

**REPEATED TEENAGE PREGNANCIES-THE MEANINGS
ASCIBED BY TEENAGERS-A COMPARISON BETWEEN
LONDON AND TWO CARIBBEAN ISLANDS**

**A thesis submitted for the degree of Doctor of
Philosophy**

**By
Jean Elaine Clarke**

**Faculty of Life Sciences
Department of Health & Social Care
Brunel University**

July 2002

**PAGE
NUMBERING
AS ORIGINAL**

Contents

Abstract.....	xi
Preface.....	xii
 PART ONE	
 Chapter one – Politics, the media and teenage pregnancy	
Contextualizing teenage pregnancy in the Caribbean	
Introduction.....	1
 Section one	
Background to the study.....	3
Why research repeat pregnancies?.....	3
The benefits of a comparative approach.....	5
 Section two	
Concerns about teenage pregnancy in the United Kingdom.....	7
Political and media discourses.....	10
Do teenage pregnancies lead to a culture of welfare dependency on the state?.....	25
What has been the impact of this sustained media coverage and political debate on teenage pregnancy policy development and execution?.....	26
Was this intensive political and media scrutiny justified?.....	34
 Section three	
Contextualizing teenage pregnancy in the Caribbean.....	41
What is the basis for the concerns relating to teenage pregnancies in the Caribbean?.....	41
Adolescent fertility rates in the Caribbean.....	41
Accounting for different media and political responses in the Caribbean.....	43
The missing discourse	50
Conclusion.....	56

Chapter two – Teenage pregnancies – a review of the literature

Section one

Introduction.....	60
Incidence of repeat pregnancies.....	61
Approaches to research on repeat teenage pregnancy.....	63
Predictors of repeat pregnancies :	
Approach to contraceptive use.....	64
Mother/daughter relationships and the impact of fathers' presence.....	69
Marriage.....	72
School drop-out.....	73
Age at first pregnancy.....	76
The extent to which the first child was wanted.....	77
Availability of income from parents.....	79
Consequences of repeat pregnancies.....	79
Race differences in relation to repeat teenage pregnancies.....	86
Strategies to reduce repeated pregnancies.....	90

Section two

Additional key themes – Teenage pregnancies in general

Family discord and dysfunction.....	93
The role of family support.....	93
Gender attitudes.....	94
Teenage sexuality.....	95
Self concept and self esteem.....	96
Peer influences and pressures.....	98
The influence of alcohol and drug use on teenage pregnancy.....	99
Sex education.....	100
Conclusion.....	104

Chapter three – Research methodology and method

Introduction	107
Paradigmatic influences.....	108
Factors influencing the design of the study.....	111
Design of the study.....	114
Drawbacks and complexities of an international comparative	

approach.....	115
The sampling process.....	118
Ethical considerations.....	127
Piloting process.....	129
The process of conducting the interviews.....	131
The Caribbean interviews.....	134
The London interviews.....	137
Comments on the interview process.....	138
Number of interviews.....	141
Validity and reliability.....	141
Generalization.....	146
Analysing the data.....	149

PART TWO

Research findings – Introduction.....	153
--	------------

Chapter four – The Caribbean findings

Section one

Contextualising the findings - socio-demographic

characteristics: .

Age of respondents.....	154
Ethnicity.....	154
Marital status.....	155
Formal qualifications obtained at the secondary school level.....	155
Grandparents' Education.....	156
Employment/income.....	157
Accommodation.....	158

Section two

The Extent and Pattern of Repeat Pregnancy

Number of pregnancies.....	158
Pattern of repeat pregnancy among respondents in Jamaica.....	159
Pattern of repeat pregnancy among respondents in Barbados.....	159
Age of first sexual activity	160
Planned and unplanned pregnancies	161
The putative fathers.....	162
Number of respondents with pregnancies among siblings	162

Emerging themes

The loss factor.....	164
Loss following stillbirths, abortions, neonatal deaths.....	165
The anti-abortion theme.....	170
The journey of search as a symptom of loss.....	173
Loss of opportunities linked to school dropout.....	175
The role of sex in the lives of the respondents.....	178
The theme of economic dependency.....	179
Unsatisfactory parent/child relationships.....	181
I don't keep friends theme.....	183
The importance of motherhood and fertility.....	184
Respondents' approach to parenting.....	186
Goal orientation.....	188
Pregnancy as a form of escape.....	190
Contraceptive use.....	192
Sex education.....	196
HIV & AIDS.....	200
Peer counselling.....	202
Knowledge of professional services.....	203
Experience of interactions with professionals.....	204
The role of governments in preventing unwanted teenage pregnancies.....	205
Responses to criticisms from the public, professionals and governments.....	206

Chapter five – The London findings

Section one

Contextualising the findings socio-demographic characteristics:

Age of respondents	207
Ethnic composition of respondents.....	208
Marital status.....	208
Formal qualifications obtained at the secondary school level.....	209
Grandparents' education.....	209
Employment/income.....	210
Accommodation arrangements.....	210

Section two

The extent and pattern of repeat pregnancy

Number of pregnancies.....	211
Pattern of repeat pregnancies.....	212
Age of first sexual activity.....	213
Planned and unplanned pregnancies.....	213
The putative fathers.....	216
Number of respondents with pregnancies among siblings.....	216

Emerging themes

The loss factor.....	217
Loss following stillbirths, abortions, neonatal deaths.....	218
Unnoticed loss.....	222
Perceptions about abortions.....	225
The importance of motherhood and fertility.....	227
Filling the void.....	228
Approach to parenting.....	230
Reversed life course rationalization.....	232
Normative acceptance of pregnancy.....	233
Understanding and use of contraceptives.....	236
The role of sex education.....	239
The role of sex in the lives of the respondents.....	246
Goal orientation.....	248
Responses to the theme of welfare dependency and teenage pregnancy.....	250
Can governments and other professionals take steps to reduce the rate of teenage pregnancies?.....	252
What can government do to help pregnant teenagers and teenage parents?.....	255
The role of peer counselling	257
Knowledge of services and experience of interaction with professionals.....	258
Knowledge of HIV & AIDS.....	262
Experiences at school.....	265

Chapter six – Repeat teenage pregnancies – the meanings ascribed by teenagers in two cultures

Introduction.....	268
-------------------	-----

Revisiting questions of generalizability, reliability and validity.....	270
Similarities and differences in relation to the characteristics of the sample.....	271
Differences in educational achievement and outlook between the two samples.....	271
Accommodation.....	274
Similarities in themes between the London and the Caribbean findings.....	274
The loss factor.....	274
Understanding loss.....	279
Attachment.....	284
Sex education.....	294
Contraceptive knowledge and use.....	295
Differences between the London and the Caribbean findings.....	298
The issue of welfare dependency.....	300
I don't keep friends theme.....	302
The role of sex.....	304
The meanings which teenagers ascribe to their pregnancies.....	305
Why do teenagers have repeat pregnancies?.....,,,	308
Conclusion.....	311
Recommendations.....	316
Bibliography.....	326
Appendix one..... Data collection instrument	
Appendix two..... Sample letter to potential respondents	
Appendix three..... Sample letter to professionals/agencies	
Appendix four..... Sample of written responses from agencies	
Appendix Five..... Sample interview consent form	
Appendix six..... Response from Ethics Committee	

Abstract

This qualitative research seeks to improve our understanding of the relatively under-researched phenomenon of repeat teenage pregnancies, by exploring the underlying factors and meanings that teenagers ascribe to their pregnancies. The study uses a comparative approach to provide a comprehensive psychosocial and economic understanding of the factors leading to repeat teenage pregnancies. This is achieved by exploring both the diverse and similar experiences of two groups of teenagers within different socio-economic environments – one group of 26 respondents from the Caribbean islands of Jamaica and Barbados and the other group of 26 respondents from London. The research also capitalises on a unique opportunity to contextualize the welfare dependency/teenage pregnancy discourse. The behaviours, motivations, values and attitudes of young women who become repeatedly pregnant in a Welfare state such as England, are compared with those living in countries with limited state resources and few state benefits. The comparison shows that in the latter case, the lack of state intervention can have the disempowering impact of fostering dependency in many insidious forms.

The findings demonstrate the very powerful influence that both intentional and hidden or masked factors can have on a young woman's decision to repeat a pregnancy. The intrinsic relationship between the personal driving forces of the young women and their repeated pregnancies is convincingly highlighted. These driving forces are accompanied by very strong and deep-rooted beliefs in the importance of motherhood and fertility, as well as anti-abortion views. When these factors are added to economic stringency, they provide the fuel for a young woman's journey into repeat pregnancies. The findings therefore caution against a reliance on a mechanistic understanding of both single and repeat teenage pregnancies and emphasise the fact that social, psychological, and emotional processes, as well as the economic influences, are also crucial to our understanding of repeat teenage pregnancies.

Preface

Whilst teenage pregnancy is generally extensively researched, this has not been the case in terms of repeat teenage pregnancies. With the exception of one study cited in chapter one, the relatively small number of studies relating to this aspect of teenage pregnancies, have all been carried out in the United States of America. In addition, the meanings that teenagers ascribe to their pregnancies have seldom been explored. The research presented here attempts to address these deficits by in-depth explorations of the factors that contribute to repeat pregnancies. In exploring meanings, the study gives a voice to the teenagers interviewed by allowing them to tell their own stories. The importance of telling their own stories has been convincingly demonstrated by studies such as Mayer & Timms (1970) which gives valuable insight into the necessity for service providers and policy makers to listen to the views and feelings of consumers. A clearer understanding of how teenagers ascribe meanings to their pregnancies will therefore have implications for educational, social and health policies.

As the title of the study suggests, this study is comparative in approach. The common practice with comparative studies is to concentrate efforts exclusively on making comparisons of social phenomena between developed countries. This study attempts to make a contribution to filling this gap by making comparisons between developed and developing countries. As the study unfolds, it will become apparent that there are many valuable lessons that can be learnt from other comparative approaches. Such comparisons can only broaden our understanding of the complexities that surround teenage pregnancies, and in this regard, it strengthens the causal claims related to our findings. One unique opportunity presented by this comparative exercise, is the opportunity to explore and contextualize the teenage pregnancy - welfare dependency discourse that has gained momentum in the United Kingdom and the United States in the latter part of the last century. This is achieved by exploring the relationship between economic insufficiency, economic sufficiency and teenage pregnancies. What better arena for this evaluation to take place than within the context of developed and developing countries?

The respondents in this study were obtained from a variety of settings, with the largest numbers coming from two main sources - hospital antenatal clinics in

London and Jamaica, and through the Medical Social Work Department, in Barbados, though they were not necessarily on the caseloads of social workers. A small number was obtained from the caseloads of social workers in London, and from Health Clinics and Family Planning Clinics in the Caribbean. Data was obtained by the use of semi-structured to unstructured in-depth interviews, aided by a set of themes to facilitate exploration of the meanings that teenagers ascribe to their pregnancies.

The thesis is divided into two parts and six chapters. **Chapter one** is divided into three sections. The **first section** provides an introduction to the research. The **second section** examines and explores the media and political discourses surrounding teenage pregnancy and welfare dependency in the United Kingdom. The **third section** is an attempt to contextualize the concerns related to teenage pregnancy in the Caribbean. **Chapter two** provides a comprehensive synthesis of existing knowledge in the field of both teenage pregnancies in general and more specifically, of repeat teenage pregnancy. **Chapter three** provides a detailed account of the methodological influences and the methods used in carrying out the study.

The second half of the thesis provides a detailed presentation and analysis of the findings of this research beginning with the Caribbean findings in **chapter four**, followed by the London findings in **chapter five**. **Chapter six**, the final chapter attempts to evaluate the similarities and differences highlighted from the comparisons. It also evaluates the contributions of this comparative approach to our knowledge and understanding of the issues raised in this study. The thesis ends with practice recommendations arising out of the study.

A number of people have helped and supported me while the idea for the research was being generated and during the researching of this topic, and to these people I owe a special debt of gratitude. Thanks to Dr David Barrett and Professor John Pitts, who, having patiently listened to my views and desire to research this topic, unhesitatingly encouraged me to take the first step in submitting the research proposal. To Professor Margaret Yelloly who after having read the draft of the research proposal, also encouraged me to submit the proposal and agreed to be my research supervisor. This led to a partnership, which has been highly successful, empowering and complementary to my approach to the work. Thanks to my colleagues in the Social Work Department of

Brunel University for psychologically supporting my endeavours in carrying out this research. I need however to single out some colleagues for special mention: Lorraine Stewart, Linda Flinn and Gloria Younger for their encouragement and support in so many different ways, Professor Steve Trevillion who approved my sabbatical to enable me to complete the final stages of this research, Cathy Aymer, Dr. Toyin Okitikpi, Betula Nelson, and Lorraine Schaffer who took on my workload, thus enabling me to have the time to work towards the writing up of this research. Special thanks are due to Dr. Okitikpi for the numerous occasions on which we have had discussions on the subject, allowing me to test my ideas and views. These sessions have been a tremendous source of support to me.

I am especially grateful to all the managerial and frontline staff in social care and health agencies in London who identified potential respondents. To some of these staff members, I owe a special debt and I therefore feel compelled to single them out for special mention. They are Midwifery Sister - Sisibel Anderson who was my first contact in the Teenage Pregnancy Clinic of St. George's Hospital, London, and Midwife Dionne Johnson of Kings College Hospital Teenage Pregnancy Unit. These two consummate professionals have been an invaluable and reliable source of help and support in identifying potential respondents and in offering encouragement. I am equally indebted to a number of individuals and groups in the Caribbean who have all helped in identifying potential respondents during the times that I visited those islands. These include: the staff of the Medical Social Work Department of the Queen Elizabeth Hospital, Barbados; Mr. Charles Pilgrim and staff of the Barbados Family Planning Unit; the staff of the antenatal clinics of The Victoria Jubilee and University College Hospitals, Kingston; the staff of the University of the West Indies Family Planning Unit, Jamaica. I am also very grateful to my sister, Wesna Nolan whose untiring efforts in Kingston Jamaica, paved the way for my access to those previously mentioned establishments in Jamaica as well as others.

I gratefully acknowledge the contribution of the undergraduate and post-qualifying students of the Social Work Department, Brunel University both past and present who have patiently sat through my interim presentations of the findings. Their interests, beliefs in my abilities, enthusiasm and questions were all invaluable contributions to the successful conclusion of this research. I am indebted to my dear friends Vilma Clarke and Jean Proverbs in Barbados, as well as my colleague Cathy Aymer, who despite their busy schedules, have found time to

painstakingly read several draft chapters and have provided invaluable feedback and suggestions. Any errors that remain are my sole responsibility.

Thanks to the most important people in this study, the respondents who have openly, spontaneously and earnestly entered into a spirit of co-operation and a process of dialogue that was invaluable to me and I am convinced, to them as well. Without their co-operation this study could not have been undertaken. Many special thanks to my sons, Paul and Mark Clarke, whose pride in my work has encouraged and supported my efforts during the life of this project. Last, but by no means least, thanks to my newly arrived grandson, Thierry Clarke who has unknowingly in his own sweet and unique way, kept me sane during the final stages of completion of this thesis.

CHAPTER ONE

Politics, the media and teenage pregnancy in the United Kingdom Contextualising teenage pregnancy in the Caribbean

Introduction

As statistical evidence of high rates of teenage pregnancy in the United Kingdom began to emerge over the last decade, successive governments have made pledges and set targets to reduce the rate of teenage pregnancy. Nevertheless high rates of teenage pregnancy have persisted. Why have these high rates of teenage pregnancy persisted? As this chapter will show, teenage pregnancy has been surrounded by much ambivalence, controversy and an on-going ideological battle waged for decades between social commentators, right wing pressure groups, politicians and the media. The rise in the incidence of teenage pregnancy in the United Kingdom has led to an unprecedented level of political and media scrutiny and debates. This is particularly true in relation to the tabloid media, but also to a lesser extent, the 'quality papers'. The approach to these debates has often been extremely moralistic and negative in tone, and this moralistic approach has led to a limited conceptualisation of the 'problem' of teenage pregnancy. This limited conceptualisation in return, has often obstructed the development of effective policies and programmes to deal with the identified issues. Overall, there has been a lack of firm commitment on the part of governments in the United Kingdom to make effective policy decisions and responses that could have an impact on the reduction of teenage pregnancies in the UK.

In the Caribbean, we see that there are also high rates of teenage pregnancy. These high rates of pregnancy have led to considerable concern to the governments and citizens of the Caribbean region. Nevertheless, teenage pregnancy has not been subjected to the intense political and media debates and controversies seen in the United Kingdom. This conclusion has been reached as a result of living and working in the Caribbean for many years, as well as a search of newspapers in Barbados and Jamaica. This therefore means that it will not be possible to provide a parallel exploration and critique of media and political discourses in relation to teenage pregnancy in the Caribbean. However, in view of the comparative nature of this research, this chapter would not be complete without some brief reference to the Caribbean's approach to teenage pregnancy

prevention and management in order to contextualize the concerns related to teenage pregnancy in the Caribbean.

The purpose of this chapter is therefore threefold. In the first section, the aim is to provide the background to the factors that have influenced the conceptualisation, design and execution of the study. The second section aims to attempt to place the concerns related to teenage pregnancy in the United Kingdom into context, by examining the political and media debates and discourses that have surrounded this subject in the United Kingdom during the last two decades. It will also examine the extent to which these debates and discourses have impacted on the development of effective policies to reduce the rate of teenage pregnancies.

In order to achieve the second aim, the second half of the chapter will begin by presenting a selection of excerpts from political speeches and media reporting. These will be explored against a background of some of the policy responses to the phenomenon of teenage pregnancy in the U.K. Every attempt will be made to maintain distinctions between political rhetoric and media coverage, but there are times when some degree of overlap will be inevitable because of the interrelated and interdependent nature of this coverage. In order to place some of these concerns in context, the chapter will also briefly look at United Kingdom approaches to teenage pregnancy and sex education in schools. It will compare these with the approach to similar issues by some of our European neighbours.

In order to contextualise the concerns relating to teenage pregnancy in the Caribbean, the third section of this chapter will focus on three main areas. In the first area there will be an attempt to identify the basis for concerns about teenage pregnancy in the Caribbean. The second area represents a brief attempt to account for the differences in the focus on teenage pregnancy by politicians and the media in the Caribbean. In the third area an attempt will be made to explore some of the missing elements in the discourses relating to teenage pregnancy in the Caribbean. This will touch briefly on the role of the state in teenage pregnancy prevention and management in the Caribbean.

SECTION ONE - Background to the study

Why research repeat pregnancy?

Teenage sexuality and fertility have been the subjects of growing concern for the last two decades (Bury, 1984; Forrest & Goldman, 1985; Jones, Bertrand et al, 1986; Trussel, 1988; Population Reference Bureau, 1992). These concerns have transcended international borders and cultures with diverse socio-economic and political structures, and have led to a common view of teenage pregnancy as a social and economic problem of immense proportions, particularly in the United States and the United Kingdom. As a result of these concerns, researchers have devoted a great deal of effort and interest to the subject of teenage pregnancy.

The substantial and growing literature on teenage pregnancy however, reveals that, to date, the vast majority of research studies explore either the mechanical causes of teenage pregnancy, focusing on adolescent sexual activity and contraception, or outcomes in terms of the consequences for the mother and child. The meanings that teenagers attach to their pregnancies have seldom been explored with respect to the implications for intervention. As Moore and Rosenthal state:

'What is also missing from the research (on teenage pregnancy) are the voices of these young mothers and fathers. In spite of the plethora of books dealing with teenage pregnancy, and with the notable exceptions of British writers such as Sharpe (1991), researchers have neglected the phenomenology of early motherhood and fatherhood. We have little idea of what it actually feels like to become a mother when one is little more than a child' (Moore & Rosenthal, 1993:165).

What is also missing from this plethora of research, is an examination and exploration of the issues related to repeat teenage pregnancy. Williams (1991:39) also highlighted this lack of research when she pointed out that in relation to the United States:

'second births have seldom been studied except to note their timing and sequencing relative to first births and to use them as evidence of programme failures. A neglected aspect of teenage pregnancy and parenting is micro level research which takes into account the perspective of the teenage mother, highlights individual diversity, and identifies coping strategies among teen mothers'.

Many years of working with pregnant teenagers and teenage parents in London and the Caribbean, have brought me into contact with the phenomenon of repeat

pregnancy. I had no reason to believe that my experiences were isolated, in relation to the number of teenagers having repeat pregnancies. More recently my hunches in terms of the numbers of teenagers experiencing such pregnancies were confirmed by Data from the Office of National Statistics (1997) cited in the Social Exclusion Unit's Report (1999) which revealed that a significant number of young women have repeated pregnancies in their teens. Additionally, one in six teenagers who terminated a pregnancy in 1997 had already had a termination or live birth, and two per cent had both. A survey conducted by Wellings et al (1996) cited in the Social Exclusion Unit's report (1999), also reported that about one in eight young women, who had their first baby during their teenage years, went on to have a second child before the age of twenty.

Many young mothers claim that their first pregnancy was unplanned and in some respects, a mistake. The question must therefore be asked, why then do so many become pregnant a second, third, fourth or even a fifth time? What are the factors that influence repeat teenage pregnancy? In spite of these statistics and the drawbacks of repeat pregnancies identified in the literature review chapter, to the best of my knowledge, only one study in the Caribbean has focused attention on the strategies to reduce repeat teenage pregnancies (Bertrand et al, 1986). None of the vast number of studies on teenage pregnancy has sought to address the issue of repeat pregnancies in the United Kingdom. Only a handful of studies have attempted to address these issues in the United States. At a time when considerable efforts are being devoted to understanding and reducing the incidence of teenage pregnancies in both Britain and the Caribbean, these are issues of substantial relevance that need to be explored. In order to devise comprehensive and effective strategies for preventing unwanted or unintended teenage pregnancies, both first and repeated pregnancies, we must first of all seek to clearly understand its complexities.

