
- What kind of student would you say you are?
- What is your best/worse subject?
- What do you normally do after school?
- What do you normally do on the weekends?
- What are your plans/dreams for when you leave school?

### 3. Understanding Teens & Toddlers

- So when you were first told about T&T what did you think about it?
- What/who did you think Teens & Toddlers for
- What do you think the programme is trying to achieve?
- Has any of this changed since you started the programme?
- Why do you think you were selected?
- How do you feel about being selected?
- Why did you want to take part?
- Have you taken part in a programme like this before?
- Have you done work experience or projects outside school before?
  
- What do your friends think about you taking part in T&T?
- What do they think happens at T&T?
- Do you tell them about everything that happens?
- Why do they think you were selected?

- Does your parent or guardian know you are taking part in Teens and Toddlers?
- How did they find out about the programme?
- What does your family think about you taking part? Why
- Did you and your parents/guardians give written consent for you to take part?

#### **4. Experience of taking part – working with toddlers**

Think back specifically to the last session you had in the nursery.

- Did you work with one toddler or more than one?
- What was your toddler(s) like that day?
- What did you do when you were with them?
- Who decided what you did?
- How long did you work with the toddler?
- Was this enough time?
  
- How does working with toddlers make you feel?
- Is working with the toddlers what you expected? How and why?
- Why do you think the programme wants young people to work with toddlers?

#### **5. Experience of taking part – the curriculum**

Tell me more about what you actually did that day in group time – the curriculum part.

- What did you do in group time (the curriculum)?
- How did you find this?
- What do you think the point of it was?
- What do you like and dislike about group time?
- How does working with the facilitator make you feel?
- How do you feel/what do you think about the topics that are discussed during the group sessions?
- Have you had one-to-one counselling? How was that?
- How did the counselling make you feel?
- Do you think it is useful?

#### **6. Impact**

Have a look again at the biographies.

(Participants chose one each and read it out).

- What difference would taking part in Teens and Toddlers make to this person?
- Why do you think that?
- What might they learn from the nursery?
- What might they learn from the group time?
- Do you think they would benefit from counselling? How?

Now think about each other/-What impact do you think taking part in Teens and Toddlers will have?

Has this programme changed how you feel at all?

Prompts:

- Has it changed how you feel about school/your education;
- children;
- having a baby of your own;
- your hopes for the future;
- who you hang out with;
- how you get on with your family;

- how you get on with teachers;
- how you get on with other adults, like the staff at the nursery;
- nurseries being a good thing for young children;
- nurseries being affordable for parents;
- combining work and being a parent;
- relationships;

Has taking part had any impact on how you feel about yourself?  
*Can you give me some examples of this?*

Thank and Close

## Topic Guide for participant interviews

- The primary aim of these interviews is to gain an understanding of respondents' understandings and experience of being on the Teens & Toddlers programme, to inform the formative process evaluation. It also covers aspects of the research process (randomisation and being interviewed) to inform research design.
- The topic guide is designed for interviewing young people in pairs or individually; they will be given the choice prior to interview which they would prefer.
- This is a *topic guide*, and wording and ordering of questions is subject to change depending on the circumstances of the interview. In all cases interviews will be conducted by researchers experienced in carrying out in-depth interviews with young people.

### **1. Introduction**

- Introduce self & NatCen
- Introduce study:
- Digital recording – check OK
- Reassure re confidentiality
- How we'll report findings
- Reminder of interview length – (max one hour) check OK
- Reiterate voluntary nature of interview (also that can take a break and fine to refuse to answer any question)
- Any questions/concerns?

### **2. Respondent background**

- Tell me about yourself
  - Age
  - Family members
  - Friends
- Do you like school?
- What kind of student would you say you are? (e.g. enjoy learning, get bored, are disruptive)
- How do you usually spend your time outside of school? (leisure time, extracurricular activities etc.)
- What are your plans/dreams for when you leave school?

### **2. Understanding Teens & Toddlers**

- How did you find out about Teens & Toddlers?
- What did the school/teachers tell you about Teens & Toddlers?
- What did you understand about the programme when you were first told about it?
- Can you tell be a bit about what Teens & Toddlers involves?
- What/who do you believe Teens & Toddlers is for?
- What do you think the programme is trying to achieve?
- Why do you think you were selected?
- How do you feel about being selected?
- Why did you want to take part?
- Have you taken part in a programme like this before?
- Have you done work experience or projects outside school before?
  
- What do your friends think about you taking part in T&T?
- What do they think happens at T&T?

- Do you tell them about everything that happens?
- Why do they think you were selected?
  
- Does your parent or guardian know you are taking part in Teens and Toddlers?
- Did you and your parents/guardians give written consent for you to take part?
- How did they find out about the programme?
- What does your family think about you taking part? Why?

### **3. Experience of taking part – the curriculum**

Tell me more about what you actually do on the programme starting with group time – the curriculum part.

- What do you do in group time (the curriculum)?
- What did you do the first day?
- What have you done since then?
- What is the tutor like?
- What is the counsellor like?
- What do you like and dislike about group time?
- How does working with the tutor make you feel?
- Do you think having a tutor is important? Why?
- How do you feel/what do you think about the topics that are discussed during the group sessions?
- What do you think about how they are presented?
- Have you had one-to-one counselling? How was that?
- Do you think having counselling is important? Why?
- How have you found the journaling aspect of the activities?

### **4. Experience of taking part – working with toddlers**

And what about the work with the toddler?

- What is the nursery like?
- What are the nursery staff like?
- Do you work with one toddler or more than one?
- Do you just do observations or do work yourself?
- What do you do when you are with the toddler?
- Who decides what you do?
- How long do you work with the toddler?
- Was this enough time?
- How does working with toddlers make you feel?
- Is working with the toddlers what you expected? How and why?
- Do you think working with the toddlers is important? Why?
- Do you have any brothers, sisters or cousins that are toddlers?
  - Do you look after them?
  - Is that different from your work in the nursery at all?

### **5. Acceptability**

- How does it feel to be part of the programme?
- What do you like best about it?
- What would you think you would change?
- What do you think you will get this from the programme?
- Why do you think some young people are more likely to experience a pregnancy in their teens than others? Prompt contraception, but also social factors.
- Do you know anyone who has experienced a pregnancy while they were still a teenager? Tell me your thoughts about this.

### **6. Friends and Risk behaviour**

- Are any of your friends also on the programme?
- Have you made any new friends through being on the programme?
- Have you lost any friends through being on the programme?
- What have you told them about being part of this programme?
- What do your friends think about you being part of this programme?
- How many of your friends would you say are going out with someone?
- Are you going out with someone? Have you ever had a boyfriend/girlfriend?
- What do you know about contraception?
- What would you like to learn about contraception?
- Do you think you will get this from the programme?
- Has the Teens and Toddlers Programme changed your views on
  - deciding when you do and don't want to have sex;
  - feeling empowered to say what you do and don't want to do
  - deciding whether to use contraception;
  - deciding what contraception to use;
  - deciding if and when to get pregnant;
  - your views on using drugs
  - your views on drinking alcohol

### **7. Impact**

Has this programme changed how you feel at all?

Prompts:

- Has it changed how you feel about school/your education;
- children;
- having a baby of your own;
- your hopes for the future;
- who you hang out with;
- how you get on with your family;
- how you get on with teachers;
- how you get on with other adults, like the staff at the nursery;
- nurseries being a good thing for young children;
- nurseries being affordable for parents;
- combining work and being a parent;
- relationships;

Has taking part had any impact on how you feel about yourself?

*Can you give me some examples of this*

- Do you gain a qualification as part of the programme?
- How do you feel about the qualification?
- Are there any drawbacks to being involved with the programme?
- Did taking part cause any problems at school?
- Were there any other drawbacks?

### **7. Research and randomisation**

*The researcher will give an explanation of the randomisation process for the next wave of the evaluation. There will be a flow chart/diagram to help explain the randomisation process.*

What do you think about deciding randomly who does and does not get to take part?

- Would you prefer the bit where we decide who does and doesn't get it to happen in public in the classroom or in private?
- Is there anything that bothers you about this way of doing it?
- If you were in this bit of the research and you didn't end up getting the programme, how would you feel?

- How does it feel to have researchers interviewing you?
  - Who would you feel most comfortable being interviewed by?
  - Where/when would you prefer to be interviewed?
  - Is there anything else that might make the interview easier for you?
- 
- Any other comments?
  - Thanks and close



## Integral process evaluation of the 'Teens & Toddlers' programme

### Topic Guide for use with control participants

- The primary aim of these interviews is to estimate potential contamination and confounding factors
- The interview will explore control participant's knowledge of the programme, and other activities that may influence the intended outcomes of teens and toddlers

Three control participants will be interviewed at each of four case study sites towards the beginning of the intervention and again towards the end. This topic guide is for the first interview.

#### 1. Introduction

- Introduce self & NatCen
- Introduce study: evaluation of Teens & Toddlers
- Digital recording – check OK, and reassure re confidentiality
- How we'll report findings
- Reminder of interview length – (30-60 mins) check OK
- Any questions/concerns?

#### 2. Context

- Tell me about yourself
  - Age
  - Family members
  - Friends
- Do you like school?
- What kind of student would you say you are? – maybe useful to offer some suggestions here
- How do you usually spend your time outside of school? (leisure time, extracurricular activities etc.)
- What are your plans/dreams for when you leave school?

#### 3. Finding out about Teens and Toddlers

Thinking now about the Teens and Toddlers programme:

- Please tell me about how you first heard of the teens and toddlers programme
  - When
  - How
- Had you heard about this, or similar programmes, before?
- Can you remember your initial impression about the programme?
- Do you know how you were selected for the programme? What do you think about this?
- In all, what information have you received about teens and toddlers?
  - From the school
  - From teens and toddlers
  - Other
- Did you find this information useful in helping you decide whether you wanted to participate?

- What were your thoughts about taking part?
  - Prompts:
  - Benefits
  - Concerns – was there anything that worried you?
- How did you feel when you were told you would not be taking part?

#### 4. Contamination

- Do you know anyone who is taking part in teens and toddlers?  
If yes
- How well do you know them?
- Do you talk about what they do while they are there? (why, why not)
  - Do you discuss what they learn from the T&T teachers?
  - Do you discuss what they learn from the T&T nursery staff?
  - Do you discuss what they do with the toddler?
  - Do you discuss what they think and feel about any of this?
- What do they people taking part say about the programme?
- Do you think the programme will help them in any way? How?
- How might the programme change those who participate?
  - Behaviour
  - Attitude
  - Aspirations
  - If it does not come up, prompt for sexual health and behaviour/att to pregnancy
- Do you think there are any disadvantages in taking part? What are these?
- Do you think you are missing out on anything by not taking part?

#### 5. Perception of teens and toddlers

- Can you tell me what the programme involves?  
Prompts
  - Nursery time
  - Group time
  - Facilitator/councillor involvement
  - Hours per week
  - Number of weeks
  - Number of young people attending
- What do you think the programme is trying to achieve?
- What do you think of this aim?
- How do you feel about the school offering the programme?
- Do you think the programme is suitable for all pupils?  
(Aim to find out if they are aware the programme is targeted or not)
- Who might the programme best be aimed at?  
Prompts
  - Gender
  - Age group
  - Risk behaviour etc

#### 6. Confounding factors

What other activities does the school offer that are not part of the curriculum?

Do you take part in any of these?

If yes, prompt for more information

What other things do you take part in, apart from school?

Prompts – sports, youth clubs, hobbies etc etc

Do any of your friends take part in these too?

Thank and close.

