

## **Teenage Pregnancy and Fertility in English Communities: Neighbourhood, Family and Peer Influences on Behaviour**

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**Teenage Pregnancy and Fertility in English  
Communities: Neighbourhood, Family and Peer  
Influences on Behaviour**

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**PhD Thesis**



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## Abstract

The British government established the Teenage Pregnancy Unit in 1999 to reduce early pregnancy. Current policy initiatives have a significant geographic dimension: specific English neighbourhoods have been identified as the sites where most early pregnancy occurs and have been targeted for intervention.

The aim of this thesis is to explore the factors that influence teenage sexual and reproductive behaviour by drawing on the neighbourhoods effects literature. Within this body of research, teenage reproduction is believed to be affected by a multiplicity of factors operating within different domains. The analysis (of survey data and qualitative material collected in three locations) was guided by two research questions: which factors within neighbourhoods, family and peer contexts are the most important in elucidating the causal pathways to teenage sex, pregnancy and fertility; and do the importance of these factors vary *between* neighbourhoods?

Overall, factors within neighbourhood and peer contexts were found to be less significant than family and individual-level factors. The analysis of British Cohort Study data showed that, for example, women who experience teenage pregnancy or birth lived in deprived areas at age 16, but other neighbourhood variables were not significant in multivariate analysis. There were some differences between neighbourhoods, but the cohort member's attitude to school was, generally, the most important factor associated with teenage sexual and reproductive behaviour. The qualitative data supported these statistical results. There was little evidence that women had been influenced by either their friends or others within their neighbourhoods (though some women reported knowing high numbers of teenage mothers), and nearly all the young mothers had low educational attainment. In conclusion, individual and family-level influences on sexual and reproductive outcomes are paramount, but behaviour is also subtly informed by wider social factors.

## **Acknowledgements**

This research was funded by Queen Mary, University of London and The University of London Central Research Fund.

Many thanks to my supervisors, Dr Ray Hall and Professor Sarah Curtis, for their patience, guidance and support. And to my examiners, Professor Paul White (University of Sheffield) and Professor Linda McDowell (University College, London) for their helpful comments and advice.

Thanks also to Professor Helen Roberts, Professor Jennie Popay, Professor Miriam David, Professor Julien Teitler, Sheila Challenger, Seeromanie Harding and Mickey Rosato for support, advice and access to unpublished papers.

The staff at Essex University Data Archive and the staff at MIMAS, University of Manchester, provided practical help with access to data. Amanda Eggett, Maddy Monaghan and Hazel Clarke helped with the recruitment of respondents. Thanks to Peter Schofield and Ana Lasiosa for help with the analysis of the BCS.

Fellow students at Queen Mary provided help and support in the early days of the research, as did colleagues at the Child Health Research and Policy Unit, City University.

Thanks to my sister, Kathryn Gray, and all my friends, especially John Flood and Tarek Elmaghrabi, for their support.

Thanks to all the Coordinators for their candidness and, most importantly, all the young mothers who welcomed me into their homes and spoke about their lives with such honesty.

## **Statement of Originality**

I certify that this thesis, and the research to which it refers, are the product of my own work, and that any ideas or quotations from the work of other people are fully acknowledged in accordance with standard referencing practices of the discipline. I acknowledge the helpful guidance and support of my supervisors.

## **Dedication**

This thesis is dedicated to the memory of my mother, Ellen Drake (1941-2000), and much-loved friend, Philip Hooper (1968-2001).

And to Sharon Breen, for her generosity and wisdom.

## **Abbreviations**

<b>BCS</b>	<b>British Cohort Study</b>
<b>Coordinators</b>	<b>Teenage Pregnancy Local Coordinators</b>
<b>NCDS</b>	<b>National Child Development Study</b>
<b>ONS</b>	<b>Office for National Statistics</b>
<b>SEU</b>	<b>Social Exclusion Unit</b>
<b>SES</b>	<b>Socio-economic status</b>
<b>TPS</b>	<b>Teenage Pregnancy Strategy</b>
<b>TPU</b>	<b>Teenage Pregnancy Unit</b>

## **Chapter One: Introduction to a Social 'Problem'**

### **1.1) Introduction**

The aim of this thesis is to explore factors in neighbourhood, family and peer contexts that influence teenage reproductive behaviour (early sexual experience, pregnancy and parenthood under the age of 21). This aim is achieved using existing survey data and qualitative material collected from young mothers and Teenage Pregnancy Local Coordinators (hereafter the 'Coordinators') in three English locations.

### **1.2) A brief overview of a social 'problem'**

#### **1.2.1) The Teenage Pregnancy Unit**

The starting point for the present research was the establishment of the Teenage Pregnancy Unit (hereafter the 'TPU') in 1999 and the publication of the TPU's first policy document (SEU, 1999) which has been described as '...perhaps the single most influential recent document on the issue of teenage pregnancy in the UK...' (van Loon, 2003:10). The TPU was created to implement the Teenage Pregnancy Strategy (hereafter the 'TPS'); a programme designed to bring about a reduction in under 18s conception rates and increased entry into education/employment for young parents. The TPU had an initial budget of £60 million and required every local or health authority to provide reports of teenage pregnancy in their area (Ferriman, 1999). There had been initiatives to reduce teenage pregnancy before 1999 (most notably in the 'Health of the Nation' strategy), but there had never been a unit dedicated solely to its reduction.

The 1999 policy document drew on the large body of research on this issue, and made a number of recommendations about the ways that teenage pregnancy can be reduced. The publication of the document generated intense interest in the media on the issue of teenage sexuality and reproduction. One consequence of the creation of the TPU was that academic research on teenage pregnancy (as well as articles in newspapers and magazines) proliferated. Most of the academic



research (and almost all of the coverage of the issue in the popular media) depicts early childbearing as a negative phenomena; the cause of ill health and poverty. The authors of the TPU's 1999 document maintain that:

Teenage parents are more likely than their peers to live in poverty and unemployment and be trapped in it through lack of education, child care and encouragement. The death rate for the babies of teenage mothers is 60 per cent higher than for babies of older mothers and they are more likely to have low birth weights, have childhood accidents and be admitted to hospital. In the longer term, their daughters have a higher chance of becoming teenage mothers themselves (SEU, 1999:6).

The implication of this statement is that a decrease in teenage parenthood would lead to a reduction in poor economic and educational outcomes for teenagers, and improved health for their children. Few observers have questioned the validity of this statement and a version of it appears in the first few pages of most local reports submitted to the TPU (by March 2001, 136 of these had been submitted to the TPU).<sup>1</sup> It is only relatively recently in the UK (Lawlor & Shaw, 2002; Macintyre & Cunningham-Burley, 1993) and in the US (Geronimus, 2003), that scholarly concern about the depiction of teenage pregnancy as a problem has become more visible—though academic interest in this issue has a longer history but has not been given the 'air time' (Geronimus, 2003).

The degree to which early pregnancy and parenthood contributes to poor outcomes cannot be considered properly here, where it is not the focus of the thesis. There is a large body of research on the outcomes of teenage childbearing. Outcomes, in this instance, are considered to have medical and socio-economic dimensions. Generally, the research on the former suggests that the adverse health implications of early childbearing are minimal when factors such as the mother's access to pre-natal care, her marital status and income are taken into account. In a large review of the medical literature it was demonstrated that the poor health outcomes associated with early motherhood

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<sup>1</sup> <http://www.info.doh.gov.uk/doh/users.nsf/fs1?readForm>

are largely attributable to socio-economic status (hereafter 'SES') rather than maternal age (Cunnington, 2001). Similarly, the poor mental health of teenage mothers may be attributable to marital status; in a study of depression, married teenage mothers and older married women had similar psychological health profiles (Kalil & Kunz, 2002).

In contrast, the research on the socio-economic outcomes of early parenthood suggests that teenage motherhood might be the cause of poverty and poor educational outcomes (or exacerbate these factors where they exist before childbearing) (Wellings & Mitchell, 1998). However, the authors of an analysis of the labour market and educational consequences of early childbearing concluded that the negative effects of early motherhood have been overstated (Chevalier & Viitanen, 2001). And an analysis of European panel data showed variation in economic and other outcomes for teenage mothers across Europe, and no significant effects in some countries, which suggests that the consequences of early childbearing are highly dependent on the context in which it occurs (Berthoud & Robson, 2001). In sum, early childbearing has not been shown to have unequivocally negative effects either on the health of mother and/or child, or on economic and educational advancement (Hoffman, 1998; Ward, 1995). Geronimus (2003; 1997; 1996; 1992) and Geronimus, Bound & Waidmann (1999) even suggest that, in some very poor populations (where individuals suffer from early health deterioration and premature mortality can lead to the diminution of kinship networks), youthful childbearing confers health and socio-economic benefits.

### 1.2.2) Trends in teenage pregnancy and fertility

In the first chapter of the 1999 policy document recent trends in teenage pregnancy and fertility in the UK were described. The 'problematic' nature of teenage pregnancy is observable in these data. In the foreword, the Prime Minister states that Britain has the 'worst record' on teenage pregnancies in Europe. And, in the opening chapter, the authors state that in England '...there are nearly 90,000 conceptions a year to teenagers; around 7,700 to girls under

16...three-fifths of conceptions...result in live births' (SEU, 1999:6).

A number of points should be made about recent trends in teenage pregnancy and fertility in light of these observations. First, there was a mismatch in timing between the creation of the TPU and the highest incidence of teenage fertility. See Table 1.

*Table 1: Teenage fertility rates, England and Wales, 1961-2000*

Year	Rate
1961	37.3
1964	42.5
1966	47.7
1971	50.6
1976	32.2
1977	29.4
1981	28.1
1986	30.1
1991	33
1992	31.7
1993	31
1994	29
1995	28.5
1996	29.8
1997	30.2
1998	30.9
1999	30.8
2000	29.2

Data taken from Table 3.1 of Population Trends 106 (ONS, 2001).  
Rates are per 1000 females aged under 20

Teenage fertility rates were highest in 1971, at nearly 51 per 1000, and (after a steep decline in the 1970s) showed only minor fluctuation in the following decades. By the beginning of the 21<sup>st</sup> century, teenage fertility rates had almost halved to around 29 per 1000. This reduction in teenage fertility has been partly achieved by an increase in use of abortion, but also by a general decline in teenage conception rates. The proportion of the teenage population engaging in sexual activity has increased over the last two decades, yet teenage conception rates have not changed substantially, which suggests there is a trend toward increasingly effective use of contraception among youth (Wellings & Kane, 1999).

Second, not only have teenage fertility rates declined in the UK, but the overall trend in teenage childbearing in most developed nations is downward—though there is wide diversity in the frequency of youthful pregnancy and its resolution. The highest teenage fertility rates are among American teenagers, and the lowest rates are found in Italy and Japan. US teenage fertility rates were highest in the early 1960s (when they were nearly 90 per 1000) and at their lowest in the late 1980s, when they decreased to 52 per 1000 (Singh & Darroch, 2000). Despite this diversity in youthful fertility rates, there is a clear ‘Anglo-Saxon’ domination of teenage conception and childbearing. Countries such as the US, Canada, Australia, the UK and New Zealand have higher rates of early pregnancy and childbearing than other developed nations (Chandola, Coleman, & Hiorns, 2001; 1999; Furstenberg, 1998; Manlove, Terry, Gitelson, Romano Papillo & Russell, 2000).

Third, trends in teenage reproductive behaviour are similar to those for older women (Macintyre & Cunningham-Burley, 1993). Fertility at *all* ages has declined in the UK, as it has in most of Western Europe (Chesnais, 1998; Hall, 1995; Lesthaeghe, 1995). Use of abortion has also increased in older age groups as well as among teenagers. There may be some kind of relationship, therefore, between teenage fertility and the fertility of older women (Teitler, 1994).<sup>2</sup> These are not distinct populations, and the demographic behaviour of teenagers should be considered alongside the behaviour of older women (most analyses of teenage pregnancy and parenthood do not do this; Teitler, 1994). However, the family formation behaviour of teenagers does appear to represent an extreme version of the behaviour of the general population. Rates of youthful marriage have declined more dramatically among teenagers compared with older individuals, for example (Kiernan, 1998; Selman, 1996), and childbearing outside marriage is more common among teenagers than the general population (SEU, 1999). Partnering behaviour can also appear less stable, with more cohabitation and shorter periods of partnership (Kiernan, 2003).

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<sup>2</sup> Professor Julien Teitler kindly provided a draft of this unpublished document.

Yet, given demographic 'fluidity' in the general population—low rates of marriage, rising divorce, partnership formation and reformation (van de Kaa, 1987)—it seems anomalous that early pregnancy and childbearing should be the cause of such official and public concern. Even in those nations with high rates of teenage childbearing, young mothers rarely constitute a sizeable proportion of all mothers; in 1995, only 6.5% of babies born in England and Wales were to teenagers (Allen & Bourke Dowling, 1998).

### **1.3) Explanations for teenage pregnancy**

The decline in youthful fertility across most of the developed world has not hindered the development of a large body of literature devoted to explaining teenage sexual and reproductive behaviour (Ward, 1995). Most of this research is American, and there has been comparatively less British research, which may be because British teenage fertility rates are about half those found in the US (Singh & Darroch, 2000).

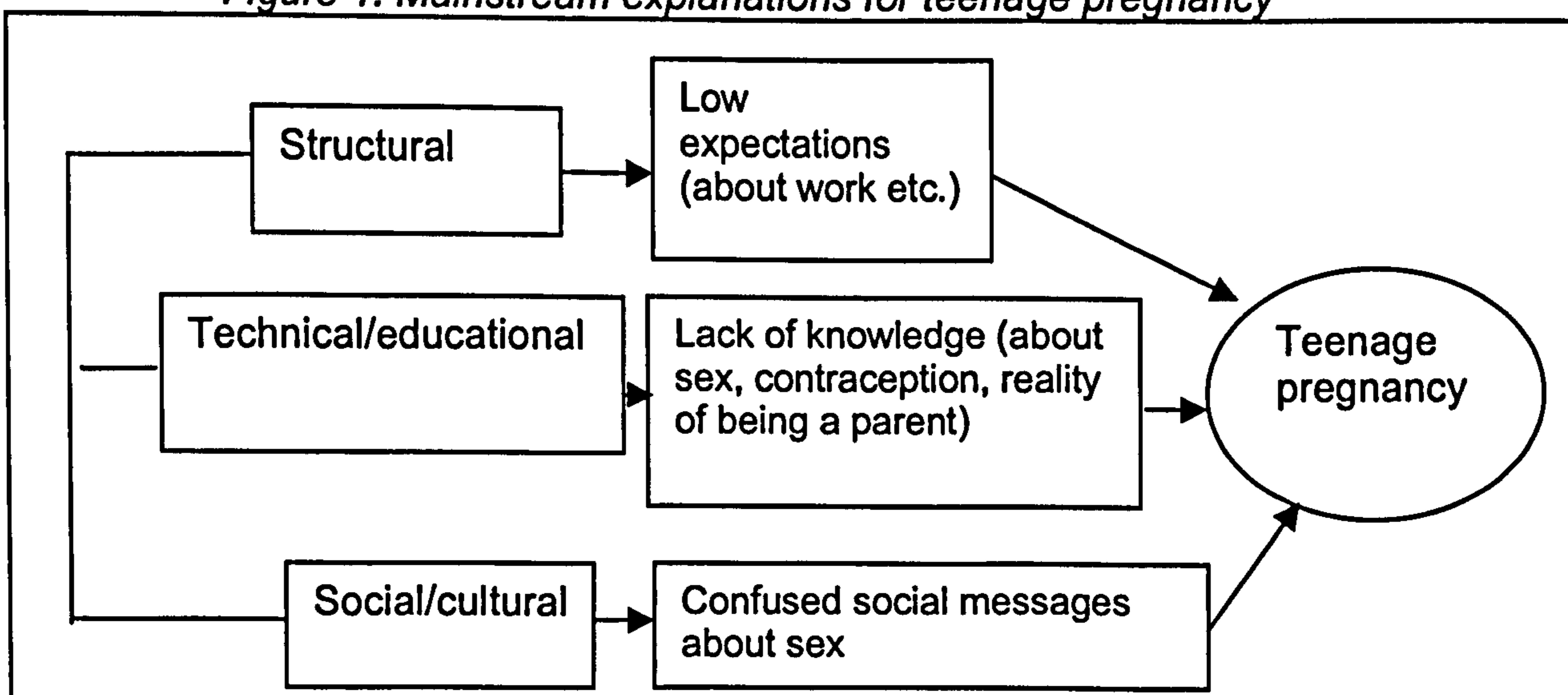
There is wide diversity in the reasons offered for teenage sexual and reproductive behaviour. Some explanations are more mainstream than others. Biological explanations which emphasise the effect of the timing of menstruation on sexual behaviour (Dann, 1996) are peripheral with current discourses. As is (relatively speaking) the research on the psychological correlates of early sexual activity, pregnancy and fertility. This research links teenage sex and reproduction to a lack of self-esteem, emotional problems and having an external locus of control (Drummond & Hansford, 1990; Kiernan, 1997; Vernon, Green & Frothingham, 1983). In much of this work, sexual activity and pregnancy is also linked to high-risk behaviours such as alcohol and drug use and aggressive behaviour (Valois, Oeltmann, Waller & Hussey, 1999).

The TPU drew on largely mainstream explanations for early pregnancy and, at the heart of the 1999 document, three reasons are offered for comparatively high rates of teenage pregnancy. These are: 'low expectations', 'ignorance' and 'mixed messages' (SEU, 1999:7). The first, 'low expectations', is caused by structural, socio-economic disadvantage. The SEU acknowledge that high levels

of income inequality in the UK leads to 'poor expectations' among youth about their chances of educational or vocational success: '...there are more young people who see no prospect of a job...they see no reason not to get pregnant'. (p.7). The second reason, 'ignorance', is a consequence of the fact that young people lack knowledge about contraception, sexual health and the reality of parenthood: teenagers '...do not know how easy it is to get pregnant and how hard it is to be a parent' (p.7). This reason is therefore largely about technical expertise (the obtaining, and effective use, of contraception) and education or knowledge (about sexual health, the nature of parenthood). The third reason for teenage pregnancy is 'mixed messages'. These are social or cultural in nature: 'One part of the adult world bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. Another part...is at best embarrassed and at worst silent...(p.7).

For the purposes of developing the arguments in this thesis, contemporary, mainstream approaches to teenage pregnancy can thus be broadly categorised into three groups: 'structural', 'technical/educational' and 'social/cultural'. See Figure 1.

*Figure 1: Mainstream explanations for teenage pregnancy*



A number of points should be made about these explanations. First, it is not immediately clear which best explain *either* early sexual behaviour *or/and* teenage pregnancy *or/and* fertility. The authors of the TPU report also seem not to be sure about this and mention 'birth rates' as much as they do 'pregnancy', though these are not the same. To cover any confusion about this, the observation is simply made that '...individual decisions about sex and *parenthood* are never simple to understand' (p.7, emphasis added). In this statement, 'sex' is synonymous with pregnancy.

However, the TPU does imply that structural ('low expectations') factors might better explain fertility (unemployment and lack of engagement with education might make an unplanned pregnancy less unattractive since it will not interfere with work or school). Technical/educational factors, in contrast, probably affect early sex and pregnancy more than fertility, since 'ignorance' about sex and contraception leads to unplanned pregnancy (though these factors also influence the decision to continue with a pregnancy; knowledge about the 'reality of parenthood' also features under this category). Social/cultural influences on behaviour also probably affect sexual behaviour and pregnancy more than fertility since, for the TPU, these are largely about messages about sex (though they could apply to decisions about childbearing; early motherhood might be more acceptable in some social contexts compared with others).

Second, not only is it not clear which factors best explain teenage sex, pregnancy or fertility, these are not mutually exclusive categories and can be easily conflated, especially technical/educational and social/cultural categories. The combination of these two can be seen in relation to teenage sexual behaviour and pregnancy (rather than fertility). Wider social messages about sexuality (especially teenage sexuality) will probably have an impact on the acceptance and success of sex education; societies that are ill at ease with sex generally, or fearful of teenage sexuality, are likely to view sex education with some suspicion (Jones, Darroch Forrest, Goldman, Henshaw, Lincoln, Rosoff et al., 1986; West, 1999). The symbiotic relationship between these explanatory categories is less evident in relation to teenage fertility; how do distal or proximate cultural

influences affect the incidence of teenage parenthood?

Third, despite the overlap between these three categories, there are inherent tensions between them. 'Family values' groups, for example, emphasise the role of cultural values (social/cultural) on teenage sexual behaviour and pregnancy (see, for example, van Loon, 2003), while sexual health advocates stress the importance of greater provision of contraception and improved sex education (technical/educational) (see, for example, Hadley, 1998).<sup>3</sup> However, the TPU avoids having to assess the contribution of each by attributing early sex, pregnancy and parenthood to all three. Though the TPU does emphasise that deprivation (structural) alone cannot explain teenage pregnancy—similarly deprived areas do not have the same teenage pregnancy rates, for example, nor do all poor people experience early pregnancy and parenthood.

The TPU may be seeking to avoid political controversy by accounting for teenage sexual and reproductive behaviour with such all-encompassing explanations, but we are still left without a clear understanding of how to understand it. Is early sex and childbearing a consequence of structural factors, or about social messages and influences—social/cultural factors? Do technical/educational explanations account for youthful pregnancy? Do these factors apply equally to sex, pregnancy *and* fertility, or do they apply differentially? Maybe these explanatory categories are not useful and reasons for teenage pregnancy must be sought elsewhere.

In fact, for most commentators of teenage sexual and reproductive behaviour (as well as for the TPU), there is often little distinction between sexual activity, pregnancy and parenthood; these are often attributed to the same factors. The fact that these explanations might overlap, or be a point of tension, is also of secondary importance (except for those high-profile groups who publicly emphasise this). For example, Anne Weyman, Chief Executive of the FPA<sup>4</sup>, referring to research suggesting that working class girls are less likely to have

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<sup>3</sup> The BBC's Social Affairs Editor, Niall Dickson, alluded to this by observing that the British government had sought a 'third way' in its efforts to reduce teenage pregnancy since it was '...caught between a strong liberal lobby anxious to promote safer sex and a strong traditional lobby anxious to discourage promiscuity among the young...' (Dickson, 1999).



abortions than their middle class counterparts, and that this was attributable to peer and local condemnation of abortion, observed: 'In this country we have a very censorious view about the unwanted consequences of sexual activity...It's a lack of being able to say 'Well I do have a choice'' (Addley & Mahey, 2000). From this perspective, factors that are structural (the working class status of the women and the communities they live in), technical/educational (the non-use or failure of contraception, reluctance to use abortion services) and social/cultural (attitudes to abortion which are informed by others, an apparent sense of fatalism, a prudishness about the consequences of sex) directly affect the incidence of youthful sex, pregnancy and parenthood. Drawing on this observation—and expanding the TPU's analysis of teenage pregnancy—factors that affect teenage sexual and reproductive behaviour can theoretically be found in all three categories. See Table 2.

*Table 2: Factors affecting teenage sexual and reproductive behaviour*

<b>Structural (opportunities and organisation)</b>	<b>Technical/educational (‘know-how’ and expertise)</b>	<b>Social/cultural (messages and influences)</b>
Socio-economic status	Sexual health knowledge/education	Wider messages about sex and reproduction
Educational attainment	Information about/use of contraception or abortion	Community messages about sex and reproduction
Employment	Knowledge about parenthood	Peer group messages about sex and reproduction

#### **1.4) The dominance of technical/educational explanations**

The degree to which any of these categories better explains either early sex, pregnancy or parenthood (or one rather than the other) is not of great importance within dominant explanatory discourses for another reason; all events are usually attributed to technical/educational factors (with an implicit understanding that these are informed by social/cultural and structural influences). The dominance of

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<sup>4</sup> Previously, the 'Family Planning Association'.

technical/educational explanations may be attributable to the fact that social/cultural influences on behaviour are not well defined and even less understood.

Another reason why technical/educational explanations are dominant is because they attribute a degree of 'ignorance' to young women about sex and its consequences. Ignorance among young women (and men, but the focus here is on women) can be remedied by better delivery of sex education<sup>5</sup> and increased provision of contraception. This suits contemporary beliefs about the transformative power of education, and reflects the spirit of the age; Technical/educational explanations became fashionable in an era in which safe, effective contraception was developed and the belief prevailed that human reproduction could be controlled. Luker reiterates this when she says that, by the 1970s, '...unwanted or untimely pregnancies came to be viewed as technological failures...' (1996: 51). Arney & Bergen (1984) note that, from 1970 on, teenage mothers became a 'technical' problem and educational intervention was required: 'The proximate cause of pregnancy was an 'appalling ignorance' about the true nature of sexuality' (p.15). Geronimus (1997) observes that 'family planners' acknowledge the connection between teenage pregnancy and poverty, but they also see it as '...an educational or medical problem to be solved by increased access to contraception, abortion and sex education' (p.3). This perspective is especially popular in the medical and health education literature, and the media (which may be because spokespersons from sexual health organisations are often invited to comment on new research or policy initiatives).<sup>6</sup>

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<sup>5</sup> This can be about parenthood as well as sex and pregnancy; many sex education programmes attempt to educate youth about the responsibilities of parenthood. This can be seen most vividly in the use of lifelike dolls that behave like babies (they cry, need changing, feeding etc.) as part of sex education programmes.

<sup>6</sup> Roger Ingham, of the Sexual Research Centre at Southampton University, speaking in response to questions about the British government's initiatives to deal with teenage pregnancy endorsed his belief in the efficacy of sex education and remarked that 'I think that the problem the government faces is that the key issue is how open we are prepared to be in this country' (BBC Online News, 11/06/99). Alison Hadley, of Brook (again in response to the government's plans to reduce teenage pregnancy) emphasised the need for the government to make a high standard of sex education compulsory to ensure the reduction of teenage pregnancy rates (BBC Online News, 14/06/99). Rachel Garbutt, of Manchester Brook, when asked to comment on the birth of twins to a girl aged 17 and fathered by a 13 year old boy in Manchester said: 'The age of

A major limitation of technical/educational explanations is that they stifle, in particular, discussion of structural influences for youthful sexual and reproductive behaviour. Socio-economic inequality, residence in a poor neighbourhood and educational underachievement are given consideration, but are not central from this perspective. It is known, for example, that women in the unskilled, manual social classes are 10 times more likely to become young mothers than their counterparts from professional class backgrounds (SEU, 1999), and that early pregnancy and childbearing is concentrated in the poorest neighbourhoods (and abortion in the most affluent) (Smith, 1993). Yet the reduction of deprivation is seldom suggested as the *principle* means of reducing teenage pregnancy (Luker, 1996). The dominance of technical/educational explanations also marginalises social/cultural explanations; there has been little research conducted, for example, on the reasons for the apparent opposition to abortion in the poorest communities (Tabberer, Hall, Webster & Prendergast, 2000).

The tone of the 1999 TPU report, and the recommendations made<sup>7</sup> suggests that technical/educational explanations for early pregnancy are paramount in current policy approaches. The Health Education Board for Scotland (Burtney, 2000) drew on the same research as the TPU in its report on teenage pregnancy. In this document, there is little reference to the importance of structural factors, though the author does accept that there are links between teenage parenthood and poverty and that reducing 'inequalities in life circumstances' would reduce inequalities in unwanted teenage pregnancy (Section 4).

Technical/educational approaches, therefore, restrict our understanding of the effects of other factors on sexual and reproductive behaviours. They are attractive because they are well defined and because they reflect a widely-held

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becoming sexually active is becoming lower and sex education is not meeting it' (Sengupta, 1999: 5). Ian Murray, in an article entitled 'A nation of prudes blamed for teenage pregnancy boom' about the findings of a Brook study of sexuality and contraception advice said: 'Britain has the highest rate of teenage pregnancy in Europe, largely because girls are frightened to talk about sex...Unlike in countries where sexual issues are discussed more openly, British reticence and prudish moral values mean that the subject is not properly handled' (Murray, 1999: 8).

<sup>7</sup>These are based on findings from 70 projects concerned with provision of sex education and/or information about contraception.

belief that 'ignorance' accounts for early pregnancy and parenthood, and all that is required to remedy this is appropriate educational input.

They are also appealing because they can be supported by the use of comparative international data. A key feature of technical/educational explanations is the use of comparisons between the UK with other countries—the TPU depends heavily on the portrayal of the UK as 'lagging behind' Western Europe (van Loon, 2003). The authors of the 1999 TPU document observe that: 'Throughout most of Western Europe, teenage birth rates fell during the 1970s, 1980s and 1990s, but the UK rates have been stuck at the early 1980s level or above' (p.14). The implication of this argument is that Western Europeans are better at preventing teenage pregnancy than the British. This evokes feelings of national embarrassment at what is seen as a particularly British problem (Le Bras, 1997). It is argued here that, of the three types of explanation, technical/educational ones are built on the least empirically convincing grounds, and this can best be seen in relation to the use of comparisons with other European countries.

#### 1.4.1) Comparisons with Western Europe

The argument on which comparisons with other European countries are based is a familiar one. Some countries (Sweden, Denmark and the Netherlands, in particular) are cited as particularly effective at reducing teenage fertility rates; these rates are believed to be the product of 'sexual openness' (Jones et al., 1986; Lewis & Knijn, 2002); and the UK could learn by the experience of these nations, particularly in respect of improved sex education (Hadley, 1998). These comparisons are built on (at least) two assumptions: first, that low, Continental teenage fertility rates are primarily a consequence of a low incidence of pregnancy (and also that pregnancy rates are uniformly low across Western Europe, with the exception of the UK); and second, that (to the relative exclusion of other factors) low teenage pregnancy rates are attributable to the effects of sexual openness and its consequences.

The first of these relates to European pregnancy rates and their variation. This variation is often hidden by judicious presentation of statistical data; conception and abortion rates are presented much less than fertility rates. In the TPU's 1999 publication, one table on international differentials in teenage abortion ratios is presented, but the full significance of this is not commented upon. Yet these differentials are substantial: in 1994, Sweden had a teenage abortion ratio of 1853 per 1000 (so, for every 1000 births to teenagers, there were 1,853 abortions), Denmark's ratio was 1624 while in the UK it was just 627 (Kane & Wellings, 1999). It is inadequately appreciated that the low teenage fertility rates in some countries is partly attributable to the widespread use of abortion rather than spectacular reductions in conceptions (Micklewright & Stewart, 1999; FPSC, 1999; UNICEF, 2001). This underscores the importance of examining teenage fertility rates alongside use of abortion. See Table 3.

*Table 3: Proportion of teenage conceptions that are terminated, European countries, 1994*

Germany	20.2
Netherlands	33.8
Belgium	35.6
Spain	36.7
Czech Republic	38.1
UK	40.2
Bulgaria	40.4
Italy	42.9
Romania	42.9
Belarus	47.5
Latvia	47.6
Estonia	49.7
Hungary	50.3
Iceland	51.1
France	51.2
Finland	52.9
Norway	59.2
Denmark	62.6
Sweden	69.6

Data taken from Kane & Wellings (1999). Data for 1994 or latest available year.

In Northern European countries, France and parts of Eastern Europe, high proportions of teenage conceptions are aborted. About 40% of conceptions to teenagers in the UK are terminated compared with 70% in Sweden. Santow & Bracher (1999) maintain that abortion was more important in the maintenance of low Swedish rates before 1975; yet, even after that date, abortion continues to be important in keeping rates low.

There is also considerable variation in European teenage conception rates. The UK has the highest youthful conception rates in Western or Northern Europe but comparatively high rates are also found elsewhere (Iceland, 43.3; Norway, 32.2; Sweden, 24.9), and low rates are present in Italy (12), the Netherlands (12.2) and Spain (12.3) (Singh & Darroch, 2000). This variation also raises another issue: low teenage conception rates are a feature of seemingly quite disparate nations, such as Spain, Italy and the Netherlands. The Netherlands (along with Belgium and Switzerland) has had low teenage pregnancy and fertility rates since the early 1960s. Spain and Italy belong to a group of nations where rates of early pregnancy fell in the late 1970s or later (Kane & Wellings, 1999). Little attention is paid by researchers and policymakers to teenage reproductive behaviour in these countries, with the key exception of the Netherlands. Spain, Italy (and especially Belgium, and also the Republic of Ireland, both of which experienced early declines like the Netherlands) are seldom celebrated for their 'successful' record on teenage pregnancy. From a technical/educational perspective, there is little to link these countries; this would seem to suggest that the reasons for these low rates are varied and complex, and may even be specific to each nation, so no or few generalisations can be made (Teitler, 1994).

The second feature of explanations that utilise comparisons between the UK and other European nations is the belief that, where teenage conception rates are low, this is attributable to sexual 'openness' and its concomitants (sex education and provision/use of contraception) (Hadley, 1998; Lewis & Knijn, 2002). Sex education policy is, of course, affected by the degree of societal openness about sex (Meyrick & Swann, 1998). Harling (1999) notes British society's '...rather peculiar attitude to sex' and says that, in the rest of Western Europe '...sex tends

to be discussed openly and honestly from an early age, whereas in Britain it is still considered a topic unfit for "polite" conversation' (p.1496). Statements like this are commonplace in the literature, but are not well supported empirically. In a 2100-strong sample of British parents, for example, nearly two thirds did not feel embarrassed talking to their children about sex. And the authors concluded that respondents displayed, on the whole, an open attitude to sex education (Marie Stopes International, 2000).

The centrality of sex education to the forging of reproductive destinies is paramount to a technical/educational perspective.<sup>8</sup> The utility of education programmes in preventing pregnancy has been demonstrated (Kirby, 2001). Yet, even where programmes have been effective, attributing effects to the programme itself is problematic because of poor methodology. Oakley and colleagues (1995) demonstrated that, of 73 young people's sexual health interventions, only 12 were considered methodologically sound. Of these 12, just two of these showed short-term effects on behaviour. Sex education appears to be more effective in increasing knowledge than in changing behaviour (Wight, Raab, Henderson, Abraham, Buston, Hart et al., 2003), and systematic reviews of educational interventions show some effects on behaviour, but often not approaching statistical significance (NHS CRD, 1997).

Teitler (1994) has questioned the assumption that sex education can explain variation in teenage reproduction. He says that this belief is 'rarely...countered by academic researchers..' (p.8), but explanations may lie elsewhere. He points out that approaches to sex education vary among European nations, yet teenage fertility rates in Western Europe are uniformly low. Northern European nations have traditionally been proactive in provision of sex education, while

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<sup>8</sup> It also dominates explanations for teenage pregnancy in media discussions of the issue. For example, on 15/11/00 on Radio 4's PM programme, Dr Sharon Tabberer (who had just produced, with colleagues, a study examining the reluctance of working class pregnant teenagers to opt for abortion) and a young mother were in conversation with Claire English, Co-presenter of the programme. When asked about how she came to have a child at the age of 15, the young mother said that she had been using a condom but that it had burst. She had taken the morning after pill, but it had failed, and then she had been offered a termination of pregnancy by her GP. After consideration she rejected the idea of abortion. Claire English remarked that this was obviously a sign of a failure of sex education.

Mediterranean nations: ‘...leave much more of the sex education to youth themselves’ (p.13).

A nation like Italy, for example, has low teenage conception and fertility rates, yet a haphazard approach to sex education. Sex education is not mandatory, parents have the right to withdraw children from classes and provision is sparse (Kane & Wellings, 1999). Abortion is restricted to the first trimester and granted only where a woman’s health is at risk (Bettarini & D’Andrea, 1996). A recent survey of Italian youths’ knowledge about sex also showed some degree of ignorance about human sexuality and reproduction, with more than half of 11-14 years old stating that AIDS could be caught from toilet seats (Usher, 1999).

Yet, despite lack of sex education, Italian teenagers’ reproductive behaviour is similar to that of their Dutch counterparts. Of course there are other factors at play, not least the contexts within which intercourse occurs. The authors of the TPU’s 1999 document referred to differences between the UK and the Netherlands in this respect. They cite research showing that first experience of intercourse is more likely to occur within a loving relationship for Dutch youth, whereas this is less likely among British counterparts, with British males citing peer pressure, physical attraction and opportunity as reasons for first intercourse. Interestingly, despite the disparity between the UK and Italy in rates of early pregnancy, young Italian men are similar to their British counterparts in this respect; Zani (1991) discovered similarly utilitarian reasons for first intercourse among young Italian males.

So diverse are the European nations with the least incidence of teenage conceptions (Italy, the Netherlands and Switzerland) that they have been referred to as an ‘...unlikely triumvirate of countries...’ in respect of teenage pregnancy (Phillips, 2000). All three have different approaches to sex education and provision of contraception. Only in the Netherlands is sex education mandatory and organised at national level and contraception freely available. Sex education policy in Switzerland is decided at canton level, as is provision of contraception, so shows some geographic variation (Kane & Wellings, 1999).



The UK's high teenage pregnancy and birth rates might be considered anomalous from a technical/educational perspective (Micklewright & Stewart, 1999). British teenagers have access to free contraception, there is widespread availability of condoms and abortion legislation is among the most liberal in the world, with termination allowed (in theory) until 22 weeks gestation (Kane & Wellings, 1999).<sup>9</sup> There may be problems with sex education, it may be too narrow in focus and provision is not universal (Kubba & Carr, 1999). There may also be some ambivalence about how best to instruct young people about their sexuality (West, 2000). Yet, considering the situation that prevails in many other nations, the situation in the UK is not easily explainable.

This paradox was highlighted when research showed that 71% of teenage mothers in the Trent region had consulted a health professional about contraception before pregnancy and 50% had been prescribed oral contraception (Churchill, Allen, Pringle, Hippisley-Cox, Ebdon, Macpherson et al., 2000). This finding upset notions about inadequate access to contraception among 'vulnerable' members of the community, with the authors concluding that: 'The reluctance of teenagers to attend general practice for contraception may be less than previously supposed' (p.486). Eighty per cent of the teenagers in Pearson and colleague's (1995) study claimed to have been using contraception when they conceived. Also, high sales of emergency contraception to teenagers have not materialised in the aftermath of changes to facilitate the 'morning after' pill's availability; most women who buy emergency contraception are aged 25-35 (BBC Online Health News, 17/8/2001). The low uptake of emergency contraception by teenagers may be attributable to the cost of the pill or lack of awareness. However, research from Scotland indicates that teenagers are well informed about the existence of emergency contraception, though they may be less knowledgeable about how to use it effectively (Graham, Green & Glasier, 1996).

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<sup>9</sup> Francome & Freeman (2000) argue that British abortion legislation is more restrictive than abortion legislation in other developed nations because of the procedures that women must follow before being allowed a termination of pregnancy (the permission of two doctors and 'grounds' for a termination are necessary—it is not granted on request). Yet, even given these constraints, British abortion legislation permits termination of pregnancy up to 22 weeks gestation, which is practically unknown in the rest of the developed world (Kane & Wellings, 1999).

In sum, technical/educational explanations for early pregnancy have a simple logic: early, unplanned pregnancy and motherhood is a consequence of ignorance and, given the right tools, can be rectified. Comparisons with other countries are a key feature of this type of explanation, yet these are built on untenable assumptions about how other nations deal with teenage reproduction. Not all societies with low teenage pregnancy rates have extensive sex education programmes, and the evidence that such programmes alter behaviour is weak. In some countries, a low teenage fertility is partly achieved by use of abortion. Ultimately, technical/educational approaches are characterised by their failure to appreciate the social contexts within which sexual and reproductive behaviour occurs. As Mellanby, Pearson & Tripp (1997) remark:

...external forces may be important—and sometimes overriding—determinants of sexual behaviour...personal knowledge and the availability of contraception are not by themselves good predictors of behaviour (p.460).

In their discussion of the contradiction between stated reproductive intentions and actual ones, Barrett & Wellings (2000) also hint at the deficiencies of technical/educational explanations when they say that:

The expectation that unplanned, unintended and unwanted births would decrease as women were provided with the tools with which to plan their pregnancy was reasonable. Only with current knowledge can we see that intentions, planning and decision-making around pregnancy...is likely to be more complicated... (p.194).

Technical/educational approaches to teenage sex, pregnancy and fertility have limited explanatory power. However, within contemporary policy approaches, there are two other ways that youthful sexual and reproductive behaviour can be explained.

### **1.5) Social exclusion and geographic variation in teenage pregnancy**

Two ideas need to be briefly introduced. These are: 'social exclusion' and 'geographic variation in teenage pregnancy and fertility'. The linkage of teenage pregnancy to social exclusion is paramount: teenage pregnancy was considered to be a 'cause and a consequence' of social exclusion by a new Labour government who made the eradication of social exclusion a central plank of its manifesto (Hoggart, 2003). The TPU was established within the newly-formed Social Exclusion Unit (hereafter the 'SEU') and the ethos of the latter informs the work of the TPU (Levitas, 1998). There is no accepted definition of social exclusion. However, the SEU describe it as:

...a shorthand term for 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 environments, bad health and family breakdown).<sup>10</sup>

A key feature of the SEU (and, by extension, the TPU) hinted at in this definition is the idea that certain kinds of phenomena (unemployment, poor health) vary geographically. For the SEU, an area-based approach is required if these problems are to be addressed (Kleinman, 1998; Wallace, 2001). Smith (1999) describes a '...significant increase in area-based initiatives...' since the election of Labour in 1997 (p.2). However, the usefulness of such initiatives is not universally accepted and, historically, has been an area of contention; Glennerster, Lupton, Noden & Power (1999) trace disagreement about area-based initiatives back to the 19<sup>th</sup> century.

Unemployment and ill-health are not the only phenomena to vary geographically. Area variation can also be seen in relation to teenage pregnancy, fertility and abortion. The Neighbourhood Renewal Unit (2002) notes large geographical variations in under 18 conception rates. In 2000, these ranged from 19.4 per 1000 in Richmond upon Thames to 89.8 in Hackney, nearly a five-fold variation.

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<sup>10</sup> <http://www.cabinet-office.gov.uk/seu>

The Unit also describes the concentration of teenage conceptions; between 1992 and 1997, '...54% of all under 18 conceptions occurred in the 20% most deprived wards'. The extent of area variation in teenage pregnancy and childbearing can be seen in Glasgow. In a recent news item, the point was made that: '...first-time mums in Glasgow's affluent areas are older than grandmothers in the city's poorest communities' (NHS Board, Greater Glasgow, 2003).

Since its inception, the TPU has made geographic variation in early pregnancy and fertility central to its analysis of early pregnancy. It focuses resources in areas where teenage conceptions are high and uses a network of Coordinators to inform and implement its policies. By 2003, there were 148 Coordinators working in England (Health Development Agency, 2003). As an area-based initiative, the TPS set area targets for the reduction of teenage pregnancy. These targets varied according to the existing level of teenage pregnancy in the local or health authority. Even in those areas where teenage pregnancy rates were low, there was still a requirement to further reduce them. Richmond, in London, for example, has the lowest under 18s conceptions rate in London yet was still required to further reduce them (Richmond & Twickenham Primary Care Trust, 2002). In Lambeth, which has high under 18s conception rates, the target was a 60% reduction by the year 2010 (London Borough of Lambeth, 2001). David (2001) observes that some areas have been designated 'hotspots' for teenage pregnancy, and have been subject to a process of 'naming and shaming' because of their high rates.

#### 1.5.1) Spatial analyses of teenage reproductive behaviour

Evidence of area variation in teenage pregnancy highlights the utility of adopting a spatial perspective on reproductive behaviour. There are a number of spatial analyses of teenage pregnancy, most of them largely descriptive (Jones, 1990), using only a limited number of explanatory variables. As such, they can provide only a partial understanding of teenage reproduction (Diamond, Clements, Stone & Ingham, 1999). Analyses of the 'simple' kind include those undertaken by Smith (1993) and Garlick, Ineichen & Hudson (1993). In the latter, it was

demonstrated that a pregnant teenager living in the deprived London Borough of Tower Hamlets is four times more likely to give birth than a pregnant teenager from wealthier Hampstead. In the former, analysis of conception rates in Tayside, Scotland showed that the rates in poor areas were three times higher than those in wealthier areas. Only a quarter of pregnant teenagers in poor areas had abortions, compared with two thirds of pregnant girls living in wealthier areas. Since all abortions were carried out in NHS hospitals (which were located near the poorer areas), ability to pay, and geographic access to services, were not important explanatory factors.

In a more sophisticated analysis, McLeod (2001) demonstrated an increase in teenage pregnancy in the 1990s (compared with the 1980s) in deprived Scottish areas. Among teenagers aged under 18, the pregnancy rate increased in the most deprived areas from 7 to 12.5 pregnancies per 1000 13-15 year olds, and from 67.6 to 84.6 per 1000 16-17 year olds, but there was little change among teenagers living in the most affluent areas. The amount of local variation in teenage pregnancy explained by deprivation more than doubled in the period from the 1980s to the 1990s.

A number of authors suggest that geographic variation in teenage reproductive behaviour might be explained by differential access to services. There is some evidence that distance between a teenager's home and the nearest clinic can affect rates of conception. An analysis of variation in rates across the (former) Wessex Regional Health Authority showed that teenagers who lived 3-7km from a youth-oriented clinic were 1.11 times more likely to conceive than those who lived 0-3 km away (Diamond et al., 1999). However, in another analysis, a significant *positive* correlation ( $r=0.51$ ) between teenage conceptions and the proportion of teenagers attending clinics was demonstrated (Wilson, Brown & Richards, 1992).

Most analyses have measured 'area' at local authority or regional level (Babb, 1993). In two studies, teenage reproductive behaviour by *type* of local area is examined. Using the Office for National Statistics' (hereafter 'ONS') classification

of local authorities (described elsewhere; Wallace & Denham, 1996), Armitage (1997) described the differences in (all age and teenage) fertility according to type of area. 'Manufacturing' areas had the highest rates of fertility (1.93) in 1994. In contrast, the 'Services and Education' areas, which embraced some of Outer London boroughs and Southern English university towns, had low overall fertility (1.66). Women in these areas also tended to delay childbearing until their thirties. The areas captured in the 'Growth Area' category tended to exhibit fertility rates close to the national average, with very little variation among its clusters (which cover areas in Southern England, areas with forces' bases, some metropolitan overspill areas, market and satellite towns). The Inner London group of areas had 'a wide variety' of fertility experiences; the wealthier 'Central' areas had low overall fertility rates, whereas the poorer 'Inner areas' had higher rates of all age fertility. The situation in these areas, however, was complicated by the presence of immigrants who tend to have children younger but within marriage.

Teenage fertility differentials were more pronounced than fertility differentials for older age groups. In particular, 'Inner London', 'Coalfields' areas and 'Manufacturing' regions had above average teenage fertility rates. The 'Most Prosperous' areas had the lowest rates at 11.4 per 1000 women under 20. The high rates for Inner London hid differences between different areas within the capital. The overall rate for Inner London was 32.7 births per 1000 teenagers, above the national average of 29. Central London had low rates at approximately 20 births per 1000, while Newham and Tower Hamlets had very high rates of above 50 per 1000 women aged under 20. Again, this is partly a reflection of the proportion of the population that hail from a minority ethnic group.

Griffiths & Kirby (2001) used the same classification of areas in their analysis and observed that conceptions to under 18s were above national average in 'Coalfields', 'Manufacturing', 'Ports and Industry', 'Established Service Centres' and 'Inner London'. Area variation in use of abortion was also explored; areas with high rates of teenage conceptions were not characterised by widespread use of abortion. The 'Coalfields' area, for example, had above average teenage conception rates (around 60 per 1000 18 year olds), but only about 30% of

conceptions were terminated. The 'Most Prosperous' area had a low pregnancy rate (of about 20 per 1000), but over half of these pregnancies were terminated. Likewise, 'Mixed Urban' areas had fairly low conception rates (of around 34) but above average use of termination. Young women in the 'Ports and Industry' areas were the least likely to use termination, despite their above average conception rates.

There are also a number of comparatively simple analyses of teenage pregnancy and fertility in other developed nations. Analysis of Australian data (Evans, 2003) revealed evidence of area variation in rates of teenage pregnancy. Inner Sydney had fairly low rates, while in remote areas, rates were higher—in some 'outback' towns, teenagers were 32 times more likely to become pregnant compared with city-dwelling teenagers (PM, Australian Broadcasting Corporation 7/7/03). In Queensland, teenage fertility rates in the poorest areas are 10-20 times higher than the rates in affluent areas (Coory, 2000), and rates are especially high in geographically remote, poor areas.

Analyses of teenage pregnancy and fertility using US state-level data all show strong evidence of inter-state variation in trends (Saul, 1999; Smith & Ramirez, 1997). A mapping of the prevalence of unmarried births to teenagers in of Texas (which has a very high teenage pregnancy rate at 70 per 1000) demonstrated the correlation between youthful childbearing, area poverty, single-parent households and minority ethnic populations (Blake & Bentov, 2001). A similar analysis using Californian data confirmed the relationship between poverty and younger teenage fertility (Kirby, Coyle & Gould, 2001), as did analysis of Appalachian data (Bickel, Weaver & Williams, 1997). Area variation in teenage reproductive behaviour can also be seen in Canada and New Zealand (see Cheesebrough, Ingham & Massey, 1999, for an overview).

### **1.6) Introducing neighbourhood effects**

Although most of these spatial analyses of teenage reproductive behaviour employ comparatively simple analytical approaches and can provide only a broad, ecological overview of behaviour, they all highlight the importance of

socio-economic factors. In attempting to explain area-based differentials in teenage pregnancy, the TPU acknowledges the central role that geographic variation in deprivation plays (SEU, 1999). In England, details of ward-level variation in teenage reproductive behaviour can be found in the reports submitted to the TPU by each English Local or Health Authority. In most of these, teenage pregnancy is positively correlated with area deprivation (see Camden & Islington Health Authority's 2001 teenage pregnancy strategy, for example).

By demonstrating the link between poverty and fertility behaviour, most spatial analyses of teenage reproductive behaviour utilise largely structural explanations for early pregnancy and fertility. That is, geographic differentials in rates are typically understood to reflect variation in area deprivation. However, the importance of revealing social or cultural factors influencing the timing of sex, pregnancy and fertility is often hinted at in spatial analyses of behaviour; there is a relationship, therefore, between area deprivation and teenage pregnancy and fertility, but other (undefined) influences on behaviour are operating within some communities.

In Bradshaw & Finch's (2001) preliminary work on neighbourhood variation in teenage pregnancy and abortion, for example, deprivation (low income, unemployment, poor health) explained about 72% of the variance in teenage conception rates for 1997, and about 45% of the variance in abortion rates. A local authority-level, teenage reproductive scenario matrix was constructed<sup>11</sup> and local authorities were allocated to each scenario on the basis of their rates. This analysis revealed the presence of 'outliers', that is, local authorities that have unusual teenage conception or abortion rates given their socio-economic profile. The authors suggest that, where local authorities do not have a 'typical' teenage conception or abortion profile, then other factors must be operating to make these rates unusual.

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<sup>11</sup> Low conceptions/low abortions; low conceptions/high abortions; high conceptions/low abortions; high conceptions/high abortions.



This observation resonates with contemporary policy accounts of teenage pregnancy. The idea is implicit in such accounts that some (especially 'socially excluded') communities 'produce' teenage parents and, as noted above, this is not always a consequence of deprivation. The authors of the TPU's 1999 document highlight the role of other factors:

...deprivation is not the whole story. There are variations (in rates) *between* seemingly equivalent (local authority) areas...even the most affluent areas usually have teenage birth rates that are higher than the national rates in...the Netherlands and France (SEU, 1999: 22).

Social exclusion is therefore *more* than about deprivation (Levitas, 1998) and other factors must be operating to 'cause' teenage pregnancy. For the TPU, where deprivation (or other structural factors) cannot account for early pregnancy, the determinants of teenage pregnancy must be technical/educational in origin (so that, for example, some communities are better served by provision of sex education, or the teenagers that live in such communities are better users of contraception). Or they might be social/cultural in nature (teenage pregnancy and parenthood might be influenced by family, peer or wider social messages about sexual and reproductive behaviour, for example).

It has already been established here that technical/educational explanations for youthful pregnancy and fertility are the least convincing of the three. Doubtless there are individuals and communities that are ill-served by the delivery of sex education programmes, but teenage pregnancy and fertility is more than about the provision of contraception and sex education (Mellanby et al., 1997; Wellings & Mitchell, 1998). How can teenage pregnancy and fertility then be explained? In particular, how can we understand teenage sexual and reproductive behaviour within the context of specific neighbourhoods or areas, given evidence of geographic variation in rates?

The 'neighbourhood effects' approach provides an opportunity to do this. In the UK, this approach has not been widely used in relation to teenage sexual

behaviour, pregnancy and fertility; in contrast, it has been extensively used in US analyses. Here, for convenience, this approach is referred to as 'neighbourhood effects', but it has no commonly accepted name; it is variously described as 'contextual', 'socio-ecological' or 'environmental' research (Teitler, 1998).

The neighbourhood effects approach is heavily informed by ecological perspectives on human behaviour (Bronfenbrenner, 1979)—it attempts to explore influences on behaviours found in all social domains (that is, within the individual, the family, the community). Factors that affect teenage sexual and reproductive behaviour can exist, therefore, within the wider community or neighbourhood (in structural form, such as deprivation, or as social/cultural factors, such as community values and norms), within neighbourhood peer groups (as peer influences), and within the family (in the form of parental example, family resources and family functioning). At the heart of this approach is the idea that neighbourhoods can have effects on behaviour that are *independent* of individual characteristics (such as SES) and which are generated primarily through an individual's social interaction with others in salient social contexts (Atkinson & Kintrea, 2001; Crane, 1991). Additionally, within poor communities, the effects of social interaction with others are likely to be stronger, given lack of opportunities in such communities and the paucity of positive role models of behaviour (Brewster, 1994; Burton & Jarrett, 2000; Crane, 1991; Dietz, 2000; Sucoff & Upchurch, 1998; Teitler, 1998).

Neighbourhood effects approaches are, therefore, largely social/cultural in nature, since the focus is on messages and influences communicated during interaction with others. The fact that such interaction occurs in a neighbourhood or family context of broad, structural deprivation also means that such approaches draw on structural explanations for behaviour. Ghate & Hazel (2002), in their discussion of children's well-being in neighbourhood settings, observe that: 'As with other urban problems...the indicators most frequently found to predict child maltreatment at the community level can be conceptualised at both the *infrastructural* and the *social* level' (p.85. Emphasis added). Henly (1995) maintains that the neighbourhood effects approach allows for: '...the

examination of *normative* as well as *structural* influences...' (p.3. Emphasis added).

In relation to the behaviour of teenagers, most neighbourhood effects research uses sexual debut and pregnancy as outcome variables, and there is comparatively less research on pregnancy and fertility (i.e. the factors that influence the transition, or otherwise, from a pregnancy to a birth). The focus on sex and pregnancy is anomalous; the factors identified in neighbourhoods effects research as influencing sexual behaviour could also (theoretically) affect fertility behaviour. Early pregnancy and motherhood may be more normative in some neighbourhoods than others, for example (Bauder, 2002). This can be powerfully reinforced by the visibility of pregnant young women, or parenting teenagers in the community (Anderson, 1991). Neighbourhood peers and schoolfriends may also communicate positive messages about early pregnancy and parenthood (in the same way that they might exert pressure on friends to initiate sex). They may also influence how unplanned pregnancies are resolved by condemning the use of abortion (Tabberer et al., 2000). Parents can 'shield' a teenager from too-early sexual behaviour (by monitoring of behaviour, for example). They can also play a pivotal role in either promoting or hindering the transmission of wider values and norms about pregnancy and fertility (Furstenberg, Cook, Eccles, Elder & Sameroff, 1999), maybe by example or by the degree of support offered to a pregnant or parenting teenager.

Most neighbourhood effects research also uses statistical methodologies, and there is much less research that uses qualitative methods. The relative lack of qualitative research is also paradoxical; the theoretical 'backbone' of most neighbourhood effects research is the idea that individuals are influenced through *social* interaction with others in community settings (Teitler, 1998); qualitative methodological approaches are (arguably) better suited for exploring the nature of this interaction.

### 1.7) Research questions

The neighbourhood effects approach provides an ideal theoretical framework for the exploration of teenage sexual and reproductive behaviour for four reasons. First, it situates individuals in neighbourhood contexts, and therefore provides an opportunity to understand neighbourhood variation in teenage sexual and reproductive behaviour. Second, it draws on ecological perspectives on human behaviour, thus facilitating an exploration of multiple influences on behaviour. Third, the importance of structural factors are recognised, but so are normative or social/cultural ones. Fourth, the neighbourhood effects approach has not been widely used in a British setting to study pregnancy and its outcomes.

Four important points need to be made about the focus of this thesis. First, as noted above most neighbourhood effects studies have examined teenage sexual behaviour and pregnancy, but the emphasis here is on pregnancy and fertility, though influences on sexual behaviour are also explored (especially in the statistical analysis). Second, given the relative lack of qualitative research in this area, the interview material is of relatively greater importance. Third, the focus is on the experience of women. Fourth, the focus is on *English* women (since the TPU's remit is confined to England), however the analysis of statistical data does include a small number of Scottish and Welsh women.

It has been argued above that policy approaches are based on a limited understanding of teenage pregnancy and motherhood. The aim of this thesis is therefore to explore how factors present in neighbourhood, family and peer contexts influence teenage sexual and reproductive behaviour. There are two research questions:

- 1) Which factors within neighbourhoods, family and peer contexts are the most important in elucidating the causal pathways to teenage sex, pregnancy and fertility?
- 2) Do the importance of these factors vary *between* neighbourhoods?

### 1.7.1) Layout of the thesis

After this introductory chapter, there are six chapters. In Chapter Two, the conceptual outline of the thesis is described further and the neighbourhood effects literature is outlined. Methodology is covered in Chapter Three, where the selection of measures used in the analysis of the BCS, the issues explored in the interviews and hypotheses are described. Substantive results are in Chapters Four (the analysis of statistical data) and Five and Six (the analysis of qualitative material). Chapter Seven contains the summary and discussion.

## **Chapter Two: Neighbourhood Effects and Teenage Sexual and Reproductive Behaviour**

### **2.1) Introduction**

The background to the present research, and the research aim and questions, were outlined in the introduction. In brief, rates of teenage pregnancy and parenthood are considered too high by the current British government and a major cause, and consequence, of social exclusion. For this reason, the TPU was established to reduce early conception rates. In the TPU's first major publication (SEU, 1999), the authors described geographical variation in youthful conceptions and noted that most of these occur in English wards defined as the most deprived. Teenage pregnancy and parenthood was thus depicted as a problem (causing poor health, economic and other outcomes) of the poorest neighbourhoods. The message of the first TPU policy document was a simple one: initiatives to reduce teenage pregnancy would have their greatest impact on young women in poor areas; by deferring childbearing, such women can ensure they do not become 'socially excluded'.

For the TPU, explanations for early pregnancy are three-fold: it can be a consequence of 'low expectations', 'ignorance' and/or 'mixed messages'. These explanations can be broadly categorised as 'structural', 'technical/educational' and 'social/cultural'. Technical/educational explanations are prominent in the research literature and in media and policy arenas. The importance of structural explanations is recognised, though the TPU believe that deprivation alone cannot explain teenage pregnancy. Technical/educational explanations are the least convincing of the three; the evidence that 'ignorance' causes early pregnancy has not been empirically substantiated.

Here, the neighbourhood effects literature is drawn on to explore influences on teenage sexual and reproductive behaviour for four reasons: it situates individuals in neighbourhood contexts, and therefore provides an opportunity to understand neighbourhood variation in teenage sexual and reproductive

behaviour; it draws on multi-faceted ecological perspectives on human behaviour; it recognises the importance of structural *and* social/cultural factors; and it has not been widely used in a British setting in relation to teenage sexual and reproductive behaviour.

In this chapter, the neighbourhood effects approach is described further, and an overview of the literature on teenage sexual behaviour, pregnancy and fertility in this body of research is presented below. Details of neighbourhood effects studies of other health behaviours are also briefly presented. In the conclusion at the end of the chapter, the main themes and issues arising from the review of the literature are described. These are used to guide the construction of measures in the British Cohort Study (hereafter, the BCS) and the issues explored in the interviews. These are thoroughly described in the next chapter.

## **2.2) Structural and social/cultural explanations for teenage sexual and reproductive behaviour**

### **2.2.1) Structural explanations**

The neighbourhood effects approach, by recognising the influence of normative and structural factors on outcomes (Henly, 1995), employs what have been described here as structural and social/cultural explanations for behaviour. These were only briefly described in the introduction but require further elaboration.

Structural explanations are characterised primarily by a focus on tangible, measurable factors that are largely material, compositional or organisational in nature. Of paramount importance in the research on youthful sexual and reproductive behaviour is SES. Structural approaches, however, are not solely about SES—or closely related variables, such as employment and educational attainment. Factors such as family structure, legal codes and provision of welfare benefits also feature in this body of research. Structural explanations are largely descriptive and employ statistical methodologies, so there is limited scope for understanding the behavioural mechanisms linking structural factors to sexual

and reproductive outcomes. SES is strongly associated with youthful pregnancy and parenthood, for example, but what is it about SES that 'causes' early pregnancy and fertility? Qualitative work conducted in Edinburgh suggests that deprivation may affect the individuals' perception of the opportunities available to them. One respondent in this study reported that 'You either go to work or you have kids...and there is no work so we'll have kids...' (de Jonge, 2001:51).

## SES

Compared with their more affluent counterparts, young people from deprived backgrounds: have sex at a younger age (Singh, Darroch, Frost & the Study Team, 2001; Wellings & Mitchell, 1998); are more likely to become pregnant (Garlick et al., 1993; NHS CRD, 1999; Singh et al., 2001; Smith, 1993; Wellings, Wadsworth, Johnson, Field & Macdowell, 1999); and to carry the pregnancy to term (NHS CRD, 1999; Hendessi & Rashid, 2002; McCulloch, 2000; Rendell, Ekert Jaffe, Joshi, Lynch & Mouglin, 2000; Rosato, 1999; Singh et al., 2001; Ward, 1995).

An analysis of 1981 census data found that the fertility rate for teenagers in social class V was 46 (per 1000 person years of risk) while the rate for those in social class I was just 4.8. Youth in local authority housing were more than three times as likely to give birth than youth in owner-occupied houses (Rosato, 1999). Teenagers who have no home—who are in care or are homeless—have even higher rates of pregnancy and fertility; in Garnett's (1992) analysis of 135 children leaving care in three English local authorities, one in seven of the girls were either pregnant or had already become mothers at the time of their discharge from care.

Analysis of National Child Development Study (hereafter 'NCDS') data showed that 17% of teenage mothers reported financial hardship in their family of origin at age seven compared with 6% of older mothers, and 22% of teenage mothers reported hardship at age 16 compared with 8% of older mothers. In multivariate analysis, girls who reported hardship at both points in time were nearly three times more likely to become young mothers than those who reported no financial



hardship (Kiernan, 1997). This analysis also highlights the importance of educational attainment to reproductive outcomes; teenage mothers were much more likely to have lower educational attainment scores at ages seven and 16 than older mothers (44% of teenage mothers reported being in the lowest quartile for educational attainment at age seven compared with 24% of older mothers). Differences for men and women were demonstrated such that '...educational achievement may be a more powerful deterrent to young motherhood' than it is for men (p.415). In multivariate analysis, educational variables continued to be significant. Young women who experienced a decline in educational achievement over time were particularly more likely to become teenage mothers. Educational achievement is cited as the most important factor in relation to early parenthood in the analysis.

In the UK (and elsewhere), sexual and reproductive behaviour shows strong differentials by social class status, and this is reflected in family-building intentions. Jewell, Tacchi & Donovan (2000) found that the working class women they interviewed considered the age range 17-25 to be the optimal age for childbearing. Their middle class counterparts reported late 20s or early 30s as the best age. Kiernan's (1997) analysis of NCDS data showed that women who became teenage mothers were more likely to express pro-early parenthood and marriage views at age 16 than those women who did not become teenage mothers. Among women who became teenage mothers, 9% reported wanting to start a family before age 19 and 30% expressed a desire to marry before age 19, compared with 2% and 14% of older mothers respectively. In a Canadian study (Kives & Jamieson, 2001) of pregnancy intentions among teenage mothers-to-be, 22 women had 'sort of' or 'really wanted' to be pregnant, 32 did not want to be pregnant and four said they did not care. Forty two said they were happy to be pregnant.