In view of these methodological and other omissions in the approach of previous studies of teenage pregnancies, this study attempts to establish the meaning of repeated pregnancy for the young women who experience it, and the ways in which they manage their lives. Within the context of this study, the concept of ascribing meaning denotes the process by which the teenagers themselves will attempt to make sense of their life experiences. It is an enabling process which allows these young women to evaluate the significance of their actions, including their pregnancies, through the process of developing a narrative of their own lived

and felt experiences in relation to their pregnancies and their lives. As the previous quotes by Rosenthal and Williams suggest, to date relatively few studies have attempted to give young women a voice in the exploration of issues related to teenage pregnancies. The chapter on methods and methodological approaches, will show that this study hopes to play a part in remedying this methodological omission by adopting an in-depth interview approach to the study of repeat teenage pregnancies. This allows the respondents to tell their own stories, and therefore give relevance to their actions. A clearer understanding of why these teenagers have repeat pregnancies, and how they view their pregnancy will have implications for educational, social, health and economic policies. It will also contribute to the body of knowledge currently being accumulated in an attempt to address the problems of teenage pregnancies in the United Kingdom and in the Caribbean.

The benefits of a comparative approach

This comparative approach focuses on London and two Caribbean islands- Jamaica and Barbados. It is often the usual practice for comparative research on teenage pregnancy to be carried out between developed countries. Having had the opportunity of living and working in both a developed and developing countries, I strongly believe that important lessons can also be learnt from other comparisons between developed and developing countries. We live in a global village with the continuous export of cultures and traditions across international borders. The lessons learnt from such comparisons are important, not only in aiding our understanding of teenage pregnancy from different cultures and traditions, but also in developing our understanding of the similarities. It will also have useful policy and practice implications for the countries involved.

There are certain similarities between the Caribbean and the United Kingdom, which lend themselves to the making of useful comparisons. In the Caribbean, there has long been a history of concern regarding the high rate of teenage pregnancies. In 1992, the Population Reference Bureau quoted figures of 84-104 births per thousand female adolescents between the ages of 15 and 19 years. These concerns, as in the United Kingdom, include the high health risks to the mother and the baby, including increased mortality and morbidity, which, in developing countries, are significantly greater in women aged 15-19 years, than those, aged 20-24 years. In addition to health concerns, like the United Kingdom,

there are also urgent socio-economic concerns about the high rates of teenage fertility in developing countries already burdened by severe economic hardships as a result of underdevelopment.

One very useful benefit of this comparative approach, is that it also provides a unique opportunity to attempt to place the alleged links between teenage pregnancy and welfare dependency in the United Kingdom in context . This will be explored in section two. It will allow me to compare behaviours, motivations, values and attitudes of young women who become pregnant in a 'Welfare State' such as England, with those living in countries such as Jamaica and Barbados where similar benefits and access to independent state provided accommodation are not available, or very limited.

In addition to the benefits outlined above, as Hudson & Ineichen point out:

'very few attempts have been made to consider teenage sexuality, pregnancy and motherhood in depth across international boundaries. International comparative studies have largely amassed and compared statistical descriptions of the subject. Few have attempted meaningful comparisons in depth between nations' (Hudson & Ineichen, 1991:1).

It is hoped that this study will go some way towards bridging this gap.

SECTION TWO

Concerns about teenage pregnancy in the United Kingdom

The Social Exclusion Unit's report shows that in the United Kingdom, England and Wales have the highest teenage fertility rates in Western Europe, as **Figure 1** shows, twice as high as Germany, three times as high as France, and six times as high as the Netherlands. Data from the Office of National Statistics (1997) cited in the Social Exclusion Unit's Report (1999) (**Figure 2**) suggest that in England there are nearly 90,000 conceptions a year to teenage girls.

The Social Exclusion Unit's report published in 1999 further shows that:

Around 7,700 are to girls under 16, (about 70 per cent to girls under 15), resulting in 3700 births.

Approximately 2200 conceptions to girls aged 14 and under.

Roughly three-fifths of conceptions – 56,000, result in live births.

An estimated 50 per cent of conceptions to under 16 year olds, ended in abortions.

These persistent concerns about high fertility rates have resulted in a focus on teenage pregnancy in the last Conservative Government's **Health of the Nation White Paper** in 1992. In the white paper a target was set to reduce the rate of conception to under sixteen year olds by half, from 9.5 per 1000 (1989 figures) to 4.8 per 1000 by the year 2000. It was hoped to achieve this by:

'producing a package of measures which substantially reduce pregnancies in the under sixteens, and may also be expected to exert a similar effect on unwanted pregnancies in those over sixteen' (Department of Health, 1992).

Nevertheless, as the Social Exclusion Unit statistics presented above show, the Conservative government failed to reach the targets that were set in the white paper. In 1997 the new Labour Government's concern about high rates of teenage pregnancy in the UK resulted in the launch of a National Task Group to explore unwanted teenage pregnancy (HEA, 1998). Their task however,

rate per 1,000 women aged 15-19

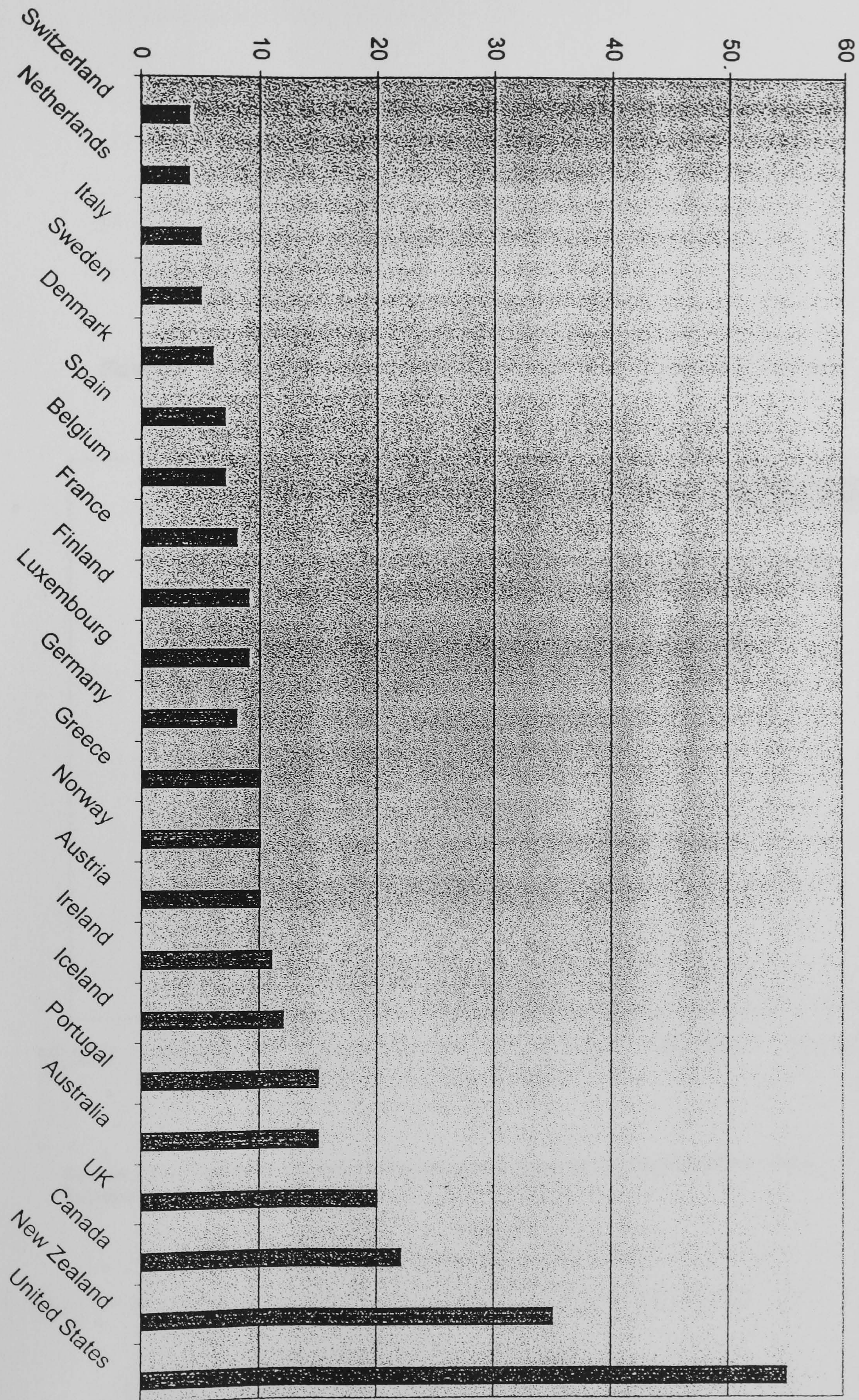
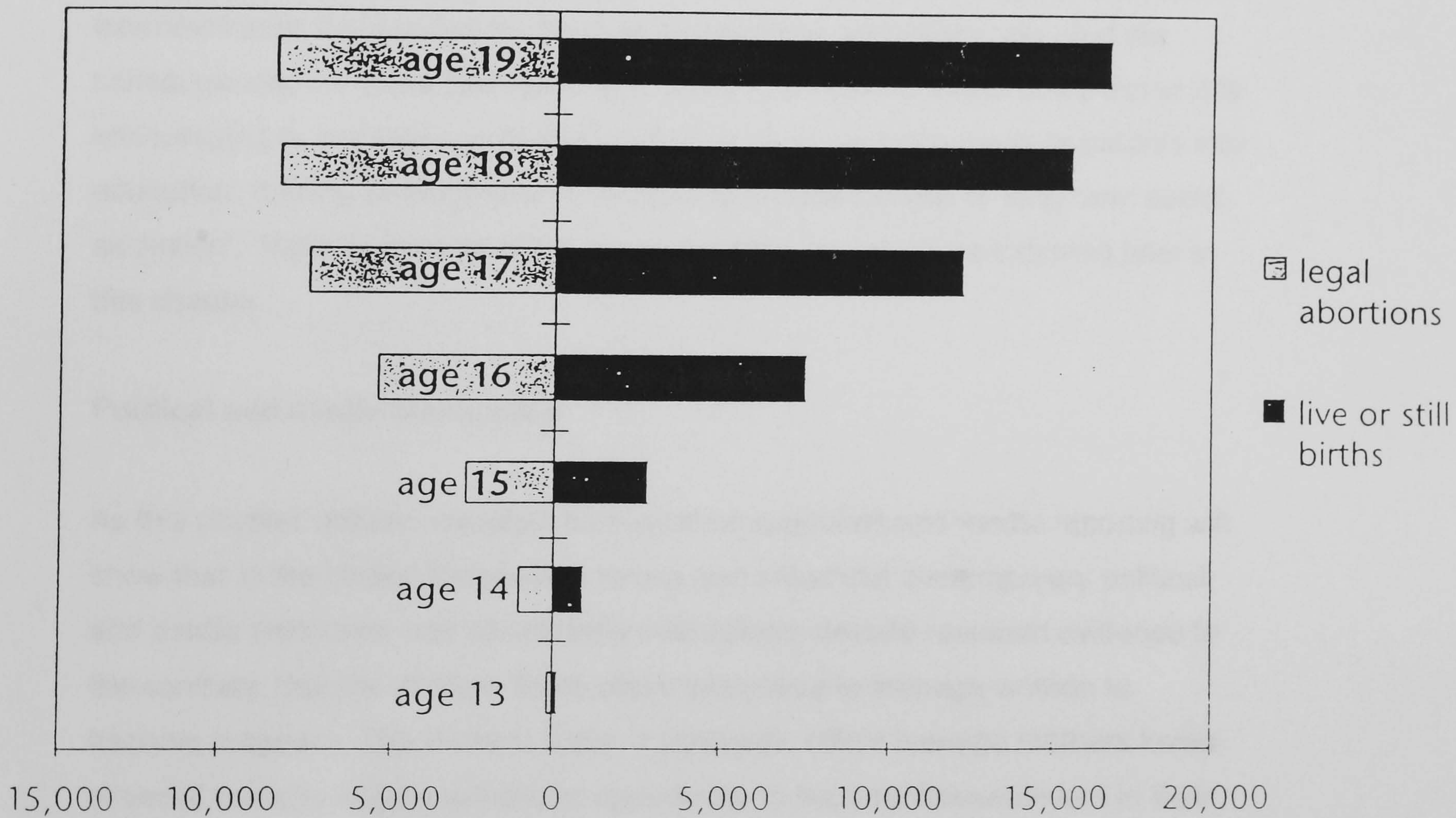


Figure 1 : Live birth rate to women aged 15-19, latest figures available

Source: Eurostat & Centre for Sexual Health Research, Southampton (cited in the Social Exclusion Unit's Report (1999))

Figure 2: Teenage conceptions – outcome by age at conception, England 1997



Source: ONS. Figures do not include miscarriages or illegal abortions (cited in the Social Exclusion Unit's Report (1999))

was taken on by the **Social Exclusion Unit** in July 1998 which had been mandated by the Prime Minister to examine the issues of teenage pregnancy and early parenthood. The aim was to suggest strategies to reduce the rate of teenage parenthood, in order to minimise the risk of social exclusion. The Unit published its findings in 1999. These findings show that the current government has gone one step further than the previous government in setting targets for halving the rate of teenage conceptions among under eighteen year olds by the year 2010, as opposed to the age limit of sixteen targeted by the previous government. This objective is welcomed because as Peckham (1993) argues, focusing on reducing pregnancies only among the under-sixteens, which represents less than 1 per cent of all pregnancies, 'ignores the substantial number of pregnancies' occurring among those teenagers aged 16 and over. The Unit has examined both the reasons for the high UK teenage pregnancy rate, and the consequences for those teenagers who become pregnant. In the Unit's report it is encouraging to see that one of its stated aims, is to get more teenage parents into education, training or employment, in order to reduce the risk of 'long term social exclusion'. Various aspects of the contents of the report will be explored later in this chapter.

Political and media discourses

As this chapter unfolds, excerpts from political speeches and media reporting will show that in the United Kingdom, a strong and influential contemporary political and media discourse, has consistently maintained, despite research evidence to the contrary, that the Welfare State offers incentives to teenage women to become pregnant. The Welfare State, it contends, offers teenage mothers levels of social benefits and an enhanced opportunity to become householders in their own right, which are unavailable to their childless contemporaries. These benefits, it argues, render marriage to the putative fathers an economically non-viable option, since this would reduce significantly their eligibility for such benefits.

The political, media and public debates about teenage pregnancy and lone parents in particular, as a result, appeared to have gathered momentum and been given new prominence in the early 1990s as statistical data began to show an increase in the number of lone parents (Burghes & Roberts, 1995). At the heart of this debate were concerns about the number of lone parents receiving state

benefits, and hence, a major financial burden on the state and its tax paying citizens.

As Duncan & Edwards (1997) citing Bortolaia-Silva, (1996) argued, increasingly viewed as a moral threat to society, single parenthood therefore assumed a:

‘political significance wider than the policy issues directly raised. It has become a symbol, and a means of political mobilization, for alternative discourses about the nature of ‘the family’ and the welfare state’ (Duncan & Edwards, 1997:45).

Much of the debate as a result, focused on the decline of the nuclear family, and gave rise to unprecedented concerns about teenage pregnancy and single parenthood during the 1980s and 1990s. This was the period that also witnessed a proliferation of arguments that teenage pregnancy is a prime avenue for creating a welfare dependency syndrome. As we will see, teenagers were repeatedly accused of deliberately making themselves pregnant in order to gain undeserved access to welfare benefits and housing. This section therefore represents an attempt to put such concerns related to teenage pregnancy in context. In doing so, it will explore the basis of these concerns and also examine the validity of these claims made by leading politicians from the Conservative Party and more recently, from the Labour Party which were picked up and amplified by the media. The main focus of this chapter will be on the discourses from the late 1980s onwards as this period witnessed the most vitriolic attacks on lone parents including pregnant teenagers. It was also the period in which governments began to set targets to reduce the rate of teenage pregnancies.

This will not be an attempt to chart a detailed account of political speeches and media coverage of the subject. However, it will be an attempt to isolate some central themes and some of the major ideological roots beneath the highly publicised rhetoric about teenage pregnancy and single parenthood of the last two decades. The aim here is to provide the raw material from which the impact of this political discourse and mass circulation media coverage, on policy development in response to teenage pregnancy, can be judged. It is important to focus on these political and media debates, because as Duncan & Edwards (1997:4) state: ‘political rhetoric... based on particular ideological stances about the welfare state and the family, both influence legislation and affect public perceptions of lone motherhood’ in a particularly powerful way. In addition, it is only by examining

these claims against a background of research evidence, that we can put the unprecedented concerns relating to teenage pregnancy into context.

A careful examination of national newspaper coverage from the late 1980s provides a flavour of the political themes that were prevalent during that period. This examination showed that the themes of lone parenthood, the family and welfare dependency were prominent in the political speeches and media coverage of the decade. Towards the end of 1988, Robin Oakley in a wide-ranging interview with Margaret Thatcher, the Prime Minister, reported that:

'The Prime Minister also acknowledged that the undermining of the family unit by women trying to jump council housing queues as single parents was a problem causing government ministers considerable anxiety' (*The Times*, 26/10/88).

Similarly, one month later Nigel Lawson, the Chancellor of the Exchequer, argued that the benefit system was making a significant contribution to the growing incidence of family break-ups and illegitimacy (*The Times*, 10/11/88). In 1990, Margaret Thatcher extended her earlier concerns about young single girls and welfare dependency, to include absent fathers, when she delivered the 'Pankhurst lecture' on the 18th July, to the 300 Group*. In this lecture she clearly set the agenda for the debates which were to follow when she outlined the government's concerns about absent fathers and the ensuing burden on welfare expenditure as a result, when she declared:

'Government, too, must be concerned to see parents accept responsibility for their children. For even though marriages may break down, parenthood is for life. Legislation cannot make irresponsible parents responsible. But it can and must ensure that absent parents pay maintenance for their children. It is not fair for them to expect other families to foot their bill too' (*The Times*, 19/7/1990)

In reporting on the Pankhurst Lecture, the *Times* political reporter, Shiela Gunn referred to the speech as the first definite announcement of the government's intention to introduce the Child Support Bill. It continued:

'Margaret Thatcher took the first initiative in the government's family policy yesterday by announcing an agency to track down absent fathers, while warning of the effects of divorce and the rise in one-parent families on children and society' (*The Times*, 19/7/1990).

* A campaigning organisation which works towards equal representation of women in parliament

In contrast, The Daily Mail's agenda was in no doubt when, reporting on the speech in their customary inflammatory style, they used the speech as an opportunity to launch an attack on the children of one-parent families when they commented:

'children without fathers are more likely to lack discipline and ability to hold down a job. Thus is generated a culture of dependency, going from one generation to another and forming a permanent ghetto of deprivation' (*Daily Mail*, 19/7/1990).

The political speeches preceding the Pankhurst Lecture showed that outwardly at least, concerns about parenthood had been prominent on the political agenda, while inwardly, the real concerns were about cuts in public spending. In an article carried by *The Times* (18/1/1990), Robin Oakley, the political editor (under the heading '**Permissive Age Attacked**'), reported that Mrs. Thatcher warned that Britain was reaping the harvest of the permissive 1960s with a breakdown in the family unit. This represents 'a new kind of threat to our whole way of life'. In the previous day's paper (*The Times*, 17/1/1990), Tony Newton, the Social Security Secretary was reported to have announced that intensive studies were to begin, designed to set up a comprehensive new system which would ensure that absent fathers paid towards the maintenance of their children as 'this is a new kind of threat to our whole way of life, the long-term implications of which we can barely grasp'.

There was also evidence of pressure being brought to bear by the media reporting which preceded the speech. In a front page headline by the *Daily Mail* reporter Steve Doughty, the twin themes of absent fathers and lone parents were kept firmly on the agenda, when under the headline –'**Scandal of Absent Fathers**' 1/1/1990, Doughty wrote:

'Absent Fathers who fail to maintain their children are costing the country more than £1 billion a year. But the government has no intention to make them pay, Whitehall admitted yesterday..... the government's admission comes as the number of single mothers soars, with one in six families now headed by a lone parent'.

In 1992, the focus on pregnant teenagers by politicians continued. In what was commonly referred to as his '**little list**' speech, Peter Lilley, the Minister of Social Security, at a Conservative Party Conference on October 7th 1992, outlined a '**list of frauds to tackle**', including 'young girls' who deliberately make themselves 'pregnant to jump the housing queue'. This claim, which began during the late 1980s, became a frequently used theme for politicians and some newspapers in the years that followed. As customary, the media capitalized on the speech and potentially disquieting headlines followed. For example, *The Daily Mail*

(8/10/1992) printed the full text of the speech under the title **'Lilley's £500m crackdown on Benefit Fiddlers'** -with the caption- **'End of the something for nothing society'**. *The Times* (8/10/1992) under the headline **'Lilley Targets scroungers'** pointed out that in the speech:

'Mr. Lilley also responded to grassroots anger about the high priority given to mothers by council housing departments.....' However, 'he had little new to offer on this front, beyond saying that the new child support agency.....would help to curb abuses'.

The focus on pregnant teenagers as a main conference theme was in no doubt when Ian Bridge, another conservative politician 'echoed the view of a number of earlier speakers' when in opening the conference debate, he remarked:

'there is no doubt in my mind that housing priorities under the Homeless Families Act and the benefits system have encouraged girls to use pregnancy as an economically viable way of leaving home..... The social benefits system must not encourage pregnancy as a way of jumping the queue' (*The Times*, 8/10/1992).

In 1993, John Redwood the Welsh Secretary, advanced the debate on lone parents with an attack on lone mothers following a visit to Cardiff's St. Mellons housing estate in July 1993. In this attack, he referred to young single mothers as **'one of the biggest social problems of the day'** (*Daily Mail* 5/7/93). He gave further credence to the view previously expressed by Peter Lilley and other conservative politicians, that young mothers were deliberately making themselves pregnant to gain access to public housing. This view intensified the attack on lone parents by other conservative politicians and the tabloid media. As Marchant states, after these comments:

'there was talk of putting single mothers in hostels; and having court injunctions to prove they had been thrown out of the parental home before they were allocated council housing' (Marchant 1993:14).

The theme of welfare dependency was echoed yet again in September 1993, when Michael Portillo, the Treasury Chief Secretary, speaking in London to a group of religious leaders, on the topic of 'Ethics and Public Finance' was reported by the Guardian's Political Correspondent, Patrick Wintour to have asked:

'rhetorically what Government can do to reduce the number of unwanted teenage pregnancies, saying the greatest increase in the receiving of social security benefits was amongst single parents' (*Guardian* 16/9/1993).