### Interviews guide for interviews with school teachers selecting participants for T&T

Theme	Prompts
<i>Background</i>	<ul style="list-style-type: none"> <li>▪ What is your main role at the school?</li> <li>▪ How long have you worked at the school?</li> <li>▪ How did you become involved with T&amp;T?</li> <li>▪ How long have you been involved with T&amp;T?</li> <li>▪ Why did you become involved with the programme?</li> <li>▪ What are your thoughts on the programme?</li> </ul>
<i>Actual selection criteria used</i>	<ul style="list-style-type: none"> <li>▪ What is your sense of the types of girls that are most likely to benefit from T&amp;T?</li> <li>▪ How did you decide which girls you would refer to the briefing meetings? (Prompt: personality characteristics, attitudes and behaviours, and background factors used to select)</li> <li>▪ Was the process different this time from previous times you've worked with T&amp;T?</li> <li>▪ In your view, do you think that the "right" girls were selected in this process?</li> <li>▪ When you speak with the girls you select about the programme, what do you say?</li> <li>▪ In general, how do they respond after you speak with them?</li> <li>▪ Which girls are most likely to show interest and which are least likely to show interest?</li> <li>▪ How do you account for confidentiality when selecting and approaching girls about T&amp;T?</li> <li>▪ In your opinion, in what other ways could girls be selected for the programme?</li> </ul>
<i>Views on guidance from T&amp;T</i>	<ul style="list-style-type: none"> <li>▪ Have you seen the teenager selection tool from T&amp;T?</li> <li>▪ If so, what did you think of it, in general?</li> <li>▪ In your view, does it include the appropriate criteria for selecting girls? Is there anything that is inappropriate?</li> <li>▪ Is there any information on the selection to that you feel unable to or reluctant to provide?</li> <li>▪ What other information about the girls would help you make your selection?</li> <li>▪ If you did not use the tool, what prevented you from using it?</li> </ul>
<i>Confidence in selection</i>	<ul style="list-style-type: none"> <li>▪ How do you feel when selecting girls for T&amp;T?</li> <li>▪ How confident are you that you chose the "right" girls?</li> <li>▪ In your view, does the T&amp;T selection tool help to recruit the "right" girls for the programme? If not, what should be changed?</li> <li>▪ In your view, is the right person doing the selection? If not, who would be better placed to make this decision?</li> </ul>
<i>Anticipated impact</i>	<ul style="list-style-type: none"> <li>▪ How do you think T&amp;T will affect the girls selected for the programme?</li> <li>▪ What are your hopes for the girls who take part in the programme?</li> <li>▪ What changes do you expect to see from the girls once they start/complete the programme?</li> </ul>

## **Appendix E.** Examples of meaning units

# CONTROL, ACCOMPLISHMENT, GROWTH WORKING w/ CHILDREN

Working with the children gives you  
purpose/sense of accomplishment

Offering guidance to the children to help  
them improve their behaviour. Mostly  
independently (without much support  
from the teachers)

Wanted to work with kids.

Want to teach kids.

My toddler is different with me than with  
others

I taught my toddler communication skills

I enjoy making my toddler happy

Working with the toddlers makes me feel  
like an adult

I'm learning how to understand young  
children

Learning how to manage the toddlers  
feelings

Helped my toddler to stop poor behaviours  
observing what the child does and taking  
note

I am proud of the fact that I am good at  
working with kids

Becoming mature and ready to learn new things

Brings the reality of parenthood/adulthood, home.  
Provides "life lessons"

Learning new things; reciprocity between "nursery time" and group time; about sexual and reproductive health

Learning to deal with peer pressure

Learning new things & more about yourself - confidence, friendship, discipline, empathy

Encourages self-reflection  
Re-examine how your behaviours impact upon/may be interpreted by others  
Self-realization

I feel more confident expressing myself

Provides an opportunity to be responsible.

I use what I learn in T&T in my life

Role playing helps me to imagine what someone else might be feeling

Love role play

We are learning empathy through role play

# LEARNING - LIFE LESSONS.

Helps you understand what you want in life and who you are.

Counselling was an opportunity to express my feelings.  
Creates a sense of relief/release

The programme requires commitment. teaches commitment.

Becoming mature and ready to learn new things

Brings the reality of parenthood/adulthood, home.  
Provides "life lessons"

Learning new things; reciprocity between "nursery time" and group time; about sexual and reproductive health

Learning to deal with peer pressure

Learning new things & more about yourself - confidence, friendship, discipline, empathy

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# LEARNING - LIFE LESSONS.

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Counselling was an opportunity to express my feelings.  
Creates a sense of relief/release

The programme requires commitment - teaches commitment.



# CHALLENGING AND DIFFICULT WORKING W/ CHILDREN

Working with children is difficult.

Need to be focussed and responsible to work with children.

Working with children in Teens & Toddlers might put a teenager off working with kids.

Working with children was confusing and intimidating at first, then became easier and the children themselves also relaxed.

Doing what they (the children) do.

Hard to keep my toddler focussed

Hard to get my toddler to participate in activities

*Surrender /  
Remove the focus  
from myself.*

Worry: Afraid of disappointing the young children;

Concerned about being wrongly accused of hurting a child

My toddler doesn't like me. He's not a bad child, but he is not always nice to others, including me

Working with children is challenging.

Facilitators were not always very helpful with the children in the nursery

Nursery teachers shout are aggressive when I make a mistake.

- SHAMING.

Some of the facilitator techniques are patronising.

Sessions with facilitators are tedious.

Teens & Toddlers is different than what we thought it would be.

DO NOT FEEL RESPECTED + SUPPORTED BY THE ADULTS INVOLVED IN THE PROGRAMME.

"They didn't tell us much about it."

(or msincerity?)

The programme "message" unclear. Mixed messages about what is "good" and what is "bad".

Also unclear what they main objective was: learn to care for children, improve employment prospects or prevent pregnancy.

When the providers are unclear the YP lose faith in them.

## **Appendix F. Excerpt of field notes 1**

This is week 4.

GROUP TIME:

" 1

OBSERVATION 1

DL.

17 MARCH 2010 (2:30)

Arrived at The nursery at 2:30. The TET sessions are held in The parents room at the rear of the school. As I approached the room a sign on the door stated ~~that~~ "do not disturb" counselling sessions are underway. So I am waiting in the hall.

The YP arrived with the facilitator at about 2:45. The counsellor was in the parent room meeting with one student. The counsellor left before the group session. In total, there were 5 girls and 2 facilitators. One girl left to perform a parade for St. Patrick's Day. All are in the room, all of us sat in a circle with a table.

The centre. The lead facilitator placed juice, fruits and cookies at the centre of the table and the girls snacked while they debriefed about the toddler trial. To help with this a flip chart, previously prepared, listed the question: 'What helped your toddler to learn today? What prevented your toddler from learning today.' Then the facilitator called one girl's name to answer the question. This girl described the challenge of helping her toddler when he/she is distracted. Then she called the name of another girl to speak next. This went on with each girl. All their accounts were similar apart from one girl who complained that her child (ages) had been nice to her. It seems that she'd initially

## My feelings at the time:

Obviously I stick out a bit because I am an adult with a funny accent that they have never met before, but sitting in the circle helped. My first impression of the girls is that they were respectful and obedient. All Afro-Caribbean-black and probably from low income homes.

I had another child but swapped because she preferred this child. During this time the facilitator fed back to each GP ~~to~~ something positive she had observed her do with her child. For example, she praised one girl for staying with her child whenever she went, keeping a good eye on her.

~~The Afro-Oh~~

The personalities of the girls became clearer as they spoke about working with the child. The first girl to speak seemed quiet or lacked some confidence in how smart she was. She seemed to hold an identity in the group as not being very smart. Overall though she did not seem to lack confidence. Perhaps only in her academic abilities?

Sitting next to this girl was a friend who appeared quite confident and smart. She answered questions appropriately and clearly. She understood the point of the questions. This was not always clear for the other girls.

Another girl also seemed to struggle with the ideas offered. She

was a hajib and seemed to hold the uplative as being a bit of a joker.

The next girl seemed a bit shy. But managed to answer the question.

The final girl seemed to really lack confidence and just smiled and was very reluctant to take part in the activities, but she eventually did. It was this girl who had trouble with her child earlier.

The next activity was the 'bag o bits' (?) it was a small ~~cloth~~ cloth bag with little cards in it. ~~The~~ The facilitator handed it to the girl who lacked confidence and asked her to



pull a card out. The card asked "Can you get pregnant if you have sex standing up".

Each girl in the circle had to answer the question. 4 said yes and 1 said no. There was some slight embarrassment at being asked these questions but they all answered. Then the facilitator explained that you can get pregnant any way you have sex. And that a condom can prevent that. She also mentioned that you can get STIs if you don't use a condom.

The confident girl seemed to help prevent the group from tripping into giggles as she seemed confident and not shy talking about the topic.

After this, The next page of the flip chart described a role play where 2 parents were ignoring a child.

~~After~~ 3 role plays were held so that each person had a chance to take part - including the facilitators + myself. In the role play, the 2 parents either argued or held a discussion and ignored the child (a girl in her knees).

After this, ~~the~~ all of us were asked how it felt to be the ignorer or the ignored.

Next, we each read a line from a poem about how a child learns what the lie. Each line made a statement such as, if a child is made to feel shame they will always

ful ~~to~~ guilty. If a child is encouraged, they will feel confident etc.

The facilitator explained words that the GP did not understand and asked whether they understood.

Finally, on the third page of the flip chart there was a question on a special time when you had a positive experience with learning and a negative experience with learning. The girls did not seem to really understand this question. The facilitator helped a lot but they had really seemed to understand what was being asked. Only the confident girl seemed to understand.

Finally, the girls were handed

Their journals and completed a pre-printed exercise that was related to these questions.

At this point, while the girls were starting to explain their good/bad experiences with learning, much of their individual backgrounds emerged.

One girl said that she only remembered being shunted at home.

Another said that she was sent out of class for throwing someone's book out of the window.

The facilitators thought that they were quieter than normal because of his presence.

## **Appendix F.** Excerpt of field notes 2

7

tu

23 June 2010.

Group + Toddler time.

Unit 8.

I interviewed ~~xxxxxx~~  
at 12 and plan to interview  
the nursery up at 4pm.

It is clear that the staff do  
not want me here. I don't  
want to be here either. They  
are the ones who want to be  
evaluated and I am just doing  
my job. I have no vested  
interest in the result of the  
evaluation. I wish they would  
make the experience difficult  
for me.

Summary:

(focus on this issue was)  
also on endings

"Health and disease begin in the womb  
Love and hate begin in the womb  
War and peace begin in the womb."  
- Huxley.

This quote was on the flip chart in the room along with "Core conditions for interpersonal relationships"

1. Empathy
2. Congruence
3. Respects.

Animal are you - check-in  
Watched film on first year  
are the friends. and down will  
Come baby. - Rod Pepper, Journalist John  
- Brought in condoms for the  
girl to look at female + male.

What was one thing that  
had the greatest impact on

you

→ Watched The wrong film.

- did not know what a dental dam was. Most advice is offered from personal experience rather than training, specific information.

2 classrooms were on a class trip.

↳ Praise for accommodating the situation.

The girls took FPA leaflets home to review to present next week.

All the girls were very interested in discussing it.

They were asked as Check-in ~~that they~~ how they would feel when T+T is over all said they would miss.



Angel did the bag-o-bits. She would not have volunteered before.

Lead facilitator was comfortable discussing sex in detail and explicitly and the girls seemed to appreciate this.

They asked questions openly and discussed any topics that came to mind.

Angel was visibly more confident, chatty and smiling.

On the post-nursery check-in they asked about how they would feel now that the programme is ending.

Some were confused about why the condoms were flawed.

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# Young women's lived experience of participating in a positive youth development programme

## The "Teens & Toddlers" pregnancy prevention intervention

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### Abstract

**Purpose** – Evaluation of the Teens & Toddlers (T&T) positive youth development (PYD) and teenage pregnancy prevention programme suggested that the intervention had minimal effectiveness partly due to its unclear theory of change. The purpose of this paper is to examine the lived experiences of young women participating in the programme to contribute to a clearer understanding of intervention process and potential mechanisms.

**Design/methodology/approach** – The authors conducted four focus groups ( $n = 20$ ), eight paired or triad interviews ( $n = 12$ ) and 15 interviews with young women participating in an randomized controlled trial of the T&T programme in England, analysing these data using a phenomenological approach.

**Findings** – T&T provided some opportunities to experience the "five Cs" that underpin PYD programme theory: competence, confidence, connection, character and caring. However, the young women did not experience the programme in a way that would consistently develop these characteristics. The lack of opportunities for skill-building and challenge in the activities constrained their ability to build competence and confidence. Some programme facilitators and counsellors were able to achieve connections and caring relationships with the young women, though other adults involved in the programme were sometimes perceived by the participants as overly critical. The character development activities undertaken in the programme addressed attitudes towards sexual risk-taking.

**Originality/value** – Few studies of the PYD approach examine young people's perspectives. This research suggests that the young women were not consistently provided with opportunities to



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achieve youth development within the T&T programmes. In refining the programme, more thought is needed regarding how delivery of particular components may facilitate or impede a PYD experience.