This preference for early motherhood can be seen at the macro-demographic level; first childbearing occurs at earlier ages in the UK than it does in the rest of Western Europe (Coleman & Chandola, 1999) and this tendency toward earlier age at first birth may also mean that teenage childbearing more closely

resembles, and is related to, childbearing in older age groups (Teitler, 1994). British orientation towards early family-building means that youth transitions—into work, education and family formation (Iacovou, 1998)—are more accelerated in the UK than other Western European nations (Galland, 1995). For Evans & Furlong (1997), the distinctiveness of British youth transitions is partly attributable to the characteristics of work/education provision after age 16. Provision is not strongly institutionalised which means that ‘...many young people are closer to the world of work and to ‘adult responsibilities’ at an early age ’ (p.36).

In recent years, these accelerated youth transitions have become less pronounced yet, despite this, Britain retains ‘...one of Europe’s fastest transition regimes’ (Roberts, 1997:63). Roberts provides the example of Germany, which is at one extreme of the continuum in that there are qualifications and training programmes that must be completed before young people can practise most occupations. Britain, on the other hand, is ‘...Europe’s self-acclaimed capital of deregulation’ (Roberts, 1997:63) and stands at the other end. In a similar vein, Galland (1995) remarks on the ‘distinctiveness’ of the British case, whose youth:

...appear to continue to be governed by a model of early maturing. Studies are abandoned early...entry to the labour market is early, as are leaving home and living as a couple...The average age for a (first) union is thus one of the lowest in Europe... (p.6).

Jones & Wallace (1990), in an analysis of 1981 NCDS and General Household Survey data, also describe the relationship between British youth transitions and class. Family formation comprises three stages: setting up an independent home, forming a partnership and having children. They conclude that, for most of the middle class, these stages occur over several years, which they attribute to career demands and the desire to save money for a home. However, these stages are ‘compressed’ for most working class individuals; working class women who followed an expected class trajectory had a median age at first birth of 21.5 years, for their middle class counterparts, it was 25.5 years. For the working classes, therefore: ‘...the period of youth begins earlier and is less gradual...’

than it is for the middle classes (p.146-147).

Wallace (1987) also described class differences in life transitions and observed that working-class individuals begin childbearing earlier than their middle-class counterparts. She attributes to young, working class women the ability to realistically appraise the impact of their social and economic circumstances on the timing of family-building. By having their children while young, nothing is lost to these women because there was little to be gained in the first place.

The relationship between deprivation and early sex, pregnancy and parenthood is evident in British and other settings. The US has the highest rates of teenage pregnancy and fertility in the industrialised world (Singh & Darroch, 2000; UNICEF, 2001), with evidence of strong differentials in sexual activity, pregnancy and fertility by race and by SES (Cheesebrough et al., 1999; Gold, Kennedy, Connell & Kawachi, 2002; Ward, 1995). In the Netherlands, where teenage fertility is rare, early parenthood is concentrated in the poorest (usually minority ethnic) groups (van Enk & Gorissen, 2000; van Loon, 2003). This is also the case in Sweden (Singh et al., 2001) and Spain (Nebot, Borrell & Villalbi, 1997). In New South Wales, Australia, teenage mothers constitute about 2% of all women giving birth in the least deprived area and nearly 7% in the most deprived (Public Health Division, NSW Health Department 2000).

A review of the relationship between SES, educational attainment and teenage sexual activity, pregnancy and childbearing undertaken in five countries (UK, US, Sweden, France and Canada) by the Alan Guttmacher Institute (Singh et al., 2001) showed that, among women with low educational attainment, about 20% of Swedish women, 18% of French women, 45% of Canadian, 36% of British and 66% of US women became young mothers. The data do not indicate if low educational attainment preceded, or was a consequence of, childbearing. In the popular imagination, early parenthood nearly always causes a girl to drop out of school, though many young mothers drop out *before* pregnancy. One British study found that, of 50 girls excluded from school, 14% had conceived during exclusion (see Brindis, 1993, for details).

In the Alan Guttmacher Institute study above, differences between women in the five countries in reports of sexual activity before age 20 by economic status were also observed, though these were smaller than those for childbearing. Use of contraception also varied by SES, with women from lower SES backgrounds less likely to use contraception.

### *Welfare benefits*

Income inequality in the US and the UK is partly a consequence of the fact that the income transfer systems in these countries are less generous than those in other countries (Selman, 1998). This fact upsets popular notions about young girls becoming pregnant to secure welfare benefits and council housing. To date, there is no British research showing that young women knowingly exploit the benefits system (Selman, 1998). Allen & Bourke Dowling (1998) observe that the young women they interviewed in their study appeared naïve about welfare benefits, and a report by the National Council for One Parent Families (2000) concluded that the housing needs of young lone mothers are often neglected and that young women are not given preferential treatment because of their age. The TPU, however, maintains that there may be an association between teenage parenthood and the requirement to be available for work (SEU, 1999), yet Gauthier (1996), speaking from a European position, maintains that benefits alone cannot affect behaviour. From a US perspective, a review of the literature examining the effects of welfare on early childbearing is provided by Wilcox, Robbennolt, O'Keefe & Pynchon (1996). These authors concluded that, overall, there is little evidence of a strong correlation between welfare provision and teenage childbearing.

### *Family structure and functioning*

The impact of family structure on teenage sexual and reproductive behaviour is a consistent theme in the literature on youthful pregnancy and fertility, and it is one that is closely aligned to SES (British lone parent families are considerably poorer than two parent families). Early sexual activity, pregnancy and parenthood are associated with growing up in a lone parent family (Kiernan, 1997) though—apart

from the link between this and deprivation—it is not clear what it is about family structure that affects sexual and reproductive behaviour.

Early sex and reproduction could be related to aspects of the parent-child relationship (Baumrind, 1971), such as the nature and scope of communication between parents and children (Wellings & Wadsworth, 1999) and parental inability to monitor behaviour (East, 1999) (these are discussed further below). In lone parent families, the relationship between the parent and child may be more strained than it is in two parent families; there may be less time (because of work commitments) to foster positive family functioning, and this may affect the level of communication between parent and child or a lone parent's ability to monitor behaviour.

There is also a growing body of literature on the effects of pathological family functioning on teenagers' sexual and reproductive behaviour (Blinn-Pike, 2003). In Romans and colleagues' (1997) New Zealand-based study, four factors predicted teenage pregnancy: living in a non-intact family; having parents who argued; being physically punished after age 12; and not having had a confidante during childhood. Serious sexual assault (i.e. rape) predicted early pregnancy independently of these four variables.

A key structural factor that is strongly associated with teenage reproductive behaviour is the age at which the teenagers' mother starts childbearing (Hardy, Astone, Brooks-Gunn, Shapiro & Miller, 1998). The daughter of a teenage mother is one and a half times more likely to become a young mother than the daughter of an older mother (SEU, 1999). Kirkman, Harrison, Hillier & Pyett (2001) observe that many of the women in their qualitative study of teenage mothers came from family backgrounds where young motherhood was common. One respondent reported that: 'She (mum) had me when she was 19. Her mum had her when she was 17, and her mum had her when she was 19' (p.285). These authors do not discuss whether a tradition of young motherhood within the family-of-origin encourages teenagers to carry on a family tradition of early fertility or not. Rather, they suggest, the 'family canon' (a history of early fertility) provides

the young women with an 'alternative plot' with which to counter dominant narratives about the inadvisability of teenage motherhood.

### *Legal codes*

The law governing sexual behaviour might also be considered structural in nature, though the research on the impact of legal codes (about sexual activity, age of consent, statutory rape) on teenage behaviours is relatively peripheral within the literature on teenage sexual and reproductive behaviour. There is some (almost all North American) research on strengthening legal codes governing consent, which might be considered important given age differences between teenage mothers and their children's fathers; the younger the mother, the greater the age gap between her and her partner, and the greater the risk of coercive sexual activity (Taylor, Chavez, Adams, Chabra & Shah, 1999).

In Canadian research (Millar & Wadhera, 1997), half of the fathers of children born to girls aged 15-17 years old were aged over 20, and 4% of men who fathered children to women aged over 17 years were aged over 30. In a sample of over 12,000 very young (under 15 years of age at conception) mothers in California, fathers were, on average, 8.8 years older than the mothers and were more likely to belong to a minority ethnic group and have a low level of educational attainment (Taylor et al., 1999). In Leitenberg & Saltzman's state-wide analysis (2000) of age at first intercourse among female teenagers in Vermont, USA, the youngest sexually experienced respondents (aged 11-12) had a higher percentage of older (five years or older) male sexual partners than older age groups.

Abma, Driscoll & Moore (1998) point out that empirically establishing the degree of control over sexual intercourse is not straightforward, given the ambiguity of the circumstances in which young women experience sex and the age discrepancy between female and male partners (which might imply 'imbalances' in control of the sexual experience). Using data from the National Survey of Family Growth study, they utilised two measures of negative sexual experience: the first was a dichotomous measure of voluntary or nonvoluntary sexual activity;

the second was a 10-point scale measuring degree of 'wantedness' of first sex which the authors hoped would capture a more 'nuanced sense of the experience of first sex. The analysis was restricted to approximately 2,000 women aged 15-24 at the time of the survey. Those women who reported voluntary first intercourse varied in their reports of 'wantedness' of sex, with about a quarter giving low scores of 'wantedness'. These women were more likely to have experienced first coitus with a man seven years or more older than themselves and they were also less likely to have used contraception. Most respondents indicated that their first experience of sex was voluntary. Those who said that it had been nonvoluntary were younger, had left home before age 16 and had lived with a single parent from birth. After controlling for a number of variables, the 'wantedness', or otherwise, of sex was not significantly related to use of contraception at first coitus. The issue of intention is also pertinent to an understanding of reproductive outcomes. British researchers have also called for more meaningful and 'nuanced' measures of pregnancy intentions (Barrett & Wellings, 2000).

This is only a brief overview of structural factors that influence the timing of sex, pregnancy and childbearing. SES, family structure (and the age at which a teenager's mother begins childbearing), the provision of welfare benefits and legal codes governing age of consent might all be considered structural in nature. Other structural factors might include more macro-level societal characteristics, such as the sex ratio (Guttentag & Secord, 1983) or population density. Barber (2000), using United Nations data on population structure, showed that births to teenagers were inversely related to the sex ratio (so that the fewer males in the population, the higher the teenage fertility rate), to urbanisation and to latitude. However, like some of the studies mentioned earlier, this type of research is peripheral within the contemporary body of literature on teenage sexual and reproductive behaviour. The most important structural influences on teenage sexual and reproductive behaviour are: SES; educational attainment; family structure; and the age at which a teenager's mother starts childbearing.

### 2.2.2) Social/cultural explanations

Compared with structural explanations for teenage sexual and reproductive behaviour, social/cultural ones are much less well defined. This is surprising given that their importance is so frequently (obliquely) referred to by researchers and policymakers. The TPU, by pointing out that deprivation alone cannot explain variation in teenage pregnancy and fertility—socio-economically similar areas can have quite different teenage reproductive scenarios, for example—focuses attention on social factors influencing teenage pregnancy. The TPU appears reluctant to specify what social factors it believes play a role in the maintenance of relatively high teenage pregnancy rates. This may be because policymakers are wary of targeting specific groups or criticising aspects of their culture (or are wary of *appearing* to do so). The TPU's 'Diverse Communities' report (2002), for example, which focuses on the fertility of British minority ethnic groups, avoids condemnation of the (generally early) family-building patterns of such groups, yet provides extensive advice on how to introduce the TPS in such communities. That there might be a conflict between the aims of the TPS and the sexual and reproductive behaviour of minority groups is not addressed in the document.

Though the TPU has said very little about social and cultural values that it believes can affect sexual and reproductive behaviour, there is some evidence that the Unit believes in their existence. The authors of a recent TPU publication observe that, when working in some communities, health workers might find that: 'Local people may feel defensive about a campaign that seems to criticise the choices they have made over generations to become parents at an early age' (TPU & NRU, 2002, p.44). The idea is present, therefore, in policy discourses that some individuals and communities are *culturally* oriented to early pregnancy and childbearing (and that health workers might encounter hostility during the implementation of the TPS).

The same inability (or hesitation) to identify social influences on behaviour can be seen in the academic research. In many spatial analyses of pregnancy and fertility, the authors can only, rather tentatively, suggest possible reasons for



variation in rates—especially in those cases where deprivation alone cannot explain it. As noted in the introduction, the ‘atypicality’ of some areas is an important (but underexplored) theme in the academic literature on area variation in teenage reproductive behaviour (Bradshaw & Finch, 2001). In one local authority, Tameside in Greater Manchester, one area in the authority (Dukinfield) has one of the highest teenage pregnancy rates in Tameside but is not especially deprived in relation to other areas in the authority (Tameside Health Authority, 2002). In the Inner London area, teenage conception rates are uniformly high (as would be expected given the socio-economic profile of the area), but use of abortion is also relatively high (i.e. above the English average). High use of abortion is usually associated with wealthier areas (Smith, 1993) and Inner London clearly does not follow the trend in this respect.

As noted earlier, variation in provision of services or sex education is often suggested as the cause of differentials in teenage pregnancy and fertility rates (Berkeley & Ross, 2003; Bradshaw & Finch, 2001; Diamond et al., 1999), but many authors hint at the possible importance of other factors, especially the influence of (undefined) social and cultural messages on sexual and reproductive behaviour. For example, neither Kirby & Griffiths (2001) nor Armitage (1997), whose analyses were described earlier, attempt to offer explanations for local area differentials in fertility (it would be impossible given the type of data they used). However, Armitage, speaking of the steep fertility differentials in the ‘Coalfields’ group (a group comprising of former mining and industrial areas), and the high rates of early fertility in this area, observes that: ‘This may reflect the worst socio-economic conditions...Early childbearing, rather than continued education and careers, might perhaps have been the pattern for a long time in areas where mining offered few job opportunities for women’ (p.27).

In a similar vein, Diamond et al. (1999) note that many studies do not provide behavioural explanations for teenage pregnancy. They suggest that access to services and sex education might explain spatial variation in teenage pregnancy but also highlight the role of cultural and attitudinal factors: ‘Differences in teenage pregnancy rates could reflect....different attitudes to sexual behaviour,

being pregnant, young mothers and termination, different aspirations for the future....' (p.273). Similarly, Garlick et al..(1993) observe that:

...the reasons for teenagers both conceiving and choosing to continue their pregnancies will be multifactorial. Social factors such as parental example, the stigma of being a single parent , housing and social support will all influence the decision and many of these factors are not amenable to change (p. 139).

In Bradshaw & Finch's (2001) analysis described in the introduction, the authors conclude that: 'Having controlled for deprivation, residual variation (in rates) must be the result of other socio-cultural factors of the population or the area and/or the operation of services' (p.9). These authors do not describe these socio-cultural factors in detail, suggesting that it might include factors such as the religious beliefs and ethnicity of the local population, and the concentration of young men in army camps. Rather, using largely anecdotal information, they emphasise differences in the provision of local services.

In a study of teenage pregnancy in Tayside (also described above; Smith, 1993), where a concentration of early pregnancies and births in the poorest areas (and abortions in the wealthiest) was observed, it is suggested that one possible reason for this area variation in rates might be that: 'For girls...having a child may be more acceptable in the deprived areas than in the more affluent areas.' (p.1235). Wellings et al. (1999) also draw our attention to the importance of area-based, socio-cultural factors in their analysis of National Survey of Sexual Attitudes and Lifestyles data: '...area of residence remains a significant effect, indicating the important influence of the cultural and economic characteristics of the place where young women live' (p.188).

Many of the authors above hint at the importance of 'perception' (about sex, the timing of pregnancy and childbearing, the right age to start family-building). As recent Australian research (Evans, 2003) shows, geographically varying social influences on behaviour can have a direct effect on reproductive outcomes by informing an individual's perception of the right time for family-building.

Attempting to explain area variation in teenage pregnancy and fertility (especially the concentration of early pregnancies in rural areas), Evans maintains that:

Girls in country areas may be less likely to use contraception, particularly methods like the pill, where they have to see family doctors. There's also issues surrounding perceptions of family. In rural areas, maybe young women feel that what they want to do is to become mothers. They may be starting on their family a little bit earlier...(PM, 2003).

The fact that social/cultural influences on teenage sexual and reproductive behaviour appear to be so little understood is not an indictment of existing research; most of the research referred to above is on spatial variation in teenage reproductive behaviour and the data that is used is statistical. There are clearly limits as to how well researchers can uncover social influences on behaviour using these kind of data—which underscores the importance of conducting qualitative research alongside the manipulation of statistical data.

Influences on youthful sexual and reproductive behaviour exist, therefore, at the normative (or social/cultural level) and the material (structural) level. In the neighbourhood effects research, both of these strands are brought together. This is examined further in the next section.

### **2.3) Defining neighbourhood effects**

There is an important distinction to be made between spatial analyses that elucidate the existence of geographically varying phenomena and neighbourhood effects. As Buck observes (2001), neighbourhood differences are not the same as neighbourhood effects. For neighbourhood effects to be seen, it must be demonstrated that these effects are *independent* of individual or family-level characteristics, so that the concentration of individuals in particular areas: ‘...gives rise to externalities with an additional effect on the opportunities, behaviour and well-being of the...local population’ (Buck, 2001: 2252). Similarly, Atkinson & Kintrea (2001) describe neighbourhood effects as simply: ‘...the

independent, separable effects on social and economic behaviour which arise from living in a particular neighbourhood' (p.1). One of the most comprehensive definitions is provided by Dietz (2001):

...a neighborhood effect is a social interaction or an endogenous effect that influences the behavior or socioeconomic outcome of an individual...If the aggregate behavior of a group affects the behavior of an individual within that group, then an endogenous effect is present. Neighborhood effects also include influences on individual behavior or outcomes due to the characteristics of an individual's neighborhood. The neighborhood component refers to the fact that these effects are typically defined in the context of a spatial relationship (p.3).<sup>12</sup>

A central issue in the neighbourhood effects research, therefore, is how spatial variations in behaviours are interpreted: as 'compositional' or 'contextual' (Curtis & Rees Jones, 1998; Frohlich, Corin, & Potvin, 2001). 'Compositional' effects relate to the individual characteristics of people, so that, regardless of location, people with the same attributes, will have similar experiences. 'Contextual' effects, in contrast, arise (independently of individual factors) out of the '...social and physical environment' of the area where people live' (Curtis & Rees Jones, 1998: 648). Given this important distinction, establishing (true) neighbourhood effects is methodologically difficult, though the development of multi-level modelling techniques represents a major advance in this respect (Curtis & Rees Jones, 1998).

Although neighbourhood effects research are not well-theorised (Atkinson & Kintrea, 2001), a number of models that attempt to explain how neighbourhood effects work have been proposed. These are shown below in Table 4 (details of

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<sup>12</sup> In this definition, a distinction is made between group (i.e. peer) effects and those arising from the characteristics of a neighbourhood (which has a more distinctly spatial component and, since these are 'characteristics', may be structural in nature rather than social). Dietz separates out these two 'lines of effect', but it is sometimes not clear in the literature if peer effects are the same as neighbourhood effects, or if a distinction is being made between social and structural features of an individual's environment. Evans, Oates & Schawb (1992), for example, do not make a distinction between peer group or neighbourhood effects; these are considered to be the same.

these models have been taken mostly from Buck, 2001).

*Table 4: Models of neighbourhood effects*

<b>Type of model</b>	<b>Main feature of model</b>
Epidemic	'Contagious' behaviour is spread among individuals in the neighbourhood
Collective socialisation	Individuals are influenced by neighbourhood role models, and their behaviour is monitored by others
Institutional model	Lack of access to services affects behaviours
Relative deprivation	Evaluation of own situation <i>vis-à-vis</i> others in neighbourhood affects behaviours
Competition models	Competition for scarce resources influences behaviours
Network model	Information, support and values are spread among neighbourhood and social networks
Alternative expectations	Perceptions of success are shaped by individual or others in neighbourhood

Of these seven models, only two are straightforwardly structural. In the 'Institutional' model, lack of services affects outcomes (in relation to teenage pregnancy, this might mean that nonexistent or poor sexual health services can lead to more pregnancies). 'Competition' models are also largely structural; 'resources' are usually material and, in some neighbourhoods, are not equally distributed. The other five models are largely social/cultural, that is, they are primarily about social or cultural values, messages, norms and influences and the impact of these on behaviours and outcomes. This is especially true of the 'epidemic' (also known as 'contagion'), 'collective socialisation' and 'network' models. Within the neighbourhood effects research on teenage sexual and reproductive behaviour, the first two models are the most widely-used (Crane,

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1991). Dietz (2001) describes epidemic and collective socialisation models thus:

Contagion theories primarily investigate peer influences that are responsible for the spread of social ills...A second model is collective socialization. This model is associated with the spread of some socially positive behavior due to the interaction of individuals with role models or community networks...Collective socialization models also examine the lack of positive role models on neighborhood outcomes (p.7).

The models shown above are not mutually exclusive; many neighbourhood effects studies incorporate elements from more than one model (early sexual activity or teenage pregnancy might be considered a consequence of poor services *and* peer pressure or influences, for example). However, it is the emphasis on social/cultural factors in the neighbourhood effects research that is, arguably, the most important feature of this approach; it is this that defines its philosophical and methodological orientation. Teitler (1998) says that, generally, the conceptual backbone of most of the neighbourhood effects research is that:

...properties or norms emerge from the collective community and these norms exert their own influence on individuals' behaviors. In other words, spatially varying cultures exist that influence, shape, constrain or confine individuals' behavioral preferences or predisposition (p.1).

Similarly, in a discussion of regional contextual effects on fertility behaviour, Hank (2002) considers the importance of 'social interactions' in 'cultural milieus' and their effects on individual behaviour:

Contextual effects are likely to operate on individuals through *social interactions*. These take place mainly in intermediate groups which are defined by *spatial or social proximity*, where the content of an individual's social network is the product of her individual preferences and 'associational opportunities and constraints'. Even in times of mass media....*community norms and direct personal communication* remain highly influential (factors)...towards family formation' (p.8-9. Emphasis added).

So, while poverty and competition for scarce resources are important structural factors affecting individuals within neighbourhood settings (Burton & Jarrett, 2000), the key to understanding the operation of neighbourhood 'properties or norms' lies in uncovering the nature and scope of social interaction with others in specific social/spatial contexts. Atkinson & Kintrea (2001) emphasise this when they say that: '...it is potential neighbourhood effects which are generated through social interaction which form the core of the more complex argument that it is worse to be poor in a poor area than one which is more socially diverse' (p.8).

### 2.3.1) Neighbourhood effects studies of health-related behaviours

It is not the intention here to consider fully the large literature on the interactions between neighbourhoods (or other contexts) and health and well-being, however a brief overview of this research is presented below.

The neighbourhood effects research on health and well-being is diverse, the geographic unit of measurement (ward, local authority, regional) varies, and a range of methodologies have been used. And, as was seen above in relation to spatial analyses of pregnancy and fertility, some of these analyses are relatively simple and are confined to exploring geographic variation in specific health outcomes, though researchers have also attempted to demonstrate the independent effects of neighbourhoods or other contexts on outcomes (thus revealing the existence of true neighbourhood or 'contextual effects').

In adult populations, neighbourhood effects researchers have examined mortality (Borrell, Rodriguez, Ferrando, Brugal, Pasarin, Martinez et al., 2002; Congdon, Shouls & Curtis, 1997; Slogett & Joshi, 1994) and other aspects of health and well-being. In Slogett & Joshi (1994), excess mortality associated with residence in deprived areas was entirely explained by the concentration of individuals in those areas with the personal or household socioeconomic factors that affect mortality. In Borrell et al. (2002), in contrast, neighbourhood effects were observed in relation to injury mortality rates even after controlling for individual variables.

Van Os and colleagues (2000) examined neighbourhood variation in rates of schizophrenia in Maastricht, the Netherlands. Using multi-level models, they controlled for individual-level factors (such as age and marital status) and found that neighbourhoods have an independent effect on rates of schizophrenia. Goldsmith, Holzer & Manderscheid (1998) also examined mental health and neighbourhood settings, using neighbourhood income, lifestyle dimensions (proportion of the population living in non-family households) and ethnicity as explanatory variables. In logistic regression, only neighbourhood income level was significant and the authors concluded that individual-level factors are more important in explaining mental illness.

Ross (2000), in an analysis of walking in neighbourhoods, found results in the opposite direction to that hypothesised. She expected residents of poor neighbourhoods to walk less (because of a fear of victimisation) yet, after controlling for individual variables, discovered that these residents walked more than people in more affluent neighbourhoods. She suggests that poor neighbourhoods may have a: '...culture in which people hang out on the street, walk to visit someone in another apartment building...' (p. 271).

In child and adolescent populations, neighbourhood effects research has examined: teenage aggression in poor neighbourhoods (Cleveland, 2003); youth smoking (Wilcox, 2003); child maltreatment (Garbarino & Sherman, 1980); neighbourhood influences on children's cognitive ability (Joshi & McCulloch, 2000); and the educational attainment of teenagers (Bowen, Bowen & Ware, 2002).

A recent overview of the literature on child and youth outcomes in neighbourhood contexts (Leventhal & Brooks-Gunn, 2003) made an important distinction between non-experimental and experimental neighbourhood effects research. The latter are rare; the financial, practical and methodological difficulties of moving people from poor neighbourhoods to wealthier ones (or *vice versa*) to observe outcomes at some (possibly very distant) point in the future would be ordinarily insurmountable. However, there do exist two well-known and high



profile US examples of experimental studies of neighbourhood effects: the Gautreaux Program and the Moving to Opportunity Program. In the former, the programme was implemented after a court order to desegregate Chicago's public housing was decreed. The second was a programme implemented across five US cities in which 4,600 families in public housing were randomly assigned to other types of neighbourhoods. These programmes are considered to have improved youth outcomes in respect of enhanced educational attainment, better mental health and reduced rates of criminal activity (Leventhal & Brooks-Gunn, 2003).

These experimental studies provide invaluable evidence that residence in a specific type of neighbourhood or community context influences behaviours, even though individual characteristics (income, family structure) remain constant. The implication is that the neighbourhood normative environment (which is created and reinforced by neighbourhood structural features and the social characteristics of its residents) alters life trajectories.

The importance of the neighbourhood normative environment is highlighted in a study of low birth weight among Mexican mothers in California. A relationship between better weight outcomes and living in an area with a high Hispanic population was observed for Mexican mothers (but not for Whites), independently of individual characteristics. The authors observed that:

...there is...an ameliorative effect of living in a Hispanic enclave for Mexican-origin women. Furthermore, this benefit is not experienced by non-Hispanic whites in the same neighborhoods, which is consistent with a theoretical perspective that emphasizes the importance of culture...Although we have identified the existence of a spatial, residential pattern, we do not have data to confirm what it is about living in those areas that precisely confers the cultural protection....qualitative in-depth analyses would...bear fruit in terms of furthering our understanding of the underlying protective mechanisms (Peaks & Weeks, 2002:135).

Here, the mechanisms promoting low birth weight are attributed to aspects of the local 'culture', though the link between this and outcomes are not specified (i.e. what aspects of culture affect outcomes?) As the authors observe, qualitative research would be appropriate to explore this issue further.

### 2.3.2) Methodological and other considerations

Diverse and interesting though this body of research is, neighbourhood effects have not been demonstrated conclusively, and findings are sometimes contradictory (Curtis & Rees Jones, 1998). This may be, in part, because this research is not well-developed theoretically (Atkinson & Kintrea, 2001). Contradictory findings may also be attributable to methodological limitations (Bauder, 2002; Teitler, 1998) or the pitfalls of the 'ecological fallacy' (i.e. erroneously attributing macro-level behaviour or phenomena to individuals). There is also a great deal of acknowledged difficulty defining 'neighbourhood' or local area (Buck, 2001; Leventhal & Brooks-Gunn, 2003). How can these concepts be meaningfully operationalised? In the US research, neighbourhood is often denoted by census tract data or by zip code, though residents' perception of neighbourhood might provide a more meaningful measure of neighbourhood (Coulton, Korbin, Chan & Su, 1997; Pebley & Vaiana, 2002) since neighbourhoods defined by zip code are usually larger than neighbourhoods defined by residents of an area (Crane, 1991).

There are also valid issues about the relevancy of this large body of work outside the US. Most of the US neighbourhood effects research on teenage behaviour examines the sexual and reproductive outcomes of 'ghetto' residents, who are usually Black or Hispanic. Transferring this approach to a British (or any national or subnational) setting is potentially problematic (Atkinson & Kintrea, 2001). The UK probably does not have ghettos, though it has many run-down and unsafe neighbourhoods (SEU, 2001). Youthful pregnancy and childbearing is also not confined to non-Whites. Racial or ethnic differentials in early pregnancy and parenthood have not been adequately described, partly because of deficiencies

in available data.<sup>13</sup> Though early childbearing is common among some minority groups, such as Pakistanis and Bangladeshis (Berthoud, 2001).

The fact that US ghettos are also geographically bounded and socially isolated in a way that is not comparable to British neighbourhoods also limits the use of neighbourhood effects approaches. However, it can be difficult to demonstrate neighbourhood effects even in the US case; the rise of global commercialism means that the values of people in even the most isolated communities can be shaped by more universal forces:

Fundamental changes have occurred in communication and transportation since we shifted our interests from ethnically segregated neighborhoods to racially or class segregated neighborhoods. One potential consequence of these changes is that youth, in particular, are socialized as part of a more global and universalistic culture... Race, gender and class identities clearly shapes adolescent experiences, but, given that youth are of one race or one gender or one class, it is likely that they share many of the same influences and language as their counterparts across town, or across the country (Teitler, 1998:18).

The neighbourhood effects research can also be controversial. There are theoretical similarities between this research and that produced by underclass theorists (Atkinson & Kintrea, 2001). Both bodies of work are centrally concerned with neighbourhood normative environments. There are, however, crucial differences between the two traditions. In underclass research, the behaviour of people in poor neighbourhoods is condemned because it is considered to be damaging to their life prospects. Murray (1996), the most prolific of the underclass theorists, believes that the 'dysfunctional' norms of some poor communities 'infect' neighbourhood residents:

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<sup>13</sup> Ethnic variation in sexual debut and activity is another under-explored area. High rates of sexually transmitted infection have been seen in Black Caribbean populations in the UK especially among individuals who report early sexual debut (Arai & Harding, 2002).

Britain has a growing population of working-aged, healthy people who live in a different world from other Britons...and whose values are now contaminating the life of entire neighbourhoods, which is one of the most insidious aspects of the phenomenon, for neighbours who don't share those values cannot isolate themselves (p.25).

In contrast, Atkinson & Kintrea (2001) emphasise that neighbourhood effects theorists emphasise *structural* influences on behaviour and do not seek '...to pathologise individuals or places' (p.8). Not all commentators would agree, however, with this interpretation. Bauder (2002) argues that, viewed from the mainstream, the norms governing behaviour in marginalised communities are considered dysfunctional. He believes this is mistaken, and observes that: 'Distinct cultural identities form within the context of the local community...childrearing ideologies, the meaning of motherhood, standards of 'making it'...differ between neighbourhoods' (p.89). The existence of distinct neighbourhood norms governing behaviour, or standards of 'success' that are different to mainstream ones, does not render them dysfunctional.

The idea of neighbourhood effects can also seem condescending. In some of the research there is an implication that youth (in particular) are naïve and gullible, and are easily influenced by their friends others in their social and neighbourhood networks. For example, Crane (1991), speaking of neighbourhood effects on teenage childbearing and school drop-out rates, observes that:

...these behaviours may not be determined by fundamental attitudes or deeply rooted personality traits....the short-term dynamics of peer interaction are an important determinant of these problems....If short-term phenomena are responsible for these problems, short-term policy interventions might be quite effective (p.1248).

This perspective not only attributes a degree of gullibility to teenagers that may not be accurate, but it also diminishes the role that individual and family factors play in influencing behaviour and outcomes.

Possibly the most problematic aspect of the neighbourhood effects approach is that it relies on a distinction between contextual and compositional effects that is both inaccurate and unhelpful (Frohlich et al., 2001). There is likely to be a symbiotic relationship between 'context' and 'composition'. As Frohlich and colleagues observe:

...what are currently known as compositional and contextual effects are mutually reinforcing and jointly influence health outcomes. Furthermore, this dichotomy may be a false one as both the attributes of people and the resources in 'space', will impinge on the social relations and practices found in 'place' (p.783).

Yet, much neighbourhood effects research has been devoted to separating out compositional and contextual effects, and thus reinforcing the idea that these are distinct and separable. (This important point has implications for the methodological approach adopted here and is discussed further in the next chapter).

## **2.4) Teenage sexual and reproductive behaviour in the neighbourhoods effects literature**

### **2.4.1) Introduction**

Adolescent health and well-being (broadly defined) is the focus of much neighbourhood effects research (Duncan & Raudenbush, 1998; Leventhal & Brooks-Gunn, 2003). This may be because individuals—after the long period of childhood when they are tied to the home and their family—branch out in adolescence, geographically and socially, and form ties with same-aged peers in school and community contexts (Furstenberg, 2000).

However, in a review of the literature exploring the place of families in urban neighbourhoods and teenage health and well-being (Burton & Jarrett, 2000) the growth of research on neighbourhoods is considered to be driven, in part, by four factors: first, the growth of 'concentrated' poverty in urban environments: second, the rise in numbers of minority immigrants in the inner cities: third, 'vivid'

journalistic, media accounts of 'social pathologies' in urban areas that prompted concern for the well-being of children and youths; and, fourth, the development of new methodologies and approaches to analysing the lives of individuals in 'multiple ecological contexts' (p.1115). Furstenberg (2000) describes a '...huge outpouring of studies' on school and neighbourhood contexts in the 1990s, and specifically links the re-emergence of neighbourhood studies to an interest in the 'urban underclass'.

Of nearly 40 neighbourhood effects studies identified in an interdisciplinary (non-systematic) review of the literature (Dietz, 2001), approximately 24 considered outcomes for teenagers and/or children. At least a third of these examined aspects of teenage sexual behaviour and/or reproduction. Many of these studies of teenage sexual and reproductive behaviour utilised 'contagion' (or 'epidemic') or 'collective socialisation' theoretical models of behaviour.

Despite the growth in the research literature, and the development of increasingly sophisticated methodologies to measure neighbourhood effects, on balance (and in relation to outcomes for teenagers) the evidence for the existence of neighbourhood effects is equivocal. Manlove, Terry-Humen, Romano Papillo, Franzetta, Williams, & Ryan (2001) maintain that the conclusions reached in most neighbourhood effects studies of teenage sexual and reproductive behaviour is that individual and family factors have a greater impact on outcomes than neighborhood characteristics. In his discussion of the utility of neighbourhood effects studies of teenage behaviours, Furstenberg (2000) says that using multilevel techniques to measure contextual effects:

...has not shown a strong impact of the quality of the neighbourhood, independent of the effects of demographic characteristics of the resident families... Rather, impacts of each context are modest and additive. It seems that adolescent development is shaped and directed by the combination of contexts rather than by any single setting (p.903).

This is an important point: neighbourhoods and other social contexts probably have only moderate effects on behaviour (Leventhal & Brooks-Gunn, 2003), and this may be true in even the poorest and most disorganised communities. The 'vivid' journalistic, media accounts of 'social pathologies' in urban areas mentioned above as partly responsible for the growth of the literature on neighbourhoods tend to understate this point; such accounts often ascribe to neighbourhoods the capacity to radically change individual behaviour (usually for the worst) (Murray, 2001; 1996). The observation that neighbourhoods, and other social contexts, are influential *in tandem with* family and individual factors provides a salutary rejoinder to the perception of some neighbourhoods as a breeding ground for pathological behaviour (Crane, 1991).

#### 2.4.2) Assessing the research

The neighbourhood effects research on teenage sexual and reproductive behaviour is difficult to appraise as a canon of work; there is wide variety in this literature in the theoretical perspective underpinning the research, conceptions and measures of neighbourhood, the number of variables used in the analysis, the population under study, outcome measures and analytic approach. In addition, while much of the literature focuses on teenage sexual behaviour (especially sexual debut) and pregnancy—and there is comparatively less research on fertility—a variety of outcomes (sexual debut, use of contraception, pregnancy, fertility) are sometimes examined together in one study. (Authors sometimes appear not to be sure what aspect of behaviour they are examining. In a highly influential study of the mid-1980s, the title refers to the 'fertility of Black adolescents' yet pregnancy, not birth, is the outcome variable; Hogan & Kitagawa, 1985).

#### *Overview*

However, despite this diversity, there are some central elements that are common to most neighbourhood effects research on teenage sexual and reproductive behaviours; these are centred around the domains of 'neighbourhood' 'family' and 'peers' (or other social contacts).

The basic premise of most neighbourhood effects research is that, in poor communities, where opportunities are restricted and the conventional means of attaining adulthood thwarted, individuals are especially susceptible to the influences of those around them (peers, friends, neighbourhood residents). Where early sex, pregnancy and fertility are commonplace, this will be communicated not only by the visibility of pregnant and parenting young women but also by peer messages about the acceptability of early sexual activity, conception and childbearing.

Unless the family is able to protect the interests of its members, teenagers will succumb to these 'deviant' wider social influences. In order to do this most effectively, the family has to be cohesive, parents have to be resourceful, exercise appropriate authority over their children and impart messages about behaviour and expectations of life that are different to those that are present in the immediate social context (Anderson, 1991). So, a central idea in neighbourhood effects research is that parents (or other authority figures) are positioned between teenagers and the potential (possibly harmful) effects of wider social influences, especially in poor neighbourhoods (Anderson, 1991; Ceballo & McLoyd, 2002; Hogan & Kitagawa, 1985; Furstenberg et al., 1999; Moore & Lindsay Chase-Landale, 1999; Xiamong, 2000; Zabin Schwab & Hayward, 1993). Furstenberg et al. (1999) refer to the processes by which parents manage the 'external world' for their children by monitoring and supervising their behaviour, and guiding them to 'safe social contacts', as 'family management strategies'.

Some of the best examples of how parents (and others) safeguard children in difficult social and physical contexts are provided by qualitative researchers. Though the focus is on younger children, Jarrett & Jefferson's (2003) study of parenting strategies among low-income, African American mothers in a Chicago housing project describes the tactics employed by parents to 'protect' their children. The authors identify key 'buffering' strategies, such as monitoring of behaviour, warnings, chaperonage and confinement of the child. In Anderson's (1991) ethnographic research undertaken in poor, African-American



neighbourhoods, the family is pivotal in the promotion of children's best interests (which, for Anderson, do not include teenage pregnancy). Anderson describes the existence of community-wide norms favouring early sexual experimentation, pregnancy and childbearing, their transmission and perpetuation by peers and neighbourhood residents, and attempts by parents to counter them (primarily by supervision of behaviour and monitoring of peer group activities). One of Anderson's respondents spoke about the efforts of her father to monitor her behaviour and interaction with neighbourhood peers: ' My father was over-protective. Though I didn't at the time, I now appreciate it' (p.386). The young woman, according to Anderson, grew up hearing '...the extremely important message that her parents care about her and expect her to have a future without youthful pregnancy...' (p.386).

As noted above, parental monitoring of behaviour in resource-poor, and sometimes dangerous neighbourhoods, can be done most successfully where the family is cohesive, parent-child relationships healthy and the channels of communication open (Manlove et al., 2001; Miller, Benson & Galbraith, 2001). Positive family functioning can also affect how pregnancies are resolved; teenagers who opt for motherhood are more likely to be satisfied with their decision if they have had support from their own mothers (Eisen & Zellman, 1984). Where a parent has a good relationship with a child, the parent is better placed to monitor their child's activities and efforts to supervise dating or sexual behaviours, in particular, will be better received. The greater rates of early sexual activity, pregnancy and childbearing among teenagers from lone parent families may be due, in part, to the difficulties of ensuring that the above conditions are met, as well as to the practical difficulties of supervising behaviour where only one parent is present.

Direct monitoring of children's behaviour may not even be necessary; even the perception that a mother disapproves of sexual activity is enough to influence a child's behaviour (though this appears to work best when the mother-child relationship is a good one). In an examination of the relationship between teenagers' perceptions of maternal disapproval of sexual intercourse, and sexual

outcomes (in his case, sex, pregnancy and use of contraception), an important distinction was made between *perception* of maternal disapproval by the teenager and *actual* maternal disapproval, since the correlation between these two has been shown to be weak in earlier studies ( $r = .28$ ).

The analysis of data collected from a 10,000-strong, school-based population utilised a number of measures relating to the mother-child relationship and sexual outcomes.<sup>14</sup> The results suggest that teenagers who believed that their mothers would disapprove of them engaging in sex, and who reported a good relationship with their mother, were less likely to engage in sex or to become pregnant when outcomes were measured a year later. This was true even for teenagers who had already experienced sexual intercourse, suggesting, say the authors, that '...a mother-based message of abstinence may have an impact for virgins and nonvirgins' (Dittus & Jaccard, 2000: 277).

Where parental abilities to monitor behaviour appear to have broken down, or have been unsuccessful, this may affect the treatment of other children in the family. East's (1999) analysis of 174 urban Californian mothers suggested that, once an teenage daughter has become pregnant (and plans to keep the baby), mothers are less likely to monitor other children in the household so closely.

Parental monitoring works best when family functioning is positive, but parental example is also important. The increased likelihood of teenage fertility among the daughters of teenage mothers has already been noted. The daughter of a teenage mother is one and a half times more likely to become a young mother herself than the daughter of an older mother. In Inazu & Little Fox's (1980) sample of 449 mother-daughter pairs from high schools in Detroit, the most powerful effects on daughters' sexual behaviour were indirect ones: the maternal role model and relationship with the daughter were more important than direct monitoring. Interestingly, the authors say that communication about sexual issues

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<sup>14</sup> Teenagers' perceptions of maternal attitudes towards them engaging in sex and using contraception; satisfaction with mother-child relationship; teenagers' perceptions of maternal control; actual maternal attitude towards teenager's sexual activity; the teenager's propensity to provide 'socially desirable' responses; the teenager's physical development.

did not have an effect on daughters' sexual behaviour.

Parental monitoring can extend to the teenager's peer group, and peer group activities. The nature of the interaction between a teenager and her peer group does not operate in isolation of other factors: peer influences operate within contexts, not outside them (Bradford Brown, 1990). Bradford Brown says that, when deviant peer groups exist, they are not composed of 'all-American kids turned bad by peer influence' (p.193). They are, instead, individuals who have pre-existing problems and seek out like-minded fellows.

Cooper & Cooper (1992) make the same point in their examination of the links between teenagers' relationships with parents and peers. They outline the two dominant views of teenage peer relationships that are found in the literature. The first is one that sees peers as 'bad' and having a negative influence on teenagers. The other view is one that sees them as 'good' and instrumental in assisting the teenager on the road to maturity. These competing views have shaped the discourses on the linkages between teenagers, families and peers.

There is a large body of research on peer influences on teenage sexual and reproductive behaviours. In a frequently cited paper of the early 1990s (Evans, Oates & Schwab, 1992), teenage pregnancy was selected as the outcome variable to explore peer group effects because, the authors maintain, pregnancy is a behaviour '...for which peer group effects are thought to be especially important' (p. 971). This analysis used US longitudinal data on over 12,000 individuals and peer group effects were measured by the proportion of children in the respondent's school who came from poor families. In the initial analysis, peer effects were significant, but disappeared in further analysis.

Kinsman, Romer, Furstenberg & Schwarz (1998) examined the role that peers play in the initiation of sex using cohort data collected from urban US schoolchildren (n=1389). Teenagers who had experienced sexual intercourse at the end of the school year (a year after completing the initial questionnaire) were more likely to be male and living in a lone parent family than those who remained virgins. In addition, they were more likely than virgins to perceive a high

prevalence of sexual initiation among peers. In multivariate analysis, the strongest predictor of sexual behaviour was the stated intention to engage in sex at the start of the school year. Intention was strongly influenced by the individual's perception that their friends had already initiated sexual intercourse. Prinstein, Meade & Cohen (2003) observed similar findings in their analysis of data on 212 New England schoolchildren (though their focus was on peer influences on oral sexual activity). In a British study (Burack, 1999), a quarter of the teenage respondents (n=1500) reported that their peers made them believe that 'sex is the main thing in a relationship'. Respondents who had already initiated sex were also significantly more likely to report being influenced by peers than respondents who were virgins (36% compared with 25%,  $p < 0.001$ ).

Some research has examined the role that *both* hormonal factors and peers have on teenage sexual behaviour. In a US study (Udry, Talbert & Mierns, 1986) that explored racial and gender differences in timing of first intercourse (and measured respondents' hormone levels), the researchers noted that the sources of social influence on White females' initiation of coitus were 'many and strong'. In contrast, the sources of social influence for White boys were 'few and far between' (p.72). No social influences on coital transition were demonstrated for Black virgin females; for them, the only variables predicting initiation of intercourse were pubertal development and stated sexual intentions. Speaking of White female teenagers who made the transition to coitus, the authors maintain that peer influences are paramount:

...virgins who had a best boyfriend and a best girlfriend who had both had sex were six times as likely to debut as girls who had only one of the two who were experienced, and more than 20 times as likely to debut as the girl who had neither a best boyfriend or a best girlfriend who had had sex' (p.74).

Thus far, the pertinent issues within family and peer contexts have been described. A key feature of neighbourhood effects research is the identification

of the salient neighbourhood characteristics that are most likely to affect behaviour. Most neighbourhood effects studies, because they use statistical data, are limited in how well they can explore aspects of the neighbourhood normative environment (though this may be measured using statistical proxies; neighbourhood disorganisation can be measured by the proportion of the population that commit crime, for example. Cohesion by the degree of participation in community activities; Furstenberg et al., 1999). These are valuable measures of the neighbourhood normative environment, but are only statistical approximations and tell us nothing about how norms are transmitted (Teitler, 1998). In this respect, perceptions of the neighbourhood environment generated through the use of qualitative methodologies may be more useful.

Within the neighbourhood effects research, there are few studies using qualitative methodologies that have examined the neighbourhood normative environment<sup>15</sup> and teenage sexual and reproductive behaviours. The work of the American ethnographers, Elijah Anderson (1991; see above) and Linda Burton (1997; 1990) is exceptional in this respect. Burton's five year long work in poor, African-American urban communities (utilising a number of data collection methods, such as focus groups, life history interviews, participant observation) generated a wealth of material on the meaning of adolescence among teenagers in disadvantaged neighbourhoods, and the impact of this on reproductive behaviours. Burton describes the existence of an 'alternative life-course strategy' among families in poor communities, one of the principle features of which is an 'accelerated life course'. This means that demographic transitions (to sexual activity, pregnancy and childbearing) are faster than they would be in wealthier populations. The earlier fertility of individuals in resource-poor environments means that family structures are 'age condensed' with a narrow distance between generations. Within such populations, adolescence does not emerge as a distinctive life stage, and the relative maturity of teenagers in high-risk

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<sup>15</sup> Outside the neighbourhood effects literature on teenage sexual and reproductive behaviour, there are a number of studies using qualitative methodologies examining individuals' perceptions of their neighbourhoods and the impact of this on health and well-being. A recent example is provided by Morrow (2001).

neighbourhoods means that they inevitably come into conflict with authority figures in schools and other institutions, where they are likely to be treated as children and not as the young adults that they believe themselves to be.

Burton's observations about the existence of the accelerated life course resonate with the findings from recent British qualitative research of neighbourhood effects on teenagers' decisions to continue with an unplanned pregnancy (Tabberer et al., 2000). The importance of the neighbourhood context is highlighted by the authors who maintain that: 'When abortion is discussed it is usually within a framework of private individual choice without examining the social context in which choices are actually made' (p.2). The analysis of qualitative data collected from teenagers living on Doncaster housing estates revealed the existence of strong, local anti-abortion norms that deterred pregnant young women from seeking termination of pregnancy. Like Burton, these authors explain early fertility by reference to an accelerated life course strategy:

Policy should...recognise the different conceptions and experiences of the life course for younger people in disadvantaged communities...maturity and claims to social competency arrive much earlier here than is seen to be the norm...there may be quite different time-frames that circulate in particular community cultures, which help normalise younger pregnancies...(p.47-8).

It is not difficult to envisage how, at aggregate level, a normative environment which is (for example) opposed to abortion can be instrumental in the creation of local cultures of early childbearing. The geographic concentration of such cultures may, in part, explain area variation in youthful pregnancy and fertility. A noteworthy similar example was provided by a health worker in the Wirral, UK. In this case, a more explicit link was made between community and family norms governing childbearing and reproductive behaviour. When asked to explain high teenage pregnancy rates in her locality, the health worker replied that:

We talk about 'normality for locality'—meaning that in a young woman's neighbourhood, she may have family members and friends under 20 years old who have had babies. Where becoming a mum a 17, 18 or 19 doesn't carry a stigma (Corbett, 2003).

Similarly, Macleod & Weaver (2003) observe that, in their sample of Hull teenage mothers, many women maintained that being a teenage mother in their neighbourhoods was culturally acceptable; the support offered to the young mothers by family and friends was tangible proof that this was the case.

*Key examples of neighbourhood effects studies on teenage sexual and reproductive behaviour*

The salient features affecting teenage sexual and reproductive behaviour within family, peer and neighbourhood contexts are described above. The interaction of these factors can be seen in some key examples from the literature.

In an early (and much cited) neighbourhood effects study (Hogan & Kitagawa, 1985) of pregnancy among Black teenagers in Chicago, the authors suggest that, in poor neighbourhoods (which may be characterised by large teenage populations, few play areas and prevailing community norms that discourage academic success) parents may '...lose control over their children...' (p.831). This can affect teenagers' sexual behaviour and lead to early pregnancy. In this study, just one measure of neighbourhood quality was used (though this was a composite measure based on a principle components analysis of census tract-level demographic, social and economic data), and this was divided up into 'high', 'medium' and 'low' neighbourhood quality categories. Family structure, social class and parental monitoring of dating were included in the analysis.

About 23% of teenagers in the lowest quality neighbourhood had experienced a pregnancy compared with 14% of teenagers in the highest quality neighbourhood. Higher proportions of women in poor neighbourhoods were sexually active (42% compared with 31% in high quality neighbourhoods). Once the effects of parental supervision were controlled for in the analysis,

neighbourhood quality had little effect on outcomes, which implies that '...the effect of neighbourhood quality on adolescent pregnancy...is mediated by parental control of early dating behaviours' (p. 851). Overall, women living in poor neighbourhoods, from 'lower' social classes, large and lone parent families, who had sisters who were teenage mothers and who were not closely monitored by parents were 8.3 times more likely to become pregnant than women with all the opposite individual, family and neighbourhood characteristics.

This study represents an early example of neighbourhood effects research, though only one (composite) measure of neighbourhood quality or attribute was used and a comparatively simple analytic approach was employed. In later studies, a greater variety of measures of neighbourhood structural and normative features are used. There is considerable variation across neighbourhoods effects studies in the use of neighbourhood or other community measures. Gold et al. (2002) used (US) state-level measures of social capital to measure community attitudes and the Gini coefficient to measure state-level socio-economic inequality. Crane (1991) used the proportion of people with professional or managerial jobs in the neighbourhood to measure neighbourhood effects on teenage childbearing; in this study, the probability of childbearing decreased as proportion of high-status workers increased in the neighbourhood. Upchurch, Sucoff, & Levy-Storms (1999) devised a classification of neighbourhood types based on class and ethnicity. Respondents' perceptions about the type of neighbourhood they live in were also used; this included physical and social aspects of the neighbourhood (level of threat perceived by the respondent, the standard of housing, the visibility of drug dealing).

In another oft-cited study of transition to sexual activity among teenage Black women (Brewster, 1994) a variety of measures of neighbourhood status were utilised. These were: community measures of SES; female labour force participation; the proportion of separated/divorced women in the local population; the index of 'marriageable males'; racial composition; and youth idleness. Of these, neighbourhood SES, the proportion of women who are divorced/separated in the community, female employment and youth idleness were all significantly



associated with sexual debut/and or contraceptive use in the multilevel analysis. Greater effects were seen for women living in large urban areas.

A wide variety of community-level variables were used by Billy and colleagues (Billy, Brewster & Grady, 1994; Billy & Moore, 1992; Brewster, Billy & Grady, 1993). In the most recent of these studies (Billy et al., 1994), the focus was on the sexual behaviour of teenage women. Community characteristics (female labour force participation, aspects of local demography such as the sex ratio, local health services) were used in the analysis, and three outcomes were measured: the likelihood of nonmarital first intercourse; coital frequency; and the consistency of exposure to intercourse (the examination of sexual behaviour *after* first coitus is unique). Community-level characteristics, the authors maintain, affect sexual behavior ‘...by providing a structure of constraints that shape the knowledge and attitudes that ultimately guide teens’ choices about their sexual behavior’ (p.388). In this study, social disorganisation, SES, religiosity, female labour force participation, population composition, and family planning service availability all affected White and Black teens’ sexual behavior, with some of the effects operating indirectly via their influence on the individual’s own characteristics or family background. In conclusion, the authors say that even very personal behaviour, such as sexual intercourse, is influenced by community characteristics.

Most neighbourhood effects studies do not consider in detail the psycho-social mechanisms linking residence in specific types of neighbourhoods to behaviours and outcomes. In an analysis of race and gender differences in teenage sexual behavior (Lauritsen, 1994), there is a detailed consideration of social control and strain theories of behaviour and their usefulness in explaining sexual behaviour. The former holds that deviance is the result of a lack of bonds to conventional society, and the latter that deviance is the result of ‘strains that conformity to accepted social norms’ will not satisfy. According to strain theory, individuals who lack legitimate opportunities for achieving goals of success are hypothesised to be highly *motivated* to commit deviant acts because the discrepancy between goals and the means for achieving goals is large. Social control theory asks what

factors *prevent* individuals from engaging in nonnormative behavior: 'As a result of these assumptions, control theorists do not ask what motivates adolescents to engage in sex, but instead what factors prevent so many more from doing so' (Lauritsen, 1994:862).

Data were taken from the National Youth Survey (n=1725) and the independent variables were taken from individual and community domains. These included: race; sex; age; family structure; family income; and a neighbourhood disorder index (which was created using parents' responses to questions about type of area they lived in). The results of the logistic regression suggest that both theories might be useful in explaining sexual behaviour, though there were differences by gender and race. Social control theory appeared to explain sexual behaviours among Whites, while strain theory better explained Black female sexual activity. While neither theory explaining Black male behaviour. The results suggest that race is not significant once family structure and neighbourhood conditions are controlled for.

Lauritsen believes that teenagers may be strongly motivated to have sex but, for reasons suggested by social control theory, many do not. Sexual intercourse might be seen as behaviour that occurs among teenagers 'who are free to do what they want' (p.879). For Black females, strain theory was more relevant; their inability to achieve life's goals appears to be: '...driving individuals to do things they otherwise would not do...Probably a larger proportion of Black females are engaging in intercourse in response to strain and...for the purpose of achieving an alternative goal' (p.879).

Most analyses of teenage sexual and reproductive behaviour focuses on females (or on females and males together) . In Ku, Sonenstein & Pleck (1993), the effect of neighbourhood, family and personal characteristics on the premarital sexual behaviours of US teenage males alone are examined. A number of outcome variables were utilised: number of female sexual partners in last 12 months; frequency of intercourse in last 12 months; use of contraception; ever having made someone pregnant; and ever having fathered a live birth or current

pregnancy. Explanatory variables included: neighbourhood employment opportunities; the take-up of welfare benefits; degree of community poverty; family-of-origin income; educational attainment; the sex ratio; ethnicity; the number of female-headed families in the community; family living arrangements; age; and metropolitan residence. Data from the National Survey of Adolescent Males (n=1880), and three sets of multivariate models were constructed (neighbourhood only, personal only, the two combined).

The results show that both neighbourhood and personal factors are related to the sexual behavior of males, with the latter being more important than the former. Counterintuitively, there was a positive relationship between personal income, the number of hours worked and sexual activity, with young men who scored highly on the former having higher rates of sexual activity. This, it is suggested, is because these young men have more resources and are, therefore, more able to date women. However, they are not more likely to use contraception, and thus have higher impregnation rates.

The most consistent neighbourhood predictor of pregnancy and fatherhood was the unemployment rate, which seems paradoxical, given that more employment in a neighbourhood decreases the risk of impregnation or fatherhood, but that more employment on a personal level increases it. Being behind at school was associated with risk of impregnation, fatherhood and less use of contraception. The proportion of the neighborhood under the poverty level was marginally associated with having more partners and more frequent sexual intercourse, but was also associated with greater use of contraception and reduced risk of impregnation, after controlling for neighbourhood and other personal traits.

Many neighbourhood effects studies examine behaviours across different types of neighbourhoods (i.e. poor, moderate and wealthy areas. See Hogan & Kitagawa, 1985). In one study (Moore & Lindsay Chase-Landale, 1999), the focus is on neighbourhood effects *within* poor communities only. In this research, the family unit is considered to influence sexual and reproductive outcomes in three ways: through socialisation; by supervision/monitoring of children's

activities; and 'structurally' (i.e. the number of parents in the family and the instability caused by marital disruption). Neighbourhood dimensions were measured using three scales (neighbourhood social support, peer influence and the proportion of the adult population in receipt of welfare).

The results from the logistic regression indicated that community environment was not significantly associated with sexual intercourse among teenagers but it was for pregnancy. Young women who lived in neighbourhoods which (although poor) were characterised by high levels of social support and low levels of adults receiving welfare were less likely to become pregnant than women in neighbourhoods with the opposite characteristics. Peer influence also appeared to make a difference to pregnancy outcomes.

It has already been noted that neighbourhood effects research on teenage sexual and reproductive behaviour using British data is uncommon. A noteworthy exception is provided by McCulloch (2001). Using 1991 census data, McCulloch described the characteristics associated with early motherhood (economic inactivity, living in local authority housing) and geographical variation in teenage childbearing. This was, as might be expected, strongly correlated with area deprivation. However, when adjustments were made for personal disadvantage, the association of teenage fertility with area of deprivation was reduced. The implication of this is that specific neighbourhoods do not 'promote' early childbearing; rather it is the concentration of women with the characteristics that predispose to early motherhood in specific locales that explains area variation in teenage fertility. McCulloch concludes, however, that since the association between teenage fertility and area disadvantage does not disappear in multivariate analysis, area characteristics as well as individual ones are important to our understanding of youthful motherhood.

## **2.5) Conclusion**

In the neighbourhood effects literature, factors that affect teenage sexual and reproductive behaviour are both structural and social/cultural. That is, the focus is on *material* and *normative* influences on outcomes. While the neighbourhood

effects approach offers an opportunity to explore the multiplicity of factors that affect behaviour, it is not methodologically unproblematic; neighbourhood effects can be difficult to demonstrate and this approach may be useful only in certain settings.

There is a large body of work on teenage sexual and reproductive behaviour in neighbourhood settings. Despite diversity in this research, most neighbourhood effects studies revolve around the same core themes. The neighbourhood effects argument is that, in poor communities—where opportunities are restricted and the 'conventional' means of attaining adulthood thwarted—individuals are susceptible to the influences of those around them. Where early sex, pregnancy and fertility are commonplace, this will be communicated not only by the visibility of parenting young women but also by peer messages. Unless the family is able to protect the interests of its members, teenagers will succumb to these 'deviant' influences. To do this, the family has to be cohesive, parents have to be resourceful, exercise authority over their children and impart positive, alternative messages.

In sum, then, the neighbourhood effects approach in relation to teenage sexual and reproductive behaviours hinges around: the nature of the neighbourhood (its level of deprivation, its material and social features, level of safety); the family (its structure, material resources, the nature of parent/child relationship, parental monitoring of children's behaviour); and peers (their engagement in 'deviant' activities, degree of influence over others). These are the core themes that guide the analyses presented below.

## **Chapter Three: Methodology and Respondents' Characteristics**

### **3.1) Introduction**

In this chapter, the methodology used in the thesis will be described. A key feature of the present research is the use of both quantitative and qualitative methods—the former in a secondary analysis of the BCS, and the latter in an analysis of material gathered via in-depth, semi-structured interviews in three English locations.

In the first section below, there is an exploration of the two research traditions, and also of the use of mixed methods. The methodology used is described next. The measures used in the analysis of the BCS, and the issues explored in the interviews, are discussed. After this, there is a section on the selection and recruitment of respondents and the interview process. The limitations of both methods are also discussed and substantive results are presented in the next three chapters.

### **3.2) Methods and mixed methods**

The use of two or more research methods in the same project is not unusual, though traditionally qualitative and quantitative methods are cast as opposites (Rank, 1992; Silverman, 1997). Bryman (1999) provides a useful description of the attributes of the different research traditions, which are summarised below in Table 5.

*Table 5: The differences between quantitative and qualitative research*

	<b>Quantitative</b>	<b>Qualitative</b>
Role of qualitative research	Preparatory	Means to exploration of actors' interpretation
Relationship between researcher and subject	Distant	Close
Researchers' stance in relation to subject	Outsider	Insider
Relationship between theory/concepts & research	Confirmation	Emergent
Research strategy	Structured	Unstructured
Scope of findings	Nomothetic	Ideographic
Image of social reality	Static and external to actor	Processual and socially constructed by actor
Nature of data	Hard, reliable	Rich, deep

Table taken from Bryman (1999)

The attributes of the two methodological approaches described above are (for the purposes of description) idealised and overly polarised. In reality, neither research tradition has exactly all these attributes nor are they so distinct (Greenhalgh, 1997; Silverman, 1997). Surveys, for example, are not always strongly structured, and often include open-ended questions. Survey data are not always reliable; in large, multi-item surveys, respondents might tire of ticking boxes and responses are likely to become meaningless. Likewise, interview data are not always 'rich and deep'. The 'success' of an interview is heavily dependent on the willingness of respondents to talk openly and on other contextual features of the interview process, such as the setting where the interview takes place. Where respondents are unwilling to talk, or hesitant or distracted, this will necessarily affect the 'richness' of the data (Murphy, 2001).

Bryman (1999) points out that the differences between qualitative and quantitative research have often been exaggerated in the literature. And, despite the growing use of mixed methods, there is still a reluctance to combine qualitative and quantitative methodology among some researchers. For Rank (1992), this reluctance centres on perceived epistemological differences and 'incompatibility' between the two traditions, or a belief that the need to follow the

natural scientific paradigm prevents the use of qualitative research methods for anything but initial exploratory research. More practical barriers to the use of qualitative and quantitative research methods might also include the costs of combining methods, or the perceived difficulties in publishing such research (Rank, 1992).

Many authors point out, however, that quantitative and qualitative methods are each appropriate to different kinds of research problem; it is the nature of the research problem that should determine which research tradition is employed. From this perspective, the difference between the two traditions is a 'technical' rather than an epistemological one (Bryman, 1999). Silverman (1997) reiterates this, pointing out that the choice between different research methods can be an entirely pragmatic one. He gives the example of using quantitative methods to gauge how people are going to vote, but using qualitative methods if the researcher wants to: '...explore people's wider perceptions or everyday behaviour...' (p.12). Hakim (2000) depicts the quantitative/qualitative issue as a macro/micro one; survey analysis is appropriate when examining the social determinants of people's behaviour at the macro-level, but inappropriate if looking at how individuals respond to these 'external realities at the micro-level' where qualitative approaches become more appropriate (p.36). She characterises the situation thus: 'If surveys offer the bird's eye view, then qualitative research offers the worm's eye view' (p.36).

Although these two methodological approaches are based on different epistemologies, and gather and analyse data in different ways, they can complement each other and they each have their respective strengths and limitations. Silverman (1997) maintains that proponents of qualitative approaches often criticise practitioners of the quantitative tradition, believing the latter to be ignorant of the socially constructed nature of some of the variables used in survey analysis. Yet, he maintains, quantitative researchers are: '...rarely dopes...epidemiologists and criminologists are only too aware of the problematic character of what gets recorded as, say, 'cause of death' or a 'criminal offence'' (p.13). In a similar vein, quantitatively oriented researchers might criticise the



small samples, unstructured questions and exploratory nature of much qualitative research. This is equally fallacious; qualitative researchers make no claims about the representativeness of their work (Murphy, 2001) and regard the exploratory nature of it as a methodological strength.