The article went on to state that Michael Portillo informed the audience that 'teenage pregnancy is seven times higher than Holland's and not I think because the British teenager is more likely to have premarital sex than her Dutch counterpart'. In keeping with the political rhetoric in relation to teenage pregnancy during the late 1980s and 1990s, there were no reports of any attempts on Mr. Portillo's part to explore and explain the factors that contributed to the increased likelihood of British teenagers becoming pregnant.

In October 1993, Sir George Young, the housing minister asked:

'How do we explain to the young couple who want to wait for a home before they start a family that they cannot be rehoused ahead of the unmarried teenager expecting her first baby, probably an unplanned child'? (*Daily Mail*, 8/10/1993).

At the Conservative Party Conference in 1993, the theme of lone parents was still very much evident on the conservative political agenda. In unveiling his anti-crime package, Michael Howard, the Home Secretary made the unsubstantiated and highly controversial statement, that, children who grew up without their fathers were more likely to turn to crime, because:

'with few adult male role models around, they are all too likely to succumb to peer pressure. And inevitably they emulate the most aggressive, the most rebellious boys in the neighbourhood' (*Daily Mail* 6/10/93).

Throughout these political speeches, it was clear that the needs of the teenage mother were secondary on the political agenda. The preoccupation was clearly on saving the public purse. There is no doubt that the public purse often picks up the cost of lone parenthood. In May 1992, for example, 957,000 lone-parent families were on income support (Parker, 1995). In such circumstances, concerns about welfare expenditure are not entirely unreasonable. It is ironic however, that the government of the day spent very little in comparison on the preventative aspects in the form of social policies designed to reduce the number of 'unwanted' teenage pregnancies and to enable more lone parents to take up employment and reduce social exclusion. This is evidenced by their cuts in public spending in the very areas that spending was needed towards achieving the Health of the Nation targets set out earlier, such as family planning and school nurses (Babb, 1993). Similarly, no consideration for saving the public purse was shown when there were cuts in the provision of childcare facilities, which would make it possible for lone parents to take up employment.

In contrast, in France for example:

'after two years in receipt of lone parents' benefit, or when the youngest child reaches three years of age, lone parents are expected to take paid work, which is feasible because every French child is guaranteed a nursery school place from the age of three.....in Britain mothers who want to work face a lethal mixture of low wages, high taxes and high work expenses.....targeting scarce resources on high quality nursery education for the children and job-training for the mothers, seem not to have been considered' (Parker, 1995:43).

The labour government in its 'National Childcare Strategy' launched in 1998, included the introduction of a guaranteed nursery placement for all four-year-olds. At a cursory level, this strategy could suggest that availability of such places would lead to an earlier return to work for those mothers who wish to do so. However, a major omission of the strategy was that no firm provision was made for children under the age of four years old. Therefore, a likely consequence is that lone mothers with children under four years will increasingly opt out of the job market at this stage. This resulting gap in their employment histories undermines future job prospects for people who are already disadvantaged due to lack of education.

In June 1994, there was a rare attempt to contextualize the welfare dependency/single parent discourse when Peter Lilley argued that:

'the main economic factor which may have affected the stability of marriage for some people has been the changing pattern of earnings.....With mechanisation of simple manual tasks, the earning power of unskilled workers has declined relative to average pay and relative to benefit level. As a result, unskilled young men cannot earn a great deal more in work than the benefits they would receive to enable them to bring up a child'.

These factors therefore, rendered them as poor prospective husbands. He went on to propose that, 'the most desirable solution is obviously to enable people to acquire skills necessary to earn enough to support a family' (*The Times* 21/6/1994).

It is not my intention to dismiss the importance of the package of measures that Peter Lilley was advocating, but it comes as no surprise that such measures were not successful, or had little impact on reducing the rate of unwanted pregnancies in Britain. Lilley's statement portrayed a one sided approach to the solution of high numbers of teen pregnancies and lone parenting. I would suggest that this approach could be described as patriarchal in tone. It implies that the complex

issues surrounding teenage pregnancies and lone parenting can be remedied by providing skills training for young men to enable them to support their children, thus reducing the burden on the state. This simple analysis ignores the other well-researched difficulties cited in the literature review chapter facing teenage and other lone parents. It is also further evidence that the underlying motives for the attacks on lone parents were more related to economic than moral and social concerns. As Zinn (1986) cited in Pearce, (1993:52) points out, what is seen as problematic about the idea of dependence on welfare:

'is not that women are dependent, for women are expected to be dependent on men', starting with their fathers and continuing with their husbands. The concern about dependency relates to concern about dependency on the state, and therefore the real issues in relation to teenage pregnancy and welfare dependency, is the issue of single parent mothers 'living and surviving economically without men'.

This change in tone was not to last. A year later, in August 1995, the attack on lone parents resumed when John Redwood repeated his earlier allegation of young parents jumping the housing queue. As he declared :

'the assumption is that the illegitimate child is the passport to a council flat and a benefits income. If no one in the family can help, maybe the girl should consider letting a couple adopt her child to provide the home the baby needs'. He further added 'couples who waited to have children often found that they were denied council homes because unmarried mothers had jumped the queue.....we do not want to offer incentives to entice young women to become mothers before their time' (*Daily Mail*, 14/8/1995).

It could be argued that the American social scientist, Charles Murray in his 'underclass' debate, provided a further impetus to the 'welfare dependency' discourse when he argued that high illegitimacy rates among single parents were a prerequisite of underclass existence (Murray, 1990). He further argued that where in the past, illegitimacy was punished by society it was now rewarded through the welfare system. These rewards encourage a certain amount of reluctance on the part of single parents to marry as they can rely on welfare benefits. The incentives built into the welfare system, therefore have the effect of deconstructing the institution of family life, as it encourages fathers to neglect their traditional responsibilities (Murray, 1990). Therefore, it was not surprising that Murray argued that social stigma is an 'essential ingredient of social order' and must slowly and cumulatively be restored (Murray 1990).

The extent of the impact of Murray's views can also be assessed by the extensive coverage devoted to his views by the *Sunday Times* in 1989. In its editorial to mark the publication of Murray's first British essay, the editor, Michael Durham commented that 'the underclass spawns illegitimate children' creating an image of breeding animals' (*Sunday Times*, 26/11/1989). The scope of this chapter does not permit a full exploration and critique of underclass theories such as those espoused by Murray and other 'underclass' theorists. However, the enormous impact of Murray's views on the debates of the last two decades which, have in no doubt' contributed to the general sharpening of the ideological debate' about teenage and other lone parents, cannot be underestimated (Lister, 1996:11). As Morris states, the notion of the 'underclass' served as a 'powerful tool of political rhetoric for both left and right' (Morris, 1994:165). These views also served to reinforce the conservative political agenda, where politicians having campaigned forcefully against deviant behaviour, were rewarded by being voted into office on the promise of re-establishing Victorian values (Muncie, 1999). However, as Walker argues:

'Murray's underclass, like all previous attempts to individualise the causes of poverty, diverts our attention from blaming the mechanisms through which resources are distributed, including the role of Government, to blaming, in William Ryan's famous phrase, the victims' (Walker, 1990:73).

This negative approach to teenage parents was by no means confined to the Conservative government. In 1997 Britain saw the end of almost 17 years of conservative rule, and while the conservatives were in power, their Labour contemporaries attacked them for the right wing moralising tenor of their approach to teenage pregnancies and lone parents. However in 1999, just two years after a Labour government was elected, increasingly some labour politicians have proved themselves to be as guilty of the very same approach for which they criticised their Conservative colleagues during the 1980s and 1990s. For example, early in 1999 Jack Straw, Home Secretary, remarked that the benefits system contributes towards the creation of 'an environment in which the natural checks that existed before on teenagers having children and keeping them has gone in some areas' (*Daily Mail* 26/1/1999).

At a conference on families organised by the Family Policy Studies Centre, Jack Straw repeated the advice given to young mothers many years previously by Michael Portillo and John Redwood to place their babies for adoption. He was

reported by the *Daily Mail* newspaper in an article entitled **'Give up Babies Plea to Single Mothers'** (*Daily Mail*, 26/1/1999) to have said that teenagers who cannot cope with children should opt for adoption. Mr Straw went on to condemn 'well meaning but not very professional' social workers who persuade unfit mothers to try to keep their children. He launched an attack on the anti-adoption culture based on 1960s thinking that the natural mother, whatever her failings, was the best person to bring up her baby. He argued that this practice has led to disappointment for thousands of would be adoptive parents, while leaving thousand of babies 'in limbo' in local authority children homes in the hope that they could be returned to their mothers later.

It is unclear on what evidence Mr. Straw based his remarks, or whether he had taken the time to speak to the 'well meaning but not very professional social workers', whom he accused. It is also interesting that throughout the press release, there was no indication of what help or initiatives Mr. Straw's government would introduce to help teen parents to develop their parenting skills, which would make them more able to effectively care for their babies, or to prevent them from having any further repeat pregnancies. What the speech implied was his lack of thought and understanding of the circumstances of these so-called 'unfit mothers'. As Ann Furedi of the British Pregnancy Advisory Services was quoted in the aforementioned article as saying:

'adoption is an entirely inappropriate solution to the problem of teenage parenthood. Fewer than one hundred babies a year are handed over for adoption, not because of legal difficulties, but because of emotional difficulties a woman faces when she gives away the child she has borne'.

It is therefore conceivable to argue that this lack of insight and understanding inevitably translates into lack of effective policies.

Mr Straw also showed no recognition or understanding of the fact which a leading Liberal Democrat politician quoted in the article, stated in response to his comments, 'the consequences of the kind of policy Mr. Straw is seeking to return to are only just being felt in terms of the number of (adopted) people trying to find out about their families'.

Mr. Straw's comments were reported by the author of the article, as the 'first attempt by a senior minister to make a case for more adoption of the children of young

mothers'. Adoption works in certain cases, but it is most certainly not a solution for everyone. The article goes on to state that these remarks came only three months after the former conservative Prime Minister, Lady Thatcher, was derided by labour MPs for suggesting that teenage single mothers should be encouraged to give up their babies to religious institutions. In addition, by providing housing and incomes to single mothers, 'we were unwittingly multiplying the number of people who had illegitimate children'. Such thinking suggests that Mr. Straw and Lady Thatcher had not learnt from the lessons of the 1950s, 1960s and 1970s, where it was shown that rushed adoptions resulted in a great deal of unnecessary pain and distress. This was not only to the mother giving up her baby for adoption, particularly if she had no proper counselling, but also to numerous adopted children later on, as they began the emotional search and journey of putting the pieces of the puzzle together. Adoptions are not always the only solution to teenage pregnancies. The focus of policy decisions needs to concentrate on getting to the root of the problems, taking all factors into consideration in order to arrive at effective solutions, which may or may not include adoption. Mr. Shaw's comments were yet again, evidence of the failure to fully acknowledge and respond to the needs of pregnant teenagers. It was also further evidence of a piecemeal political response to a complex, multi-faceted phenomenon, which requires a comprehensive package of measures, which successive governments in the UK have failed to develop.

Towards the end of the twentieth century, we continued to see that the scapegoating of pregnant teenagers by the media, though less vitriolic in tone than the early 1990s, shows little signs of abating. In 1999, there were still headlines in our National Daily papers, such as '**Ministers to take a harsh line on Single Mothers**' –Andrew Grice, *Independent*, 10/2/1999. It is interesting to note that this article was in fact about the Welfare Reform Bill, which did not focus solely on single parents, nevertheless, the title singled out single parents, confident in the knowledge that this type of sensational headline would get the public's attention.

On the same day the *Daily Mail's* headline by David Hughes, was '**Welfare: The Crackdown**'. This article began with the caption, '**Single parents will be forced to take at least a first step towards finding work as Tony Blair cracks down on the benefits culture**'. The article went on to inform its readers that a tough new welfare regime to be unveiled by the Premier that same day, would make all

claimants turn up for job-seeking interviews. Although the title of the article would suggest that this crackdown would be aimed at all welfare claimants, and in fact the article went on to make reference to claimants on the whole, such as those on incapacity benefits, the spotlight on lone parents was in no doubt, as the above caption implies. Further, it was not long before its focus was redirected again to single parents when it stated that:

'the most controversial part of the package will be the measures targeting 1.1 million lone parents living on benefit. The overwhelming majority make no effort to find work according to the government's own figures'.

As is common with a number of similar newspaper headlines, no effort was made to put the facts into context and to attempt to offer explanations regarding the possible reasons why lone parents may be prevented from seeking work. In the *Daily Mail* article of 10/2/1999 entitled '**Welfare: The Crackdown**, author David Hughes was still focusing on:

'fears that a combination of benefit payments and priority treatment on housing having combined to make a life on welfare as a single mother an attractive proposition for many teenagers and young women as John Redwood controversially proclaimed when he was the conservative government's Welsh Secretary'.

These views have persisted in spite of mounting research evidence to show that access to benefits and housing is not the prime motivating factor in young women becoming pregnant. The article stated that Mr. Blair was dismayed by the low take-up of the Government's New Deal package by lone parents. The only reference to the fact that the reason single parents were not rushing to respond to the government's New Deal package, was covered in only four lines of one column taking up 2 x 5/8 inches of space. This states that '**other single parents, who want to work but face practical problems, may not appreciate the help that is available, particularly with child care**'. There were no attempts to analyse why there has been a low take up of these resources. There was also no acknowledgement of the fact that the high cost of childcare is a significant disincentive to lone parents to seek or remain in employment (Bradshaw & Millar, 1991). Additionally, as studies by the Family Policy Studies Centre show, the fact that sixty per cent of mothers in two-parent families work, compared to forty per cent of single mothers, infers that the cost, convenience and availability of childcare are at the forefront of the decision for some women to return to, or take up employment (Family Policy Studies Centre, 1996).

Another article with the headline **'One in five girls 16-19 admits having multiple partners -Shock Truth on Teenage Sex'**, *Daily Mail*, 13/3/1999, by Steve Doughty, went on to state:

'the full extent of teenage promiscuity was revealed in official figures yesterday. They will fuel concern about the effects of allowing youngsters sexual freedom but giving them little or no moral guidance. The new study comes with the rates of abortion, single motherhood and sexually transmitted diseases all at record levels. It shows that, among both girls and boys aged 16 to 19, one in five admit having two or more sexual partners in the preceding year. One in twenty girls, and almost twice as many boys, had had sex with four or more people'.

The article quoted a response to the report from 'family campaigners' who were concerned that 'promiscuity was being fuelled by sex education and contraceptive campaigns, and by obsession with sex magazines and broadcasters'. Among those quoted in the article was Hugh McKinney of the Conservative Family Campaign who was reported to have repeated a familiar, but unsubstantiated claim by such campaigners that:

'The blame lies with those people who try to persuade teenagers into sexual activity at an age when they are not capable of handling the responsibility of relationships.....we see the results in high levels of abortions and single parenthood'.

Another commentator, Valerie Riches of Family and Youth Concern was quoted as saying, 'The sex education industry is promoting 'sex for fun' among young people. The tragedy is that the government is financing it with heavy subsidies for so-called family planning groups'.

Just who are those people are that are supposed to be persuading teenagers into sexual activity? Mr. McKinney did not make this clear. The one-sided approach to this article was evidenced by the fact that the only other point of view that was presented, was a view from the Royal College of Nursing, which said that school nurses should be allowed to hand out the morning after pill to girls as young as eleven years old. This took up about four and a half lines in the final column of the article, at the very end with no attempt to put this quote in context.

Given the views advocated above by the Daily Mail and other commentators, it was no surprise that in 2000, the Mail greeted the government's proposal for sex education in schools, with the headline **'£60m to tell girls that it is ok to be a virgin'**. The article continued:

'taxpayers money to be poured into sex education to reinforce the message it is okay to be a virgin.....last night the campaign was condemned as a misguided attempt by the Blair government to interfere in matters best left to parents and teachers' (*Daily Mail*, 10/10/2000).

It is important to focus on reports such as those exemplified by the sample of excerpts presented throughout this chapter. They are often the only source of information about highly topical and emotive issues to which a significant proportion, if not the majority, of the general public have access. Consequently, as we will see later, these articles may be very effective in forming the basis of the views, attitudes and beliefs held by the general public about such issues as teenage pregnancy and lone parenthood. They play on the unfounded fears that many people have about governments using their hard-earned taxes on supporting people who do not intend to work. Public opinion, including the media, has a significant impact on political responses, as politicians from all parties strive for votes. This ultimately, as we will also see later in this chapter, has led to a reluctance on the part of successive governments to take the kind of radical action, which is necessary, but not necessarily popular with certain groups of people, to deal with the issues presented by teenage pregnancies. It is therefore not surprising that politicians become so ambivalent about these issues, which result in half hearted policy making decisions that clearly ignore available evidence.

These feature articles often make no real attempt to provide an alternative and balanced point of view. In many instances, selective reporting of statistics is used to inflame rather than to inform. They achieve this by playing on the weaknesses of official statistics, as figures are presented without context. Statistics alone tell us very little about the underlying reasons and causes, or about differences in motives. These statistics are simply presented for their sensational and opinion forming impact. Over the years, a number of writers have highlighted the way in which the news is socially constructed. They have focused attention on the ways in which the media consistently construct, select and present what they believe to be newsworthy. In doing so, there is frequent omission of all the facts, as a consequence, they often present the public with a partial view of the world (Cohen and Young, 1973; Hall et al, 1978; Hay, 1995; Weymouth, 1998). The media therefore, 'define for the majority of the population what significant events are taking place, but, also, they offer powerful interpretations of how to understand these events' (Hall, 1980:57).

Evaluation of the political and media debates tells us that pregnant teenagers and other lone parents are frequently referred to as one homogenous group, with no attempts made to explore fundamental and motivational differences between teenagers of different ages who become pregnant. Macintyre and Cunningham-Burley sum this up very well in stating that:

‘Commentators often conflate aspects of teenage pregnancy that are analytically and empirically distinct, such as chronological age, marital status and the planned or wanted nature of the pregnancy’(Macintyre and Cunningham-Burley, 1992:61)

Research presented in the literature review chapter has shown that the experience of becoming pregnant would be very different for a fourteen-year-old than it would be for an eighteen-year-old. These differences have to be taken into consideration, both in evaluating the impact of teenage pregnancy and in devising strategies to meet the identified needs of these teenagers.

It was no surprise that the media relished in the coverage of such political speeches, and their own portrayal of teenage pregnancy as a burden on the financial resources of the state. They had already established an impressive record of scapegoating other groups. For example, the 1970s witnessed a burst of ‘scroungermania’ by the press in general, and the popular press in particular. As Golding & Middleton remarked in 1978:

‘The floodgates were open in July, with the trial and conviction of Derek Deevy, a 42 year old unemployed Liverpudlian found guilty of obtaining Social security by deception. This was the case that launched a thousand clippings. Dubbed ‘king con’ by the *Daily Express*, Deevy’s opulent lifestyle..... and his evident industrious guile in perpetrating fraud, came to represent for the press the clinching proof of widespread abuse of social security. The trial and its reporting crystallised many of the themes of the subsequent anti-welfare frenzy. The generous level of benefits, the erosion of the work incentives, the firm suspicion that Deevy was but one of an untold host of similar miscreants,..... the unjust burden on the ordinary tax paying population’ (Golding & Middleton, 1978:195).

This is not to deny the existence of welfare fraud, what is in contention here is the overly sensationalized, exaggerated and one-sided approach to the coverage of such issues by the popular press. Two decades later, as we have seen, many of these themes are still used to form the basis of coverage and public opinion on teenage pregnancy.

Do teenage pregnancies lead to a culture of dependency on the state?

There are a number of factors that some observers may take as validation of a very strong link between teenage pregnancy and welfare dependency. These factors include the high rates of teenage pregnancy in the United Kingdom, and research evidence that suggests that the majority of lone teenage mothers claim income support (Bottling et. al, 1998). Additionally, as Burghes & Brown (1995) argue, the fact that the majority of lone mothers who are in receipt of welfare benefits in the UK are not teenagers, is seen as irrelevant, as the problem begins in the teenage years, when half of these mothers had their children before the age of twenty. Some researchers in the United States have also reported that teenagers with a repeat pregnancy were more likely to be receiving welfare assistance than those teenagers who avoided a subsequent pregnancy (Polit & Kahn, 1986). It is not too difficult to see why this should be the case, as a repeat pregnancy further restricts a teenager's chances of becoming independent of state assistance, particularly if there is a lack of support for these young women to become independent. Noteworthy however, are the findings of other researchers that some teenagers in receipt of welfare benefits took more care than those teenagers not in receipt of welfare benefits to prevent further pregnancies, and were less likely to have rapid repeat pregnancies (Presser & Salsberg, 1975; Furstenberg, 1976a;). These findings are entirely plausible, and I would argue that after experiencing the difficulties of early parenthood, and having to manage with the relatively meagre amounts of such benefits, this would be a very powerful incentive for some teenagers to avoid further pregnancies and dependence on state assistance. However, as we will see from the evidence in relation to repeat pregnancies in the literature review chapter, this is not always the case.

A substantial number of research studies dating back to the 1970s have found no evidence to support the hypothesis that availability of welfare benefits encourage and create a culture of dependency, or contribute to the rise in the birth rates among unmarried teenagers (Presser & Salsberg, 1975; Moore & Caldwell, 1977; Ellwood & Bane, 1984; Ozawa, 1989;). More recently, research conducted in 1998 in the UK further challenges the link between teenage pregnancy and welfare dependency. These researchers found no evidence to support the view that teenagers deliberately make themselves pregnant in order to become eligible

for welfare benefits. For example, of a sample of 84 young women aged 16-19 at the time of their pregnancy, the researchers found that the majority of the young women interviewed, had not planned to become pregnant. Over half said that they were not aware that having a baby would make them eligible to claim benefits. Although some women had knowledge of benefit entitlements prior to becoming pregnant, they did not have detailed knowledge about the benefits to which they may be entitled (Allen, & Dowling, 1998). Similarly, research commissioned by the Health Education Authority in 1999 found 'no evidence to suggest that young women were deliberately becoming pregnant simply in order to get welfare benefits or access social housing' (HEA, 1999:3). Some international studies also point to the fact that other social and economic factors play a larger contributory role to the rate of teenage pregnancies than availability of state benefits. For example, Jones et al (1996), in their study on teenage pregnancy in industrialized countries, found four key factors in countries with low rates of teenage pregnancies; an open attitude about sex; easy access to contraception; per capita spending on education and equality of income distribution.