**Keywords** Schools, Young people, Qualitative methods, England, Sexual health promotion, Asset development in youth

**Paper type** Research paper

## Introduction

Teenage pregnancy has been a major concern in the UK for decades. The UK government’s Teenage Pregnancy Strategy (1999-2010) (Social Exclusion Unit, 1999; Department for Children, School and Families, 2010) was associated with a decline in the conception rate for under-18s in England and Wales but did not meet the strategy’s target of a 50 per cent reduction. The current rate of 27.9 per 1,000 women aged 15-17 remains the highest in Western Europe (Public Health England, 2014; Office of National Statistics, 2014; UNICEF Office of Research, 2013). The strategy included a focus on positive youth development (PYD) interventions as a means of prevention (Philliber *et al.*, 2002; Kirby, 2007).

PYD views young people as having assets to be developed, rather than as problems to be solved (Pittman *et al.*, 2000). It seeks to promote social and emotional development by supporting young people to gain skills, knowledge and competencies (Roth *et al.*, 1998; Catalano *et al.*, 2002; Benson *et al.*, 2004; Benson, 2007). PYD stands in contrast to deficit models of treatment or prevention in that it focuses not merely on preventing problem behaviours but also on developing young peoples’ positive assets. Proponents argue that PYD should aim to develop five positive attributes: competence (including academic and social skills); confidence; connection (close relationships to family, peers and community); character (positive values and integrity); and caring (Roth and Brooks-Gunn, 2000). Similarly, the Development Asset Model identifies 40 features of young people’s ecologies and resources that when enhanced contribute to healthy development (Benson, 1997; Benson and Scales, 2009; Lerner *et al.*, 2011).

The argument that PYD and development of the five “C”s may be protective against adverse sexual health outcomes is supported by empirical evidence demonstrating that some of these assets, such as academic attainment and good relationships with teachers and parents, are associated with improved sexual health (Arai, 2009; Allen *et al.*, 2007; Kirby, 2007; Crawford *et al.*, 2013) as well as evidence that PYD interventions can reduce sexual risk (Gavin *et al.*, 2010). There is less consistent evidence that self-esteem is associated with reduced risk of teenage pregnancy (Goodson *et al.*, 2006; Arai, 2009).

While the broad aims of PYD are generally agreed, the conceptual basis for how PYD might reduce sexual risk behaviours is under-developed and there is a lack of consensus about which ingredients of programmes contribute most to effectiveness (Roth and Brooks-Gunn, 2003; Kirby, 2007; Spencer and Spencer, 2014). However, particular programmatic features tend to recur across the various models: emphasis on young people’s positive attributes and potential; an atmosphere of “hope”; the sense of being part of a “caring family”; and opportunities for young people to cultivate their interests, develop skills and gain exposure to new experiences (Roth and Brooks-Gunn, 2003). Which of these is most important, and whether all must be present to achieve PYD remains unclear (Roth and Brooks-Gunn, 2003). Given the lack of an over-arching conceptual framework and variability in implementation, it is not surprising that evaluations of PYD interventions report mixed results (Wiggins *et al.*, 2009; Kirby, 2009; Bonell *et al.*, 2013).

In a randomized controlled trial (RCT) of the Teens & Toddlers (T&T) teenage pregnancy prevention programme, Bonell *et al.* (2013) examined the success of the



intervention in reducing unprotected sex and expectations of teenage parenthood, and increasing a measure of youth development, as well as various secondary outcomes. The programme providers did not have an explicit theory of change for the intervention though the evaluators developed one as part of a formative evaluation conducted prior to the RCT (Jessiman *et al.*, 2012). The RCT reported that T&T had no impact on its primary outcomes, but intervention participants were less likely to experience a decrease in their self-esteem than the control group (Bonell *et al.*, 2013). The authors concluded that the lack of a prior, explicit theory of change linking intervention components and outcomes might have contributed to its limited impact.

Process evaluations examine intervention delivery but less often examine the mechanisms underlying intervention effectiveness or lack thereof (Oakley *et al.*, 2006). The complexity of the mechanisms by which PYD aims to improve sexual health underlines the importance of such in-depth process evaluation in this field, though this is rarely done (Roth and Brooks-Gunn, 2003). For example, although the evaluation of the Young People's Development Programme, a UK-based PYD initiative targeting at risk 13-15 years old, did have a process evaluation, it was insufficiently focused on intervention mechanisms to be able to explain the unexpected findings of intervention harm suggested by the outcome evaluation (Wiggins *et al.*, 2009).

Process evaluations of implementation and intervention mechanisms must attend to the perspectives of intervention participants (Oakley *et al.*, 2006; Spencer, 2013). However, despite the avowed youth-centeredness of PYD, few evaluations have included the perspectives of young people in seeking to understand the potential barriers and facilitators to success (Krenichyn *et al.*, 2007; Fletcher *et al.*, 2008). Understanding how young people experience particular elements of PYD programmes can generate new insights into how potential, empowerment and hope are engendered and contribute to the development of a sounder conceptualization of the approach.

In this paper, using qualitative data collected during the process evaluation of T&T, we aimed to examine how young women participating in T&T experienced it; and what this suggests about the mechanisms underlying the programme. In doing so, we aimed to generate hypotheses about why the programme had limited impact.

## Methods

### *Intervention*

The data for this study were collected as part of an independent evaluation of the T&T programme funded by the UK's Department for Education led by NatCen and the London School of Hygiene and Tropical Medicine (LSHTM). T&T aims to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (Teens & Toddlers, 2008) (Table I). Over the course of the 18-20 week programme, young women are identified by their teachers as potentially benefiting from participation in T&T on the basis of being perceived as at risk of teenage pregnancy. Those who consent to participate spend one afternoon per week in a pre-school nursery, each mentoring a child aged 3-5 years old in need of additional attention for approximately 90 minutes, supervised by the nursery staff and up to two T&T facilitators. T&T believes that pairing vulnerable teenagers and young children under the supervision of skilled adults offers benefits for each, such as improvements in personal, social and communication skills ([www.teensandtoddlers.org](http://www.teensandtoddlers.org)). The young women also spend 90 minutes in facilitated group sessions focused on child development, effective parenting skills, and sex and relationships education.

These sessions are intended to develop skills to be applied when mentoring children. Sessions at the start of the programme provide a foundation for the mentoring work by introducing the young women to the nursery and developing skills needed for mentoring the child. Participants also receive mandatory one-to-one sessions with a trainee counsellor (who generally contribute their time in partial fulfilment of requirements for a counselling qualification) two to three times during the programme. Upon completion of T&T, participants receive a National Award in Interpersonal Skills, Level 1 (National Council for Further Education).

### Sample

The process evaluation collected qualitative data from four case-study schools in London, selected to encompass different levels of experience in delivering T&T (first time vs previous experience); and ratings of school quality as judged by government inspectors[1] (“good” vs “satisfactory”). In each case-study school, data were collected from young women in year 9 (age 13/14 years) randomised to participate in the programme or serve as controls, as well as teachers, T&T facilitators and counsellors, and nursery staff, through participant observations, focus groups, and paired and individual interviews. Here, we present only data from programme participants in order to examine our research question concerning participants’ experience of the programme. The overall process evaluation is reported elsewhere (Jessiman *et al.*, 2012).

### Data collection methods and tools

The researchers designed a sequence of qualitative data collection methods in order to build mutual respect, trust and rapport with the young women and encourage them to speak openly about their experience of the intervention (Alderson and Morrow, 2004). We began with focus groups at the start of the intervention, moving to paired/triad interviews and then to one-to-one in-depth interviews. AS and TJ each conducted two focus groups (four total) with participants using a range of interactive methods, including vignettes and flash cards, ( $n = 20$ ) with approximately five participants in each group; paired or triad interviews (eight) with 12 participants overall; and 15 interviews with individual participants. Topic guides addressed various issues including those related to the research questions explored in this paper.

Intervention length	18-20 weeks, 1 day a week, 3-4 hours a day
Recruitment (2 phases)	1. Schools are recruited from areas (boroughs, districts) with high rates of teenage pregnancy 2. Teachers and other school staff responsible for inclusion, discipline and/or pastoral care identify students
Participants	Students between the ages of 13-15 considered to be at high risk of teenage pregnancy
Activities	Classroom curriculum focused on child development, effective parenting skills, anger management, sexuality and relationships Mentoring young children between the ages of 3-5 who are thought to be in need of additional learning or emotional support in a nursery or primary school setting Meetings with a trained counsellor for hour-long one-to-one sessions
Award	National Award in Interpersonal Skills, Level 1 (NCFE)

**Table I.**  
The Teens & Toddlers multicomponent positive youth development programme for the prevention of teenage pregnancy

All the interviews and focus groups were conducted with participants' informed consent in private spaces at the pre-school nursery, and were recorded and fully transcribed. Each interview lasted between 60 and 90 minutes and focus groups between 90 and 120 minutes. The research ethics committees of NatCen Social Research and LSHTM granted ethical approval for the study.

### *The analytical approach*

We adopted a phenomenological analytic approach (Creswell, 2007) to describe the meaning of the experience of participation in a PYD programme from the perspective of young women. Transcripts were read through several times by AS and preliminary meaning units identified. AS and KM reviewed, refined and agreed upon a final set of meaning units and worked together to develop clusters of interconnected meaning units (Smith *et al.*, 2009). AS, in consultation with KM, then undertook line-by-line coding of data in NVivo using the clusters of meaning units as a coding frame (Table II). During this process, the researchers attempted to "bracket out" their personal experience and/or opinions of the intervention and observe the data as if for the first time. This was challenging for AS because of her involvement in the T&T evaluation, but KM had not been involved in the data collection and was able to offer a novel perspective.

### **Results**

Data from 28 young women were analysed for this paper (Table III). We identified three cross-cutting themes regarding participants' experiences of the programme and how this was experienced as impacting upon their development of social and emotional competencies. We report our findings, by theme, below.

#### *Being challenged*

Young women selected to participate in T&T were enthusiastic about the programme, viewing it as an opportunity to gain a qualification, "boost" their educational and employment prospects, and gain experience working with young children:

**So when you were first told about Teens & Toddlers what did you think about it?**

It was exciting.

**Exciting?**

Yeah.

**Why?**

Because the way they were describing it, like working with the toddlers and that (Paired interview 1, School 3).

PYD programmes seek to offer an "engaging experience" (Vandell *et al.*, 2005), that allows for intrinsic motivation, effort and concentration. Engagement is reflected in the extent to which young people are focused and excited about the activities in which they are participating (Walker *et al.*, 2005; Larson, 2000). This high level of pre-programme enthusiasm potentially sets the stage for an atmosphere conducive to PYD. However, this was put to the test immediately, as participants began to engage with the children:

**What was it like for you the first time you visited the nursery?**

Annoying. [Laughs.]

	Theme cluster 1 Building confidence	Theme cluster 2 Connecting and engaging with adults in the programme	Theme cluster 3 Learning about yourself
Meaning unit 1a "A boost"	Meaning unit 1b Overcoming a challenge	Meaning unit 1c Purpose, accomplishment and growth	Meaning unit 3c "I'm changed"
1a codes Creating options	1b codes Working with children challenging and fun/frustrating	1c codes Building confidence	3b codes Taking responsibility with regard to risk
Increased concentration in school	Children unpredictable and difficult to control	Freedom and creativity	3c codes Adults treat me with more respect now
Desire to further education	Exhausting activity	Fun and accomplishment	Empathise with parents
Trying out a potential career	Facilitators coach us	Proud of skills in working with children	Choice and independence
	Facilitators create a safe environment for children and young women	Learning new things	Encourages self-reflection and self-realisation
		Learning new for adults	Getting a "reality" check

**Table II.**  
Meaning units,  
themes clusters and  
examples of codes  
generated from  
phenomenological  
analysis

**Annoying? Why?**

‘Cos the little kids were rude to me.

**They were rude? What they say?**

When I’d talk to them they would spit and didn’t answer me back, and when you told them to stop doing something, they would just walk off (Focus group, School 1).

Contrasting with their anticipated friendly welcome, the initial rejection from the children resulted in feelings of hurt and disenchantment with the programme:

Yeah, I don’t actually like it [the programme] ‘cause it’s just sometimes you don’t get along with the child and you just can’t [...]

**Do you get along with your child?**

Not that much.

**No?**

He hates me.

**He hates you?**

Yeah. He tells me to go away (Paired interview, School 1).

Further challenges emerged: the children were difficult to predict and often did not follow instructions. Some of the children exhibited disruptive behaviours, such as crying, being aggressive or “throwing strops”, and the young women found it difficult to respond effectively. On occasions where their attempt to work with the children failed, some young women felt “anxious”, “scared” and overwhelmed:

Cos sometimes, yeah, it’s nice to hang round Jessica, but then the thing that happened was, after she threw the scissors [...] she got sent away, and she was crying, and I thought that because she was crying and she looked angry, I thought she would be angry with me and she wouldn’t want to talk to me, so I was kind of scared that I might lose my toddler. And then she went and she came back and she wasn’t talking to me so I was scared [...] (Focus group, School 3).