These considerations are especially salient in relation to the literature on teenage sexuality, pregnancy and fertility. In statistical analyses of sexual behaviour, for example, questions about sexual activity are often dichotomous ('Have you had sexual intercourse?'). There is limited scope within such analyses for an exploration of other forms of non-penetrative sexual behaviour (which might ultimately lead to penetrative sex and, therefore, a greater risk of pregnancy) or of the factors that might promote or hinder the transition to full intercourse.<sup>16</sup>

Attitudes to, or experience of, termination of pregnancy can also be easily measured using survey data, but we are left with only partial understanding of the motivation for use (or non-use) of abortion. Respondents are typically asked if termination was considered after conception, and (if a termination was sought), where and at what stage in the pregnancy. The reluctance of young, working class women to seek termination of pregnancy has been established in the research literature; young women from less well-off backgrounds are more likely to be 'anti-abortion' than their better-off peers (Tabberer et al., 2000) and to believe that it is better for women to have children at a young age (Jewell et al., 2000; Kiernan, 1997). Recent qualitative research has demonstrated that young working class women are also likely to be affected by the anti-abortion views of the people in their local communities, and fear condemnation if they do seek abortion (Tabberer et al., 2000). It is unlikely that these kinds of insights could have been generated using survey data.

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<sup>16</sup> This has been partly rectified by an emerging body of research on non-penetrative sexual behaviour among teenagers (see, for example, Prinstein et al., 2003; Remez, 2000). Since this research is based primarily on analysis of survey data, the motivation for sexual behaviour change, and the contexts in which such behavioural change occurs, cannot be properly understood (though the analysis itself provides useful information that has important implications for teenagers' sexual health).

The major limitation of qualitative data is its lack of representativeness (Murphy, 2001). It can be problematic to draw conclusions about the frequency and determinants of a behaviour on the basis of a limited number of interviews conducted with individuals who have been selected in a non-random way (through snowballing, for example) and who may be clustered in one location. Moreover, the quality of material collected via in-depth interviews varies greatly and, as noted above, is heavily dependent on how much the respondent understands the interview format and process, comprehends the questions and is willing to answer them. This is true of survey questions, though the more simplified and less ambiguous format of surveys may make them more accessible for some individuals. Bowler (1997) provides a useful account of her failure to elicit full responses (using ethnographic techniques) from south Asian women on their experience of maternity services. She identifies a number of issues that might account for the problems she encountered. One is that the women did not understand the interview process, another is that they could not comprehend that their views might be important.

### 3.2.1) An example of a study that has used mixed methods

The respective strengths and limitations of these two approaches can be illustrated by describing a study where both have been used. Rank (1992), speaking from a family research perspective, provides an account of his work that combines two or more methods (and, in addition, it is a study that has some relevance here).

In his study of the childbearing behaviour of women receiving welfare in the state of Wisconsin, Rank employed three methods of data collection. He analysed computerised case notes, conducted in-depth interviews with a number of respondents and went out into the 'field' (by observing how the welfare system operates in social services offices etc).

Analysis of the case note data led to the calculation of fertility rates for women on welfare. These were standardised and found to be lower than for women generally. Observations in the field validated this, as did conversations with

individuals involved with the welfare system. An exploration of the reasons for the lower fertility of this group of women was undertaken using interview data. The interviews indicated that all the respondents bar one (26 out of 27) had not had children to secure extra welfare benefits, and that almost all the women believed that their situation was not financially or emotionally conducive to bearing more children. Rank thus rejected the widely held belief that welfare benefits promote increased childbearing, especially among unmarried women.

In his discussion of the mix of methods used in the research, Rank maintains that the two methods complement each other:

The strength of qualitative data lies in its richness and depth...Furthermore, these approaches allow participants to structure the world as they see it, rather than as the analyst sees it...Qualitative approaches do not lend themselves to studies of incidence and prevalence (p.295).

He also points out that another advantage of combining methods is increased validity (assuming consistent results across methods). Even where data are at odds with one another, this can be beneficial and can lead to a redirection of the research process.

### 3.2.2) Reasons for using quantitative and qualitative approaches in the present research

Many of the *general* reasons for the use of qualitative data are described above. There are, in addition, three other reasons why qualitative material was collected alongside an analysis of statistical data here.

First, the analysis of the BCS is comparatively simple, partly because of missing data (this is described further below) and also because the qualitative research is of relatively greater importance here, given the dominance of statistical analyses of teenage sex, pregnancy and fertility. Qualitative research has enriched the literature on youthful pregnancy and childbearing (see, for example, de Jonge, 2001; Kirkman et al., 2001; Phoenix, 1990; Sciarra & Ponterotto, 1998; Tabberer

et al., 2000) but there is still a need for further qualitative work in this area, particularly where young mothers' accounts form the sole or main focus of the research. Despite being the objects of intense social concern and scholarly interest, it has been observed elsewhere that young mothers' perspectives are often absent from the literature on teenage pregnancy and parenthood (Jewell et al., 2000). The relative absence of young mothers' voices in the literature is striking given that many teenage mothers do not recognise their own experiences in popular depictions of teenage pregnancy and are aware of (and resent) the stigma attached to their 'anomalous' parenting status (Kirkman et al., 2001). However, despite the lesser importance of the analysis of survey data here, it does help provide a rounded picture of influences on teenage sexual and reproductive behaviour, and sets the context for the presentation of qualitative data.

Second, not all the factors that (theoretically) affect teenage sex, pregnancy and fertility could be explored using the BCS; collection of qualitative material provided an opportunity to explore some of the issues that might arise, or cannot be adequately dealt with, in an analysis of the BCS. Much of the research on teenage pregnancy and fertility is descriptive and employs statistical methodologies, and there is not the scope within this type of research to explore, for example, the meanings attached to motherhood (especially the advantages or disadvantages of young motherhood) or the reasons why a young women might opt for birth rather than abortion. Community norms influencing the timing of fertility (which here is explored using respondents' perceptions about the prevalence of early motherhood in their communities and their experience of local hostility) could not be explored in the BCS. The questions asked of cohort members about the neighbourhoods they lived in at age 16 do attempt to 'tap' community social dimensions (level of neighbourhood monitoring, for example) but most neighbourhood variables in the BCS are structural and community normative influences on behaviour cannot be properly explored using this dataset.

Third, the collection of qualitative data provides an opportunity to explore teenage pregnancy and fertility in three locations (Inner London, Greater Manchester and Northumberland), and thus elucidate the existence (or otherwise) of geographically varying local influences on behaviour. This could not have been done using the BCS, where there are no data on local influences on reproductive behaviour (in the analysis of the BCS, however, there is an examination of differences between three different types of neighbourhood). The locations selected for the fieldwork do not correspond to the types of neighbourhoods present in the analysis of the BCS; the selection of respondents was guided as much by the difficulties of recruitment to the study, and the effective use of existing contacts in the three areas, as by the need to ensure a geographically representative sample of women.

In an ideal research scenario, the factors explored in the analysis of the BCS would be the same as those explored in the interviews, and the types of neighbourhoods that feature in the BCS analyses would be the same as those from which respondents were recruited. Not only would this approach provide a comprehensive description of influences on teenage pregnancy and fertility, but it would also offer useful insights into the degree to which the use of both approaches generates the same results. For the reasons noted above, and also because of time and other constraints, this was only partly achieved here; the issues explored in the interviews were not exactly the same as those examined in the BCS. This does not necessarily compromise the validity of the research or detract from its findings.

### **3.3) Measures used in the BCS and main issues explored in the interviews**

The choice of measures used in the analysis of the BCS, and the selection of areas explored in the interviews, were based on a reading of the literature; the idea of core themes in the neighbourhood effects research was described earlier (see Chapter Two). These are summarised in Tables 6, 7 and 8, and are discussed in the following sections.

*Table 6: Outcome measures in the BCS and the interviews*

<b>Outcome</b>	<b>BCS</b>	<b>Interviews</b>
Early sexual experience	Early sex	Sexual relationship context in which pregnancy occurred
Teenage pregnancy	Teenage pregnancy	Teenage pregnancy
Teenage birth	Teenage birth	Teenage birth

*Table 7: Explanatory measures and issues explored in the BCS and the interviews*

<b>Major level</b>	<b>Broad description of measure/issue</b>	<b>Specific measure/issue</b>	<b>Used in analysis of BCS</b>	<b>Teenage mothers</b>
Neighbourhood	Neighbourhood deprivation	Area deprivation	*	*
		Physical/social features	*	*
	Neighbourhood features	Monitoring	*	
Family	Family structure	Family structure	*	*
		Cohort member's mother's age at first birth	*	*
		Financial hardship	*	*
		Tenure	*	*
	Family process	Parental monitoring	*	*
		Time spent with parents	*	*
Peers	Deviance	Deviant activities	*	*
	Influence on behaviour	Influence on behaviour	*	*
Individual	Deviance	Own deviance	*	*
	Education	Attitudes to school	*	*

*Table 8: Other issues explored in the interviews with teenage mothers*

Major level	Broad description of issue	Specific issue
Neighbourhood	Fertility-timing norms/values	Visibility of teenage mothers in neighbourhood; local hostility to teenage mothers
Family	Family process	Family adversity
	Parental acceptance of teenage motherhood	Parents' support of mother and baby Parents' reaction to pregnancy
Peers	Influence on decision to continue with pregnancy	Peer example
		Peer pressure
Individual	Current/recent employment	Current/recent employment
	Pregnancy and birth	Use of contraception
		Reaction to pregnancy
	Attitudes to abortion	Attitudes to abortion

### 3.3.1) The British Cohort Study 1970-2000 <sup>17</sup>: history, data considerations and the construction of measures

#### *Background*

In 1970, an attempt was made to question the mother of every child born in England, Northern Ireland, Scotland and Wales born in just one week: April 5<sup>th</sup>-11<sup>th</sup>. Over 98% of babies born in that week were included in the study—around 17,000 children in total.

Initially, the BCS had a (largely) medical orientation; the focus of the first questionnaire was primarily on gathering information about obstetric and maternal health outcomes, and the family situation of mother and child. By the time of the 1986 sweep, the BCS had expanded and included questions on diverse aspects of physical and social development. The questionnaires used in 1986, in particular, are very broad in their scope; over 18 survey instruments

<sup>17</sup> The principal investigator and depositor of the BCS is registered as: J.M. Bynner, City University, Social Statistics Research Unit. The BCS was initially funded by: The Leverhulme Trust Adult Literacy and Basic Skills Unit; Paul Hamlyn Foundation; International Centre for Child Studies; Dulverton Trust; Trustee Savings Bank plc. Further details are available at: <http://www.data-archive.ac.uk/findingData/bcsTitles.asp>. The original data creators bear no responsibility for the present analysis of BCS data.

were administered. The latest sweep of the survey was in 2000, when cohort members were all aged 30. Although a sample size of over 11,000 was achieved in 1986, not all cohort members completed every survey instrument. This has important implications for the analysis presented below, which uses data collected in 1986 and in 2000. See Table 9.

*Table 9: BCS questionnaire completion numbers*

Document C: Student Score Form 6,003
Document E: 'Moving On' 4,433
Document F: Health-related Behaviour 5,265
Document G: Home and All That 6,349
Document H: Friends and the Outside World 6,290
Document J: Life and Leisure 6,417
Document K: Dietary Diary 4,693
Document L: Educational Questionnaire 3,816
Document M: Head Teacher Questionnaire (not yet cleaned)
Document O: Parental Interview Form 9,584
Document P: Maternal Self-completion Form 8993
Document Q: Student Health Questionnaire 6,898
Document R: Medical Examination Form 6,143
Document S: Leisure and Activity Diary 7,544
Document T: Family Follow-up Form 7,336
Total answering one or more questionnaires: 11,622

Table taken from Goodman & Butler (1986)

### *Why use a cohort study and why the BCS?*

The BCS is the latest British cohort study, excluding the new Millennium study.<sup>18 19</sup> A cohort study is used here because there is a long tradition in Britain of using cohort data (particularly in youth studies) and cohort data are of generally good quality and well used by researchers. Cohort data also provides a unique opportunity to follow individuals from one point in time to another and, therefore, limit the possibility of recall and other biases. It is possible, of course, to ask teenage parents about the nature of their lives at an earlier point in time in a cross-sectional survey, and to link this to an outcome (pregnancy, abortion,

<sup>18</sup> The Millennium Study began (as its name suggests) in 2000. Clearly, there are not yet the data available in this study to facilitate an exploration of areas that are of interest here.

<sup>19</sup> See Appendix A for an important discussion of period differences between BCS cohort members' data and respondents' data.



childbearing) at a later stage. There is always the risk, however, that the respondent will inaccurately recall information (they might simply have forgotten it) or will try to make sense of an outcome by spuriously linking it a factor present at an earlier point in time (post hoc rationalisation).

There are a number of reasons why the BCS is used here. First, the BCS covers a wide variety of areas. At age 16 (in 1986), a number of questions relating to the areas that are of interest here were asked. Family and peer relationships, attitudes to school and neighbourhood features were all explored in the 1986 sweep. These data can be easily linked to outcome data collected at age 30, when cohort members were asked their reproductive history.

Second, there are a number of reasons why the BCS rather than the NCDS or another cohort study is used here. The BCS is more up-to-date than the NCDS and it is probable that those experiencing teenage pregnancy and birth in the BCS are quite a different population to those in the NCDS. Women in the NCDS who experienced a teenage pregnancy and birth would have had their children in the 1970s, when having children young was a relatively normative phenomenon (and still within marriage in the early part of the decade) (Selman, 1998; Wallace, 1987). In this respect, they may not have differed so greatly from the general population. Women in the BCS, however, who experienced a pregnancy and birth as a teenager would have done so in the mid to late 1980s, when youthful pregnancy and childbearing was a more stigmatised behaviour, and teenage fertility tended to occur outside marriage more than within it (Selman, 1998). Such women are, probably, emerging as a distinct population with different, possibly more 'polarised' characteristics than the general population (this, in fact, is the finding of a recent inter-cohort analysis of family formation using NCDS and BCS data; See Berrington, 2002).

Third, the BCS is comparatively underused compared to the NCDS and teenage pregnancy and fertility have not been as fully explored using the BCS compared with the NCDS. The major limitations and barriers to the use of the BCS are those relating to varying sample sizes (at age 16) and spurious, unreliable

responses to questions (though this is not a problem confined to the BCS). The missing data at age 16 is a serious obstacle to a thorough analysis of the data. Here, an attempt has been made to address this issue through constructing composite or 'hybrid' variables (where this was possible) (Yeaton, Langenbrunner, Smyth & Wortman, 1995). However, for some of the variables in the analysis, around 40% of the responses are missing, and these data are not randomly missing. These serious obstacles to the analysis should be borne in mind when considering the analysis below.

### *Outcome variables*

There are three binary outcome variables: 'Sex', 'Pregnancy' and 'Birth'. The first of these was constructed using variables from the 1986 dataset. The second and third outcome variables were constructed using variables from the 2000 dataset. 'Pregnancy' was the most important outcome, since the focus here was factors affecting the transition from pregnancy to birth (rather than sex to pregnancy) and the timing of fertility. For this reason, all cohort members had to have experienced at least one pregnancy (at any age) to be included in the analysis.

#### *1) Early sexual experience*

In 1986, cohort members were asked a series of statements about sexual activity. Cohort members were asked if any of the following statements applied to them: I have had sex once; I have had sex several times; I have had sex regularly; I have only had sex with one person; I have had sex with more than one person; I am glad I have had sex; I enjoy sex.

Any cohort member who indicated that any of these statements applied to them was considered to have experienced early sexual intercourse (up to and including age 16). Where cohort members had not specified that any of these applied, and were present for the questionnaire, they were considered not to have had any sexual experience. See Table 10.

*Table 10: Early sexual experience*

	Frequency	Percent
Some sexual experience	899	54.1
No sexual experience	763	45.9
Total	1662	100.0

## 2) *Pregnancy and birth*

Data on all women in the BCS in 2000 (when cohort members were aged 30) who answered either 'yes' or 'no' to the question: 'Have you ever been pregnant?' were used to construct the next two binary outcomes.

In 2000, there were 5790 women in the BCS: 14 of these did not provide responses to the question. Details of cohort members who did not give an answer, or who provided anomalous responses, were removed from the dataset. This left a potential sample of 5738 women who provided a response to the question about pregnancy, provided details of the outcome of the pregnancy and details of the year of the year of the reproductive event (s) (in at least one case).

Data on the women's reproductive history were analysed according to the year in which the reproductive event(s) occurred. Events occurring in the period 1970-1990 were considered to be 'teenage' (age 0-20), and events occurring from 1991-2000 were considered to be 'older' events (age 21+). Teenage reproductive events thus include events up to, and including, those that occurred at age 20 on the grounds that a pregnancy or birth at age 20 *may* be the result of a conception at age 19.

For the purposes of the analysis, it was assumed that the reproductive events of 'birth', 'stillbirth', 'miscarriage' and 'still pregnant' (at the time of data collection in 2000) constitute 'Birth'. This definition of birth is broad and includes miscarriages that might have been resolved by use of termination. There is no way of knowing if these miscarriages would have resulted in a birth or not. Using these data, two binary outcome variables from the 2000 dataset were constructed. These are 'Pregnancy' (teenage, older) and 'Birth' (teenage, older).

Since most explanatory variables were taken from the 1986 dataset, when cohort members were aged 16, details of women who experienced pregnancy/birth before age 17 were deleted from the dataset. It would be difficult to establish cause and effect if details of these cohort members were left in (i.e. did pregnancy precede or follow the explanatory event?). There were 129 such women who experienced a pregnancy and/or birth in the period up to 1987.

After constructing the three outcome variables, data had to be selected from 1986 (when all cohort members were 16 years old). First, data had to be merged from the two points in time. After merging data from two points in time, we are left with a sample of women who were present at both points in time and, who answered the question 'Have you ever experienced a pregnancy?' and for whom there is sufficient information on outcomes (type and year of event) in 2000. Of the 4502 female BCS cohort members who were present at both points in time (1986 and 2000), just under 15% had experienced a pregnancy as a teenager (aged 17 To 20), nearly 47% had experienced a pregnancy aged 21 or older and 38% reported no pregnancy. This leaves a total sample size of 2762 present at both points in time and reporting at least one pregnancy. Of these 2762 women, 663 reported a teenage pregnancy, 2099 reported pregnancy at an older age only. Of the 663 women reporting a teenage pregnancy, 544 (82%) reported a birth as a teenager. See Table 11.

*Table 11: Pregnancy and birth*

Pregnancy	Older pregnancy only	76.0% (2099)
	Teenage pregnancy	24.0% (663)
Total		100.0% (2762)
Birth	Older birth only	79.1% (2063)
	Teenage birth	20.9% (544)
Total		100.0% (2607)

*Explanatory variables*

As noted above, a major problem with the BCS is missing data at age 16. For this reason, a number of similar variables were used together to either create a scale or to complete missing data on one variable. Using this approach, where this was possible, means that many variables taken from 1986 are composite or 'hybrid' variables (Yeaton et al., 1995). Thirteen explanatory (predictor) variables were taken from the 1970 and 1986 datasets. These are shown below See Table 12.

*Table 12: The explanatory variables*

	N	Minimum	Maximum	Mean	Std. Deviation
Area deprivation	2753	1.00	3.00	2.0022	.8969
Neighbourhood features	1629	1.00	3.00	1.9969	.7935
Neighbourhood monitoring	1747	1.00	3.00	2.0172	.7209
Number of parents living with at age 16	2502	1.00	2.00	1.7434	.4368
Cohort member's mother: birth	2557	1.00	2.00	1.6023	.4895
Family troubled by finance hardship past yr	2200	1.00	2.00	1.8386	.3679
Housing tenure	2540	1.00	2.00	1.7043	.4564
Parental supervision	1643	1.00	3.00	2.0274	.9266
Time spent with parents	2157	1.00	3.00	2.0445	.8848
Friends deviance	2073	1.00	3.00	1.9773	.8875
Get led into things would not do on own	1607	1.00	3.00	2.4331	.7191
Own deviance	2160	1.00	3.00	2.8769	.4438
Attitudes to school	1684	1.00	3.00	2.0315	.8278

### Neighbourhood (three measures)

#### 1) *Area deprivation.*

Area deprivation is a standard measure in many spatial analyses of behaviour, and in the neighbourhood effects literature. Here, this was based on the local education authority's (LEA) deprivation level (measured by the Carstairs 1991 local authority index of deprivation).

In the BCS in 1986, cohort members lived in one of 120 local education authorities. Of these, 100 were English LEAs, eight Welsh and 12 Scottish. Although the focus of this thesis is on the reproductive behaviour of English teenagers, data from women living outside England at age 16 were kept in the analysis. This was partly to boost sample size, but also because these women represent a very small proportion of the overall sample. The qualitative data, in contrast, was collected only from women in English locations.

There are three limitations to the use of the Carstairs index. Local authority geographical boundaries do not correspond exactly with those of the LEA's, so data on area deprivation are approximate. Second, reliable data on area deprivation were not available for the year 1986 (when the data were collected from cohort members), so these area deprivation figures are likely to be slightly out-of-date.<sup>20</sup> Third, data on area deprivation were only available at ward-level. In order to construct a LEA-level figure, data for each ward were summed and averaged by the number of wards. This is a rather simplistic method of constructing LEA-level data, but a more precise deprivation score would have necessitated the use of ward-level population data.

Area deprivation was categorised into three categories ('high/high deprivation'; 'neither high nor low'; and 'very low/low deprivation' for the analysis. This was done to keep cell sizes large enough for meaningful statistical analysis.

## *2) Neighbourhood features*

Other neighbourhood dimensions include its physical and social features. 'Neighbourhood features' was constructed from five questions about the type of area the cohort members live in at age 16. Cohort members were asked if they lived in an area where there were: noisy neighbours or loud parties; graffiti on walls or buildings; teenagers hanging round the streets; drunks or tramps on the streets; and lots of rubbish lying about. In correlation analysis, all these items significantly and positively correlated with one another, though coefficients were sometimes quite low (see Table A1). In a reliability analysis, a high Cronbach's Alpha was obtained (0.7692).

Responses for each cohort member were summed and then recoded into three categories measuring the features of the neighbourhood they lived in at age 16. These were neighbourhoods with: 'poor features'; 'mixed features'; and 'good features'.

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<sup>20</sup> The Carstairs Index uses data from the 1991 census.

### *3) Neighbourhood monitoring*

Neighbourhood monitoring was measured using three variables. Cohort members were asked if they considered it likely that their neighbours would call the police under the following circumstances: if the neighbours see teenagers trying a car door; climbing in windows; or graffitiing. In correlation analysis, these variables correlated positively and significantly with each other (see Table A2). In a reliability analysis, these items attained a Cronbach's Alpha (0.8115), and were thus considered to be highly related to one another.

Responses were summed for each cohort member and then recoded into three categories: 'low', 'moderate' and 'high' neighbourhood monitoring.

#### Family (six measures)

The factors within the family were divided up into structural and family process factors. The first four of these—structural (which here includes family structure; the age at which the cohort member's mother began childbearing; financial hardship; and housing tenure)—are standard measures in most analyses (see, for example, Kiernan, 1997; Rosato, 1999). The family process variables were used to measure monitoring or supervision of behaviour by parents, and the degree of family 'connectedness', which here was measured by the amount of time that parents spend with their children.

#### *1) Family structure*

Two variables from the 1986 dataset were used to create one variable measuring family structure at age 16. Possible responses to this question were: 'single mother/father, or neither'; and 'both natural parents'.

#### *2) Cohort member's mother: birth*

This measure was constructed using three variables from the 1970 dataset: cohort member's mother's year of birth, the delivery year of first pregnancy and mother's age at delivery (in 1970).



### *3) Financial hardship*

This measure was based on responses to one question about financial hardship within the cohort member's family in the past year. Anomalous or uncertain responses were deleted and a dichotomous variable was created. Ideally, data on the social class status of the cohort member's family would have been used to measure financial/material resources. However, the response rate for the question about financial hardship was higher (82%) than that for family social class (at around 65%). Financial hardship has also been used in other analyses of teenage fertility (Kiernan, 1997).

### *4) Tenure*

Seven variables from 1986 were used together to create one variable. Possible responses to this question were: 'rented or other' and 'owner-occupier'.

### *5) Parental supervision/monitoring*

This measure was constructed using the following variables from the 1986 sweep of the BCS. Cohort members were asked six questions about parental supervision of their behaviour. These were: do parents ask who you going out with?; do parents ask where are you going?; do parents ask what you are going to do?; do you tell your parents who you really going with?; do you tell your parents where you are really going?; do you tell your parents what you really going to do? These variables were all positively and significantly correlated with each other (see Table A3). In a reliability analysis, the variables attained a high Cronbach's Alpha (0.8306).

### *6) Time spent with parents*

This was measured using responses to questions about the amount of time that the cohort member spends with her parent(s). Cohort members were asked: how much time mother spends with the teenager; how much time husband spends with the teenager; and how much time as a family is spent with the teenager (See Table A4). In a reliability analysis, a very high Cronbach's Alpha was obtained

(0.8752).

### Peers (two measures)

Two variables were used to measure interaction with, and influence of, peers. The first was measured the degree of friends' deviance, and the second, the extent of peer influence.

#### *1) Friends' deviance*

This measure was created by summing responses to 14 questions about the criminal or anti-social activities of friends (friends could be 'close' and 'other'). These questions, which covered an increasingly serious range of events, included, for example: 'have you a friend who's been moved on by police?'; 'have you a friend who has been stopped for questioning by the police?'; 'have you a friend who has been arrested and taken to the police station?'; 'have you a friend formally cautioned by the police?'; and 'have you a friend who has been found guilty in a court of law'. These variables were all significantly and positively correlated with each other (see Tables A5 & A6 ). In a reliability analysis, a high Cronbach's Alpha was observed (0.8731).

The response to these questions was low, so this newly created variable was used with another to create a composite measure of friends' deviance. This second measure was constructed using variables measuring a series of anti-social and criminal activities. Cohort members were asked if they had friends who had: broken windows or smashed other peoples' property; sold stolen or shoplifted items; stole something worth less than £5 from a shop' broke into a house to take something; stole something worth £5 from a shop; taken something not theirs that was left lying around; taken a bike not intending to give it back; taken something from other people; taken others peoples' cars or bikes for a ride; and taken something from others peoples' shed/garden. In a reliability analysis, a very high Cronbach's Alpha was observed (0.9940). This second measure was then combined the first to create one variable measuring peer deviance. See Tables A5 & A6 ).

## *2) Peer influence on behaviour*

This was based on one question in the 1986 dataset. Cohort members were asked if they are likely to 'get led into things they would not do on their own'. The original responses were selected from one of five categories ('yes, often' to 'don't know'). These categories were recoded into: 'often/sometimes', 'rarely/don't know' and 'never'.

### Individual (two measures)

Two individual-level measures were used in the analysis. The first was the cohort member's own deviance and the second, attitudes to school. The cohort members reported own level of deviance was used as a control for peer deviance (teenagers who are 'deviant' may be likely to seek out similarly 'deviant' friends; Bradford Brown, 1990). Attitudes to school is an important measure since early pregnancy and fertility is strongly associated with educational success (Kiernan, 1997).

#### *1) Own deviance*

This measure was created from a number of variables in the 1986 dataset. These were similar to those used above for the construction of measures of friends' deviance. Cohort members were asked a series of questions about anti-social or criminal behaviour they had committed. This included acts such as: breaking windows or property; using physical force to obtain money; taking money or items from a stranger by threat; stealing from a shop, etc. Cohort members were asked how many times in the past year they had done any of these things. The responses to these questions were all positively and significantly correlated with each other (see Tables A5 & A6 ). In a reliability analysis, a Cronbach's Alpha of 0.7576 was obtained.

Because response to this question was quite poor, this variable was used with a second series of variables also measuring the level of cohort member's deviance. These measured the cohort member's level of involvement with the police ('how often have you: been let off with a warning by police since the age of 10'; ' been

arrested and taken to the police station since the age of 10', etc.). These variables significantly and positively correlated with each other (see Tables A5 & A6 ). In a reliability analysis, a Cronbach's Alpha of 0.8378 was obtained.

## *2) Attitudes to school*

Five variables were used to create a composite measure of the cohort member's attitude to school. Cohort members were asked if they agreed or disagreed with the following statements: 'I feel school is largely a waste of time'; 'I think homework is a bore'; 'I find it difficult to keep my mind on work'; 'I never take work seriously'; and 'I do not like school'. In correlational analysis, these variables positively and significantly correlated with one another (though quite low coefficients were observed). See Table A7.

In a reliability analysis, a Cronbach's Alpha of 0.7559 was obtained, suggesting that these variables were all measuring the same underlying dimension. Responses to each question were summed for each cohort member (who had supplied a response) and possible responses for this variable were: 'negative attitudes to school'; 'moderate attitudes to school'; and 'positive attitudes to school'.

## *Missing data*

Despite the construction of hybrid variables, there is still a problem with missing data for the explanatory variables. Table 13 shows where, and what proportion, of these data are missing.

*Table 13: Missing data*

	N	Missing	
		Count	Percent
AREADEP	2753	9	.3
NEIGFE	1629	1133	41.0
NEIGPOL	1747	1015	36.7
FAMSTRUC	2502	260	9.4
CMMBTH	2557	205	7.4
FINHARD	2200	562	20.3
TENURE	2540	222	8.0
PARSUPE	1643	1119	40.5
TIMEPAR	2157	605	21.9
FRIENDEV	2073	689	24.9
LED	1607	1155	41.8
OWNDEV	2160	602	21.8
SCOATT	1684	1078	39.0

AREADEP= area deprivation, NEIGHFE=neighbourhood features, NEIGPOL=neighbourhood monitoring, FAMSTRUC=family structure, CMMBTH=cohort member's mother's age at first birth, FINHARD=family financial hardship, TENURE= housing tenure, PARSUPE=parental supervision, TIMEPAR=time spent with parents, FRIENDEV=friends' deviance, LED=friends' influence, OWNDEV=cohort members' own deviance, SCOATT=attitudes to school.

For some variables (neighbourhood features, parental supervision and peer influences), around 40% of the data were missing at age 16. Responses to questions and attitudes to school were also poor (with just under 40% of the data missing). The response rate was low for some of the other variables but, by creating hybrid variables, this problem was (partly) dealt with. In the case of those variables with a lot of missing responses, it was not possible to combine them with other variables because of basic differences in the variables or in response categories. Overall, only a third of the cohort members provided full responses. See Table 14.

*Table 14: Number and proportion of missing responses*

	Frequency	Percent
No missing responses	915	33.1
1-4 Missing responses	727	26.3
5-10 Missing responses	980	35.5
11+ missing responses	140	5.1
Total	2762	100.0

Very importantly, the data were not missing at random. In terms of the outcome variables, there were no statistically significant differences in missing data by 'Sex', but, at age 16, women who went on to experience a teenage pregnancy and birth were significantly more likely not to provide full responses compared with their counterparts who did not experience early pregnancy and birth.

*Table 15: Distribution of missing data by 'Pregnancy'*

		Pregnancy	
		Older pregnancy only	Teenage pregnancy
Missing responses	No missing responses	732 34.9%	183 27.6%
	1-4 Missing responses	554 26.4%	173 26.1%
	5-10 Missing responses	707 33.7%	273 41.2%
	11+ missing responses	106 5.1%	34 5.1%
Total	2099 100.0%	663 100.0%	

Table 15 shows the missing data distributed by the 'Pregnancy' outcome. Of the 663 women who went on to experience teenage pregnancy, just 28% provided full responses at age 16, compared with nearly 35% of women who reported pregnancy at older ages. Although there were no percentage differences between these two groups in '11+ missing responses' category, 41% of those

experiencing a teenage pregnancy did not provide data for 5-10 of the explanatory variables, compared with 33% of women reporting pregnancy at older ages only. These differences were statistically significant (Pearson Chi-Square=16.041, df=3, p=0.001). A similar picture emerges in relation to the 'Birth' outcome variable.

*Table 16: Distribution of missing data by 'Birth'*

		Birth	
		Older birth only	Teenage birth
Missing responses	No missing responses	711 34.5%	141 25.9%
	1-4 Missing responses	539 26.1%	142 26.1%
	5-10 Missing responses	704 34.1%	234 43.0%
	11+ missing responses	109 5.3%	27 5.0%
Total	2063 100.0%	544 100.0%	

In this case, 26% of those experiencing teenage pregnancy provided full responses (to the variables of interest) at age 16 compared with 35% of women experiencing pregnancy at older ages. Again, the difference between the two groups in missing data was statistically significant (Pearson Chi-Square=19.158, df=3, p=0.000).

Although the differences between the women in relation to missing data were not excessively large (in percentage terms), they were statistically significant, a serious source of bias and might have affected the results: it is likely that the results were 'underpowered' for women who experienced teenage pregnancy and/or birth. Probably, this tended to mute the results of the analysis in relation to these respondents (rather than exaggerate them).

The distribution of missing data was also examined by other key variables. There were no significant differences in missing data by area deprivation. Women in very deprived areas were more likely than women in areas of moderate or low deprivation not to provide responses, but these results were not statistically significant (6% of the former had 11+ missing responses, compared with 4.1% and 4.5% of the latter (Pearson Chi-Square=9.221,  $p=0.162$ ). Women living in a lone parent family structure at age 16 were also less likely than women living in two-parent families to provide full responses (39% of the latter provided full responses compared with 29% of the former. Pearson Chi-Square=29.829,  $df=3$ ,  $p=0.000$ ). Nearly 29% of cohort members who had mothers who began childbearing in their teens gave full responses compared with nearly 41% of women whose mothers began childbearing after age 20 (Pearson Chi-Square=55.227,  $df=3$ ,  $p=0.000$ ).

Women from families that had suffered financial hardship in the year before the data were collected at age 16 were also less likely to have provided full responses at age 16 (43% of women who did not report financial hardship in their families provided full responses at age 16, compared with 35% of those who did report financial hardship. Pearson Chi-Square=12.857,  $df=2$ ,  $p=0.002$ ). Over 44% of women living in rented property at age 16 did not give full data for 5-10 questions compared with 33% of women living in owner-occupied property (Pearson Chi-Square=39.711,  $df=3$ ,  $p=0.000$ ). About 50% of women who reported being influenced by their peers at age 16 gave full responses compared with 62% of women saying that they were rarely influenced by friends (Pearson Chi-Square=11.264,  $df=4$ ,  $p=0.024$ ).

Somewhat counter intuitively, women who reported a moderate level of own deviance at age 16, were more likely than those who reported high or no deviance to have data missing for 5-10 variables (38% compared with 15% of women reporting high deviance and 24% of women reporting low deviance)—though women who reported high deviance were the least likely of all the groups to provide full data (20% of those reporting high deviance at age 16 gave full responses, compared with 43% reporting moderate deviance and 43% of women



reporting low deviance. Pearson Chi-Square=56.480, df=4,p=0.000).

Overall, at age 16, women who experienced a teenage pregnancy or birth, who lived in lone parent families, who had mothers who began childbearing in her teens, who reported recent family financial hardship, who lived in social housing, who were influenced by friends and reported a high level of own deviance were less likely than other cohort members to provide data for the variables of interest here. As noted above, this inevitably means that the results of the analysis in relation to these individuals are probably underpowered, and the results presented below should be interpreted with this in mind.

#### *Analytic approach and procedure*

In Chapter Two, the point was made that neighbourhood effects research assumes that factors potentially affecting outcomes are found at distinct levels (neighbourhood, family, individual). For the purposes of the present analysis, it is recognised that no such distinction really exists, and that factors at the wider community level, those found at lower levels (within peer contexts, for example) and individual attributes are likely to exert influence in combination. So, there is less emphasis here on 'teasing out' (Frohlich et al., 2001) compositional from contextual effects. For this reason, no multi-modelling techniques were used and logistic regression procedures were employed instead. In this way, there is less of an emphasis here on measuring true neighbourhood effects, but rather on elucidating the factors that influence teenage behaviours at different levels.

Another reason why logistic regression and not multi-level modelling techniques were used is that the statistical analysis is necessarily comparatively simple because of poor response at age 16 (which affects the overall quality of the data) and the relatively greater importance of the qualitative material.

There are, in addition, a number of neighbourhood effects studies of teenage sexual and reproductive behaviour that do not use multi-level modelling techniques (Hogan & Kitagawa, 1985; Moore & Lindsey Chase-Landale, 1999), so neighbourhood effects can be explored without the use of such techniques.

In the all area and different neighbourhood scenario analyses, each outcome variable ('Sex', 'Pregnancy', 'Birth') was cross-tabulated with the explanatory variables in an 'ecological' format (that is, neighbourhood factors first, then family, then peer, with individual factors as controls). Statistically significant associations between explanatory and outcome variables were noted (where  $p \leq 0.05$ ).

These significant variables were then entered into three binary, logistic regression analyses (since all the outcome variables are dichotomous and all the explanatory variables are categorical) so the effect of each variable could be independently measured. The default 'forced entry' method of regression was used (this places all the variables together in one block, with parameter estimates calculated for each block; Field, 2000) and the 'indicator' contrast for the categorical variables was selected. For each regression, the Nagelkerke R Square statistic was noted. This figure provides an approximate measure of the proportion of the outcome that is explained by the use of the variables entered into the model. Data were analysed on SPSS version 10.

### 3.3.2) The collection and analysis of qualitative data

#### *Selection and recruitment of respondents*

##### Teenage mothers

Not all teenage parents were suitable for inclusion in the study. Given the association between very early teenage pregnancy (under 15 years of age) with phenomenon such as sexual and physical abuse (SEU, 1999), women who had their first child before the age of 15 were excluded from the study (even though they may have been older when the interview took place). Also, no parent who was below the age of 16 at the time of interviewing was contacted; parental consent for the interview would be required.

Young women were interviewed in three different locations. These locations were wards in: the London Boroughs of Islington, Hackney and Tower Hamlets (Inner London); Northumberland; and Tameside (Greater Manchester). Here, the names of the wards in which the women lived have been 'aggregated up' for two

reasons: first, to ensure respondent anonymity and, second, to simplify presentation of results. It was important, however, that respondents lived in specific, relatively small locales so that neighbourhood effects on behaviour could be properly explored. If respondents in Northumberland, for example, had lived in geographically diverse areas of the county, it would be difficult to draw any meaningful conclusions about area influences on behaviour.

Areas were chosen with two criteria in mind. First, it was anticipated that it might be difficult finding suitable respondents for inclusion in the study (this was borne out), so these areas were selected partly because they were accessible (in terms of gaining access to potential respondents). Existing reliable and helpful contacts in all three areas made recruiting individuals easier. In the case of Northumberland, the interviewer had a long-standing contact with a schoolteacher in a secondary school. In the case of Greater Manchester, family and personal contacts facilitated the recruitment of respondents. Respondents in London were recruited through the existing social networks of the interviewer.

Second, these areas contrasted with—and were also similar to—each other in relation to: geographic location (South East, North West, North East); population density and type of area; proportion of the population that are unemployed; and teenage reproductive scenarios. There may be distinctive regional fertility cultures that influence the timing of childbearing (Hank, 1992); and it was anticipated that these might become apparent by speaking to women in different areas. The population density of an area might, theoretically, affect fertility rates; in sparsely populated, rural areas, there may be less scope for interaction with others who might influence behaviour. Also, the proportion of the population who are unemployed provides an approximate measure of employment opportunities in the area. In areas with high unemployment, early childbearing might be more attractive and represent an alternative vocation (de Jong, 2001). The characteristics of each area are shown in Table 17.

**Table 17: Teenage fertility and other features in respondents' locations**

	<b>Region</b>	<b>Type of area</b>	<b>Proportion of population unemployed<sup>21</sup></b>	<b>Regional teenage fertility rate<sup>23</sup></b>
Inner London	South East	Densely populated, urban	London=7.9%, Inner London=10.2% <sup>24</sup>	28.4 <sup>25</sup>
Northumberland	North East	Sparsely populated, largely rural	North East=7.5%, Northumberland=6.1%	35
Greater Manchester	North West	Densely populated, urban	North West=5.3%, Greater Manchester=5.1%	32

As can be seen in Table 17, there were similarities and differences across the areas. There were two densely populated urban areas (Inner London, Greater Manchester) and one sparsely populated, largely rural area (Northumberland). The proportion of the local population unemployed varied from a high of over 10% in Inner London to a relative low of over 5% in Greater Manchester. The regional teenage fertility rate varied from 28 per 1000 teenagers in London to 35 per 1000 in Northumberland (the UK teenage fertility rate is around 29 per 1000).

Respondents' details were obtained by two methods. Initially, leaflets describing the study were sent out to selected youth organisations in the North London Boroughs of Camden and Islington, and leaflets were left at a number of doctors' surgeries in and around the area. However, only one respondent came forward this way. Teenage mothers have been observed elsewhere to be a difficult group to reach (Allen & Dowling, 1998; de Jong, 2001) and the process of finding suitable respondents was time-consuming and sometimes frustrating. The other 15 respondents' details were obtained via personal recommendation and 'snowballing'. This necessitated some degree of reliance on 'gatekeepers', which,

<sup>21</sup> Figures for 2001/2002, unless stated otherwise.

<sup>22</sup> Government Office Region

<sup>23</sup> Rate per 1000 women aged 15-19

<sup>24</sup> Figure for 1999

<sup>25</sup> Figure for London

at times, slowed down the collection of data. A number of telephone calls and emails had to be sent to Coordinators and other health service workers in the different locations and, on one occasion, an organisation refused contact with the young women that used its services (on the grounds that another project was taking place at the same time). However, most gatekeepers and contacts were happy to help with the project. Using these recruitment methods, 15 young mothers agreed to be interviewed. See Table 18.

*Table 18: Respondents' characteristics*

Study name	Location	Age at first birth	Number of children	Ethnicity	Marital status	Living arrangements
Katie	Inner London	18	1	White	Single	Living in hostel
Diana	Inner London	19	1	Black Mixed	Single	Lone adult in household
Zaheda	Inner London	18	1	Asian	Divorced	Living with partner
Suzy	Inner London	17	1	White	Single	Lone adult in household
Charlie	Inner London	18	1	White	Single	Living in hostel
Kath	Northumberland	17	2 (pregnant at time of interview)	White	Married	Living with husband
Hillary	Northumberland	18	1 (pregnant at time of interview)	White	Single	Living with partner
Sally	Northumberland	17	1	White	Single	Living with parents
Julie	Northumberland	18	1	White	Single	Living with parents
Caroline	Northumberland	16	1	White	Single	Living with parents
Jilly	Greater Manchester	16	1	White	Engaged	Living with partner
Ellie	Greater Manchester	18	1	White	Engaged	Living with partner
Chloe	Greater Manchester	15	1 (pregnant at time of interview)	White	Single	Lone adult in household
Donna	Greater Manchester	16	1	White	Single	Lone adult in household
Yvonne	Greater Manchester	20	1	White	Single	Lone adult in household

*Table 19: Summary statistics, age at first birth*

Age at first birth, range	15-20 years
Sample mean age at first birth	17.4 years
Sample median age at first birth	17.5 years

The age range of first birth among the young women was 15-20 years, the mean was 17.4 years. Two thirds of teenage mothers in the UK are aged 18 and older (FPSC, 1999), so this group of women, while slightly young, were broadly representative of British teenage mothers in respect of maternal age at first birth. Most women (14) had just one child, though three respondents were pregnant at the time of the interview, and one was expecting her third child. All but two of the women were of White ethnicity; the two non-White respondents both came from London. One woman was married at the time of the interview, one was divorced (she had married at age 16) and two were engaged to be married. Most women were securely housed (either in their own homes or with their families) but two were living in hostels (in both cases in London) waiting to be rehoused by the local authority.

### The Coordinators

It was anticipated that the influence of community or neighbourhood factors on the timing of childbearing could only be partly explored using the young mothers' accounts. There was no way of knowing before the interviews how long the women had been living in each area at the time of the interview, or how they would respond to questions about community influences on behaviour (they might have been offended by suggestions that early motherhood is common in their localities, or have little awareness of such issues). For this reason, the interview data provided by mothers were collected alongside accounts provided by Coordinators (n=9). The data provided by the Coordinators were used to supplement the mothers' interviews, but it was also expected that it might contrast with it. As the representatives of the TPU, the Coordinators represent the interface between policymakers and the subjects of policy—teenage mothers themselves. Their position in the community affords them a unique opportunity to gauge the validity and likely success (or otherwise) of the TPS, and areas of dissonance between policy and the reality 'on the ground'.

The recruitment of Coordinators to the study was guided by one consideration: that they represent a variety of areas. 'Area', in this respect, related to geographic

location (e.g. North, South), type (urban, rural) and teenage reproductive scenarios (e.g. high teenage pregnancy/low use of abortion, low teenage pregnancy/high use of abortion). In this way, the accounts of teenage pregnancy provided by the Coordinators could (in theory) be contrasted across locations in the same way as the young mothers' accounts. For reasons of confidentiality, the exact location (local or health authority area) of the Coordinators will not be identified.

Coordinator respondents were identified after a search of the TPU website.<sup>26</sup> This generated a name and email address or telephone number. The reports for each area that the Coordinator worked in were obtained and read before, during and after the interview (these reports were available on the respective website of the local or health authority that the Coordinator worked in. Or, in a couple of cases, were posted by the Coordinator). Time and workload pressures, and distance to the areas that the Coordinators worked in, meant that all of the interviews had to be conducted by telephone. The characteristics of the areas that the Coordinator worked in are shown in Table 20.

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<sup>26</sup> <http://www.teenagepregnancyunit.gov.uk/>



*Table 20: The characteristics of the areas the Coordinators worked in*

<b>Geographic location</b>	<b>Type of area</b>	<b>Teenage reproductive scenario</b>
East London	Urban	High conception rates, high abortion rates
North London	Urban	High conception rates, high abortion rates
North London	Urban	High conception rates, high abortion rates
West London	Urban	Low conception rates, high abortion rates
South England	Rural/mixed	Low conception rates, high abortion rates
North West England	Urban	High conception rates, low abortion rates
North East England	Rural	Mixed
East England	Rural/mixed	Low conception rates, high abortion rates
South West England	Rural/mixed	Low conception rates, low abortion rates

The data on the teenage reproductive scenario presented in Table 20 relates to the area that the Coordinator worked in; this could be at either local authority-level, county-level or health authority-level. In most situations, there was variation in the scenario across the area the Coordinator worked in (low county-level teenage pregnancy rates, for example, but high rates in specific wards).

#### *Ethical and practical considerations*

The major ethical consideration related to ensuring that the respondents had given their informed consent for the interview to take place and that their anonymity was guaranteed. The latter was achieved by giving all the respondents' pseudonyms and by not identifying their exact location. Informed consent was secured by giving all the young mothers a letter before the interview that described the purpose and nature of the interview, the researcher's contact details, the types of questions that respondents might be asked, arrangements for safeguarding confidentiality and plans for dissemination of the research (Arksey & Knight, 1999). In addition, the letter explained that respondents could

refuse to answer questions that made them feel uncomfortable (see Appendix D for a copy of this letter). This advice was repeated during the interview. Respondents were also given the option of withdrawing their accounts from the study after they had been interviewed. Respondents were given £10 for expenses. In two instances, respondents would not accept the money.

Although the focus of interviews was not primarily on sexual behaviour *per se*, it was anticipated that issues round sexual behaviour and sexuality would arise during the interview, so care had to be taken with the framing of questions to avoid offending or upset respondents (Ringheim, 1995). Many other issues explored in the interviews were potentially very sensitive. Attitudes to abortion, for example, were an important part of the interview and, similarly, sensitivity and tact in the framing of questions was important. The interviewer avoided, for example, telling the respondents her own views on abortion (which were different to those held by most respondents). Where necessary, issues about sexual behaviour, use of contraception and attitudes to abortion were addressed indirectly, so that a number of 'lead in' questions were asked ('were you surprised when you found out that you were pregnant? Rather than the more forthright 'were you using contraception when you became pregnant?'). Kasper (2003) says that, in her study of women with breast cancer, she made an effort to 'avoid exploitation' by not asking direct questions about very sensitive issues such as sexuality or body image. She waited for the respondent to raise the issue and, only then, would she 'carefully pose a question' (p. 175). This approach was adopted here where necessary.

In the interviews, the use of the term 'teenage pregnancy' or 'teenage motherhood' was avoided where this was possible. Instead, the terms 'young mothers' was used. It became apparent during the interviews that most respondents did not think of themselves as stereotypical 'teenage mothers' and often made a distinction between other 'teenage mums' and themselves. Other researchers have also observed this (Kirkman et al., 2001; Jewell et al., 2000; Phoenix, 1991). Very few respondents actually used the word 'teenager' and, to avoid causing offence, alternative terms were used.

Where respondents were unsure about how to answer a question, they were asked to use an imaginary scale. So, in the case of relationships with parents, they were asked 'how well would you say your relationship was with your parents, on a scale of 1-5, for example, where '1' is very poor and '5' is excellent. Once respondents had answered using this scale, they were then probed further ('why a '3'?'). This scale was also used for questions about family financial hardship. Although important in helping respondents answer potentially difficult questions, there was not too much reliance on this method; scales are used routinely in survey data collection. The intention with the qualitative material was to gather as rich data as possible.

Since interviews were conducted over the telephone with the Coordinators, they did not see a copy of the letter advising respondents about informed consent. In the initial emails that were sent out, the Coordinators were assured that the interviews would be confidential and that their names or locations would not be identified. All Coordinators were asked if it would be okay to tape the telephone conversation.

The major practical consideration was where, how and when to conduct the interviews. Many of the young mothers had limited time because of their domestic commitments. The use of 'gatekeepers' who acted as a go-between meant that most young mothers were comfortable with being interviewed in their own homes. In one case, an interview was conducted in a café (the respondent had replied to an advertisement and did not know the interviewer). There were also difficulties using public transport in some cases (this was the case in Northumberland, which is the largest English county but is underpopulated for its size and has relatively undeveloped public transport services). In one case, a planned face-to-face interview had to be cancelled because there were no transport links to the respondents' home (a telephone interview was conducted instead).

*Interview schedules*

The areas explored are shown above in Tables 6, 7 and 8. Two interview schedules were constructed (in the case of the interviews with Coordinators, the schedule consisted of a list of topics and prompts).

For teenage mothers, the interviews were conducted using a semi-structured format with an interview schedule that was organised in an 'ecological' format (following the same pattern as the analysis of the BCS). The approach to the interviews broadly utilised a 'life course' perspective which has been used before with young mothers (Phoenix, 1991).

Questions were asked initially about the respondent's age, age at which she gave birth, her present location, employment etc. Questions were then asked about her family-of-origin, and then about her past and present relationship with parents and the nature and degree of parental supervision. There was an extensive exploration of friendships (their importance, the age at which close friends started childbearing, and whether this affected the respondents' attitudes to motherhood or not). Respondents were also asked about the kinds of areas they grew up in and if they thought that early childbearing was common in their areas (this was explored using a direct question 'do you think it is quite common for women to have their children young around here?'). Respondents were also asked about local attitudes to young mothers, and asked to relate details of specific incidents where they had encountered hostility. The circumstances surrounding pregnancy and birth (including the use of contraception, attitudes to abortion) were explored. Respondents were asked if they wanted to talk about anything else that had not been addressed in the interview, but that they considered important.

Coordinators were, first, asked very general questions about the area they worked in and were responsible for, and how long they had been in their present post. The interview then focused in on their particular (geographic) area. Key questions were asked about the main socio-economic and demographic features of their areas (its level of poverty, the presence of minority groups) and local rates and trends in teenage pregnancy and fertility and abortion. Coordinators

were also asked what they thought the reasons were for high/intermediate/low rates in their area, about small area variation in rates and local initiatives (e.g. sexual health services). Local attitudes (such as resistance to abortion) and hostility (generally and locally) to teenage mothers were also explored

### *Interview process*

Interviews with teenage mothers varied in range and depth. Interviews lasted, on average, 45-60 minutes. An unanticipated problem was that most women had their babies and small children with them when the interview took place and this often disrupted the interview. In one case, a small child pulled over a bookshelf and only narrowly avoided serious injury after the interviewer intervened to pull him out of harm's way (his mother was, understandably, distracted after this and this affected the depth and length of the interview). Some women had very young babies, who needed feeding, changing and soothing during the interviews (these women, incidentally, were the most tired of the respondents. One woman was interviewed when she had slept for only a couple of hours; her son had been crying in the night). In another case, the interview took place with a young mother while her best friend, fiancé's sister and three small children were present. Given that it was the respondents' home (and she did not appear ill-at-ease with other people present), it was not considered appropriate to suggest that this might not be the best setting to explore sensitive issues (such as use of contraception, or attitudes to abortion).

The degree of rapport with the young mothers varied. The interviewer is also a mother (who had her child in her early 20s) and sister to a teenage mother, and the interview process was made easier by 'small talk' about birth, children's development and well-being and, in the case of the London respondents, the quality of schools (coincidentally, one respondent had attended the same primary school as the interviewer's daughter). The young women (especially those who had younger children) appeared to enjoy seeing their babies being made a fuss of; interest in the children was genuinely felt, but also aided the interview process.

Some respondents seemed very relaxed and did not hesitate to 'open up'. Other respondents were more restrained and, at times, monosyllabic. However, among nearly all the respondents, there was a degree of defensiveness. Most seemed eager to convince the interviewer that they were good and happy mothers, and had made considered, and correct decisions, about their lives. Teenage mothers are a stigmatised group, the objects of public hostility and official concern, and most of the young women (while not directly referring to this) seemed to be aware of it (see also, Kirkman et al., 2001).

As noted above, some women made a distinction between themselves and other teenage mothers, believing that they are 'different' to other young mothers (in their attitudes, lifestyle, the care of their children). Phoenix (1991) made similar observations more than a decade ago (and when teenage mothers were, relatively speaking, a less visible group than they currently are). The construction of teenage pregnancy and motherhood as a problem not only has the potential to warp the research endeavour, but it may have implications for the well-being of young mothers and their children; the mothering process is likely to be less successful where mothers internalise dominant (and inaccurate) notions of themselves as problematic.

It was also sometimes difficult to listen to mothers' accounts of their lives (Arksey & Knight, 1999). Some respondents reported abuse (physical and emotional) or bad treatment at the hands of partners. In one instance, a young mother became distressed during the interview, so the interview was brought (prematurely) to an end (the tape machine was turned off and the young woman given time to compose herself, though, in this case, the interview was not restarted). Listening to these stories was, sometimes, emotionally draining, or they evoked feelings of anger. There is always the risk, as well, of appearing voyeuristic, so care had to be taken when respondents related details of distressing events not to appear *too* curious in such events. A fine line had to be walked between being engaged and sympathetic and being prying or 'greedy'. However, of the 16 interviews, only three or four were this difficult. Most interviews proceeded relatively well, despite time pressures and interruption.

The interviews with Coordinators were all conducted over the telephone, and this had benefits and drawbacks. The use of the telephone to collect qualitative data can be controversial; Ibsen & Balweig (2003) observe that some methods texts books caution against the use of the telephone, while others recommend it. Usually, though, it is not discussed at all. Here, the anonymity of the telephone interview seemed to facilitate candidness among the Coordinators. A number of Coordinators questioned the validity of the TPS, for example, and did not feel constrained about divulging what they considered to be the true motives behind the government's interest in teenage pregnancy (this will not be fully discussed here, where it is not the primary focus of the research).

The major disadvantage of using the telephone for the collection of data is that respondents' body language cannot be read. In the interviews with the young mothers, body language and other visual cues (especially eye contact), provided (usually subconscious) pointers about the acceptance or otherwise of certain lines of enquiry. On the telephone, all the cues are verbal, and the researcher has to become quickly adept at recognising these.

As was the case with the young mothers, the interviews with the Coordinators varied in length of time and range/depth of subjects covered: the shortest interview was about 15 minutes long and the longest was over an hour long. Some Coordinators did not have the time to provide a full interview (they had to attend meetings, for example). One Coordinator became irritated during the conversation and remarked that many people contacted her about teenage pregnancy. There were numerous interruptions during the interviews by Coordinators' colleagues. It also became apparent during the interviews that many Coordinators were not actually recruited for the post they were in at the time of the interview (a number were in the post temporarily). This meant that their knowledge of issues around teenage reproductive health in their localities was sometimes limited.

### *Analysis of the data*

The interview data from the young mothers were transcribed and subjected to a thematic analysis (Aronson, 1994; Rice & Ezzy, 2000). Thematic analysis is a comparatively simple method of analysing qualitative material, and is often used for analysing ethnographic and highly unstructured data (Aronson, 1994). The semi-structured nature of the data collected for this project limited the extent to which a full thematic analysis could be performed: based on a reading of the literature, it was already decided before the interviews what the important 'themes' would be, though there was scope within the structure of the interview format for freely emerging themes. Thematic analysis, however, can be used with semi-structured material, and has also been used elsewhere to analyse data collected from teenage mothers (Burns, 1999; Cronin, 2003; Whitehead, 2001).

Aronson (1994) observes that, although thematic analysis has been well described, there is a lack of literature outlining the 'pragmatic process' of thematic analysis. At its simplest, thematic analysis requires the reading and re-reading of the transcribed interview data to ascertain the existence of themes. These initial themes are then grouped and regrouped according to major, overarching themes. This strategy was employed here: all the transcripts were read and re-read several times over, and key themes emerging from the texts were noted. Following the schema of the interview, these themes were initially grouped into four domains: 'individual', 'family', 'peers', and 'neighbourhood'. In the case of young mothers only, 34 key themes emerged across these four domains (15 at the level of the 'individual', 10 at the level of the 'family', three at the level of 'peers' and six at the 'neighbourhood' level). This does not mean that all of these themes are relevant for every young mother, but these were the first major themes to emerge from the interview data. A re-reading, and re-grouping, of these initial themes led to the emergence of 12 major themes. These are shown below in Chapter Five and are used to structure the reporting of the qualitative data provided by the young mothers.



The interview data gathered from the Coordinators were not analysed thematically. There was more variability in the scope and nature of these interviews; as noted above, some Coordinators were too busy to speak for more than 15 minutes, while one interview lasted for about an hour. Given these limitations, this material should be considered exploratory. It was used, primarily, to supplement (and contrast with) the accounts provided by the young mothers, and to provide additional insight into community-wide influences on reproductive behaviour and reasons for variation in rates. A similar approach was used by Ingham, Clements & Gillibrand (1999) in an analysis of changes in rates of teenage pregnancy across selected English areas. Health professionals in each area were contacted and questioned about the possible reasons for changes in rates in their area. In this case, questionnaires, face-to-face interviews and telephone interviews were employed to collect data. These authors also note the difficulties in using these approaches; one of these was that respondents often could not find time to help with the study.

### **3.4) Hypotheses**

The aim of this thesis is to explore neighbourhood, family and peer influences on teenage sexual and reproductive behaviour by drawing on the neighbourhoods effects research. The analysis of survey and qualitative data was guided by two research questions:

1. Which factors within neighbourhoods, family and peer contexts are the most important in elucidating the causal pathways to teenage sex, pregnancy and fertility?
2. And, do the importance of these factors vary *between* neighbourhoods?

Based on a reading of the research literature, a number of hypotheses were generated, these were broad and overlapping, but guided the analysis of the BCS and the type of issues explored in the interviews (some of these hypotheses were more germane to the analysis of the BCS rather than the interview data and *vice versa*). It was hypothesised that:

1. Area deprivation will be significantly associated with teenage sex, pregnancy and fertility (SEU, 1999; Smith, 1993).
2. Other neighbourhood characteristics, such as neighbourhood monitoring and features, will be important, but less so (Furstenberg et al., 1999; Moore & Lindsay Chase-Landale, 1999). The young mothers will live in communities where teenage motherhood is normative (Macleod & Weaver, 2003).
3. Family structural factors (such as family structure, the cohort member's mother's age at first birth, family financial hardship and housing tenure) will be very significant (Kiernan, 1997; Rosato, 1999).
4. Family process factors (here measured by the amount of time spent with parents and supervision of the teenager's activities) will be important, especially parental monitoring (Miller et al., 2001; Moore & Lindsay Chase-Landale, 1999).
5. Teenagers who experience early sex, pregnancy and motherhood will be highly likely to mix with 'deviant' peers and to be influenced by them. Teenage mothers will likely have many friends who are also young mothers.
6. Individual-level factors will be important, especially those relating to education (Kiernan, 1997).
7. There will be differences in the importance of all the factors according to area deprivation. In poorer areas, structural factors may be less important, and peer influences may be stronger (Tabberer et al., 2000). The role of the family may also be more important in poorer areas, in 'protecting' children from early pregnancy and motherhood (Furstenberg et al., 1999). In non-deprived areas, structural factors may be more important than peer or family process factors.

## **Chapter Four: The Analysis of the British Cohort Study: Exploring Neighbourhood, Family and Peer Influences on Behaviour**

### **4.1) Introduction**

The history and development of the BCS, and the rationale for (and construction of) the variables of interest here was described above in Chapter Three. In this chapter, the results of the analysis are presented. These are summarised at the end of the chapter, and are discussed in Chapter Seven.

The two research questions guiding the analysis of the BCS were: first, which factors within neighbourhoods, family and peer contexts are the most important in elucidating the causal pathways to teenage sex, pregnancy and fertility?; and, second, do these vary by neighbourhood. To answer these questions, two types of analysis were undertaken: the first is an all area analysis; and the second, an analysis by different neighbourhood scenario.

### **4.2) Results: all area analysis**

#### **4.2.1) Bivariate analysis**

The first analysis was of the dataset as a whole, with no distinction made by neighbourhood scenario (this is presented below). The first analysis was undertaken to explore which factors, overall, at neighbourhood-level and within family and peer contexts (as well as at individual-level), are the most important in relation to the outcome variables (early sex, teenage pregnancy and teenage birth).

Table 21: Neighbourhood factors and sex, pregnancy and birth: all areas

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Area deprivation	High/very high deprivation	39.4% (300)	37.7% (338)	38.0% (795)	46.9% (309)	37.9% (779)	50.4% (272)
	Neither high nor low deprivation	19.2% (146)	22.3% (200)	19.3% (404)	20.5% (135)	19.4% (399)	20.6% (111)
	Low/very low deprivation	41.4% (315)	40.0% (359)	42.7% (895)	32.6% (215)	42.8% (880)	29.1% (157)
Total		100.0% (761)	100.0% (897)	100.0% (2094)	100.0% (659)	100.0% (2058)	100.0% (540)
Neighbourhood features	Poor features	26.7% (201)	35.9% (314)	29.2% (372)	40.3% (143)	28.8% (357)	43.1% (122)
	Mixed	37.8% (285)	36.5% (319)	37.1% (473)	36.9% (131)	37.9% (469)	35.3% (100)
	Good features	35.5% (268)	27.7% (242)	33.7% (429)	22.8% (81)	33.3% (412)	21.6% (61)
Total		100.0% (754)	100.0% (875)	100.0% (1274)	100.0% (355)	100.0% (1238)	100.0% (283)
Neighbourhood monitoring	Low	23.3% (133)	25.5% (164)	23.7% (323)	30.3% (116)	23.9% (319)	29.0% (89)
	Moderate	48.4% (277)	48.8% (313)	49.3% (673)	43.3% (166)	49.3% (657)	42.7% (131)
	High	28.3% (162)	25.7% (165)	27.0% (368)	26.4% (101)	26.7% (356)	28.3% (87)
Total		100.0% (572)	100.0% (642)	100.0% (1364)	100.0% (383)	100.0% (1332)	100.0% (307)

There were no significant differences between those cohort members who reported early sex and those in did not in level of area deprivation at age 16.

Nearly 47% of women who reported a teenage pregnancy lived in areas of high or very high deprivation compared with 38% of women reporting pregnancy at older ages. Almost equal proportions lived in areas that were neither deprived nor affluent, and 33% of women reporting teenage pregnancy lived in areas of low deprivation compared with 43% of women who had a pregnancy at older ages. These differences were statistically significant (Pearson Chi-Square=23.039,  $df^{27}=2$ ,  $p=0.000$ ).