Despite these findings however, unsubstantiated claims persist, and have either directly, or indirectly, led to failure on the part of successive governments in the UK to take appropriate action to reduce the rate of teenage pregnancy. As a result of this prolonged preoccupation with the theme of welfare dependency, successive governments have to varying degrees, focused on a number of return-to-work initiatives, with relatively little attention to strategies aimed at preventing early teenage pregnancy.

What has been the impact of this sustained media coverage and political debate on teenage pregnancy policy development and execution?

Over a period of many years, the Department of Health has repeatedly commissioned studies on teenage pregnancies, in an attempt to assess the true extent of what has been seen as a growing social and moral problem. Given the consistently high rates of teenage pregnancy in the UK, it would be feasible to argue that the successive government initiatives and programmes referred to in the previous section, have not gone far enough to address the identified issues. This chapter is therefore forced to conclude that for many years, there has been little evidence of a strong determination, beyond the point of rhetoric on the part of successive governments to act on the recommendations from these reports and

other research. One very clear example is the case of sex education. There have been mixed views about the effectiveness of sex education in schools.

Nevertheless, as the literature review chapter will show, a significant number of research studies suggest that a well executed approach to sex education can have a positive effect on reducing the rate of teenage pregnancies. Despite this evidence however, it is disheartening to also see evidence from research that shows that teenagers have almost unanimously pointed to the inadequacy of sex education provision in schools throughout the U.K. This inadequacy, as we will see, is largely the result of poorly conceived and contradictory legislation and government policy guidelines related to sex education and other teenage pregnancy strategies.

We only have to look at examples from countries such as the Netherlands for evidence of the vital role that governments can play in reducing the rate of teenage pregnancies. For example, Francis (1994:30) states:

'During the 1960s, the Dutch Government became concerned about the country's ability to sustain its rapidly rising population. At the same time, there was a long political struggle over legalising abortion. To deal with these two issues, the government developed a very effective policy of prevention of pregnancy during the 1970s. The Dutch Government remained committed to family planning in the 1990s'.

In addition, as Polly Toynbee of the *Guardian* reports, the Dutch government reduced the rate of pregnancy by a 'vigorous public strategy' of openness with young people about sex, with easy access to well advertised confidential clinics. As a result, the average age of first sexual encounter has gone up, not down as critics of this approach had expected (*The Guardian* 28/8/98). There is no doubt that the Dutch approach is markedly opposite to a British approach. As one of the few balanced newspaper articles on sex education states:

'When AIDS first became a reality in Britain, the British government put out mysterious ads showing icebergs, while the Dutch television demonstrated how to use a condom on prime time family television' (Tony Sheldon, *Guardian* 11/2/1998).

In the same article, a very enlightening account of a Dutch sex education class in operation was provided, which also showed a marked contrast to the British approach. As Sheldon states:

'I sat at the back of the class and listened in amazement as 14 year olds talked about sex. Not giggly or shy, just plain talking – about masturbation, penis size, abuse, homosexuality, AIDS, condoms, marriage, the coil and sperm'.

In case British critics respond by saying that this sort of open talk about sex encourages early sexual activity, the article continued, 'They also talked of choice, responsibility, self protection, power and love.'

This open attitude to sex education has been endorsed by Michael Carrera, a New York expert on adolescent sexuality, who when quoted in a *Sunday Times* newspaper feature article, remarked in relation to the United States:

'there is still a tremendous level of confusion, or resistance in understanding that giving children open and honest and non moralising information about sex, is not the same as encouraging or recommending it' (Carrera, cited in Allen-Mill's article- *The Sunday Times*, 12/1/1997).

For many years since 1993, Britain's approach to sex education in schools, can clearly be seen in the amendment of the Education Act 1993 and the 1994 Guidelines on sex education in schools. These documents show that since September 1994, maintained secondary schools are required by law to make provision for sex education for all registered pupils. However, it also allows parents the right to withdraw their children from sex education, except from those parts that are within the National Curriculum. This seriously undermines the entitlement of all school age children to the type of education that prepares them for life as required by the Education Act 1988. In an age when sexually transmitted diseases are no longer just a case of embarrassment and discomfort to those afflicted, but become a matter of life and death, it is important that such an education should include potentially life-saving information about sexuality, relationships and sexually transmitted diseases including HIV & AIDS. Instead Section 241 of the Education Act, 1993 also removed human sexuality and its effects on HIV & AIDS from the National Curriculum in Science. The fact that schools may provide the only opportunity for many young people to obtain reliable advice about contraceptives, HIV & AIDS was ignored or not deemed to be relevant.

There is an inherent contradiction and lack of firm commitment to sex education on the part of a government, which makes sex education compulsory by law, and at the same time, a discrete part of the secondary curriculum, which is not tied to the National Curriculum. This is even more confusing as this amendment came two years after the Health of the Nation targets were set to reduce teenage pregnancy.

There is evidence to suggest that the Conservative government at that time, ignored repeated advice from professional bodies, not to allow parents the right to withdraw their children from sex education. One example of this, was in 1994 when the public health doctors passed a resolution warning that the guidelines would not promote the health of school children. In addition, they would run counter to the government's Health of the Nation strategy, aiming to curb teenage pregnancy and the spread of AIDS (*The Guardian*, 15/6/1994).

The contradictions between rhetoric and policy action become further evident, when we turn our attention to Primary schools in England, we see that for many years they have been required by law to have a policy on sex education, though this does not mean that they are compelled to teach it. In this regard, the policy may be that sex education would not be taught. The result of this lack of firm direction on the part of government, as this quote from the Social Exclusion Unit report shows, is that:

'In primary schools, practice seems to vary widely. Some schools do nothing, with the result that girls start their periods with no idea what is happening to them, and a very small minority become sexually active before they have received any sex education at all' (Social Exclusion Unit Report, 1999:39)

In the 1994 guidance issued to schools, a number of points about process and factors that schools should bear in mind when designing their policies were made. The guidance did not go as far as to advise what is considered appropriate at what age to include in sex education. Consequently, for many years, it has been left to the governing bodies of primary schools to decide 'whether their schools should provide sex education and if so, what it should consist of' (Dept. of Education and Science Circular number 5/94). In addition, the guidelines distinguished between individual counselling and advice and general education and sexual matters. This distinction was made because it was considered inappropriate for teachers to advise children under sixteen years about contraceptives, because sexual intercourse is unlawful for under-sixteens. Teachers approached by under-sixteens for advice should emphasise the 'moral and physical risks', and the unlawfulness of their conduct. They should be encouraged to talk to their parents, and where necessary, seek advice from health services professionals. As a result of these educational policy restrictions and lack of clear direction, for many years the provision of sex education was not consistent across the country, and was

influenced by the values and views of individual headmasters and school governors. As a consequence, as Scott & Thomson (1992:132) remarked, sex education, 'remains more of a patchwork than a pattern'. These policy restrictions are yet again an indication of the ambiguous nature of public policies in relation to teenage pregnancies in the United Kingdom.

The Social Exclusion Unit's report has acknowledged the shortcomings and deficiencies of the 1994 Guidance in stating that:

'this guidance made a number of points about process and factors that schools should bear in mind in designing policies. But it had little to say about what materials or information were appropriate at what stage' (SEU:39).

In the report's action plan, a clear reference is made to fact that, 'the Government will issue new and better guidance on sex education in schools, to replace the DfEE circular 5/94' (SEU:99).

The Department for Education and Employment acting on the recommendations of the Social Exclusion Unit Report on Teenage Pregnancy has recently issued revised guidelines on 'Sex and Relationship Education Guidance' (DfEE, 0116/2000) which replace circular 5/94. Review of these guidelines shows marked improvement in rectifying some of the deficiencies highlighted by the Social Exclusion Unit Report, by being more specific about the areas that 'should be' covered in sex and relationship education at both primary and secondary levels. However, in the final analysis much is still left to:

'the governing body (including heads of schools) in consultation with parents... to develop policies (including the content) which reflect the parents' wishes and the community they serve' (DfEE, 0116/2000:4).

I would question the wisdom of this decision for two reasons. Sex education in the United Kingdom still remains highly controversial. A diverse range of views about the rights and wrongs of sex education are still prevalent in various communities which school governors represent. These are some of the factors that restricted effective sex education in schools during the last decade and I see no current evidence to suggest that the views of community representatives such as school governors, have altered significantly. In the final analysis, therefore, it is likely that the current situation of widespread inconsistencies and wide variations in policies and content in relation to sex education, will remain largely unchanged.

Another gap in the recommendations is the failure to remove the right accorded to parents to withdraw their children from sex education. This failure persists despite all the available research evidence, including that presented in the Social Exclusion Unit Report, which shows that parents are often reluctant, or embarrassed to talk to their children openly about sex, and that young people are reluctant to approach their parents about sex. In addition, research shows that 96 per cent of parents and 95 per cent of teenagers felt that schools should play the main role in providing information about sex (Allen, 1987). The government however, intends to take no action to prevent parents from withdrawing their children from Sex and Relationship Education because:

'removal of the right of parents to withdraw their children from sex education would require a change in legislation, which is not currently being considered' (Social Exclusion Unit Report, 1999:39).

If as a nation we consider that children have a right to sex and relationship education as part of their overall educational development, we must demonstrate conviction to that commitment regardless of how unpopular this action may appear to the minority. Consequently, there should be no right to withdraw, as is the case with many of our European neighbours mentioned in the Social Exclusion Unit's Report, such as Germany, France, The Netherlands, Sweden, Denmark, Portugal, Spain. Many of whom as Figure 1 shows, have much greater success in reducing the rate of teenage pregnancies. I fully appreciate that this is not an easy issue to resolve. Britain is a multi-cultural, multi-ethnic society with a powerful role played by the established church and other religious denominations. These churches have not been reticent in expressing their views about social and educational matters. This is clearly evidenced by the churches' opposition to the current government's attempts to repeal the controversial section 28 of the Local Government Act 1988 ruling, which bans local authorities from promoting homosexuality. There is however, abundant evidence to suggest that a problem does not go away simply by ignoring it. What the Social Exclusion Unit's recommendations have unwisely done is to put off the issue rather than address it.

The new guidance states that for parents who withdraw their children:

'schools should make alternative arrangements..... The DfEE will offer schools a standard pack of information for parents who withdraw their children from sex and relationship education'.

Whether such parents will make use of this pack when it becomes available, will depend on their reasons for withdrawal in the first place. What impact the loss of opportunities to enter into meaningful dialogue with their peers in a classroom setting and the opportunities to consider different views and to respect difference, will have on those children who have been removed, remains to be seen. My beliefs in the rights of the child have led me to argue that a strict condition of issuing a pack to such parents should be that they provide proof that the pack has been used, or that their children are receiving comparable sex education outside the school.

There is also a significant gap in the new guidelines in relation to primary schools. The Guidance acknowledges that 'children..... need to know about puberty before they experience the onset of physical changes' (DfEE, 2000:9). Notwithstanding, the guidance places more emphasis on the teaching of facts 'related to puberty' and 'how a baby is conceived and born' in the 'transition year before moving to secondary school'. In practice, this is likely to mean that sex education in primary schools will not begin in earnest until about the age of 10 or 11. This takes little account of the fact that for many children, puberty can be as early as 9 years or younger. By this time, children would have picked up a lot of information about sex, and much of this information is wrong (Barnado's 1992). The recent newspaper headlines about 12 year-old girls becoming mothers provide evidence of the need for sex education to start much earlier. Research evidence also supports the need for sex education to start as early as possible (National Curriculum Council, 1990; National AIDS Trust, 1991).

Critics who point out that in spite of more than thirty years of access to contraceptives and sex education in schools, we still have high rates of teenage pregnancies in Britain, should also take the time to examine and evaluate the controversies surrounding the policies and practices relating to sex education in British schools. They should include in this evaluation, the restrictions imposed by legislation, the inadequacies of successive policies, the reality of what has up to now, constituted sex education in British schools, and the obstacles to effective contraceptive use which the numerous research studies quoted in the literature review chapter show.

Over the last few years, there have been growing concerns expressed about the high rate of pregnancies among teenagers who have been in care. For example, research shows that between 1 in 4 and 1 in 7 young women leaving care at the age of 18 is either a mother, or is pregnant (Rickford, 1992). Recently, these concerns were confirmed by the Social Exclusion Unit's report that states:

'Children in care or leaving care, have repeatedly been shown to be at higher risk of teenage pregnancy. Studies of the 1958 UK birth cohort found that women who have been in care or fostered, were nearly two and a half times more likely than those brought up with both their natural parents to become teenage mothers. For a more recent generation one survey showed that a quarter of care leavers had a child by age sixteen, and nearly all were mothers within 18-24 months after leaving care' (Social Exclusion Unit Report, 1999:17).

Despite these concerns, there has been no clear cut indication or direction from the Ministry of Health of successive governments, which would make social workers and other care staff responsible for caring for children in care, feel more confident about talking to children about sexual matters, including the prevention of unwanted pregnancies and sexually transmitted diseases. Social workers discussing sex and sexuality with young people in care are governed by the aforementioned contradictory legal framework- Section 28 of The Local Government Act 1988. This has often led to confusion among staff who are uncertain about what constitutes promotion of homosexuality. The consequence is that, many residential social work staff are either reluctant or scared to talk to children in their care openly about sex and sexuality. This is likely to inadvertently have an impact on the high numbers of teenagers who have been in care becoming pregnant.

Many local authorities have produced guidelines for staff in response to section 28. Additionally, the Children Act 1989 guidance Volume 47.48 states that young people leaving care have a right to sex education. In practice, however, many social workers lack the necessary training that would enable them to provide this service effectively (Sex Education Forum, 1998). Research on young people in public care, found that there was no policy on training for carers to carry out work in relation to sexual development, contraception and relationships in 11 local authorities. In addition, there was 'a general absence of policies relating to sexual behaviour and the provision of contraception for looked after young people'. (Corlyon & McGuire, 1997:34). The Social Exclusion Unit's report in its action plan states that the:

'DH and DfEE will produce joint guidance for social workers and youth workers that makes it clear that they can and should direct young people to seek advice and contraception, if it appears that they are contemplating sexual activity or are sexually active' (Social Exclusion Unit Report, 1999:98).

This was due to be issued in 2000, however in the 'Implementation of the Teenage Pregnancy Strategy Progress Report' from the Department of Health March 2001, there was no mention of any action being taken so far.

The proposed guidance quoted above, still falls short of addressing the concerns of social care workers. While it makes clear that they 'can and should direct young people to seek advice and contraception'. It ignores the fact that local authorities are corporate parents, and in this role they are obliged to ensure that young people in their care have access to effective sex education. Young people in care suffer many disruptions such as frequent moves and these increase the possibility that they would miss out on sex education at school (Corlyon & McGuire, (1997). Care workers acting in loco parentis, therefore urgently need clear guidelines and training in talking to young people about sex and relationships. This would help to remove some of their current uncertainties, and would empower them to be able to discuss such issues as they confront them on a daily basis, in a responsible and confident way with the children in their care.

Was this intensive political and media justified?

The welfare dependency claim has not been substantiated by research evidence. In addition, as the literature review chapter will show, many of the adverse consequences that have been associated with teenage pregnancies are also partial causes of teenage pregnancy that require action from governments. For example, as Upchurch & McCarthy (1990) state, lack of vocational opportunities and educational failures, are among the factors which research has clearly shown to be contributory factors to early teen pregnancies and the subsequent disadvantages (including repeat pregnancies). Factors that encourage early pregnancy and childbearing and also amplify its disadvantages do reflect societal failures and require societal responses, not scapegoating. As some researchers have argued, part of the weakness in the portrayal of teenage pregnancy as problematic, relates to the fact that there has been lack of agreement and clarity about the extent of the problem of teenage pregnancy. This has been summed up

very well by Rhode & Lawson in relation to the United States, but also applies to the UK, when they state:

'the issue has prompted growing concern, but no coherent policy. Much of the problem arises from lack of consensus about what the problem actually is. Is the primary issue morality, fertility or poverty? What makes early childbearing problematic? For whom? Under what circumstances? Should public policy focus largely on pregnancy prevention? Alternatively, should the goal be expanding adolescents' capacity for reproductive choice and reducing the disadvantages that some choices entail? (Rhode & Lawson, 1993:1)

It is also not clear to what extent the difficulties experienced by the children of teenage mothers are attributed to inadequate teenage parenting, rather than to socio-economic status (Furstenberg et al, 1986). Therefore as Lawson & Rhode (1993:11) further state:

'too much blame has been placed at the individual level, on teenagers who want too much too soon in sexual relationships'. Consequently, 'inadequate attention has focused on the societal level, on institutions that offer too little too late – too little birth control and prenatal assistance, too little reason to complete school, and too few opportunities for childcare and meaningful employment'.

These are just some of the questions that require answers and effective policy responses, not panic. Therefore no justification can be found for the type of coverage of teenage pregnancy by the popular press and the exaggerated political rhetoric which was so prevalent during the last two decades. The moralistic tenor of political, media and public debate has not contributed to the solution of a reduction of high rates of teenage pregnancies. Its only conceivable end result, as Burghes and Roberts (1995) point out, was to increase the level of social stigma which all lone parents, including teenage parents, experienced. This resulted in pregnant teenagers and other lone parents gaining an image of being feckless, irresponsible and inadequate parents that has proved hard to erase throughout the years despite mounting evidence to the contrary. This ultimately results in limitations in the way that teenage pregnancy is conceptualised. If there are limitations in the understanding of the issues, it follows that there will be limitations in the strategies and practices developed to address the issues, as blaming the teenager diverts attention from the wider social, economic and political roots of the problem. It also 'underscores the cultural constraints' on teenage decision-making, that is, the extent to which it is difficult to say 'no in a society that links masculinity with virility and femininity with sexual attractiveness'. It also ignores the fact that, for many teenagers from disadvantaged backgrounds, sex and childbirth are two of the few avenues available to satisfy their needs to love

and be loved (Rhode & Lawson, 1993). These issues will be explored more fully in this research.

Considerable amount of research effort has been devoted to assessing the influence of the mass media on attitude formation and opinions. The evidence for the general power of the press to affect its readers directly remains inconclusive. However, as McQuail (1969) points out, it may be that the media have little immediate impact on attitudes as commonly assessed by social scientists, but it seems likely that they have other important effects. In particular, they would seem to play a major part in defining for people what the important issues are, and the terms in which they should be discussed.

It is therefore possible to argue that these scenes that were so vigorously played out by politicians and the media, do have an impact on social policy. They frame public debate, advancing priorities and a sense of issues in a way that media researchers have termed 'agenda setting'. The impact on politicians, as we have seen in relation to sex education and contraceptives, was and is to a certain extent, to produce legislation and policies that were more effective in quietening so called popular 'outrage', than in dealing with the issues presented by teenage pregnancy. The effect was to create what McQuail (1969) refers to as 'placebo policies', which on the surface satisfies a demand for action, while avoiding attention to the real underlying problems.

The rates of teenage pregnancies vary considerably over time and culture. In many cultures, over many hundreds of years, teenage pregnancy and childbirth have been viewed as a normal reproductive pattern and current levels are by no means unprecedented. For example, between 1960 and 1985, teenage sexual activity and rates of pregnancy rose, but the rates of teenage childbearing declined, mainly as a result of greater access to terminations (Brook Advisory Centres, 1994). In spite of the fact that in recent years pregnancy among younger teenagers has risen, they account for only a small percentage of the total rates of teenage pregnancies. A significant number of teenage births occur in the 18-19 age group, an age group that cannot be exactly viewed as children. In addition, not all the disadvantages associated with teenage pregnancy are as pervasive or permanent as is sometimes assumed. Numerous newspaper reports and political speeches consistently paint a picture of doom and gloom, but what does the available evidence suggest? There is no disputing the research evidence

provided in chapter two that suggests that there is some link between social and economic disadvantage and early childbearing. What is less clear however, is the extent of this disadvantage.

As Furstenberg et al (1986) state, the accuracy of this picture of gloom can be challenged on several fronts. Firstly, there has been a failure by researchers to reach a consensus on the outcomes of such pregnancies. Secondly, there has been growing evidence to suggest that a substantial number of teenage mothers do manage to break out of the cycle, either as a result of intervention from the state, and/or family support, or as a result of their own determination and sense of goal orientation. The vast majority of teenage mothers eventually triumph over adversity. They complete their education, secure gainful employment and contrary to popular belief, avoid long term welfare dependency. Furthermore, two-thirds of their children have completed high school, or were close to doing so at the time the study was conducted. Three quarters of them did not repeat the cycle of becoming teenage parents themselves (Furstenberg, Brooks-Gunn & Morgan, 1986).

It appears therefore, as Rhode (1993) argues, that this intensive coverage of teenage pregnancy and the sense of crisis generated as a result, have less to do with the rate of conceptions and births to teenage mothers. It is more related to the socio-economic context in which these births and conceptions occur, as well as the societal norms and cultural ideology that they challenge.

One of the worst consequences of this media coverage has been to intimidate schools, health professionals and senior politicians to such an extent that they fail, or are afraid to act positively and decisively on the recommendations from research. This includes effective sex education in schools and well-advertised contraceptive services for young people. It also leads to failure to act on recommendations which stem from research reports which look at other countries in Europe that have had proven success in reducing the rate of teenage pregnancies. As we have seen, there are numerous examples of the negative impact of the media's portrayal of teenage pregnancies to justify this claim. In addition, in the summer of 1998, the Family Planning Association was pilloried in the media for daring to challenge people to talk about sex during Sexual Health Week. Another example comes from the Social Exclusion Unit's report which states:

'Many of those (schools) involved in Sex and Relationships Education are concerned that those who are innovative would become the subject of unwelcome media attention. Several school heads said that although they were proud of the quality of their schools' SRE, they did not want, for this reason and because of the possible reaction from parents, to become known as 'good schools' for sex education (Social Exclusion Unit, 1999:40).