Exposure to such challenges was an intended element of the programme, both to introduce participants to the realities of raising children, but also to allow them to overcome challenges. Confronting such challenges required many young women to reassess their expectations about the work; it was going to require more effort than anticipated. At this point, about a quarter of young women dropped out (Bonell *et al.*, 2013).

Young women	School 1	School 2	School 3	School 4	Total
Focus groups with participants	1 (5)	1 (5)	1 (5)	1 (5)	4 (20)
Paired/triad interviews with participants	1 × paired 1 × triad	1 × triad	2 × paired	3 × paired	8 (18)*
One-on-one interviews with participants	5	3	3	4	15*

**Note:** \*Some students who participated in the focus group dropped out of the programme by the time the interviews were conducted

**Table III.**  
Types of data collected during the study

The intensity of the immediate challenge of working with the children may have lessened the sense of hope and motivation that is essential for PYD. Larson (2000) has argued that for the “development of initiative” three elements must co-occur: intrinsic motivation to participate in an activity; concerted attention and engagement in the activity; and engagement with the experience over time. This is similar to the notion of “flow” (Csikszentmihalyi, 1990; Rich, 2003), i.e. a balance between challenge and skill so that negative consequences such as anxiety or boredom are minimised. For some young women, T&T may have failed to create a “flow” experience by presenting immediate challenges that they did not feel equipped to overcome.

There was variation in the amount of supervision and support the facilitators provided to the young women while they were working with the children. Some closely accompanied the young women while they worked with the children and others only offered light guidance and observed from afar (Jessiman *et al.*, 2012):

**Has the facilitator helped you to work with her, at all?**

Sometimes [...] they told me to like, if I felt ill they said, oh, just keep playing with her and then you're going in in a minute.

**Anything else they did to try and make it easier for you or [...]?**

[No response heard]

**No? Okay** (Interview 1, School 4).

The young women described how some facilitators provided positive reinforcement and actively coached them to continue with T&T. For these young women, the experience became less daunting and more enjoyable and most persevered:

Yeah sometimes when I was really like I wanted to give up they were like just keep trying, don't worry, it takes a long time but it will work (Interview 3, School 3).

Those who were able to forge relationships with the child felt a sense of achievement and were also sometimes able to make connections with meeting other challenges in their lives:

Maybe it makes you feel a bit more confident because once you get over an obstacle with your toddler then it's like I helped him through it so maybe I could again or maybe I can do that (Triad interview, School 1).

PYD theorists suggest that without support young people have limited ability to overcome challenges on their own, and may stall, become stuck and lose initiative (Larson *et al.*, 2005). PYD practitioners should therefore assign appropriately challenging tasks to encourage young people to grow, but provide the correct support to avoid negative experiences.

*Connecting and engaging with adults in the programme*

Evidence suggests that caring relationships with at least one non-parental adult helps to build self-esteem and self-efficacy, and protects against risk (Eccles and Gootman, 2002; Laursen and Birmingham, 2003; Bowers *et al.*, 2014). For successful PYD, young people need to view non-parental adults as a problem-solving resource and an “open ear” (Bowers *et al.*, 2014). The T&T programme counsellor, in particular,

became a trusted source of support and advice about managing difficult emotions for many participants:

She asks and she knows what to say. And it never gets silent.

Never gets silent.

Like, the only time it gets silent is if you've told her something sad and she'll sit there and be like "oh", and then she'll know what to say as quick as [...]

[...] It's the comeback, isn't it?

It's like, boom, and then she knows exactly how you feel (Focus group, School 4).

The counselling sessions were an opportunity for a confidential conversation with a trusted adult. However, attending the sessions was mandatory and for the young women who did not want counselling, the sessions sometimes felt uncomfortable as they felt obliged to share more information than they would have liked:

It was weird because I haven't done it before, and it's like, just there, talking, and just quite. It's weird. [Laughs.]

**Ok. So it's a bit awkward. Would you do it again?**

You have to, but I wouldn't want to.

[...]

[...] we thought, "We'll go in there, she'll ask us questions," but she only asked us a few, and we'd just have to talk and talk about anything, and then, like, sometimes we wouldn't know what to say. And then, like, 'cos, yeah, it's awkward, the silence, you just end up telling her everything, and you don't want to (Focus group, School 1).

Children and adolescents with concerns about confidentiality, judgement and stigma, and who are uncomfortable with expressing their emotions are often reluctant to seek professional help. Adolescents in particular, tend to prefer self-reliance or speaking to friends and family when dealing with problems (Del Mauro and Jackson Williams, 2013). For most of the young women participating in T&T, this was the first time they had spoken to a counsellor and they may have experienced some uneasiness as a result.

In group sessions, some facilitators shared personal experiences to help illustrate particular issues. These "real life" experiences appeared to be valued by participants and engendered a sense of connection and mutual understanding:

Like [the facilitator] and us, we're close 'cause she uses her experiences and tells us [...] if we ask questions she won't just read it from a book, she'll talk of her experience and what she thinks and then give us, and then just elaborate on what she's saying basically. [...] It's better because, instead of talking from a book you know, oh well the book says that, but once you get an, when she gets someone's experience you can say well they've been through it so they should know about it, and they're telling you from what they know [...] (Interview, School 1).

However, not all of the facilitators managed to create a trusting atmosphere, resulting in awkward and uncomfortable moments:

**What does working with [facilitators] what is that like?**

YW1: They don't really know what to say.

YW2: Like they'll go silent and then smile at us and we don't know where to look.

YW3: That's when we start laughing in the class (Paired interview 2, School 4).

The discomfort of some facilitators may have been due to lack of training (Jessiman *et al.*, 2012), underscoring the importance of investment in the development of relevant skills among adults expected to fulfil the role of “caring adult” (Bowers *et al.*, 2014). However, in most cases participants felt that the T&T facilitators treated them with more respect than the teachers at school:

YW1: They teachers like kinda belittle you, [...]

YW3: Like if they’re talking, they don’t expect you to say nuffink, yeah, you’re just basically something little to them, you’re just, “nuffin”, they just talk to you like anyhow they like, they don’t care.

YW2: And it’s like they have to act like they’re above you, it’s like they can’t come down and talk to you properly (Paired interview (with 3 participants), School 1).

In contrast, the young women sometimes felt the pre-school nursery staff were less supportive. For example, one young woman felt that a member of staff at the nursery was “having a go at” or criticising her:

That teacher, I was running around in the playground and just running around, wasn’t I, just running around with the kids and she had a go at me and I was like ‘what?’ She was like “don’t run around with the kids, I don’t want you running round with the kids” and when I asked why, she was like “because I don’t want you doing it, you could fall over” I thought to myself “I’ve been doing this for ages and now you’re telling me I can’t do it” (Focus group, School 4).

In effective PYD, adults help young people to feel secure, cared for and valued (Nitzberg, 2005). Though not the main programme providers, difficult relationships between the nursery teachers and the young women may have adversely influenced their experience of the programme and their likelihood of achieving positive development.

From the perspective of the young women, some adults involved in T&T were skilful in making connections, building trust, and warmth, and treating the young women with respect but this was not consistent across the programme.

### *Learning about yourself*

PYD models vary in terms of what they identify as personal and social assets that comprise positive development, but they all tend to focus on building confidence, emotional self-regulation, moral character and self-esteem. During group sessions, the facilitators introduced activities, such as participants reflecting upon their work and relationships with the children, as well as role-playing, and journaling to encourage the young women to develop empathy, improve their behaviour and value themselves (Jessiman *et al.*, 2012):

In one session, we had to look at our toddler and see if there was any, like, anger about and, where they would show it. And then we had to come back into the classroom time and say what we found out about their anger, and then where we show our anger from [...] (Interview 4, School 1).

The process of reflection on their experience in the nursery and in the counselling helped some young women to “discover” their abilities and qualities, and understand how their behaviour might affect others:

The counselling session and also the part in the nursery when I watched the children.

[...] from the toddlers I saw how, I don’t know how to say it, like I reflected it to see how I act and I just like saw myself from a different view and looked how I act and everything like that, so I guess I just changed a little bit [...] (Interview 2, School 3).



Through journaling, they were able to chart their progress and improvement over time:

[...] when you're writing in your journal and you think back, you realise, "Well, yeah, I have done a good job today, and I'll try and do a little bit better and a little bit better," and then it's like, when you're writing in your journals you realise that you have done better and better (Focus group, School 3).

Though the relationship between self-esteem and teenage pregnancy is unclear (Goodson *et al.*, 2006), many interventions, including T&T, aim to increase self-esteem to reduce sexual risk behaviours. Across the various components of the T&T intervention, the young women had opportunities to build self-esteem through overcoming the challenge of working with a child, sharing with and seeking advice from a trusted adult, and reflecting upon their strengths and weaknesses via specific activities in the group sessions. This entire process appeared to have an impact on the young women's self-esteem:

**Has Teens & Toddlers changed how you feel about yourself in any other way that we haven't talked about yet?**

Just like understanding that I'm important [...] (Interview 4, School 4).

T&T also deliberately sought to enhance participants' understanding of their risk of early pregnancy. Despite not initially seeing themselves as at risk, some participants began to discuss delaying sex, using condoms, and putting their well-being at the centre of any decision to have sex. Some young women also began to express the view that it was important to develop a stronger connection with someone before having sex. The programme appeared to influence the young women's attitudes, although this does not necessarily indicate an imminent change in behaviour:

[...] like everything we spoke about on relationships, like that you should only like have sex with someone if you really wanna be with them sort of thing, and that's sort of changed like [...] Not that I would go and sleep around sort of thing, but I know that it's not just about them, it's about me as well [...] (Interview, School 4).

## Discussion

The nature of PYD is "top-down" in that it defines what constitutes healthy development for young people, but it also aims to empower young people to make choices and contribute to their communities. However, little previous research on PYD has examined participants' views about the programmes and how these might impact upon them. This study aimed to contribute to filling this gap.

A number of key themes and findings emerge from our analysis. The initial excitement about participation in T&T set the stage for an engaging experience (Vandell *et al.*, 2005). However, for many, the challenge of working with young children did not provide the right balance of challenge and skill (Larson, 2000) to support building competence and a sense of achievement. However, with coaching from facilitators others persevered and overcame these challenges. These findings suggest that activities that offer a stimulating but achievable challenge for young people are more likely to result in feelings of accomplishment and engender confidence. Furthermore, it is important that adults working with young people actively support young people to meet the challenge, rather than merely monitor progress.

In many cases, the adults who were involved in T&T played a special role in creating a caring environment. T&T providers became trusted sources of guidance

and support. However, some nursery staff were perceived as critical and perhaps introduced a negative aspect to the non-parental adult relationship building that is central to PYD (Bowers *et al.*, 2014). Interactions with adults that appeared to produce trust and connection were based on honest communication and mutual respect.

Reflecting upon their experience helped some participants to develop self-esteem and moral character. Furthermore, the programme aimed to link participants' sense of personal development with their attitudes to risk of pregnancy and sexual behaviour. Though these interviews may have been susceptible to social desirability bias, the young women expressed feeling differently about their sexual lives as a result of participation in T&T, particularly because of the moral character they built while participating in the programme.

Our study had a number of limitations. Our qualitative research aimed to produce a rich account of experiences and processes rather than to develop statistically representative findings. However, the relevance of our findings to other participants in T&T or other PYD programmes is uncertain. Given that approximately a quarter of participants dropped out of the programme within the first eight weeks (Bonell *et al.*, 2013), our study is liable to selection bias whereby the most satisfied participants remained in the programme.

Our study has a number of implications for policy and research. PYD interventions continue to be developed and delivered to improve sexual health and there is some evidence that such approaches are effective (Gavin *et al.*, 2010). Our research on young women's experiences of a PYD programme offers a number of useful insights, which should help inform further refinements to PYD interventions and theories of change. PYD interventions would benefit from: ensuring a good balance between challenge and support; ensuring participants develop trusting relationships with all adults involved in programmes through the provision of advice and support, and the exchanging of experiences and the development of self-awareness, not only in terms of self-esteem but also in terms of developing empathy and a realistic assessment of vulnerability to adverse sexual health. Existing empirical evidence suggests that assets, such as the five “C”s are associated with better sexual health. More attention to engendering such positive development is likely to result in improved effects in sexual health outcomes.