Similar differences were found for 'Birth', though these were steeper: more than half of those who gave birth as a teenager lived in very poor areas, compared

<sup>27</sup> df=degrees of freedom. This abbreviation is used throughout this chapter.

with 38% of those who gave birth at age 21 or older (Pearson Chi-Square=36.940, df=2, p=0.000). Teenage pregnancy is, therefore, more equally distributed by level of area deprivation than teenage motherhood (though it is still concentrated in very poor areas). Most teenage mothers (in this sample, at least) lived in non-affluent areas at age 16 (over 70% lived in very deprived or moderate neighbourhoods compared with about 50% of older mothers). Though these differences are statistically significant, they are not excessively large; it clearly is not the case that *all* teenage mothers live in very deprived locations, which is the prevailing public view of teenage mothers (Clarke & Thomson, 2001).

Cohort members who experienced early sex were significantly more like than those who had not experienced early sex to live in neighbourhoods with poor features at age 16 (36% compared with 27%. Pearson Chi-Square=19.152, df=2, p=0.000). Both teenage mothers and those who experienced a teenage pregnancy lived, at age 16, in neighbourhoods with poor features (these features are physical *and* social). The differences were statistically significant for both groups ('Pregnancy': Pearson Chi-Square=21.242, df=2, p=0.000; 'Birth': Pearson Chi-Square=25.482, df=2, p=0.000) and were quite large (40% of women who had a pregnancy as a teenager lived in areas with poor features at age 16, compared with 29% of women who reported pregnancy at older ages). Again, the differences between the cohort members were steeper in relation to the birth outcomes, suggesting that there may be aspects of the area or neighbourhood that have a stronger influence on how individuals resolve pregnancy than on pregnancy itself. Neighbourhood monitoring was significant only for 'Pregnancy' (24% of women who experienced a teenage pregnancy lived in areas with low neighbourhood monitoring compared with 30% of women reporting pregnancy at older ages. Pearson Chi-Square=7.476, df=2, p=0.024). The next level of analysis relates to family structural characteristics.

Table 22: Family structural factors and sex, pregnancy and birth: all areas

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Number of parents living with at age 16	Single mother or father or neither	17.1% (127)	28.3% (245)	23.4% (447)	32.9% (195)	23.7% (444)	32.9% (160)
	Both natural parents	82.9% (616)	71.7% (620)	76.6% (1463)	67.1% (397)	76.3% (1426)	67.1% (326)
Total		100.0% (743)	100.0% (865)	100.0% (1910)	100.0% (592)	100.0% (1870)	100.0% (486)
Cohort member's mother: birth	Teenage mother	28.0% (195)	40.8% (342)	36.4% (710)	50.7% (307)	38.4% (697)	55.1% (276)
	Older mother	72.0% (501)	59.2% (496)	63.6% (1242)	49.3% (298)	63.6% (1216)	44.9% (225)
Total		100.0% (696)	100.0% (838)	100.0% (1952)	100.0% (605)	100.0% (1913)	100.0% (501)
Family troubled by finance hardship past yr	Yes	11.6% (71)	16.6% (119)	13.5% (226)	24.3% (129)	13.8% (227)	26.5% (114)
	No	88.4% (543)	83.4% (599)	86.5% (1443)	75.7% (402)	86.2% (1413)	73.5% (317)
Total		100.0% (614)	100.0% (718)	100.0% (1669)	100.0% (531)	100.0% (1640)	100.0% (431)
Housing tenure	Rented or other	20.0% (149)	30.5% (264)	25.3% (490)	43.2% (261)	25.6% (486)	48.5% (241)
	Owner occupied	80.0% (595)	69.5% (601)	74.7% (1446)	56.8% (343)	74.4% (1409)	51.5% (256)
Total		100.0% (744)	100.0% (865)	100.0% (1936)	100.0% (604)	100.0% (1895)	100.0% (497)

The differences between the cohort members were statistically significant in relation to all the family structural variables (family financial hardship, cohort member's mother: birth, family structure and housing tenure). Cohort members who reported early sexual experience were significantly more likely than those who experienced sex after age 16 to: have lived in a lone parent family at age 16 (28% compared with 17%. Pearson Chi-Square=28.350, df=1, p=0.000); to have a mother who began childbearing young (41% compared with 28%. Pearson Chi-Square=27.355, df=1, p=0.000); to have reported recent family financial hardship (17% compared with 12%. Pearson Chi-Square=6.793, df=1, p=0.009); and to have lived in rented property at age 16 (31% compared with 20%. Pearson Chi-Square=28.083, df=1, p=0.000).

At age 16, cohort members who reported a teenage pregnancy were more likely than those who experienced pregnancy at an older age only to: to have lived in a single parent family structure (33% compared with 23%, Pearson Chi-Square=21.544, df=1, p=0.000); to have a mother who began childbearing in her teens (51% compared with 37%. Pearson Chi-Square=39.819, df=1, p=0.000): to have reported financial hardship (24% compared with 14%, Pearson Chi-Square=34.418, df=1, p=0.000); and to have lived in social housing (43% compared with 25%, Pearson Chi-Square=70.848, df=1, p=0.000).

Similar results were seen in relation to the birth outcome. Again, these were generally steeper than those for pregnancy. Compared with women who had their children after age 20, women who began childbearing in their teens were more likely to: have lived in a lone parent family (33% compared with 24%. Pearson Chi-Square=17.046, df=1, p=0.000); and to have a mother who started childbearing young (55% compared with 37%. Pearson Chi-Square=57.425, df=1, p=0.000). Nearly 27% of women who later became teenage mothers reported financial hardship in their families compared with 14% of women who experienced birth after age 21 (Pearson Chi-Square=39.449, df=1, p=0.000). Nearly half of teenage mothers lived in social housing at age 16, compared with 26% of older mothers (Pearson Chi-Square=97.127, df=1, p=0.000).

So, although there is clear evidence that women who experience pregnancy and birth as teenagers come from relatively deprived backgrounds, these individuals are not *all* deprived. Nearly 50% of teenagers lived in social housing at age 16, but over 50% lived in owner-occupied housing. A third lived with one parent, but two thirds lived in a two-parent family.

*Table 23: Family process factors and sex, pregnancy and birth: all areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Parental supervision	Very low/low supervision	32.8% (250)	49.1% (433)	38.4% (494)	53.2% (189)	38.7% (484)	55.7% (157)
	Moderate supervision	14.2% (108)	14.1% (124)	14.1% (181)	14.4% (51)	14.0% (175)	13.8% (39)
	High/very high supervision	53.0% (404)	36.8% (324)	47.6% (613)	32.4% (115)	47.4% (593)	30.5% (86)
Total		100.0% (762)	100.0% (881)	100.0% (1288)	100.0% (355)	100.0% (1252)	100.0% (282)
Time spent with parents	Very little/little time	32.9% (205)	40.4% (293)	36.7% (606)	37.9% (192)	36.4% (589)	39.4% (164)
	Some time	24.1% (150)	20.8% (151)	21.8% (360)	20.8% (105)	21.7% (352)	20.0% (83)
	Quite a lot/a lot of time	43.0% (268)	38.8% (281)	41.5% (685)	41.3% (209)	41.9% (678)	40.6% (169)
Total		100.0% (623)	100.0% (725)	100.0% (1651)	100.0% (508)	100.0% (1619)	100.0% (416)

Two (closely related) variables measured aspects of family process. Among those women who experienced early sexual activity, 49% reported low levels of parental supervision at age 16, compared with 33% of women who had not engaged in early sexual behaviour (Pearson Chi-Square=50.573, df=2, p=0.000). Over 40% of the former also reported that they spent very little time with parents (Pearson Chi-Square=8.190, df=2, p=0.017).

Women reporting a teenage pregnancy were more likely than other cohort members to have reported low levels of parental supervision at age 16 (53% compared with 38%, Pearson Chi-Square=29.362, df=2, p=0.000). Similar (slightly steeper) results were seen for teenage mothers (56% compared with 39%, Pearson Chi-Square=30.745, df=2, p=0.000). The amount of time spent with parents was not statistically significant in relation to either teenage pregnancy or birth.



Table 24: Peer factors and sex, pregnancy and birth: all areas

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Friends deviance	High deviance	31.7% (220)	46.1% (386)	37.8% (606)	49.7% (234)	37.7% (590)	49.2% (187)
	Moderate deviance	23.1% (160)	18.7% (157)	21.3% (341)	21.0% (99)	21.6% (339)	21.6% (82)
	Low deviance	45.2% (314)	35.2% (295)	40.9% (655)	29.3% (138)	40.7% (637)	29.2% (111)
Total		100.0% (694)	100.0% (838)	100.0% (1602)	100.0% (471)	100.0% (1566)	100.0% (380)
Get led into things would not do on own	Often/sometimes	11.6% (87)	15.3% (131)	13.5% (170)	13.8% (48)	13.4% (164)	14.7% (41)
	Rarely/don't know	30.5% (229)	28.7% (246)	29.9% (376)	28.4% (99)	29.0% (355)	28.8% (80)
	Never	57.9% (434)	56.0% (480)	56.6% (712)	57.9% (202)	57.6% (704)	56.5% (157)
Total		100.0% (750)	100.0% (857)	100.0% (1258)	100.0% (349)	100.0% (1223)	100.0% (278)

Cross-tabulations of the outcome variables with two measures of peer effects showed that, among women who experienced early sex compared with those who did not, there was a higher level of association with 'deviant' peers (46% compared with 32%. Pearson Chi-Square=32.848, df=2, p=0.000), though this did not affect the degree to which they were led into doing things they would not ordinarily do (reported degree of peer influence was approximately the same for both groups).

Women who experienced a teenage pregnancy were also more likely to mix with 'deviant' friends; nearly 50% of women who had a teenage pregnancy had 'deviant' friends at age 16 compared with 38% of women who had pregnancy at older ages (Pearson Chi-Square=25.409, df=2, p=0.000). This did not affect reported peer influence; similar proportions of both groups reported 'often' being influenced by their peers (14% for both).

Very similar results were observed for 'Birth'. Teenage mothers had more 'deviant' friends than older mothers at age 16 (49% compared with 38%. Pearson Chi-Square=20.651, df=2, p=0.000), but both groups reported similar levels of

peer influence (around 14% for both). The final area that was explored was that relating to the cohort member's own characteristics.

*Table 25: Individual factors and sex, pregnancy and birth: all areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Own deviance	High deviance	2.5% (19)	7.7% (68)	4.0% (67)	5.9% (29)	4.1% (67)	6.6% (26)
	Moderate deviance	1.5% (11)	3.6% (32)	3.2% (54)	4.1% (20)	3.3% (54)	3.8% (15)
	Low deviance	96.0% (727)	88.7% (788)	92.8% (1551)	90.0% (439)	92.6% (1516)	89.6% (352)
Total		100.0% (757)	100.0% (888)	100.0% (1672)	100.0% (488)	100.0% (1637)	100.0% (393)
Attitudes to school	Negative attitude to school	23.0% (171)	40.7% (352)	28.7% (377)	47.2% (174)	28.8% (370)	49.0% (144)
	Moderate attitude to school	30.7% (228)	31.8% (275)	32.6% (429)	27.1% (100)	32.2% (413)	28.2% (83)
	Positive attitude to school	46.2% (343)	27.5% (238)	38.7% (509)	25.7% (95)	39.0% (500)	22.8% (67)
Total		100.0% (742)	100.0% (865)	100.0% (1315)	100.0% (369)	100.0% (1283)	100.0% (294)

There were two individual-level factors used in the analyses: own deviance and attitudes to school. Those who reported early sex reported higher levels of own deviance at age 16 (8% compared with 3%. Pearson Chi-Square=30.068, df=2, p=0.000) and negative attitudes to school (41% compared with 23%. Pearson Chi-Square=77.045, df=2, p=0.000).

Among women who reported a teenage pregnancy, there were no significant differences between the two groups of women in relation to level of own deviance. Among women who had a teenage pregnancy, 47% had negative attitudes to school compared with 29% of women who had a pregnancy at an older age (Pearson Chi-Square=46.388, df=2, p=0.000).

Similar results were seen for teenage mothers. Levels of own deviance did not vary significantly between the two types of mothers. Almost half of teenage

mothers reported poor attitudes to school at age 16 (compared with a third of older mothers. Pearson Chi-Square=48.382, df=2, p=0.000).

#### Summary of results: all area bivariate analysis

##### *Sex*

In relation to the 'Sex' outcome, area deprivation was not significant, but neighbourhood features were ('features' here included social aspects of neighbourhood as well as physical; it included the cohort member's perception about 'teenagers hanging around the neighbourhood', for example). Neighbourhood monitoring was not important for 'Sex' (this was based on cohort member's perceptions about how neighbours would respond if they saw various anti-social acts being committed). All the family structural and process factors were significantly associated with early sex. One peer factor, deviant friends, was strongly associated with initiating sex at a young age (though peer influence was not). Cohort members who engaged in early sex also reported high levels of own deviance and poor attitudes to school.

##### *Pregnancy*

There were 11 variables for 'Pregnancy' that were identified as statistically significant in bivariate analysis. There was no difference between women who reported early sex and those who did not in the deprivation of the area they lived in at age 16; this was not the case for women who reported a teenage pregnancy. These women were more likely to have lived in poor areas at age 16 than women who had pregnancies at older ages only. Neighbourhood features and neighbourhood monitoring were both significantly associated with early pregnancy. All the family structure and process factors were significantly associated with teenage pregnancy, except for the amount of time spent with parents. Women who had an early pregnancy were significantly more likely than those who had pregnancies at older ages to have mixed with 'deviant' friends at age 16 (though, as was the case for women who initiated sex before age 16) this did not affect the cohort member's behaviour in any way. Negative attitudes to

school were also disproportionately concentrated among women who a teenage pregnancy (compared with those who did not).

### *Birth*

The significant results for 'Birth' were almost the same as those for pregnancy, with one exception: living in a neighbourhood with low monitoring at age 16 was not significantly associated with later teenage motherhood. For teenage mothers, area deprivation, neighbourhood features, family structure, age of cohort member's mother at first birth, family financial hardship, housing tenure, parental supervision, friends' deviance and attitudes to school were all significant in the initial cross-tabulations.

#### 4.2.2) Multivariate analysis

### *Sex*

In multivariate analysis, the variables entered into the regression explained about 14% of the variance (Nagelkerke R Square=0.141). The results for 'Sex' are shown in Table 26.

Table 26: Logistic regression, sex: all areas

## Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1								
NEIGFE			2.022	2	.364			
NEIGFE(1)	-.227	.163	1.957	1	.162	.797	.579	1.095
NEIGFE(2)	-.165	.170	.947	1	.331	.848	.608	1.182
FAMSTRUC(1)	-.270	.170	2.531	1	.112	.763	.547	1.065
CMMBTH(1)	-.421	.145	8.423	1	.004	.656	.494	.872
FINHARD(1)	-.189	.204	.856	1	.355	.828	.554	1.236
TENURE(1)	-.297	.169	3.071	1	.080	.743	.533	1.036
PARSUPE			10.052	2	.007			
PARSUPE(1)	-.393	.201	3.822	1	.051	.675	.455	1.001
PARSUPE(2)	-.450	.147	9.354	1	.002	.638	.478	.851
TIMEPAR			7.555	2	.023			
TIMEPAR(1)	-.454	.174	6.827	1	.009	.635	.452	.893
TIMEPAR(2)	-.297	.152	3.830	1	.050	.743	.552	1.000
FRIENDEV			4.448	2	.108			
FRIENDEV(1)	-.299	.178	2.827	1	.093	.741	.523	1.051
FRIENDEV(2)	-.291	.153	3.640	1	.056	.747	.554	1.008
OWNDEV			11.594	2	.003			
OWNDEV(1)	-.122	.631	.038	1	.846	.885	.257	3.049
OWNDEV(2)	-1.156	.434	7.104	1	.008	.315	.134	.736
SCOATT			12.761	2	.002			
SCOATT(1)	-.232	.166	1.949	1	.163	.793	.572	1.098
SCOATT(2)	-.588	.167	12.350	1	.000	.555	.400	.771
Constant	3.295	.502	43.104	1	.000	26.991		

a. Variable(s) entered on step 1: NEIGFE, FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, TIMEPAR, FRIENDEV, OWNDEV, SCOATT.

In the all area analysis, the most significant factors associated with early sex were: the age at which the cohort member's mother began having children; parental supervision; time spent with parents; level of own deviance; and attitudes to school.

Compared with women who have young (i.e. teenage) mothers, women whose mothers began family-building after the teen years had a reduced chance of having had sex by age 16 (odds ratio=0.656, where reference category=1). Women with very positive attitudes to school also had a reduced chance of

having had sex by age 16 (odds ratio=0.555, 95% CI<sup>28</sup>= 0.400-0.771). None of the confidence intervals seen in Table 26 crosses '0', so these results were valid even though the selection of variables explained only about 14% of the variance.

### *Pregnancy*

The use of the significant variables in the regression accounted for only 12% of the variance (Nagelkerke Square=0.122).

*Table 27: Logistic regression, pregnancy: all areas*

		Variables in the Equation					95.0% C.I. for EXP(B)		
		B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Step 1 <sup>a</sup>	AREADEP			8.308	2	.016			
	AREADEP(1)	-.505	.234	4.673	1	.031	.603	.382	.954
	AREADEP(2)	-.489	.192	6.504	1	.011	.613	.421	.893
	NEIGFE			1.074	2	.584			
	NEIGFE(1)	-.172	.204	.713	1	.399	.842	.565	1.255
	NEIGFE(2)	-.210	.224	.876	1	.349	.811	.522	1.258
	NEIGPOL			1.648	2	.439			
	NEIGPOL(1)	-.151	.205	.542	1	.461	.860	.575	1.286
	NEIGPOL(2)	.106	.235	.204	1	.652	1.112	.701	1.763
	FAMSTRUC(1)	-.404	.195	4.297	1	.038	.668	.456	.978
	CMMBTH(1)	-.288	.178	2.607	1	.106	.750	.529	1.063
	FINHARD(1)	-.267	.237	1.272	1	.259	.765	.481	1.218
	TENURE(1)	-.412	.196	4.425	1	.035	.662	.451	.972
	PARSUPE			4.601	2	.100			
	PARSUPE(1)	-.114	.248	.211	1	.646	.892	.549	1.450
	PARSUPE(2)	-.411	.193	4.540	1	.033	.663	.454	.968
	FRIENDEV			2.022	2	.364			
	FRIENDEV(1)	-.048	.222	.047	1	.828	.953	.616	1.473
	FRIENDEV(2)	-.273	.198	1.888	1	.169	.761	.516	1.123
	SCOATT			13.822	2	.001			
SCOATT(1)	-.528	.201	6.916	1	.009	.590	.398	.874	
SCOATT(2)	-.757	.217	12.216	1	.000	.469	.307	.717	
Constant	.777	.319	5.955	1	.015	2.176			

a. Variable(s) entered on step 1: AREADEP, NEIGFE, NEIGPOL, FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, FRIENDEV, SCOATT.

<sup>28</sup> CI=confidence intervals. This abbreviation is used throughout this chapter.

Five factors emerged as important in the regression analysis in relation to 'Pregnancy': area deprivation; family structure; tenure; parental supervision; and attitudes to school. Area deprivation remained independently significant in relation to the pregnancy outcomes: women in moderate and affluent neighbourhoods had approximately 60% the chance of becoming pregnant as a teenager compared with women living in poor neighbourhoods (all other factors held constant). As was the case with 'Pregnancy', the cohort member's attitudes to school were also important. Cohort members expressing 'pro-school' attitudes at age 16 were about half as likely to become pregnant as cohort members with negative attitudes to school. Women reporting high levels of supervision by their parents also had a reduced chance of becoming pregnant as a teenager (odds ratio=0.663).

### *Birth*

Just under 19% of the variables entered into the model explained the amount of variance (Nagelkerke R Square=0.186).

Table 28: Logistic regression, birth: all areas

## Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1			9.963	2	.007			
AREADEP								
AREADEP(1)	-.283	.231	1.501	1	.220	.753	.479	1.185
AREADEP(2)	-.638	.202	9.950	1	.002	.528	.355	.785
NEIGFE			1.603	2	.449			
NEIGFE(1)	-.239	.207	1.334	1	.248	.788	.526	1.181
NEIGFE(2)	-.229	.233	.966	1	.326	.795	.503	1.256
FAMSTRUC(1)	-.132	.203	.422	1	.516	.877	.589	1.304
CMMBTH(1)	-.375	.183	4.203	1	.040	.688	.481	.984
FINHARD(1)	-.421	.232	3.308	1	.069	.656	.417	1.033
TENURE(1)	-.795	.193	17.054	1	.000	.451	.309	.658
PARSUPE			6.490	2	.039			
PARSUPE(1)	-.207	.266	.610	1	.435	.813	.483	1.368
PARSUPE(2)	-.513	.201	6.489	1	.011	.599	.404	.888
FRIENDEV			5.246	2	.073			
FRIENDEV(1)	.174	.227	.583	1	.445	1.190	.762	1.858
FRIENDEV(2)	-.349	.208	2.828	1	.093	.705	.469	1.060
SCOATT			19.291	2	.000			
SCOATT(1)	-.563	.204	7.653	1	.006	.569	.382	.849
SCOATT(2)	-.991	.236	17.638	1	.000	.371	.234	.589
Constant	.870	.294	8.774	1	.003	2.388		

a. Variable(s) entered on step 1: AREADEP, NEIGFE, FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, FRIENDEV, SCOATT.

In relation to the birth outcome, five factors were seen to be independently significant: area deprivation; cohort members' mothers age at first birth; tenure; parental supervision; and attitudes to school. Four of these (area deprivation, tenure, parental supervision; attitudes to school) were the same factors that were seen to be significant in relation to 'Pregnancy'.

For the birth outcome, parental supervision was significant. Cohort members who reported high levels of parental supervision at age 16 were less likely (odds ratio=0.599) than cohort members who reported very low levels of supervision to have a child as a teenager. It is not immediately clear why this should be important in relation to 'Birth' and not to 'Sex' or 'Pregnancy'. Attitudes to school continue to be important (as they had been for 'Sex' and 'Pregnancy'; cohort members reporting positive attitudes to school at age 16 were significantly less likely to become teenage mothers than cohort members expressing negative



attitudes to school; odds ratio=0.371). Cohort members living in affluent areas at age 16 were about half as likely to become young mothers compared with women living in deprived areas.

### 4.3) Results: different neighbourhood scenarios

#### 4.3.1) Introduction

Thus far, the results of the analysis have been presented for cohort members as a whole, regardless of the type of area they lived in at age 16. Although area deprivation appeared to be a significant factor in relation to both teenage pregnancy and birth, it would be illuminating to contrast the experience of cohort members across areas. There may be more influences on behaviour in certain types of neighbourhood (social interaction factors may be more important in poor neighbourhoods, for example). In the neighbourhood effects literature, individuals in poorer environments are more susceptible to external influences, which, compounded with structural poverty, means that they are oriented to early sex, pregnancy and fertility.

*Table 29: Area deprivation at age 16*

	Frequency	Percent
High/very high deprivation	1104	40.1
Neither high nor low deprivation	539	19.6
Low/very low deprivation	1110	40.3
Total	2753	100.0

Data were missing for nine women (0.3%). There were 1104 women living in areas of high/fairly high deprivation in 1986. There were 539 women living in areas that were neither deprived nor affluent and 1110 women lived in non-deprived areas. Women in deprived areas at age 16 were significantly more likely than women living in moderate or non-deprived areas to report a teenage pregnancy or birth, but not early sexual experience.

*Table 30: Sex, pregnancy and birth, distribution by area*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Area deprivation	High/very high deprivation	39.4% (300)	37.7% (338)	38.0% (795)	46.9% (309)	37.9% (779)	50.4% (272)
	Neither high nor low deprivation	19.2% (146)	22.3% (200)	19.3% (404)	20.5% (135)	19.4% (399)	20.6% (111)
	Low/very low deprivation	41.4% (315)	40.0% (359)	42.7% (895)	32.6% (215)	42.8% (880)	29.1% (157)
Total		100.0% (761)	100.0% (897)	100.0% (2094)	100.0% (659)	100.0% (2058)	100.0% (540)

Almost equal proportions of those reporting sexual experience by age 16 and those not reporting early sex lived in areas of high/very high deprivation. However, nearly 47% of women reporting a teenage pregnancy lived in a deprived area compared with 38% of women reporting pregnancy at an older age (Pearson Chi-Square=23.039, df=2, p=0.000). Teenage pregnancies were only slightly higher (overall) in areas of high deprivation compared with the other areas, though these differences were significant.

Of the 1104 pregnancies reported by women living in very deprived areas in 1986, only 28% were to teenagers (compared with 25% and 19% in the other groups; there is, therefore, only a 9% difference between the poorest and the most affluent areas). Seventy two per cent of pregnancies in poor areas were to older women. A similar pattern can be seen in relation to births. Among women reporting birth as a teenager, 50% lived in very deprived areas, 21% in moderate areas and 29% in non-deprived areas (Pearson Chi-Square=36.940, df=2, p=0.000).

There were more births to teenagers in poor areas (26%), but most births were to older women and there was only around a 10% difference between poor and wealthy areas in the proportion of births that are to teenagers. The same type of analysis (cross-tabulations, binary logistic regression) was run for three area types: deprived areas, moderate areas, and non-deprived areas. Results were then compared across all three areas.

#### 4.4) Deprived areas

##### 4.4.1) Bivariate analysis

There were 1104 women living in a very deprived/deprived area in 1986 who experienced at least one pregnancy. Of these, 309 had a pregnancy as a teenager. And of 1051 women who experienced at least one birth, 272 gave birth while a teenager. Of the 638 women in deprived areas, over half had experienced sex by age 16.

*Table 31: Neighbourhood factors and sex, pregnancy and birth: deprived areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Neighbourhood features	Poor features	32.7% (97)	41.9% (138)	34.4% (158)	46.1% (77)	34.4% (153)	48.6% (69)
	Mixed	36.4% (108)	35.0% (115)	37.0% (170)	31.7% (53)	37.1% (165)	31.0% (44)
	Good features	31.0% (92)	23.1% (76)	28.5% (131)	22.2% (37)	28.5% (127)	20.4% (29)
Total		100.0% (297)	100.0% (329)	100.0% (459)	100.0% (167)	100.0% (445)	100.0% (142)
Neighbourhood monitoring	Low	23.8% (54)	25.4% (65)	22.2% (117)	31.7% (58)	22.2% (114)	30.6% (48)
	Moderate	48.9% (111)	43.8% (112)	48.8% (257)	39.9% (73)	48.6% (250)	39.5% (62)
	High	27.3% (62)	30.9% (79)	29.0% (153)	28.4% (52)	29.2% (150)	29.9% (47)
Total		100.0% (227)	100.0% (256)	100.0% (527)	100.0% (183)	100.0% (514)	100.0% (157)

Although all these women lived in very deprived communities, there were significant differences between those reporting early sex, teenage pregnancy or birth and those reporting birth at older ages in neighbourhood characteristics.

Women in poor areas who reported early sex and teenage pregnancy, were significantly more likely to report living in a neighbourhood with poor features ('poor features' includes not only the presence of rubbish on the streets and graffiti, but also the numbers of teenagers hanging around the streets) (42% of women who experienced early sex lived in such neighbourhoods compared with 33% of women who were still virgins at age 16. Pearson Chi-Square=7.280, df=2,

$p=0.026$ ; 46% of women who had a teenage pregnancy lived in such neighbourhoods compared with 34% of women who had an older pregnancy only. Pearson Chi-Square=7.279,  $df=2$ ,  $p=0.026$ ). This was also the case for teenage mothers (49% compared with 34%. Pearson Chi-Square=9.538,  $df=2$ ,  $p=0.008$ ). The results were slightly steeper for 'Birth'. Neighbourhood monitoring was significant in relation to 'Pregnancy' only (32% compared with 22%. Pearson Chi-Square=7.286,  $p=0.026$ ).

*Table 32: Family structural factors and sex, pregnancy and birth: deprived areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Number of parents living with at age 16	Single mother or father or neither	16.8% (49)	28.1% (92)	24.1% (172)	28.2% (79)	24.4% (170)	26.0% (64)
	Both natural parents	83.2% (243)	71.9% (235)	75.9% (542)	71.8% (201)	75.6% (528)	74.0% (182)
Total		100.0% (292)	100.0% (327)	100.0% (714)	100.0% (280)	100.0% (698)	100.0% (246)
Cohort member's mother: birth	Teenage mother	33.2% (89)	45.6% (146)	41.1% (302)	52.1% (148)	41.0% (295)	55.1% (140)
	Older mother	66.8% (179)	54.4% (174)	58.9% (433)	47.9% (136)	59.0% (424)	44.9% (114)
Total		100.0% (268)	100.0% (320)	100.0% (735)	100.0% (284)	100.0% (719)	100.0% (254)
Family troubled by finance hardship past yr	Yes	12.2% (29)	19.9% (55)	16.3% (101)	27.3% (69)	16.7% (102)	28.8% (64)
	No	87.8% (208)	80.1% (221)	83.7% (519)	72.7% (184)	83.3% (507)	71.2% (158)
Total		100.0% (237)	100.0% (276)	100.0% (620)	100.0% (253)	100.0% (609)	100.0% (222)
Housing tenure	Rented or other	27.7% (81)	33.3% (108)	32.2% (231)	50.0% (142)	32.5% (228)	54.0% (135)
	Owner occupied	72.3% (211)	66.7% (216)	67.8% (487)	50.0% (142)	67.5% (474)	46.0% (115)
Total		100.0% (292)	100.0% (324)	100.0% (718)	100.0% (284)	100.0% (702)	100.0% (250)

Within deprived areas, at age 16, women who experienced early sex were significantly more likely than virgins to: live in a lone parent family structure (28% compared with 17%. Pearson Chi-Square=11.305,  $df=1$ ,  $p=0.001$ ); have a mother who started childbearing as a teenager (46% compared with 33%. Pearson Chi-Square=9.371,  $df=1$ ,  $p=0.002$ ); and report family financial adversity (20% compared with 12%. Pearson Chi-Square=5.508  $df=$ ,  $p=0.019$ ). There were no

significant differences between the two groups in relation to tenure.

Cohort members who had a teenage pregnancy were significantly more likely than those who had a pregnancy at older ages to: have mothers who started childbearing as a teenager (52% compared with 41%. Pearson Chi-Square=10.096, df=1, p=0.001); report family financial hardship at age 16 (27% compared with 16%, Pearson Chi-Square=13.820, df=p=0.000); and to be living in social housing (50% compared with 32%, Pearson Chi-Square=27.677, p=0.000). There were no significant differences in relation to family structure.

Similar results were seen for teenage mothers (family financial hardship: 29% compared with 17%. Pearson Chi-Square=14.852, p=0.000; age at cohort members' mothers' first birth: 55% compared with 41%. Pearson Chi-Square=15.072, df=1 p=0.000); housing tenure: 54% compared with 33%. Pearson Chi-Square=36.194, p=0.000). Again, family structure was not significantly different between teenage mothers and older mothers (which may be because, in deprived areas, there are comparatively high numbers of single parent families, so effects on behaviour are likely to come from other factors).

The results for teenage births were, generally, steeper than those for pregnancy. But, as noted above, only about half (54%) of teenage mothers were living in social housing at age 16 (compared with a third of older mothers).

*Table 33: Family process factors and sex, pregnancy and birth: deprived areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Parental supervision	Very low/low supervision	40.1% (120)	50.2% (167)	44.0% (205)	49.4% (82)	44.5% (201)	53.2% (75)
	Moderate supervision	11.4% (34)	13.8% (46)	12.4% (58)	13.3% (22)	12.2% (55)	12.1% (17)
	High/very high supervision	48.5% (145)	36.0% (120)	43.6% (203)	37.3% (62)	43.4% (196)	34.8% (49)
Total		100.0% (299)	100.0% (333)	100.0% (466)	100.0% (166)	100.0% (452)	100.0% (141)
Time spent with parents	Very little/little time	35.6% (83)	37.3% (106)	38.1% (236)	33.7% (82)	36.9% (225)	35.9% (78)
	Some time	24.5% (57)	22.2% (63)	21.8% (135)	23.5% (57)	22.7% (138)	21.7% (47)
	Quite a lot/a lot of time	39.9% (93)	40.5% (115)	40.2% (249)	42.8% (104)	40.4% (246)	42.4% (92)
Total		100.0% (233)	100.0% (284)	100.0% (620)	100.0% (243)	100.0% (609)	100.0% (217)

In relation to the parent-child relationship, there were no significant differences between the groups of women, except in one respect: women who initiated sex before age 16 were significantly more likely than virgins to report lower levels of parental supervision at age 16 (50% compared with 40%. Pearson Chi-Square=10.055, df=2, p=0.007).

*Table 34: Peer factors and sex, pregnancy and birth: deprived areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Friends deviance	High deviance	35.0% (96)	45.9% (146)	37.3% (227)	48.8% (105)	36.9% (219)	50.3% (94)
	Moderate deviance	18.6% (51)	19.2% (61)	20.7% (126)	21.4% (46)	21.4% (127)	20.9% (39)
	Low deviance	46.4% (127)	34.9% (111)	41.9% (255)	29.8% (64)	41.7% (247)	28.9% (54)
Total		100.0% (274)	100.0% (318)	100.0% (608)	100.0% (215)	100.0% (593)	100.0% (187)
Get led into things would not do on own	Often/sometimes	13.6% (40)	14.2% (46)	13.9% (63)	14.0% (23)	13.9% (61)	14.3% (20)
	Rarely/don't know	32.3% (95)	27.8% (90)	33.3% (151)	20.7% (34)	31.8% (140)	22.1% (31)
	Never	54.1% (159)	58.0% (188)	52.9% (240)	65.2% (107)	54.3% (239)	63.6% (89)
Total		100.0% (294)	100.0% (324)	100.0% (454)	100.0% (164)	100.0% (440)	100.0% (140)

Women living in deprived areas at age 16, and who reported early sexual experience were significantly more likely than virgins to mix with 'deviant' peers (46% compared with 35%. Pearson Chi-Square=9.079, df=2, p=0.011). There were no significant differences between the two groups in relation to peer influence (though those who were sexually active actually reported less peer influence at age 16).

Within deprived areas, women who had a teenage pregnancy were significantly more likely to report having 'deviant' friends (49% compared with 37%. Pearson Chi-Square=11.316, df=2, p=0.003), and to report being *less* likely than women reporting older pregnancy to be influenced by their friends (65% of the former said that they would 'never' be led into doing something they would not ordinarily do, compared with 53% of the latter. Pearson Chi-Square=9.608, df=2, p=0.008).

Similar results were observed for 'Birth'. Significant results were also observed for and friends' deviance (50% compared with 37%. Pearson Chi-Square=12.335, df=2, p=0.002). Higher proportions of young mothers (64% compared with 54% of older mothers) said that they were not influenced by friends, though this was not statistically significant.

*Table 35: Individual factors and sex, pregnancy and birth: deprived areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Own deviance	High deviance	3.7% (11)	6.6% (22)	3.8% (24)	5.4% (12)	4.1% (25)	5.7% (11)
	Moderate deviance	2.0% (6)	3.3% (11)	3.7% (23)	4.5% (10)	3.7% (23)	4.6% (9)
	Low deviance	94.3% (282)	90.1% (300)	92.5% (582)	90.1% (201)	92.2% (566)	89.7% (174)
Total		100.0% (299)	100.0% (333)	100.0% (629)	100.0% (223)	100.0% (614)	100.0% (194)
Attitudes to school	Negative attitude to school	27.5% (80)	39.2% (129)	30.2% (145)	44.3% (78)	30.2% (141)	46.3% (69)
	Moderate attitude to school	30.6% (89)	33.1% (109)	31.5% (151)	31.3% (55)	31.5% (147)	32.9% (49)
	Positive attitude to school	41.9% (122)	27.7% (91)	38.3% (184)	24.4% (43)	38.3% (179)	20.8% (31)
Total		100.0% (291)	100.0% (329)	100.0% (480)	100.0% (176)	100.0% (467)	100.0% (149)

Though levels of own deviance were higher for women reporting sexual activity, pregnancy and birth, none of these were statistically significant.

In contrast, negative attitudes to school were pervasive: among the sexually active, 39% reported negative attitudes to school compared with 28% of virgins (Pearson Chi-Square=15.750, df=2, p=0.000). Among women who experienced an early pregnancy, 44% reported negative attitudes to school compared with 30% of women who reported pregnancy at older ages (Pearson Chi-Square=14.763, p=0.001); 46% of teenage mothers had negative attitudes to school at age 16 compared with 30% of older mothers (Pearson Chi-Square=18.852, p=0.000).

#### 4.4.2) Multivariate analysis

##### Sex

All the variables found to be significant for 'Sex' in the bivariate analysis were entered into a logistic regression—though the results were restricted only to



women in poor areas. The variables selected explained about 11% of the variance (Nagelkerke R Square=0.107).

*Table 36: Logistic regression, deprived areas: sex*

		Variables In the Equation					95.0% C.I. for EXP(B)		
		B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Step	NEIGFE			1.155	2	.561			
1	NEIGFE(1)	-.239	.240	.988	1	.320	.787	.491	1.261
	NEIGFE(2)	-.215	.267	.650	1	.420	.807	.478	1.360
	FAMSTRUC(1)	-.402	.258	2.431	1	.119	.669	.404	1.109
	CMMBTH(1)	-.770	.218	12.493	1	.000	.463	.302	.710
	FINHARD(1)	-.302	.302	.997	1	.318	.740	.409	1.337
	PARSUPE			.795	2	.672			
	PARSUPE(1)	.087	.308	.079	1	.779	1.090	.596	1.995
	PARSUPE(2)	-.160	.232	.478	1	.489	.852	.541	1.342
	FRIENDEV			1.550	2	.461			
	FRIENDEV(1)	-.205	.276	.552	1	.458	.815	.474	1.399
	FRIENDEV(2)	-.289	.237	1.487	1	.223	.749	.470	1.192
	SCOATT			3.285	2	.193			
	SCOATT(1)	.095	.258	.137	1	.711	1.100	.664	1.822
	SCOATT(2)	-.347	.261	1.770	1	.183	.707	.424	1.178
	Constant	1.723	.389	19.604	1	.000	5.600		

a. Variable(s) entered on step 1: NEIGFE, FAMSTRUC, CMMBTH, FINHARD, PARSUPE, FRIENDEV, SCOATT.

Just one variable emerged as significant: the age at which the cohort mother began childbearing. Women whose mother began childbearing after adolescence had about half the odds (0.463, 95% CI=0.302-0.710) of having experienced early sex compared with cohort member's mothers who had children as teenagers.

### *Pregnancy*

In relation to the pregnancy outcome, the selected variables explained only about 16% of the variance (Nagelkerke R Square=0.162).

Table 37: Logistic regression, deprived areas: pregnancy

## Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1								
NEIGFE			2.634	2	.268			
NEIGFE(1)	-.418	.295	2.002	1	.157	.659	.369	1.175
NEIGFE(2)	-.441	.336	1.728	1	.189	.643	.333	1.242
NEIGPOL			2.688	2	.261			
NEIGPOL(1)	-.424	.309	1.893	1	.169	.654	.357	1.198
NEIGPOL(2)	-.006	.337	.000	1	.987	.994	.514	1.925
CMMBTH(1)	-.280	.262	1.144	1	.285	.755	.452	1.263
FINHARD(1)	.439	.395	1.232	1	.267	1.551	.715	3.365
TENURE(1)	-.544	.283	3.700	1	.054	.581	.334	1.010
FRIENDEV			3.626	2	.163			
FRIENDEV(1)	-.396	.333	1.412	1	.235	.673	.350	1.293
FRIENDEV(2)	-.555	.303	3.364	1	.067	.574	.317	1.039
LED			15.772	2	.000			
LED(1)	-.778	.443	3.092	1	.079	.459	.193	1.093
LED(2)	.468	.402	1.360	1	.243	1.598	.727	3.510
SCOATT			7.439	2	.024			
SCOATT(1)	-.375	.304	1.520	1	.218	.687	.378	1.248
SCOATT(2)	-.914	.335	7.436	1	.006	.401	.208	.773
Constant	.179	.578	.096	1	.757	1.196		

a. Variable(s) entered on step 1: NEIGFE, NEIGPOL, CMMBTH, FINHARD, TENURE, FRIENDEV, LED, SCOATT.

The significant variables to emerge from the logistic regression were: attitudes to school (odds ratio of experiencing a teenage pregnancy for women with positive attitudes to school=0.401, 95% CI= 0.208-0.773). Peer influence was also significant, but women who experienced a teenage pregnancy were *less* likely to report peer influence at age 16 than women who experienced pregnancy at older ages only.

### Birth

The use of the variables explained about 14% of the variance in relation to 'Birth' (Nagelkerke R Square=0.139).

Table 38: Logistic regression, deprived areas: birth

		Variables In the Equation						95.0% C.I. for EXP(B)	
		B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Step	NEIGFE			2.593	2	.273			
1	NEIGFE(1)	-.365	.283	1.670	1	.196	.694	.399	1.208
	NEIGFE(2)	-.462	.333	1.920	1	.166	.630	.328	1.211
	CMMBTH(1)	-.436	.252	3.000	1	.083	.647	.395	1.059
	FINHARD(1)	-.191	.329	.339	1	.561	.826	.433	1.574
	TENURE(1)	-.738	.270	7.459	1	.006	.478	.282	.812
	FRIENDEV			3.922	2	.141			
	FRIENDEV(1)	.078	.310	.064	1	.801	1.081	.589	1.985
	FRIENDEV(2)	-.517	.296	3.047	1	.081	.596	.334	1.066
	SCOATT			4.096	2	.129			
	SCOATT(1)	.048	.285	.028	1	.868	1.049	.600	1.833
	SCOATT(2)	-.585	.334	3.064	1	.080	.557	.289	1.073
	Constant	.259	.354	.533	1	.465	1.295		

a. Variable(s) entered on step 1: NEIGFE, CMMBTH, FINHARD, TENURE, FRIENDEV, SCOATT.

Within poor areas, the only significant factor affecting birth outcomes was housing tenure. Women living in owner-occupied housing at age 16 had a reduced chance of having a baby as a teenager compared with women living in social housing (odds ratio=0.478, 95% CI =0.282-0.812).

#### 4.5) Moderate areas

##### 4.5.1) Bivariate analysis

Looking only at areas that were neither deprived nor affluent ('moderate' areas), of the 539 pregnancies in these localities, 135 (25%) were to teenagers. Around 22% of all births were to teenagers. Of the 346 women living in moderate areas who provided information on sexual activity, 58% had experienced sex by age 16.

**Table 39: Neighbourhood factors and sex, pregnancy and birth: moderate areas**

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Neighbourhood features	Poor features	26.2% (38)	38.7% (75)	29.4% (78)	47.3% (35)	27.9% (73)	47.5% (28)
	Mixed	32.4% (47)	34.0% (66)	32.5% (86)	36.5% (27)	34.4% (90)	35.6% (21)
	Good features	41.4% (60)	27.3% (53)	38.1% (101)	16.2% (12)	37.8% (99)	16.9% (10)
Total		100.0% (145)	100.0% (194)	100.0% (265)	100.0% (74)	100.0% (262)	100.0% (59)
Neighbourhood monitoring	Low	24.1% (28)	29.1% (39)	24.2% (66)	26.7% (20)	24.3% (65)	24.1% (14)
	Moderate	48.3% (56)	46.3% (62)	48.0% (131)	50.7% (38)	48.7% (130)	50.0% (29)
	High	27.6% (32)	24.6% (33)	27.8% (76)	22.7% (17)	27.0% (72)	25.9% (15)
Total		100.0% (116)	100.0% (134)	100.0% (273)	100.0% (75)	100.0% (267)	100.0% (58)

Neighbourhood monitoring was not significant in relation to sex, pregnancy or birth.

Neighbourhood features, however, differed significantly by the outcome variables. Nearly 39% of women who experienced early sex lived in neighbourhoods with poor features at age 16 compared with 26% of virgins (Pearson Chi-Square=8.846, df=2 p=0.012). Over 47% of women who reported a teenage pregnancy lived in neighbourhoods with poor features at age 16 compared with 29% of women reporting pregnancy at older ages (Pearson Chi-Square=14.141, df=2, p=0.001). Similar results were observed in relation to 'Birth' (Pearson Chi-Square=12.056, df=2, p=0.002).

**Table 40: Family structural factors and sex, pregnancy and birth: moderate areas**

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Number of parents living with at age 16	Single mother or father or neither	19.1% (27)	28.9% (55)	24.7% (92)	43.8% (53)	25.0% (92)	44.9% (44)
	Both natural parents	80.9% (114)	71.1% (135)	75.3% (281)	56.2% (68)	75.0% (276)	55.1% (54)
Total		100.0% (141)	100.0% (190)	100.0% (373)	100.0% (121)	100.0% (368)	100.0% (98)
Cohort member's mother: birth	Teenage mother	25.7% (35)	39.6% (74)	33.0% (125)	54.9% (67)	33.3% (124)	57.8% (59)
	Older mother	74.3% (101)	60.4% (113)	67.0% (254)	45.1% (55)	66.7% (248)	42.2% (43)
Total		100.0% (136)	100.0% (187)	100.0% (379)	100.0% (122)	100.0% (372)	100.0% (102)
Family troubled by finance hardship past yr	Yes	12.1% (14)	12.3% (19)	11.9% (39)	25.2% (26)	12.5% (41)	27.2% (22)
	No	87.9% (102)	87.7% (135)	88.1% (290)	74.8% (77)	87.5% (286)	72.8% (59)
Total		100.0% (116)	100.0% (154)	100.0% (329)	100.0% (103)	100.0% (327)	100.0% (81)
Housing tenure	Rented or other	18.2% (26)	28.4% (54)	22.7% (86)	43.5% (54)	23.3% (87)	48.5% (47)
	Owner occupied	81.8% (117)	71.6% (136)	77.3% (293)	56.5% (70)	76.7% (287)	53.5% (54)
Total		100.0% (143)	100.0% (190)	100.0% (379)	100.0% (124)	100.0% (374)	100.0% (101)

Significant differences were found for all outcome variables in relation to family structural variables.

Within moderate areas, women who reported early sex were more likely than virgins to: live in a lone parent family structure at age 16 (29% compared with 19%. Pearson Chi-Square=4.170, df=1, p=0.041); to live with a mother who had started childbearing in her teens (40% compared with 26%. Pearson Chi-Square=6.742, df= 1, p=0.009); and to live in social housing (28% compared with 18%. Pearson Chi-Square=4.687, df=1, p=0.030). Family financial hardship was not significantly distributed differentially among virgins and non-virgins.

Women who experienced a teenage pregnancy were more likely than those who reported pregnancy at older ages to: report a history of family financial hardship (25% compared with 12%. Pearson Chi-Square=11.000, df=1, p=0.001); live in a

single family structure at age 16 (44% compared with 25%. Pearson Chi-Square=16.135, df=1, p=0.000); and to live in social/rented housing (44% compared with 23%. Pearson Chi-Square=14.826, df=1, p=0.000); and to have a young mother (55% compared with 33%. Pearson Chi-Square=18.789, df=1, p=0.000). Almost exactly the same (significant) results were observed in relation to teenage motherhood, though these were slightly steeper.

*Table 41: Family process factors and sex, pregnancy and birth: moderate areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Parental supervision	Very low/low supervision	26.7% (39)	49.5% (97)	34.8% (93)	57.3% (43)	34.8% (92)	61.0% (36)
	Moderate supervision	16.4% (24)	16.8% (33)	16.5% (44)	17.3% (13)	16.7% (44)	16.9% (10)
	High/very high supervision	56.8% (83)	33.7% (66)	48.7% (130)	25.3% (19)	48.5% (128)	22.0% (13)
Total		100.0% (146)	100.0% (196)	100.0% (267)	100.0% (75)	100.0% (264)	100.0% (59)
Time spent with parents	Very little/little time	34.1% (42)	39.5% (62)	36.4% (118)	39.2% (38)	36.8% (118)	43.4% (33)
	Some time	25.2% (31)	19.1% (30)	20.4% (66)	23.7% (23)	20.6% (66)	18.4% (14)
	Quite a lot/a lot of time	40.7% (50)	41.4% (65)	43.2% (140)	37.1% (36)	42.7% (137)	38.2% (29)
Total		100.0% (123)	100.0% (157)	100.0% (324)	100.0% (97)	100.0% (321)	100.0% (76)

The amount of time spent with parents was not significantly different by outcome variable. Parental supervision, however, differed significantly by outcome. Nearly 50% of cohort members who reported early sex had parents who did not monitor their behaviour at age 16 compared with 27% of those who were still virgins (Pearson Chi-Square=21.240, df=2, p=0.000). Over 57% of women who had a teenage pregnancy reported very low levels of parental supervision compared with 35% of women who had pregnancy at older ages (Pearson Chi-Square=14.812, df=2, p=0.001). The results were similar for teenage motherhood (61% compared with 35%, Pearson Chi-Square=16.064, df=2, p=0.000).

*Table 42: Peer factors and sex, pregnancy and birth: moderate areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Friends deviance	High deviance	33.3% (43)	42.5% (76)	37.9% (117)	53.5% (53)	38.2% (116)	49.4% (40)
	Moderate deviance	20.2% (26)	20.1% (36)	20.1% (62)	21.2% (21)	20.4% (62)	22.2% (18)
	Low deviance	46.5% (60)	37.4% (67)	42.1% (130)	25.3% (25)	41.4% (126)	28.4% (23)
Total		100.0% (129)	100.0% (179)	100.0% (309)	100.0% (99)	100.0% (304)	100.0% (81)
Get led into things would not do on own	Often/sometimes	11.9% (17)	17.3% (33)	14.2% (37)	17.6% (13)	14.8% (38)	17.2% (10)
	Rarely/don't know	23.8% (34)	24.1% (46)	21.9% (57)	31.1% (23)	20.2% (52)	34.5% (20)
	Never	64.3% (92)	58.6% (112)	63.8% (166)	51.4% (38)	65.0% (167)	48.3% (28)
Total		100.0% (143)	100.0% (191)	100.0% (260)	100.0% (74)	100.0% (257)	100.0% (58)

There were no significant differences between virgins and nonvirgins in either reported friends' deviance or peer influence. However, friends' deviance appears to be significantly associated with teenage pregnancy; 54% of women who had a teenage pregnancy had deviant friends compared with 38% of those who had pregnancy at older ages only (Pearson Chi-Square=10.051, df=2, p=0.007). These figures were 49% and 38% respectively for 'Birth', though this was not significant. Peer influence was significant only for teenage mothers (with 65% of older mothers reporting that they are 'never' influenced by their friends compared with 48% of teenage mothers. Pearson Chi-Square=6.524, df=2, p=0.38).

*Table 43: Individual factors and sex, pregnancy and birth: moderate areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Own deviance	High deviance	1.4% (2)	10.2% (20)	3.9% (13)	9.6% (10)	4.3% (14)	10.8% (9)
	Moderate deviance	1.4% (2)	5.6% (11)	3.9% (13)	4.8% (5)	4.0% (13)	3.6% (3)
	Low deviance	97.2% (140)	84.2% (165)	92.2% (307)	85.6% (89)	91.8% (302)	85.5% (71)
Total		100.0% (144)	100.0% (196)	100.0% (333)	100.0% (104)	100.0% (329)	100.0% (83)
Attitudes to school	Negative attitude to school	18.7% (26)	41.1% (78)	24.0% (63)	56.0% (42)	23.8% (62)	59.3% (35)
	Moderate attitude to school	29.5% (41)	32.1% (61)	36.1% (95)	17.3% (13)	35.2% (92)	16.9% (10)
	Positive attitude to school	51.8% (72)	26.8% (51)	39.9% (105)	26.7% (20)	41.0% (107)	23.7% (14)
Total		100.0% (139)	100.0% (190)	100.0% (263)	100.0% (75)	100.0% (261)	100.0% (59)

Both explanatory variables were significantly associated with early sex. Compared with virgins, women who reported sex by age 16 were more likely to: report high levels of own deviance at age 16 (10% compared with 1%. Pearson Chi-Square=15.415, df=2, p=0.000), and to have 'poor' attitudes to school (41% compared with 19%. Pearson Chi-Square=26.231, df=2, p=0.000).

Over half (56%) of women who experienced a teenage pregnancy reported negative attitudes to school at age 16 compared with 24% of women who became pregnant at older ages (Pearson Chi-Square=28.512, df= 2, p=0.000). Among teenage mothers, this figure rose to 59% (compared with 24% of older mothers. Pearson Chi-Square=28.933, df=2, p=0.000). There were no significant differences for 'Pregnancy' or 'Birth' in relation to levels of own deviance.

#### 4.5.2) Multivariate analysis

##### Sex

Overall, the variables entered into the regression explained about 21% of the outcome (Nagelkerke R Square=0.214).



Table 44: Logistic regression, moderate areas: sex

## Variables In the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1			2.228	2	.328			
NEIGFE								
NEIGFE(1)	-.248	.331	.563	1	.453	.780	.408	1.492
NEIGFE(2)	-.501	.336	2.217	1	.136	.606	.314	1.172
FAMSTRUC(1)	-.206	.327	.396	1	.529	.814	.429	1.546
CMMBTH(1)	-.140	.289	.236	1	.627	.869	.493	1.531
TENURE(1)	-.432	.328	1.738	1	.187	.649	.342	1.234
PARSUPE			4.776	2	.092			
PARSUPE(1)	-.331	.391	.720	1	.396	.718	.334	1.544
PARSUPE(2)	-.675	.311	4.721	1	.030	.509	.277	.936
OWNDEV			8.505	2	.014			
OWNDEV(1)	.068	1.326	.003	1	.959	1.070	.079	14.403
OWNDEV(2)	-1.851	.783	5.594	1	.018	.157	.034	.728
SCOATT			10.534	2	.005			
SCOATT(1)	-.279	.348	.644	1	.422	.756	.382	1.496
SCOATT(2)	-1.007	.338	8.861	1	.003	.365	.188	.709
Constant	3.738	.901	17.210	1	.000	42.017		

a. Variable(s) entered on step 1: NEIGFE, FAMSTRUC, CMMBTH, TENURE, PARSUPE, OWNDEV, SCOATT.

Within moderate areas, early sexual experience was associated with attitudes to school, but also with parental supervision and own deviance. In the case of attitudes to school, women with positive attitudes to school were about a third as likely to engage in early sex than women who reported negative attitudes (odds ratio=0.365, 95% CI=0.188-0.709). Women who reported high levels of parental supervision at age 16 had a reduced chance of engaging in early sex compared with women who reported low levels of supervision (odds ratio=0.509, 95% CI=0.277-0.936). Women who reported high levels of own deviance had a significantly increased chance of engaging in early sexual behaviour compared with women who reported lower levels of deviance.

*Pregnancy*

About 32% of the variance was explained by the variables (Nagelkerke R Square=0.316).

*Table 45: Logistic regression, moderate areas: pregnancy*

**Variables in the Equation**

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1 <sup>a</sup>			2.137	2	.344			
NEIGFE								
NEIGFE(1)	.186	.445	.175	1	.676	1.205	.503	2.885
NEIGFE(2)	-.582	.558	1.091	1	.296	.559	.187	1.666
FAMSTRUC(1)	-.535	.458	1.365	1	.243	.586	.239	1.437
CMMBTH(1)	-.395	.409	.931	1	.334	.674	.302	1.502
FINHARD(1)	-.863	.542	2.534	1	.111	.422	.146	1.221
TENURE(1)	-.797	.422	3.566	1	.059	.451	.197	1.031
PARSUPE			1.950	2	.377			
PARSUPE(1)	-.403	.560	.518	1	.472	.668	.223	2.004
PARSUPE(2)	-.646	.472	1.875	1	.171	.524	.208	1.321
FRIENDEV			1.030	2	.598			
FRIENDEV(1)	.270	.529	.261	1	.609	1.310	.465	3.694
FRIENDEV(2)	-.254	.443	.329	1	.566	.775	.325	1.850
SCOATT			13.113	2	.001			
SCOATT(1)	-1.745	.537	10.575	1	.001	.175	.061	.500
SCOATT(2)	-1.267	.480	6.955	1	.008	.282	.110	.722
Constant	1.786	.662	7.285	1	.007	5.967		

a. Variable(s) entered on step 1: NEIGFE, FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, FRIENDEV, SCOATT.

Attitudes to school emerged as the only significant variable in relation to 'Pregnancy'. Women with positive attitudes to school were about as third as likely as women with negative attitudes to become pregnant as a teenager (odds ratio=0.282, 95% CI=0.110-0.722).

*Birth*

In relation to the Birth outcome, the model explained about 36% of the variance (Nagelkerke R Square=0.360).

Table 46: Logistic regression, moderate areas: birth

## Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1 <sup>a</sup>			.305	2	.858			
NEIGFE								
NEIGFE(1)	.253	.511	.245	1	.620	1.288	.473	3.510
NEIGFE(2)	.027	.616	.002	1	.965	1.027	.307	3.438
FAMSTRUC(1)	-.838	.526	2.540	1	.111	.433	.154	1.212
CMMBTH(1)	-.331	.461	.516	1	.472	.718	.291	1.772
FINHARD(1)	-.643	.614	1.096	1	.295	.526	.158	1.751
TENURE(1)	-1.152	.474	5.913	1	.015	.316	.125	.800
PARSUPE			1.094	2	.579			
PARSUPE(1)	-.327	.610	.287	1	.592	.721	.218	2.386
PARSUPE(2)	-.561	.550	1.043	1	.307	.570	.194	1.676
LED			4.920	2	.085			
LED(1)	.659	.653	1.017	1	.313	1.932	.537	6.948
LED(2)	-.462	.606	.582	1	.446	.630	.192	2.067
SCOATT			10.889	2	.004			
SCOATT(1)	-1.497	.594	6.356	1	.012	.224	.070	.717
SCOATT(2)	-1.627	.583	7.785	1	.005	.197	.063	.616
Constant	1.528	.803	3.617	1	.057	4.607		

a. Variable(s) entered on step 1: NEIGFE, FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, LED, SCOATT.

In relation to the birth outcome in moderate areas, just tenure and attitudes to school were seen to be significant. Women with very positive attitudes to school were less than a fifth as likely to have a teenage birth as women with negative attitudes to school (odds ratio=0.197, 95% CI=0.063-0.616).

#### 4.6) Affluent areas

##### 4.6.1) Bivariate analysis

Among women living in affluent areas at age 16, over 80% reported experiencing pregnancy over the age of 21 only and 85% of births were to older mothers. Over 53% of cohort members reported early sexual experience.

*Table 47: Neighbourhood factors and sex, pregnancy and birth: affluent areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Neighbourhood features	Poor features	21.3% (66)	28.9% (101)	24.8% (136)	27.7% (31)	24.8% (131)	31.3% (25)
	Mixed	41.6% (129)	39.1% (137)	39.4% (216)	44.6% (50)	40.3% (213)	42.5% (34)
	Good features	37.1% (115)	32.0% (112)	35.8% (196)	27.7% (31)	35.0% (185)	26.3% (21)
Total		100.0% (310)	100.0% (350)	100.0% (548)	100.0% (112)	100.0% (529)	100.0% (80)
Neighbourhood monitoring	Low	21.9% (50)	23.6% (59)	24.6% (138)	29.8% (37)	25.2% (138)	28.6% (26)
	Moderate	48.2% (110)	55.2% (138)	50.7% (284)	44.4% (55)	50.5% (276)	44.0% (40)
	High	29.8% (68)	21.2% (53)	24.6% (138)	25.8% (32)	24.3% (133)	27.5% (25)
Total		100.0% (228)	100.0% (250)	100.0% (560)	100.0% (124)	100.0% (547)	100.0% (91)

None of the neighbourhood variables differed significantly by the outcomes. Although higher proportions of women living in affluent areas at age 16 and reporting early sex, teenage pregnancy and teenage birth lived in areas with 'poor' features, these proportions did not differ significantly compared with the other groups ('Sex': 29% compared with 22%; 'Pregnancy': 28% compared with 25%; 'Birth': 32% compared with 25%). Similar results were seen for neighbourhood monitoring.

**Table 48: Family structural factors and sex, pregnancy and birth: affluent areas**

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Number of parents living with at age 16	Single mother or father or neither	16.2% (50)	28.0% (97)	22.1% (181)	33.0% (62)	22.5% (180)	36.7% (51)
	Both natural parents	83.8% (258)	72.0% (249)	77.9% (638)	67.0% (126)	77.5% (620)	63.3% (88)
Total		100.0% (308)	100.0% (346)	100.0% (819)	100.0% (188)	100.0% (800)	100.0% (139)
Cohort member's mother: birth	Teenage mother	24.1% (70)	36.8% (121)	33.7% (281)	45.6% (89)	33.7% (276)	52.5% (74)
	Older mother	75.9% (220)	63.2% (208)	66.3% (553)	54.4% (106)	66.3% (542)	47.5% (67)
Total		100.0% (290)	100.0% (329)	100.0% (834)	100.0% (195)	100.0% (818)	100.0% (141)
Family troubled by finance hardship past yr	Yes	10.4% (27)	15.7% (45)	12.0% (86)	18.5% (32)	12.0% (84)	20.6% (26)
	No	89.6% (232)	84.3% (242)	88.0% (631)	81.5% (141)	88.0% (617)	79.4% (100)
Total		100.0% (259)	100.0% (287)	100.0% (717)	100.0% (173)	100.0% (701)	100.0% (126)
Housing tenure	Rented or other	13.7% (42)	29.2% (102)	20.7% (173)	33.2% (64)	21.0% (171)	40.6% (58)
	Owner occupied	86.3% (265)	70.8% (247)	79.3% (662)	66.8% (129)	79.0% (644)	59.4% (85)
Total		100.0% (307)	100.0% (349)	100.0% (835)	100.0% (193)	100.0% (815)	100.0% (143)

In relation to family structural variables, there were significant differences between the women. At age 16, women who reported early sexual behaviour were significantly more likely than virgins to: live in a lone parent family structure (28% compared with 16%. Pearson Chi-Square=13.023, df=1, p=0.000); to have a young mother (37% compared with 24%. Pearson Chi-Square=11.543, df=1, p=0.001); and to be living in social housing (29% compared with 14%. Pearson Chi-Square=23.038, df=1, p=0.000). A history of family financial hardship did not significantly differ by either group of women

Even though all these cohort members lived in relatively affluent areas, the analysis suggests that women reporting teenage pregnancy and birth were more likely than other women to: report family financial hardship at age 16 (19% compared with 12%, Pearson Chi-Square=5.124, df=1, p=0.024. Birth: 21% compared with 12%, Pearson Chi-Square=6.933, df=1, p=0.008); to live in a lone parent family at age 16 (pregnancy: 33% compared with 22%. Pearson Chi-

Square=9.884, df=1, p=0.002; Birth: 37% compared with 23%. Pearson Chi-Square=12.857, df=1, p=0.000); and to live in social housing (pregnancy: 33% compared with 21%. Pearson Chi-Square=13.680, df=1, p=0.000; Birth: 41% compared with 21%. Pearson Chi-Square=25.635, df=1, p=0.000). For both pregnancy and birth, the age at which the cohort member's mother started childbearing was also significant (Pregnancy: 46% compared with 34%. Pearson Chi-Square=9.798, df=1, p=0.002; Birth: 53% compared with 34%. Pearson Chi-Square=18.227, df=1, p=0.000).