The actions of the media could also be said to have had a negative impact on health care workers – doctors and nurses, in relation to talking to young people about sex and pregnancy prevention. One example of this is the school nurse, in Leeds in 1994 who attracted front-page newspaper coverage when she answered frankly, a young boy's question about what a 'mars bar party' was. The attack by the press was so forceful that it effectively frightened other school nurses into silence. This resulted in a wall of unhelpful and unproductive silence by many professionals, while the rate of unwanted teenage pregnancy soars.

Significant amounts of research have been done about teenage pregnancy. These studies have often made recommendations. Successive governments have expressed commitment to tackle the rate of teenage pregnancies as evidenced by targets set by the former Conservative government's Health of the Nation White Paper and the current government's Social Exclusion Unit's investigation into teenage pregnancy in the United Kingdom. In view of all this activity, this chapter revisits the question asked earlier, why does Britain continue to have the highest rate of teenage pregnancy in Europe? I would argue that the problem is not due to lack of knowledge about the issues involved in teenage pregnancies. Rather there is evidence to suggest that the problem stems from government apathy (including lack of funding), but also to an atmosphere of general tentativeness on the part of educationalists as a result of a lack of courage on the part of government to act on recommendations made by research. This lack of courage is due to a persistent reluctance to offend a tiny, but vociferous and often powerful minority in politics, the church, the press and the public, as has been so far shown in relation to sex education in this country.

There is evidence to suggest that when governments are prepared to take well-informed action, the outcome has been encouraging. For example, while it is true that the number of under sixteen-year-olds engaging in sexual activity increased during the last two decades, the rate of teenage pregnancy fell sharply in the UK during the 1970s, down to 56 conceptions per 1000 women aged fifteen to

nineteen in 1983 (Babb, 1993). This fall in the rate of teenage pregnancy coincided with the period when contraceptives became free to all under the NHS Reorganisation Act (1974). Contraceptive clinics were opened and contraception and abortion became easier to obtain. During this period government also advised health authorities to set up separate, informal services to advise young people, and the DHSS clarified that it was quite lawful for doctors to provide contraceptives to under-16s without telling their parents (Brook Advisory Centres, 1994). What is worthy of note however, is the fact that the numbers increased again in the 1980s, reaching a level of 69 conceptions per 1000 women in 1990 (Babb, 1993). These increases coincided with the Conservative government's cut of contraceptive clinics for the young, and also with issues surrounding confidentiality which were triggered by the 1984 Appeal Court (Gillick vs DHSS) decision, prohibiting doctors from giving under 16s contraception without parental consent. This resulted in teenagers becoming afraid, or reluctant to approach their general practitioners for fear of breaches of confidentiality that might result in their parents being informed (Brook Advisory Centres, 1994). In essence, government expressed concern over the rising rates of teenage pregnancy at the same time as they proceeded to introduce policies such as restrictions in sex education, cuts to family planning services. The cost of these policy limitations is often considerable. As we will see from the literature review, restrictions on contraceptive services, only result in restriction in contraceptive use, not sex. As Lawson & Rhode argue:

'policies that require parental involvement for adolescents seeking contraception and abortion have been ill-advised. Such requirements have increased unwanted pregnancies and childbearing among those least able to cope with the consequences - teenagers who are too young unsophisticated and poor'(Lawson & Rhode, 1993:12).

Therefore as with sex education, parental consent requirements in the provision of contraceptive services, reflect political compromises for which teenagers have paid the price. This is not, as Lawson & Rhode further argue, to undervalue the need for more effective communication between parents and their children, but as experience has shown, forced communication is not the most effective way of fostering such communication.

There has been abundant evidence to suggest that teachers are perhaps not the best people to deliver the kind of sex education that young people say they need, for all the reasons that will be discussed in the literature review and other

chapters of this thesis. As a result, it has been suggested that perhaps highly trained school nurses that the students will feel able to trust, and who feel at ease in talking about sexual health, may be better suited to play a more significant part in sex education. This was not suggested to make the role of teachers redundant, but instead to complement it. In spite of this recommendation, school nursing was cut severely under the last conservative government administration. It was reported in 1999 that there are now fewer than 3,000 school nurses for 25,000 schools throughout the country. Of the 3000, many work part-time and find themselves having to cover too many schools to build effective working links with the staff and students in the schools in which they work (Poly Toynbee, *Guardian*, 16/6/1999). I have seen no evidence in the Social Exclusion Unit's Report that any action will be taken by the current government to increase the number of school nurses.

SECTION THREE

CONTEXTUALIZING TEENAGE PREGNANCY IN THE CARIBBEAN

What is the basis for the concerns relating to teenage pregnancies in the Caribbean?

As previously outlined in the introduction to this chapter, there are also concerns about the high rates of teenage pregnancy in the Caribbean. This section will be an attempt to identify the basis for these concerns. The following Table shows teenage fertility rates in the Caribbean between 1950-1990

Adolescent fertility rate (Births per 1,000 girls aged 15-19 years (source: Jagdeo 1994)*

COUNTRY	1950	1989/1990
Guyana	169	62
Belize	136	122
Suriname	182	83
Jamaica	109	119
Trinidad	169	80
Barbados	130	80
Leeward Islands	150	80
Windward Islands	150	90

As the teenage pregnancy rates shown above clearly indicate, there has been a marked decline in teenage pregnancy rates in the Caribbean between 1950 and 1990. These figures also show that teenage pregnancy is not a recent social phenomenon in the Caribbean. Therefore, what is the basis for current concerns? Jagdeo (1994) argues that while the rate of teenage pregnancies in the Caribbean has declined, it still remains far too high. 'It is twice as high as some groups in the United States and 12 times as high as in Scandinavian countries' (Jagdeo 1993:9).

* Throughout this section, frequent references to the work of Jagdeo will be made. This is due to the fact that he is the most prolific researcher on teenage pregnancy in the Caribbean.

In a review of the literature, conference speeches and discussions with many professionals in the Caribbean, it became evident that concerns about teenage pregnancy are often expressed in terms of the impact of teenage pregnancy upon the individual's social, economic and personal development. There is no doubt that these social and economic costs are extremely high for young women in the Caribbean as pregnancy often means the curtailment of educational opportunities. In a region with very limited economic resources, where economic advancement is so closely dependent on educational achievement, an interrupted education often exacerbates already poor and uncertain economic conditions. This can set in motion a definite cycle of 'intergenerational transmission' of poverty (Kurtz et al 1995). Of particular relevance to this research, is the fact that in such situations, early childbearing often leads to repeated pregnancies, which put these young women at risk for low and undesirable standards of living (Singh & Wulf 1990).

There are additional elements of concern related to teenage pregnancy in the Caribbean, which have held the attention of governments and professionals in the Caribbean for several decades. Jagdeo summarises these concerns when he argues that:

'The populations in the Caribbean are quite young and, unless there are compensating fertility declines among older women, rising levels of teenage pregnancy will shift the age structure further in this direction. This, in turn, will create demands for public services to serve the needs of young populations..... Planners, then will be faced with the following dilemmas: whether to respond to the short-term goals of maintaining existing unsatisfactory quality of life indexes by meeting immediate adolescent and child care needs or to invest in the kinds of capital generating projects that would guarantee a better quality of life in the future. Caribbean governments cannot do both' (Jagdeo 1984: 15).

Alongside concerns about the rate of teenage pregnancies, concern is also expressed about its causes (Chevannes 1993). It is therefore not surprising that like many other countries in the world, which have concerns about teenage pregnancy, a great deal of effort is spent on identifying the causes and outcomes of teenage pregnancies for the young women of the Caribbean. Many of these causes have been discussed in the literature review. Indeed many of the causes of teenage pregnancies identified by researchers and professionals in the Caribbean are no different from the causes of teenage pregnancies identified in other countries in the world. For example, the Caribbean literature shows that variables such as: peer pressure, low self esteem, poor parent/child relationships

and communications, lack of understanding and use of contraceptives, lack of sex education, school drop-out, sexual abuse etc have been frequently linked to teenage pregnancies in the region (Brody, 1981; Chevannes, 1983; Aymer & Pichery, 1993a & b; Jagdeo, 1984, 1986, 1994; Contraceptive Prevalence Survey, 1993). Therefore, I will not attempt to discuss all of these variables in this section, as they have been covered extensively in the literature review. However, in an attempt to complete the third task previously outlined, that is, to identify the issues that I believe are often absent from these discourses, I will elaborate on some of these causes with special reference to the Caribbean, in the final part of this section.

Accounting for different media and political responses in the Caribbean

Numerically, as the previous section shows, there is a problem in relation to high rates of teenage pregnancies in the Caribbean. Yet these concerns have not attracted a comparable level of political and media scrutiny and discourses seen in the United Kingdom. Several factors might explain this markedly different emphasis on the expression of the concerns relating to teenage pregnancy in the Caribbean. Among these are:

- (1) As we have seen in section two of this chapter, concerns about teenage pregnancy in the United Kingdom and the United States of America have focused almost exclusively and for the most part unhelpfully, on the central theme of welfare dependency. We have also seen evidence to suggest that the driving force behind this intense level of scrutiny in the United Kingdom has been a concern with levels of welfare expenditure for lone parents, including teenage parents. However there is little or no welfare benefit provision for pregnant teenagers in the Caribbean. For example, in Barbados:

'there is no child benefit paid as of right. Any person having custody of a child who is unemployed with no other means of support can apply to the Welfare Department which can provide national assistance to those in need, including children. There is no legal poverty line below which it is mandatory to give support and payments are discretionary' (Clift 1997:14).

The amounts of benefit paid in the above circumstances is very low i.e. the equivalent of about £9 per week, in a country where the cost of living is very high. Similarly in Jamaica:

'there is no child benefit paid as of right and no general unemployment benefit. The poorest members of society can obtain food coupons under the provisions of Government Poverty Alleviation schemes or from the National Insurance Fund'. (King 1997:51)

These coupons are worth \$500 Jamaican dollars per week, the equivalent of about £7.20, and the cost of living is also very high.

This absence of, or very small amounts of welfare benefits, removes the impetus for a similar focus on public expenditure to maintain lone parents by politicians and the media in the Caribbean.

(2) In the Caribbean, for many years, services in relation to teenage pregnancy prevention and management have been provided by a mixture of public sector institutions, non-government organisations – primarily family planning organisations, as well as other organisations. These services include direct service delivery such as those that attempt to intervene before major problems arise. They focus on adolescent health and development, the teaching of life skills, the prevention of unintended pregnancies and sexually transmitted diseases. Other agencies provide services to teenagers in crisis situations, which include unintended teenage pregnancies, rape and domestic violence. Some services focus on helping teenage mothers, their partners and their families by the provision of support, guidance, counselling and educational skills etc (Kurtz et al 1995). This mix of service provision has the impact of reducing the burden of expenditure on the public purse, because these non-governmental organisations often rely on donations from international agencies and other private sector sources for the majority of their funding (Kurtz et al 1995). This in turn, results in far less political and media scrutiny in relation to teenage pregnancy expenditure, than is the case in the United Kingdom and the United States.

(3) While governments and other non-governmental agencies in the Caribbean have repeatedly expressed concerns about teenage pregnancies at a national level, there is also in existence at the community level, an element of unexpressed ambivalence in relation to these concerns about teenage pregnancy. For example, at a local community level, there are undoubtedly concerns about teenage fertility among parents and others in the Caribbean. As Maughn (1994:14) states: 'the pregnancy of a teenager can have a traumatic effect on the family. There is much gossip, village talk, and scorn for the family. The result is much

embarrassment, especially if the family is well respected in the community'. Similarly, Jagdeo (1984) in discussing the issue of how parents deal with the news that their teenage daughter is pregnant, points out that in general terms, most parents disapprove of teenage pregnancy. He further points out that 'this disapproval is expressed in terms of disappointment, anger, verbal and physical abuse, expulsion from the home and sometimes a tired sense of *deja-vu*' (Jagdeo 1984:76). Despite these responses, at another level however, within the same communities there is evidence to suggest that there is a lesser degree of outrage and condemnation about teenage pregnancy than that which exists at government and professional levels. This inevitably results in a greater degree of acceptance of these pregnancies. Jagdeo further endorses this view when he states:

'The community does not penalise teenage parents in any way. Indeed, teenage sexual activity and pregnancy have become very much part of the mores of the working class community, and although people do remark unfavourably upon the 'rising' levels in teenage pregnancy; this takes the form of gossip as an information sharing rather than as a social control device' (Jagdeo 1984:129).

What factors might account for this reduced degree of outrage and greater acceptance? For a number of historical and contemporary reasons, there is a well-established pattern of early pregnancies in the Caribbean as evidenced by statistics that have been provided earlier. It is frequently the case that an inter-generational cycle of early pregnancies exists, where the mothers of pregnant teenagers were themselves pregnant teenagers; hence the sense of *deja-vu* among some parents referred to earlier. Therefore, 'although the mothers of these girls shower recriminations on them when they become pregnant, the girls can frequently point accusatory fingers at their mothers, their elder sisters, aunts, and neighbours' (Jagdeo 1994:9). In addition, as Jagdeo (1984:37) further argued:

'Very simply, parents cannot be credible enforcers of social standards that they themselves have failed to meet. As a result, adolescents seldom experience psychological stresses of guilt and failure when they become pregnant early and out of wedlock largely because these occurrences are immediately interpretable as continuous with current community and family patterns. They have simply conformed'.

In view of these factors, the potential and scope for politicians and the media (who are themselves members of these communities) to generate a sense of moral panic in the wider society as is the case in the United Kingdom becomes considerably weakened. However, what is important to note here are the long-term implications of the differences in the conceptualisation of the problem of

teenage pregnancy at a national and at a local level. If this dual level of concern is allowed to remain, and a common consensus about the nature of the problem is not reached, the possibility of achieving lasting change remains a distant goal. This point is clearly illustrated by C Wright Mills' concepts of 'public issues' and 'private troubles' when he points out that in every society there are 'public issues' and 'private troubles'. Public issues are the social problems recognised by society as requiring public responses. Private troubles are the problems experienced by individuals in a private context. Wright Mills argued that 'many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues' (Wright Mills 1959:226). Therefore, until a point of understanding between the public issues and private troubles is reached, and these private troubles are reconstructed into public issues that the state sees as its responsibility, a public response will not occur. In translating these concepts to the Caribbean, there is therefore an urgent need for a point of consensus to be reached both at a national and at a local level about the nature of the problem. This is in order to facilitate further progress in the fight against high rates of teenage pregnancies in the region.

A brief look at the family structure in many Caribbean societies also helps to explain this often unspoken level of acceptance among some communities. The literature on the family structure in the Caribbean consistently shows that there are similarities in the organisation of the family in countries like Jamaica, Barbados and other islands in the English speaking Caribbean. Therefore, no distinctions will be made between the islands of Jamaica and Barbados. Although, like in other societies, family structures and 'mating patterns' often vary, teenage sexual activity appears to be heavily associated with a prevalent, though not dominant, form of family structure or pattern in the Caribbean. This is a very low-income family in which the mother heads the household and often works full time outside the home (Kurtz et al 1995). This is not to adversely label the existence of single parent families. Throughout the world (including the Caribbean) single parent families are on the increase. There is growing evidence to suggest that despite the inherent difficulties, many of these families do a very good job of raising their children. However, it is the circumstances surrounding many single parent families in the Caribbean that have been reported to have some clear links with teenage childbearing and this level of community acceptance. It is important to note here that all of the existing literature on teenage pregnancy in the Caribbean makes no reference to class differences,

both in terms of the rate and response to teenage pregnancy. It is therefore not possible to comment on class differences in this section.

Throughout the Caribbean though marriage is seen as the ideal family pattern, there is nevertheless, the now well-documented phenomenon of the 'visiting union' as a distinct family pattern which evidence suggests, can be traced back to the days of slavery in the Caribbean*. The term 'visiting union' is used in situations where:

'unwed couples, living in separate households, establish relationships which include regular rights of sexual access but where the rights and responsibilities associated with the issue of such unions are ill-defined, and more often than not, are shouldered by the mother. It is not uncommon for a woman to have a series of such relationships in her life but these form a serial pattern – very much like a series of monogamous relationships – so the paternity of the issue of such unions is seldom in doubt' (Jagdeo 1984:32)

Visiting unions are distinct from 'common law unions' where the man and the woman take up common residence (Chevannes 1993). In visiting unions, even when a man is married or involved in a longstanding relationship with one woman, he may also have a steady relationship with another woman, commonly referred to as the 'outside woman' who may also bear him one or more children. To a certain extent it could be argued that visiting unions have gained an often unspoken public recognition in the Caribbean, and their legitimacy was assured after they first appeared in the 1970 census in Jamaica (Chevannes, 1993). However, as Chevannes (1993) went on to point out, although 'public recognition implies social sanction, yet, like common-law, but unlike legal marriages, its dissolution may be affected at will. This is the source of its apparent instability' (Chevannes 1993:19). Visiting unions give the male exclusive sexual rights, but no such exclusive rights exist for the female. In addition, visiting unions have a number of disadvantages for women, 'one being, the ability of the male to deny paternity or to escape its obligations' (Chevannes 1993:22)). This is in fact what happens in many cases, despite the legal requirement for fathers to maintain their children. Others do support their children at first, but for a variety of reasons, later discontinue support (Clift 1997). This absence of maintenance often places added stress on

** Dechesnay (1986) points to a direct link between the effects of slavery and contemporary sexual and marital practices in the Caribbean where: 'it was definitely not to the slaveholders interest to encourage familial ties among slaves. Slave women were paid to have children because children in the labour force were the norm and slaves were not allowed to marry. The impossibility for slave couples to establish a common home formed an extra-residential mating system that is still in force today' (Dechesnay 1986:294).

the mothers of the children. In Jamaica for example, the woman is the sole breadwinner in 4 out of 10 families (King 1997), and 33% of Barbadian households are headed by women (Clift 1997).

There is no doubt about the prevalence of visiting unions in Caribbean societies. For example, data based on the 1970 census in Jamaica showed that eight or nine out of every ten females aged 15-19 years who are in a union, are in a visiting union. These figures fall markedly over the next ten years, to three or four out of ten up to age 29 years. By age 30, 30% of women are in visiting union relationships (Roberts and Sinclair (1978) cited in Chevannes 1993). Though similar information is not available in relation to the number of women in visiting unions in Barbados, it is interesting to note that 69% of Barbadians aged between 20 and 44 years have never been married (The Census Office (1990) cited in Ferguson 1997). This makes it likely that there are also high numbers of women involved in visiting relationships in Barbados. In addition, as Jagdeo (1984:32) points out: the fact that:

‘both the incidence of visiting unions and fertility rates are highest in the 15-29 year old category, reinforces the conclusion that most Caribbean children are born and experience their formative years within the context of visiting unions’.

Evidence suggests that the structure of the visiting union therefore provides the least stable context for raising and guiding children. It is inevitable that the unpredictable and insecure nature of these relationships place an inordinate amount of strain on the mother and her children. Jagdeo (1984) provides an example of ‘a typical scenario’ where:

‘Very early in her fertility career, a woman has a child with her boyfriend. For several reasons the relationship comes to an end and the man leaves abdicating both his economic and parenting obligations to his child. For a while, the young mother turns to the maternal household for support but eventually has to find another partner to meet her economic and socio-emotional needs. This places the woman on an unstable cycle of changing partners as she reaches out for a stable relationship... and in this process many women end up having several children by several men (Jagdeo 1984:32).

It is worth pointing out however, as Zalduondo & Bernard (1995) writing in relation to Haiti states, that not all men in visiting relationships are involved in multiple sexual relationships and the same observation is true for the English speaking Caribbean.

(4) The role played by the media in the Caribbean in relation to issues of public concern also throws light on the differences in approach to teenage pregnancy between the United Kingdom media and the Caribbean media. Unlike the United Kingdom, the various information media in the Caribbean have had a longstanding and well-established record of working in close co-operation and collaboration with both public sector and non-governmental organisations in health promotion and other social issues. This often takes the form of educating, promoting and informing teenagers as well as other members of the public about issues of national concern. As a result, many organisations and professionals working in the field of teenage pregnancy prevention and management readily make use of the media in getting their messages across and in disseminating information of various types. For example, family planning organisations and medical personnel often make use of facilities for live 'call-in' radio and television programmes to answer questions and to discuss issues raised by young people and other members of the community. They use television programmes to discuss and disseminate health promotion information. They also put their creative talents to the full use when they have:

'used popular entertainers to sell its messages. Traditional nursery rhymes have been altered to convey a message related to teenage pregnancy: "Jack and Jill went up the hill, and did more than fetch some water, Jack came down, is no longer around, and now Jill has a daughter" (Sargeant 1994:28).

From my search of newspapers in the Caribbean I have observed that the print media when they do report on issues like teenage pregnancy, simply confine their reports to factual information to inform and educate the public, rather than to inflame public opinion. Taking all of these interrelated and interdependent factors into consideration, it is possible to see how the scope for highly negative political and media discourses surrounding teenage pregnancies in the Caribbean becomes considerably reduced and less influential.

Having explained the reasons for the concerns in relation to teenage pregnancy in the Caribbean, and for the markedly different approach to the media and political discourses surrounding teenage pregnancy in the Caribbean, I will now move on to the final area identified at the start of this section. This will be an attempt to explore some of the missing elements in the discourses relating to teenage pregnancy in the Caribbean.

The missing discourse

In attempting this task, I am particularly mindful of the point made by Jagdeo (1994:8) that: 'addressing the issue of teenage pregnancy in the Caribbean is a difficult task made harder by the proliferation of local opinions about the causes'.

Notwithstanding this difficulty, as we have seen from the previous paragraph, the causes of teenage pregnancy in the Caribbean as identified by many professionals, researchers and agencies, almost without exception, tend to be focused very much at the level of individual pathology and blame.