#### Note

1. Ofsted (Office for Standards in Education, Children's Services and Skills) inspects and regulates services for children and young people, and those providing education and skills for learners of all ages in the UK.

#### References

- Alderson, P. and Morrow, V. (2004), *Ethics, Social Research and Consulting with Children and Young People*, Barnardo's, Ilford.
- Allen, E., Bonell, C., Strange, V., Copas, A., Stephenson, J., Johnson, A.M. and Oakley, A. (2007), “Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomized trial of sex education”, *Journal of Epidemiology and Community Health*, Vol. 61, pp. 20-27. doi: 10.1136/jech.2005.
- Arai, L. (2009), *Teenage Pregnancy: The Making and Unmaking of a Problem*, The Policy Press, Bristol.
- Benson, P.L. (1997), *All Kids are Our Kids: What Communities Must do to Raise Caring and Responsible Children and Adolescents*, Jossey-Bass, San Francisco, CA.

- Benson, P.L. (2007), "Developmental assets: an overview of theory, research and practice", in Silbereisen, R.K. and Lerner, R.M. (Eds), *Approaches to Positive Youth Development*, Sage, London.
- Benson, P.L. and Scales, P.C. (2009), "Positive youth development and the prevention of youth aggression and violence", *European Journal of Developmental Science*, Vol. 3 No. 3, pp. 218-234.
- Benson, P.L., Mannes, M., Pittman, K. and Ferber, T. (2004), "Youth development, developmental assets, and public policy", in Lerner, R.M. and Steinberg, L. (Eds), *Handbook of Adolescent Psychology*, 2nd ed., John Wiley & Sons Inc., Hoboken, NJ, pp. 781-814.
- Bonell, C., Maisey, R., Speight, A., Purdon, S., Keogh, P., Wollny, I., Sorhaindo, A. and Wellings, K. (2013), "Randomized controlled trial of 'teens and toddlers': a teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery", *Journal of Adolescence*, Vol. 36, pp. 859-870.
- Bowers, E., Johnson, S., Buckingham, M., Gasca, S., Warren, D.J.A., Lerner, J.V. and Lerner, R.M. (2014), "Youth development across mid- to late-adolescence: the moderating effect of parenting profiles", *Journal of Youth and Adolescence*, Vol. 43 No. 6, pp. 897-918.
- Catalano, R.F., Hawkins, D.J., Berglund, L., Hawkins, J.D., Berglund, M.L., Pollard, J.A. and Arthur, M.W. (2002), "Prevention science and positive youth development: competitive or cooperative frameworks?", *Journal of Adolescent Health*, Vol. 31, pp. 230-239.
- Crawford, C., Cribb, J. and Kelly, E. (2013), "Teenage pregnancy in England", Report No. 6, Centre for Analysis of Youth Transitions (CAYT), Institute for Fiscal Studies, London.
- Creswell, J.W. (2007), *Qualitative Inquiry and Research Design*, 2nd ed., Sage Publications, London, New Delhi and Thousand Oaks, CA.
- Csikszentmihalyi, M. (1990), *Flow*, Harper and Row, New York, NY.
- Del Mauro, J. and Jackson Williams, D. (2013), "Children and adolescents' attitudes towards seeking help from professional mental health providers", *International Journal for the Advancement of Counselling*, Vol. 35 No. 2, pp. 120-138.
- Department for Children, School and Families (2010), "Teenage pregnancy strategy: beyond 2010", Report No. DCSF-00224-2010, Department for Children, School and Families, London.
- Eccles, J. and Gootman, J. (2002), *Community Programs to Promote Youth Development*, National Academy Press, Washington, DC.
- Fletcher, A., Harden, A., Brunton, G., Oakley, A. and Bonell, C. (2008), "Interventions addressing the social determinants of teenage pregnancy", *Health Education*, Vol. 108 No. 1, pp. 29-39.
- Gavin, L.E., Catalano, R.F., Davis Ferdon, C., Gloppen, K.M. and Markham, C.M. (2010), "A review of positive youth development programs that promote sexual and reproductive health", *Journal of Adolescent Health*, Vol. 46, pp. S75-S91.
- Goodson, P., Bui, E.R. and Dunsmore, S.C. (2006), "Self-esteem and adolescent sexual behaviors, attitudes and intentions: a systematic review", *Journal of Adolescent Health*, Vol. 38 No. 3, pp. 310-319.
- Jessiman, T., Keogh, P., Scott, S., Wollny, I., Sorhaindo, A. and Bonell, C. (2012), "Teens and Toddlers integrated process evaluation", Report No. DFE-RR212, Department for Education, London.
- Kirby, D. (2007), *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, Washington, DC.

- Kirby, D. (2009), “Reducing pregnancy and risky behaviours in teenagers. Youth development programmes don’t always work”, *British Medical Journal*, Vol. 339, pp. 116-117. doi: 10.1136/bmj.b2054.
- Krenichyn, K., Schaefer-McDaniel, N., Schaefer-McDaniel, N., Clark, H. and Zeller-Berkman, S. (2007), “Where are young people in youth program evaluation and research?”, *Children, Youth and Environments*, Vol. 17 No. 2, pp. 594-615.
- Larson, R., Hansen, D. and Walker, K. (2005), “Everybody’s gotta give: development of initiative and teamwork within a youth program”, in Mahoney, J.L., Larson, R.W. and Eccles, J.S. (Eds), *Organized Activities as Contexts of Development: Extracurricular Activities, After-school and Community Programs*, Lawrence Erlbaum Associates, Inc., Mahwah, NJ, pp. 159-184.
- Larson, R.W. (2000), “Towards a psychology of positive youth development”, *American Psychologist*, Vol. 55 No. 1, pp. 170-183.
- Laursen, E. and Birmingham, S. (2003), “Caring relationships as a protective factor for at-risk youth: an ethnographic study”, *Families in Society: The Journal of Contemporary Human Services*, Vol. 84 No. 2, pp. 240-246.
- Lerner, R.M., Lerner, J.V., von Eye, A., Bowers, E.P. and Lewin-Bizan, S. (2011), “Individual and contextual bases of thriving in adolescence: a view of the issues”, *Journal of Adolescence*, Vol. 34, pp. 1107-1114.
- Nitzberg, J. (2005), “The meshing of youth development and community building”, *New Directions for Youth Development*, Vol. 106 No. 106, pp. 7-16.
- Oakley, A., Strange, V., Bonell, C., Allen, E. and Stephenson, J., RIPPLE Study Team (2006), “Process evaluation in randomised controlled trials of complex interventions”, *British Medical Journal*, Vol. 332 No. 7538, pp. 413-416.
- Office of National Statistics (2014), “Conceptions in England and Wales, 2012”, Statistical Bulletin, Office National Statistics, London, 25 February.
- Philliber, S., Williams Kaye, J., Herring, S. and West, E. (2002), “Preventing pregnancy and improving health care access among teenagers: an evaluation of the children’s aid society – Carrera program”, *Perspectives on Sexual and Reproductive Health*, Vol. 34 No. 5, pp. 244-251.
- Pittman, K., Irby, M. and Ferber, T. (2000), “Unfinished business: further reflections on a decade of promoting youth development, international youth foundation”, Youth Development: Issues, Challenges and Directions, Public/Private Ventures, Philadelphia, PA.
- Public Health England (2014), “Sexual and reproductive health profiles”, Public Health England, London, available at: <http://fingertips.phe.org.uk/profile/sexualhealth/data> (accessed November 6, 2015).
- Rich, G.J. (2003), “The positive psychology of youth and adolescence”, *Journal of Youth and Adolescence*, Vol. 32 No. 1, pp. 1-3.
- Roth, J. and Brooks-Gunn, J. (2000), “What do adolescents need for healthy development? Implications for youth policy”, Social Policy Report 14 No. 2, The Society for Research in Child Development, Ann Arbor, MI.
- Roth, J., Brooks-Gunn, J., Murray, L. and Foster, W. (1998), “Promoting healthy adolescents: synthesis of youth development program evaluations”, *Journal of Research on Adolescence*, Vol. 8 No. 4, pp. 423-459.
- Roth, J.L. and Brooks-Gunn, J. (2003), “Youth development programs: risk, prevention and policy”, *Journal of Adolescent Health*, Vol. 32 No. 3, pp. 170-182.
- Smith, J.A., Flowers, P. and Larkin, M. (2009), *Interpretive Phenomenological Analysis: Theory, Methods and Research*, Sage Publications, London.

- Social Exclusion Unit (1999), "Teenage pregnancy", Her Majesty's Stationary Office, London.
- Spencer, G. (2013), "Young people's perspectives on health: empowerment, or risk?", *Health Education*, Vol. 113 No. 2, pp. 115-131.
- Spencer, M.B. and Spencer, T.R. (2014), "Invited commentary: exploring the promises, intricacies, and challenges to positive youth development", *Journal of Youth and Adolescence*, Vol. 43 No. 6, pp. 1027-1035.
- Teens & Toddlers (2008), "Teens & Toddlers intensive implementation programme", Teens & Toddlers, Haringey, London.
- UNICEF Office of Research (2013), "Child well-being in rich countries: a comparative overview", Innocenti Report Card No. 11, UNICEF Office of Research, Florence.
- Vandell, D.L., Shernoff, D.J., Pierce, K.M., Bolt, D.M., Dadisman, K. and Brown, B.B. (2005), "Activities, engagement and emotion in after-school programs (and elsewhere)", *New Directions for Youth Development*, Vol. 105, pp. 121-129.
- Walker, J., Marczack, M., Blyth, D. and Borden, L. (2005), "Designing youth development programs: toward a theory of developmental intentionality", in Mahoney, J.L., Larson, R.W. and Eccles, J.S. (Eds), *Organized Activities as Contexts of Development: Extracurricular Activities, After-school and Community Programs*, Lawrence Erlbaum Associates, Inc., Mahwah, NJ, pp. 399-418.
- Wiggins, M., Bonell, C., Sawtell, M. *et al.* (2009), "Health outcomes of youth development programme in England: prospective matched comparison study", *British Medical Journal*, Vol. 339, Article Number b2534. doi: 10.1136/bmj.b2534.

### Further reading

- Allen, J.P. and Philliber, S. (2001), "Who benefits most from a broadly targeted prevention program? Differential efficacy across populations in the teen outreach program", *Journal of Community Psychology*, Vol. 29 No. 6, pp. 637-655.
- Arie, S. (2014), "Has Britain solved its teenage pregnancy problem?", *British Medical Journal*, Vol. 348, Article Number g2561.
- Kirby, D., Lezin, N., Afriye, R.A. and Gallucci, G. (2003), *Preventing Teen Pregnancy: Youth Development and After-school Programs*, ETR Associates, Scotts Valley, CA.

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## Being targeted: Young women's experience of being identified for a teenage pregnancy prevention programme



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### ARTICLE INFO

#### Article history:

#### Keywords:

High-risk  
Prevention  
Risk management  
Targeting  
Teenage pregnancy  
School

### ABSTRACT

Research on the unintended consequences of targeting 'high-risk' young people for health interventions is limited. Using qualitative data from an evaluation of the Teens & Toddlers Pregnancy Prevention programme, we explored how young women experienced being identified as at risk for teenage pregnancy to understand the processes via which unintended consequences may occur. Schools' lack of transparency regarding the targeting strategy and criteria led to feelings of confusion and mistrust among some young women. Black and minority ethnic young women perceived that the assessment of their risk was based on stereotyping. Others felt their outgoing character was misinterpreted as signifying risk. To manage these imposed labels, stigma and reputational risks, young women responded to being targeted by adopting strategies, such as distancing, silence and refusal. To limit harmful consequences, programmes could involve prospective participants in determining their need for intervention or introduce programmes for young people at all levels of risk.

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### Introduction

The UK Teenage Pregnancy Strategy (1999–2010) (Department for Children Schools and Families (DCSF), 2010; Social Exclusion Unit, 1999) recommended targeting preventative programmes to high-risk individuals and areas. Although the strategy coincided with a decline in the conception rate for under-18s in England and Wales (Arie, 2014; Crawford, Cribb & Kelly, 2013), the rationale and benefits of targeting remain contested (Bonell & Fletcher, 2008; Fletcher, Gardner, McKee, & Bonell, 2012; Crawford, Cribb & Kelly, 2013).