*Table 49: Family process factors and sex, pregnancy and birth: affluent areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Parental supervision	Very low/low supervision	28.3% (89)	48.0% (168)	35.3% (195)	55.4% (62)	35.6% (190)	55.0% (44)
	Moderate supervision	15.9% (50)	12.9% (45)	14.3% (79)	14.3% (16)	14.2% (76)	15.0% (12)
	High/very high supervision	55.9% (176)	39.1% (137)	50.5% (279)	30.4% (34)	50.2% (268)	30.0% (24)
Total		100.0% (315)	100.0% (350)	100.0% (553)	100.0% (112)	100.0% (534)	100.0% (80)
Time spent with parents	Very little/little time	29.8% (79)	44.3% (125)	35.4% (249)	44.2% (72)	35.5% (243)	44.2% (53)
	Some time	23.4% (62)	20.6% (58)	22.6% (159)	15.3% (25)	21.6% (148)	18.3% (22)
	Quite a lot/a lot of time	46.8% (124)	35.1% (99)	42.0% (295)	40.5% (66)	42.9% (294)	37.5% (45)
Total		100.0% (265)	100.0% (282)	100.0% (703)	100.0% (163)	100.0% (685)	100.0% (120)

Parental supervision differed significantly among the women. Among women who reported early sex, nearly half had parents who did not closely monitor their activities at age 16 (compared with 28% for virgins. Pearson Chi-Square=27.641, df=2, p=0.000). For 'Pregnancy' these figures were 55% and 35% respectively (Pearson Chi-Square=17.722, df=2, p=0.000), and for 'Birth', 55% compared with 36% (Pearson Chi-Square=12.876, df=2, p=0.002). The degree of time spent with parents was significant only for 'Sex' (44% compared with 30%. Pearson Chi-Square=12.793, df=2, p=0.002) and 'Pregnancy' (44% of women who had a teenage pregnancy spent very little time with their parents, compared with 35% of

those reporting older pregnancy. Pearson Chi-Square=6.104, df=2, p=0.47).

*Table 50: Peer factors and sex, pregnancy and birth: affluent areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Friends deviance	High deviance	27.7% (80)	48.1% (163)	38.2% (260)	48.4% (75)	38.0% (253)	47.3% (52)
	Moderate deviance	28.4% (82)	17.4% (59)	22.3% (152)	20.0% (31)	22.4% (149)	21.8% (24)
	Low deviance	43.9% (127)	34.5% (117)	39.5% (269)	31.6% (49)	39.5% (263)	30.9% (34)
Total		100.0% (289)	100.0% (339)	100.0% (681)	100.0% (155)	100.0% (665)	100.0% (110)
Get led into things would not do on own	Often/sometimes	9.3% (29)	15.3% (52)	12.9% (70)	10.1% (11)	12.4% (65)	12.8% (10)
	Rarely/don't know	32.2% (100)	32.4% (110)	31.0% (168)	38.5% (42)	31.1% (163)	37.2% (29)
	Never	58.5% (182)	52.4% (178)	56.1% (304)	51.4% (56)	56.5% (296)	50.0% (39)
Total		100.0% (311)	100.0% (340)	100.0% (542)	100.0% (109)	100.0% (524)	100.0% (78)

Peer factors did not differ significantly, except in one case: women who experienced early sex were significantly more likely than those that were still virgins at age 16 to report having deviant friends (48% compared with 28%. Pearson Chi-Square=28.713, df=2, p=0.000).

*Table 51: Individual factors and sex, pregnancy and birth: affluent areas*

		Sexual experience by age 16		Pregnancy		Birth	
		No sexual experience	Some sexual experience	Older pregnancy only	Teenage pregnancy	Older birth only	Teenage birth
Own deviance	High deviance	1.9% (6)	7.3% (26)	4.2% (30)	4.4% (7)	4.1% (28)	5.3% (6)
	Moderate deviance	1.0% (3)	2.8% (10)	2.5% (18)	3.1% (5)	2.6% (18)	2.6% (3)
	Low deviance	97.1% (303)	89.9% (321)	93.2% (658)	92.5% (147)	93.3% (644)	92.1% (105)
Total		100.0% (312)	100.0% (357)	100.0% (706)	100.0% (159)	100.0% (690)	100.0% (114)
Attitudes to school	Negative attitude to school	20.6% (64)	42.2% (145)	29.6% (169)	45.7% (53)	30.2% (167)	46.4% (39)
	Moderate attitude to school	31.6% (98)	30.5% (105)	32.1% (183)	27.6% (32)	31.5% (174)	28.6% (24)
	Positive attitude to school	47.7% (148)	27.3% (94)	38.2% (218)	26.7% (31)	38.3% (212)	25.0% (21)
Total		100.0% (310)	100.0% (344)	100.0% (570)	100.0% (116)	100.0% (553)	100.0% (84)

Level of own deviance was significant only in relation to 'Sex' (7% compared with 2%. Pearson Chi-Square=13.824, df=2, p=0.001). Significant differences were observed for attitudes to school (46% of women who had a teenage pregnancy reported negative attitudes to school at age 16 compared with 30% of women who had an older pregnancy only. Pearson Chi-Square=11.816, df= 2, p=0.003). Similar results were observed for 'Birth' and 'Sex'.

#### 4.6.2) Multivariate analysis

##### Sex

About 18% of the factors influencing early sexual experience were explained by the use of the variables entered into the regression (Nagelkerke R Square=0.184).



Table 52: Logistic regression, affluent areas: sex

## Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Step 1								
FAMSTRUC(1)	-.218	.263	.684	1	.408	.804	.480	1.348
CMMBTH(1)	-.271	.232	1.365	1	.243	.762	.484	1.202
TENURE(1)	-.674	.273	6.082	1	.014	.510	.299	.871
PARSUPE			8.485	2	.014			
PARSUPE(1)	-.767	.317	5.872	1	.015	.464	.250	.864
PARSUPE(2)	-.561	.227	6.083	1	.014	.571	.366	.891
TIMEPAR			5.253	2	.072			
TIMEPAR(1)	-.335	.271	1.524	1	.217	.715	.420	1.218
TIMEPAR(2)	-.540	.237	5.202	1	.023	.583	.366	.927
FRIENDEV			8.036	2	.018			
FRIENDEV(1)	-.709	.276	6.602	1	.010	.492	.287	.845
FRIENDEV(2)	-.521	.233	5.020	1	.025	.594	.376	.937
OWNDEV			2.790	2	.248			
OWNDEV(1)	-.466	1.068	.191	1	.662	.627	.077	5.090
OWNDEV(2)	-1.043	.678	2.365	1	.124	.353	.093	1.331
SCOATT			6.178	2	.046			
SCOATT(1)	-.581	.261	4.968	1	.026	.559	.335	.932
SCOATT(2)	-.550	.256	4.611	1	.032	.577	.349	.953
Constant	3.365	.751	20.097	1	.000	28.931		

a. Variable(s) entered on step 1: FAMSTRUC, CMMBTH, TENURE, PARSUPE, TIMEPAR, FRIENDEV, OWNDEV, SCOATT.

In relation to 'Sex', tenure, parental supervision, time spent with parents, attitudes to school and friends' deviance were all significant. In the case of housing tenure, women living in private (i.e. not social) housing were about 50% less likely to have experienced early sex than women living in rented or social housing. Women who mixed with 'low' deviance friends at age 16 and living in affluent areas were about half as likely as those with more deviant friends to have experienced sex.

### *Pregnancy*

The model explained about 14% of the variance for 'Pregnancy' (Nagelkerke R Square= 0.136).

Table 53: Logistic regression, affluent areas: pregnancy

## Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
								Lower	Upper
Step 1 <sup>a</sup>	FAMSTRUC(1)	-.764	.296	6.671	1	.010	.466	.261	.832
	CMMBTH(1)	-.124	.290	.181	1	.670	.884	.500	1.561
	FINHARD(1)	-.659	.355	3.450	1	.063	.517	.258	1.037
	TENURE(1)	-.449	.312	2.075	1	.150	.638	.347	1.176
	PARSUPE			3.351	2	.187			
	PARSUPE(1)	-.513	.465	1.217	1	.270	.599	.241	1.489
	PARSUPE(2)	-.514	.298	2.984	1	.084	.598	.334	1.072
	TIMEPAR			2.246	2	.325			
	TIMEPAR(1)	-.553	.377	2.154	1	.142	.575	.275	1.204
	TIMEPAR(2)	-.254	.300	.720	1	.396	.775	.431	1.396
	SCOATT			7.319	2	.026			
	SCOATT(1)	-.755	.329	5.258	1	.022	.470	.247	.896
	SCOATT(2)	-.731	.327	4.992	1	.025	.481	.253	.914
	Constant	.867	.458	3.581	1	.058	2.379		

a. Variable(s) entered on step 1: FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, TIMEPAR, SCOATT.

In relation to 'Pregnancy' just two variables were significant: family structure and attitudes to school. Women living with both parents at age 16 were about half as likely to report a teenage pregnancy (odds ratio=0.466, 95% CI=0.261-0.832) as women living in a lone parent family. Attitudes to school were highly significant: the chances of early pregnancy were approximately halved for women with moderate or positive attitudes to school.

*Birth*

The variables explained about 16% of the variance (Nagelkerke R Square=0.154).

Table 54: Logistic regression, affluent areas: birth

## Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
								Lower	Upper
Step 1 <sup>a</sup>	FAMSTRUC(1)	-.710	.332	4.574	1	.032	.492	.257	.942
	CMMBTH(1)	-.378	.325	1.353	1	.245	.685	.362	1.296
	FINHARD(1)	-.561	.405	1.921	1	.166	.571	.258	1.262
	TENURE(1)	-.627	.345	3.305	1	.069	.534	.272	1.050
	PARSUPE			3.587	2	.166			
	PARSUPE(1)	-.659	.575	1.313	1	.252	.517	.167	1.597
	PARSUPE(2)	-.599	.344	3.031	1	.082	.549	.280	1.078
	SCOATT			9.045	2	.011			
	SCOATT(1)	-.886	.379	5.457	1	.019	.412	.196	.867
	SCOATT(2)	-1.031	.399	6.669	1	.010	.357	.163	.780
	Constant	.533	.485	1.206	1	.272	1.704		

a. Variable(s) entered on step 1: FAMSTRUC, CMMBTH, FINHARD, TENURE, PARSUPE, SCOATT.

The results were similar to those for 'Pregnancy': family structure and attitudes to school were the most important factors in relation to birth outcomes in affluent areas. Cohort members reporting pro-education attitudes at age 16 had approximately a third (0.357) chance of becoming a teenage mother (all other factors held constant) compared with a young woman reporting anti-education attitudes.

## 4.7) Conclusion

### 4.7.1 Summary of all results

The results from all multivariate analyses are summarised below.

4.7.2) Sex*Table 55: Summary of all results: sex*

Variable	Multivariate analyses			
	All area analysis	Deprived areas	Moderate areas	Affluent areas
Area deprivation		NA	NA	NA
Neighbourhood features				
Neighbourhood monitoring				
Family structure				
Cohort member's mother: birth	S	S		
Family financial hardship				
Housing tenure				S
Parental supervision	S		S	S
Time spent with parents	S			S
Friends' deviance				S
Friends' influence				
Own deviance	S		S	
Attitudes to school	S		S	S

NA= not applicable, S=statistically significant (at  $p \leq 0.05$ )

Two general points can be made about the results shown above: first, none of the neighbourhood-level variables were significant (even though neighbourhood features had been significant in the bivariate analysis); and, second, there were more influences on behaviour observed in affluent communities compared with the other two types of neighbourhood. For 'Sex', family and individual factors were important (peers much less so; women who initiated early sex in affluent communities were more likely to mix with 'deviant' peers than other women, but this was only the case in one type of neighbourhood). Attitudes to school was important across neighbourhood types, so was parental supervision.

In sum, individual factors (attitudes to school, own deviance) and family structural and process factors (cohort member's mother's age at first birth, time spent with parents, parental supervision) rather than peer or neighbourhood factors were important.

## 4.7.3) Pregnancy

Table 56: Summary of all results: pregnancy

Variable	Multivariate analyses			
	All area analysis	Deprived areas	Moderate areas	Affluent areas
Area deprivation	S	NA	NA	NA
Neighbourhood features				
Neighbourhood monitoring				
Family structure	S			S
Cohort member's mother: birth				
Family financial hardship				
Housing tenure	S			
Parental supervision	S			
Time spent with parents				
Friends' deviance				
Friends' influence		S		
Own deviance				
Attitudes to school	S	S	S	S

NA= not applicable, S=statistically significant (at  $p \leq 0.05$ )

For the pregnancy outcomes, area deprivation was independently significant in the all area analysis, but no other neighbourhood-level factor was important (this was the case across all neighbourhoods). Friends' influence on behaviour was important in deprived areas, but in the opposite way to that proposed in the neighbourhood effects research (women who experienced a teenage pregnancy were *less* likely than women who experienced pregnancy at an older age to report being influenced by friends). Across all four settings (all area, deprived, moderate and affluent areas), attitudes to school were highly significant (and more so than they were for 'Sex'). Again, it is largely individual and family (structural) variables that emerge as the most important influences on pregnancy.

## 4.7.4) Birth

Table 57: Summary of all results: birth

Variable	Multivariate analyses			
	All area analysis	Deprived areas	Moderate areas	Affluent areas
Area deprivation	S	NA	NA	NA
Neighbourhood features				
Neighbourhood monitoring				
Family structure				S
Cohort member's mother: birth	S			
Family financial hardship				
Housing tenure	S	S	S	
Parental supervision	S			
Time spent with parents				
Friends' deviance				
Friends' influence				
Own deviance				
Attitudes to school	S		S	S

NA= not applicable, S=statistically significant (at  $p \leq 0.05$ )

In relation to the birth outcome, area deprivation was again significant (as it had been for 'Pregnancy' but not 'Sex'), but no other neighbourhood-level factor was significant. Housing tenure and attitudes to school were very important across three of the four neighbourhood types. For 'Birth', housing tenure emerged as highly significant in three neighbourhood scenarios (all area, deprived, moderate), so that women living in social housing (regardless of other characteristics) had a much greater chance of early motherhood than women living in owner-occupied property. There were no peer effects at all.

As was the case with 'Sex' and 'Pregnancy', individual and family factors were more important than wider influences. The implications of these results are discussed in Chapter Seven.

## **Chapter Five: Listening to Teenage Mothers and Local Teenage Pregnancy Coordinators Part I: Individual and Family Influences on Behaviour**

### **5.1) Introduction**

The results of the analysis of qualitative material collected from teenage mothers (n=15) and Coordinators (n=9) in three English localities are presented in this chapter and the next. This material is organised according to the major themes that were identified during a thematic analysis of the data. The main findings are summarised at the end of the chapters and the implications of these findings are discussed in Chapter Seven.

### **5.2) Results**

#### **5.2.1) The major themes**

As noted in the Chapter Three, 12 major themes in four domains were observed in a thematic analysis of the young mothers' interview data. These are shown below.

*Table 58: Major themes identified in the thematic analysis*

<b>Individual</b>	<b>Family</b>	<b>Peers</b>	<b>Wider community</b>
Low academic achievement and relative lack of opportunity	Family fragmentation, adversity and effects on the parent/child relationship	Lack of peer influence on behaviour	Little awareness of community norms governing behaviour
History of personal adversity	Adequate supervision of teenager's activities		Relative lack of local condemnation of teenage motherhood
Unusual reproductive history and pregnancy as a 'surprise'	Acceptability of young motherhood/parental support after birth of child to teenage mother		
Variety of sexual relationship contexts into which the baby was born			
Opposition to abortion			
Birth as a positive transforming event			

Four general points need to be made about the themes identified here. First, there was a great deal of overlap between them. The 'history of personal adversity' theme that was identified at the level of the individual linked into the 'family fragmentation and adversity' theme at family-level, for example: among respondents, there was a clear linkage between personal adversity (this is explained in detail below) to phenomena such as family break-up, domestic violence and difficulties in the parent/teenager relationship. Similarly, the 'birth as a positive transforming event' theme was clearly linked to 'acceptability of young motherhood/parental support after birth of child to teenage mother'. For most young mothers, the birth of their child 'healed' family breaches and parents offered practical and emotional support where previously there may have been an antagonistic relationship between the teenager and her parent (s).

Second—and very importantly—although these major themes were present, to some degree, across the young mother's accounts, it became clear during the data collection and analysis phase of the project that the respondents could be



roughly divided up into two groups: those women who had experienced severe adversity in their early childhood or teenage years, and women who had (generally) not suffered such adversity. Although the themes identified above were pertinent for all or most respondents, there was a clear distinction between the women in this way, and the extent to which these themes are relevant for each respondent varied according to the degree to which the young woman had experienced adversity. The implications of this are discussed in Chapter Seven.

This distinction has important implications for our understanding of teenage pregnancy and childbearing. Although in contemporary policy accounts of teenage pregnancy (and in much of the research literature) the impact of 'ignorance' about sex and contraception on outcomes is emphasised (SEU, 1999), this is often linked to some of the more 'extreme' determinants of teenage pregnancy and motherhood; that is, there is a focus on the 'pathological' causes (and consequences) of early pregnancy and parenthood, such as abuse, neglect, too-early sexual behaviour, sexual assault and domestic violence. The linkage of these with teenage pregnancy and childbearing can lead to an 'over-pathologisation' of early motherhood (SmithBattle, 2000) which promotes the perception that young motherhood is strongly associated with adverse phenomena and is always problematic. Not only is this inaccurate but it can result in greater stigmatisation of young motherhood. Yet, among the respondents here at least, most had experienced relatively 'normal' childhoods and, for those who did suffer severe adversity, parenthood provided a means of recovery from early life trauma.

Third, the diversity of experience among the women should be emphasised. Though there were common themes and issues that emerged from the data, which makes limited generalisations possible, the women did not represent all 'teenage mothers'; there is no such thing as a 'teenage mother'.

Fourth, these themes were present across the women in all three locations. There were only two differences by location: women in the Northern locations were more likely than those in Inner London to report having friends who were

young mothers and they were also more likely to mention being aware of other young mothers in their neighbourhoods.

### **5.3) Individual**

At individual-level, six major themes emerged from the analysis of the interview data: 'low academic achievement and relative lack of opportunity'; 'history of personal adversity'; 'unusual reproductive history and pregnancy as a 'surprise''; 'variety of sexual relationship contexts into which the baby was born'; 'opposition to abortion'; and 'birth as a positive, transforming event'.

#### **5.3.1) Low academic achievement and relative lack of opportunity**

The first of these themes—'low academic achievement and relative lack of opportunity'—was present in nearly all of the interviews with the young mothers, across all locations, and was also a key theme that emerged during interviews with Coordinators.

Lack of opportunity is a central issue in the neighbourhood effects literature. Individuals with poor work prospects (and little education) residing in areas of concentrated poverty are considered to be more susceptible to peer and other influences than individuals in more affluent areas; lack of opportunity colours perceptions about life expectations, which will likely affect the timing of sexual activity and childbearing (Anderson, 1990; Lauritsen, 1994). Within contemporary policy explanations for teenage pregnancy, low academic achievement and lack of opportunities (specifically, poor work prospects) leads to 'low expectations' (SEU, 1999).

Though no young mother explicitly said that she had 'low expectations' (and that this had affected her behaviour) it might be inferred from the interviews that this was the case. These expectations seemed realistic given the generally low educational attainment of the women and poor local job opportunities. The TPU emphasises the interruption to education and work that childbearing causes for teenagers (SEU, 1999) but nearly all of the young mothers had a weak attachment to the education system *before* they became pregnant and many

mothers had worked (and continued to work) in low-grade or temporary jobs, or were (at the time of the interview) not in paid employment at all.

Julie (Northumberland) was in a trainee hairdressing job (three respondents trained/had worked as hairdressers) and was paid £50 for a 40-hour week when she became pregnant. Caroline (Northumberland) worked in a local chip shop a couple of nights a week. Sally (Northumberland) had been made redundant from her temporary job just before she was interviewed: 'Got laid off yesterday...(been there) since Christmas, just to get some extra money...I got laid off with no notice'. She was not entitled to any redundancy money because she had been employed through an agency and she made about £120 a week (about £50 a week more than the 'dole'). Jilly (Greater Manchester) worked in a local supermarket: '...I work at Sainsbury's. Just round the corner. I did work on the tills. I work in the cafeteria now'.

Few of the women reported that they liked either the jobs they had before pregnancy, or their current jobs. Two exceptions were Hillary (Northumberland), who reported enjoying her (present) job as an accounts administrator, and Ellie (Greater Manchester), who had enjoyed her previous job, but had to leave when she became pregnant. She didn't want to leave her daughter to go back to work so she became a child-minder for her sister. Like a number of women in the study, she had always wanted to work with children:

I loved it there (old job), but then when I had (daughter), I did go back two days a week but...after, I had her (daughter), I didn't want to leave her so my sister came up with (the idea that) I look after her children for the whole week. It's hard work, but I love it because I get to stay at home with (daughter), my niece who is three and my nephew is eight, so it's like....it is hard work, but it's what I wanted to do when I left school so I am doing what I wanted to do.

The employment prospects of the women did not vary by location; of the five London-based women, four were unemployed. The concentration of almost all the working women in badly-paid, temporary and unskilled work is a

consequence not only of local employment patterns, but also to their generally poor educational attainment. Only one of the women had entered higher education, though most (9) had completed their basic education (at 'GCSE' level). Just four of the 15 women did not have GCSE's (because they had left school early. This was not a result of pregnancy in every case). See Table 59.

*Table 59: Educational attainment of the respondents*

	No GCSEs	Completed GCSEs only	Entered further education only	Entered higher education only	Postgraduate
Number of respondents	4	9	1	1 <sup>29</sup>	0

Overall, 14 out of 15 respondents had either none or only the most basic educational attainment. However, some women expressed a desire to re-enter education at a later stage, and several had already organised to go on courses. Crèche provision, and practical issues relating to fitting courses in with domestic commitments, was central to any decision to re-enter education:

LA<sup>30</sup>: Do you have any qualifications?

Charlie (C) (Inner London): I've just got GCSEs. I was studying, going to the sixth form to do Business Studies then I got pregnant. I was going to the Sixth Form, yeah.

LA: Are you going to go back?

C: In September, I am doing fashion...It's in (name) House, in (place). It's got a crèche in it as well.

I am actually starting a course in September, same as (friend), to be a classroom assistant. Hopefully, I will complete it by next September, I'll be fully qualified and I'll be able to go into a school. It's one night a week and then you have to do five weeks placement in a local school. My niece and nephew go to one round here....that's what I really want to do (Ellie, Greater Manchester).

<sup>29</sup> This respondent was in higher education at the time of the interview.

<sup>30</sup> LA is 'Lisa Arai'. This abbreviation is used throughout this chapter and the next.

Most women reported not liking school very much, but the reasons for this varied, as did the steps that women had taken to cope with their antipathy to school. Julie (Northumberland), for example, was not academic. She disliked school, but was not a trouble-causer:

LA: Did you get into trouble at school then?

Julie: No. Never got into trouble. I always had my essays in but I just didn't like school. If I could go back and do it again...I wouldn't. If I did go back, I'd be the same I think. I don't think I'd try any harder. I just hated it. It wasn't for me, I don't like being stuck in somewhere...I like being out and about.

For other respondents, this dislike of school was more pronounced and extended to habitual truancy. This was the case for Caroline (Northumberland):

Caroline(C): I didn't really have a great time (at school). Year nine (age 13-14), I never went, not at all. The second year, I went to the first half of the year and I had a pager, so that when you miss a lesson they (the school) page your mam. My mam had the pager and every lesson the teacher has to tell...if you're there or if you're not in, and she pages your mam.

LA: Were you the only kid in the class to have that?

C: Yeah.

LA: Were you embarrassed?

C: Not really. After...I realised I had to go to school, just to get my mam off my back.

Zaheda (Inner London) also 'bunked off' school, though she started doing so at an earlier age. This confused her parents who gave her a lot of freedom (a freedom, incidentally, that was denied to many other young women in the Bangladeshi community that Zaheda grew up in):

I was always bunking off school. What my parents couldn't understand is why. It wasn't that I wasn't allowed to go out...We was always out, going to places and doing stuff, so they couldn't understand...It started at age 11, as soon as I started at my secondary school. I was quite a destructive child.

For Chloe (Greater Manchester), school wasn't a 'terrible' place to be, but she: '...just didn't like it, I didn't like being there and if I could skive off, I used to you know, stay at home. I went in a lot, but I was like 50/50, half in half not'. Diana (Inner London) also just 'didn't like' education. Though, for her, her lack of interest was compounded by parental disinterest.

LA: How did you feel about going back (to college after dropping out)?

Diana (D): I spent a lot of time not going and, when I did go, I didn't (learn much)...

LA: How did you feel about what you were actually learning?

D: Well the only thing I enjoyed was child development. And I was encouraged to do that. The other lessons I couldn't enjoy.

LA: So you didn't enjoy anything else?

D: No. I hated it. I think it was more, when we left, when we were asked about our options and things I didn't really know. At that age, I think it's a pressure, you have to know what you want to do. And I hadn't got any encouragement from my mum. Anything I was good at, she never pushed me to do it. She was so concerned with my sister, because my sister was much more academic than me. I was more creative. And I think that my mum was so concerned about her and put so much effort into her that she sort of forgot...I don't think my mum knew I had left school till (I had already left).

Sally (Northumberland) became pregnant when she was studying for her 'A' levels but, as was the case with many other respondents, she had ambivalent feelings about the idea of entering further education and, in this case, did not like the college's strict educational 'regime'. Yet, Sally still anticipated that she might resit her 'A' levels and train as a social worker:

LA: How useful do you think what you learnt at school was?

Sally (S): Erm...the stuff they taught me was good, when they made the lessons fun and that. Some of the teachers' attitudes I didn't agree on, the way they taught you...

LA: What, were they a bit strict?

S: Yeah. It was like...they put you where you had to sit and tell you that you had to sit like this because it was the best way of learning. You can't sit with your friends, which I found the best way of learning. You're not allowed to talk. Everything has to be done by such and such a time. At (name) college, you were given your work

and given your deadlines, and that would be ok.

LA: So do you think that if you got your 'A' levels then, could you see yourself going to university?

S: Erm... I want to be a social worker. So hopefully, I'll go.

Katie's (Inner London) experience of the education system was the most extreme of all the respondents. For those women who did not like school, most mentioned (at the very least) indifference and boredom. Those women who were more resistant to education reported truancy, or occasional 'bunking off'. Katie was the only one to mention expulsion:

Katie (K): Erm...I was expelled from (name) school because I didn't do no homework and my Humanities teacher he said, like there was a whole class of people, and he said that he expected to see me on the streetcorner...basically saying like I'd be a prostitute or something...or behind the till at Sainsbury's or something. So I hit him with a chair..

LA You hit him with a chair?!

K: Yeah...

LA: What you picked a chair up...did it hit him?

K: Yeah.

LA:...Was he alright then?

K: He just cut his head. He's still working there.

LA: So you had to leave because of that? But he shouldn't have said that, should he?

K: No. He shouldn't have said that at all...I did make a complaint...

LA: Were they sympathetic at all? Did they understand why you did that

K: Erm..not really.

This experience left an already jaded Katie even more resistant to the education system. She moved schools several times after this (because her mother moved house) and, after a brief spell of homelessness, sat for, and obtained, her 'GCSE's.

While nearly all the respondents did not like school, Charlie (Inner London) was the only woman to say that she positively 'loved it'. In her case, her problems with school centred around the fact that she talked a lot in class:

Charlie (C): I thought it was a really good school. I loved it! I loved school. The teachers are really good. A lot of teachers left that year...so a lot of people got lower grades than predicted, cause we didn't have teachers there. But other than that, yeah it was good. There were a lot of rules...

LA: What about what you were taught?

C: Yeah, I think all my lessons, I was taught really well. I used to get in trouble for overtalking. I was always a good worker but I was such a terrible talker. I was always split up. I got moved out of two classes because I spoke too much.

The respondents were asked how 'well-off' they considered their families to have been when they were children and as teenagers. This was a difficult question to ask, but necessary given the link between low SES and educational outcomes (SEU, 1999). No attempt was made to properly measure the objective SES status of the respondent's families, but all the young mothers came from working class families—most respondents' parents were working in skilled and semi-skilled manual jobs, for example. This was the same across all the locations. Respondents' mothers often worked as carers (four women said their mothers worked as carers). Fathers worked in the army, in local factories and as electricians. Jilly (Greater Manchester) reported that her: '...dad's a mechanic and...mum's an auxiliary (at the hospital)'. Diana's (Inner London) mother was a nurse. Caroline's dad (Northumberland) worked as a barman (at the village club) and her mother was a carer. Respondents' parents usually had only the most basic education, and most had left school at a young age:

LA: Do you know what age your mum and dad left school?

Charlie (C) (Inner London): I think my dad left school about 14, yeah. I think he went to work with his dad after that. Doing carpentry too. Think my mum left early too.

LA: Are they working now?

C: My mum works now, in Iceland at the (place). My dad's not working at the moment now...Half the estate work there at the same store!! All the neighbours. Cousin of mine works there. Mum, she was off work for a while because she was looking after my granddad.



LA: Do you know when your mum left school?

Katie (K) (Inner London): She left quite early, I think. Her mum wanted her to leave....she had to help out with things at home.

LA: Quite young then?

K: Yeah, quite young.

LA: Was your dad the same then?

K: No, my dad..he went to college.. and... and he got GCSEs...but he never got any 'A'levels or anything.

Although most women came from working class families, almost no respondent considered that she came from a poor family and most women reported that they came from reasonably 'well-off' or comfortable families. Sally (Northumberland) mentioned being 'spoilt rotten' by her parents as a child:

LA: And, how well off would you say you were...as a family?

Sally: I was spoilt rotten. Got everything I wanted. And if my mum didn't get it me, then my dad got it for me. Yeah....Mummy's little girl.

Ellie (Greater Manchester) also considered her family to be 'well off':

We've never been struggling. My dad's always had his own business. We've never wanted for anything. Well, as we got older (we got better off). He's (dad) got a caravan, car etc. They don't have to worry at their time of life.

Respondents' definitions of 'well off' varied. Jilly (Greater Manchester) reported that her family were '...not very well off' when she was a child, however:

... we always had a car each. We always had holidays. They've got a nice house and they are always decorating....when I was a lot younger...they've done a lot of work on it now. When I was about 12/13 we had a big conservatory built. Not well off, but enough to get by.

Only two respondents specifically mentioned financial hardship in their families when they were younger. In Katie's (Inner London) case, a change in her mothers' circumstances led to hardship:

We ..weren't too well off at all. But, I know when I was young I was really spoilt....I know when we moved to (place)and..erm, my mum wasn't working then so there wasn't a lot of money then.

So, all of the young mothers came from working class families, their parents were generally employed in unskilled and semi-skilled work and had left school at a young age. This was also the case for the young women; most had only the most basic education (though a number had decided to re-enter education) and, where they were in employment, the work was low-paid and insecure. There was clear evidence of lack of opportunity among the women, yet almost none of the women reported coming from poor backgrounds and most believed that their families were reasonably 'well off'.

These observations were partly reflected in the Coordinators' accounts. For example, there was recognition among the Coordinators that young women with educational or career aspirations were less likely to become pregnant, and more likely to use abortion services, than young women without such aspirations. They knew this from the research and from their own experiences 'on the ground'. One Coordinator (North East) pointed out that she had an awareness of the link between educational opportunity/attainment and teenage pregnancy before the TPU produced its 1999 document which made the same point:

I had a sense of it (before the TPU publication)...You were more aware of young women who were more likely to get pregnant and continue with that pregnancy and aware of the young women who weren't doing so well at school, or weren't even going to school, they were the kinds of young women who tended to be presenting with positive pregnancy tests.

Most Coordinators recognised that deprivation and lack of opportunity contribute to teenage pregnancy. Yet, they also believed that attitudes to sex, sex education and knowledge about contraception also played a role. In this respect, they reiterated the main findings in the TPU's report on teenage pregnancy. When asked which they thought was more important, Coordinators said that all these factors were important and were generally unwilling, or unable, to estimate how much of each 'causes' teenage pregnancy and parenthood. Asked which she thought was more important, one Coordinator for an area with high teenage pregnancy rates (Inner London) replied, with some hesitation: 'I think....it's all part of the bundle, it's really difficult to pull out any one thing, probably I would say, yes, inequality factors are probably more significant than anything else'.

Similarly, when asked if teenage pregnancy is largely about socio-economic factors, educational attainment or sex education, the Coordinator for an urban area with relatively high (but now declining) teenage pregnancy rates (North West), replied:

I would say 50/50 good sex education and employment, because with no jobs young people need to know that there is a future for them, and I 'm not saying that young people get pregnant just for something to do. However, if there were other things in place for them to aspire to, and that's why it comes back to the class thing, if you have a young woman who's gone to a grammar school, is educated to a high standard, the last thing on her mind is 'Oh, I can't wait to have a baby' It's the bloody last thing!...and if she does find herself pregnant she is more likely to have a termination. That is a fact.

Some Coordinators made specific reference to the impact that 'social exclusion' can have on an individual's behaviour. Talking of comparisons between the UK and the Netherlands, the Coordinator for an Inner London area maintained that:

Coordinator (C): The Social Exclusion Report identifies it, a lot of young people are choosing to get pregnant, or they are becoming pregnant because of social exclusion and poverty. The Teenage Pregnancy Initiative on its own will not address the wider issues of

social exclusion and poverty amongst large sections of the community. And we are in an area of high deprivation.

LA: Also, they (the Netherlands) have less of a problem with social exclusion generally. They don't have the rates of deprivation.

C: For me, that's the key across the whole of the Western Europe there is a much bigger middle class and much less inequality whereas here we have much greater levels of inequality and that's the fundamental thing.

This point was recognised, to some degree, by most Coordinators:

LA: So do you think that the issue is not primarily about sexual health services, *per se*, but about things that exist before?

Coordinator (East): Yes, it goes much wider than sexual health.

Coordinators could only speak very generally, of course, about their perceptions of why teenage pregnancy rates are high (or low) in their areas. Their explanations for teenage pregnancy, however, often resonated with the research findings. Abortion is less used to resolve unplanned pregnancy in areas with high teenage pregnancy rates than it is in areas with low rates (Smith, 1993) and this was reflected in the following account:

LA: Do differences (in teenage pregnancy rates) correlate with area deprivation?

Coordinator (C) (East): Absolutely.

LA: Completely, down the line?

C: Oh yeah. The four areas that are higher than national average are the four towns that have significant deprivation levels...The thing that surprises me with the terminations is that, equally, we only have four areas...that are lower than the national average for terminations, so right across the patch.

LA: Those four areas are the areas where conceptions are high?

C: Absolutely, yeah. It swaps over....it's a national phenomenon and it's replicated locally, with the high conceptions and low terminations and *vice versa*.

For most Coordinators, the link between being poor, living in a deprived community, lack of opportunity and early pregnancy and parenthood (and

antipathy to abortion) was a simple, observable fact based on the research and their experience of being 'on the ground':

I think deprivation is a clear, clear link that has been proved...it is just very, very obvious because when you see where the high rates are and you know (they are)...the wards that have high deprivation...it's totally linked with deprivation (Inner London).  
...you might get young women in more affluent areas, more confident young women going 'God, a baby's going to ruin me life, it's not what I want (North West).

In areas with higher deprivation...where young people have less ambition ...they are more likely to continue with their pregnancy...in (Coordinator names wealthier area where rates are low and abortions high)...a lot of the kids go to college and university, and their parents are in employment and they are going to school, and they have that ambition...(Inner London).

Two Coordinators (North West, South) knew of areas that were not deprived but that still had high rates of teenage pregnancy but neither could account for this. In these cases: 'The deprivation angle doesn't work'.

The behavioural mechanisms linking poverty to reproductive outcomes could (generally) not be identified by the Coordinators. The following statement was typical: '...we need to know more about it (teenage pregnancy)...we don't have a huge grasp of why we have high rates and the different issues going on' (Inner London). Though, for the following Coordinator (Inner London), poverty affects sexual and reproductive behaviour by lowering the self-esteem of young women:

It (the borough) has pockets of deprivation, but it probably has more well-off (people)... as well...the national research has shown that if you've got ambition or see yourself with a career or whatever then you might be more likely to terminate if you got pregnant or to use contraception. I think for some people it probably is a calculated thing. Just from the people that work with the teenage mums, some have made a conscious decision and that's probably linked with lots of issues around self-esteem.

This first theme that came out of the interviews was probably the most important since it affects all aspects of life, health and well-being. In sum, all of the young mothers came from working class families and their parents were generally employed in unskilled and semi-skilled work. This was true also for the young women themselves; most had only the most basic education and, where women did work, employment was low-paid and insecure (yet almost none of the women reported coming from poor backgrounds).

The kind of deprivation and lack of opportunity identified by the Coordinators as major determinants of behaviour (and which they observed in their daily working life) seem, in comparison with the women's accounts, more extreme. Maybe the young women were not aware of the degree to which they experienced lack of opportunity as children and young adults. On balance, it is not deprivation that emerges as significant in the women's accounts (because so few of them reported it), but their poor educational attainment (which affects the kind of jobs they can do as adults and will, therefore, affect their material well-being).

### 5.3.2) History of personal adversity

Another prominent theme in the interviews was 'history of personal adversity'. As noted above, the respondents can be categorised (broadly) into two groups: those who reported a history of personal adversity and those who did not (though that does not mean that these women did not experience *some* adversity in their childhood and adolescence). Definitions of 'adversity' vary, but the type of adversity reported by the first group would probably be recognised as serious by anyone's standards: these respondents reported a history of emotional and physical abuse and residence away from their family-of-origin in the care system (either in a children's home or with foster carers).

An example of extreme adversity was represented by Suzy (Inner London) who had been bullied at her secondary school and came from a violent family background (she had frequently witnessed her father physically abusing her mother). She had made suicide attempts as a child and put herself into care at the age of 12:

Suzy (S): Yeah. He (father) was a very sick man as far as I am concerned. I just thought to myself 'This is not natural, this is not right, living in fear all the time'.

LA: (Was this) from a very young age?

S: Yeah. From when I was two. Erm...he was beating up my mum, and my little sister was there. She was probably about three, I was about six. Where there was so much panic in the house, he used to be laying into her. My sister used to be screaming and in hysterics. She used to run to the toilet. So I was like...trying to calm my sister down and trying to stop my dad from hitting my mum. It was a nightmare. I was always living in fear.

Suzy recognised the profound effect that these events had had on her life.

...if your home base is not structured, there's no foundation there, wherever you go, you gonna feel unbalanced because you haven't got no balance from the home...At home and as a child as well, you want to feel secure and comfortable. But I never did feel that.

Suzy's life represents an example of what the American ethnographer, Linda Burton (1997), calls the 'accelerated life course': individuals in difficult environments mature early and demographic events are compressed into shorter time spans. Suzy confirmed this when she said that she 'grew up quickly', and was working by the time she was 13 (she lied about her age to secure employment):

Yeah, with the stress and all of it. I 've always been mature. I 've had to grow up faster than my actual, natural growth. I've had to grow up faster. I couldn't have been walking around innocent for longer. I just blagged it. Went in there, went in for an interview and they said 'Yeah, you've got the job'.

The news of her pregnancy at the age of 16 was greeted with joy. She said that she had wanted to be loved and that:

I didn't know how to get it. The only way I would be able to receive it is through having (daughter). I remember on the day that I found out that I was pregnant...I was shouting out 'I am having a baby!'...I was happy.

Suzy's sister also had a child in her adolescence. Suzy believed that she and her sister were both 'looking for love', and this lay behind their decisions to have children young:

She was 18 when she had (son). It was a bit of a coincidence that we both had children young. I think that what it really was....I know what it was...I just wanted, basically, love. Again, like the same story that you hear.

Katie (Inner London) had also experienced the care system. She did not 'get on' with her mother's boyfriend and left home at the age of 13. She spent a week living rough and started living in a squat with intravenous drug users. Kath (Northumberland) had been in care since the age of five and at the time of the interview had little contact with her biological family. Donna (Greater Manchester) did not have a fraught home life but she was badly bullied at school. Her mother believes that this affected her mental well-being: 'After being bullied, me head got messed up, which (my) mother blames for the pregnancy'. Ellie (Greater Manchester) was one of six children whose biological father had left the family unit when she was three, when his heavy drinking and abusive behaviour escalated. She regards her stepfather as her natural father ('he...took four children on at the age of 25') when her parents' marriage broke up: '(Mum's) first marriage was awful, he used to hit her and hit the older kids. She is so happy with her (present) husband'.

These are extreme examples of early life adversity, but some of the Coordinators confirmed that young women who have experienced adversity or have been in the care system are over-represented among teenage mothers in their localities. One Coordinator (North West), explained the possible behavioural connection



between having been in care and young parenthood:

Having worked with young people in local authority care who find themselves pregnant, there's this real need to try and make things better for themselves and their babies so...there...(is) a negative response to termination, (with teenage mothers) saying 'Well, I am not going to get rid of my baby, I'm gonna give it a better life than I ever had'.

Another Coordinator (South West) made a slightly different connection between being in the care system and youthful motherhood:

...it's (teenage motherhood) so understandable. You just think 'Well, you can see how it all goes so badly wrong for them'. And I guess when you come out of care, and you are suddenly abandoned, having a baby and something to love must seem like a good idea, I would imagine. I think that's quite a hard situation and I think we do have to try and work with these young women to try and offer them something else.

For young women who have experienced childhood distress, having a child can be seen as a relatively 'ordinary' behaviour. This is not to imply that birth was not major event for these women but that, compared to the events that had happened before pregnancy, it was relatively mundane. More than one young woman, on finding herself unexpectedly pregnant, said that she had 'Just got to get on with it'. This type of comment might be interpreted as a sign of fatalism; it might also indicate a stoicism and realism in the face of adversity and lack of opportunity.

### 5.3.3) Unusual reproductive history and pregnancy as a 'surprise'

The third major theme to emerge from the qualitative material was 'unusual reproductive history and pregnancy as a 'surprise'. It is in relation to this theme that the accounts provided by the Coordinators and those provided by the mothers most differed. An improvement in sexual health services and sex education may be central to the TPU's strategy to reduce teenage pregnancy, but

the accounts given by teenage mothers suggests that it may make little difference. The idea that early pregnancy is attributable to 'ignorance' about contraception was not borne out here; most (12) of the respondents said that they had been using contraception when they became pregnant. Most had been using the pill, and five mentioned a burst condom. Only three respondents were not using contraception (and one of these wanted to become pregnant). Some respondents said that they had also used the 'morning after' pill' but that it had not worked.

Many respondents could not account for their pregnancy. For Julie (Northumberland), her pregnancy came as a complete surprise: 'I was on the pill, I was being safe and then it happened'. Some women believed that they are not biologically suited to the pill. Kath's (Northumberland) comments were typical:

Kath (K): I was on the pill. Twice this happened to us...this time (indicating that she is pregnant again) as well. This is twice now.  
 LA: Did you take antibiotics or something?  
 K: No. I don't know what happened. ...doesn't agree with me, this pill.

Zaheda (Inner London) sometimes forgot to take the pill, but also suggested that she was not physically (and emotionally) suited to it:

Zaheda (Z): And, yes, I was taking the pill..  
 LA: Did you forget to take it?  
 Z: Yeah, sometimes I forgot to take it. And then...my body can't take it, but I wasn't aware of it at the time. And I think I became depressed actually.

While Yvonne (Greater Manchester) was just forgetful: 'I was on the pill, but I kept forgetting to take it'.

Charlie (Inner London) said that the condom that she and her long-term boyfriend were using must have burst, but she was not sure: 'That's the only thing we can put it (the pregnancy) down to. I think it must have been that, because we were

always careful, neither of us wanted kids that young'. Charlie's pregnancy came as a complete surprise:

When she (doctor) told me I was pregnant, she said 'It's positive', I was like 'What does that mean?' And I was really shocked and I just couldn't focus. She said 'You're pregnant.' I just sat there and she said 'What do you want to do, keep it or have a termination?' and I said 'Hold on a minute. It hasn't really sunk in yet. I'll have to get back to you on that one. I'll come back.' That was up the clinic and that was it.

Jilly (Greater Manchester) had also been using condoms: 'We were using condoms, yeah. It snapped. And I took the morning after pill as well and it didn't work. She was meant to be, that's what I think'. Contraceptive failure may be related to the unusual reproductive histories that a number of the women reported. This included sporadic periods and medical failure to detect pregnancy. Sally's (Northumberland) experience was possibly the most extreme:

LA: So when you became pregnant, were you trying to have a child?

Sally (S): No.

LA: Were you using contraception?

S: I was yeah...we were using condoms. But it split. Didn't think nothing of it, 'cause I had really irregular periods anyway, I didn't think nothing of it.

LA: Had you heard of the morning after pill?

S: I had yeah...

LA: Did you think about (using) the morning after pill?

S: No. I (had) heard of it. But I had periods every year...once every year or something, 15<sup>th</sup> of July every year! I had seen a doctor about it but they said it would take a couple of years to settle down.

Caroline (Northumberland), not realising that she was pregnant, had gone to her GP with severe abdominal pain. He diagnosed constipation and gave her medication:

I got rushed into hospital after I found out that I was pregnant. I hadn't eaten properly. So I was eating enough for me and (baby) was taking everything from me so I passed out. I just wasn't eating enough. I was having stomach pains for about six weeks and my doctor was giving us laxatives for blocked bowels and then I found out I was pregnant and there was nothing the matter with my bowels. Then I had a scan to make sure.

Ellie (Greater Manchester) had been ill for some time, and convinced she was anaemic, went for a pregnancy test:

Well, what it was, about the month before I'd missed a period and I thought I was pregnant then, so I went to the doctor and took a blood test ...and it was negative. So a month after that I missed one (a period), so I thought 'There's something not right if I'm missing a period'... I thought it was (anaemia) so I went to a clinic round here just to say 'I want a pregnancy test', just so when I go to the doctor's I don't have to go through having a pregnancy test, waiting. Because I didn't think I was because I'd missed a period before and wasn't pregnant. So anyway, I sat there and was waiting and I said 'I know I'm not pregnant, just making sure' and she (nurse) sighed and....'Well, you are about five weeks (pregnant)....He (boyfriend) asked me 'Is everything alright' and I said 'Five weeks pregnant' and his face just dropped. But after we'd got used to it, we were fine. We were really happy.

More than one respondent suggested that her pregnancy was attributable to use of antibiotics. In Donna's (Greater Manchester) and Caroline's (Northumberland) cases, they had not been told that antibiotics might interfere with the pill's effectiveness:

I was on the pill. I had just gone on the pill. Me mum said 'Right, at this age now, you need to...because you get a lots of girls (getting pregnant), and stuff', so I went on the pill. But, I had had a chest infection the week before, and the doctor never told me that antibiotics can affect it (Donna).

LA: Were you using contraception?

Caroline (C): Yes, I was on the pill.

LA: Did you forget to take it, or take antibiotics?

C: Yes...I had an ear infection for two weeks. My doctor didn't know me, he didn't tell me about the pill and antibiotics.

LA: You took a week's course of antibiotics?

C: Yes. Nobody warned us until I found out I was pregnant.

The high rate of contraceptive failure among women in the study might indicate poor use of contraception; contraceptive failure in teenagers is higher than that for older women, and also varies by socio-economic status (Glei, 1999; Singh et al., 2001; Williams, 1995), or their greater natural fecundity compared with older women (Dunson, Colombo & Baird, 2002). Most of the mothers clearly knew about contraception and had accessed sexual health services. It was impossible to ascertain how well respondents had been using their method of contraception, but all of the women that were using it appeared knowledgeable: 'I was really careful about (not getting pregnant)...I didn't want to get pregnant' (Katie, Inner London).

The only respondent who 'planned' her pregnancy was Diana (Inner London). Both she and her partner appeared to subconsciously desire pregnancy, though she now believes that they were too young. She contrived to make the pregnancy look like a mistake to appease her mother:

LA: So were you surprised when you got pregnant?

Diana (D) : No, I was trying to get pregnant. I don't think my mum knows that but I was, yeah.

LA: And how long were you with (your daughter's) dad?

D: A year.

LA: Did he want her?

D: He knew what I was doing? We both knew what was happening but I think we were both so young and naïve. You know, in my mind I was not young but, when I think back, we were both (young)

LA: Did he say to you... (about not getting pregnant?).

D: No, he didn't. He just ignored it.

There was, of course, no way of knowing if respondents were being truthful about their reported use of contraception. However, apparently high use of contraception among the women suggests that strategies to promote greater access to contraception may be unwarranted. For at least three women, the use of antibiotics appears to have interfered with the pill's effectiveness. Initiatives, therefore, to increase contraceptive use *knowledge* (rather than uptake) might be more successful in reducing pregnancy (this might also be useful for some GPs as well).

Most Coordinators believed that the answer to reducing teenage pregnancy rates lay with improved services, greater use of contraception and increased sexual health knowledge:

I think it's absolutely fantastic that we are providing appropriate health services, sexual health services for young people. A... positive thing is that, within (place), there are nine new young peoples' sexual health clinics. So that's a very generic thing in a sense, they're going to target not those young people who are susceptible to teenage pregnancy, but other young people who just need sexual health advice. So, I'm very very pleased about that, and applaud the health authority and the TPU for providing money to do that. And I also am very pleased with the fact that we are developing standards in schools for head teachers to respond appropriately to teenage mothers (North West).

To support their observations about the importance of better sexual health knowledge, Coordinators frequently mentioned comparisons with other European countries:

It's one of the highest rates in Europe and we can't ignore that, that's just there. That's just smack bang in comparison with our European counterparts it's very high. However, we've got a lot to learn from the way that they deal with sex education in schools. We're slowly...recognising that if we talk about it doesn't mean to say that young people are going to do it, it has the opposite effect. So we've got a lot to learn about a number of things right across the board and we are learning that with drugs and alcohol as well. So teenage pregnancy is just another thing we need to learn to talk

about and recognise that if we talk to young people about it doesn't mean to say that they are going to go and do it (North West).

I personally think that we do have very high rates and other countries have managed to get their rates down and we haven't. Even places like the States, whose rates are much higher than ours, they have managed to turn things around (Inner London).

However, it was recognised by some Coordinators that widely-held beliefs about the superiority of European approaches to sexual health are not always accurate:

Coordinator (C) (Inner London):...the concern is that (conception rates) are not going down as fast as they are in Europe.

LA: That's what I wanted to ask you about....this is a central argument. How useful do you think comparisons are between the UK and Western Europe?

C: Erm...personally I think they are really useful...I used to work at (sexual health organisation) so my concerns are about broader sexual health issues, so I suppose banging on about teenage pregnancy is not always necessarily helpful for me because I think there are much bigger issues that affect greater number of the population and that's about STDS but it's about just generally poor sexual health as in people not having positive sexual health. But in terms of...you make comparisons between Europe...quite often people look at Holland...Sometimes they can be inclined to paint a bit too much of a gloss on Holland and say, for example, that the sex education in Holland is fantastic...I have also heard reports that the sex education in schools in Holland isn't necessarily any better than ours or any less patchy than ours what makes the fundamental difference is that people are more open talking about sex and that, it's a very sexualised society as well, but it's less 'nudge nudge, wink wink' you know it's 'Let's just be open about this' it's part of our lifestyle, it's part of what we do. Let's do it safely, let's do it in relationships which are respectful.

Yet, at the same time, most Coordinators recognised that improved services and sexual health promotion would not, on their own, reduce teenage pregnancy:

Coordinator (C) (Inner London): I think it's probably a real mixture of things, because there are services, but (not for young people)...even if there were...there are still issues around them having the confidence and the ability and...their lives being organised enough to get (themselves) in (to) gear.

LA: It's about motivation?

C: Exactly....I have heard other people say that 'You could have as many young peoples clinics or sexual health clinics as you want but...on its own, (it) wouldn't make a difference'.

Provision of sexual health services and sex education is a central plank of the TPU's strategy to reduce teenage pregnancy in England, but it was clear from the Coordinators' accounts that there was no simple relationship in their own areas between sexual health services, sex education and reproductive outcomes. In one Eastern county, overall (county-level) rates of teenage pregnancy were very low, and use of abortion high by national standards. However, there were four localities within the county that had high under 18s conception rates, low abortion rates and significant levels of deprivation. Asked to explain this in the Coordinator's locality, the Coordinator said:

We don't really know, I mean (place with low teenage pregnancy rates) like to think that they've got a very good school-based (sex) education programme, with the school nurses, but I would argue, and they would perhaps argue with me...it's no different to anywhere else...the school nurses all belong to the same trust that work across (county) so it's a very complex issue isn't it...

In another, smaller, Southern county, with similarly low teenage pregnancy rates, the Coordinator pointed out that transport to services is a major issue for young people. The county is largely rural and services are geographically disparate, yet youth in this county still seem able to avoid pregnancy, with rates well below national average. This was also the case for an affluent local authority in South West England, which has extremely low under 18s conception rates. The Coordinator mentioned transport difficulties compounded by the isolation of some communities, yet this did not appear to affect rates of youthful pregnancy or



fertility.

Comparing accounts of contraceptive use provided by the young women and Coordinators' observations about the situation in their own localities, at least two anomalies can be discerned. First, most Coordinators believed that greater access to contraception and more education was needed to reduce early pregnancy and, while the latter might have been useful for some of the young mothers, the high use of effective (i.e. the pill, the morning after pill) contraception among the young women suggests that they probably could not be described as 'ignorant' and greatly in need of education. It is difficult to know how education programmes can teach young women how to remember to take the pill. The fact that some women were forgetful may also mean that prevention of pregnancy was not of paramount importance for them (if it had been of such great importance, they might have resolved their pregnancies by use of termination).

Second, within some of the Coordinators' accounts, it was seen that those areas with low rates of teenage pregnancy were not always the ones best served by sexual health services and initiatives—and many Coordinators recognised that the existence of these services alone might have little effect on rates—yet teenage pregnancy was still seen as partly a consequence of failure to use contraception. So, despite the recognition that teenage pregnancy can be attributed to a multiplicity of factors, it was still considered to be something that could be resolved by technical/educational means.

Clearly, Coordinators do not have it in their power (or their remit) to address the wider, more structural factors that influence the incidence of teenage pregnancy. Their endorsement of the TPU's efforts to improve sexual health services and initiatives is understandable. In some respects, they are in a difficult position; they have to implement the TPS yet are not entirely convinced of its success. And, despite the commitment of the Coordinators to their work, more than one questioned the validity of the government's approach. One Coordinator, for example, remarked that:

Coordinator (C): If you have ever been at the Teenage Pregnancy Coordinators' conference...as soon as....(names prominent figure in the TPU)... sort of starts talking about government figures, well, you ought to hear the laughter in the room. Sort of people are going 'Ah, yeah'!

LA: About them ( the targets) being unrealistic?

(C): It's just because, there is a sort of government agenda and...a lot of Coordinators are questioning the government take on everything. And it's not realistic to take the government take when realistically there are so many other problems.

#### 5.3.4) Variety of sexual relationship contexts into which the baby was born

Respondents were not asked directly when they had started engaging in sexual activity—establishing age at first intercourse (or variety and scope of sexual experiences) was not the main focus of the interviews and, given the defensiveness shown by some respondents, it was considered too direct a question to ask. A couple of respondents, however, did spontaneously mention the age at which they started having sex.

Rather, respondents were asked about the sexual relationship contexts into which their babies had been born. They were asked if they were still with their partners and how long they had been with them. Using information on the age of the women's' children, or women's reports of age at conception, it was possible to gauge approximate age of conception which can be used as a proxy for age at first sex.

*Table 60: Approximate age at conception*

Range	15-19
Mean	16.3
Median	16
Mode	15

Using this method, the approximate mean age at conception was 16.3 years, the median was 16 and the mode was 15. There were five women who had conceived at age 15, four at age 16, three at age 17, two at age 18 years and

one at age 19. If we accept age at conception as a proxy for age first sex, then the women here did begin (penetrative) sexual activity at a younger age than has been reported elsewhere; the median age at first intercourse for British women (aged 20-24 at the time of data collection) is 17.5 years (Darroch, Singh, Frost & the Study Team, 2001).

Several respondents also mentioned having boyfriends who were substantially older than them when sex was first initiated or conception occurred. This confirms previous research on age differences between teenage mothers and their sexual partners (see Chapter Two for a brief overview of this research). Yet what became clear during the interviews was that not many of the women reported having had much sexual experience (or very extensive sexual experiences) before pregnancy; though they may have initiated sex at an earlier age than is the norm, there was little evidence of promiscuity among the women. Many babies were born to women who were (or had been) in relatively stable and monogamous sexual relationships. For Ellie (Greater Manchester), who was engaged to her daughter's father, her child had been born into a genuinely loving relationship:

LA: How long have you been with (daughter's) dad?

Ellie (E): I've been with him three years. I knew him for four years before I got with him. I was in love with him for a year before we got together and he was in love with me for six months before we got together, but nobody knew. And for the last year that I was with (previous boyfriend), he was cheating on me...but then when I found out...then we (Ellie and new boyfriend) started going for drinks and then...we became a couple.

Charlie's (Inner London) son was the result of a long and stable relationship that had broken up at the time of the interview because of the pressure of being homeless. The fact that her child's father was well-known to her family and friends, and well-liked by them, meant that her pregnancy was not received as badly as it might have been:

LA: When did you meet (boyfriend)?

Charlie (C): I met (boyfriend) I when I was about 13. We started going out when I was 14 and a half.

LA: Were you together all that time (till she became pregnant at 17)?

C: Yeah. I was with him the whole time. We only split up really due to having nowhere to live. We grew apart then.

LA: You're not together now?

C: Not really. I mean, I got a little lecture off my dad when he found out. And I think it helped the fact that I had been with (boyfriend) about three years. If I'd become pregnant after six months, I think my mum and dad would have gone ballistic. But because I'd been with him for three years it eased it a little bit. And think my dad was more worried about what people were going to think of me. What his friends are going to think. Because everybody knew (about us)...for three years.

LA: If you'd been married, would that have made a difference?

C: Probably. Because my dad always brought us up to believe that you get married first and then have children, it's more respectable.

Julie (Northumberland) was also in stable relationship but, like Charlie, the couple could not live together because of housing problems:

Julie (J): He's (boyfriend) a (painter), working in the shipyards.

LA: Have you been with him a long time?

J: Two and a half years.

LA: So maybe at some point you will live together?

J: Eventually. At the minute we can't get a mortgage or anything because he doesn't work enough weeks. He gets six-month contracts.

For Caroline (Northumberland), her baby's father was her first 'proper' boyfriend:

My boyfriend, being like two and a half years older than us...I started going out with him when I was 13 and he was 15...I was with (son's) dad before I actually had sex. He was my first proper boyfriend. We'd been together just over two and a half years when I fell pregnant with (son), so it wasn't such a shock to ma mam. We'd been together so long.

On average, those women who reported more stable sexual relationships, with committed partners, came from relatively untroubled family backgrounds or did not report personal adversity. Ellie (Greater Manchester) reported very early life adversity but her mother had successfully remarried and Ellie thought of her stepfather as her natural father. She was engaged to be married at the time of the interview and planning to have another child. Jilly (Greater Manchester) did not report any family adversity and was also engaged. Charlie (Inner London), from a very loving background, had been in a long-term relationship but it had broken down. Julie (Northumberland) did not report any difficulties as a teenager and was also in a stable relationship. Caroline (Northumberland), who conceived within the context of a long-term relationship, did report hostility between herself and her parents as a teenager but this had since been resolved. None of these women had ever been in the care system.

In contrast, those women not in stable relationships at the time of conception, or who conceived after a one-night stand or brief liaison, were more likely to have been in the care system. Suzy (Inner London), for example, who came from a troubled family background and put herself into the care system at the age of 12, met her child's father when she was 15. He was older than her and she was initially impressed with his lifestyle, but soon tired of the relationship:

LA: You must have been 16?

Suzy (S): I was 15.

LA: How old was he then?

S: 25....he was a postman, he had a big car, all his friends. They were 'with it' The clubs, the people, the parties, the drugs....the lights, the glamour...So, Yeah, we moved in with each other...We got engaged, we had a baby and then we moved in with one another. And then I looked around me and I thought 'Oh, no. I don't want this.' I was just so bored with him. His personality was dull. Here's me, just want to go out and party still. He used to come in and go to bed. My mum used to live over the road so I used to drop (daughter) off with my mum and I used to go out, with somebody else that was a bit more exciting.

Kath (Northumberland), who entered the care system at age five, was in a casual sexual relationship when she fell pregnant, but she met her husband soon after:

LA: So when you fell pregnant with (son) you were 16? So you were with his father?

Kath (K): I wasn't actually. I wasn't actually with him, we just sort of saw each other every now and again, because he was actually from (place) and I 'd moved back down here. And when I fell pregnant, I didn't actually hear from him once, since then.

LA: In all that time?

K: Yeah.

LA: Presumably you told him you were pregnant?

K: Oh, yeah.

LA: And how did he react?

K: He just wasn't interested...He just didn't want to know. Which was fine. I didn't particularly really want to stay with him, y'know. So, that was it and I basically said then 'It's my baby and I'm going to keep it'. Y'know, it was just going to be me and him (son), as far as I knew. And I didn't actually meet (husband) until I was (pregnant)...And we got together, and he knew I was pregnant...well he could tell! And we just took it from there. He was there when he was born. And he's always looked on him as...(his son).

Similarly, Sally (Northumberland), who became pregnant at 16 and did not report being in the care system or personal adversity, had tried to ensure the success of her relationship with her child's father, but he had made empty promises about supporting her and their baby:

Sally (S): Actually I was at college. I met him in a pub there, at (name) college. And then....I fell pregnant and he was like 'Yeah, yeah' and then we finished. And he was like 'I still be there for the baby'....and they (boyfriends' family) wouldn't pay anything so I wouldn't let him see him. So. I've had nowt to do with him. I'm better off without him. He was all full of lies and broken promises. He was working then he stopped going to work and wanted to stay in bed all day.

LA: Was he a bit older than you?

S: He was five years older than me.

The only respondent who conceived after a one-night stand was Donna (Greater Manchester). She, and Chloe (Greater Manchester), both reported personal adversity (though neither had been in the care system):

Donna (D) (Greater Manchester): I were out one night in (place), gone out for me birthday. I got off with somebody. First time I slept with somebody, first time I got drunk, I got pregnant.

LA: What, the first time you slept with someone?

D: Yeah...the midwife said, she said 'Normally, people are doing it outside, on the benches, at the park, but they don't get pregnant'. And she said 'That's what you get'.

Chloe (Greater Manchester), the youngest of the mothers, suggested that her first experience of sex (with a much older partner) was not pleasurable, and this had contributed to contraceptive failure:

I was 14 when I met me little boy's dad. He was my first sexual partner. I turned 15, then I got with him, and we was together three or four months, and then I started sleeping with him and then I got caught pregnant with (son)...I weren't using the pill, I was using the condom, but it (burst)...and I had the morning after pill....I think it was because it was my first few times, and I was so sore and tight, and with him being a lot older than me...I don't think my body was ready for it.

The contexts in which some of the women began their sexual lives may not seem the most suitable (or sexually pleasurable). It would be easy to blame these women for making ill-informed choices about their sexual partners. However, in some cases, women did believe that their partner was committed to them when they conceived. The fact that these relationships did not succeed does not necessarily suggest that these women made poor choices; the men concerned were either reluctant fathers or did not have the resources to support the mother and baby (contemporary working class men are less able to provide for their partners and children than their fathers were; McDowell, 2002; Wilson, 1987).

Women who reported early life adversity, especially those who had been in the care system, appeared to be more at risk of being in an uncommitted relationship. In these cases, early sex and pregnancy may represent an attempt to escape from an intolerable home situation or may reflect the existence of an unmet emotional need on the part of the woman. This was reflected in the following account by a Coordinator (South West), working in an area with generally low rates of teenage pregnancy, but where there were significant pockets of deprivation and early pregnancy was commonplace. She remarked that:

One of the questions I am always asked by the media is 'They only do it to get a council house, don't they?' A lot of the young girls I meet I think 'Well, actually I understand totally why they want to leave home because life at home is awful' but actually again I don't believe that when they are having sex they are thinking about that, I think generally they are probably gritting their teeth and wondering why they are doing it. That's the other thing I find upsetting, is that the majority of them that seem to have sex don't seem to have any (pleasure)...it's not for them, it's not like it's a great pleasure. They do it because their boyfriend will go off with their best mate or...it is interesting when you do talk to them and you find out that for very few of them it's a nice experience....And often they do it for...the fact that somebody wants to touch (them), they mistake that for being loved but if you've never had a hug and a cuddle in your life, then you know.