What is often missing from this discourse? In many countries of the world, school dropout is often associated with teenage pregnancy. This is no less true in the Caribbean. However school dropout assumes particular significance in the Caribbean region, because of the high value placed on educational achievement for all the reasons previously discussed. I therefore wish to spend some time focusing on school dropout in the Caribbean in order to highlight one of the missing elements in the discussion in relation to teenage pregnancy. Many commentators in the Caribbean frequently identify the fact that a significant number of teenagers drop out of school because of teenage pregnancy. They also go on to state the detrimental effects of this experience. However, despite these expressed concerns, there are very few attempts to explore the causes of school dropout and address its implications. It is disheartening to discern an air of inevitability when professionals and government officials talk about the dangers of losing out on education for these teenagers, without any acknowledgement that an early pregnancy does not have to result in loss of educational opportunities. In focusing on the response from schools following school dropout, there is evidence to suggest that many schools, far from taking action to minimise the detrimental impact of school dropout, actually reinforce it. As Jagdeo points out:

'To be required to leave school because of a pregnancy – this hurts to the quick and is the single most important reason why girls fail to complete their basic education. As a matter of custom, pregnant girls in the Caribbean are turned out of school and have very few opportunities of ever returning to the school system again' (Jagdeo 1984:47).

My experience of working with pregnant teenagers in Barbados and of discussing the incidence of school dropout with many social care professionals in the Caribbean also validates Jagdeo's claim. Therefore the question that needs to be asked is: what role do the governments of Caribbean countries play in developing

policies that would ensure that young people are not prevented from returning to school following an unplanned pregnancy? Evidence shows that in most cases, it has been left to non-governmental organisations to attempt to plug this gap.

In a 'feature' address at the opening of a regional conference on teenage pregnancy, held in Barbados in March 1993, the Permanent Secretary in the Ministry of Education identified a number of risk factors linked to teenage pregnancy. These risk factors, she states, 'also include losing out on the final part of her education, and consequential lack of skills and education to seek employment' (Applewhaite 1994:5). She went on to say:

'The Education Act *in Barbados states that education is compulsory up to the age of 16 years. Thus if a girl withdrew from school because of pregnancy, she could re-enter school to continue her education. In practice however, the responsibilities attendant upon having a child make this impossible' (Applewhaite 1994:6).

Why is it impossible for young girls to return to school following an unplanned pregnancy? Given the high value placed on education to ensure economic survival, what could, and needs to be done to reverse this situation of impossibility? The issue of girls being turned out of school was not acknowledged in the Permanent Secretary's speech. Additionally, nowhere in that speech was any suggestion of any intention on the part of the government to explore and implement policies to address this problem.

Other factors that are often noticeably absent, or minimised in the teenage pregnancy discourse; are: the role that poverty plays in teenage pregnancy and, the lack of financial resources to help towards the prevention and management of teenage pregnancy. For example, nowhere in the speech mentioned above was there any acknowledgement of the role of poverty in teenage pregnancy, let alone the mention of any strategies to reduce the detrimental effects of poverty. The extent to which the impact of poverty on teenage pregnancies in the region has been minimised by professionals, researchers and government officials was clearly evident from a review of eight conference papers delivered at a regional conference on teenage pregnancy in the Caribbean. Only two of the eight speakers briefly made reference to the link between lack of financial resources and teenage pregnancy. It was interesting to note that the two speakers in

* The act referred to above is the Education Act 1983. Cap 41. S.41. In Jamaica the Education Act 1965 S. 21 also provides compulsory state education for children up to 16

question were teenage mothers themselves. One of them pointed out that: 'Teenagers engage in sexual intercourse as early as 12 years of age, becoming involved with men much older than themselves. Many do so to buy material things which their parents cannot afford' (Bridgeman 1994:11). Similarly, the other teenager stated that: 'some teenagers who are from low-income families often seek help from adult men whom they believe can help them in a situation. Many of these men take advantage of the girls who usually end up pregnant' (Turner 1994:15). Within the voices of these two teenage women are clear indications of observations made by Zalduondo & Bernard (1995), that the economic context in which people live has 'recognised significance' for sexual behaviour. Given the economic conditions that prevail in the Caribbean, the impact of these conditions on sexual and family relationships in the Caribbean therefore has to be given due attention, evaluation and action.

The issue of poverty also becomes apparent when in attempting to answer the question of why do young girls in the Caribbean become pregnant, Jagdeo further states:

'One reason relates to the family structure in many low-income situations. Not infrequently the mother of a single-parent family is away from home, perhaps selling agricultural products in a neighbouring island; the 13-16 year old girls remain at home, taking care of the household, minding the younger siblings, doing the household shopping, and assuming all the roles of mature women. They think of themselves as women, and they find themselves in situations where they have to make decisions with regard to sexual intercourse' (Jagdeo 1994:9).

These missing elements from the discourses about teenage pregnancy in the Caribbean urgently need to be acknowledged and addressed. If their importance is minimised, this can undermine and sabotage any other strategies used to address the issues posed by teenage pregnancy in the region. Fine (1988:48) sums up this point well when she points out that, attempts at:

'changing people but not structures or opportunities – which leave unchallenged an inhospitable and discriminating economy and a thoroughly impoverished child/social welfare system are inherently doomed to long-term failure.....In the absence of enhanced life options, low-income young women are likely to default to early and repeat motherhood as a source of perceived competence, significance, and pleasure'.

Another element that is frequently ignored, or not consistently addressed, in this discussion, is the role that boys, and particularly men, play in teenage pregnancies. As we have seen before, commentators often point the finger of

years.

blame for teenage pregnancies at the feet of individual young women. As a consequence, attention is often focused disproportionately at strategies such as the emphasis on abstinence, use of contraceptives, safer sex etc, with little or no acknowledgement of the very influential role and power which men can, and often do exercise over women. Additionally, these strategies often 'take little account of the barriers which young women face in attempting to put this knowledge into practice in their sexual encounters' (Holland, et al 1990:338). The connection between poverty, teenage sex and male dominance and exploitation is often not acknowledged, and requires urgent attention from the state. This is particularly relevant to the Caribbean region where situations of poverty further increase the dependency of young women on men for financial help. It has to be pointed out however, that addressing the issue of male exploitation and its links with teenage pregnancy will only be effective, if governments simultaneously address the problems presented by the absence of state benefits to help young women and their families who are experiencing poverty. The evidence in relation to the behaviour of men in visiting unions referred to earlier, provides a good example of the factors that propel young women into situations of dependency and exposure to male dominance, exploitation and abuse. There therefore needs to be an acknowledgement of the need to shift the focus on 'fragmented individual responsibility for personal behaviour change, to see safer sex as located in the context of social relationships'. In addition, 'the effectiveness of health education for women will depend on the effectiveness of health education for men' (Holland et al 1990:341).

In focusing on the role of the state, there is a need to acknowledge the economic problems faced by Caribbean governments such as capital shortages, high unemployment rates, fragile economies, externally imposed constraints on public spending. Nevertheless, a number of clear policy decisions could be made which would not entail significant increases in public expenditure. For example, throughout the Caribbean, as we have seen, education legislation is already in place to ensure educational provision for children up to the age of 16 years. There is no reason why policies should not ensure that this right is also accorded to those who become pregnant while still at school. Given the experiences of many pregnant teenagers, who have been refused re-entry into schools following an unplanned pregnancy, this will not happen however, unless there are policies in place to ensure that pregnant teenagers are allowed to return to school. At present too much is left to the discretion of individual heads of schools to decide whether or not to allow a teenage girl re-entry to school following a pregnancy.

There is already an impressive record of public/private partnerships in the Caribbean in relation to social issues. The services provided by non-governmental organisations could be extended to include the provision of crèche facilities, to allow those teenagers without family support to return to school, confident in the knowledge that their child is being well cared for. This may be difficult but certainly not impossible.

The recognition of the problems caused by teenage pregnancies has been met with service provision responses from a wide range of service providers as pointed out earlier. Judging by the prominent role played by family planning organisations throughout the region in the fight against teenage pregnancy, the emphasis on the provision of contraceptives as a means of reducing the rate of teenage pregnancy is very clear. However it has to be borne in mind that as many researchers and government officials point out, despite the efforts placed on the marketing and provision of family planning services, many teenagers 'embark on their sexual careers with considerable ignorance of matters relating to human sexuality'. In addition, 'contraceptive use among in-union adolescents is very low' (Sargeant 1994). Other researchers, such as Jagdeo (1984); Brody (1981); Chambers and Chevannes (1991), have also acknowledged this lack of knowledge about human sexuality and contraception and its link to teenage pregnancies in the Caribbean.

These concerns point us in the direction of the lack of sex education, which has been identified in the literature review as a cause of teenage pregnancy in the Caribbean, as elsewhere. Evidence is also provided of the existence of 'guidance and counselling programmes throughout schools across the Caribbean' (Applewhaite 1994:6). In addition, as the Permanent Secretary in the Ministry of Education in Barbados while addressing the issue of teenage pregnancies in the Caribbean region further remarked:

'Family Life education and training in human sexuality continue to be conducted at the regional and national level. Family Life education materials were developed and books and other materials on human sexuality were also published and distributed throughout the English-speaking Caribbean. Yet, in spite of the wealth of information gathered and programmes established over the years, teenage pregnancy continues to be of concern throughout the region'. She went on to ask: 'what are we doing wrong? What is missing in our training and counselling programmes and sessions with our students and youth?' (Applewhaite, 1994:6).

One answer may be related to the deficiencies of content, as well as lack of fit between the curriculum contents and actual delivery in the classroom. For

example, Sargeant (1994:29) points out that:

'Examination of various school curricula for family life education reveals a major emphasis on the brushing of teeth and caring for the body, but I share with others a concern that insufficient attention is paid to the issue of human sexuality: often, while it may be written into the curriculum, one finds that the issue of human sexuality is just not confronted in the classroom. I think this is because many of us have not confronted our own sexuality; we may never have had the opportunity to face certain things'

These inconsistencies between service provision and outcomes should signify to policy makers and service providers the need to regularly update and evaluate the effectiveness of the services provided, as well as the policies that are already in place. The lack of positive outcomes despite the existence of a number of varied services make a strong case for this evaluation to take place. This is particularly important in a region with scarce financial resources. Policy makers and programme providers need clear evidence of what strategies work, under what circumstances, in order to target scarce resources in a way that generates the most positive outcomes.

Also of relevance to note from a review of the literature in relation to teenage pregnancy in the region, is a lingering tendency to focus attention on abstinence messages as a form of teenage pregnancy and sexually transmitted diseases prevention. There is already enough evidence to show that such approaches are the least likely to be effective. This is particularly true in a region where, as we have seen, some of the existing family structures are conducive to high fertility rates.

It is time to accept that Caribbean teenagers like others throughout the world are sexual beings and will express their sexuality. If we accept teenage sexuality as inevitable, then we also have to accept that despite our best efforts, teenagers have and will continue to be sexually active. The number of social and economic factors in the region that often propel some teenagers into sexual activities also strengthen this point. The focus on abstinence strategies is therefore inconsistent with this acceptance of sexuality among teens. It also results in a failure to acknowledge, include and explore what Fine (1988:33) refers to as 'a discourse of desire' in the sex education curriculum. In this regard, she is referring to 'the naming of desire, pleasure, or sexual entitlement particularly for females'. The futility of this omission is further evidenced by the realisation that, 'a discourse for desire,

though absent in the official curriculum, is by no means missing from the lived experiences or commentaries of young women'. (Fine 1998:35). Therefore, facilitating this dialogue 'would invite adolescents to explore what feels good and bad, desirable and undesirable, grounded in experiences, needs and limits'. (Fine1988:33). These opportunities would ultimately empower young people to be able to think purposefully about the choices that they often have to make, which might or might not, include abstinence.

Finally, it is important to acknowledge the number of positive features that are already in existence in the Caribbean region which make Caribbean governments and service providers well placed to respond to the challenges presented by teenage pregnancies in the region. These include a strong commitment among professionals in the Caribbean to develop awareness of the needs and issues affecting teenagers, and to provide effective service responses. This commitment is evident by the established partnerships that already exist between public sector and non-governmental sector organisations. In addition, despite the lack of financial resources in the Caribbean, there is no shortage of expertise in the form of well-qualified and experienced personnel working in the field of teenage pregnancy prevention.

As we have seen, there is also already in existence in the region, a number of innovative and effective approaches to teenage pregnancy management. One notable example is the Women's Centre in Jamaica which was first set up in 1978 at one location in Kingston, and has since that time developed into a national entity with 7 main Centres and 11 outreach stations islandwide. The Centre's focus is to 'deal with the problem of interrupted education due to an early pregnancy.....and to delay subsequent pregnancies until the young woman has reached her professional or vocational goal' (Women's Centre of Jamaica Foundation, 1994). There are a number of other individual examples throughout the Caribbean. However, there needs to be greater collaboration between governments and professionals at a national, as well as at a regional level to pool scarce resources and expertise to maximum effect (Kurtz et al 1995).

CONCLUSION

As this chapter has shown, the media orchestrated a series of themes about pregnant teenagers and other lone parents that were already present to some

extent in British culture. These were amplified by particular precipitating events, notably the unprecedented attacks on pregnant teenagers and other lone parents which began in earnest with Margaret Thatcher's Pankhurst lecture, and the subsequent development and extension of the ideologies espoused in that lecture by other Conservative politicians. These attacks helped to popularise the concept of single parents as prime members of a British 'underclass'. This in turn, helped to give further prominence to the themes of 'scroungermania' that were popularised by the media in the 1950s. The political responses which followed, affirmed the dominance of these themes, by a failure to address the root issues that led to rising teenage pregnancy rates in the United Kingdom, while the structural roots of poverty and the distribution of wealth remain invisible, as economic anxieties are inevitably expressed by hostility to those affected.

As this chapter has further shown, there has been no conclusive evidence to suggest that a clear link exists between teenage pregnancy and welfare dependency. In spite of this lack of evidence, a blaming the victim strategy persisted to obsessive proportions and therefore remained at the crux of political and media responses to teenage pregnancy. To a greater extent, this strategy in turn resulted in policies that were more concerned with saving the public purse than in implementing the kind of measures that have been shown to be effective in other countries in Europe.

Tackling the problem of high rates of teenage pregnancy, requires major ideological changes to the way in which the issues are perceived and exploited. As a nation we must accept that teenagers like the rest of the population, are sexual beings. If we accept this, then we are likely to stop wasting time on fruitless efforts to prevent the expression of their sexuality and instead implement systems where they have access to good sex education, and contraception methods in order to prevent unwanted teenage pregnancies and sexually transmitted diseases. We also need schemes to deal with the root causes of poverty which limit the options of our young people making teenage pregnancy an attractive viable alternative to a career.

It would be fair to argue that the current Government by some of the proposed actions arising out of the Social Exclusion Unit's Report, some of which have already been implemented, have shown a higher level of commitment to reducing the rate of teenage pregnancies in the UK. However, some strategies have still

not gone far enough given the longstanding record of failure to reduce such pregnancies. Much of the language in the new guidance on sex and relationship education for instance portrays an image of caution and tentativeness. Words and terms like 'should' 'might' and 'would usually', appear with too much frequency in the guidance in relation to the curriculum. Given that sex and relationship education is mandatory in this country, I would have liked to see this reflected in the new guidance with a greater determination and conviction conveyed by more frequent use of the word 'must' in relation to the curriculum. Radical action is needed to remove the UK from this persistently entrenched position of ambivalence in relation to teenage pregnancy that we have found ourselves in for too many years. However, it is too early to evaluate the impact of these proposed action plans. Only time will be the judge of the success of these actions.

In turning our attention to the Caribbean, we see in existence and enviable partnership between public sector and other non-governmental organisations in marshalling the fight against high rates of teenage pregnancies in the region. As a result of these partnerships, a number of creative services are in place. However since funding for services are often threatened or uncertain, the gap between service provision and outcomes needs to be evaluated on a regular basis in order to ensure that limited resources are used to maximum effect.

The public/voluntary partnership should not lead to complacency on the part of the state to take a lead role in policy development and implementation when needed. In spite of the excellent role being played by the non-governmental sector organisations, there are times when nothing short of action by government will work. The example of school dropout shows quite clearly when action is required by the state to ensure that disadvantaged young people are not disadvantaged further by policy omissions.

We have also seen the tendency for professionals, government officials and others to focus on the identification of causes of teenage pregnancy at the level of the individual while often ignoring societal causes. This focus needs to be widened because of the interrelated nature of the factors that impact on teenage pregnancy. In addition, an over preoccupation with individual sexual behaviour can 'deflect attention away from economic pressures on contexts for sexual behaviour which apply to larger portions of the population' (Zalduondo & Bernard 1994:159). Understanding of all the relevant factors is crucial in order to develop effective

policies and strategies. If we ignore structural, cultural and economic factors, our intervention strategies will by implication be ineffective. Ineffective strategies result in wasted resources which the Caribbean, like so many other third world countries can ill afford.

Finally, having established the broad contexts in which teenage pregnancy occurs in the United Kingdom and the Caribbean, the thesis will now go on to explore how far the findings from this research, specifically in relation to repeat teenage pregnancy, support or challenge these popular stereotypes in the United Kingdom, and the issues and concerns expressed in relation to teenage pregnancies in the Caribbean. The close examination and attention to the lessons and insights that will be gained from the international comparative approach to the study will be one of the approaches used to achieve this analysis. The second approach will come from attempts to gain a greater understanding of the phenomenon of repeat teenage pregnancies, by in-depth exploration of the meanings that teenagers ascribe to their pregnancies.

CHAPTER TWO

Teenage pregnancies - A review of the Literature

Introduction

Persistent concerns related to teenage pregnancy over several decades have resulted in a prolific literature on the subject. Less substantial however, is the literature specifically related to repeat teenage pregnancy. This review will present a synthesis of existing knowledge in the field of teenage pregnancy in general, and repeat teenage pregnancy in particular, by highlighting the more prominent themes that have emerged from the literature. In view of the comparative approach to this research, the review will also include relevant literature from the Caribbean.

All, except one study on repeated teenage pregnancy and a high proportion of the more general research on teenage pregnancy reviewed in this chapter have been carried out in the United States of America. This is not surprising, as for several decades the rate of teenage pregnancies in the United States has far exceeded the teenage pregnancy rates in other western industrialized countries (Babb, 1993). There are however, some fundamental differences between the United Kingdom, the United States and the Caribbean, which have to be borne in mind when attempts are made to contextualize the findings of research from the United States. For example, in the United States policies vary markedly about a number of social issues such as abortions, teenage pregnancies and contraceptive use (Phoenix 1991). Teenage sexuality, pregnancy and parenting have become 'topics of intense national debate' in the United States (Polit & Kahn, 1986:167). Although these issues are of immense concern in the United Kingdom and the Caribbean, they generate relatively less rigid attitudes. Nevertheless, the contribution of research from the United States to our understanding of the highly complex phenomenon of teenage pregnancy cannot be underestimated. This is particularly the case in evaluating the impact that certain economic, social and psychological variables can have on both the occurrence and outcomes of teenage pregnancies, because in many respects the social factors influencing high teenage pregnancy rates are often similar.

The first section of this chapter will be devoted to a review of the literature on

repeated teenage pregnancies. However in order to avoid any unnecessary repetitions, where there are similar themes in relation to both single and repeat teenage pregnancies, these will also be included in this section. The second section will focus on the themes more generally related to single teenage pregnancies which were not covered in the first section.

REPEAT TEENAGE PREGNANCIES

Incidence of repeated teenage pregnancies

As highlighted before, no research on repeated teenage pregnancy has been conducted in the United Kingdom. Some researchers in the United Kingdom have made reference to repeat teenage pregnancies among their samples (Hudson & Ineichen, 1991; Simms & Smith, 1985; Smith, 1993), but this has always been in statistical terms. For example, Smith (1993:1235) states that:

'between 1980 and 1990 I identified 1075 girls who had two pregnancies as teenagers.....I also identified 136 girls over the same period who had had three pregnancies as teenagers, 12 who had had 4, and 1 who had had 5'.

In all of these studies, no attempts were made to explore the factors leading to such pregnancies. The reasons for this lack of research on repeat teenage pregnancy in the United Kingdom are unclear, particularly in light of information provided in chapter one, which suggests that a significant proportion of young women have repeated pregnancies in their teenage years (ONS, (1997) cited in the Social Exclusion Unit Report (1999). In addition, survey research evidence shows that one in eight young women, who had their first pregnancies as teenagers, went on to have a second child before age twenty (Wellings et al, 1996) cited in the Social Exclusion Unit Report (1999). Even in the United States where the vast majority of research on teenage pregnancy has been conducted, the research on repeated teenage pregnancy is relatively sparse in comparison to research on teenage pregnancy in general (Williams, 1991). There are however, some studies that point to a fairly high rate of early repeat pregnancies among young mothers in the United States. According to Polit et al (1986:167):

'Reports (conducted in the United States), based on large scale surveys indicate that one out of five teenage mothers - regardless of race or ethnicity - become pregnant again within 12 months of delivering their first child'.

Other reports based on evaluation of various programmes developed in the USA specifically designed for young mothers, have reported rates of repeat pregnancy in the range of 20-25 per cent (Klerman & Jekel, 1973; Furstenberg, 1976). This trend has continued into the 1990s with reports that over one fifth of teenage births in the United States are second births or higher (Ventura et al, 1998).

Several studies conducted in the United States have shown that early age at the first pregnancy is often associated with difficulties in preventing repeated pregnancies (Klerman & Jekel, 1973; Currie, Jekel and Klerman, 1976; Furstenberg, 1976); Manlove et al, 2000). In addition, repeat pregnancies often compound the problems that are said to be typically associated with teenage childbearing (Polit et al 1986). This lack of research on repeat teenage pregnancy therefore becomes even more surprising.

In the Caribbean, there have been long-standing concerns about repeat teenage pregnancies. In 1986 these concerns prompted the development and evaluation of a project in Barbados, designed to test the most feasible method of providing contraceptive counselling in order to reduce the numbers of repeat pregnancies among teenager mothers (Bertrand et al, 1986).

Similarly, in Jamaica, concerns about the high numbers of repeat teenage pregnancies, led to the establishment of the Women's Centre in 1978 to reduce the incidence of repeat teenage pregnancies (see footnote, page 123, chapter three). These centres are still in existence throughout the island. It was therefore surprising to see data from a national Contraceptive Prevalence Survey conducted in Jamaica in 1993, which suggest that less than 1 per cent of women 15 - 17 years have had more than one pregnancy. I would urge caution in interpreting these figures, in view of the findings of the same survey with respect to sexual experience and contraceptive use, which show that the majority of both men and women aged 15-24 have had sexual intercourse, 78 per cent and 85 per cent respectively. Less than half of the young women surveyed in the study, reported use of contraceptives at first intercourse. I would also be inclined to think that this lack of contraceptive use also extends to subsequent sexual activity, in view of the fact that contraceptives are not issued free of charge in Jamaica.