Targeting interventions toward individuals or groups with increased risk of an adverse outcome is thought to improve equity, enable more efficient use of resources (Carey & Crammond, 2014; Cerdá, Tracy, Ahem, & Galea, 2014; Kreuter et al.,

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2014; Kreuter & Wray, 2003) and focus on the specific problem or individual/group at risk rather than those unlikely to be affected. The approach is, however, criticised for its limited potential impact on incidence at the population-level, and limited recognition of the wider social determinants (Fletcher et al., 2012). Considering teenage pregnancy for example, risk is normally distributed and most pregnancies will arise from the larger group of young women at low or medium risk rather than the smaller group at high risk (Kneale, Fletcher, Wiggins, & Bonell, 2013; Rose, 1992). High-risk strategies, if successful, only result in reducing a fraction of the potential cases in the overall population and require continued intervention with new cases, as overall susceptibility in the population remains unaddressed (Grimes & Schulz, 2002; Rose, 1992).

Targeting also assumes an ability to identify those at high-risk and to distinguish between these individuals and the rest of the population (Grimes & Schulz, 2002; Rose, 1992). Kneale et al. (2013) tested the capacity of targeting, based on indicators of risk, to locate future teenage mothers in three UK cohort study databases and found that this group is difficult to identify thus targeted interventions would not reach the majority of young women who would become teenage parents.

There may be unintended consequences for individuals who are targeted. For example, interventions that identify young people as 'at risk' may lead to negative self-perception or 'labelling' (e.g., naughty, problematic) and the associated stigma attributed to the label (Goffman, 1959, 1963). The approach may also inadvertently lower young people's expectations and engender poor behaviour and outcomes (Bonell & Fletcher, 2008; Dishion, McCord, & Poulin, 1999; Evans, Scourfield, & Murphy, 2014; McCord, 2003; Rorie, Gottfredson, Cross, Wilson, & Connell, 2011; Weiss et al., 2005; Wiggins et al., 2009). A qualitative exploration of a social and emotional learning intervention with students aged 12–14 in secondary schools in Wales identified four unintended effects related to targeting criteria and composition of the intervention groups: negative labelling, elevation of status among targeted (poorly behaved) students, marginalisation of unknown peers in mixed groups, and amplification of deviancy within friendship groups (Evans et al., 2014). This experience of targeting, labelling and stigma, particularly in formal systems of intervention, may have long-term repercussions rooted in a young person's inability to overcome having been categorised, and having internalised, a negative label (Creaney, 2012).

Stigma is associated with sexual health outcomes, such as sexually transmitted infections (STIs) (Balfe et al., 2010; Foster & Byers, 2013) and teenage pregnancy (SmithBattle, 2013; Weimann, Rickert, Berenson, & Volk, 2005) leading to worries about judgement, guilt, shame and rejection among those who experience it. Being considered at high-risk for teenage pregnancy or to be singled out for a teen-pregnancy intervention may provoke similar sentiments among young women identified. While previous studies provide important evidence on the unintended consequences of targeting, none capture the nature of the experience from the perspective of the young people considered at risk. Examination of the meaning of the experience of being targeted may facilitate an understanding of why the approach results in unintended effects. Interpretive phenomenological analysis seeks to illuminate the lived experience of a phenomenon by interrogating the perceptions of individuals who experienced the same phenomenon. In general, a phenomenological approach aims to address two central questions: What was experienced? and What contexts or situations have influenced or affected the experience? In doing so, the approach investigates the significance of an experience, in contrast to examining the consequences (van Manen, 1990; Moustakas, 1994; Smith, Flowers, & Larkin, 2009). In this research, we explore via a phenomenological approach, the experience of being targeted for the Teens & Toddlers teenage pregnancy prevention programme (T&T): What it felt like to be deemed at risk of teenage pregnancy; and, how the process of selection influenced the meaning of the experience, from the perspective of the young women who were selected to participate in the T&T programme.

## Methods

To explore young women's lived experience of being targeted, we drew on qualitative data from the evaluation the T&T intervention.

### *The intervention*

Teens & Toddlers is a teenage pregnancy prevention programme that aimed to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13–17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (Teens & Toddlers, 2008). The programme had three components: a classroom-based curriculum focussed on the development of interpersonal skills, healthy parenting and sexual health, and including weekly journaling; mentoring a child between the ages of 3–5 years old in need of extra attention in a nursery or primary school setting for one to two afternoons a week; and one-to-one hour-long sessions with a trained counsellor over the course of 18–20 weeks (Sorhaindo et al., 2009).

### *The targeting strategy*

Schools were recruited from areas with high rates of teenage pregnancy. To identify potential participants for the intervention, school staff responsible for pastoral care or inclusion compiled a list of year 9 or 10 (aged 13–14) students whom they believed were at risk of teenage pregnancy. To assist with this process, T&T provided school staff with a 'selection tool' or checklist of factors related to a young person's personality, behaviours, and background, which the T&T programme believed indicated risk of teenage pregnancy (Sorhaindo et al., 2009). At the time of this study, T&T was undergoing evaluation via Randomised Controlled Trial (RCT) and the evaluators also offered a list of evidence-based risk factors for teenage pregnancy

to assist school staff with the selection of appropriate programme participants. Later during the evaluation, we discovered that staff responsible for selection rarely used either of these tools (Jessiman et al., 2012), but rather based their selection of potential programme participants on their documented and anecdotal knowledge of the student and/or their intuitive sense of the students' risk for teenage pregnancy (Jessiman et al., 2012, p. 29; Sorhaindo et al., 2016).

Young women who were identified as at risk for teenage pregnancy were invited to attend an informational meeting where a representative from T&T described the programme. The potential programme participants were asked to complete a brief survey and were given personal and parental consent forms for the purposes of the intervention. T&T was described to the young women as an opportunity to gain expertise in working with young children and a National Award in Interpersonal Skills, Level 1 (NCFE). The young women were not told how or why they had been selected or about the programme's focus on teenage pregnancy. The personal and parental consent forms mentioned that the programme included information on sexual health, but did not state why they had been selected. Limited provision of information about the purpose of the programme and how participants were selected was a conscious effort by T&T and school staff to avoid stigma and to encourage young women to participate (Jessiman et al., 2011, pp. 22–23).

### Evaluation design

Normally, outside of the RCT, the first 6–8 students submitting signed parental consent forms would be accepted onto the programme, but to enable the RCT, young women who were selected and returned the consent forms were randomised to either participate in the T&T intervention or to serve as comparisons. Comparisons were not offered any additional intervention. Data for the RCT were collected at three points in time via self-completion questionnaires: prior to random allocation (baseline), immediately following the intervention, and one year later. The specific measures, analysis and results of the RCT are published elsewhere (Bonell et al., 2013).

### Data sources

The qualitative data used in this analysis were collected during the RCT's integrated process evaluation conducted in four case-study schools based in four different boroughs of London with high rates of teenage pregnancy (Bonell et al., 2013; Jessiman et al., 2012). Table 1 provides a selection of socio-demographic characteristics for each of the boroughs included in the case study for the first year of the evaluation. In each case study school, data were collected from young women randomised to participate in the programme (intervention arm) and randomised to serve as controls (comparison arm), through focus groups, and paired and individual interviews. The first and fourth authors conducted four interactive focus groups with 20 participants overall, 8 paired or triad interviews with 18 young women overall, interviews with 15 programme participants and 8 interviews with comparison participants, two from each case study school (Table 2). Researchers used a

**Table 1**  
Selection of socio-demographic characteristics of London Boroughs where case studies were conducted.

<i>% Non-UK born, 2009</i>	
School 1	53.0
School 2	38.8
School 3	33.3
School 4	28.2
Greater London	33.8
United Kingdom	11.4
<i>% of Population who are Black, Asian or Minority Ethnic (BAME), 2013</i>	
School 1	64.9
School 2	50.2
School 3	46.9
School 4	39.6
Greater London	41.8
England	14.6
<i>Teenage conception rate, 2009 (per 1000 young people under 18)</i>	
School 1	38
School 2	37
School 3	63
School 4	59
Greater London	41
England	38
<i>% of 16–18 year olds who are NEET,<sup>a</sup> 2009</i>	
School 1	4.6
School 2	4.7
School 3	8.7
School 4	6.6
Greater London	5.3
England	Not available

Source: London Data Store: <http://www.data.london.gov.uk/dataset/London-borough-profiles>.

<sup>a</sup> A NEET is a young person who is "Not in Education, Employment, or Training".

**Table 2**  
Summary of qualitative data collected.

	School 1	School 2	School 3	School 4	Total
<b>Young people</b>					
Focus groups with participants (each including 5 young women)	1	1	1	1	4 (n = 20)
Paired/triad interviews with participants	1 × paired 1 × triad	1 × triad	2 × paired	3 × paired	8 (n = 18)
In depth interviews with participants	5	3	3	4	15
In depth interviews with comparison participants	2	2	2	2	8

step-wise process of increasingly more in-depth data collection techniques to build trust and rapport with the young women before conducting one-to-one interviews (Alderson & Morrow, 2004). Furthermore, this process allowed space for young women who were reluctant to participate in the larger group setting to more comfortably share their thoughts. The focus groups and interviews focussed largely on the participants' experience of and perceptions of recruitment, the acceptability, fidelity and impact of the programme, and possible causal pathways. The interviews conducted with the control participants (n = 8) focused on the potential for contamination and confounding, perceptions of the programme, the selection process and experience of and views on recruitment.

All the interviews and focus groups were conducted in private spaces on-site either at the school or at the nursery or primary school where the intervention was taking place. Semi-structured topic guides were developed to lead the discussions, which were conducted and recorded with permission, and later transcribed verbatim. Each interview lasted between 60 and 90 min and focus groups between 90 min and 2 h. The research ethics committees of NatCen Social Research and the London School of Hygiene and Tropical Medicine (LSHTM) granted approval for the study.

### Analysis

We adopted techniques associated with phenomenological and thematic analysis (Creswell, 2007). The first author read through the transcripts several times and took notes or highlighted sections of texts that appeared to represent some aspect of the young women's accounts of the experience of being targeted. These notes and sections of texts were written or printed onto small pieces of paper, reviewed separately from the transcripts and organised into emergent themes.

The first and final authors then worked together to develop connections between the themes and grouped them into 'meaning units', including creating super-ordinate and sub-ordinate units. Finally, the first author coded the data line-by-line in NVivo using the previously created meaning units as a coding frame (Creswell, 2007; Smith, Flowers, & Larkin, 2009), but undertook constant comparison analysis of the coding frame refining the meaning units and the codes during this process. When the text was coded in NVivo, the first author crosschecked the data by collection method (focus groups, paired interviews and single interviews) and noted any significant inconsistencies or deviant cases.

## Results

### Characteristics of study participants

We only collected year of study from the participants during focus groups and paired interviews. However, in one-to-one interviews with the same young women, researchers asked their age, ethnicity and information about whom they lived with. All were 14 years old, apart from one in School 4, and in either year 9 or 10. Most were from Black or mixed ethnicities (Table 3).

### Exploring experiences

We present four aspects of participants' lived experiences of being selected for the T&T programme emerging from our data; two themes influenced by the targeting strategy: 'Confusion about why they were selected' and 'Increased resentment and mistrust of teachers' and two themes related to being categorised as at high-risk: 'Labelling and reinforcing stereotypes' and 'Managing risk reputations'.

#### Confusion about reason for selection

As the school and programme providers avoided informing the young women of the reason they were targeted for T&T, the majority of participants began the programme without knowing: that they had been identified as at risk for teenage pregnancy; and that the aim of the intervention was pregnancy prevention. Furthermore, almost all of the young women interviewed expressed confusion about how they were selected for T&T:

*Do you have any idea why you were selected?*

I don't know!