#### 5.3.5) Opposition to abortion

The young women became mothers because they opted to continue with pregnancy, unlike their counterparts from better-off backgrounds who are more likely to use abortion to resolve unplanned pregnancies (Smith, 1993). Young women in communities where teenage motherhood is prevalent have been found to hold strong anti-abortion views and are influenced by the anti-abortion views of others in their neighbourhoods (Tabberer et al., 2000). The reluctance of young working-class women to have abortions has also been attributed to fatalism or prudishness about the consequences of sex (Addley & Mahey, 2000).



These observations do not accord with the findings here: all of the young women were aware, or had been made aware, of their choices, but decided to continue with the pregnancy anyway, and no respondent reported that she was affected by others' views about abortion. However, nearly all the women could be considered to hold anti-abortion views, though they were not as opposed to abortion as previous research suggests, and most women did believe that, in some limited circumstances, abortion is morally justified.

Kath (Northumberland) for example, could have had an abortion (she found out that she was expecting early in the pregnancy), and was informed about her choices, but opted for motherhood anyway:

LA:...you never considered a termination?

Kath (K): I was told that was an option. And I said 'Well, no, not really' because I personally don't believe in it, y'know.

LA: Did the doctor tell you it was an option?

K: No, it was actually my social worker at the time. And, by the time I got to the doctor, I'd already made up my mind...I was actually only eight weeks when I found out. So, I mean I could still have had one (a termination)...But it just wasn't an option. I knew I wanted to keep him, and just have to manage.

Like Kath, Donna (Greater Manchester) was given advice about her options (and assurances of support):

Well, I were young and...me mum said 'Look at both options, what you could do', but me mum said that she could never tell me what to do, 'cause it's my baby. She said 'I'll stand by you whichever way you want to go'...Obviously (other people), they all suggested it and told me what the options are, but they all knew that I was capable of looking after him.

The youngest mother, Chloe (Greater Manchester) had been 'persuaded' by her mother that abortion was the best decision, but like many respondents, she was happy to be pregnant and did not want an abortion:

It didn't enter my head, I wanted it. If I could have prevented it, I would have done, but I really wanted a baby, I really wanted one... I think it's because me and me mum never really got on and I wanted something that was mine, something for me. When me mum found out I was pregnant, she said 'What are you going to do about it?' And I said. 'I am going to keep it'. She said 'You can't keep it'. And she talked me into having an abortion. I booked it and everything. But after a few days, I went to me Grandmas and I said 'Grandma, I don't want to get rid of this baby, I want it'. So, she said, 'You have it then, I 'll help you'. So, I changed me mind. I backed out of the abortion....I really wanted it. He (boyfriend) wanted it as well.

The people closest to Suzy (Inner London) were also not convinced that her decision to continue with the pregnancy was in her best interests:

LA: Did (boyfriend) try and talk you into having an abortion?

Suzy: Yeah, he asked my mum. He (said) 'Try and talk to your daughter about having an abortion'.

All of the young women (with the exception of the one respondent who had planned her pregnancy and was not asked about abortion) had thought carefully about the moral implications of having an abortion, and many had developed quite complicated arguments about why abortion might not be right for them. Even though most women were anti-abortion, many were not *totally* opposed to it, and women often reported that abortion was acceptable for other people (if not for themselves) under certain circumstances:

LA: So you disagree with abortion, or you just wouldn't have had one yourself?

Jilly (Greater Manchester): I don't disagree with it. I think everybody's circumstances are very different, and some people have good reasons and some...you know...I am not anti it, but I'd never do it myself.

LA: Did you consider a termination?

Sally (Northumberland): No, because...me and (boyfriend) got myself into this situation. And....I don't agree with abortion, unless there's something wrong with the child, or they've got pregnant

through getting raped, something like that, I don't agree on terminations otherwise.

And one woman (Chloe, Greater Manchester) reported that her mother had terminated a pregnancy as a teenager. In this case, it was justifiable given her mother's circumstances:

She got pregnant when she was 16 but her boyfriend beat her up so she made a wise decision and thought about it and she had an abortion. He came to the hospital after the abortion, with these chains and he was whipping her and shouting 'You're a murderer!' and the police had to come and get him.

Donna (Greater Manchester) who, like most respondents, was opposed to abortion did report that abortion might be acceptable for her because of her son's young age:

Donna (D):...I wouldn't have one now. Don't think it's right.

LA: Why don't you think it's right?

D: I'd have one now, 'cause he's (son) so young, but I wouldn't have one in, say, another year, something like that. Just don't think it's right...unless you were raped or something.

LA: Have you always felt like that?

D:Yeah.

LA: But, like you say, if you were to get pregnant now as young as he is, you'd consider it?

D:Yeah, with him being so young.

Yvonne (Greater Manchester), although generally opposed to abortion, found herself during her pregnancy in a situation that made her revise her opinions:

LA: Are you against abortion generally?

Yvonne (Y): Erm...I was. I didn't see why people had to have abortions unless there was something wrong with the baby. But then getting pregnant myself it totally changed my views on it.

LA: What, did it make you more pro- or anti-abortion?

Y: A bit of both really....it is a personal opinion. It is a personal choice and no one can make that for you.

LA: Did anyone (else) suggest abortion?

Y: No, but I had a big think about it later on in pregnancy, because at 18 weeks, I had my blood test for Down's Syndrome and it came back that he could have had neural tube defects, which is like spina bifida or stomach problems. I had about two weeks to wait (to find out)...but I did think about it again. But I didn't want to bring a disabled baby into the world. Obviously, if it's something minor (that's ok). A lot of people thought I was wrong, to think what I did, but I didn't want to raise a child that I thought wouldn't have much of a life.

And for one mother, the experience of becoming pregnant made her completely revise her view of abortion:

...I've never agreed with it (abortion). But when I got pregnant, it changed my views...because I was in a situation where I was faced with that, I understand how women do do it. Now, I would never say 'You are wrong to do that' I would completely, 100% support somebody who wanted an abortion... before...I was quite naïve to think it was wrong to have an abortion, because you don't know until you are in that situation (Ellie, Greater Manchester).

So, although most women were opposed to abortion, some conceded that they might, under some circumstances, use abortion themselves and (more commonly) that it was acceptable for other people if absolutely necessary. The picture that emerges is a more complex one than that found elsewhere, where young mothers are depicted as being very opposed to abortion (SEU, 1999). In fact, many respondents reported that they did consider abortion; the reasons they continued with the pregnancy were not only because of moral concerns about the use of abortion, but because of an awareness that motherhood would be difficult at their young age:

Caroline (C) (Northumberland):...we (boyfriend and respondent) didn't speak for two weeks after. Not because of (boyfriend) because of me. I wanted to be on my own and get my head round and decide what I was going to do. Obviously the first thing that went through my head was abortion. I don't believe in them but I was only 15 and I had my whole life ahead of me, and it was going

to stop us from doing this and that and then...I couldn't after I had my scan.

LA: So you had a scan at seven weeks...Then they found out you were pregnant?

C: To make sure he wasn't in my tube. And when I saw the scan I couldn't.

For Katie (Inner London), the short duration of the relationship context in which her son was conceived made her consider the use of abortion:

We (respondent and boyfriend) are against abortion. I thought he (boyfriend) was going to disappear as well, we don't have a strong relationship, and we've only been together a couple of months. And, that's when I started having doubts and then I thought 'I've got enough, I've got my mum... I can't kill him, the baby', and so I went ahead with it.

Ellie (Greater Manchester) also briefly contemplated use of abortion, so did her boyfriend, but both wanted to continue with the pregnancy:

At first I was really scared because we had only been together (a short time)...but I knew I was in love with him. And I knew him for four years but it was still the fact that we had only been together four months and I was pregnant. Erm... we discussed abortion but deep down I didn't want one, and deep down he didn't want one but because we both thought it was what we wanted to hear so....then we both agreed to have an abortion but then five minutes after said 'I can't' and...he went 'I'm glad, because I didn't want you to' so I said 'Right, if we are going to have the baby, then we need to start being 100% honest with each other' because that would have been a disaster if I had gone and had one and he didn't want me to. So, that was good. I think we were more concerned about telling our parents, but that went alright as well. My mum, she knew...she said to me when I said that 'I need to talk to you' she said, 'I know what you're going to say'.

Most of the women justified their rejection of abortion by referring to their 'pro-life' beliefs but, not only were they not as opposed to abortion as previous research suggests (Tabberer et al., 2000), for some women, the espousal of anti-abortion

beliefs seemed to mask a genuine desire for motherhood (unexpectedly pregnant young women—who are happy to be pregnant but might be wary about appearing so, given their age and their ‘transgression’—might be put under less pressure to terminate the pregnancy by parents or other authority figures if they hold apparently anti-abortion views).

Most Coordinators did not discuss the use of abortion by pregnant teenagers, though a number acknowledged that it is politically controversial; the TPU cannot be seen to promote the use of abortion or it risks offending pro-life sentiment. Coordinators did recognise, however, that pregnant teenagers were often opposed to abortion. One Coordinator (South West) believed that this antipathy to abortion, late presentation for pregnancy testing (which would affect the teenager’s access to services) and cultural acceptance of teenage motherhood together explained early fertility:

It is culturally quite acceptable to have children young in (place)... But quite often for young people it is about the fact that they don't do anything about it very quickly. They're scared. They don't know who to tell. I think they hope it would go away...It's (abortion) extremely controversial...For a lot of young women, the thought of a termination is just abhorrent.

Nearly all the women who reported at what stage in pregnancy they found out they were expecting, <sup>31</sup> found out before they were three months pregnant. The latest stage was at 10 weeks and the earliest was soon after conception (the respondent said that she knew soon after conception that she was pregnant). The average stage in pregnancy when women found out they were expecting was at about six weeks. If these women had elected for termination, they would almost certainly have been provided with access to abortion. The accounts presented here indicate that many women did consider it, but chose not to for a variety of reasons.

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<sup>31</sup> This was not asked of all respondents. In two cases, it was not appropriate (in the case of one, the interview was concluded early, in another, the respondent had planned her pregnancy). In the

### 5.3.6) Birth as a positive transforming event

A major theme that emerged from the interviews was the idea that, for the young women and their families, the birth of their child had been a positive, transforming event; one which brought families together and healed breaches. The idea of birth positively changing the lives of young women has been observed elsewhere (Clemmens, 2003; SmithBattle, 2003). In a synthesis of qualitative studies of teenage motherhood (Clemmens, 2003), one of the main themes that emerged from the analysis of 18 studies was 'Motherhood as positively transforming'. This theme was present in more than half of the studies and was considered to have personal dimensions (motherhood provided a sense of identity, promoted maturity and stability among the women), but was also related to impact of the birth on the teenage mother's family. The author, speaking of one study, notes that: '...the experience of labor and delivery...appeared to be a catalyst for the reframing of the adolescent's fragile relationship with her own mother' (p. 97). Here, this finding resonates strongly with women's accounts of the impact on motherhood on their lives.

Donna (Greater Manchester), for example came from a fractured family unit. Her mother so disliked her ex-husband that: 'She used to be sick if she saw him (ex-husband), she just couldn't stand it. That's how me mum were about me dad, when she seen him'. Yet the birth of her son caused a transformation. Donna's parents rallied round after she became pregnant: 'Me mum helps out a lot. Me mum got me all this furniture. Me mum and me dad together'. She says of her son that: 'When he were born. He brought us all together'. Motherhood helped Donna see how much she loved her mother:

I never knew how much I love me mum till I got pregnant. She gave me so much support. 'Cause every teenager hates their mum and dad, don't they? When you are a teenager...you think they are always wrong, don't you?...I love her to bits now.

This was also true of Chloe (Greater Manchester), who had a strained relationship with her mother from her early teenage years: 'As soon as I had (son), everything changed, it's been brilliant...I think it was because I have my own independence'. Caroline (Northumberland) also had a troubled family background. She did not have a good relationship with her mother's husband, but the birth of her son changed family dynamics:

Caroline (C): With my stepfather, we never used to get along until I had (son) and he doesn't treat us like a child anymore. Me and my mam we were never actually in the same room...anything...until I had (son) and we're like best friends now. I tell her everything and respect each other more. She's realised that I'm old enough to have a child and I'm not a child myself anymore.

LA: So, it's all been since (son) was born?

C: Yeah.

Not one young mother said that she regretted having her child. All reported adjusting to motherhood well. Hillary (Northumberland) said that, if she had her time again, she: 'Wouldn't change anything. (It would be) exactly the same'. Even where they encountered hostility from other people, the young women were eager to point out that they had benefited from the birth of their child. The nature of these benefits varied. For Julie (Northumberland), having a daughter meant she was less lonely:

Julie (J): (A woman) who works in the High School, she serves food or something. She was talking...(she said) 'I am old enough to be your mother', and I said 'I am a mother' and I said 'What are you shaking your head for?' She says 'You're pathetic. You've ruined your life.' And I said 'I'm quite happy. It has changed my life but it hasn't made it worse.'

LA: Has it made it better?

J: Yeah. Because if (boyfriend) is working away, I've got someone there all the time to keep up company. I've got (daughter). When he was away when she first born...she was like there for me when he wasn't. And when he wasn't there, I couldn't cope but now it doesn't bother us.



For Chloe (Greater Manchester), having a baby while young meant that you have your life (and your figure) when you are older:

Chloe (C) ...deep down I always wanted a baby, I wanted one young and there was no way I was getting rid of it...

LA: Why?

C: So I can have me life...if I have me children first, where they're older, I'll still be young and I can do what I want then...people say 'Do you regret having him, you're so young now?' and I say, 'If could have had him younger, I would have done. I would have had him younger'....'Cause, at the end of the day, if they are looking down on me I just think...'Well, when you are having your kids, my kids will be older and I'll have my body back and you'll be fat!'

Donna (Greater Manchester) also believed that her life had been transformed by the birth of her son. Like many respondents, she thought it better to have children while young:

Lots of people have said to me that it's better to have your babies young and have your life after. Which I agree with now. I wouldn't tell someone to have a baby, no. It's not easy, no. But I have never found it hard like people say. They say 'Oh, it's awful'.

Macintyre & Cunningham-Burley (1993) point out that many young mothers, because they come from larger families where they may have had recent responsibility for helping to raise younger siblings, adjust well to motherhood. Caroline (Northumberland) mentioned this in relation to her time in hospital after the birth of her son:

There was a woman there, she was 33 and I was helping her, you know, because I was 10 when me mam had (sister) so I knew everything and I was helping her. I was helping this woman who was 33, changing nappies, and things, because I already knew everything.

The young mothers portrayed parenthood as having a wholly positive impact on their lives. However, there was a clear tension between the idea of early motherhood as beneficial *and* problematic in the Coordinators' accounts. Most Coordinators could think of situations where early motherhood had been advantageous for some women, for example, but they often thought it unfortunate that such young women become mothers and believed that the odds are against them:

I have definitely spoken to some who have said that it made them turn their life around, whereas before they've been excluded from school, in trouble...getting pregnant actually made them think 'Okay, I've got to get some education now'. But I think at the same time it's just incredibly difficult, just because of their young age...I don't believe being a young parent makes you a bad parent, it's just that you've got so many things against you in terms of money and housing and support and education, it's just incredibly difficult. But they can be great parents...for some, I'm sure it's a positive thing. (Inner London).

If a woman chooses to have a child, if she has that information and the right support at 15 or 16, not that I'm saying that it's right or not, but some women feel that's the right choice for them at that time, and I don't necessarily feel it's the role of the government to necessarily say that they shouldn't have children because some young people are able to be good parents at 15. Some are very good parents at 15. I have met some amazing young people in the work that we have done at that age, but it's not something for everybody. If a young person chooses to have a child at an early age and it's an intentional and a planned pregnancy, then I think that's absolutely fine (Inner London).

Whatever their reservations about early parenthood, most Coordinators were keen not to contribute to a negative image of early motherhood. One Coordinator, in a largely rural area with low rates of early pregnancy, said:

I say it quite often when people say to me 'Why, do you have such a big problem' I don't want to talk about it like it's a problem. For some girls...there is a problem but I've met many young women for whom it's been a really positive experience. And they say to me 'If I

hadn't got pregnant...then I would probably be on drugs and...having a baby made me realise that I had to, you know, pull myself together, be a role model' (South East).

This same Coordinator (in common with most) emphasised that her role is a 'holistic one', which is not just about teenage pregnancy but about supporting young women and promoting good sexual health. Young mothers, however, may not be aware that Coordinators think of them this way:

I can remember going to a young mother's group in (Coordinator names place) and when I got there, they all were really hostile to me because...my job is to stop young people having babies, that's how they saw it. And I was really upset because...they were feeling pretty pissed off and didn't want to talk to me particularly and...(after talking to them) in the end they could see that I wasn't the enemy.

Kirkman et al. (2001) observe that, among their teenage mother respondents, the belief held by most women that birth brought positive benefits was evidence of the existence of a 'consoling plot'. That is, the assertion that young motherhood is beneficial allows '...an interpretation of the vicissitudes of life in a way that makes them bearable' (p.287). The reasons cited for the benefits of early motherhood by the respondents in their study were similar to the ones described above: that life is enriched; that young mothers will be free in the future (when others are tied down); and that children bring families together. Kirkman and colleagues stress that the existence of a consoling plot in no way means that their respondents are deluding themselves. Rather, by using a consoling plot, the young mothers 'emphasise the positive' aspects of motherhood and acknowledge its drawbacks.

Only two young mothers, Chloe (Greater Manchester) and Suzy (Inner London) mentioned the disadvantages of young motherhood. In both these cases, these centred on not being able to go out with friends. Overall, most mothers believed that birth had changed their lives, and the lives of those around them, for the better.

## **5.4) Family**

At the level of the family, three major themes were observed: 'family fragmentation, adversity and effects on the parent/child relationship'; 'adequate supervision of teenager's activities'; and 'acceptability of young motherhood/family support after the birth of the child'. The first of these was strongly linked to the 'history of personal adversity' theme at individual-level and the last was highly related to the idea of 'birth as a positive transforming event'.

### **5.4.1) Family fragmentation, adversity and effects on the parent/child relationship**

A prominent theme in the neighbourhood effects literature is the idea that, in physically and socially difficult community settings, the family can be 'protective' in counteracting the potentially negative influences of peers and others (Anderson, 1991; Furstenberg et al., 1999). The ease with which families are able to do this depends not only on a family's material resources (parents with cars, for example, can transport their children around in more dangerous neighbourhoods; Furstenberg et al., 1999), but also on the strength of family ties and on the nature of the parent/child relationship (Baumrind, 1971). Where families are cohesive, ties strong and channels of communication open, there is more opportunity to safeguard children's interests (Moore & Lindsay Chase-Landale, 1999). Teenage mothers are often depicted as having a conflictual relationship with their parents, one that is hostile and usually lacking in communication (about sex as well as other aspects of life and well-being) (Wellings et al., 1999).

Many respondents came from lone parent, or otherwise disrupted family backgrounds. The relationship between family disruption (divorce, separation, remarriage, being taken into the care system) and early sexual behaviour, pregnancy and fertility has been well described in the literature (Kiernan, 1997; SEU, 1999). Here, in relation to family structure, respondents could be put into three groups: women who had been taken into the care system (who may or may not have come from lone parent backgrounds); women who came from lone parent families (and who had not been in the care system); and women who

came from two parent families. Overall, seven women came from lone parent backgrounds.

*Table 61: Family structure and adversity among the respondents*

<b>Women who had experienced the care system</b>	<b>Women from lone parent/disrupted family backgrounds</b>	<b>Women from two parent family backgrounds</b>
3	5	7

Three women had been in the care system at some point (the earliest, Kath in Northumberland, had been taken into care at the age of five). Among those women who had not been in the care system, five came from lone parent backgrounds (though their mothers/fathers may have since remarried) and seven came from two parent backgrounds.

Women from two parent backgrounds reported better relationships with their parents and less experience of family adversity than the other two groups. In contrast, women who had experienced the care system reported the most acrimonious relationships with parents and the greatest experience of adversity. Two of these women reported a history of abusive family relationships (one woman almost daily witnessed her father beating her mother up, and one was bullied by, and fought with, her mother's boyfriend).

For Katie (Inner London), her experience of the care system was preceded by a brief spell of homelessness. She did not 'get on' with her mother's boyfriend and, after rowing with him, left the family home:

LA: What was it like when you were you were living with her (your mother)?

Katie (K): It was terrible...my mother's boyfriend...he used to try tell me what to do and everything...I didn't like that so I moved out when I was 13.

LA: Where did you go to when you were 13?

K: Erm...at first, it was like Christmas, I stayed on the street for about a week.

LA: The street! When you were 13?

K: I didn't know where I was going...

LA: What time of year was this?

K: Erm...New Year. It was freezing cold.

LA: Did you have blankets?

K: No, I had this massive jumper on...(I was) in the bus shelter in (place).

LA: So, it was mostly about him (mother's boyfriend) then?

K: Yeah...He tried to hit me a few times, had fights with me. But I knew she was happy with him, so at first, after I got over that stupidity I was like 'No, she's happy with him.' My cousin used to tell me 'If your mum's happy...just let her have a little bit of happiness. You know your dad's messed her around.' But then he started fighting me, bullying me.

Family adversity was commonly reported by women from lone parent backgrounds. Among those women from lone parent backgrounds who had not experienced the care system, adversity was often linked to acrimonious relationships between divorced or separating parents.

Among those women from two parent family backgrounds, there was little (disclosed) evidence of family adversity (though one of the women did enter the care system at age 12; her parents' marriage is still intact). So, although half of the respondents came from lone parent backgrounds, and three had some experience of the care system, half came from relatively stable, two parent families and did not report family adversity. As was the case with respondents in relation to their history of personal adversity, the respondents fell broadly into two camps: those who reported a long-standing history of poor relationships with parents (though this was resolved after the birth of the child) and those who reported warm and communicative relationships with parents (especially mothers)—though they may well have experienced a rebellious period as a teenager.

Overall, the picture that emerges of parent/child relationships from the interviews is probably not so different from that for many non-parenting teenagers. Most women mentioned a period of 'difficulty' with their parents in their early-mid teens (in the case of those women who reported severe adversity—Suzy, Katie and Chloe, in particular—this was quite a protracted period and, in three of these

cases, led to a period of time in care), but nearly all women came out of their adolescence with intact and positive relationships with parents. For Charlie (Inner London), her relationship with her parents had always been good, and she had never really experienced any conflict with them:

LA: And what would you say your relationship with your parents was like (as a teenager)?

Charlie (C): It's always been really good... It's actually got better since I had my son, even though I was 17 at the time. Yeah, I've always got on really well with my parents actually.

LA: You never had any ups and downs with them?

C: No, not really.

LA: And what about communication with your parents?

C: My mum always. I always told my mum everything. I told her straightaway when I fell pregnant, 'cause I don't keep anything from her. I got my mum to tell my dad. I don't really talk to him as much.

LA: Could you talk about sex with her?

C: Not really, my dad was really the one to say 'Don't go out and get in trouble, and don't come home pregnant without being married.' And all the rest of it. He always told us that we had to be married first.

This was also the case for Ellie and Jilly (both Greater Manchester). In Ellie's case, she had overcome very early life adversity and had a frank and loving relationship with her mother:

Ellie (E)...I told my mum everything...we've always been close.

LA: Did you talk about sex?

E: Yeah. My mum knows. My mum knew everything.

LA: Did she talk to you about contraception?

E: Yeah. She did.

LA: What would you say your relationship with your parents was like when you were a teenager?

Jilly (J): Erm...it was alright. I got on with my mum very well. I always have done. Not so much with my dad. But, I think that's just teenage girls for you, isn't it really?

LA: Could you talk with your mum?

J: Oh yeah. About everything and anything. Not with me dad. Could tell me mum anything.

LA: What about now? Do you get on with them now?

J: Fantastic. Brilliant. Absolutely fantastic. They were brilliant when I told them. I mean, obviously, they were upset when I told them I was pregnant and that, but...(we get on) very well.

Julie (Northumberland) said that, as a teenager, she was ‘...quite a wild child. I was hard work. Going out and everything and getting drunk’. Yet, she still had a good relationship with her parents:

LA: What would you say that your relationship with your mum and dad was like (as a teenager)?

Julie (J): I get on really well with my mum and dad.

LA: Have you always got on with them?

J: Yeah.

LA: Did you always talk to them?

J: Oh yeah. Always.

For Yvonne (Greater Manchester), who did not report a (particularly) conflictual relationship with her mother, the problem was primarily about poor communication: ‘I never really shared anything with me mum, no, I kept it all to myself. I probably spoke more to me friends than me mum. But like, now, we are definitely closer’.

In Sally’s case (Northumberland), her relationship with her parents was exacerbated by external events over which she had no control. Her father was in the army and the family moved a lot. She led a relatively sheltered life and, when the family finally settled, her parents were anxious about the people that Sally came into contact with. This compromised her relationship with her parents:

LA: What about being able to talk to them about whatever, personal things?

Sally (S): Erm... yeah. Yeah....

LA: But did you have a period in your early teenage years...when you were a bit rebellious?

S: Oh, I hated my parents when I was 13 or 14.

LA: Why did you hate them?

S: Oh, I don’t know, we were constantly moving and we’d get



settled somewhere and then my dad would get posted somewhere else and ...We'd settle down and make friends and then we'd have to move again. ... And then I was about 13 or 14, when I came here and settled down.....because...my parents being in the army, there didn't seem to be as outgoing as people here and there didn't seem to be any violence and kids hanging around on street corners. And then I got in with a group...(there were kids) hanging around here.

Zaheda (Inner London) came from a close-knit Bangladeshi family. Her parents had given her a lot of freedom, but she was just 'headstrong':

Zaheda (Z): Well, I think when I was about 11, my relationship with my parents wasn't (very good). But, my parents, like I said we lived on an estate where there were a lot of Bengali people and there were a lot of restrictions, particularly on women, but with my parents that wasn't the case, which was actually quite good. ...So, my relationship with my parents, it was like, anything they said, I would do the opposite.

LA: So, it was a bit of a mixed bag with your parents?

Z: Yeah.

LA: What is it like now?

Z: Oh, we've got a really good relationship now. I mean we're adults now so our relationship has changed quite a lot. I think we've got a very good relationship now.

The most extreme examples of poor parent/child relationships were related by Suzy, Katie (both Inner London), and Chloe (Greater Manchester). In Suzy's case, the fact that her father physically abused her mother (and her mother could not escape the situation), meant that her emotional and developmental needs were not addressed:

LA: Did you communicate well with your parents... your mum?

Suzy: No, because she was so wrapped up with the problem with my dad. I can never, ever remember them encouraging me. To prosper in any way. I just felt that I was being kicked in the stomach. Even to this day. I still feel like that.

For Chloe (Greater Manchester), who was the youngest mother and also reported a history of depression, her relationship with her mother had always been poor and she made an explicit link between this and her early pregnancy: 'I think (the pregnancy happened), because me and me mum never really got on, and I wanted something that was mine, something for me'.

Katie's (Inner London) relationship with her mother was hostile partly because her stepfather tried to dominate her. This was so severe that she left home at a young age (and endured a brief spell of homelessness):

LA:...thinking about your relationship with your mum now, and how well you get on with your mum and everything, how well do you get on with her, on a scale of one to five again?

Katie (K): Four or five. We get on very well. Now we do.

LA: What was it like when you were you were living with her?

K: It was terrible...I know at one point...I don't call him my stepfather, but my mother's boyfriend, (name)...he used to try to tell me what to do and everything...I didn't like that so I moved out when I was 13.

#### 5.4.2) Adequate supervision of teenager's activities

The degree to which a family 'protects' its children is central in the neighbourhood effects literature. Family protection strategies involve, principally, monitoring or other supervision of behaviour (general as well as sexual) (Hogan & Kitagawa, 1985) and other family management strategies (Furstenberg et. al., 1999) and work best when a family has an 'authoritative' (i.e. warm but not permissive) parenting style (Baumrind, 1971). Respondents were asked if and how their parents had monitored behaviour, and if their parents had restricted their contact with any of their friends.<sup>32</sup>

There was little evidence from the interviews with young mothers that their

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<sup>32</sup> There were three women in the study who had spent some time in care. One of these had spent almost all her childhood in care and the other two had spent some or most of their adolescence in care. In two of these three cases, it was clearly not appropriate to ask about parental supervision of behaviour.

parents had not supervised either their general or their dating/sexual behaviour when they were younger. For most respondents, parents set fair but firm limits:

(Charlie) (C) (Inner London): Well, obviously, as I got older I was given more freedom. But when I was 13/14 I wasn't allowed to stay out and had to be in by 9pm every night. Or my mum would come looking...probably the latest I was allowed to stay out when I was 14 was half nine at the weekends...And then as I got older, I was allowed to stay out till ten or half ten or 11.

LA: Did you have to account for where you were going?

C: Not that I had to tell her, but I always would anyway.

L: Did you tell her who you were going with?

C: Yeap. More or less every time. I never went anywhere where I shouldn't have done.

Jilly (J) (Greater Manchester): They didn't let me do what I wanted.

LA: Were they quite strict with you?

J: Not very strict. But they always said 'You've got to be in at 10'...they always set limits.

Not only did parents set firm (but fair) limits on behaviour, but they often further monitored their daughters' activities by asking to meet friends and boyfriends, or calling the parents of their daughters' friends on the telephone:

LA: And they (parents) didn't try and restrict you from seeing boys?

Sally (S) (Northumberland): Oh, no. I always told my mum I was going out with someone. As long as I told her and as long as she met him at some point, she was fine.

LA: Did you have to be by a certain time?

S: Yeah...as I got older, the time increased by half an hour, then an hour..at weekends. By the time I was 16, I had to be in by 10pm at night.

LA: Was that the same as your friends?

S:...my friends was the same as that as well. We all had to be in by the same time.

LA: Did she (mother) let you go out?

Donna (D) (Greater Manchester): No. I said I was staying at a friend's house so I could go out. She used to ring my friends' parents up. Me mum was so strict.

LA: Do you think she was too strict?

D: No, she was just fair.

In a couple of cases, respondents considered that their mothers had been too strict, and this had contributed to rebellion by the teenager:

I moved out...She was always strict with me, me mum, about going out. ...now I've got me own children, I realise that she was protective. But, at the time, I was like 'God, me cousin goes out all the time, but I can't go anywhere' and I hated it. I had a boyfriend at school, I was with him for eight months, when I was about 14, and I was sick of her telling me what to do....so I ran off (to Grandma's)...I did go off the rails at 14....I used to get drunk (Chloe, Greater Manchester).

The young women often breached the limits set by their parents, though this is typical of many teenagers not just those who become young mothers. Asked how her mother supervised her as a teenage, Katie (Inner London) said that her mother had carefully monitored her activities but that she did not like it:

Katie (K): Whenever she was like that (trying to monitor her behaviour), I'd be like 'Don't worry, I won't run off with an old man' And...stuff like that.

LA: Did you have to come in at a certain time?

K: Yeah. I had a curfew, it went up to midnight but I kept breaking it.

Zaheda (Inner London) was also given fair limits but fought against them, so did Yvonne (Greater Manchester):

They tried to check on me, and they were quite fair. Looking back now, they were quite fair. They were actually saying 'yes, you can do this but as long as you tell us where you are, what time you'll come back', you know. Then it's all fine. But I wasn't having it...

LA: Did your mum try and stop you from seeing people?

Yvonne: She didn't really like me going out. One day—we all used to meet at the park—and I wasn't allowed out, so I snook out of the

house (she was 15 at the time), I went to the park and she came and found me and took me home. She had a real bad go at me. But after that, she still didn't like me going out, but I think she realised that I was getting older...She knew all my friends, they had been to the house and everything...

Parents did not seem overly anxious about peer influences. This might suggest that they were indifferent to their children's activities, but the excerpts above would appear to indicate that this was not the case. Parents did not regard peers as problem because they were not considered to be so. Only one respondent believed that her mother's failure to supervise her contributed to her pregnancy:

She tried to ground me when I was 16 but it didn't work because I had never heard the word 'grounded' before, so she'd never stopped me from going out. And it didn't work....My mum gave (my sister) all the attention. I was sort of left and forgotten about...From a certain age I was going out and doing what I wanted to do. My mum didn't realise that I'd fallen into that trap...she was quite concerned about what was going on with my sister...My mum, she sat down and said that if she had taken more care, I wouldn't have got pregnant...(Diana, Inner London).

Sally (Northumberland) was one of the few respondents to report that her parents had imposed quite strict restrictions on her activities with friends when they became worried that her behaviour might be adversely affected by others (Sally was also the only respondent who believed that she had been unduly influenced by her friends):

Sally (S): People round here....they are like a bad influence on you.

LA: In what way were they a bad influence?

S: They were all drinking, and trying drugs and stuff...stuff like cannabis, nothing hard... (my parents) didn't want me to have nothing to do with them.

LA: So they tried to restrict you from seeing them?

S: Yeah.

LA: So how did your parents restrict you? Did they come to the park?

S: They ground me and wouldn't let me out of the house.

LA: Did this go on for a long time?

S: ...for about six months and then I sort of came to my senses.

For most respondents, there was little or no conflict with their parents about their friends. In Charlie's (Inner London) case, her sister (who was not a teenage parent) had the 'bad' friends:

LA: Your parents never stopped you from going out? Did they stop you from hanging out with certain people?

Charlie(C): No.... not me. I always had the good friends!

LA: Did they say that to you?

C: Not really, but I know that my mum did say to my sister 'Why can't you find some good friends like your sister?' I'm the better one.

#### 5.4.3) Acceptability of young motherhood/parental support after birth of child to teenage mother

This theme was strongly linked to the 'birth as a positive transforming event' theme described above; the support offered to young mothers was central to the idea that birth positively transformed relationships.

Popular images of young mothers often depict them as unsupported and alone. Here, those women who did not live in the family home all reported strong links with their mothers (especially) and fathers, and help from friends and others. Many young women were able to work or study with the help of their families. Macintyre & Cunningham-Burley (1993) made a similar observation about the support given to young mothers. They note that the loneliest and least well-supported mothers are usually middle class, married women, who are geographically distant from their families.

Support offered to mothers was a visible manifestation of the fact that previously acrimonious relationships had improved. Without exception, parents (and a foster mother in one case) offered practical and emotional support to the women when their baby was born. This support was forthcoming partly because the women's

families all recognised that it was necessary given the young age of the mother, but also because all the women lived in their communities-of-origin (though they may have moved a short distance from the family home).

The kind of practical support offered to Caroline (Northumberland) by her mother and father was extensive. In this case, Caroline's mothers' own experience of being a young unmarried mother meant that she did not want her daughter to suffer as she had done:

Caroline (C): I was relieved (when I told mother) because I had already disappointed my mam so much. I didn't want to disappoint her more. Actually she was quite pleased about it.

LA: Was she cross with you at first?

C: No, not really. She was upset but she wasn't really cross, she knew that I was having sex and that I was on the pill. It was my age really. She didn't want me to go through what she'd had to. She was 19. That's why she's been here for us. My mam had nobody when she had me.

LA: Did she get kicked out when she got pregnant?

C: Yeah....I think that's why she's here, my mam never had a life when she had me. I go out on a Friday night. That's my night and I go to school on a Thursday and I go to work on a Sunday, Monday, Tuesday, they're my nights. And, if I am really really tired, me mam will take (son) out for an hour me so I can catch up on my sleep. She's really good like that. So is my dad.

All the respondents reported that their families 'adored' their children. Even where a pregnancy came as a disappointment to parents, they always rallied round once they had adjusted to the idea of their daughters as mothers. For Hillary (Northumberland), who was living at home when she became pregnant, her pregnancy was not well received by her parents ('...my dad didn't speak to us for three weeks, and my mum was really disappointed'), but when she brought her son home her parents offered her support. For Zaheda (Inner London), her pregnancy came as a shock to her parents (even though she was married):

....he (father) was so angry that I was pregnant. My dad couldn't believe it he kept saying 'Oh my god, she's a baby' and he was just

completely mad at me. When I was actually giving birth, my dad was crying. He was so angry that I was having a child.

Yet Zaheda's father adjusted to his daughter's pregnancy and, when she left her husband, he and Zaheda's mother supported their daughter and grandson. Ellie's (Greater Manchester) mother and father also offered practical support:

LA: Was your mum okay about it (the pregnancy)?

Ellie: She got on her knees to him (boyfriend) and begged him to look after me...my dad knew that he (boyfriend) would look after me. They helped us out a lot my mum and dad. We got the house...and moved in the November.

Some of the young mothers' own mothers had started childbearing in their teenage years (often within a pre-marital courtship setting). Charlie's (Inner London) parents, for example, were engaged to be married when Charlie's mother became pregnant: 'They got married at 18. They had my sister at 18, me at 19 and my brother at 20...they got married just in time!! She didn't lie to us. Mum told us that she got pregnant. They were getting married anyway'. Ellie's (Greater Manchester) mother was married at 20, soon after she became pregnant: 'She was pregnant, and then she got married. They were planning on getting married anyway and then she fell pregnant, and then she had four (children) within her first marriage and then in her second marriage, she's had the two'.

The fact that a number of the respondents' own mothers had started childbearing at a young age—and parents' acceptance of their daughters' pregnancy (and the support offered to young mothers)—suggests that in respondents' families, early childbearing was often acceptable.

The findings here contrast starkly with those presented in the TPU's 1999 document on teenage pregnancy (SEU, 1999). Drawing on findings from consultation with young people, a series of quotes are presented in the document describing how parents reacted to the news of their daughter's pregnancy. These



are all unremittingly bleak. One woman reports, for example, that: 'I've just found out I'm pregnant. My mum gave me three days to decide on an abortion. When I told her I wanted to keep it, she threw me out. But I want to go back home. I miss her'. Another woman says that: 'My dad threw my sister out when she got pregnant. He's hit her before'. Another, 'I'm so scared I think I'm going to run away'. One young pregnant respondent discloses that she is: '...15 tomorrow. I'm pregnant. The doctor told me I should have an abortion. My mum told me to get out and let social services put me in care. I just want to go home.' (SEU, p.55).

### **5.5) Conclusion**

Twelve major themes at individual and family-level were identified in a thematic analysis of interview data collected from teenage mothers in three different small areas. At individual-level, six themes emerged as important: 'low academic achievement and relative lack of opportunity'; 'history of personal adversity'; 'unusual reproductive history and pregnancy as a 'surprise''; 'variety of sexual relationship contexts into which the baby was born'; 'opposition to abortion'; and 'birth as a positive transforming event'.

- The first of these is arguably the most important. Low educational attainment and poor local job prospects were mentioned by nearly all the women. However, while all the Coordinators recognised the link between teenage pregnancy and parenthood and poor education or work prospects, they also mentioned the importance of deprivation. Most women did not believe that they came from deprived families, though most parents were working in unskilled and semi-skilled jobs. A 'history of personal adversity' was mentioned by a number of women. Some respondents reported a history of family abuse (physical and emotional) and three women had been in the care system. The impact of adversity on reproductive behaviour was recognised by the Coordinators.

Some respondents reported unusual reproductive histories and, despite high use of contraception here, pregnancy nearly always came as a 'surprise' to most women. Most Coordinators believed that there is still a need to improve sexual health services, though many recognised that teenage pregnancy is more than a

sexual health issue. Among the young women, a variety of sexual relationship contexts into which the baby was born were reported. Some of these relationships were stable and long-standing, others were more transitory in nature. Women who reported early life adversity were less likely to have become pregnant within the context of a stable relationships than women who did not report adversity.

Most women were opposed to abortion, but many did consider it when they became pregnant and would not necessarily condemn others for using abortion (especially in the case of rape or foetal abnormality). 'Birth as a positive transforming event' was another central theme; not one respondent said that she regretted the birth of her child. Birth was seen as beneficial by all the women; it healed family rifts and helped women recover from early life adversity.

At family-level, three themes were discerned: 'family fragmentation, adversity and effects on the parent/child relationship'; 'adequate supervision of teenager's activities'; and 'acceptability of young motherhood/parental support after birth of child to teenage mother'. The first of these was strongly linked to the respondents history of personal adversity. Half of the women came from lone mother backgrounds and some had been in the care system. Yet, although many reported previously poor relationship with parents, this was not true in every case. And, where this was true, this was resolved after the birth of the baby. There was little evidence that parents had not supervised their children's behaviour; most parents set firm but fair limits (though some of the women breached these).

The last theme, 'acceptability of young motherhood...' was strongly linked to the idea of birth as positively transforming. All the women reported extensive support from their parents after their babies were born. All of the women's parents accepted the parenting status of their daughters, and lovingly cared for their grandchildren. This may be partly because early motherhood is normative in some of the women's families.

## **Chapter Six: Listening to Teenage Mothers and Teenage Pregnancy Local Coordinators Part II: Peer and Neighbourhood Influences on Behaviour**

### **6.1) Introduction**

In the previous chapter, the results of the analysis of qualitative data in relation to individual and family influences on behaviour were presented. Here, the results relating to peer and neighbourhood influences are presented. These results are summarised at the end of this chapter and the implications of all findings are discussed in Chapter Seven.

### **6.2) Peers**

The potentially negative influence of peers on the behaviour of teenagers is a prominent theme in the neighbourhood effects literature. This influence is believed to be more harmful in poor neighbourhoods, where geographic (and social) mobility is restricted and where there are fewer positive role models, so that peer influences are likely to have a concentrated effect (Hogan & Kitagawa, 1985; Moore & Lindsay Chase-Landale, 1999). The potentially damaging influence of peers is also an idea present in British discourses on teenage sexual and reproductive behaviour (Burack, 1999; SEU, 1999; Waiton, 2001).

The young mothers were asked about their teenage friendships, friends' influences on behaviour and if any of their friends had experienced pregnancy or parenthood. The focus of the research was not on peer influences on sexual behaviour *per se* but rather on the possibility of friends influencing respondents' perceptions of teenage pregnancy and childbearing (by either being pregnant themselves, or by opting for motherhood rather than termination). However, peer influences on sexual behaviour were mentioned spontaneously by a number of respondents. Influences on more general behaviour (peer group activities, especially) were also explored to gauge how receptive to peer messages the women were.

In the initial stages of the thematic analysis, two principal (and highly interrelated) themes emerged from the qualitative material: 'the importance of friends'; and 'relative lack of influence on behaviour'. Questions about peer influences on behaviour could only be asked after establishing if friendships had been important to the respondents (peers are not likely to have any influence if an individual reports that she had no friends, or friendships were not important to her). In this way, the first theme emerged as a precursor to the second. For this reason, these themes are considered together below.

### 6.2.1) Lack of peer influence on behaviour

Almost all the women regarded their friendships, those they had as teenagers and as young adults, as having great importance in their lives. Most friends had been supportive before pregnancy (and many were after birth): 'That's when my friends were very important to me (in adolescence). I had really good friends then. They'd do stuff for me and I'd do stuff for them. And I had some good boyfriends as well...(Katie, Inner London).

Asked how important her friends were as a teenager, Charlie (Inner London) replied: 'Really important...My friends were really important to me. Really important to have good friends, and to get on with them'. Just one woman mentioned that her friends (in early adolescence and at the time of the interview) were not of great importance in her life. Chloe (Greater Manchester) was suffering from depression when she was interviewed (she reported that she had been depressed for a 'long time'). It was impossible to ascertain if Chloe's mental health status affected their friendships, or coloured her perceptions about friends, though this seems plausible.

The geographic and social contexts in which the dynamics of friendship were played out varied among the women. Charlie (Inner London), for example, just 'hung about' the neighbourhood she lived in:

We all used to hang around on the estate. On the grass down there or the back. And we were all in the same class at school. All at the same school. From age 11 to 17, we were all good mates. My mum knew all of them, even the boys.

For Katie (Inner London), being out with friends also afforded an opportunity to be away from a tense family situation. In her case, 'hanging out' with friends also meant going to nightclubs and staying out late, even though she was still in her early teens:

LA: And what were you doing when you were out?

Katie (K): Erm...I went to clubs LA: When you were 13,14?

K: Yeah, and just hanging out with my friends.

LA: Where were you hanging out?

K: Just at their houses really. There were a couple of times when we were out on the street. I am a bit ashamed of it now. But, yeah, we used to go out at one o'clock in the morning, out on the street.

Diana's (Inner London) friendship circle contained a lot of boys as well as girls (which she attributed to the fact that she went to a girls' school and, when she did meet up with boys, she seized on the opportunity to 'hang out' with them. Like Katie, she also started going to clubs at a relatively young age:

Diana (D): I think that's why I was more into boys because we never used to see them. So when they did come out of school, we used to go to school and put our make-up on and hang out with them...I think it's not good, all girls at *that* stage in your life. I think you need to be around men.

LA: What, so you weren't actually equipped to deal with boys, is that what you're saying? Did you know what you were up against?

D: Yeah, yeah. I was, like, more worried about relationships and kissing and that kind of thing. It was made such a big thing of...So it didn't make me naïve or foolish with boys or anything. It was more that we used to hang out with guys you know, it was more like a hanging out...

LA: At age 15, 16, (did you) start going to clubs?

D: Oh no, not till about 5<sup>th</sup> form. It was like once or twice in the 5<sup>th</sup> year—sorry, a couple of times in the 5<sup>th</sup> form and then when I went back to do a 6<sup>th</sup> year.

Having established that almost all respondents valued their friendships as teenagers—and considered the contexts in which friendships were played out—friends' influence on behaviour was then explored. The picture that emerged from the interviews was very different to the one commonly portrayed of teenage peer groups and friendships (Cooper & Cooper, 1992); there was little evidence of naivety or of gullibility among the young women, and most women reported no peer pressure of any kind. In fact, a number of the women reported being the instigators (or co-instigators) of 'deviant' behaviour, rather than the followers of friends' whims.

Chloe (Greater Manchester), for example, engaged in 'wild' adolescent behaviour, but the relationship between her behaviour and that of her friends was a symbiotic one:

Chloe (C)...they were all doing it (drinking alcohol) so I just joined in. I used to go a bit too far. I used to black out and I don't know how I got home.

LA: Was it all your doing?

C: Yeah, I wouldn't say people was like 'Go, go on' because I had me own money and I bought it myself, and I drank it myself....I never gave her (mother) any indication. I was always dead quiet. And when I got pregnant with my little boy, I think she was shocked more than anything because I never went anywhere and I was so quiet....they say quiet ones are the worst don't they?

The relative lack of peer influence on the young mothers became evident in an unanticipated way during the interviews: a number of the young women mentioned that, as teenagers, they mixed with individuals who took drugs but they themselves had not used them: 'The kids I went to school with, they have all turned out on drugs ...me mum said to me 'You could have been like that'. I never tried anything, anything (Donna, Greater Manchester).

Often, drug-using associates were older than the young mothers, and in a position of relative power, *vis-à-vis* the young women:

Ellie (E) (Greater Manchester):...the lad that I started seeing, he was a lot older than me...I didn't want to be (with him) anymore because he was on drugs and I was frightened.

LA: Hard drugs?

E: Yeah. He had a psychotic (breakdown)...it was awful...all his friends were taking drugs. I can honestly say, there has never been a day when I have taken drugs, and that's something I am very proud of because I was around it for about five or six months from the age of 14. Where everybody around me was taking them...

Zaheda (Z) (Inner London): I wasn't that gullible actually...I used to hang around with these people who were a lot older than me...and they used to go to people's houses and I used to hang out with them. I know it was really, really wrong. Everyone was taking drugs and... but I (was) never ever influenced into (taking drugs)...I had tried cannabis, but I never tried hard drugs...Although I was quite rebellious, I knew what was right and wrong...I knew my limits, what to do and what not to do.

LA: Do you think that was the same of your friends?

Z: No. I can say that now because I know where they are today.

LA: So, where are they?

Z: ...nowhere...nowhere. I think I was quite headstrong when I was young and I did a lot of things.. and I knew that there are certain boundaries that you don't go beyond.

Katie's (Inner London) experience of mixing with drug-using peers was the most extreme:

Katie (K): And then when I went up to Scotland, I was 14, I was living in a squat, like, with 20 year olds... and they were all (junkies)...I tried to keep levelheaded...

LA: How long were you there for?

K: Not that long...I couldn't handle it...they were stoned, they were dirty there.

LA: Did they try and give you heroin?

K: Yeah...

(Katie left the squat soon after being offered heroin).

For Caroline (Northumberland), her friends took drugs and 'bunked off' school with her and, though she did not engage in the former, she considered that her

truancy was entirely her responsibility:

Caroline (C): I started smoking when I was 13 and I never really done like my friends...I didn't drink, all I done was smoke. And all me mates, like even now, they take drugs and things. I haven't even tried them.

LA: Hard drugs?

C: Like ecstasy and that...so my mam knows all of them do, but as long as I don't (take drugs), she's not bothered about it now, but when I was about 13, it was like 'No, no I don't trust you'. But she trusts us now, enough to realise that I hadn't and I won't.

LA: Do you think that was true (what your mother said when you were 13)?

C: Not really. Cause if I didn't want to, I wouldn't.

LA: And the bunking off (truancy) and everything, that was your decision?

C: Yeah. Half the time it was me, actually.... everybody was as bad as each other. If you don't want to do something, you're not going to do it.

LA: So nobody...influenced you, you don't think?

C: Not really no.

Just two respondents mentioned that friends had influenced their substance-using habits (in these cases, alcohol and cigarettes). For Sally (Northumberland), this influence was pervasive; she was the only respondent who reported that she had been led into doing things that she would not ordinarily do by her friends:

LA: Do you think that the...people that you hung out with tried to influence you?

Sally (S): Yes. I have never, ever in my life had alcohol before—apart from a glass of wine at Christmas—I have never tried anything else! They were like 'Oh try this!' Like vodka and cider and stuff like that, and you felt that you had to try it because everyone was doing it, and you felt like different from them all. They were sitting and drinking like a bottle of 'White Lightning' cider in the park.

Similarly, Charlie (Inner London) reported that she did not consider that any of her friends had influenced her behaviour—with one exception:



LA: Did your friends influence you (in any way)?

Charlie: Erm...smoking. One of my friends got me on smoking. When I was 14. I stopped when I was pregnant.

Yvonne (Greater Manchester) also mentioned smoking, but claimed that nobody had influenced her decision to start smoking: 'I started smoking, but more from curiosity ...no one ever put any pressure on me to smoke'.

As stated above, establishing peer effects on sexual behaviour was not one of the major issues in the interviews (where the focus was on pregnancy and, especially, parenthood). However, where respondents did raise the issue of sexual behaviour, no evidence of peer effects was discerned. The idea that friends exert pressure to have early or inappropriate sexual activity has been described by the TPU. In the 1999 policy document, for example, a respondent (who had been interviewed as part of the TPU's consultation with young people) says: 'I didn't feel ready (for sex), all my friends egged me on by telling me that it was excellent and that they had all done it. Half of them haven't; they wanted me to do it so I could tell them all about it' (SEU, 1999:42).

This contrasts with the findings here. Not only did respondents generally not consider that their friends affected their general or substance-using behaviour, but no evidence emerged of peer effects on sexual behaviour. Diana (Inner London) said that she had her first 'proper' boyfriend at 16, though they did not have full sexual intercourse. Her friends were more sexually 'advanced':

Diana (D): It was my birthday (16<sup>th</sup>)...I can't remember really. I was actually, I was 16, when I first had my proper boyfriend. And I was like, late. Just kissing and fumbling without actually doing anything.

LA: So your friends had started (full sexual intercourse) earlier?

Diana (D): Yeah, they'd started earlier, yeah.

LA: Did they put any pressure on you (to have sex)?

D: No, not at all. No.

LA: Presumably, you talked about (sex) with them?

D: Yeah, we used to...Actually, I've never thought about that but none of them put pressure on me.

Zaheda (Inner London) was not sexually active when her friends were, but her mother was concerned that she might be:

Zaheda (Z): Oh, I wasn't allowed to have a boyfriend. Although I used to date lots of boys, I never really, like, slept with any of them. And I used to think (of mother) 'What is she going on about?' It didn't actually occur to me to have sex, although most of my friends around me were having sex at that time. It just didn't occur to me to have sex. And, she used to ask me these weird questions, in a sort of coded way...

LA: Why didn't you have sex?

Z: I didn't....I think for me a boyfriend was like a friend, kind of thing.

The fact that many babies were born into established relationships may mean that peers were less likely to influence sexual behaviour (though, of course, it is still possible for this to happen). Most respondents were quite candid about the most personal aspects of their life (relating histories of sexual and physical abuse, for example) and it seems likely that if they did believe that their sexual behaviour had been influenced by others, this would have been more frequently reported.

Once a young woman conceives, friends who are pregnant or already parenting, might affect how a young woman sees her pregnancy. Friends can exert direct or indirect pressure to terminate the pregnancy, or to continue with it (Tabberer et al., 2000). In this way, same-aged friends who are parents might constitute role models (Anderson, 1991). To measure peer effects on the decision to continue with the pregnancy, respondents were asked if anyone (family members, friends or health service personnel) had suggested that they have an abortion or tried to deter them from having one (all of the respondents held anti-abortion views, though not as strongly as previous research has indicated. See Chapter Five). The respondents were also asked how many friends they had who had either become pregnant as teenagers, or were teenage mothers. Definition of 'friends' varied; some women mentioned 'knowing girls at school' who became pregnant, while others spoke only about close friends. It was difficult to ascertain the exact

nature of these friendships, or how close 'good' friendships were (and often these relationships were fluctuating; that is, schoolfriends may have been briefly close friends but the friendship changed over time and 'cooled off').

No young mother believed that her decision to continue with the pregnancy was affected by her peers or by other individuals, such as health service personnel. All the respondents emphasised that it had been their decision to continue with the pregnancy, though they had consulted others. Charlie (Inner London) said that: '...none of my friends tried to discourage me from having a baby, or tried to put me off or tried to put termination into my head'. Katie (Inner London) said the manager of the hostel where she was staying tried to talk her into having an abortion, and when Katie was taken to hospital with a suspected ectopic pregnancy, this manager contacted her:

...she phone(d) up and I told her it might be an ectopic pregnancy and it might have to be taken out. And she was going 'Oh, it's all for the best anyway'. (Boyfriend) went mad about it. He had a go at her.

Yvonne (Greater Manchester) was happy to be pregnant and would not consider an abortion even though it was suggested to her:

LA: So, when you found out, were you shocked?

Yvonne (Y): Yeah...I was shocked. I was happy inside. I thought of abortion, and things like that, but I just couldn't...

LA: Did any of your friends mention abortion?

Y: No. When I told the baby's dad, he didn't say things like 'Get rid of it' but he had said 'Have you thought about abortion?' And I said 'Yeah' but I couldn't. I was only about eight weeks but I had got used to the idea.

Jilly (Greater Manchester) was offered advice and support by her partner and her father, but also decided to continue with the pregnancy:

LA: When you were pregnant, did you think about a termination, or did anybody suggest it to you?

Jilly (J): My partner said to me 'It's your choice, I'll stick by you'. I couldn't have had a termination.

LA: You couldn't?

J: No...

LA: Did anyone (else) suggest it to you?

J: My dad said '..Don't just think of all the good things with a baby....It's not all good...'

There were differences across the locations in the number of friends mentioned as either experiencing a teenage pregnancy or birth; the young women in the two Northern locations were more likely to have friends who had become pregnant as teenagers, or who were also young parents, than women in Inner London. See Table 62.

*Table 62: The number of friends who experienced teenage pregnancy/motherhood*

Study name	Location	Number
Katie	Inner London	0
Diana	Inner London	0
Zaheda	Inner London	0
Suzy <sup>33</sup>	Inner London	-
Charlie	Inner London	0
Kath	Northumberland	3
Hillary	Northumberland	0
Sally	Northumberland	0
Julie	Northumberland	1
Caroline	Northumberland	4
Jilly	Greater Manchester	6
Ellie	Greater Manchester	9
Chloe	Greater Manchester	4
Donna	Greater Manchester	1
Yvonne	Greater Manchester	3
Total		31

<sup>33</sup> The respondent was not asked this question

*Table 63: Summary of Table 62 by location*

Inner London	Northumberland	Greater Manchester
0	8	23

Across the three locations, women in Greater Manchester were the most likely to mention knowing people (close friends or school friends) who either experienced a teenage pregnancy or motherhood (23 friends were mentioned by five respondents). Just eight friends were mentioned by three respondents in Northumberland. None were mentioned among the London-based young women. Charlie (Inner London) remarked that: '...not any of my friends that I've grown up with have got children'. Katie (Inner London) suffered a diminution of her friendship circle because motherhood was so unusual among her friends:

L: Have friends the same age as you got kids?

Katie: No, not really. I'm pretty much the only one. Some are at university. That's what I mean, when I got pregnant, slowly the 'phone calls stopped and now I've only got a few main friends. There were a few more, but they...just hang on and I thought 'No I don't need them in my life'.

On the other hand, Jilly (Greater Manchester) mentioned the relatively high number of girls who became pregnant at her school:

I do know, perhaps about, six girls in my year at school that have got children now... out of the whole year (group)...It's funny because we had friends round the other day, and we had a photograph of the year, with everybody on. We were going (pointing to the photograph) 'Oh, she's had a baby, she's pregnant'.

Chloe (Greater Manchester) also knew people at school who had had their children young (though Chloe did begin childbearing at a very early age):

Chloe (C): There was three at my school that had babies. One in my class...my other friend, she's got on really well. She's not with

the baby's dad.

LA: (What about other) friends?

C: There's loads of us from my school that have just had babies. They are all having them now, whereas I had mine a bit younger.

Caroline (Northumberland) also had a number of same-aged friends with babies, though she made a distinction between her reasons for becoming a parent and her friend's:

LA: So how many of your close friends have had children quite young?

Caroline (C): Three, and then my friend is pregnant at the minute.

LA: But you don't think the fact that everyone of those had a child...influenced your decision to go ahead with the pregnancy?

C: No, 'cause my friend, her lifestyle is completely different to mine. To me, I don't think my mate should have had her baby...she was brought up with drugs and things in the house, like....I think she had her baby for all the wrong reasons...When she had her baby she was out every day, she used to leave her baby with whoever...I would never leave (son) with anybody I didn't know or anybody I didn't trust.

Peer influences on the behaviour of young women who become teenage mothers was mentioned by a couple of Coordinators. One Coordinator (East) attributed variation in rates across the county specifically to aspects of local culture and peer pressure:

LA: Presumably it (teenage pregnancy) varies across (county), with it being such a big area?

Coordinator: Different cultures, very very different cultures in different areas. Very different peer pressure.

One Coordinator (South West) did not mention peer influences as such, but believed that the support and attention given to young pregnant women might affect how their peers view early pregnancy:

The thing about, if you are 14 and you see your best mate get pregnant and suddenly she gets a lot of attention and she's doing this and doing that...when you are 14, you start thinking 'What's in it for me not to get pregnant? She's getting lots of attention and actually I'd quite like that as well'. We have to be able to offer them something for the young women who don't get pregnant too. It's a difficult balance.

While, for some Coordinators, lack of opportunity (and its effect on ambition) and peer influences are both partly responsible for early fertility:

A young woman from a very poor area who may not feel that there is a future, nobody's directing her to that neither, her mate down the road might have a baby, and she might go 'Yeah, have one with me, we'll go to park together, we'll do this, we'll do that' there's no aspiration (North West).

There was little support for this idea from the young mothers (though lack of aspiration was evident in the sample). The more positive picture that emerges from the interviews suggests that the negative depiction of peers on general, sexual and reproductive behaviour is unwarranted. However, the fact that women in the two Northern locations mentioned knowing more young mothers (or women who had experienced teenage pregnancy) suggests that early pregnancy and motherhood may be more normative in some friendship networks or social contexts than others. As observed above, it was difficult to establish the nature of these friendships (their closeness or otherwise) and, therefore, how important they were in influencing the young women's perception about pregnancy and childbearing.

### **6.3) Neighbourhood**

In the neighbourhood effects literature, women with poor educational and employment prospects, and living in run-down and marginalised communities, are likely to be affected by the behaviour of the individuals living around them (Anderson, 1991). They are likely to live in places where young motherhood is

commonplace and socially accepted; the visibility of young motherhood makes it normative. Because of this, they are also not likely to encounter local hostility.

Before respondents were asked about the visibility of teenage mothers in their localities, they were asked about the neighbourhoods they grew up in. At the time of the interview, all the respondents lived in the neighbourhoods they had grown up in, though they may have moved a relatively short distance within those communities. Most respondents had strong ties with family living locally and friends. The two women living in hostels (Charlie and Katie, both Inner London) saw their families most days since the hostels were not located that far from their parents' homes. As noted earlier, all the women came from working class families (though few mothers reported financial hardship). Asked about the types of places they grew up in, most respondents did not think that they came from deprived communities, though they often mentioned 'rough' places where they had once lived or that were near their present homes:

LA: What kind of neighbourhoods were you raised in?

Suzy (S) (Inner London): An estate. It was rough. My home was rough enough.

LA: And the estate was rough enough?

S: Yeah.

LA: Do you think that on the estate that you were raised in, there were other families that had similar problems?

S: Yeah. I think a lot of their parents were single parents, or if they wasn't a single parent, they was with someone but they might as well not be with that person because they probably wasn't there, hardly ever. So it is like a rat race where everyone's been put in this kind of square.

One young woman (Caroline, Northumberland) moved home (with her parents) after the birth of her son because: '(place) is a rough area. ...This is a better place to bring up a child'. Asked if the fact it was such a rough area influenced her parents' decision to move, Caroline said:

(Place) is a rough area....everybody knew everybody's business, there was no privacy at all. This is a better place to bring up a child than (Place)....It was actually me (who influenced parents' decision



to move). I didn't want to bring (son) up down there. I didn't want him brought up in drugs and things like that, even though they weren't actually in our house. On the streets, you know. And I never really thought about moving till I found out I was pregnant. And then, it was like, either we all move together or I was going to find my own house...me mam wanted to start again.

Even though Katie (Inner London) was living near the area that she had grown up in, she had moved around a lot as a young teenager. It was difficult to establish what type of neighbourhood she had grown up in (this was also the case for those women who had been in the care system). The number of schools she had attended was evidence of her geographic mobility as a child:

LA: So, you went off when you were 13. And you stayed with (mum's friend) for a bit. Then you went back home. The you went...to the hostel? When you were 14?

Katie (K): No, I went to the hostel when I was 17. But in between that I was in Scotland...

LA: It must have been really hard to stay at school given the fact that you were moving around a lot.

K: No, I wasn't at school a lot.

LA: Ok, school.... I know we've talked about school a bit. So, basically...you probably went to quite a few schools didn't you?

K: Yeah....I went to (name) Girls'....Then I went to (school) in (place)...Then I went to (school), then I went to (school) in (place)...that's four.

LA: Four secondary schools?

K: Yeah.

Having established what types of communities that respondents grew up in, issues around the prevalence and acceptability of young motherhood were then explored. Here, two key themes emerged from the interviews with young mothers in relation to effects on behaviour at the neighbourhood-level: 'little awareness of community norms governing reproductive behaviour'; and 'relative lack of local condemnation of teenage motherhood'.

### 6.3.1) Little awareness of community norms governing reproductive behaviour

The interview data provided by Coordinators was very important at this level: Coordinators had a 'bird's eye-view' of teenage pregnancy in their localities. The Coordinators offered valuable insights into how community norms operate in relation to youthful reproductive behaviour. A recurring idea in these interviews was that some communities welcome, or even promote, early childbearing. This is not to imply that the Coordinators accepted this as a desirable state-of-affairs; the remit of the Coordinators is to reduce teenage pregnancy in their areas and most Coordinators were wary about either condemning teenage pregnancy or accepting it. However, community attitudes to family-building sometimes made it difficult for health workers to implement programmes:

LA: In some...communities, it's (considered) okay to have children young. Is there a conflict between what the TPU wants to do and the community?

Coordinator (Inner London): I suppose that's the thing, that the (teenage pregnancy) strategy...should be saying 'Really, we are looking at addressing unintended teenage pregnancies'...I suppose if pregnancy is intentional and its part of a community's culture to have children quite young so that you grow up with your children and...you can get on with your own life once your children are grown up, so it's actually the reverse to the Western kind of approach where you go through education and have children in your mid-40s...so those messages do grate against the...core values of some of the communities (that) we work with...it's quite difficult to get into those communities....because they just think 'Well, for us, it's not a problem you know. We marry young, have children young and the extended family support you in that.