There is also an additional factor to consider, despite the generally more open attitudes to abortion in many countries; it is still the case that there is a

considerable amount of stigma associated with abortion. This makes it more likely that in Jamaica, as elsewhere, young women would be reluctant to admit having had a previous pregnancy or pregnancies which ended in abortion. This reluctance must be taken into account when statistics on repeat pregnancies are collated and interpreted.

It is my hypothesis that one reason for this lack of research may be related to the fact that accurate statistics of repeat teenage pregnancy are not always available, and this makes it difficult to ascertain the true rate of such pregnancies. A possible reason for this lack of statistical information, certainly as far as the Caribbean is concerned, is that young girls pass through the antenatal system at different times, or may attend different hospitals for antenatal care of subsequent pregnancies. This makes accurate estimation of the true numbers of repeated pregnancies more problematic. It could also be the case that in the United Kingdom:

‘conception statistics are made up of the numbers of conceptions leading to registered births and legal abortions (registered under the 1967 Abortion Act). Maternities resulting in one or more live and stillbirths are included. Multiple maternities, i.e maternities resulting in one or more live or stillbirths are counted only once. Pregnancies leading to spontaneous abortions (miscarriages) are not included as they are difficult to monitor and it is assumed that the proportion of pregnancies resulting in spontaneous abortions is fairly constant from year to year (Peach et al, 1994:3).

This dearth of research on repeat teenage pregnancy has left a significant gap in our understanding and interpretation of statistical data on teenage pregnancy.

Approaches to research on repeat teenage pregnancy

It is possible to identify four distinct but interrelated thematic approaches to research on repeat teenage pregnancy. The first category concentrates on efforts to identify the factors that would predict which teenagers are likely to have a repeat pregnancy. The second category focuses on the consequences and long-term outcomes of repeat pregnancy. The third category places emphasis on identifying the relationship between race differences and repeat pregnancy. The focus of the fourth category is on evaluating the effectiveness of post-natal multi-service programmes to prevent repeat pregnancy. It therefore seems appropriate to present these findings in relation to these areas of focus.

1. PREDICTORS OF REPEAT PREGNANCIES

In a study using structured interviews carried out by Gispert et al (1984), the researchers compared a group of 58 teenage girls who had become pregnant once during a two-year period, with another group of the similar age and size, who had become pregnant at least twice during the same period. Several factors explored during the interviews were identified as 'predictors' of repeat pregnancies. These included:

Approach to contraceptive use

A substantial number of studies of both repeated and single pregnancies, as well as government policy documents on teenage pregnancy, devote a lot of attention to the impact of contraceptive use, viewing it as the single most important factor in reducing the rate of unwanted pregnancies. Internationally, failure to use contraceptives has been cited as a major reason for early pregnancies in many studies.

In exploring the link between contraceptives and repeat pregnancies, researchers have focused on evaluating the difference between actual practice and expressed attitudes to contraceptive use, in an effort to predict which teenager is likely to have a repeat pregnancy. Gispert et al (1984) found that a positive attitude towards contraceptive use expressed by teenagers did not always imply that these teenagers would use contraceptives. Surprisingly, the girls who reported a more positive attitude towards contraceptives were the ones who would usually fail to use contraceptives on a regular basis, and therefore experienced repeat pregnancies. The single pregnancy girls on the other hand, had used contraceptives regularly in spite of less positively expressed attitudes about contraceptive use. The single pregnancy girls also reported more unpleasant side effects from long-term contraceptive use, and this, the researchers claimed, might explain their more negative attitude.

Ford's 1983 study also reported that an unrealistic approach to contraceptive is a predictor of repeated pregnancies. These researchers stress the point that in assessing the likelihood of repeat pregnancies, professionals should give greater weight to the actual practice of a young girl in relation to contraceptive use, rather

than reported attitudes which may bear little relationship to what happens in reality. The underlying reasons for the gap between expressed attitudes and practice remained unclear (Gispert et al, 1984). The researchers did find however, that the single pregnancy girls reported a more positive relationship with their mothers which could in turn influence their approach to contraceptive use.

Inadequate knowledge and lack of access to contraceptives reported in many studies of single teenage pregnancies to have a bearing on teenage pregnancy was not always shown to be a major factor in repeat teenage pregnancies. Polit et al (1986) found that despite the fact that 'virtually every teenager' in their study reported having some contraceptive counselling, often repeatedly, the rate and incidence of repeat pregnancies were substantial. Also worthy of note, is the finding from Jekel et al (1973) that the mere prescription of contraceptives is not sufficient to prevent subsequent pregnancies. Contraceptive prescription and other factors such as the motivation and/or ability to remain in school may be crucial to the avoidance of repeat pregnancies. Jekel et al (1973) reported that the motivation to get an education emerged in their study as the most important predictor of contraceptive use and consequently, the avoidance of repeat pregnancies.

The findings from the literature on single teenage pregnancies could also be relevant to repeat pregnancies in many respects. For example, in several studies of single teenage pregnancy, a high proportion of girls had never used contraceptives prior to the first pregnancy, neither had they used contraceptives on a regular basis subsequently (Bury, 1984; Jagdeo, 1984 and 1986; Simms & Smith, 1986; Curtis et al, 1988; RCOG, 1991; Chevannes, 1993). In Skinner's (1986) study for example, only 27 per cent of young mothers had used any form of reliable contraceptives. This links very closely with the evidence that young women having their first sexual experience under the age of sixteen are the least likely to use contraceptives (Trussell, 1988; Hudson and Ineichen, 1991; Winter & Breckenmaker, 1991). It is therefore not surprising, that several studies suggest that the youngest teenage mothers seldom use contraceptives (Bury, 1984; Phoenix, 1991; Konje et al, 1992; Smith, 1993). There is evidence to suggest that this failure to use contraceptives may be related to lack of information and understanding about contraceptives (Phoenix, 1991).

In addition to lack of use, there have been reports of delays in seeking

contraceptive advice among many teenagers, until after they have started sexual activity, or when they believed that they might already be pregnant (Corlyon & McGuire, 1997). For a number of these teenagers, the delay in seeking advice could be as long as six months or more (Birch, 1987). They also have a higher reported rate of failure in use of contraceptives. These young women are also the least likely to be knowledgeable about the risks associated with their sexual activities such as unwanted pregnancies and sexually transmitted diseases (Hudson & Ineichen, 1991; Bury, 1991; Mellamby et al, 1992; Chevannes, 1993).

In the Caribbean research also suggests that contraceptives are not often used during the first sexual intercourse. This may be linked to the belief identified by researchers that many Caribbean teenagers hold, that it is not possible to become pregnant after the first intercourse. These surveys suggest that, only 40 percent of girls younger than 20, and 10 percent of boys younger than 18 use contraceptives at the first sexual encounter (Pan American Health Organization, 1994). Lack of access to contraceptives was the reason given by 40 per cent of girls, and 50 percent of boys for their failure to use contraceptives. The younger the age of the respondents, the higher the likelihood that they would give this reason (Chevannes, 1993). When teenagers reported using contraceptives, 80 percent reported using the condom (Chevannes, 1993). While this is welcomed news for HIV and AIDS and other sexually transmitted diseases prevention, the condom on its own as a method of contraceptive, is not a reliable method of pregnancy prevention.

As we will see from the evidence provided later in this chapter, many teenage pregnancies are unplanned. Research evidence also points to the potential for poor outcomes of these pregnancies. Given these potentially adverse outcomes to early unplanned pregnancies, why do so many young women fail to use contraceptives? As we have seen from the evidence provided earlier in this chapter, reasons why young girls fail to use contraceptives are varied and complex. There is some evidence to suggest that some teenagers do want to become pregnant (Oakley, 1994), while others have very mixed feelings regarding pregnancy. In such cases, it is likely that they will not use contraceptives.

Lack of availability of contraceptives may also be a cause of failure to use contraceptives. Despite popular perception of the widespread availability of

contraceptives, many young people experience great difficulty in gaining access to contraceptive services (Brooke Advisory Centres, 1991; Jones, 1992). There is also uncertainty about how to obtain contraceptives (Hudson & Ineichen, 1991; Phoenix, 1991; Konje et al, 1992; Family Planning Association, 1993; Hyman, 1999). Many of the identified factors that are said to have a negative impact on teenage pregnancies are compounded by lack of access to contraceptives. These obstacles, as Kirby et al (1991) argue, make the provision of knowledge and skills about contraceptive use by relevant agencies meaningless and ineffective, if young people are denied the means to make contraceptive use a reality.

Other reasons for failure to use contraceptives could be closely tied to the concerns that many young women often have about being viewed as promiscuous if they make attempts to obtain and use contraceptives (Hudson & Ineichen, 1991; Bury, 1991; Ford, 1993). There is also some evidence which shows that embarrassment and feelings of guilt which this labelling can generate, is likely to deter teenagers from using contraceptives (Bury, 1991; Ford, 1993). These factors can inhibit young girls approaching agencies to discuss their contraceptive needs, for fear of being labelled or reprimanded. This may also help to explain the very low use of contraceptives among the youngest teenagers.

Concerns about confidentiality have been reported to be a major deterrent in seeking advice (Sally, 1993; Kari & Donovan et al, 1997). This is particularly the case if the teenager is under sixteen years (Wilson & Heslop (1991; Sally, 1993; Wilson et al, 1994). As Wilson & Heslop (1991) argue, the fact that these concerns are mainly related to GP surgeries suggests that more widespread provision of services in other settings is urgently needed to allow greater choice and anonymity. In attempting to explain the issues surrounding confidentiality, Sally (1993:1158) points out that:

‘although doctors’ legal position regarding the provision of contraceptive services to young people under 16 was clarified by the House of Lords judgement in the case of Gillick vs West Norfolk and Wisbech Area Health Authority in 1985, uncertainty has surrounded the issue of confidentiality. While most doctors will respect the confidentiality of those seeking contraceptive advice, the suspicion has remained that a few, because of their personal beliefs, would breach confidentiality in the case of someone under 16’.

Another factor that appears to influence the use of contraceptives either negatively or positively is the attitude of doctors, nurses and other health care staff. In the USA, Klein (1974) found that contraceptive use and other pregnancy

prevention measures are difficult to achieve when the attitude of health care staff is negative. Similarly, in the UK, unavailability of `contraceptives, as well as negative attitudes and treatment from health care staff, were among the main reasons given for failure to use contraceptives. For example, a Brook Advisory Centres survey in 1991, showed that a significant number of requests for emergency contraception advice appointments were not given within one week. In addition, many young women reported that they experienced very off-putting, negative and often moralizing attitudes from the staff that they approached for help and advice. Many were refused help, and were referred to their GPs instead. For the majority of these girls, this was not an acceptable alternative due to fears about a breach of confidentiality.

While I have no reason to doubt the above findings, I would urge caution however, about apportioning blame only to ignorance of contraceptives or reluctance to go to General Practitioners for contraceptives. For example, evidence from research on young people in public care (Corlyon & McGuire, 1977), suggests that while the young women in their study understood the need to use contraceptives, many 'omitted to use it'. Similarly, in a recent study in the British Medical Journal of 240 cases of teenage pregnancy in fourteen General Practices, researchers compared the consultation patterns of teenagers who became pregnant with those of age matched peers. They reported that seventy one per cent of these teenagers had discussed contraceptives with a nurse or doctor during the previous year, and fifty per cent had been prescribed the pill. This led the researchers to conclude that 'the reluctance of teenagers to attend general practice for contraception may be less than previously supposed' (Churchill et al, 2000:487). However, because the data was obtained solely from general practice records, the researchers have no way of knowing why these teenagers failed to prevent pregnancies despite consultations and prescriptions for contraceptives. This finding clearly illustrates the need for more in-depth exploration of the failure to use contraceptives despite availability and access.

Teenage pregnancy not only happens as a result of failure to use contraceptives. There is evidence that even where young people use contraceptives on a regular basis, some still become pregnant (Simms & Smith, 1986; Phoenix, 1991; Oakley, 1994). Contraceptive failure has been reported by a substantial number of teenagers to be a major cause of pregnancy. In several studies, a significant number of those interviewed said that they had been using contraceptives when

they became pregnant (Simms & Smith, 1986; Griffiths, 1990; Phoenix, 1991). However I would argue that this information should be viewed in relation to the evidence that many young women discontinue the use of a prescribed method, most often the pill, if they experience physical complications such as problems with menstruation, weight gain, headaches and nausea (Davis, 1994). Weight gain or nausea as a result of taking the pill may be very important issues for many teenagers who are 'preoccupied with physical appearance and personal comfort' (Williams, 1991:20).

Lack of knowledge and poor attitude on the part of service providers, are only two parts of this complex puzzle. Risk-taking among teenagers is another aspect, (Bury, 1984; Hayes, 1987; Corbett & Mayer, 1987; Curtis et al, 1988; RCOG, 1991; Moore & Rosenthal, 1993; Mellamby et al 1993). In relation to HIV & AIDS, Moore and Rosenthal (1983:128) termed to this phenomenon as the 'NOT ME myth', the same can be applied to teenage pregnancy where there is a feeling that such experiences as teenage pregnancy and HIV & AIDS only happen to others and not to themselves.

This practice could also be described as what Moore & Rosenthal (1993:130) referred to as a 'risk-and-be-damned' syndrome. It shows that while a lack of, or failure to use contraceptives may be one of the reasons why a teenager becomes pregnant, lack of use is not always related to lack of knowledge. It could also relate to the fact that a substantial number of girls aged under sixteen years are the least likely to be in a stable relationship, and, this may influence their pattern of contraceptive use. These are often the young women who are the most in need of parenting, and the least able to realistically assess the full consequences of early-unplanned pregnancies. In addition, it has to be acknowledged that it is often very difficult for these young women to make informed decisions about relationships and contraceptive use as they frequently receive mixed and conflicting messages from boyfriends, peers, professionals and the media. Lack of sex education has also been linked to failure to use adequate contraceptives. These issues will be explored in section two.

Mother/daughter relationship and the impact of father's presence in the home

We have already seen the likely impact of good relationships between the single

pregnancy group and their mothers in relation to better contraceptive use in Gispert et al's study. These researchers also report that a good mother/daughter relationship extends to other aspects of their daughters' lives, such as their sexual behaviour and by implication, the prevention of repeat pregnancies (Gispert et al, 1984).

There is evidence to suggest that the link between mother/daughter relationship also applies to first teenage pregnancies. Skinner's (1986) study of 550 girls in South London in 1986, found a clear link between teenage pregnancy and mothers who appeared to care little about their daughters' activities (217 of a sample of 550). This view is further validated by research evidence which suggests that if parents are perceived to be overly permissive in their approach to parenting, this may have an adverse impact on the teenagers' view of sexual activity (Curtis et al, 1988; Santelli & Beilenson, 1992). In such circumstances the chance of an early pregnancy increases.

Other researchers have examined the ties between mothers and daughters in the hope of understanding the ways in which these relationships can have a bearing on teenage pregnancies. A number of reasons for this link have been reported. For example, some mothers of pregnant teenagers have been found to be emotionally distant from their daughters, while others appeared to be unable to make distinctions between their own needs and the needs of their daughters. This prevents them from responding to their daughters' own unique needs (Coblener 1981). Others have suggested that teenage pregnancies are more likely to occur in mother dominated households (Landy et al, 1983; Eldeman, 1987), and teenage girls may be seeking to fulfill their mothers' spoken or unspoken wish for another baby (Musick, 1993). Teenage pregnancy has also been viewed as a symptom of family conflict (Hudson & Ineichen, 1991). It is therefore possible to deduce from these findings, that in these situations the young woman will lack the necessary guidance and stability needed to withstand pressures directly or indirectly, to become pregnant.

Some studies have found that the daughters of mothers who were also pregnant as teenagers are at increased risk of becoming pregnant teenagers themselves (Furstenberg et al, 1990; Konje et al, 1992). Many reasons for this increased risk have been advanced. For example, it has often been argued that a syndrome of self-fulfilling prophecy is at work in situations where the young woman's mother

was also a pregnant teenager. This can lead to the expectation on the part of the mother that her daughter will also become pregnant during her teenage years (Fiigel, 1982). On the other hand, it may be the case that such mothers may not want their daughters to repeat the same mistakes that they did. However, because the daughter sees her mother long after she has 'recovered' from the detrimental effects of an early pregnancy, the consequences may not seem so terrible (Williams, 1991). In such cases it would be difficult to advise their daughters against an early teenage pregnancy.

The absence of a father in the home was the third predictor of repeat pregnancies identified by Gispert et al (1984). Father's presence in the home may help to prevent further pregnancies, as there are two parents available to supervise their daughter's sexual behaviour. The researchers argued that teenagers, who were able to seek and obtain support from parents during the crisis of the first pregnancy, were less likely to become pregnant again than those who received no support.

In explaining the influence of father's presence in preventing repeat pregnancies, Gispert et al state:

'the presence of father in the home usually implies that an adolescent's parents have managed to build a relatively stable relationship.....such values would usually encourage a view of human relationships that makes sexuality only one part of a much broader relationship. This view, in turn, would reinforce the importance of thoughtful control in sexual behaviour, as in human relationships generally' (Gispert et al, 1984:723).

Father's absence, has also been identified as a contributory factor to first pregnancies (Zongler, 1977; Hogan & Kitagawa, 1985). However, as with repeat pregnancies, the impact of father's presence would depend on the quality of the relationship with his daughter(s), as some researchers have pointed out, that the presence of father in the household does not always prove to be effective in preventing his daughter(s) from becoming pregnant. This is particularly the case if he is uncaring and distant in his manner (Osofsky, 1978). I would also hypothesize, that in some cases father's absence from the home has no marked adverse impact on his daughter, if this absence is experienced as the norm in a family where at no time during its existence, a father was present. In some cases, I would go as far as to suggest that father's absence could be experienced as satisfying, if father is absent for reasons of emotional and physical abuse of his

family.

There is no doubt that when parents work together, the effort of each is enlarged. However, these findings raise important questions about the ability of single parent households to overcome the lack of support from a second parent, in helping the teenager to overcome the difficulties often associated with the first and repeat pregnancies.

Marriage

Marriage has been cited both as a predictor and a background characteristic that has a bearing on repeat teenage pregnancy. In Gispert et al's (1984) study none of the single pregnancy adolescents married during the two years following their initial pregnancy, while 17 per cent of the repeat pregnancy group got married. They therefore argued that marriage was a good predictor of a repeat pregnancy, however it did not follow that a second pregnancy was a good predictor of marriage, as the vast majority of the adolescents who had a repeat pregnancy did not marry. This finding was also supported by other studies. Koenig & Zelnik, (1982), found that half of the number of pregnant teenagers who marry while pregnant, conceived again within 24 months of the outcome of their first pregnancy. Similarly, Kalmuss & Namerow (1994) found that teenagers who marry either prior to, or after the birth of their first child, have an increased risk of repeat pregnancies.

Married teenagers, it has been argued, are more likely to have a repeat pregnancy because of the increased likelihood of engaging in frequent sexual intercourse than their unmarried peers, whose sex lives tend to be more irregular and sporadic (Furstenberg, 1971). This situation is not as clear-cut as it may appear, as infrequent and sporadic sexual activity can lead to an attitude of complacency regarding contraceptive use. These girls tend to be often less reliable in maintaining a pattern of consistent contraceptive use, as they feel that the pattern of their sex lives does not require consistent contraceptive use (Zelnik, Kanter & Ford, 1981). This could therefore be an additional contributory factor to repeat pregnancies because of the difficulties in providing contraceptive counselling and advice to encourage effective use of contraceptives.

The link between repeat pregnancies and marriage however, has not been clearly

demonstrated, and conflicts with the findings of other researchers. For example, Trussell & Menken in a 'National Survey of Family Growth' found that marital status at first pregnancy has 'relatively little effect on subsequent fertility' (Trussell & Menken, 1978:218). Similarly, Manlove's et al, (2000) longitudinal study, found no link between marital status and repeat pregnancy. Other studies report that young women who married while they are pregnant, had the highest levels of contraceptive use. This level of contraceptive use, I would argue, should mitigate against repeat pregnancies. In Ford's (1983) study for example, 89 per cent of the women who married while pregnant, were using contraceptives in the years following the first birth. These conflicting findings suggest that while there may be some links between marriage and repeat teenage pregnancies, the extent to which marriage could be cited as a predictor of repeat teenage pregnancy is open to question. This is particularly so in view of the fact that many more teenagers are choosing to remain single in contemporary societies than was the case two or three decades ago, yet repeat teenage pregnancy persists.

School dropout

Another predictor of repeat pregnancy identified by several researchers was school dropout (Dickens, Hartshome & Garcia, 1973; Jekel & Klerman, 1973; Klein, 1974; Furstenberg, 1976; Trussell & Menken, 1978; Stevens-Simon et al, 1986). This was increasingly preceded by poor attendance before the final withdrawal (Klein, 1974; Card & Wise, 1978; Mott and Maxwell, 1981; Hofferth & Hayes, 1987). Teenagers who remained in school following the first pregnancy and who did not have a poor dropout record prior to the first pregnancy were 'significantly less likely than other teenagers to have a repeat pregnancy' (Polit et al, 1986:169).

Among the reasons cited for school dropout, is pressure from families to leave school due to economic hardships and childcare responsibilities. A high number of poor students are likely to become pregnant and drop out after the birth of their babies (Rindfuss, St John and Bumpass, 1984). In most cases, pregnancy usually precedes school dropout (Hofferth & Hayes, 1987). However the findings that teenagers who become pregnant have a poorer school attendance record prior to the first pregnancy (Klein, 1974); and that, 'young adolescents may be moving towards a development trajectory that leads to low educational expectations and low academic achievement prior to the occurrence of pregnancy' (Scott-Jones, 1991:462),

are also significant. They suggest that the link between school dropout and repeat pregnancy is not as uncomplicated as it may appear. Other variables such as the factors that lead to poor attendance prior to conception and low educational expectations, may be more accurate predictors of repeat pregnancy than school dropout per se.