*You have no ... do you care?*

**Table 3**  
Characteristics of study schools and interview participants.

	Age at the time of interview	School year	Ethnicity	Family life
<b>School 1<sup>a</sup></b>				
Interview 1	14	9/10	Black or Black British	Lives with both parents; 4 brothers and two sisters
Interview 2	14	9/10	Black or Black British	Lives with mother; two brothers and one sister
Interview 3	14	9/10	Black Caribbean	Lives with mother; young brother and younger sister
Interview 4	14	9/10	Black or Black British	Live with mother mum; has an older sister no longer at home; father has stepdaughter with girlfriend
Interview 5	14	9/10	No response <sup>b</sup>	Lives with both parents and has four brothers and 1 sister
Comparison 1	14	9/10	Black British	Lives with mother and six siblings
Comparison 2	14	9/10	Black British	Lives with mother, father, sister and brother.
<b>School 2</b>				
Interview 1	14	9	Mixed English	Has one sister [No information on parents]
Interview 2	14	9	Asian	Lives with mother, two sisters, cousin and nephew.
Comparison 1	14	10	Black British	Lives with mother, father, sister and brother; is the youngest child
Comparison 2	14	9	Data not collected	Lives with mother and father and has 2 brother and 2 sisters; only one brother and one sister live with them
<b>School 3</b>				
Interview 1	14	9	Black Caribbean	Lives with mother, sister and two nieces; and occasionally another niece comes to stay
Interview 2	14	9	Polish	Only child and lives with mother and father. Emigrated from Poland to UK when she was 11.
Interview 3	14	10	Black	Lives at home with 5 brothers and sisters, mother and stepfather
Comparison 1	14	9	Data not collected	Lives with mother, grandmother and sister
Comparison 2	14	9	Mixed Caribbean	Lives with mother, father and two brothers
<b>School 4</b>				
Interview 1	14	Data not collected	White	Lives with mother, father, sister and brother
Interview 2	13	Data not collected	White	Lives with mother, two younger brothers, and mother is expecting
Interview 3	14	Data not collected	White	Lives with mother and stepfather; has two brothers
Interview 4	14	Data not collected	White	One brother and one sister [No information on parents]
Comparison 1	14	9	Data not collected	Lives with father and two sisters
Comparison 2	14	9	Data not collected	Has an older brother and a younger brother [No information on parents]

<sup>a</sup> Students moved from year 9 to year 10 within the same school year.

<sup>b</sup> Respondent chose not to respond.

What that I got picked?

*Yeah, I mean about why, yeah. Coz not everybody went right, so...*

No. I think coz I have older brothers and sisters, and ... I don't know. I think maybe! And they have younger kids and then, yeah, I think so. But I'm not sure!

*Interview 3, School 4*

In three of the focus group discussions and several of the interviews, the young women discussed their theories for how and why they were selected the programme, including choosing the most misbehaved students, teachers' choosing, having younger siblings, and their responses to the RCT baseline questionnaire. However, other young women believed that they had been selected randomly; and were happy about this: "Yeah, I was happy that I got chosen, 'cause it was random and not everyone got chosen so the fact that I did, yeah, I was happy about it." [Interview 3, School 1] These students did not understand that they were initially selected by their teachers to enter a pool of young women that were randomised for the RCT.

During the focus groups discussions, many of the young women expressed their existing doubt of teachers' trustworthiness.

YW1: We think that they read the forms. They chose people according to the forms...

But they said, like, everyone has an equal chance [but decided that] we're just going to pick out the names.

YW2: Yeah, they said they were going to pick it out of a hat, but, like, they changed - I think, I think they did read them and decide for themselves.

*Focus group, School 1*

"After my friend told me, then I was kind of thinking that ... I think a teacher *would* kind of do that, but I don't know." [Focus group, School 3]

### *Increased resentment towards and mistrust of teachers*

Following this period of confusion, the purpose of the programme and the reason the young women were selected for the study became known to some young women via passing comments, rumours and gossip at their school. For example:

*Do you know why or how you got chosen to go to that room [where the informational meeting was held]?*

Nope.

*Do you have any ideas?*

There were just rumours and whatnot.

*What were the rumours?*

Erm, they picked the girls that are most likely to get pregnant.

*Comparison interview 1, School 1*

Learning about the targeting strategy in this manner appeared to exacerbate negative feelings about their teachers:

I didn't really like it, for teachers to think that [...], you're going to get pregnant, they don't really know me outside of school, so I don't think like they have the right to actually say to me you're going to get pregnant, you have to go to this programme, you have to work with kids. [...] So it's a bit like sad to hear that teachers think something like that about you. It's scary actually.

*Comparison interview 1, School 1*

Some young women described feeling “insulted”, “annoyed” and “angry” that their teachers believed them to be at risk for teenage pregnancy:

They [other students] were like, ‘Oh, you only got picked because you put you had sex [on the RCT baseline questionnaire]’, and I was, ‘No, I didn’t’...

*Did you believe them at all?*

Yeah.

*How did that make you feel when you were believing them?*

Annoyed and angry at the teachers that picked us.

*Interview 2, School 4*

For a few women, their latent mistrust of teachers was simply confirmed and perhaps strengthened through this experience.

### *Labelling and reinforcing stereotypes*

For some study participants, particularly in one school, their perception of a predominance of young Black and Minority Ethnic (BME) women identified for the programme signalled T&T's focus on risk.

*Okay, so what about the girls that you saw [at the informational meeting] made you think [the programme was about teenage pregnancy]?*

Because they were all, like, black girls. So I just thought that it was, that it was that.

*Okay, does anybody else think that?*

Yeah

*In the school or in the group?*

In the group. At first we all did, but then, not now we don't.

*Okay, did it bother you at all?*

Not really.

*Interview 4, School 1*

The young BME women in this study not only appeared to be aware of this perception, but may have also internalised or accepted it.

For the participants in two of the schools, a preponderance of peers who had a reputation of being “loud” was another clue to the purpose of T&T: “[The informational meeting] was like most of the loud girls, but it's like most of the black girls, like a few Somali girls, and one Asian girl, but she hangs around with the loud group.” [Comparison interview 1, School 1]

When discussing why they may have been selected for T&T, the young women quoted below characterised their behaviours positively, yet at the same time appeared conscious of the incongruence of such behaviour with the expectations of their teachers and the school: “Because us lot are more outgoing, isn't it?” “Yeah”. “If that make sense, we're really, like, straightforward about things”. [Focus group, School 4]

In the focus groups, voices regarding dissatisfaction with being considered at risk were dominant. Only later, in more intimate settings, were opposing voices heard. For example, in a triad interview, it emerged that other young women in this study were indifferent about being considered by their teachers to be at risk of teenage pregnancy.

*How do you feel that somebody might put you in a group of people that [...] they think might have children when they're a teenager? How does that feel?*

YW1: That feels insulting.

YW2: I don't really mind.

*You don't mind.*

YW1: I would be insulted by that.

*Triad interview, School 1*

A couple of the young women felt that labelling could encourage young people to participate in risky behaviour and that in fact information about sexual health and parenting would be useful for all young people.

Putting tags on girls, 'cause they don't really know us outside of school, [...] so they can't just tell us, you're going to be pregnant, we're trying to stop you from being pregnant. That's gonna make the girls want to go and get pregnant.

*Comparison interview 1, School 1*

“I think it should be for, good for all peoples, [...], so then like they can all understand, because it could be anyone that, like needs, [...], doesn't know what to expect or how to understand little kids”. [Comparison interview 1, School 4]

Another young woman thought it would be hard to determine, based on assumptions about particular background characteristics, who would experience a teenage pregnancy:

... some people say like, ‘Oh, children with bad families and that might get in that predic...’ I think they can be the most quietest person and you would never know they get into that predicament, but I don't think it's any sort of person, I think anyone could really do it.

*Comparison interview 2, School 3*

*Managing risk reputations: distancing, silence and refusal*

Young women targeted for T&T appeared to employ three risk reputation management mechanisms in reaction to being identified as at risk for teenage pregnancy: distancing, silence and refusal. For example, one young woman in the control arm described feeling relief when she discovered that she had not been picked to participate in the T&T programme.

I was actually relieved.

*Relieved that you didn't get picked?*

Yeah, 'cause I thought they picked the girls that were like proper most likely to get pregnant, that's what I thought, ain't it, so, [...] like wow they don't think that about me anymore.

*Comparison interview 1, School 1*

She was not aware that she had been randomly allocated to the control group. Albeit erroneous, she interpreted her *not* being selected to participate in T&T as a welcome indication that she was not in the same category as her *riskier* peers; she had avoided a potential loss of status by not being chosen, thus distancing herself from the associated stigma (Link & Phelan, 2001; Goffman, 1959, 1963).

Though the young women were typically excited about participating in the T&T programme, (Sorhaindo et al., *in press*), some described how they managed the stigma associated with being labelled as at risk of teenage pregnancy by remaining silent about the programme's aim when talking about it with others, including their parents.

*...what do you think your mum would think about that?*

Mum would get angry.

My mum would be really upset.

Yeah, she'd be like, “What...?”

*...so do you tell her?*

And my dad would be upset...

No, I didn't tell her, because then I don't really want my mum to be like, "Oh, well, you can't go there any more," 'cos my mum is that kind of person...

I really want to do this.

Yeah. So I just didn't tell my mum.

*Focus group, School 3*

Some young women simply refused to accept that they were at risk of teenage pregnancy:

I think the one where you got picked because you're more likely to have children soon, I think that's rude. 'Cause I know I'm not one of those people and I know like all of us that are there would not [...]

*So why would you think it's rude?*

Because that means I'd be seen as a person that is most likely to have sexual intercourse at a young age, and I'm not.

*Single interview 2, School 1*

Others exhibited refusal by recasting the meaning of participation in line with their, less negative, self-perception. In an interactive activity where the young women were asked to fill-in-the-blank of a statement written on a card provided by the study researchers, one group changed their response:

At first we wrote, what's it? [reading card] 'Girls that are vulnerable and gullible to get pregnant at a young age.' But then we realised that we're in the programme so this was talking about ourselves, and I'm not vulnerable. [Laughter.] So then we changed it to 'Girls that are mature enough to know when it's right to have children'.

*Focus group, School 3*

## Discussion

Existing literature on targeting high-risk young people suggests that the approach can have unintended consequences (Bonell & Fletcher, 2008; Dishion et al., 1999; Evans et al., 2014; Wiggins et al., 2009). This study contributes to this literature by highlighting aspects of the experience of being targeted: feelings of confusion and resentment, the experience of labelling and reinforcement of stereotypes, and the need for additional identity work to manage risk reputations.

This study is limited by small sample size, as is common in qualitative research, and focussed only on London schools. Furthermore, though the lack of demographic information on the focus groups and paired/triad interviews participants somewhat limits our ability to contextualise the findings this information was collected from in-depth interviews with the same young women. The study was also imbedded in a larger evaluation with a different aim and a complicated recruitment strategy. In fact, the RCT could have been responsible for some of the students' (and teachers') confusion about the targeting criteria and strategy. Finally, as about one-quarter of the young women who participated in T&T eventually dropped out mostly due to conflict with lessons or because they disliked the programme (Bonell et al., 2013), this study could have suffered from selection bias whereby the students with potentially less interest in school and more satisfaction with the programme remained. Despite these shortcomings, it provides insight into the experience of being targeted.

Many of the young women began the programme with lack of clarity regarding what the programme was for and why they had been selected to participate. They speculated about a number of potential reasons, and several expressed doubt regarding their teachers' honesty about the selection process. Learning that their teachers believed that they were at risk for teenage pregnancy and needed intervention left many young women feeling angry and mistrustful. Previous research by Evans et al. (2014) also found that inadvertent discovery of the targeting criteria led to negative labelling and bitterness among the intervention participants. Research on student disruption and teacher discipline in schools found an association between teachers who focussed on respect, personal regard and trust in their approach to discipline, and low student defiance; the relationship was mediated by students' perception of teacher trustworthiness (Gregory & Ripski, 2008; Schneider, Judy, Ebmey, & Broda, 2014). As positive relationships with teachers are important for learning, behaviour and overall wellbeing (Gorard & See, 2011; Gregory & Ripski, 2008; Holfve-Sabel, 2014), this experience could have wider implications.

Some study participants believed that the assessment of their risk for teenage pregnancy was based on prejudices related to their BME status and a negative interpretation of their outspoken character; and the characteristics of the women selected for the programme seemed to reinforce these existing stereotypes (Ali, 2003; Archer, Halsall, & Hollingworth, 2007; Ferri & Connor, 2010; Jackson, 2006). Half of the young women selected by their teachers and included in the RCT were from non-White ethnicities (Bonell et al., 2013). However, in only one of the four case-study schools was the overall proportion of students from non-White ethnicities close to this (45%). Only one-quarter of the students in two of the schools and 18% in the fourth school were non-White. Therefore, it is not surprising that the study participants observed that the proportion of young women from BME groups put forward by their teachers for participation in the intervention did not reflect the actual distribution of BME at their school.