In one Inner London location, the ethnicity of the local population, its traditions and attitudes to family-building, were believed to influence the area's youthful fertility rate: '...within certain communities in (Place)...teenage pregnancy...doesn't fit the national stereotype and...it's to do with communities who positively promote early marriage...'. These communities are not necessarily always minority ethnic ones: one Coordinator, also in an Inner London area, said of her area that: '(There) are well-established generations of White indigenous

working-class people and there can be a tradition of early pregnancy within those groups'.

Community norms governing family-building patterns can also affect the use of abortion. The unwillingness of young women in deprived communities to use abortion to resolve unplanned pregnancy has been attributed to local anti-abortion sentiment. As noted above, Tabberer and colleagues found that, in the working-class community where they conducted their interviews, young women who opted for termination could experience local censure. Most Coordinators recognised that teenage mothers tend to hold anti-abortion views. Asked if the Coordinator was aware of pressure on young women to terminate or not to terminate a pregnancy, this Coordinator (North East) replied (with some defensiveness):

I couldn't comment on that. That would be for the young women to comment on, not me...When I was involved in that work, I always gave unbiased information and encouraged the young woman to make the decision themselves. They were encouraged to think about all the options and not just termination or having the baby, but also adoption...I can't say what the pressures were from their peers or their families...I mean, perhaps in certain cultures there's more pressure not to have an abortion and in some areas, there's more pressure not to have a baby. But I couldn't really say about that.

An Inner London-based Coordinator did believe, however, that community norms against abortion, and pro early family-building, influenced women's perceptions about pregnancy and fertility:

Coordinator (C): I suppose...one of the ways of addressing that (unplanned pregnancy) is through prevention and education and enabling women to realise that they can make choices because I think a lot of young women don't see termination as an option.

LA: Why do you think that is? In your area?

C: Well, I think there's a variety of issues. There's religious pressures around. There's also an expectation that it is not the done thing to do. I think there's a lot of family pressures around...there is the attitude that it is killing babies and, y'know,

education can point out that you don't necessarily have to accept that viewpoint.

So, although most Coordinators believed that wider community influences were important in the construction or maintenance of high teenage pregnancy rates, their accounts were often general in nature. Ethnicity, religion, a local tradition of early motherhood were all cited as important in this respect.

To explore neighbourhood effects on the young mothers, they were asked about their perception of the prevalence of youthful childbearing in their neighbourhoods and about their experience of local hostility. Defining neighbourhoods and communities is methodologically fraught (Teitler, 1998) and, since 'neighbourhood' was respondent-defined, some respondents were not sure what was meant when asked questions about their communities. It was also difficult to ask questions that seemed to suggest that there might be a culture of early pregnancy in the locality without implying that there was something wrong with this. Among some of the women, there seemed to be an anxiety about being judged and found morally or sexually 'loose'. One young mother, when asked why rates of early motherhood are high in her neighbourhood, jokingly replied 'We are all slappers in (place)!' This defensiveness was also evident in assertions from some of the women they are 'different' from other teenage mothers:

The thing is, it's different circumstances for everybody, and I mean, me and (partner) did not plan our baby but I would not change it for the world, but with my situation and my circumstances, I could afford to buy a house with (partner) and I can afford to stay at home because I'm looking after my sister's children, and it's like, I don't know what it would be like to be on my own like a lot of the girls who are pregnant who have had babies at my school. I mean, I consider myself quite lucky (Ellie, Greater Manchester).

I just think my situation is very different to a lot of people's...I think that (daughter) exists for a reason ....she brought me and (partner) together. I just think everybody's circumstances are different and I

am fortunate that my partner has stuck by me and financially supported us (Jilly, Greater Manchester).

Similarly, three of the respondents mentioned that they had not had their children at *such* a young age, thus making a distinction between themselves and younger mothers.

However, a number of the women did comment on the visibility of young mothers in her area. Yvonne (Greater Manchester) mentioned young motherhood not being especially common in her neighbourhood, but her account seemed to suggest otherwise:

LA: In the areas that you have lived in, was it quite common for people to have children young?

Yvonne (Y): Erm...not really, not that I remember no. There was never any teenage pregnancies at school. No. But then in my last year, three girls in my year got pregnant, but to be honest with you, it's not that many that I know that have got children. But the ones that have got children have got two or three of them. I have never actually heard of any teenage pregnancies, anything like that. Mind you, saying that, when I was about 15, two people on the street had children.

Donna and Jilly (both Greater Manchester) also mentioned the commonness of early motherhood in their areas, though Jilly was more hesitant about this:

Donna (D) But most of them are young now, that are having babies...

LA: Round here?

D: Anywhere really.

LA: Do you think it's different in different areas?

D: No, I think it's the same everywhere now. In Manchester...the amount of girls that are babies now that are young..

LA: But you don't know anyone?

D: No, but like I say, you can see them walking about. When I speak to families, it's like 'Oh, I've got a niece, that's like 20, had hers at 17

LA: Do you think it's quite common then?

D: Yeah.

LA: And what about (young mothers) in your neighbourhood? Presumably a lot of the kids in school were the same people in the neighbourhood?

Jilly (J): There is one girl up the road, actually, that went to my school, she was in the year below me at school and she lives on this street and she's got a baby. A little boy.

LA: So, it's reasonably common in the neighbourhood as well?

J: Erm...not in this neighbourhood....the only person I know of is that young girl up there. I don't know many in the neighbourhood, you know.

### 6.3.2) Relative lack of local condemnation of teenage motherhood

The young mothers were asked about specific incidents where people had been unkind or hostile to them. Coordinators were also asked if they thought that teenage mothers are 'demonised' and if they considered teenage parenthood 'problematic'. This line of questioning provides a (very approximate) measure of the degree of acceptance of early childbearing in the localities that the women lived in, and offers useful insights into how dominant, negative notions of teenage motherhood impact on the lives of young mothers (Kirkman et al., 2001).

Nearly all the women in the sample said that they had experienced hostility towards them as a result of being young mothers, though this hostility usually took the form of isolated incidents and was not pervasive—no women reported it affecting her daily movements, for example. And the individuals responsible were usually older, unrelated people, and not family or friends. Asked if they had encountered any hostility locally, Charlie and Katie (both Inner London) and Yvonne and Donna (both Greater Manchester) all mentioned older people giving them 'looks':

Not from my family and friends, people that care about me. But I did get the odd look on the street and off older people that are a bit more 'no sex before marriage' that sort of stuff. Yeah, I could see them looking at me and thinking 'She's a bit young' as I was pushing the pram. I could hear this man...(saying)... 'You're too young to be a mother aren't you?' It was generally men that said it, actually, than it was women (Charlie).

LA: You had (son) quite young and everything. Do you think people look down on you?

Katie (K): I used to go shopping and stuff and I'd walk... and I see these old people and they'd...see me with him, the baby, and I still get looks.

LA: Older people?

K: A lot of older people, yeah

LA: Do you think that people look down on you?

Donna (D): Some people. They walk past and look at you, 'cause you look young

LA: Where, round here?

D: In the street, anywhere. They look at you, they give you a dirty look. Obviously, you know what they're thinking.

LA: What are they thinking?

D: Look how young she is, with a baby...

LA: What kind of people?

D: Older, some in their 40s. Not old people, you know. Not young 'uns.

LA: Do you think that people look down on you?

Yvonne: Some people do. The elder generation. They don't actually say anything, but it's the looks. They tend to give you looks and things like that, as if to say, you are too young to have that baby, sort of thing.

While Jilly (Greater Manchester) reported being 'looked down' on by health service personnel:

LA: I don't know if in this area it's the same, but people are often very negative. Has anybody ever said anything to you (about being a young mother)?

Jilly (J): I've had people look at me, you know, especially when I was pregnant and things like that.

LA: What kind of people?

J: Old people...People the same age. I think it's just, people that obviously I knew at school, and they look at us, they do notice that I am pregnant. People do gossip. But yeah, older people. And midwives...

LA: Were they rude to you?

J: Yeah. Not extremely rude but you could tell...not all of them. Not all of them. There were a few though...Bit snotty...

And Ellie (Greater Manchester) related a poignant tale:

Ellie (E): When she (daughter) was about 5/6 months old, I took her and (niece) to a playgroup, but nobody knew that (niece's name) was my niece, they all assumed I had two (children) and instead of asking me, nobody spoke to me...I tried to make conversation but they'd answer me with one word and then turn their backs.

LA: What kind of women were these?

E: In their 30s, you know, the proper age to have children, as they feel. But there were about four or five women that I actually knew, that live round here, and that hurt me more, and as I was walking home I got really upset and I started crying.

Chloe (Greater Manchester), who was the youngest mother, did not notice people giving her 'dirty looks', but others did:

People look at me...I still get on the bus for 40p now! And people look at me, and I don't notice them me looking at me but me cousin notices and she'll say 'God, she's giving you a dirty look, what's she giving you a dirty look for?' Because I look so young, people can't believe that me son's four. 'God he's four!!' They are more shocked than anything'.

Yvonne (Greater Manchester) believed that local people don't look down on her because of the age at which she started childbearing, but because of her single status:

When I was pregnant, it was mainly the men who would ask. I remember one man saying to another, 'That girl is having a baby' and the other one said 'Is she married?' And he said 'No; and he tutted. A lot of the women are fine about it...I think a lot of them do think that you have to be married to have a child.

In sum, there was evidence of local hostility to the young mothers, but this was intermittent and not pervasive. It may also have been as much about the women's unmarried status as about their age and most women did not spontaneously mention it.

Looking at the Coordinators' accounts, many recognised that teenage mothers are sometimes the target of local hostility, though they often reported that



teenage mothers are less demonised by wider society than they were in the past:

Back in the 80's it (teenage pregnancy) was demonised. Society was sort of 'People having children and then have another child just to get a home' and stuff like that. I think that still exists to a certain extent (Inner London).

LA: Do you think teenage mothers are still demonised?

Coordinator (North West): I would have to agree with that in a sense, I think that there is more of an openness and people are talking about it and that's a very positive thing. We've got local councillors who are mentioning about conception rates in different wards going down. Before, you didn't even talk about because you just didn't want to admit that we have a problem anyway.

Coordinator (Inner London): I think maybe within the local community. I don't feel it in terms of organisations, 'cause the work I do, I don't feel that there's negative (feelings). I don't feel that I am struggling to get things set up for teenage parents, I don't feel that they are saying 'God, those stupid girls' or whatever, I don't feel that at all. I feel that there's a lot of commitment for developing housing and all sorts of services. But I think in the community, just with speaking with the young women themselves, that they do get comments, on the bus. They get comments from other people. Same with like accessing ante- and postnatal classes, they won't, they don't because they think they are going to be judged.

Two Coordinators observed that the much-celebrated low rates of teenage fertility in the Netherlands and elsewhere are partly about community norms that condemn it:

I think that what struck me as different between us and the Netherlands is that they say they are more liberal, but they're not. They (parents) would be sent to Coventry...(by) the people in their community if they found out that their child was pregnant. So they are not more liberal (South East).

I think we have probably gone soft on teenage parents. Forty or 50 years, it much so frowned upon wasn't it. And I hear as well, there's still that sort of attitude in the Scandinavian countries. Being a

teenage mother, I've heard. In places like Holland, it's still very much frowned upon. It's a moral issue there. And therefore that's bound to have an influence to some degree. Whereas I don't think we have that any more in this country. We almost applaud it to some degree (East).

Although the Coordinators worked in different areas (with different rates of teenage pregnancy), there was a remarkable similarity across their accounts in their depictions of wider, community influences on behaviour. This is probably because, even in those areas with low rates of early pregnancy, there were pockets of high rates (nearly always correlated with deprivation). One area (in the South West) is particularly interesting in this respect. The low county-wide rates of teenage pregnancy hid very high rates in the poorest and most marginalised communities. The Coordinator for the area maintained that:

We could virtually justify putting all our money into the looked-after children and young children in the youth offending team, 'cause actually they are our client group really and they're at risk not only of pregnancy.

Asked about the features of the communities where rates of teenage pregnancy are high, the Coordinator painted a dreary picture of life for people in one area living next to another area that was also poor but where (for a number of reasons) this appears not to have had *such* a corrosive impact on the well-being of the local population:

(First place) is different because it has really, really large areas of immense poverty. Immense poverty. (First place) has areas that are really deprived, really low educational attainment. Whereas (Second place) tends to be less like that and...they don't have the same kind of levels of unemployment but what they do have are very high levels of people on benefit. So a lot of people on family credit, so what we've got is an area where people work but are very low paid. And a lot of it is seasonal jobs, so you've kind of got a different sort of thread there...again, there's lots of areas where there's no ambition and no aspirations for young people and, yeah, there's a level of poverty that's different like what you have in (First place) where people are really up against it. There are several

wards in (First place) where things are really bad. It's where the majority of the teenage pregnancies are, it's where all the drug addicts are, it's where they put all the teenage mothers, it's where they dump the paedophiles. We have these real sort of dump estates in (First place) whereas in (Second place), it's much more kind of... less severe but just this sort of current of poorness, but because people have got low paid jobs and claim benefits.

#### **6.4) Conclusion**

The themes that emerged, within peer and neighbourhood contexts, from an analysis of qualitative material are presented above; there were three themes in the two domains: 'lack of peer influence on behaviour'; 'little awareness of community norms governing reproductive behaviour'; and 'relative lack of local condemnation of teenage motherhood'.

On balance, there was little evidence of either peers, or wider community factors, affecting behaviour, though women in the two Northern locations reported knowing more women who had either experienced teenage pregnancy or parenthood. So, while few young mothers believed that either their general, sexual or reproductive behaviour was affected by peers, there is some evidence that young motherhood may be more normative in some social networks and areas than others. Women in all locations reported relatively minor acts of local hostility towards them, but this may have been as much about their marital status as their age, and was not pervasive (no woman mentioned that it affected her daily movements, for example), and no young woman mentioned it spontaneously (questions about this had to be directly asked).

There was some divergence between accounts provided by the Coordinators and those by the young mothers. Generally, Coordinators tended to see young women as 'vulnerable' to the influence of their communities (their friends, their social networks) and believed that some communities 'promoted' early sexual and reproductive behaviour.

## **Chapter Seven: Summary and Discussion**

### **7.1) Introduction**

The results of a study of neighbourhood, family and peer influences on teenage sexual and reproductive behaviour are presented above. The analyses of survey data and qualitative material drew on the neighbourhood effects research. Within this body of literature, factors that affect teenage sexual and reproductive behaviours are largely structural and social/cultural in origin—so that deprivation and lack of opportunity are considered alongside the effects of social messages about sex and reproduction within neighbourhood settings. Norms and messages are transmitted through social interaction with peers and others in the community, and can be reinforced or countered by family members and other authority figures. These ideas have been extensively explored using quantitative (Hogan & Kitagawa, 1983; Moore & Chase-Lansdale, 1999) and (to a lesser extent) qualitative methodologies (Anderson, 1991; Burton, 1997; Burton & Jarrett, 2000) in US settings.

### **7.2) Main results: general observations and reiteration**

#### **7.2.1) General observations**

Before the implications of the results are discussed, a number of general points about the results from both strands of the research need to be made.

First, in the analysis of the BCS, the results are, overall, very mixed. However, attitudes to school were important in the all area and different neighbourhoods scenario analysis. Second, again in relation to the analysis of the BCS, in the multivariate analyses the variables selected only explained a small proportion of the variance (depending on the outcome). This suggests that the explanatory variables selected here were only partially useful. This may reflect a problem with the variables (the way they have been constructed, their validity), or it may be that other variables are necessary to provide a clearer understanding of the influences on teenage sexual and reproductive behaviours.

In relation to the qualitative material, five general points should be made about the themes identified in the thematic analysis. First, there was a great deal of overlap between them. Second, the respondents could be roughly divided up into two groups: those women who had experienced severe adversity in their early childhood or teenage years, and women who had (generally) not suffered such adversity (the implications of this are discussed further below). Third, the diversity of experience in the sample should be emphasised; their monolithic status as 'teenage mothers', with all that that term implies, is not helpful either to the research endeavour or the young mothers' well-being and sense of self-esteem. Fourth, the themes that emerged from the analysis were present, to some degree, across the women in all three locations. There were only two differences by location: women in the Northern locations were more likely than those in Inner London to report having friends who were young mothers and they were also more likely to mention being aware of other young mothers in their neighbourhoods. Last, although some of the interview data were very different in tone and content to that produced by the TPU in its 1999 policy document, the findings here generally replicate those from other qualitative research. The present findings, therefore, represent a valid contribution to the existing body of research.

### 7.2.2) Reiteration of main results

The first research question related to identifying the factors that elucidate the causal pathways to early sex, teenage pregnancy and fertility. Overall, and in relation to both strands of the research, family and individual-level factors (especially attitudes to school) were more important than peer and neighbourhood factors.

However, although respondents did not report being affected by their peers or others in their communities, women in the two Northern locations did know more people who had experienced teenage pregnancy/parenthood (either as friends or as residents in their neighbourhoods). This suggests that, while individual and family characteristics are paramount, sexual and reproductive behaviours may

also be subtly influenced by wider, more contextual factors. From this perspective, factors external to the individual and her family (in the immediate and wider social context) are important, but not overly so. This finding confirms previous research, where contextual influences on behaviour have been observed, but these are considered to have only modest effects (Teitler, 1998).

The fact that respondents reported not being affected by the behaviour of others in their social and wider networks does not mean that these effects do not exist; the women may not have wanted to appear gullible or easily pressurised by their friends (Wellings & Mitchell, 1998), or they may simply not have been aware of friends' or wider influences on their behaviour. Within the social networks of these women, early pregnancy and fertility may be normative; the fact that the women were not aware of this may be because they have internalised these norms and, they are, therefore, taken-for-granted.

The second research question related to neighbourhood variation in the importance of these factors. There was quite a lot of variation by neighbourhood type, though (again) attitudes to school were important in all neighbourhoods for most outcomes.

A number of hypotheses were suggested; generally, these were only partly confirmed. It was hypothesised that area deprivation will be significantly associated with teenage sex, pregnancy and fertility. This was confirmed in relation to pregnancy and birth in the all area analysis, but not to sex. The respondents all lived in areas of relative deprivation, and the Coordinators associated early pregnancy and motherhood with areas of deprivation. However, in the interviews, most women did not consider that they came from poor families, or deprived communities.

It was also hypothesised that other neighbourhood characteristics would be important yet, in the multivariate analyses, no neighbourhood-level factor was independently significant.

It was hypothesised that the young mothers would all live in communities where early childbearing is normative. This was only partly confirmed; some respondents mentioned the visibility of teenage mothers in their communities and, while a number of women reported minor acts of local hostility, all the young women seemed to be accepted within their neighbourhoods.

The suggested importance of family structural factors was only partly confirmed. Housing tenure was important, for example; it was observed to be significant in five out of 12 multivariate analyses and was significant in deprived areas, but was also important in the all area analysis in relation to 'Pregnancy' and 'Birth'. Other family structural variables (financial hardship, the age at which the cohort member's mother begins childbearing, family structure) were not as important as tenure. Family financial hardship was not significant in any of the multivariate analyses even though it was significant in many of the initial cross-tabulations. Family structure was more important and was observed to be independently significant in three out of 12 analyses. In affluent areas, family structure seemed to make a difference to whether a young woman experienced pregnancy or not, and if she became a teenage mother; women living with both parents at age 16 in such areas are about half as likely to have a teenage pregnancy as women living in a lone parent family. The significance of family structure in affluent areas, but not in deprived ones, may be related to greater number of lone parent families in deprived areas.

A family process factor, parental supervision, was also significant in five out of 12 analyses, and partly confirmed the fourth hypothesis. This was important for all outcomes in the all area analysis, but was not significant in deprived areas. It may be that those factors that predispose towards early pregnancy and birth in poor areas are so pervasive that parental supervision has little effect on behaviour. In non-deprived locations, in contrast, parental supervision may make a difference. In the interviews, there was little evidence of poor parental supervision of behaviour, rather the firm but fair imposition of rules governing behaviour and movement.

The other family process factor, the degree of time spent with parents, was only important in relation to sexual behaviour in affluent areas. Cohort members in affluent areas who reported spending a lot of time with parents had a reduced chance of engaging in early sexual activity than cohort members who spent very little time with parents. It is possible, of course, that the amount of time spent with parents is not a very good measure of family process. At age 16, when cohort members are on the cusp of young adulthood even those who enjoy good relationships with parents are likely to be spending a lot of time away from the home with peers.

The idea that teenagers who experience early sex, pregnancy and motherhood are likely to mix with 'deviant' peers and to be influenced by them was not confirmed in either the analysis or the interviews.

The sixth hypothesis related to individual-level factors; the centrality of these was borne out in the analysis of the BCS and the interviews. Attitudes to school were the most important factor (this variable was found to be significant in 10 out of 12 multivariate analyses) and confirmed in the interviews. Young women who express pro-education attitudes at age 16 are much less likely than women who hold negative attitudes to school to engage in early sex, experience a pregnancy as a teenager or become a teenage mother. This confirms previous research on the importance of education (Wellings & Mitchell, 1998).

It was hypothesised that there would be differences between the three locations in the importance of the factors. There was evidence of this in the analysis of the BCS (though individual and family-level factors were the most consistently significant). In relation to the interviews, there was little evidence of this except in one respect: the number of friends that the respondents knew who had either experienced a teenage pregnancy or had their children young (in friendship networks and in the wider community). Women in Greater Manchester and Northumberland were much more likely to mention knowing someone who was a teenage mother than women in Inner London. This may suggest that early pregnancy and childbearing is more normative in these two locations.



### **7.3) Limitations**

#### **7.3.1) The analysis of the BCS**

There are problems, in particular, with the analysis of the BCS. The missing data at age 16 posed exceptional methodological problems. The BCS is not unique in having a lot of missing data; many longitudinal studies suffer from attrition. However, for the reasons outlined in Chapter Three, the BCS was the most appropriate dataset to use here. Any further analysis of the BCS could explore, more fully, the potential for combining variables or modelling missing data, or other ways of dealing with poor response. The large number of variables in the 1986 dataset means that more refined hybrid variables could be constructed. The problems posed by differences in response categories across seemingly similar variables would have to be addressed, however, as would issues around reconciling anomalous responses to apparently similar variables.

There are also problems with some of the variables for which missing data were not so problematic. Here, the use of the outcome variables ('Sex' 'Pregnancy' 'Birth') was not unproblematic. Although sufficient numbers of cohort members reported at least one pregnancy to make the analysis meaningful, there is no way of knowing the extent of under-reporting among this cohort. Cohort members may have not wanted to reveal details of pregnancies (or how they were resolved). The questions relating to potentially sensitive issues (sexual experience, in particular) may not have been answered accurately (Clark, Brasseux, Richmond, Getson & D'Angelo, 1997). Cohort members were asked a series of attitudinal questions about sexual behaviour, but the exact nature of the behaviour was not specified. 'Sex', in this context, probably relates to penetrative sexual intercourse yet cohort members may have engaged in non-penetrative sexual acts, and this may have influenced how they responded to these questions in the BCS.

Apart from the issue of missing data at age 16, there were additional problems with the variables from the 1986 sweep of the BCS. For one, the lowest geographic unit of measurement available to researchers (LEA) may be too large to properly measure neighbourhood effects. If ward-level data were available,

and could be linked to the variables of interest in the BCS, more meaningful effects might be detected. However, for reasons of confidentiality, the lowest level is actually a fairly large geographic area (equivalent to a borough or county, in most cases), and there is wide diversity within LEAs in levels of deprivation. The Inner London area, for example, varies considerably in its experience of deprivation.

Also, many of the measures used in the analysis were based on the subjective assessment of the cohort member. Cohort members may have interpreted definitions of family hardship in different ways; 'hardship' to one person might be relative luxury to the next. 'Parental supervision' can be time and place specific; parents might exercise greater powers of monitoring if a child is travelling some distance from home (late at night, for example), but not bother to enquire about a child's movements if they are staying close to home.

### 7.3.2) The analysis of interview material

There are a number of limitations in relation to the qualitative material. The primary limitation is the relatively small sample size; 15 young mothers and nine Coordinators were interviewed in three locations. The selection of respondents in three locations may also limit the usefulness of the material. There is no way of knowing how typical or unique the respondents are.

In addition, the quality, length and depth of each interview varied. Although qualitative researchers make no claims about the representativeness of their results (Murphy, 2001), the sample size and the use of snowballing methods limits the results. Snowballing methods were used primarily because it was difficult to recruit respondents to the project, but this method does introduce bias into the sample; the women may have been more similar to each other than would ordinarily be found, given that they all knew each other, or had friends and acquaintances in common. The fact that similar themes could be discerned across the mothers (in particular, the failure of contraception, personal and family adversity and birth as positively transforming) may suggest that this is the case. However, despite these similarities, the women were not all the same and each

story they told was unique.

In addition, a number of the women seem wary about being interviewed, and appeared defensive about being asked questions about their 'anomalous' parenting status. This affected the quality of the interviews, and some women seemed overly concerned about depicting themselves as happy and capable mothers.

There are a number of ways in which the collection of qualitative data might have been improved. In retrospect, it might have been sensible to administer a small questionnaire designed to elicit basic demographic information (age, location, educational attainment etc.) either a day or so before the interview (by post or email). This questionnaire could have been used with telephone follow up to clarify any points of confusion or uncertainty, where necessary. Quite a lot of time was spent establishing the level of educational attainment of the women, and the timing of specific events (especially those relating to pregnancy; it wasn't always clear at what point in the pregnancy women found out that they were expecting, for example). Questions about family structure could also have been answered using a brief questionnaire. This would have freed up time to explore other issues in more depth.

Although most women were happy to be interviewed in their own homes, the presence of small children often interfered with the interview process. If the means had been available, the interview data might have been better collected in another setting (in a nearby community centre, for example. Maybe one where short-term childcare was available).

There are at least two key areas that, for the reasons mentioned above, were not explored as thoroughly here as possible; both of these merit further research. First, the fact that there were such differences among the women across the three locations in the number of women they knew who had either experienced a teenage pregnancy or motherhood requires further investigation. It was difficult to establish the true nature of these friendships given time constraints and changes in the nature of relationships (i.e. close friends might become more distant friends

over time, and *vice versa*). Again, this could have been partially measured using a brief questionnaire administered before the interview. The use of such methods of data collection would not detract from the interview proper, but would be used as a 'building block' on which to conduct the interviews.

Second, questions about respondents' neighbourhoods (their perception of the prevalence of youthful childbearing in their areas, their experience of hostility) were asked towards the end of the interviews. By this point, the respondent was often tiring and, rather than risk causing offence, the interview was brought to a close. The neighbourhood settings in which the respondent had lived were a central issue in the thesis and the data might have been improved by exploring these issues at an earlier stage in the interview.

In sum, a number of limitations of the research have been outlined, and ways that the research might be improved suggested. Yet, despite these limitations, the research here represents a valid contribution to the existing literature, both confirming and extending previous research. For example, many of the results in the analysis of the BCS (especially in the bivariate analyses) were in the expected direction. And the strong association of cohort member's attitudes to education with the outcomes in both bivariate and multivariate analysis confirms previous research (Kiernan, 1997; SEU, 1999). Methodological problems notwithstanding, the analysis of the BCS is useful in elucidating the causal pathways to early sex and reproduction.

The problems with the interview material have been noted. However, on balance, most women were happy to be interviewed and this is reflected in their accounts, which are diverse, candid, insightful and illuminating.

#### **7.4) Synthesis and policy implications**

In terms of synthesising the main results from the research, and suggesting implications for the creation and implementation of policy, five main sets of implications can be discerned.

#### 7.4.1) Early childbearing can have a positive impact on the lives of young women

Early motherhood was reported by all the respondents to have had a positive impact on their lives, and the lives of the people around them. For those young women who had previously had fraught relationships with parents, birth transformed the dynamics of these relationships by healing family breaches and bringing families closer. The extensive support offered to young mothers by their parents was tangible proof of this; no mother reported being shunned by her family when her pregnancy was confirmed (though parents were not initially happy about the pregnancy in every case).

These observations contrast sharply with the findings reported in the TPU's 1999 report on teenage pregnancy, where pregnant teenagers disclosed hostile reaction to news of their pregnancy. The quotes offered by the TPU paint a harsh picture of parental rejection of the mother-to-be and apparently only the remotest of possibilities of support for the young woman. This contrasts with findings here and elsewhere (Macintyre & Cunningham-Burley, 1993; SmithBattle, 2000).

The levels of support offered to women by their families were considerable. Almost all the women in the study were able to work part-time (albeit in low-paid work) or attend classes because their parents offered practical support. Women in the UK have to struggle to combine parenting, work and education. Low pay, poor work conditions, the difficulties and expense of suitable child care are prominent features in the lives of working class women who have more than one role in life. The women in the study were assisted in a way that would be unthinkable to most older women. This is not to imply that the young women did not struggle; at least two women mentioned being recently made redundant and there seemed little hope of decently paid and satisfying work in their areas after they had lost their jobs. However, supported by their parents, and other kinfolk, these difficult transitions were made easier.

Here, those women who reported severe early life adversity (being in the care system, homelessness) had made relatively successful transitions to parenthood. That these women had so few inner resources to draw on, and yet made the

transition effectively, is a testament to their strength of character and resilience.

It would be easy for an observer to conclude that these young women had 'made a bad situation worse' by having their children young. This line of reasoning is not only patronising, but inaccurate; birth was a catalyst for change and represented a new start for many women (Clemmens, 2003). The impetus for change that birth brought about was often belied by women's assertions that they 'had just got to get on with it' when confronted with news of pregnancy. The use of such mundane and pragmatic language in relation to such a major life transition does not detract from the impact of the transition, or negate it.

The Coordinators also recognised that birth transformed lives. More than one Coordinator mentioned that early motherhood should not be seen as always problematic. Yet, while many Coordinators would accept that early motherhood can have a positive effect they would, at the same time, lament it. More than one Coordinator said that their role is to widen young women's horizons and to help them to see that there is more to life than being a young mother. This perspective, while not wrong, reflects the professional responsibilities of the Coordinators and their own class background. It also overlooks the fact that working class women who become mothers in their adolescence—and when they are most physically fit for childbearing (Dunson et al., 2002)—can re-enter education and the workplace at a later age, when they are freed from the responsibilities of childcare (Furstenberg, Brooks-Gunn & Philip Morgan, 1987). A compassionate society would facilitate this sequence of events not condemn it.

Given that birth appeared to have such a positive effect on the lives of these women, research on the negative effects of early childbearing may be failing to measure the true impact of teenage fertility. Typically, most studies of the consequences of teenage childbearing examine socio-economic outcomes (education, employment, income) (e.g. Chevalier & Vitaanen, 2001). These clearly could not be measured here, where they were not the focus of the thesis. However, research on the consequences of early motherhood might be more empirically meaningful if women's accounts of the benefits (and the hazards) of

early motherhood were incorporated into the analysis. As Macintyre & Cunningham-Burley (1993) have observed, much of the literature on teenage pregnancy focuses excessively on the negative aspects of early motherhood, and none of its joys.

#### 7.4.2) Young women do not necessarily become pregnant because they are ignorant

Technical/educational perspectives on teenage pregnancy, which were discussed in the introduction, rely on the depiction of young women as ignorant about sex and contraception. Nearly all the women in the study were using contraception when they became pregnant. There was no objective way of accounting for contraceptive failure; though some women mentioned that they were not suited to the pill. Others had taken antibiotics and this had reduced the pill's effectiveness, while some women were just forgetful. So, while efforts to increase access to contraception may not be warranted, there is some scope for educational intervention (clearly, some women are not aware that some medicines interfere with the pill's effectiveness and there may be a need to educate them about this).

This approach may, however, produce only a limited reduction in teenage pregnancy rates. Though many of the women expressed broadly anti-abortion opinions, many recognised that (in some situations) it might be the best way to resolve unplanned pregnancy. Given this, it might be reasonable to assume that, if they had been so opposed to the idea of motherhood they would have opted for abortion. Clearly, the idea of motherhood was not so terrible for most of the women in the study, and there are strong indications that early motherhood was emotionally and culturally acceptable to them. Some respondents came from families where early motherhood might be considered normative (that is, they had mothers who began childbearing as teenagers themselves), and a number of women also reported wanting to work with children.

In the analysis of the BCS, the cohort member's mother's age at first birth was not of great importance (it was significantly associated with the outcome in three out of 12 analyses). Yet, other statistical and qualitative research has shown that

young motherhood is 'transmitted' down generations of families (Kiernan, 1997; Kirkman et al., 2001). The fact that this was not shown to a great degree in the analysis of the BCS may be related to problems with the data or other limitations of the analysis.

As observed in the introduction, the depiction of early pregnancy as a consequence of sexual naivety or ignorance is fundamentally limited. Policymakers find it hard to believe that young women, often in the least auspicious circumstances, might actually *want* to be mothers. Young women may not say as much; to do so is to invite censure in an age in which it is considered strange to want to have children so young (see, for example, Alan Guttmacher Institute, 2002). Policymakers come from class backgrounds that celebrate the idea of 'being in control' and, when they consider the reproductive behaviour of young women in poor communities, they do so from a class perspective that is fundamentally different to that of youth in such settings (Bauder, 2002). The apparent fatalism of young mothers partly reflects their class background, with its relatively limited life options, but it also reflects a genuine desire for the maternal role.

The difference between working and middle class women, in this respect, lies in timing; working class women favour an earlier ideal age for family-building than middle class women (Jewell et al., 2000; Macintyre & Cunningham-Burley, 1993) and, traditionally, have made the transition to motherhood earlier than their middle class counterparts (Wallace, 1987). Despite the widespread perception that teenage motherhood is nearly always accidental—the consequence of poor/nonuse of contraception—there is some evidence that it is a desirable state for some young women. From this perspective, teenage pregnancy is not necessarily a consequence of ignorance, but is a demographic phenomena reflecting working class beliefs about the best age to start family-building.

Beliefs about the appropriate age to start childbearing are, as noted in Chapter Two, strongly linked to social class. For the TPU, the lack of opportunity that is so much a feature of belonging to certain social classes creates 'low



expectations'. This is undoubtedly true, but calls for better access to contraception and better sex education by the TPU and other bodies (OFSTED, 2002) seem not only condescending (assuming, as they do, that working class women are 'ignorant') but also represent a short-term and limited way of dealing with pervasive inequality.

#### 7.4.3) Young women are only subtly influenced by their peers and others in their communities

As noted above, in the analysis of the BCS, there was little evidence that peers had any direct influence on outcomes, nor was there any evidence that wider, neighbourhood-level factors affected behaviours. These findings were confirmed in the interviews, though the fact that women in two locations were more likely than women in the third location to know other teenage mothers suggests that behaviour can be subtly influenced by wider, social factors (Sloggett & Joshi, 1998; Teitler, 1998).

Within current policy approaches to teenage pregnancy, there is an emphasis on peer influences in particular (SEU, 1999; Wellings & Mitchell, 1998), and (to a lesser extent) aspects of local culture that are believed to promote early sex and fertility (TPU & NRU, 2002). It is not the contention here that peer or wider influences on behaviour do not exist, but that they are over-emphasised (certainly in the case of peer influences). Moreover, the negative depiction of peer influences, especially in respect of sexual behaviour, is potentially damaging (Waiton, 2001). Successful transitions to adulthood necessarily involve a movement away from parents to peers and, from there, into wider society. Adolescent friendship networks are an integral part of this development and can promote successful transitions among youth (friends can be useful sources of help and advice, for example). There is some evidence that peer messages and pressures can affect transitions to sexual activity (SEU, 1999), but this is over-emphasised in current discourses; only relatively small numbers of people report being pressurised by their peers into engaging in sex (Mitchell & Wellings, 1998).

Factors that affect sexual and reproductive behaviour originate, overwhelmingly, in the individual and the family; behaviour is only subtly informed by contextual influences. The policy focus on peers or wider influences is ill-judged and also erroneously attributes to peers the capacity to radically change the behaviour of others.

#### 7.4.4) Early childbearing can be a 'rational' behaviour

Teenage parenthood is typically depicted as a calamity, which will change forever (and for the worse) a young girl's life. This may be true of middle class women, who have '...opportunities stretching well beyond age 18 or 19 to become better educated, better skilled...middle class youth have every reason to believe that they will be better providers for their children if they delay parenthood.' (Geronimus, 1997: 421). The same cannot be said of working class women who are most likely to become young mothers. For them, early childbearing can represent a meaningful life option and rational behaviour.

For the young mothers, the idea of rationality can be explored by dividing the respondents into two (approximate) groups: those who had experienced severe early life adversity and those who came from less fraught backgrounds (and usually loving ones). For both groups, early childbearing can be seen as a positive, and even rational, behaviour, but for different reasons. For the latter group, early childbearing represented an alternative 'vocation'. Most of these women were in low-paid jobs before pregnancy, or were in school but had few academic aspirations. Had these women lived in the 1960s or 70s, they would probably have married their child's father (more than one respondent said that her parents had married after a youthful, premarital conception had occurred within a courtship setting). The other group are those who have experienced severe early life adversity and are quite different. Their experiences are such that they have a strong orientation towards childbearing, usually as a way to be loved.

In both cases, it could be argued that teenage pregnancy and motherhood is not the pertinent issue. For the those women who see teenage motherhood as an 'alternative vocation', it is lack of ambition and poor educational attainment that

are the important issues. Efforts to boost the employment and education of young women (particularly in areas of deprivation) might be more effective than initiatives to promote greater use of contraception. Some of the women in the study, however, would be unlikely to re-enter the education system no matter how attractively education programmes are packaged. For these women—who enjoy being mothers—their parenting status should be respected and efforts should be directed instead at ensuring that they and their families are not rendered poverty-stricken because they are not engaged in remunerative work (Ward, 1995). Given the clear dislike of the education system reported by many women, it is not immediately obvious how they can be assisted (if that is considered necessary) to improve their levels of educational attainment.

For the second group of women, those who have experienced early life adversity such as family disruption, family discord and time in the care system, efforts to delay sexual activity and reduce pregnancy are likely to have only limited success. These women recognised that pregnancy is partly a response to adversity; for them, sexual experience, pregnancy and motherhood often provided a means of escape from fragmented and discordant family situations.

In the interviews, one Coordinator reported that she had attended a meeting where she encountered hostility from the young mothers present. Young mothers' perception that Coordinators are opposed to them is unwarranted (no Coordinator said that she was 'opposed' to young motherhood) but it is not difficult to see how such perceptions arise. Early pregnancy and parenthood is depicted as problematic or even pathological and young mothers are aware of this (Jewell et al., 2000; Kirkman et al., 2001; Phoenix, 1991). We need to begin to understand that young parenthood is not necessarily pathological, and can be a rational, meaningful behaviour.

#### 7.4.5) The focus on teenage pregnancy, and its concentration in specific neighbourhoods, is mistaken

It is not the intention here to suggest that teenage pregnancy is never problematic, and that there are not problems with poverty and lack of opportunity

in specific areas. However, it might be worthwhile briefly considering why teenage pregnancy has become a significant policy issue, given the decline in childbearing among teenagers and equivocal evidence about the consequences of early fertility? The concern about teenage pregnancy, and the growth of a body of research on the issue, seems ill-timed and anomalous. This has been noted by other commentators (Macintyre and Cunningham-Burley, 1993), as has the intense (and sometimes prurient) interest among academics, policymakers and the media in teenage sexual and reproductive behaviour (Luker, 1996; Macintyre and Cunningham-Burley, 1993).

The present government's concern with teenage pregnancy may be largely about other issues: concern about (too early, too much) sexual activity, the changing structure and role of the family, the cost of welfare benefits and the growth of 'dangerous classes' in poor neighbourhoods (Levitas, 1998). If this is the case, the focus on teenage pregnancy and social exclusion (especially in poor neighbourhoods) is a smokescreen for other, less palatable, concerns.

Policymakers might be fearful about appearing to pathologise the cultural, sexual and reproductive norms and behaviour of some communities. However, operating within discourses about social exclusion is the (implicit) idea that the socially excluded are subject to pathological moral and social norms. This evokes notions of the 'underclass'. Levitas (1998) observes that the Labour government see social exclusion as more than about poverty, there is a 'moral underclass' discourse operating in New Labour policy. This is a:

...gendered discourse with many forerunners, whose demons are criminally-inclined, unemployable young men and sexually and socially irresponsible single mothers...whose (self-)exclusion, and thus potential inclusion, is moral and cultural. (p.7-8).

For Levitas, one of the defining characteristics of this discourse is the focus of attention on the behaviour of the poor rather than on the structure of society. Speaking of the establishment of the SEU, Levitas notes that: 'As so often, the

statement that exclusion was about 'more than poverty' became the justification for not addressing poverty directly' (p.149).

Overall, the TPU may not be helping young women by implementing the TPS. Teenage pregnancy will probably not be reduced by the promotion of increased access to contraception and more sex education. In the analysis of the BCS, the cohort member's attitudes to school were the most common significant influences on outcomes; women who expressed negative attitudes to school at age 16 were more likely than women who held positive attitudes to engage in early sexual activity, experience a teenage pregnancy and become a teenage mother. This was confirmed in the interviews, where most respondents had low educational attainment. This, and a history of personal adversity among many young women, suggest that current efforts to reduce teenage pregnancy, which focus on the promotion of use of contraception and improved sex education, are unlikely to succeed.

The government's efforts to reduce teenage pregnancy may appear benign but there is an implicit message in government policy that teenage pregnancy is inherently wrong. A recent government initiative is newsworthy in this respect; teenage pregnancy is now so stigmatised that it has been put into the same category as criminal activity:

Tony Blair is to announce plans to put up to half a million children deemed at risk of becoming criminals or getting into other trouble on a new computer register....The new 'identification, tracking and referral' system will allow the authorities to share information on vulnerable children, including their potential for criminal activity. It will be an extension of the child protection register which, at present, is restricted to listing the names and addresses of children who are vulnerable to physical and sexual abuse. Professionals will be encouraged to include other factors, such as the likelihood of *teenage pregnancy* or the risk of "*social exclusion*", in deciding which children should be monitored (Elliott & Bamber, 2003. Emphasis added).

This approach to teenage pregnancy will only further stigmatise young mothers, and possibly the health and well-being of their children. We need a different language to understand influences on youthful sexual and reproductive behaviour rather than one which ultimately pathologises it. The implications of the present research suggest that we may need to develop a more complex and nuanced discourse around young mothers, one that recognises them in all their complexity.

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## **Appendix A: A note on period differences between the BCS and interview data.**

The BCS data used in the analysis above relates to reproductive events that occurred in two time periods. The first, the period 1987 to 1990, when all cohort members were aged 17-20 years. Reproductive events occurring in this period are, therefore, 'teenage'. The second period is from 1991 to 2000, and any reproductive event experienced by a cohort member in this period is considered to have happened to an 'older' (i.e. not a teenager) individual. In contrast, the teenage mothers who were interviewed face-to-face had given birth to their children in the late 1990s and the early years of the new decade. There is, therefore, an approximate ten year gap in experience of pregnancy/childbearing between teenage mothers in the BCS and women who were interviewed face-to-face.

It would have been possible to interview women who had children in the late 1980s-1990 (and whose experience, theoretically, mirrors the experience of women in the BCS), but it was important that women were interviewed a reasonable length of time after pregnancy/childbearing for two reasons. First, the strategy used here minimised recall bias (women who had their children in the late 1980s might not accurately recall aspects of their pregnancy/childbearing experience). Second, the government's strategy for addressing teenage pregnancy did not come into existence until 1999—soon before/around the time when many of the women interviewed here became pregnant or gave birth. childbearing. Given this, the women interviewed here might be considered the genuine 'objects' of official concern about teenage pregnancy, and their experience of motherhood may be influenced by prevailing, public attitudes to young mothers that are informed by current policy approaches.

It might have been possible to reconcile period differences using a more contemporary dataset. However, there are no longitudinal, national datasets yet available that could have been used here instead of the BCS.

## Appendix B: The Original Explanatory Variables Used in the Analysis of the BCS

Major level	Broad description of measure	Specific measure	BCS variable
Neighbourhood	Neighbourhood deprivation	Deprivation	Carstairs
	Neighbourhood features	Physical/social features	hc4.1-hc4.5
		Monitoring	q44.1-q44.3
Family	Family structure	Family structure	oa11.4, oa11.8
		Cohort member's mother's age at first birth	a0002, a0052, a0005a
		Financial hardship	oe4.1
		Tenure	of3.1-of3.7
	Family process	Parental monitoring	hb7.1-hb8.3
		Time spent with parents/ 'connectedness'	pc2.1-pc2.3
Peers	Deviance	Deviance	hc10a.1-hc10g.2
			q21.1-q21.13
	Influence on behaviour	Influence on behaviour	hc2
Individual	Deviance	Own deviance	hc10a.3-hc10g.3
			q22.1-q22.26
	Attitudes to school	Attitudes to school	jb14a-jb14f

## Appendix C: Correlation Analysis of the BCS Explanatory Variables

*Table A1: Neighbourhood features*

		In area noisy neighbours or loud parties	In area graffiti on walls or buildings	In area teenagers hanging round streets	In area drunks or tramps on streets	In area lots of rubbish lying about
Spearman's rho	In area noisy neighbours or loud parties	1.000 . 2935	.377** .000 2930	.370** .000 2927	.249** .000 2927	.277** .000 2931
	In area graffiti on walls or buildings	.377** .000 2930	1.000 . 2938	.569** .000 2931	.383** .000 2930	.506** .000 2933
	In area teenagers hanging round streets	.370** .000 2927	.569** .000 2931	1.000 . 2937	.351** .000 2929	.468** .000 2931
	In area drunks or tramps on streets	.249** .000 2927	.383** .000 2930	.351** .000 2929	1.000 . 2934	.414** .000 2933
	In area lots of rubbish lying about	.277** .000 2931	.506** .000 2933	.468** .000 2931	.414** .000 2933	1.000 . 2938

\*\* . Correlation is significant at the .01 level (2-tailed).

*Table A2: Neighbourhood monitoring*

		Neighbours call police-teen try car door	Neighbours call police-climb in window	Neighbours call police-teen do graffiti
Spearman's rho	Neighbours call police-teen try car door	1.000 . 3005	.597** .000 2992	.506** .000 2995
	Neighbours call police-climb in window	.597** .000 2992	1.000 . 2999	.468** .000 2993
	Neighbours call police-teen do graffiti	.506** .000 2995	.468** .000 2993	1.000 . 3002

\*\* . Correlation is significant at the .01 level (2-tailed).

Table A3: Parental monitoring

		Do parents ask who you going out with	Do parents ask where are you going	Do parents ask what you are going to do	Tell parents who you really going with	Tell parents where you are really going	Tell parents what you really going to do
Spearman's rho	Do parents ask who you going out with	1.000 .000 2931	.734** .000 2927	.607** .000 2928	.313** .000 2921	.270** .000 2915	.249** .000 2913
	Do parents ask where are you going	.734** .000 2927	1.000 .000 2934	.592** .000 2928	.297** .000 2922	.292** .000 2920	.253** .000 2917
	Do parents ask what you are going to do	.607** .000 2928	.592** .000 2928	1.000 .000 2929	.248** .000 2920	.249** .000 2916	.388** .000 2914
	Tell parents who you really going with	.313** .000 2921	.297** .000 2922	.248** .000 2920	1.000 .000 2929	.727** .000 2921	.641** .000 2919
	Tell parents where you are really going	.270** .000 2915	.292** .000 2920	.249** .000 2916	.727** .000 2921	1.000 .000 2924	.734** .000 2919
	Tell parents what you really going to do	.249** .000 2913	.253** .000 2917	.388** .000 2914	.641** .000 2919	.734** .000 2919	1.000 .000 2920

\*\* . Correlation is significant at the .01 level (2-tailed).

Table A4: Time spent with parents

		Time mother spends with teenager	Time husband spends with teenager	Time as a family spent with teenager
Spearman's rho	Time mother spends with teenager	1.000 .000 3261	.714** .000 2826	.613** .000 2919
	Time husband spends with teenager	.714** .000 2826	1.000 .000 2870	.763** .000 2753
	Time as a family spent with teenager	.613** .000 2919	.763** .000 2753	1.000 .000 3277

\*\* . Correlation is significant at the .01 level (2-tailed).

Table A5: Friends' and own deviance<sup>34</sup>

		Close friend been moved on by police	Store detect accuse close friend theft	Close friend arrested & taken to station	Close friend been found guilty by court
Spearman's rho	Close friend been moved on by police	1.000 .000 2843	.206** .000 2800	.292** .000 2800	.258** .000 2799
	Store detect accuse close friend theft	.206** .000 2800	1.000 .000 2820	.416** .000 2798	.296** .000 2794
	Close friend arrested & taken to station	.292** .000 2800	.416** .000 2798	1.000 .000 2817	.525** .000 2805
	Close friend been found guilty by court	.258** .000 2799	.296** .000 2794	.525** .000 2805	1.000 .000 2815

\*\* . Correlation is significant at the .01 level (2-tailed).

Table A6: Friends' and own deviance 2

		Broke windows/sma shed others' property	Sold stolen/shop lifted items	Physical force get money from non-family	Stole something worth <#5 from a shop
Spearman's rho	Broke windows/smashed others' property	1.000 .000 2988	.333** .000 2973	.179** .000 2965	.341** .000 2967
	Sold stolen/shoplifted items	.333** .000 2973	1.000 .000 2988	.146** .000 2963	.431** .000 2969
	Physical force get money from non-family	.179** .000 2965	.146** .000 2963	1.000 .000 2972	.124** .000 2958
	Stole something worth <#5 from a shop	.341** .000 2967	.431** .000 2969	.124** .000 2958	1.000 .000 2986

\*\* . Correlation is significant at the .01 level (2-tailed).

<sup>34</sup> The full results of the correlation analysis cannot be displayed here for lack of space. These are correlations based on a subset of variables

Table A7: Attitudes to school

## Correlations

	Feel school is largely a waste of time	Think homework is a bore	Find it difficult to keep mind on work	Never take work seriously	Do not like school
Spearman's rho					
Feel school is largely a waste of time	1.000 .000 2965	.352** .000 2953	.316** .000 2950	.393** .000 2945	.455** .000 2938
Think homework is a bore	.352** .000 2953	1.000 .000 2980	.388** .000 2957	.356** .000 2955	.421** .000 2947
Find it difficult to keep mind on work	.316** .000 2950	.388** .000 2957	1.000 .000 2973	.412** .000 2954	.336** .000 2948
Never take work seriously	.393** .000 2945	.356** .000 2955	.412** .000 2954	1.000 .000 2970	.411** .000 2941
Do not like school	.455** .000 2936	.421** .000 2947	.336** .000 2948	.411** .000 2941	1.000 .000 2981

\*\* . Correlation is significant at the .01 level (2-tailed).

## **Appendix D: Copy of the Letter Given to all Teenage Mothers before the Interview**

Dear

### Teenage pregnancy and childbearing project: informed consent

Many thanks for agreeing to take part in the project. Your help is invaluable. This letter contains details about the 1) project and about the 2) interview stage of the project. There are a number of points that will be made below to reassure you if you have any concerns about either.

#### **1) The Research project**

The research is being conducted by a research student from the Department of Geography, Queen Mary, University of London, Mile End Road, London E1 4NS. Her personal telephone number appears at the bottom of this letter. The student is being supervised by Dr Ray Hall in the Department of Geography at Queen Mary (Telephone: 020 7975 5400).

The research is about teenage pregnancy and childbearing in the UK. The researcher is interested in why some people have children at a fairly young age and why some do not. Questions will be asked about a number of things: school experiences and achievement; family background, relationships with parents and boy/girlfriends and the kinds of communities that you grew up in.

#### **2) The Interview**

It is important that you give your free, informed consent to be interviewed. If you have not given your free, informed consent the interview cannot take place because it would be unethical.

You can refuse to answer any of the questions that the researcher asks you. It is up to you to decide which questions you want to answer. You do not have to give an explanation. You can stop the interview at any time. You do not have to give an explanation. The interviewer will ask you if she can record the interview with a



cassette recorder. This is done so that the interview can be listened to at a later date and summarised. If you do not want the interview to be tape recorded, please tell the researcher. Instead, notes can be taken at the time of the interview.

All the information that you provide the researcher with is considered highly confidential. Anything that can identify you (such as your surname or full address) will not be asked for. Your first name will be changed when the project is written up.

You can contact the research student or the supervisor of the project at any time and ask for information that you have provided to be taken out of the final document. You do not have to give an explanation. A summary of the research findings can be sent to you, at no cost, when the project is completed.

If you have any queries you can, at any time, contact either the researcher, Dr Hall or Queen Mary. Instances of unethical behaviour during data collection are taken very seriously by the college and by the university.

In recognition of your help with the project, you will receive a small payment (£10).

Once again, many thanks

Yours Sincerely,

Lisa Arai

## **Appendix E: Published Papers**

# COMMENTARY & ISSUES

□ LISA ARAI

*Queen Mary, University of London*

## **British policy on teenage pregnancy and childbearing: the limitations of comparisons with other European countries**

### *Abstract*

British policy makers justify their concern about youthful pregnancy and childbearing by comparing relatively high British teenage pregnancy rates with lower rates in other European countries. These comparisons are a feature of 'technical/educational' explanations for youthful childbearing (explanations that depict adolescent pregnancy as a consequence of a lack of sex education and poor use of contraception). Such comparisons are inappropriate for a number of reasons. They fail to take account of the variation in adolescent reproductive behaviour and outcomes in the rest of Europe (such as variation in pregnancy rates and differential use of abortion). They also attribute low rates of teenage pregnancy to sexual openness and sex education, yet the evidence for this is mixed. In addition, such comparisons assume that Britain can learn from the experience of other European nations, despite evidence that Britain is unique, in some respects, within Europe. Policy makers must recognize the multiple reasons for early childbearing.

**Key words:** adolescent, births, conceptions, contraception, sex education

A reduction in youthful conception and birth rates is a central aim of New Labour's efforts to address social exclusion in the UK. So pressing is the 'problem' of adolescent pregnancy that the government has established a Teenage Pregnancy Unit within the Social Exclusion Unit (SEU), appointed local coordinators to monitor rates in their area and launched a major publicity campaign. The government's goal is

ambitious: to halve conception rates among the under-18s (Ferriman, 1999).

The need for such measures is seldom questioned; in the public imagination (and often in the research literature), there is a belief that teenage pregnancy and childbearing are increasing and that action is necessary to stem the growing numbers of young mothers (FPSC, 1999). A closer reading of the statistics reveals, however, a less sensational scenario than that commonly depicted. Rates of adolescent childbearing are declining practically everywhere in the developed world, including the UK. England and Wales had an adolescent birth rate of around 50 births per 1000 girls in the early 1970s; by 1995, this had declined to under 30 (Singh and Darroch, 2000). The conception rate has not changed substantially between these two periods, although teenage sexual activity has increased, and the relative stability of the conception rate suggests that the sexually active are better at preventing pregnancy now than they were a generation ago (Wellings and Kane, 1999).

The goals of the Teenage Pregnancy Unit are not necessarily undermined by evidence of a downward trend in adolescent childbearing. Where early childbearing does occur, it is believed to be injurious to the health of the mother and/or the child or the cause of poverty and low maternal educational achievement (SEU, 1999). There is a large body of literature on the outcomes of youthful childbearing, but there is not the scope here to properly consider it. However, much of the research is often at odds with the common perception of the harmfulness of teenage fertility. Young parenthood may have detrimental socioeconomic effects, net of pre-existing deprivation (Hobcraft and Kiernan, 1999), although this is not always true in the American (Hoffman, 1998; Hotz et al., 1999) and some European settings (Berthoud and Robson, 2001). Studies of the health outcomes of adolescent childbearing are also mixed (Cunnington, 2001). There is some evidence that younger maternal age protects children from diabetes (Bingley et al., 2000) and women from breast cancer (McPherson et al., 2000), and obstetric outcomes are often more favourable in this population compared with older age groups (Wolkind and Kruk, 1985). In sum, much of the research that is cited as evidence of the negative outcomes of early childbearing is highly selective.

How can the government justify its campaign to reduce teenage pregnancy and childbearing given that birth rates among teenagers

are falling and the research on the consequences of youthful childbearing is equivocal? Where the government appears to be on safer ground is in their oft-repeated assertion that British adolescent birth rates are substantially higher than those in other Western European nations. From this perspective, British rates are a cause of national embarrassment (see Tony Blair's foreword in SEU, 1999) and the British are depicted as ignorant in matters of sexual health (Hadley, 1998).

Youthful childbearing is undoubtedly more prevalent in the UK compared with many other European nations and teenage pregnancy rates are also relatively high. Comparisons with other European countries are drawn with such ease and frequency, however, that their suitability is seldom considered. It is argued here that these comparisons are inappropriate for a variety of reasons. A consideration of these is the focus of this article.

### **'Technical/educational' explanations for youthful pregnancy and childbearing**

Comparisons with other European nations in respect of adolescent reproductive outcomes are a feature of a type of explanation that might be broadly described as 'technical/educational' in nature; that is, explanations for (and solutions to) early pregnancy and childbearing tend to focus on the use of contraception (technical) and instruction in sex education (educational). Both of these are the concomitants of 'sexual openness' (Jones et al., 1986).

A major limitation of technical/educational explanations for youthful pregnancy and childbearing is that they stifle discussion of contextual or structural influences on sexual behaviour and reproductive outcomes. From this perspective, factors such as socioeconomic inequality, educational underachievement and residence in a blighted neighbourhood are given consideration, but are not central. It is well known, for example, that women in the unskilled, manual social classes are 10 times more likely to become adolescent mothers than their counterparts from professional social class backgrounds (SEU, 1999) and that early pregnancy and childbearing are concentrated in the poorest neighbourhoods (and abortion in the most affluent) (Smith, 1993). Yet the reduction of deprivation is seldom suggested as the principal means of reducing adolescent pregnancy (Luker, 1996).

The tendency to give priority to technical/educational explanations for teenage pregnancy and childbearing is evident in the SEU's (1999) analysis of teenage pregnancy. The SEU identified three factors that contribute to high rates of youthful pregnancy, which are: (1) low expectations among teenagers (a consequence of poverty); (2) 'ignorance' about contraception; and (3) 'mixed messages' about sex. All three are important and are acknowledged as such by the authors, but greater weight is given to the latter two factors, with the authors emphasizing the role of non-structural explanations by pointing out that 'deprivation is not the whole story . . . even the most affluent areas usually have teenage birthrates that are higher than the national rates in, for example, the Netherlands and France' (SEU, 1999: 22).

The feature of technical/educational explanations that we are concerned with here is the use of comparisons with other European nations. The argument that usually accompanies such comparisons is a familiar one: some countries (Sweden, Denmark and the Netherlands in particular) are cited as particularly effective at reducing (or retaining) low adolescent birth rates; these low rates are believed to be the product of 'sexual openness' in these countries, which means that young people are better instructed in matters of sexual health (Jones et al., 1986); the UK could learn by the experience of these nations, particularly in respect of improved sex education (Hadley, 1998; Harling, 1999).

This type of argument is built on at least three features (or assumptions): first, that low continental adolescent birth rates are primarily a consequence of a low incidence of conception (and also that conception rates are uniformly low across Western Europe, with the exception of the UK); second, that (to the relative exclusion of other factors) low teenage pregnancy rates are attributable to the effects of sexual openness and its consequences; and, finally, that the experience of other European nations can be applied to a British setting. This is a simplified (albeit fairly accurate) description of the three principal features of arguments that use such international comparisons. Each of these will be discussed in turn below.

### Variation in conception rates

The first of the features described above is that relating to European conception rates and their variation. This variation is often hidden by

judicious presentation of statistical data, with conception and abortion rates presented much less than birth rates. In the SEU's principal publication on teenage pregnancy (SEU, 1999), one table on international differences in teenage abortion ratios is presented, but the full significance of this is not commented upon. Yet these differentials are substantial: in 1994, Sweden had an abortion ratio of 1853 per 1000 adolescent births (thus, for every 1000 births to teenagers, there were 1853 abortions); Denmark's ratio was 1624; while in the UK it was just 627 (Kane and Wellings, 1999). It is inadequately appreciated that the low incidence of births to teenagers in some countries (such as Sweden and Denmark) is partly attributable to the widespread use of abortion rather than to spectacular reductions in conception rates (FPSC, 1999; Micklewright and Stewart, 1999; UNICEF, 2001).

The adolescent abortion ratio tells us only how likely an abortion is compared with a birth and not the overall rate of abortion, which is a function of the conception rate. Conception rates can only ever be roughly estimated since they are based on the sum of births and abortions, and estimates for the same country can vary. For example, the estimated English and Welsh teenage conception rate in 1995 ranged from a high of 59 per 1000 (ONS, 1998) to a low of 47 per 1000 girls in the same year (Singh and Darroch, 2000). Methodological considerations aside, the UK has the highest teenage conception rate in Western or Northern Europe, but comparatively high rates are also found in a number of other countries (Iceland, 43.3; Norway, 32.2; Sweden, 24.9) and low rates are present in Italy (12), the Netherlands (12.2) and Spain (12.3) (Singh and Darroch, 2000). In the Swedish case, by 1995, about 68 percent of adolescent conceptions were terminated; the figure for England and Wales was 40 percent in the same year (calculation based on Singh and Darroch's data, 2000). Santow and Bracher (1999) maintain that abortion was more important in the maintenance of low Swedish adolescent birth rates before 1975; even after that date, abortion continues to be important (albeit less so) in keeping rates low.

A consideration of variation in European conception rates also highlights another issue: low teenage conception and birth rates are a feature of quite disparate nations such as Spain, Italy and the Netherlands. The Netherlands has, for a long time, had low adolescent pregnancy and birth rates compared with other Western European nations. Along with countries such as Belgium and Switzerland,

its adolescent birth rates have been low since the early 1960s. Spain and Italy belong to a group of nations where rates of teenage pregnancy and childbearing fell in the late 1970s or later (Kane and Wellings, 1999).

Interestingly, little attention is paid by researchers, journalists and policy makers to teenagers' reproductive behaviour in these countries, with the key exception of the Netherlands. Spain, Italy and especially Belgium, but also the Republic of Ireland (the latter two experiencing early declines as in the Netherlands), are seldom celebrated for their 'successful' record on teenage pregnancy. From a technical/educational perspective that emphasizes the role of contraception and sex education in adolescent reproductive outcomes, there is little to link these countries. This would seem to suggest that the reasons for these low rates are varied and complex and may even be specific to each nation, so that no or few generalizations can be made.

### Sexual 'openness'

The second feature of explanations that utilize comparisons between the UK and other European nations is the belief that, where adolescent conception and birth rates are low, this is attributable to sexual 'openness' and its concomitants (Hadley, 1998; Harling, 1999). This argument is undermined by the fact that, as shown above, some nations are better than others at preventing youthful pregnancy. Those nations with a longstanding sex education programme (the Swedish one has been in existence since 1955; Kane and Wellings, 1999) obviously cannot entirely depend on it to prevent teenage pregnancy.

Teitler (1999) questions the assumption that sexual openness and sex education can explain variations in adolescent reproductive outcomes. This belief, he says, is 'rarely . . . countered by academic researchers' (1999: 8), but explanations may lie elsewhere. Approaches to sex education vary among European nations, yet teenage birth rates in Western Europe are uniformly low. Northern European nations have traditionally been proactive in their provision of sex education while Mediterranean nations 'leave much more of the sex education to youth themselves' (1999: 13).

This consideration of the role of sex education in the maintenance of low adolescent pregnancy rates is not meant as a criticism of all sex



education programmes. The utility of such programmes has been demonstrated (Kirby, 2001), although attributing changes in behaviour to the programme itself is problematic. Oakley et al. (1995) show that, of 73 young people's sexual health education interventions that had been evaluated, only 12 were considered methodologically sound enough to draw conclusions from. Of these 12, just two appeared to show effects on behaviour or knowledge.

A nation like Italy, for example, has low teenage conception and birth rates, yet a haphazard approach to sex education. Sex education is not mandatory; parents have the right to withdraw children from classes and provision is sparse (Kane and Wellings, 1999). In addition, abortion is restricted to the first trimester and is highly conditional (Bettarini and D'Andrea, 1996). A recent survey of Italian youths' sexual knowledge shows some degree of ignorance of human sexuality and reproduction, with more than half of 11–14 year olds questioned stating that AIDS could be caught from toilet seats (Usher, 1999).