The stereotyping of BME youth is pervasive in modern schools and young people's BME status is often "equated with failure and risk". As young white women co-opt this culture they are also similarly pathologised as hypersexualised 'problem girls' (Ali, 2003; Ferri & Connor, 2010). In an exploration of the 'ladette' culture among young women in the UK, Jackson (2006) points out how this modern departure from traditional and 'acceptable' forms of middle-class, and largely White femininity, signifies risk. From the perspective of the young people engaging in the culture, their posturing and behaviours were, in part, about protecting their self-image and presenting themselves more favourably (Goffman, 1959, 1963). However, in the school context, this further identified them as deviant and needing intervention (Jackson, 2006). Previous research suggests that young women in London secondary schools with low levels of achievement use strategies, including poor behaviour in the classroom, which they described as "being loud" and "speaking their mind", to challenge the quiet and passive feminine norms that are typically rewarded at school. Such behaviour often put the young women at odds with the school and was interpreted as deviant (Archer et al., 2007). Furthermore, "loud" behaviour from BME groups may reinforce stereotypes about Black students as belligerent (Archer et al., 2007; Fordham, 1993).

Young people may adopt a range of strategies to manage and control being considered 'at risk' (Mitchell, Crawshaw, Bunton, & Green, 2001). Several young women in this study felt it necessary to distance themselves from or reject risk identities. Silence is a common feature of stigma and risk management strategies (Van Brakel, 2006). The young women's concern about their parents' possible negative reaction to them being targeted for the T&T programme may have been warranted. In a focus group with parents (not related to young people participating in T&T), conducted during the formative evaluation phase of the larger project, some parents expressed concern that their children could be selected based on stereotypes, specifically related to ethnicity, and that there would be consequences associated with the 'at risk' label. Further, despite an awareness of the written guidance provided to teachers, they were sceptical about whether teachers would be objective and about teachers' competency for making sexual health risk assessments (Sorhaindo et al., 2009).

Some young women were indifferent to being targeted for intervention. Though it is difficult to interpret this, some possible explanations could be that, in the context of schools where categorisation and labelling are common, perhaps young women targeted for T&T were accustomed to being perceived as problematic and had come to accept this characterisation. Alternatively, this response could indicate the effects of labelling taking hold. Link and Phelan (2001) argued that individuals internalise social perceptions and beliefs about undesirable characteristics and thus anticipate rejection and discrimination (Sampson & Laub, 1997).

## Conclusion

Targeting as a strategy for allocating resources towards prevention and treatment has its merits, potentially both in terms of equity and impact, if risk is not normally distributed. However, the approach may carry consequences that prevent interventions achieving their full benefit. The process of selecting young people for T&T led to negative emotion, potentially reinforced existing stereotypes and forced the participants to conduct additional identity work to manage the label imposed upon them. An alternative approach would be to include prospective participants in the process by informing them of the targeting strategy and/or inviting them to opt in based upon open discussions and mutual assessments about their sexual health needs. Not only could this potentially prevent some of the negative experiences found here, but also, consciously engaging in an intervention to prevent risk behaviour may lead to increased adherence and intervention effectiveness, which may outweigh the costs of any reduction in participation. Otherwise, schools may introduce programmes that operate on the population-level, including all students, regardless of their risk. This approach would limit the unintended consequences of targeting and reduce incidence of teenage pregnancy, by lowering risk in the overall population.

## Acknowledgements

We would like to thank the young women who participated in this research, the Teens & Toddlers programme and the English Department of Education for funding the larger study from which this work was developed.

## References

- Alderson, P., & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. Ilford, Essex: Barnardo's.
- Ali, S. (2003). 'To be a girl': culture and class in schools. *Gender and Education*, 15, 269–283. <http://10.1080/09540250303859>.
- Archer, L., Halsall, A., & Hollingworth, S. (2007). Inner-city femininities and education: 'race', class, gender and schooling in young women's lives. *Gender and Education*, 19, 549–568. <http://10.1080/09540250701535568>.
- Arie, S. (2014). Has Britain solved its teenage pregnancy problem? *British Medical Journal*, 348. <http://dx.doi.org/10.1136/bmj.g2561>.
- Balfe, M., Brugha, R., O'Connell, E., McGee, H., O'Donovan, D., & Vaughan, D. (2010). Why don't young women go for chlamydia testing? A qualitative study employing Goffman's stigma framework. *Health, Risk and Society*, 12, 131–148. <http://10.1080/13698571003632437>.
- Bonell, C., & Fletcher, A. (2008). Addressing the wider determinants of problematic drug use: advantages of whole-population over targeted interventions. *International Journal of Drug Policy*, 19, 267–269.
- Bonell, C., Maisey, R., Speight, A., Purdon, A., Keogh, P., Wollny, I., et al. (2013). Randomized controlled trial of 'teens and toddlers': a teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery. *Journal of Adolescence*, 36, 859–870. <http://10.1016/j.adolescence.2013.07.005>.
- Carey, G., & Crammond, B. (2014). A glossary of policy frameworks: the many forms of 'universalism' and policy 'targeting'. *Journal of Epidemiology and Community Health*. <http://dx.doi.org/10.1136/jech-2014-204311>.

- Cerdá, M., Tracy, M., Ahem, J., & Galea, S. (2014). Addressing population health and health inequalities: the role of fundamental causes. *American Journal of Public Health*, 104, S609–S619. <http://10.2105/AJPH.2014.302055>.
- Crawford, C., Cribb, J., & Kelly, E. (2013). *Teenage pregnancy in England Center for Analysis of Youth Transitions impact study* (Report no. 6). London: Institute for Fiscal Studies.
- Creaney, S. (2012). Targeting, labeling and stigma: challenging the criminalisation of children and young people. *Criminal Justice Matters*, 89, 16–17. <http://10.1080/09627251.2012.721967>.
- Creswell, J. W. (2007). *Qualitative inquiry and research design* (2nd ed.). Thousand Oaks, London and New Delhi: Sage Publications.
- Department for Children, School and Families (DCSF). (2010). *Teenage pregnancy strategy: Beyond 2010* (DCSF-00224-2010). London: Department for Children Schools and Families.
- Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm. *The American Psychologist*, 54(9), 755–764.
- Evans, R., Scourfield, J., & Murphy, S. (2014). The unintended consequences of targeting: young people's lived experiences of social and emotional learning interventions. *British Educational Research Journal*, 41, 381–397. <http://10.1002/berj.3155>.
- Ferri, B. A., & Connor, D. J. (2010). 'I was the special ed. girl': urban working-class young women of colour. *Gender and Education*, 22, 105–121. <http://dx.doi.org/10.1080/09540250802612688>.
- Fletcher, A., Gardner, F., McKee, M., & Bonell, C. (2012). The British government's Troubled Families Programme: a flawed response to riots and youth offending. *British Medical Journal*, 344, e3403. <http://dx.doi.org/10.1136/bmj.e3403>.
- Fordham, S. (1993). "Those loud Black girls": (Black) women, silence and gender "passing" in the academy. *Anthropology and Education Quarterly*, 24, 3–32.
- Foster, L. R., & Byers, E. S. (2013). Stigmatization of individuals with sexually transmitted infections: effects of illness and observer characteristics. *Journal of Applied Social Psychology*, 43, E141–E152. <http://dx.doi.org/10.1111/jasp.12036>.
- Goffman, E. (1959). *The presentation of self in everyday life*. London: Penguin Books Ltd.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon & Schuster, Inc.
- Gorard, S., & See, B. H. (2011). How can we enhance enjoyment of secondary school? The student view. *British Educational Research Journal*, 37, 671–690.
- Gregory, A., & Ripski, M. B. (2008). Adolescent trust in teachers: implications for behavior in the high school classroom. *School Psychology Review*, 37, 337–353.
- Grimes, D. A., & Schulz, K. F. (2002). Uses and abuses of screening tests. *The Lancet*, 359, 881–884.
- Holfve-Sabel, M. A. (2014). Learning, interaction and relationships as components of student well-being: difference between classes from student and teacher perspective. *Social Indicators Research*, 119, 1535–1555.
- Jackson, C. (2006). 'Wild' girls? An exploration of 'ladette' cultures in secondary schools. *Gender and Education*, 18, 339–360. <http://dx.doi.org/10.1080/09540250600804966>.
- Jessiman, T., Keogh, P., Scott, S., Wollny, I., Sorhaindo, A., & Bonell, C. (2012). *Teens and toddlers integrated process evaluation* (Department for Education Research Report DFE-RR212).
- Kneale, D., Fletcher, A., Wiggins, R., & Bonell, C. (2013). Distribution and determinants of risk of teenage motherhood in three British longitudinal studies: implications for targeted prevention interventions. *Journal of Epidemiology and Community Health*, 67, 48–55. <http://dx.doi.org/10.1136/jech-2011-200867>.
- Kreuter, M. W., Hovmand, P., Pfeiffer, D. J., Fairchild, M., Rath, S., Golla, B., et al. (2014). The 'long tail' and public health: new thinking for addressing health disparities. *American Journal of Public Health*, 104, 2271–2278. <http://dx.doi.org/10.2105/AJPH.2014.302039>.
- Kreuter, M. W., & Wray, R. J. (2003). Tailored and targeted health communication: strategies for enhancing information relevance. *American Journal of Health Behavior*, 27, S227–S232.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385.
- van Manen, M. (1990). *Researching lived experience*. Albany, NY: The State University of NY (SUNY).
- McCord, J. (2003). Cures that harm: unanticipated outcomes of crime prevention programs. *The Annals of the American Academy of Political and Social Science*, 587(1), 16–30. <http://dx.doi.org/10.1177/0002716202250781>.
- Mitchell, W. A., Crawshaw, P., Bunton, R., & Green, E. E. (2001). Situating young people's experience of risk and identity. *Health, Risk & Society*, 3, 217–233. <http://dx.doi.org/10.1080/13698570124548>.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Rorie, M., Gottfredson, D. C., Cross, A., Wilson, D., & Connell, N. M. (2011). Structure and deviancy training in after-school programs. *Journal of Adolescence*, 34(1), 105–117. <http://dx.doi.org/10.1016/j.adolescence.2010.01.007>.
- Rose, G. (1992). *Rose's strategy of preventive medicine*. Oxford: Oxford University Press.
- Sampson, R. J., & Laub, J. H. (1997). A life-course theory of cumulative disadvantage and the stability of delinquency. In T. Thorberry (Ed.), *Developmental theories of crime and delinquency* (pp. 1–29). New Brunswick, NJ: Transactions Publishers.
- Schneider, B., Judy, J., Ebmey, C. M., & Broda, M. (2014). Trust in elementary and secondary urban schools: a pathway for student success and college ambition. In D. Van Maele, P. B. Forsyth, & M. Van Houtte (Eds.), *Trust and school life: The role of trust for learning, teaching, leading and bridging*. Dordrecht, the Netherlands: Springer Science+Business Media.
- SmithBattle, L. I. (2013). Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal Child Nursing*, 38, 235–241. <http://10.1097/NMC.0b013e3182836bd4>.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, methods and research*. London: Sage Publications.
- Social Exclusion Unit (SEU). (1999). *Teenage pregnancy*. London: Her Majesty's Stationary Office.
- Sorhaindo, A. M., Bonell, C., Fletcher, A., Jessiman, T., Keogh, P., & Mitchell, K. (2016). *How do teachers conceptualise risk for teenage pregnancy?: An exploration of the process of selecting "at risk" young women in schools for targeted prevention intervention*. Unpublished manuscript. Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.
- Sorhaindo, A., Keogh, P., Bonell, C., Jessiman, P., Smith, R., & Wollny, I. (2009). Findings from pre-RCT formative evaluation of the Teens & Toddlers programme: interim report for DCSF. Unpublished document.
- Sorhaindo, A. M., Mitchell, K., Fletcher, A., Jessiman, T., Keogh, P., & Bonell, C. (2016). Young women's lived experience of participating in a positive youth development programme: the "Teens & Toddlers" pregnancy prevention intervention. *Health Education* (in press).
- Teens & Toddlers. (2008). *Teens & Toddlers intensive implementation programme*. Haringey. Unpublished internal document.
- Van Brakel, W. H. (2006). Measuring health-related stigma – a literature review. *Psychology, Health & Medicine*, 11, 307–334. <http://dx.doi.org/10.1080/13548500600595160>.
- Weimann, C. M., Rickert, V. I., Berenson, A. B., & Volk. (2005). Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health*, 36, 352. e1–352.e7.
- Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., & Weisz, J. R. (2005). Iatrogenic effects of group treatment for antisocial youth. *Journal of Consulting and Clinical Psychology*, 73, 1036–1044.
- Wiggins, M., Bonell, C., Sawtell, M., Austerberry, H., Burchett, H., Allen, E., et al. (2009). Health outcomes of youth development programme in England: prospective matched comparison study. *British Medical Journal*, 339, b2534. <http://dx.doi.org/10.1136/bmj.b2534>.