Yet, even without sex education, Italian adolescent reproductive outcomes are remarkably similar to Dutch ones. Of course, there are other factors at play, not least the contexts within which sexual intercourse occurs. The SEU (1999) cites evidence that demonstrates that the first experience of intercourse is more likely to occur within a loving relationship for Dutch teenagers, whereas this is less likely among their British counterparts (with British males citing peer pressure, physical attraction and opportunity as reasons for first intercourse). Interestingly, despite the disparity between the UK and Italy in rates of teenage pregnancy, young Italian men are similar to their British counterparts in this respect; Zani (1991) discovered similarly utilitarian reasons for first intercourse among Italian male adolescents.

The UK's comparatively high adolescent conception and birth rates might be considered anomalous from a technical/educational perspective. British teenagers have access to free effective contraception and abortion legislation is among the most liberal in the world, with free termination allowed (in theory) until 22 weeks' gestation (Jones et al., 1986; Kane and Wellings, 1999). The paradox of this situation was highlighted recently when research indicated that 71 percent of young mothers in the Trent region had consulted a health professional about the use of contraception before the conception of their babies and 50 percent had been prescribed oral

contraception. This appears to contradict the widely held belief that teenage mothers are ill-educated in matters of sexual health, with the authors concluding that: 'The reluctance of adolescents to attend general practice for contraception may be less than previously supposed' (Churchill et al., 2000: 486).

### The British setting: demography, inequality and youth transitions

The third feature of explanations for youthful pregnancy that utilize comparisons between Europe and the UK is the belief that the experience of other European countries can be applied to a British setting. Even if it is the case that sexual openness and sex education are responsible for lower rates of youthful pregnancy elsewhere in Europe (which is questioned here), there are a number of reasons why such measures would probably be of limited effectiveness in a British setting. These reasons owe much to the distinctiveness of Britain within Europe and, once the nature and scope of this is understood, early childbearing appears a more *rational* behaviour and possibly one that is less amenable to the kind of intervention proposed by the Teenage Pregnancy Unit.

Features of the UK that render it distinctive within Europe are, broadly speaking, demographic and socioeconomic. First, childbearing occurs at earlier ages in the UK than it does in the rest of Western Europe. In 1994, mean age at first birth in England and Wales was 26.5; the West European average was nearly 29 years in the same year (Coleman and Chandola, 1999). This tendency towards earlier age at first birth may mean that teenage childbearing more closely resembles, and is related to, childbearing in older age groups (Teitler, 1999). Second, the size of the British population and high levels of income inequality (which is correlated with adolescent childbearing) may mean that there is no uniformity in the meanings attached to youthful childbearing. These meanings can vary from one community to another, with the result that childbearing among teenagers might be accepted in one place, but condemned in another (Bauder, 2002; Tabberer et al., 2000; Teitler, 1999).

Comparisons between the UK and countries such as Sweden and the Netherlands, which have smaller, less economically polarized populations, are simplistic. Jones et al. (1986) make the same point

about the differences between Sweden and the USA (another country with high teenage pregnancy rates). The greater socioeconomic homogeneity of Sweden and its considerably smaller population compared with the US and the UK also facilitate social control. In such a setting, sex education programmes may be more effective. Features of the Swedish benefit/employment system might also cause the postponement of fertility: parental leave benefit in Sweden is based on income earned just before childbearing, so there is an incentive to attain as high an income as possible before the birth of a child (Andersson, 2001).

There is not the scope here to properly discuss the more appropriate comparisons that could be made between the UK and other countries. However, if comparisons are needed, they should be made between the UK and other English-speaking nations such as the US, Canada, Australia and New Zealand. As Chandola et al. (2001) point out, there seems to be 'a statistically distinctive set of demographic attributes common to the English-speaking populations which make them stand out as a group in conventional statistical analysis when compared with the other countries of the Western world' (2001: 360). These authors describe youthful fertility, relatively high fertility and young age at marriage, and also 'substantial and protracted baby booms' as the features (more or less) common to these countries. Some Eastern European nations also have similar demographic features (FPSC, 1999).

These aspects of the British demographic and socioeconomic landscape inevitably affect youth transitions into work, education and family formation. It is widely acknowledged that such transitions are more accelerated in the UK than other Western European nations (Galland, 1995) which affects when and under what conditions childbearing commences. For Evans and Furlong (1997), the distinctiveness of British youth transitions is partly attributable to the characteristics of work/education provision after age 16. The provision model is not strongly institutionalized which means that 'many young people are closer to the world of work and to "adult responsibilities" at an early age' (1997: 36).

In recent years, these accelerated youth transitions have become less pronounced, yet, despite this, Britain retains 'one of Europe's fastest transition regimes' (Roberts, 1997: 63). Roberts gives the example of Germany, which is one extreme along the continuum in that there are qualifications and training programmes that must be

completed before young people can practise most occupations. Britain, on the other hand, is 'Europe's self-acclaimed capital of deregulation' (1997: 63) and stands at the other end of the continuum. In a similar vein, Galland remarks on the 'distinctiveness' of the British case, whose youth

appear to continue to be governed by a model of early maturing. Studies are abandoned early . . . entry to the labour market is early, as are leaving home and living as a couple. . . . The average age for a (first) union is thus one of the lowest in Europe. (1995: 6)

Wallace made similar observations in 1987, although she noted class differences in transitions, with unskilled and semi-skilled working-class individuals starting their childbearing earlier than their middle-class counterparts. Wallace's study is now outdated and refers to an era when teenagers could be 'persuaded' to marry if a premarital conception occurred, but even she notes the 'moral censure' that 'creeps into the accounts of those who consider the so-called "problem" of early marriage and conception' (1987: 155). She also observes that, even when teenage marriage was more normative, there were calls for more education for irresponsible young women who conceived and married young.

## Conclusion

The British government justifies its policy of reducing adolescent pregnancy on the grounds that British rates are higher than those found elsewhere in Europe. These comparisons are inappropriate for the reasons discussed above since: they ignore variations in conception rates and the use of abortion across the rest of Europe; they attribute a low incidence of teenage pregnancy to the effects of sexual openness and sex education although the evidence for this is mixed; and they assume that the experience of other European nations can be applied to Britain. The reasons for low teenage pregnancy and birth rates in other European nations are varied. Probably there is no single reason and attempts to apply an overarching explanation will necessarily be limited.

On a final note, youthful childbearing is usually associated with individuals and communities that are, in the common parlance, 'socially excluded' (although this does not mean that their early childbearing *causes* their exclusion). To imagine that the problems

faced by these communities can be dealt with by the promotion of sex education is patronizing. We must resist the tendency to see adolescent parents as a kind of 'demographic residuum' in need of educational intervention. Bauder (2002) argues that, viewed from the mainstream, the norms governing behaviour in marginalized communities are considered dysfunctional. He criticizes this tendency and observes that: 'Distinct cultural identities form within the context of the local community . . . childrearing ideologies, the meaning of motherhood, standards of "making it" . . . differ between neighbourhoods' (2002: 89). In some poor communities, early childbearing makes sense for health, economic and cultural reasons (Geronimus et al., 1999) and policy makers who do not recognize this risk further marginalizing such communities.

## Acknowledgements

Queen Mary and the University of London Central Research Fund provided funding for the research on which this article is based. The author would like to thank Sharon Breen, Dr Ray Hall and Seeromanie Harding for their helpful comments on earlier drafts.

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# **Low expectations, sexual attitudes and knowledge: explaining teenage pregnancy and fertility in English communities. Insights from qualitative research**

*Lisa Arai*

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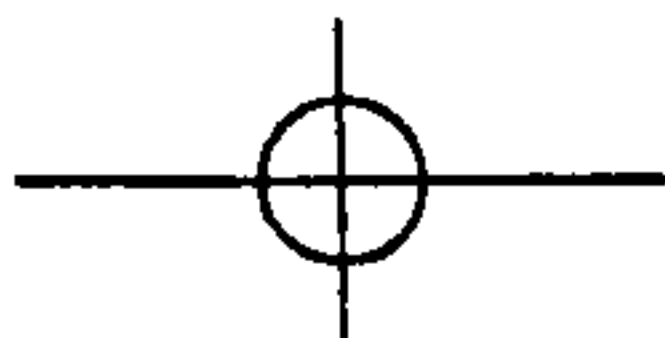
## **Abstract**

In the UK, youthful pregnancy and parenthood is considered an important social and health problem and is the focus of current government intervention. Contemporary policy approaches depict early unplanned pregnancy as a consequence of relative deprivation and a lack of opportunity, leading to 'low expectations' among youth, and as the result of sexual 'mixed messages' or poor knowledge about contraception. This small scale, qualitative study explores how well these explanations accord with accounts of pregnancy and motherhood provided by young mothers and Teenage Pregnancy Local Co-ordinators in diverse English localities. The results suggest that structural factors may be more important in explaining early pregnancy than those relating to sexual attitudes and knowledge. The tension between the idea of early motherhood as problematic, or even pathological, and early motherhood as rational is also considered.

## **Introduction**

Youthful sexuality and reproduction continues to rouse interest in British policy, research and media arenas into the 21<sup>st</sup> century. Though concern about youthful fertility is not new (Wallace, 1987), the recent resurgence of interest in early pregnancy and parenthood owes much to the creation of the Teenage Pregnancy Unit (TPU) in 1999. The TPU was established to implement the Social Exclusion Unit's (SEU) Teenage Pregnancy Strategy, the two main goals of which are to reduce conception rates among English teenagers aged under 18 and to ensure that young parents continue with their education or employment after childbirth (Ferriman, 1999; SEU, 1999). The TPU had an initial budget of £60 million and established a network of Teenage Pregnancy Local Co-ordinators to implement the Strategy in every local or health authority area in England.

Despite the widespread perception that the TPU was formed in response to ever-increasing rates of teenage pregnancy, there was actually a mismatch



*Lisa Arai*

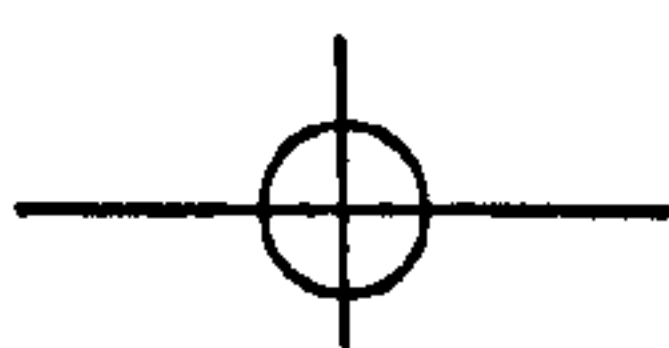
in timing between its creation and the highest incidence of youthful pregnancy and fertility. By the late 1990s, rates of adolescent fertility were less than 30 births per 1,000 girls in England and Wales – a figure significantly below that of earlier decades (in 1970, this figure was around 50 births per 1,000) (Singh and Darroch, 2000). The conception rate for girls under 20 has fluctuated since the 1970s but the overall trend is downward, and the under 16s conception rate has remained relatively stable over a 20 year period. Currently, less than one girl under 16 in every 100 becomes pregnant in England and Wales (CRD, 1997).

A key feature of the Teenage Pregnancy Strategy is its focus on areas where youthful pregnancy rates are high. There is significant geographic variation in under 18s conception rates in England. In the period 1992–7, these ranged from a low of 15.4 per 1,000 in Chiltern to a high of 85 in Southwark – a five-fold variation (Griffiths and Kirby, 2000). There is a positive correlation between teenage conception and area deprivation (Bradshaw and Finch, 2000; SEU, 1999) and use of abortion varies geographically. Young women in the poorest areas are more likely to become pregnant than their counterparts in wealthier areas, and they are less likely to use abortion to resolve unplanned pregnancies (Griffiths and Kirby, 2000; Smith, 1993).

### **Teenage pregnancy and parenthood in deprived communities**

Early pregnancy and fertility in England is, therefore, largely a feature of relatively deprived communities, and it is with the sexual and reproductive behaviour of youth in such places that the TPU is most concerned. The behavioural mechanisms that facilitate early pregnancy and childbearing in such settings are not sufficiently understood. Nowhere can this be seen more clearly than in the puzzlement expressed by researchers for continuing differentials in teenage pregnancy and fertility despite widespread availability of free contraception and legal abortion (Micklewright and Stewart, 1999). Researchers often gauge the behaviour of individuals in poor communities from their own, relatively privileged, vantage point (Bauder, 2002) and they cannot understand why – when the technical means are available to prevent pregnancy and childbearing – youth in such settings appear to be poor users of contraception and unwilling to have abortions.

Within contemporary policy approaches, the apparent failure of teenagers in some communities to use contraception and abortion services is explained in two principle ways. In the first of these the relationship between deprivation and early parenthood is recognised and early childbearing is attributed to 'low expectations', by which it is meant that early childbearing is more common among young people '... who have been disadvantaged in childhood and have poor expectations of education or the job market ... (young people) see no reason not to get pregnant' (SEU, 1999: 7). In the second, the emphasis is on sexual attitudes and knowledge; early pregnancy and fertility is



*Explaining teenage pregnancy and fertility in English communities*

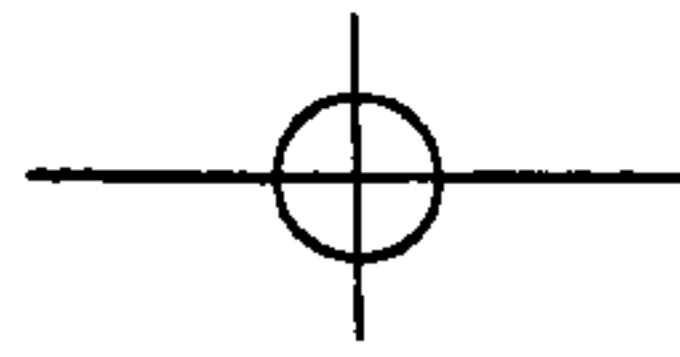
explained by reference to the effects of embarrassment or confusion about sex (sexual 'mixed messages') or poor knowledge about how to prevent conception ('ignorance' about contraception) (SEU, 1999). These are not mutually exclusive explanations, and the SEU does not say how much of each is responsible for teenage pregnancy.

The 'low expectations' explanation for early pregnancy and childbearing, which is fundamentally about socio-economic structure and class position, is a powerful one which has been noted by many British researchers (Garlick *et al.*, 1993; Rosato, 1999; Selman, 1998; Smith, 1993; Wilson, 1991). However, it is the 'mixed messages' and 'ignorance' explanations that are given greater weight in current policy, so that there is a greater focus on the extent to which young people in some communities have access to contraception and sexual health education/information (Arai, *forthcoming* 2003). The advocates of this type of explanation often refer to a body of research that appears to show that British youth are deficient in their sexual health knowledge, are poor users of contraception, are shy about sex or wary about accessing services (Blake and Jolly, 2002; Hadley, 1998; Harling, 1999; West, 1999).

In fact, there is no simple relationship between service provision and use, sexual attitudes, knowledge about contraception and reproductive outcomes such as early pregnancy, birth and abortion. In one Scottish study (Smith, 1993), teenage pregnancy rates were six times higher in deprived areas than wealthier ones, and young women in deprived areas were less likely to use abortion to resolve their pregnancies (about a quarter of pregnancies ended in abortion in poor areas compared with two-thirds in wealthier areas). Most of the abortions were performed in two NHS hospitals, and, since these were located closer to deprived areas than affluent ones, geographical distance to services (and ability to pay) were not important factors in explaining variation in reproductive outcomes. In Wilson and colleagues' (1991) analysis of English regional data on teenage pregnancy and use of contraception, a significant *positive* relationship between teenage pregnancy and the proportion of teenagers attending family planning clinics was observed.

Analyses of awareness and use of contraception have shown that young people are often knowledgeable about contraception, including emergency contraception (Salihi *et al.*, 2002) and that young women who become mothers are not necessarily hesitant about approaching their GPs for contraception before conception (Churchill *et al.*, 2000). Better sex education is often suggested as an appropriate remedy for early pregnancy (OFSTED, 2002) though research has shown that it often has little effect on behaviour, though it may improve knowledge (Kirby, 1985; Oakley *et al.*, 1995; Wight *et al.*, 2002).

Contemporary policy approaches to youthful sexuality and reproduction are thus characterised by a dependency on accounts of teenage pregnancy that do two things. First, the structural determinants of early pregnancy and fertility are recognised, but the emphasis is primarily on changing the *motivations* that arise from these rather than on changing the determinants themselves (Levitas, 1998). Second, improvements in services, greater use of



*Lisa Arai*

contraception and better sex education are proposed as ways of reducing teenage conceptions, even though the research that an absence of these factors 'causes' early pregnancy is equivocal. Current policy approaches ultimately pathologise early pregnancy and childbearing, since it arises (according to the logic of these explanations) out of inappropriate motivations, ignorance or sexual embarrassment.

This paper draws on qualitative material collected as part of a PhD research project. The aim here is to explore how well these policy explanations for early pregnancy and fertility accord with accounts provided by young mothers in diverse English communities. The representatives of the TPU in such communities are the Local Co-ordinators; as such, they represent the interface between policymakers and the subjects of policy – teenage mothers themselves. Their accounts of early pregnancy and fertility are compared with those provided by young mothers.

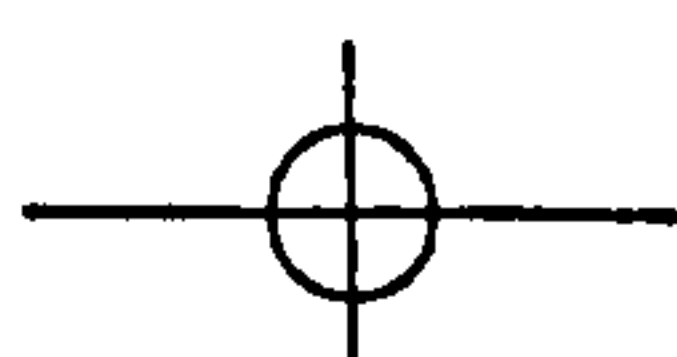
It has been observed elsewhere that young mothers' perspectives are often absent from the (growing) literature on teenage pregnancy and parenthood (Jewell *et al.*, 2000) and one aim of the PhD was to address this. Qualitative research has enriched the literature on youthful sexuality, pregnancy and childbearing (see, for example, de Jonge, 2001; Kirkman *et al.*, 2001; Sciarra and Ponterotto, 1998; Tabberer *et al.*, 2000) but there is still a need for further qualitative work in this area and, since the focus here is on the *meanings* attached to pregnancy and motherhood, a qualitative methodological approach was more appropriate than a quantitative one (Rice and Ezzy, 2000).

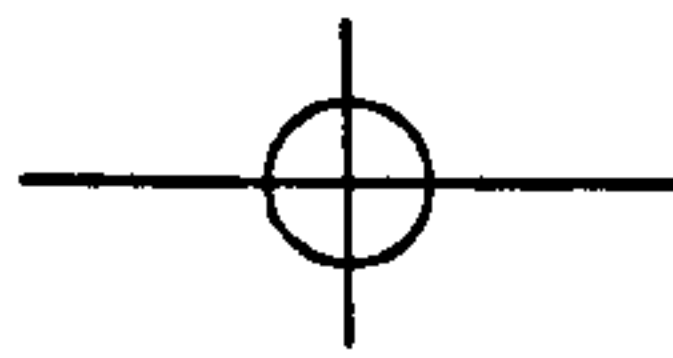
## **The respondents**

### *Teenage pregnancy local Co-ordinators*

Interviews were conducted with nine Teenage Pregnancy Local Co-ordinators. The Co-ordinators represented different types of area (urban, rural), geographic location (north, south) and adolescent reproductive scenarios (high teenage pregnancy/low use of abortion, low teenage pregnancy/high use of abortion) and do not necessarily work in the areas that the respondents lived in. For reasons of confidentiality, the locations of the Co-ordinators are not identified. Time, workload pressures and distance to the areas that the Co-ordinators worked in meant that all of the interviews had to be conducted by telephone. Questions were asked on a variety of issues; the most relevant topics explored were those about the teenage reproductive scenario in the Co-ordinator's area, the Co-ordinator's perception of teenage pregnancy and if the Co-ordinator believed that early motherhood could ever be beneficial.

These interviews varied in length of time and range/depth of subjects covered. The shortest interview was about 15 minutes long and the longest was an hour long. Given this variability in the quality and scope of





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the interviews, the observations made here using this material are largely exploratory.

*Young mothers*

Data were collected by in-depth, face-to-face, semi-structured interview with 12 women who had their first child before age 20. The approach to the interviews (broadly) utilised a 'life course' perspective which has been used before with young mothers (Phoenix, 1991). After standard questions about age at birth, family background, education etc., the topics explored included: attitudes to school, work history and the circumstances surrounding pregnancy and birth.

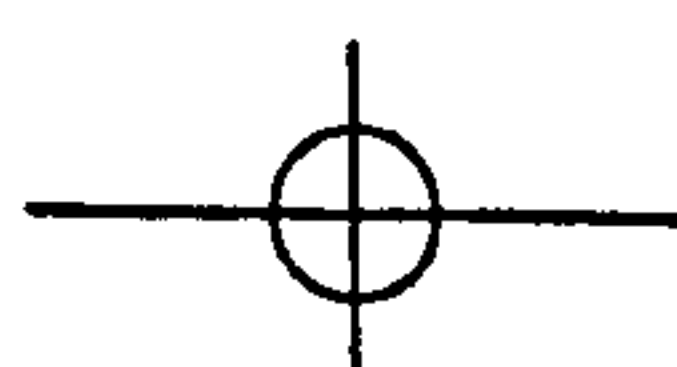
Interviews lasted, on average, 45–60 minutes. Young women were interviewed in three different locations: Inner London, Northumberland and Greater Manchester. These are areas with high rates of teenage pregnancy and/or childbearing, though pregnant teenagers in Inner London are more likely to terminate their pregnancies than teenagers in the other two locations (Kirby and Griffiths, 2000) and the situation in Northumberland (the largest English county) is mixed, with low rates of teenage pregnancy in some localities and high ones elsewhere.

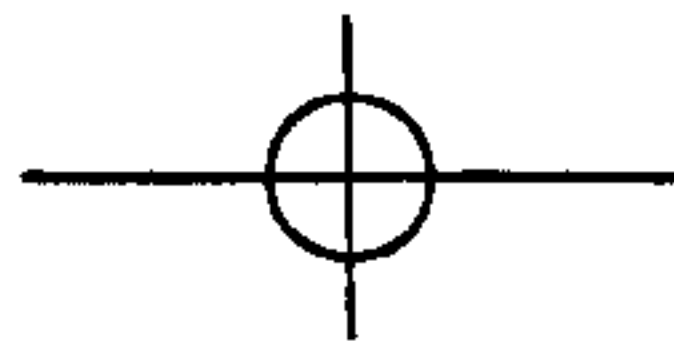
Most respondents were recruited using 'snowballing' techniques (Rice and Ezzy, 2000). There had been an attempt to recruit respondents by advertising in clinics and youth centres, but only one person came forward this way (teenage mothers have been observed elsewhere to be a difficult group to reach; Allen and Dowling, 1998). These interviews also varied in range and depth. An unanticipated problem was that many women had their babies and small children with them when the interview took place and this often disrupted the interview. Respondents were reassured that their real name or location would not be used and were given £10 to cover expenses.

The interview data from both groups of respondents were transcribed and subjected to a thematic analysis (Aronson, 1994; Rice and Ezzy, 2000). The aim here is not to present an exhaustive analysis of these data, but to offer some insights on youthful pregnancy and fertility using this qualitative material.

**Explaining teenage pregnancy and parenthood in English communities: insights from qualitative research**

Local Co-ordinators believed that both 'low expectations' and sexual attitudes and knowledge contribute to comparatively high English adolescent pregnancy rates. In this respect, they reiterated the main conclusions in the SEU's report on teenage pregnancy (SEU, 1999). Most Co-ordinators, when asked which they thought was more important, said that both sets of factors were important and were generally unwilling or unable to estimate how much of





*Lisa Arai*

each 'causes' teenage pregnancy and parenthood. Asked which she thought was more important, one Co-ordinator for an inner city area with high teenage pregnancy rates replied, with some hesitation: 'I think. . . it's all part of the bundle, it's really difficult to pull out any one thing, probably I would say, yes, inequality factors are probably more significant than anything else'.

### *Structure and 'low expectations'*

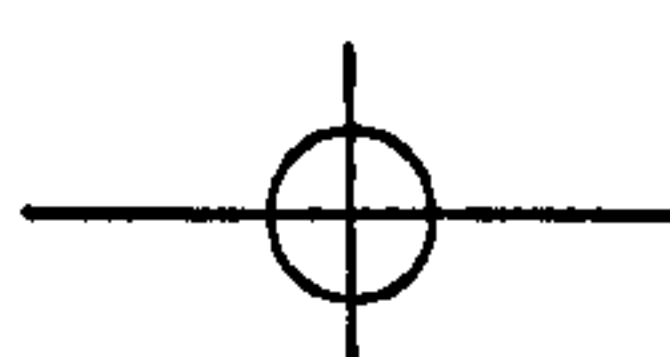
When asked specifically about the kind of structural factors that are associated with youthful pregnancy and fertility, all the Co-ordinators recognised the link between being poor, living in a deprived community, lack of opportunity and early pregnancy and parenthood. For most, this was a simple, observable, fact based on the research and their experience of being 'on the ground':

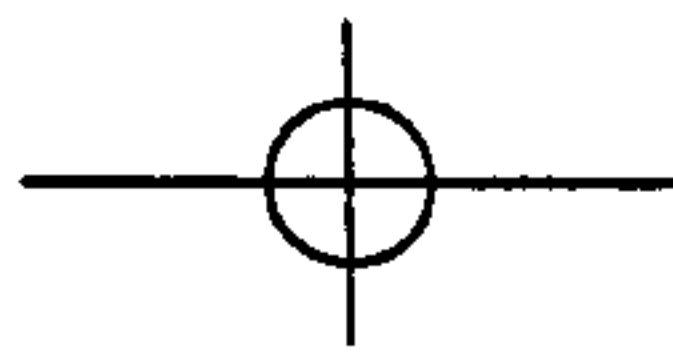
I think deprivation is a clear, clear link that has been proved . . . it is just very, very obvious because when you see where the high rates are and you know (they are) . . . the wards that have high deprivation . . . its totally linked with deprivation'.

Two Co-ordinators knew of areas that were not deprived but that still had high rates of teenage pregnancy; neither could account for this. In these cases: 'The deprivation angle doesn't work'. The behavioural mechanisms linking poverty to reproductive outcomes could (generally) not be identified by the Co-ordinators. The following statement was typical: ' . . . we need to know more about it (teenage pregnancy) . . . we don't have a huge grasp of why we have high rates and the different issues going on'.

Though all the Co-ordinators recognised the link between deprivation (or living in a deprived area) and early motherhood, this was only partly reflected in the young mothers' accounts. Although all the young women came from working class families and communities, no respondent considered that she came from a poor family and most young mothers did not think that they came from poor communities, but often mentioned 'rough' places where they had once lived or that were near their present homes.

As noted above, in policy explanations for teenage pregnancy and parenthood, a link is made between structure and 'low expectations'. 'Low expectations' are considered to particularly affect young people who do not do well at school or who do not have good job prospects. All the Co-ordinators recognised that young women with educational or career aspirations are less likely to become pregnant and more likely to use abortion services than young women without such aspirations. Again, they knew this from the research and from their own experiences 'on the ground'. One Co-ordinator for a largely rural area with a mixed adolescent reproductive scenario, pointed out that she had a strong sense of the link between opportunity, expectations





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and early pregnancy before the SEU report published in 1999 made the same point:

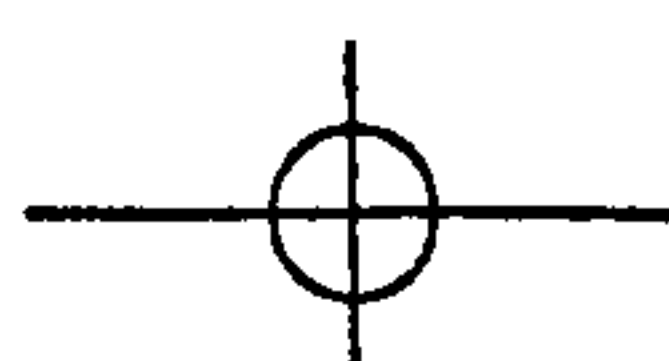
I had a sense of it (before the SEU publication) . . . You were more aware of young women who were more likely to get pregnant and continue with that pregnancy and aware of the young women who weren't doing so well at school, or weren't even going to school, they were the kinds of young women who tended to be presenting with positive pregnancy tests.

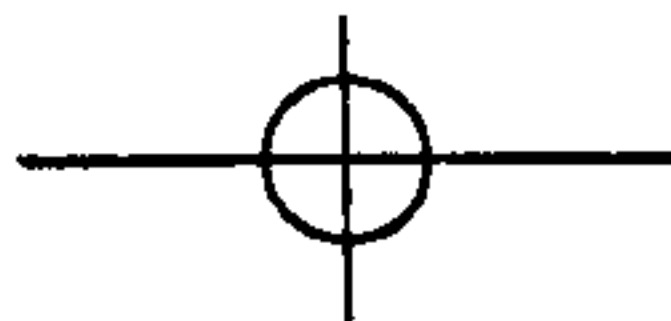
Though no young mother explicitly said that she had 'low expectations' and that this had affected her reproductive behaviour, it might be inferred from the interviews that this was, in fact, the case. These expectations seemed realistic given the generally low educational achievement of the women and poor local job opportunities. The disruption caused to education and employment is often emphasised as one possible negative outcome of early parenthood (SEU, 1999), but nearly all of the young mothers had a weak attachment to the education system *before* they became pregnant and many were in low-grade jobs. Julie (Northumberland) was in a trainee hairdressing job and paid £50 for a 40-hour working week when she became pregnant. She was not academic, disliked school, but was not a trouble-causer:

- Lisa Arai: Did you get into trouble at school then?  
 Julie: No. Never got into trouble. I always had my essays in but I just didn't like school. If I could go back and do it again . . . I wouldn't. If I did go back, I'd be the same I think. I don't think I'd try any harder. I just hated it. It wasn't for me, I don't like being stuck in somewhere . . . I like being out and about.

For other respondents, this dislike of school was more pronounced and extended to habitual truancy. This was the case for Caroline (Northumberland):

- Caroline(C): I didn't really have a great time (at school). Year nine (age 13–14), I never went, not at all. The second year, I went to the first half of the year and I had a pager, so that when you miss a lesson they (the school) page your mam. My mam had the pager and every lesson the teacher has to tell . . . if you're there or if you're not in, and she pages your mam.  
 Lisa Arai (LA): Were you the only kid in the class to have that?  
 C: Yeah.  
 LA: Were you embarrassed?  
 C: Not really. After . . . I realised I had to go to school, just to get my mam off my back.





*Lisa Arai*

### *Sexual attitudes and knowledge*

The second way that early pregnancy and parenthood is explained is by reference to the effect of sexual attitudes and knowledge on behaviour. From this perspective, early pregnancy is partly a consequence of ignorance about contraception and sexual embarrassment. Most Co-ordinators believed that the answer to high teenage pregnancy rates lay with improved services, greater use of contraception and increased sexual health knowledge. Yet, at the same time, most recognised that these factors would not, on their own, reduce teenage pregnancy:

Local Co-ordinator (LC)(inner city): I think it's probably a real mixture of things, because there are services, but (not for young people) . . . even if there were . . . there are still issues around them having the confidence and the ability and . . . their lives being organised enough to get (themselves) in (to) gear.

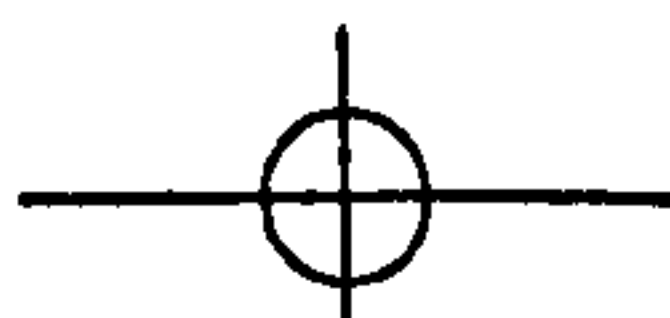
Lisa Arai: It's about motivation?

LC: Exactly. . . I have heard other people say that 'you could have as many young peoples clinics or sexual health clinics as you want but . . . on its own, (it) wouldn't make a difference'.

Provision of sexual health services and improved sex education is a central plank of the Teenage Pregnancy Strategy, but it was clear from the Co-ordinators' accounts that there was no simple relationship in their own areas between sexual health services, sex education and reproductive outcomes. In one county, overall (county-level) rates of teenage pregnancy were very low, and use of abortion high by national standards. However, there were four localities within the county that had high under 18s conception rates, low abortion rates and significant levels of deprivation. Asked to explain the high rates in these areas, the Co-ordinator said:

We don't really know, I mean (Co-ordinator mentions place with low teenage pregnancy rates) like to think that they've got a very good school-based (sex) education programme, with the school nurses, but I would argue, and they would perhaps argue with me . . . it's no different to anywhere else . . . the school nurses all belong to the same trust that work across (county) so it's a very complex issue isn't it . . .

In another, smaller, southern county, with similarly low adolescent pregnancy rates, the Co-ordinator pointed out that transport to services was a major issue for young people. The county is largely rural and services are geographically disparate, yet youth in this county still seem able to avoid pregnancy and rates are well below national average. This was also the case for an affluent local authority in west England which has extremely low under 18s conception





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rates. The Co-ordinator mentioned transport difficulties compounded by the isolation of some communities yet this did not appear to affect rates of youthful pregnancy or fertility.

It is in respect of sexual attitudes and knowledge about contraception that the accounts provided by the Co-ordinators and those provided by the young mothers most differed. Improved sexual health services and sex education may be central to the Teenage Pregnancy Strategy, but the accounts given by teenage mothers suggests that it may make little difference. The idea that early pregnancy is attributable to 'mixed messages' about sex and 'ignorance' about contraception was not borne out here; most (nine) respondents said that they had been using contraception when they became pregnant. Most had been using the Pill and two mentioned a burst condom. Only three respondents were not using contraception (and one of these wanted to become pregnant). Two respondents said that they had also used the 'Morning-After Pill' but that it had not worked. Many women could not account for their pregnancy and believed that they were not biologically suited to the Pill. Kath's (Northumberland) comments were typical:

Kath (K): I was on the Pill. Twice this happened to us . . . this time (indicating that she is pregnant again) as well. This is twice now.

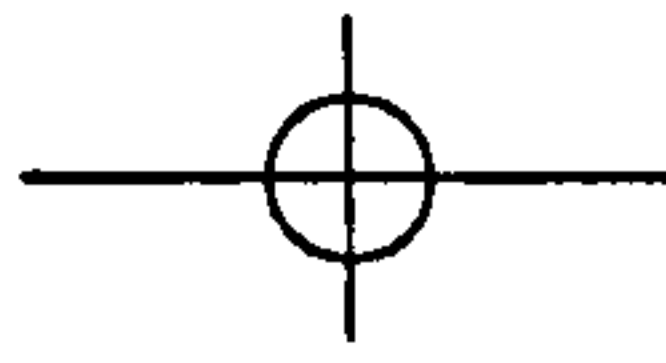
Lisa Arai: Did you take antibiotics or something?

K: No. I don't know what happened . . . doesn't agree with me, this Pill.

Charlie (Inner London) said that the condom that she and her long-term boyfriend were using must have burst, but she was not sure: 'That's the only thing we can put it (the pregnancy) down to. I think it must have been that, because we were always careful, neither of us wanted kids that young'.

The high rate of contraceptive failure among women in the study might signal poor use of contraception – contraceptive failure in teenagers is higher than that for older women, and also varies by socio-economic status (Glei, 1999; Singh *et al.*, 2001) – or their greater fecundity compared with older women (Dunson *et al.*, 2002). It was impossible to ascertain how well respondents had been using their method of contraception, but all of the women that were using it appeared knowledgeable: 'I was really careful about (not getting pregnant) . . . I didn't want to get pregnant' (Katy, Inner London).

The young women became mothers because they opted to continue with pregnancy, unlike their counterparts from better-off backgrounds who are more likely to use abortion to resolve unplanned pregnancies (Smith, 1993). Young women in communities where teenage motherhood is prevalent have been found to hold anti-abortion views, and they may be influenced by the anti-abortion views of others in their neighbourhoods (Tabberer *et al.*, 2000). The reluctance of young working-class women to have abortions is typically attributed to a sense of fatalism or prudishness. The Chief Executive of the Family Planning Association, for example, has said that the reason working



*Lisa Arai*

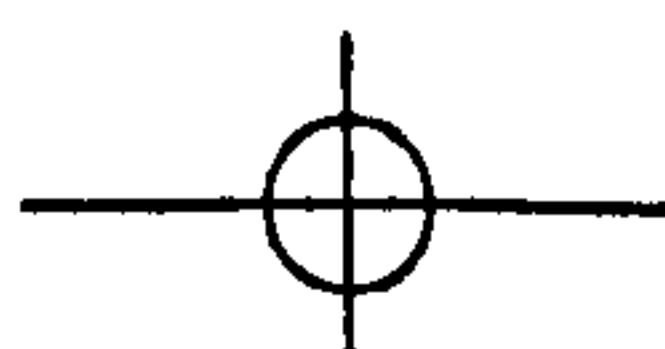
class girls are less likely to have abortions than their middle class counterparts is because: 'In this country we have a very censorious view about the unwanted consequences of sexual activity . . . It's a lack of being able to say 'Well I do have a choice'' (Addley and Mahey, 2000).

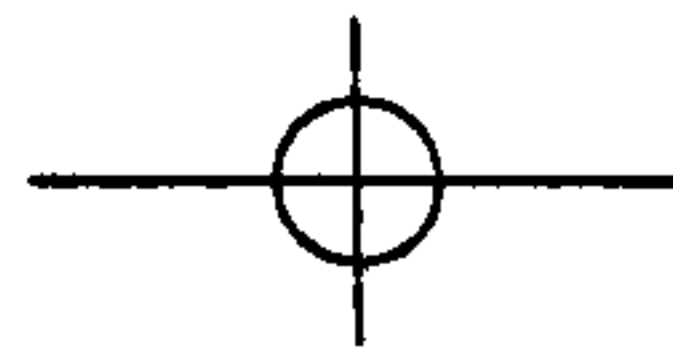
This statement does not accord with the findings here: all of the young women were aware – or had been made aware of their choices by health services personnel, or family and friends – but decided to continue with the pregnancy anyway:

- Lisa Arai (LA): . . . you never considered a termination?  
 Kath (K) (Northumberland): I was told that was an option. And I said 'Well, no, not really' because I personally don't believe in it, y'know.  
 LA: Did the doctor tell you it was an option?  
 K: No, it was actually my social worker at the time. And, by the time I got to the doctor, I'd already made up my mind . . . I was actually only eight weeks when I found out. So, I mean I could still have had one (a termination) . . . But it just wasn't an option. I knew I wanted to keep him, and just have to manage.
- Lisa Arai (LA): When you were pregnant, did you think about a termination, or did anybody suggest it to you?  
 Jilly (J) (Greater Manchester): My partner said to me 'It's your choice, I'll stick by you'. I couldn't have had a termination.  
 LA: You couldn't?  
 J: No . . .  
 LA: Did anyone (else) suggest it to you?  
 J: My dad said ' . . . don't just think of all the good things with a baby. . . . It's not all good . . . '

Most of the women justified their rejection of abortion by referring to their 'pro-life' beliefs but they were not as opposed to abortion as previous research suggests (Tabberer *et al.*, 2000) and, for some, the espousal of anti-abortion beliefs seemed to mask a genuine desire for motherhood (unexpectedly pregnant young women – who are happy to be pregnant but might be wary about appearing so, given their age and their 'transgression' – might be put under less pressure to terminate the pregnancy by parents or other authority figures if they hold apparently anti-abortion views). For one mother, the experience of becoming pregnant made her revise her view of abortion:

. . . I've never agreed with it (abortion). But when I got pregnant, it changed my views . . . because I was in a situation where I was faced with that, I understand how women do do it. Now, I would never say 'you are wrong to do that', I would completely, 100% support somebody who





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wanted an abortion . . . before . . . I was quite naïve to think it was wrong to have an abortion, because you don't know until you are in that situation (Ellie, Greater Manchester).

*The pathology and rationality of early motherhood*

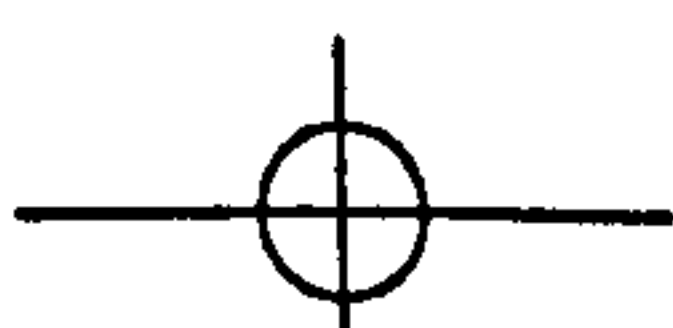
However early pregnancy and motherhood is explained, within contemporary discourses it is depicted as problematic and even pathological. This portrayal of early parenthood is justified on the grounds that early motherhood has poor health and socio-economic consequences (Lawlor and Shaw, 2002; SEU, 1999). In fact, the evidence for this is mixed. A large review of the research showed that the poor health outcomes associated with early motherhood are largely attributable to socio-economic status rather than maternal age (Cunnington, 2001). The authors of an analysis of the labour market and education outcomes of early childbearing concluded that the negative effects of early motherhood do exist, but have been overstated (Chevalier and Viitanen, 2001) and an analysis of European panel data showed variation in economic and other outcomes for teenage mothers across Europe, and no significant effects in some countries, which suggests that the socio-economic consequences of early childbearing are highly dependent on the context in which it occurs (Berthoud and Robson, 2001). In the US, it has been argued that early childbearing might even be the best reproductive strategy in very poor populations (Geronimus, 1997; Geronimus *et al.*, 1999).

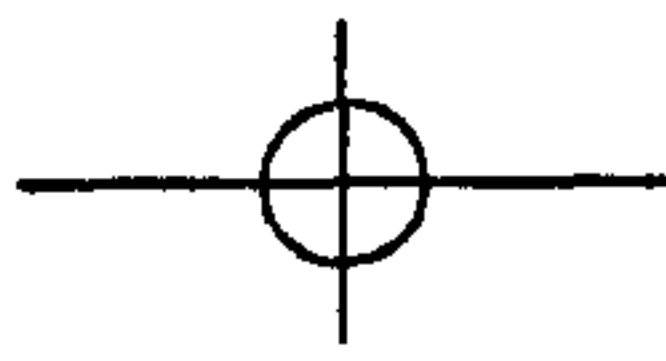
A tension between the idea of early motherhood as problematic and early motherhood as beneficial, and even rational (Geronimus, 1997), was present in the Co-ordinators' accounts. Most Co-ordinators could think of situations where early motherhood had been advantageous for some women, but they often thought it unfortunate that young women become mothers and believed that the odds are against them:

Local Co-ordinator (inner city): I have definitely spoken to some who have said that it made them turn their life around, whereas before they've been excluded from school, in trouble . . . getting pregnant actually made them think 'Okay, I've got to get some education now'. But I think at the same time it's just incredibly difficult, just because of their young age . . . I don't believe being a young parent makes you a bad parent, it's just that you've got so many things against you in terms of money and housing and support and education, it's just incredibly difficult. But they can be great parents . . . for some, I'm sure it's a positive thing.

Despite their reservations, most Co-ordinators were keen not to contribute to a negative image of early motherhood. One Co-ordinator, in a largely rural area with low rates of early pregnancy, said:

I say it quite often when people say to me 'Why, do you have such a big problem' I don't want to talk about it like it's a problem. For some girls





*Lisa Arai*

... there is a problem but I've met many young women for whom it's been a really positive experience. And they say to me 'If I hadn't got pregnant ... then I would probably be on drugs and ... having a baby made me realise that I had to, you know, pull myself together, be a role model'.

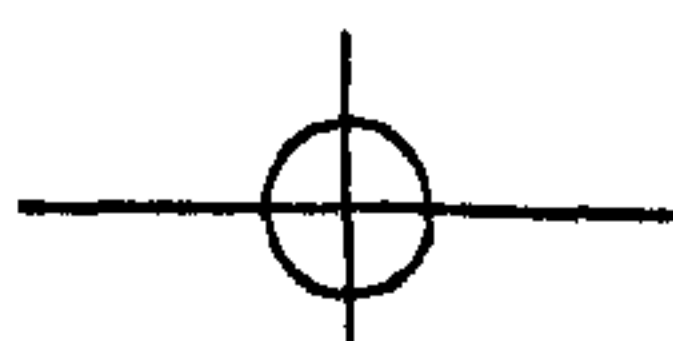
This same Co-ordinator (in common with most) emphasised that her role is a 'holistic one', which is not just about teenage pregnancy but about supporting young women and promoting good sexual health. Young mothers, however, may not be aware that Co-ordinators think of them this way:

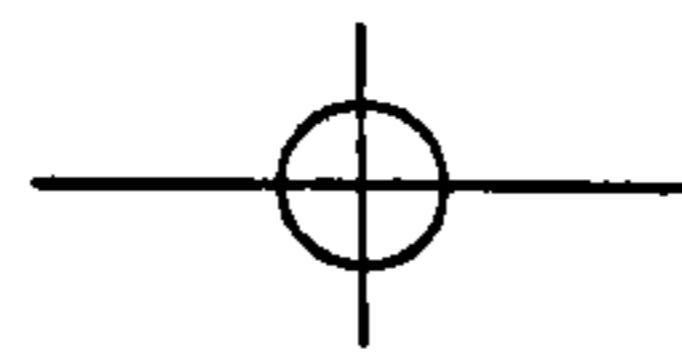
I can remember going to a young mother's group in (Co-ordinator names place) and when I got there, they all were really hostile to me because ... my job is to stop young people having babies, that's how they saw it. And I was really upset because ... they were feeling pretty pissed off and didn't want to talk to me particularly and ... (after talking to them) in the end they could see that I wasn't the enemy.

Teenage parenthood is typically depicted as a calamity, which will change forever (and for the worse) a young girl's life. This may be true for middle class women, who have '... opportunities stretching well beyond age 18 or 19 to become better educated, better skilled ... middle class youth have every reason to believe that they will be better providers for their children if they delay parenthood.' (Geronimus, 1997: 421). The same cannot be said of working class women, who are most likely to become young mothers. For them, early childbearing can represent a rational and meaningful life option.

For the young mothers, the idea of rationality can be explored by dividing the respondents into two (approximate) groups: those who have experienced severe early life adversity and those who came from less fraught backgrounds (and usually loving ones). For both groups, early childbearing can be seen as a positive, and even rational, behaviour, but for different reasons. For the latter group, early childbearing represented an alternative 'vocation'. Most of these women were in low-paid jobs before pregnancy, or were in school but had few academic aspirations. Had these women lived in the 1960s or 70s, they would probably have married their child's father (more than one respondent said that her parents had married after a youthful, premarital conception had occurred within a courtship setting).

The other group are those who have experienced severe early life adversity and are quite different. Their experiences are such that they have a strong orientation towards childbearing, usually as a way to be loved. There were five women who fell into this category. Three had been in the care system and two had experienced family disruption or tension. The most extreme example of adversity was represented by Suzy (Inner London) who had been bullied at her secondary school and came from a violent family background (her father was physically abusive towards her mother). She had made suicide





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attempts as a child and put herself into care at the age of 12. Suzy recognised the effect that these events had had on her life:

... if your home base is not structured, there's no foundation there, wherever you go, you gonna feel unbalanced because you haven't got no balance from the home ... At home and as a child as well, you want to feel secure and comfortable. But I never did feel that.

Suzy's life represents an example of what the American ethnographer, Linda Burton (1997), calls the 'accelerated life course': individuals in difficult environments mature early and demographic events are compressed into shorter time spans. Suzy confirmed this when she said that she 'grew up quickly', and was working by the time she was 13 (she lied about her age to secure employment). The news of her pregnancy at the age of 16 was greeted with joy. She said that she had wanted to be loved and that:

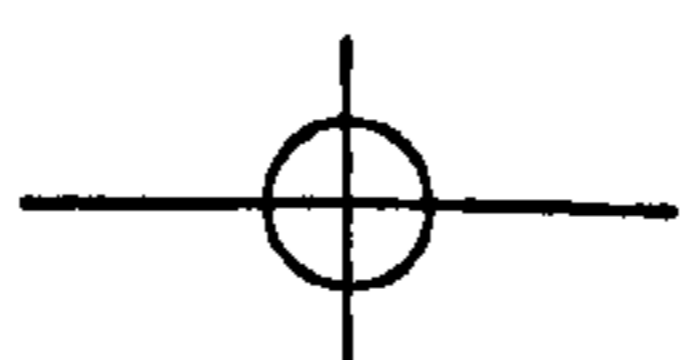
I didn't know how to get it. The only way I would be able to receive it is through having (daughter). I remember on the day that I found out that I pregnant ... I was shouting out 'I am having a baby!' ... I was happy.

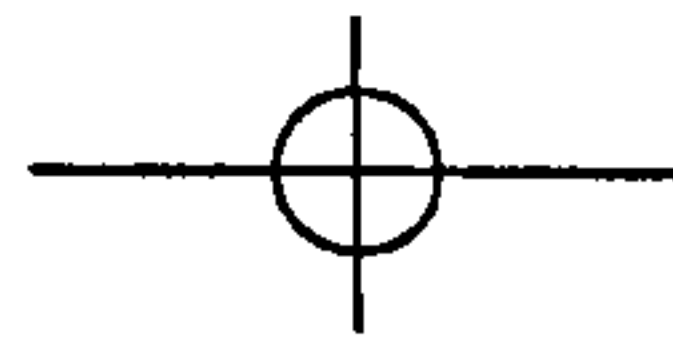
Katy (Inner London) had also experienced the care system. She did not 'get on' with her mother's boyfriend and left home at the age of 13. She spent a week living rough and started living in a squat with intravenous drug users. Kath (Northumberland) had been in care since the age of five and at the time of the interview had little contact with her biological family.

These are extreme examples of early life adversity, but some of the Local Co-ordinators confirmed that young women who have been in the care system are over-represented among teenage mothers in their localities. One Co-ordinator in an urban area with above average rates of early pregnancy, explained the possible connection between having been in care and young parenthood:

Having worked with young people in local authority care who find themselves pregnant, there's this real need to try and make things better for themselves and their babies so ... there ... (is) a negative response to termination, (with teenage mothers) saying 'Well, I am not going to get rid of my baby, I'm gonna give it a better life than I ever had.'

For young women who have experienced early life distress, having a child can also be seen as a relatively 'ordinary' behaviour. This is not to imply that birth was not major event for these women but that, compared with events before pregnancy, it was relatively mundane. More than one young woman, on finding herself unexpectedly pregnant, said that she had 'just got to get on with it'. This type of comment might be interpreted as a sign of fatalism; it





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might also indicate a stoicism and realism in the face of hardship and lack of opportunity.

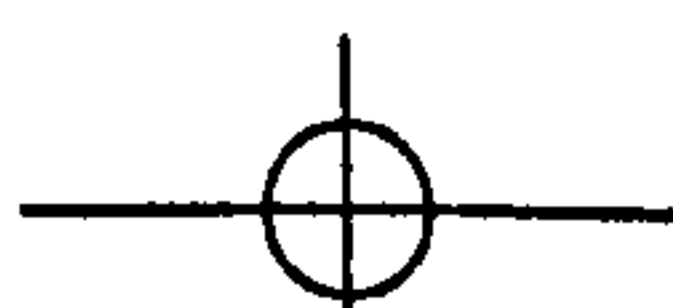
### Summary and implications

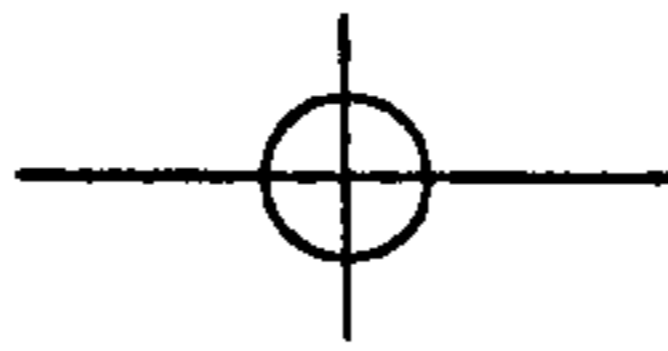
How well do contemporary policy explanations for teenage pregnancy and fertility accord with accounts of pregnancy and motherhood provided by young mothers and health professionals working in areas where rates of teenage pregnancy are high? Is teenage pregnancy and fertility related to structure and 'low expectations', and do deficiencies in knowledge about contraception and sexual attitudes affect rates of youthful pregnancy?

Policymakers maintain that both sets of factors contribute to teenage pregnancy (and the British government has indicated that it intends to address poverty and inequality as well as improve sex education and provision of contraception to teenagers). However, the accounts provided by the Co-ordinators and the young mothers suggest that the 'low expectations' explanation for youthful pregnancy and parenthood may be more powerful than explanations that emphasise sexual attitudes and knowledge. The young mothers did not specifically refer to poverty, lack of opportunity and low expectations but their stories suggest that these are prominent themes in their lives. All the Co-ordinators recognised this and, in this respect at least, their accounts of early pregnancy and motherhood resonated with those provided by young mothers.

There was little convergence of accounts in relation to the effects of sexual attitudes and knowledge about contraception on reproductive behaviour. However, the fact there was little evidence of ignorance or sexual embarrassment among the women in this study does not negate this aspect of contemporary approaches to teenage pregnancy; the high contraceptive failure rate among the women may be related to poor sexual health knowledge. A limitation of the study was that sexual naivety, embarrassment or confusion could not be properly determined; a consequence of early motherhood is rapid maturity and, if they were once naïve, the young mothers in the study had long since ceased to be so.

However, to depict early motherhood as primarily a consequence of sexual naivety and ignorance is limited. Policymakers find it hard to believe that young women, often in the least auspicious circumstances, might actually *want* to be mothers. Young women may not say as much; to do so is to invite censure in an age in which it is considered strange to want to have children so young (see, for example, Alan Guttmacher Institute, 2002). Policymakers come from class backgrounds that celebrate the idea of 'being in control' and, when they consider the reproductive behaviour of young women in poor communities, they do so from a perspective that is fundamentally different to that of youth in such settings (Bauder, 2002). The apparent fatalism of young mothers partly reflects their class background, with its relatively limited life options, but it





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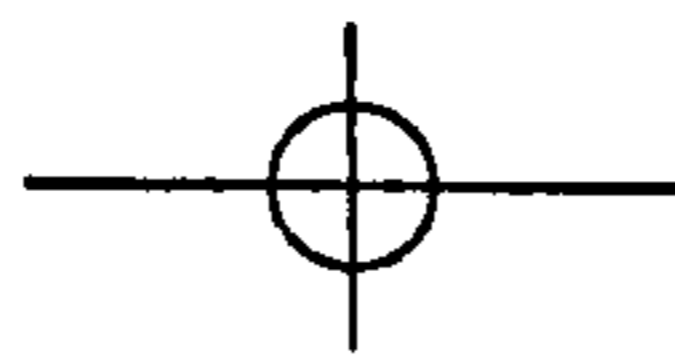
also reflects a genuine desire for the maternal role. The difference between working and middle class women, in this respect, lies in timing; working class women favour an earlier ideal age for family building than middle class women (Jewell *et al.*, 2000; Macintyre and Cunningham-Burley, 1993) and, traditionally, have made the transition to motherhood earlier than their middle class counterparts (Wallace, 1987). Extending life options for working class women will always be a good thing, but many of the young women in the study did not like school, were not academically bright and actually wanted to be mothers (a number of the women in the study expressed a desire to work with children, and two were training to be classroom assistants).

Earlier, the confusion expressed by some researchers for continuing high rates of early pregnancy in some communities despite widespread availability of free contraception, was noted. The question asked by researchers appears to be 'Why do young women become pregnant, when they have access to contraception, and why do they continue with their pregnancy, when they can use abortion?' The key to understanding youthful pregnancy and parenthood in some communities requires the rephrasing of this question into 'why should young women *not* become pregnant and have children in some settings?' Possible answers to this might be: that some young women have a strong orientation to motherhood. This orientation should not be read as a sign of immaturity, but its reverse, a sign of maturity – particularly for those women who have had to grow up quickly because of early life adversity; many young mothers have a weak attachment to the education system or paid work before pregnancy, and mothering, for them, is a meaningful vocation; and there are few obstacles to early mothering in some communities, particularly those where education and employment opportunities are limited.

Most Local Co-ordinators would agree with this analysis yet, at the same time, would lament it. More than one Co-ordinator said that their role is to widen young women's horizons and to help them to see that there is more to life than being a young mother. This perspective, while not wrong, reflects the professional responsibilities of the Co-ordinators and their own class background. It also overlooks the fact that working class women who become mothers in their adolescence – and when they are most physically fit for childbearing (Dunson *et al.*, 2002) – can re-enter education and the workplace at a later age when they are freed from the responsibilities of childcare (Furstenberg *et al.*, 1987). A compassionate society would facilitate this sequence of events not condemn it.

Contemporary approaches to early childbearing tend, however, to be characterised by a lack of imagination. Instead, there are calls for improved access to contraception and better sex education by the TPU and other organisations (OFSTED, 2002; IAGOTP, 2001; UNICEF, 2001). Barrett and Wellings (2000) maintain that the development and greater accessibility of effective contraception has led to a widespread belief that women would have greater control over their fertility, yet, over time: '... the situation has become more rather than less complex. ... Only with current knowledge can we see that inten-





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tions, planning and decision-making around pregnancy . . . is likely to be more complicated' (p. 194). This guarded statement hints at the limitations of contemporary approaches to understanding fertility and, in particular, of the idea that most women 'make' decisions about when, and under what circumstances, they have their children. As Geronimus has noted (1997), policymakers need to make a distinction between young women who require assistance to avoid pregnancy and those who – no matter how much they are discouraged – will become pregnant anyway, simply because that is the best option for them given their circumstances.

The resistance of ordinary people to government interference in their reproductive lives is understandable. Young mothers' perception that Local Co-ordinators are opposed to them is unwarranted but it is not difficult to see how such perceptions arise. Early pregnancy and parenthood is depicted as problematic or even pathological and young mothers are aware of this (Jewell *et al.*, 2000; Kirkman *et al.*, 2001). Policymakers never describe early motherhood in these terms and use, instead, the language of social exclusion – though they may be aware that in, trying to reduce early parenthood in some communities, local hostility may be an issue. The authors of a recent TPU publication offering advice to those considering undertaking 'teenage pregnancy work' in their neighbourhoods, observe that teenage pregnancy can be an 'emotive' and 'difficult' issue in some areas. Local people, for example: '... may feel defensive about a campaign that seems to criticise the choices they have made over generations to become parents at an early age' (TPU & NRU, 2002: 44).

## Acknowledgements

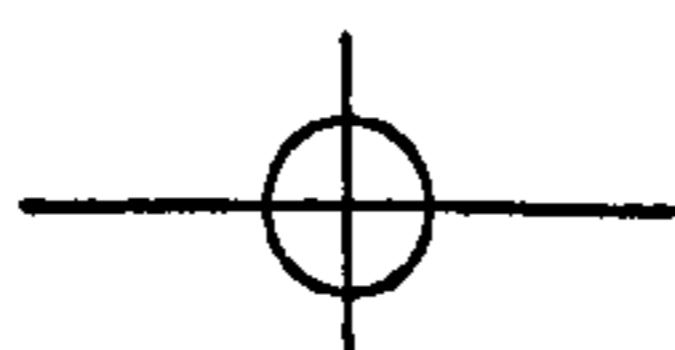
Funding for the research on which this paper is based was provided by Queen Mary and the University of London Central Research Fund. Thanks to Dr. Ray Hall (Department of Geography, Queen Mary, University of London) and Professor Helen Roberts (Child Health Research and Policy Unit, City University) for their helpful comments on earlier drafts of this paper. Thanks also to the reviewers and, most importantly, the respondents.

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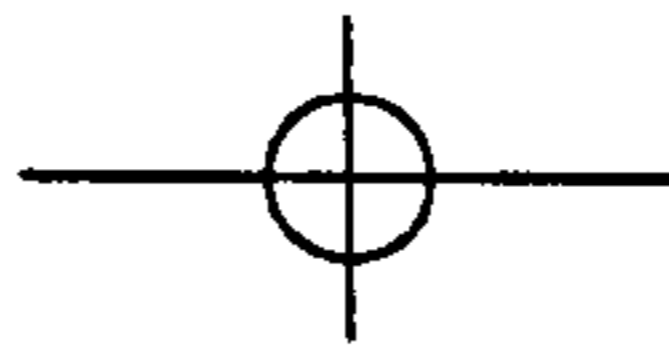
Received 3 September 2002  
Finally accepted 11 February 2003

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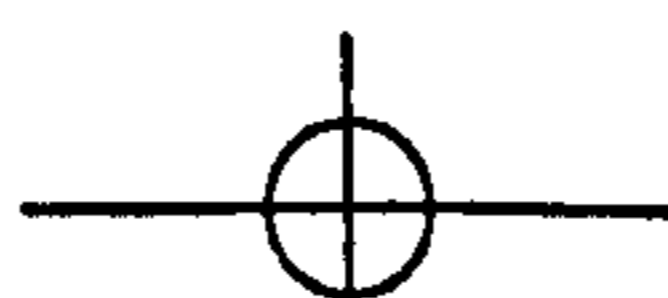


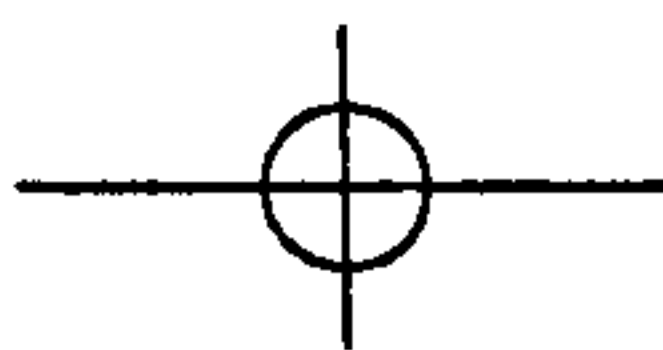




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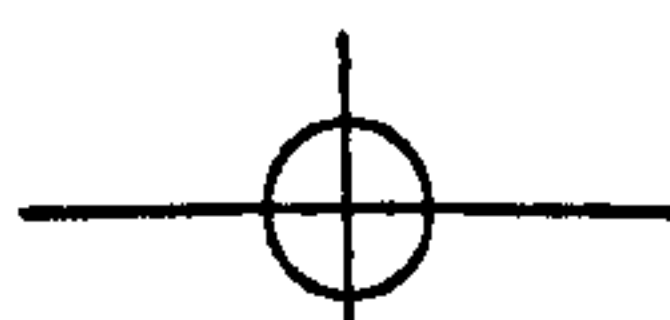
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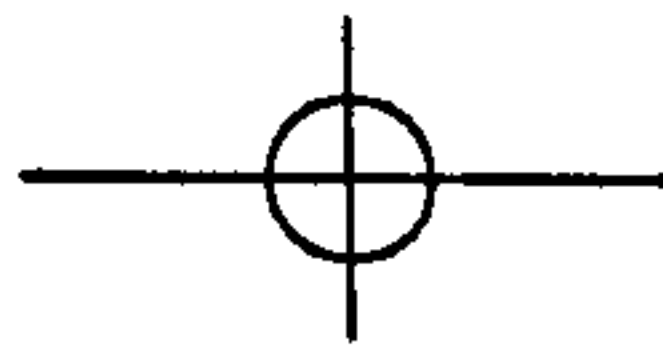




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