It would also appear that the negative effects of school dropout have more long-term consequences, and span more than one generation. Mott's (1986) study found that compared with young mothers whose mothers are high school graduates, those whose mothers dropped out of school are more likely to have a second child within two years. A later study by Paik (1992) also found that girls whose mothers dropped out of school have a higher incidence of repeat teenage pregnancies than those whose mothers have finished high school.

While it is possible to speculate on the probability of a relationship between school dropout and repeat pregnancies, the drawback with these findings is the difficulty in identifying the precise link between school dropout and repeat pregnancies. For example, Stevens-Simon et al, (1986:193) found that the failure to return to school after delivery 'does not necessarily result in a high repeat pregnancy rate'. To compound the uncertainty, Upchurch & McCarthy's (1990) study found that giving birth at school age was not always a predictor of school drop out. Nor did many teenagers drop out of school in anticipation of becoming pregnant. The majority of teenagers, who dropped out of school, went on to have children more than nine months after leaving school. The study revealed that socioeconomic and other personal background characteristics were more significant contributory factors towards a young woman's risk of dropping out of school. A good example of these social factors is the previously reported finding of the higher incidence of repeat pregnancies for those teenagers whose mothers had dropped out of school.

As previously stated, these varied findings suggest that unexplored socioeconomic and cultural factors may have a significant impact on repeat pregnancies rather than school dropout per se. Additionally, in cases where early pregnancy may lead to a failure to return to school, for a variety of reasons, it operates by hindering return, rather than a cause of school leaving in the first instance. Therefore while it could be argued that pregnancy or childbirth while still at school is a fairly accurate predictor of repeat pregnancy, this is complicated

and exacerbated by additional variables that need to be taken into account, in evaluating the true impact of school dropout on teenage pregnancies, or vice versa.

Similar to repeat pregnancies, single teenage pregnancies have been linked to school dropout, and consequently, fewer years of completed education (Robbins et al, 1985; Mott & Marsiglio, 1985; Upchurch & McCarthy, 1989). A number of reasons have been advanced for this link. Some researchers have suggested that leaving school either before or after the pregnancy, is due to the young woman's preference for being a mother rather than a student (Ireson, 1984). The issues that are often left unexplored in this equation are the factors that influence a teenager's preference for early motherhood as an alternative to a career. This is particularly relevant in view of research evidence which suggests that for these young women, motherhood becomes a career alternative only in the absence of other opportunities (Bury, 1984; Phoenix, 1991).

Additional factors also influence school dropout. Many girls report that they did not return to school mainly as a result of embarrassment. Many have poor attendance records prior to their pregnancies. Some have left school for up to a year or more before becoming pregnant (Gribben, 1992; Rhode, 1993). 23 per cent of teenage mothers in Oz and Fine's (1988) study did not drop out of school after pregnancy, and a small number (two) of the girls who did not leave school completed grade 13 and expressed their intention to go to university. In addition, 15 per cent of teenagers, all of whom had left school before their pregnancies, were able to return to regular classes after confinement.

In the United Kingdom, as we have seen in chapter one, all of these issues are compounded by the fact that there was until quite recently, no national policy on education for teenagers who become pregnant while at school. The end result is a very piecemeal and inconsistent provision for such girls by different education authorities (Dawson, 1989). The 1993 Education Act places a duty on Local Education Authorities to make provision either at school or otherwise for pupils who have particular needs (other than special needs). Additionally, circular 11/94 – 'Education of Pupils Educated Otherwise Than at School' provided guidance on how local authorities should discharge this duty. For example, as far as possible, pregnant schoolgirls and teenage mothers should be allowed to continue their education at school. Pregnancy in itself, is therefore not a justifiable reason for

girls to leave school, either of their own choosing, or because of exclusion. Despite this legislation and guidance, research has found that in practice, the existing provision by local education authorities tends to be minimal (Dawson, 1996). Some teenage mothers despite their motivation to return to school, discover that their attempts are thwarted by the negative attitude of some teaching staff (Dawson, 1997). As a consequence, there is evidence to suggest that only a relatively small number complete their education, are able to proceed to colleges of further education or university, or to obtain training to improve their employment prospects (Dawson, 1996). This is also due to a lack of public child care provision and/or lack of public funding (Field, 1989). Lack of adequately subsidized childcare is one area, which has been particularly restricting to the teenagers' chance of returning to school or college (Hudson & Ineichen, 1991; Social Exclusion Unit Report, 1999).

Age at first pregnancy

Early age at first pregnancy has been cited as a significant predictor of repeat teenage pregnancy. Several studies have shown that women who begin childbearing at a very young age, are on average, expected to have more children in the course of their lifetimes, than if first births were delayed until later (after age twenty) (Trussell & Menken, 1978; Mott, 1986; Manlove et al, 2000).

Additionally, women who give birth before age twenty tend to have shorter intervals between the second, third and fourth births, than women who postpone their first births beyond age twenty (Bumpass et al, 1978). For these teenagers, not only is the pace of repeat pregnancies more rapid, but that the rate of pregnancy also continues to exceed the fertility rates of those teenagers who postpone childbearing until later (Milman and Hendershot, 1980). These findings are not at all surprising as it is feasible to argue that the earlier fertility commences, the more reproductive years the young woman has ahead of her in which to have additional pregnancies.

An early first birth may also restrict educational progress and as a consequence, prevent or hinder the pursuit of activities that are alternatives to pregnancy. This in turn can have an impact on subsequent fertility by making it appear more attractive to young women upon realizing that their chances for pursuing career activities outside the home become increasingly limited, thus 'solidifying their role

as mothers' (St. John, 1982). These findings are in keeping with other research which suggests that teenage mothers who have a second child soon after the first, often appear to be overwhelmed by an increased amount of responsibilities, and are therefore likely to abandon their plans for other personal and career achievements. A likely consequence of this attitude is another unplanned pregnancy (Seitz & Apfel, 1993).

Early childbearing also leads to what has been termed a 'syndrome of failure' (Klein 1974:249). This syndrome includes:

- 'A failure to fulfill the functions of adolescence
- Failure to remain in school
- Failure to limit family size
- Failure to establish stable families
- Failure to be self-supporting
- Failure to have healthy infants'

It is the recognition of the impact of these failures and the need to prevent further repeat pregnancies, that have often been influential in the establishment of a number of multi-disciplinary care facilities for pregnant adolescents that will be looked at later in this chapter.

While the link between early age at first pregnancy and repeat pregnancies cannot be denied, it is important to note however, that concerns about the rate of repeat pregnancy expressed by some of the studies cited above, were not borne out by Furstenberg's et al seventeen year longitudinal study. Encouragingly, the study found that most of the women had fewer children than originally forecasted. Family size did not increase at the rapid rate that was initially predicted (Furstenberg et al, 1987).

The extent to which the first child was wanted

In terms of predicting the occurrence of repeat pregnancies, some researchers have reported a link between what they termed 'wantedness' of the first child and the occurrence of repeat teenage pregnancies. Teenage mothers who reported that they wanted the first child have a 'significantly higher overall probability' of having a second child within two years, than is the case with other mothers. This difference is 'particularly pronounced within the youngest sub-group' of the study. 37 per cent of young women whose first pregnancies were wanted, quickly went on

to have a second child, compared to 21 per cent of those who reported unwanted first pregnancies (Mott, 1986:10). If one adds to this scenario, early age at first birth, it is possible to hypothesize that the combination of these two variables would have a powerful influence on the decision to have a repeat pregnancy.

The issue of 'wantedness' however, is far from straightforward. For example, the terms 'unwanted', 'unplanned' and 'planned' pregnancies are frequently used in the literature in relation to teenage pregnancies. However, the extent to which teenage pregnancies could be said to be either planned or unplanned, varies from study to study. Some researchers have argued that the majority of repeat pregnancies are unplanned and unwanted (Hartshore & Garcia, 1973; Klein, 1974; Moore & Waite, 1977; Trussell & Menken, 1978; Dickens, Jagdeo, 1994). While others suggest that a large proportion of teenage pregnancies are 'unintended' (Metson, 1988; Fleissig, 1991; Ibbotson 1993; Health Education Authority, 1994), but not necessarily unwanted.

In the Caribbean, research suggests that most teenage pregnancies are unplanned. In Jagdeo's study, 70 percent of the adolescents interviewed, said that they would have preferred to wait until they are older before becoming pregnant (Jagdeo, 1994). In other studies, the term 'mistimed' is used. This term indicates that although the respondents had planned to have a child sometime in the future, they had not planned for their pregnancies to occur at the time at which it occurred (Chevannes, 1993; Contraceptive Prevalence Survey, 1993).

However, in spite of the predominantly negative picture painted by numerous researchers about unplanned pregnancies, increasingly researchers are discovering that these widely reported concerns do not always represent the realities for many teenagers who become pregnant. A number of these pregnancies are the result of a conscious decision to become pregnant (Morrison, 1985; Simms & Smith, 1986; Phoenix, 1991). In Simms and Smith's study, 'the majority of teenagers...declared themselves well pleased with their lives and their babies...' (Simms & Smith, 1986:10). In addition, as Moore and Rosenthal (1993) argue, for these young women, the decision to become pregnant is often influenced by social factors such as a history of early pregnancies in the family. Often a young woman's mother and/or, her friends and relatives have had an early pregnancy and some have stable relationships. In such cases a teenage pregnancy is likely to be viewed in a more positive light.

Quite often researchers have been inclined to provide an overly simplistic analysis of the notion of unwanted pregnancies, often misinterpreting reports of unplanned pregnancies as an indication of unwanted pregnancies. However, it is important that clear distinctions between 'unintended' and 'unwanted' pregnancies are made, as it is often not the case that an 'unintended', 'unplanned' or 'mistimed' pregnancy is an unwanted pregnancy (Chevannes, 1993; Fleissig, 1994). In spite of the initial distress about becoming pregnant, there is a lot of evidence to suggest that many teenagers very quickly adjust to their changed circumstances and often feel very happy to be pregnant (Sharpe, 1987; Hudson & Ineichin, 1991; Phoenix, 1991; Faculty of Public Health Medicine, 1994). In addition, once the baby arrives, these teenagers state that life without their child is unimaginable, regardless of the unplanned nature of the pregnancy (Oz & Fine, 1988). They also state that having a child gave them a sense of meaning and purpose that was felt to be a highly satisfying experience (Phoenix, 1991; HEA 1998).

Availability of an income from parents

Paik's (1992) study found that girls whose parents supported them financially after the first birth, had an overall lower incidence of repeat pregnancies than those who received an income from other sources. It is therefore feasible to argue that financial help from parents is likely to have the impact of preventing teenage mothers from becoming locked in a cycle of dependence and repeat pregnancies. This can prevent a young woman from being trapped in a situation where she is forced to rely exclusively on financial support from the putative father, which in some cases could lead to a loss of control over decisions relating to fertility rates.

2. CONSEQUENCES OF REPEAT PREGNANCIES

A second feature of the research on repeat teenage pregnancy which is closely linked to age at first pregnancy discussed earlier, is the focus on the outcomes for mother and children. There is some evidence to suggest that teenage mothers who have a second child soon after the first birth, are likely to face 'serious obstacles to becoming educated and economically self sufficient' (Seitz & Apfel, 1993:572). Similar concerns have also been reported by other researchers such as Furstenberg et al (1976 & 1984) and Manlove et al (2000).

Some researchers have argued that not only is early marriage a predictor of repeat pregnancies, but if the marriage survives, the increase in the number of children leads to further economic and social disadvantage (Bumpass et al, 1978; Trussell and Menken, 1978; Milman & Hendershot, 1980). Furthermore, this social disadvantage is transmitted in one form or another to the children (Baldwin & Cain, 1980; Hamburg, 1981; Brooks-Gunn and Furstenberg, 1985). Others have linked early teenage pregnancies not only with economic disadvantage but also with high rates of marital disruption and instability in teenage marriages (McCarthy & Menkell, 1979).

In addition to studies of repeat pregnancy, numerous research studies on teenage pregnancy from the U.K, the Caribbean and the USA have often painted a very dismal and gloomy picture of the long-term social, physical, psychological, emotional and medical outcomes of pregnancy for mother and child. For example, some researchers have argued that long term socioeconomic disadvantage, regardless of how it manifests itself, is more likely to be found among families where childbearing began in adolescence, than among families who delayed having children until later. As a result, in the United Kingdom, the United States and the Caribbean, a significant number of research studies point to a distinct link between socioeconomic factors such as overcrowding, economic dependency, poverty, and teenage pregnancies. (Rotchell, 1983; Jagdeo, 1984; Miller & Moore, 1990; Santelli & Beilenson, 1992; Konje et al, 1992; Nord et al, 1992; Wilson et al, 1992; Garlick, Hudson & Ineichen, 1993).

Research conducted by the Family Policy Studies Centre found that, compared to those young women who become first time mothers in their 20s, teenage mothers were four times more likely to be living in poor housing conditions. They were also over eight times as likely to have been lone parents, and almost three times as likely to lack qualifications, by the age of 33 (Allen & Dowling, 1998).

These adverse factors are particularly notable among the lower social classes (Klernan, 1980; Washington, 1982; Russell, 1983; Bury, 1984; Ireson, 1984; Coyne, 1986; Robbins et al, 1985.). One study reported that the risk of becoming a teenage mother is almost 10 times as great for young girls from the unskilled class, than those from the professional classes (Botting et al, 1998).

Similarly in the Caribbean, research suggests that the incidence of teenage pregnancy seems to be highest among 'working class' peoples of the Caribbean (Jagdeo, 1984:128). This qualitative study conducted on a sample of 141 teenagers from 3 countries in the Caribbean region, arrived at several controversial conclusions by indicating that:

'the problem is severest in those working class families where the locus of moral authority is weak or ill defined. Such families exhibit one or more of the following characteristics: unmarried parents, multiple absent fathers, and a life where different persons at different points of their formative years' brought up young people'.

In addition, Jagdeo argued, for working class families where there was more stability with respect to those determining factors identified, the incidence of teenage pregnancy appears to be lower (Jagdeo, 1984). While I will not attempt to deny the adverse effects of such characteristics mentioned by Jagdeo, these characteristics have to be analysed within the context of a number of other interrelated and interconnected factors. Among them is the extreme disadvantage that is the pattern of the daily lives of poor families in the Caribbean, where, as we have seen in chapter one, economic deprivation and need often force women to rely on a succession of men for financial assistance. Such issues are very complex and not simply because the 'locus of moral authority is weak, or ill-defined'. The part which males play in these teenage pregnancies also has to be examined. This examination should include: their failure to live up to their parental responsibilities, the context of their perceived role within the wider sociological, political, economic, as well as historical contexts of the society, where male exploitation and dominance are viewed by some members of society to be an inalienable right.

There is no doubt that the evidence in relation to social class and teenage pregnancy is convincing, This is particularly so when analysed in relation to statistics from the Office of National Statistics, which show a correlation between high rates of teenage pregnancy and deprived London boroughs and other regions of the United Kingdom (ONS, 2000). What is noteworthy however, is the finding from a study conducted in 1998 which suggests that teenage mothers in the United Kingdom come from a variety of social and educational backgrounds (Allen & Dowling, 1998), and not exclusively from deprived groups as is widely believed. I would also argue that teenage pregnancies among the higher echelons of society are underrepresented in the statistics of teenage pregnancies,

because these statistics do not reflect the research findings that there are higher rates of abortions for pregnant teenagers from more affluent areas (Smith, 1993). This factor therefore:

'raises the worrying question of whether girls in the most affluent area are placed under undue social and parental pressure to terminate their pregnancies possibly against their real wishes (Smith, 1993:1235).

Researchers do not always agree about the extent to which these socioeconomic factors contribute to teenage pregnancies. For example, Oz and Fine's comparative study, found 'no solid evidence for the existence of significant differences between teenager mothers and non- mothers with respect to demographic backgrounds' (Oz & Fine, 1988:257). The only exceptions were mainly related to other factors such as having been in foster care, having an abusive boyfriend and experiencing difficulties in school. Other researchers argue that teenage pregnancy does not lead to poverty, but may exacerbate an already economically deprived situation (Williams, 1991).

Longitudinal studies on teenage pregnancy have revealed that while there is no denying the impact of the initial disadvantages and drawbacks of early pregnancies, and the fact that these disadvantages may persist throughout life; poor financial, occupational, familial and social outcomes are by no means inevitable (Lawson & Rhode, 1993). Many teenage mothers and their children achieve good levels of educational and occupational progress. Additionally, Bury (1984) found evidence to suggest that if teenagers are well supported by their partners, families and services, outcomes for their children are likely to improve.

Teenage mothers have also been reported to be more prone to stress and other mental health difficulties (Simms & Smith, 1984; Maskey, 1991). In Maskey's study for example, of the 52 teenagers studied, one quarter was reported to have a possible mental disorder. Teenage mothers have also been identified, as vulnerable to sexually transmitted diseases, including HIV & AIDS as a result of ineffective contraceptive use and unsafe sexual practices (Hudson & Ineichen, 1991; Bury, 1991; Mellamby et al, 1992; Chevannes, 1993; Public Health Laboratory Service, 2000).

The medical risks associated with teenage pregnancy have been an issue of international concern and have been widely reported in several studies. One

notable exception, is Hudson & Ineichen (1991:57) who state that:

'the health of teenage girls is generally good, and pregnancy is unlikely to be health threatening', because 'many of the health problems encountered by pregnant teenagers are not the result of medical complications per se, but spring from inappropriate life styles'.

Elsewhere it is usually the norm for teenage mothers to be associated with a higher risk of complications such as low birth weight babies (Rotchell, 1983; Simms & Smith, 1984; Nicholson, 1991;). There has also been a higher reported prevalence of foetal distress and premature/post mature babies. In addition, the children of teenage mothers are more likely to be hospitalized for accidents and other complaints such as gastroenteritis during the first five years (Taylor et al, 1983; Bury, 1984).

Klein's (1974) study of repeated pregnancies found that the premature birth rate was significantly higher for girls aged sixteen and under compared to girls aged seventeen to nineteen years. A clear link was also found between perinatal mortality and age at first birth. For example, the study found that perinatal mortality rates per thousand births were 39.3 per 1000 for those girls aged sixteen and under, 36,7 per 1000 for those aged seventeen to nineteen, and 30.7 per 1000 for those aged twenty and over. The study concluded that:

'foetal mortality, neonatal mortality and perinatal mortality rates were all consistently higher for younger patients, but the numbers of deaths are small and the differences are not proved to be statistically significant'(Klein, 1974:251).

McCormic et al (1984) also found that post-neonatal mortality rates are approximately twice as high for infants of teenagers less than seventeen years of age as for older women. In addition, pregnant teenagers under 15 years have a maternal death rate that is 2.5 times that of mothers age 20 - 24 (Bury, 1984, Corbett & Meyer, 1987). Complications arising from childbirth and abortion were among the five principal causes of death among young women in the 15-19 age group, in Latin America and the Caribbean (Harper, 1989).

Pregnant teenagers are also more likely to develop anaemia and other problems during pregnancy such as toxemia, premature delivery, prolonged labour and cervical trauma (Rotchell, 1983; Bury, 1984; Corbett & Meyer, 1987; Hayes, 1987; Hudson & Ineichen, 1991; Nicholson, 1991; WHO, 1991). There are also medical

risks associated with termination of pregnancies. However, not all research supports this view. In the case of abortion, some researchers argue that the increased physical risks are linked to a large extent to the tendency for teenage girls to present late for abortions, which increases the overall risks, rather than risks associated with abortions simply being related to age (Zabin & Sedivy, 1992). In addition, it is also important to make distinctions between younger and older teenagers in relation to the risks linked to abortions. For example, Russell (1983:159) found that the risk of complications following abortions, 'is significantly greater in teenagers aged 16 and under than in older girls aged 17, 18, and 19'.

These reports of adverse medical complications of teenage pregnancy cannot and should not be ignored, particularly in the third world where in some countries there is a high rate of maternal and infant mortality, which is outside the scope of this review to explore. There is nevertheless, evidence to suggest that such reports may be exaggerated as far as developed countries are concerned. For example, a large-scale retrospective case record analysis study of 715 births which occurred to girls aged 16 and under between 1977 to 1988 in the UK, found few differences in health between pregnant younger teenagers and pregnant women in their early twenties. There were however, some exceptions such as anaemia, urinary tract infections and hypertension, which were found to be more common among the younger age group (Konje et al, 1992). I am also inclined to agree with McAnarney et al (1989:75) when they state that:

'the effects of young maternal ages on obstetric and neonatal outcomes are often difficult to separate from the influence of low socioeconomic status, educational disadvantage, overcrowding and lack of support'.

Further poor outcomes include the findings that the children of teenage mothers are more likely to be physically abused (Butler et al, 1981) and to perform less well in school (Brooks-Gunn & Chase-Lansdale, 1991). Similarly, several studies suggest that children of teenage mothers exhibit more behavioural problems and lower scores on 'intellectual tests' than school-aged children of adults (Oppel & Royston, 1971; Hardy et al, 1978). What is unclear however, are the reasons why these children have more developmental problems. Whether the reasons for behaviour and learning difficulties lie in factors such as mother-child interaction, the lack of father figure, socioeconomic disadvantage, or other factors, is still unclear and needs further exploration. Furthermore, the emphasis on the age of the mother as an indicator of parenting capacity often ignores the range of

potential for becoming successful mothers, or of the diversity that exists among young mothers.

There is no denying the facts that adolescence years can often be turbulent and unpredictable, and that early-unplanned pregnancies may add further stress to what is often a very stressful time for adolescents. Therefore to cite examples of how a young mother responds to the pressures of parenting during such turbulent years, as an indicator of future outcome, may offer an extremely incomplete picture of adolescent parenting in terms of outcomes. Such views also fail to take into account the enormous capacity for coping and for personal growth and change, of which human beings are capable. Various workers in the caring professions witness such changes on a daily basis, and an increasing number of studies provide evidence of teenage mothers coping well with the demands of motherhood (Furstenberg et al, 1987; Phoenix, 1991; Schofield, 1994).

In view of the above evidence so far presented, it is reasonable to conclude that while teenage pregnancies can be experienced as a problem for some young people, this is by no means inevitable. The arguments in terms of teenage pregnancies being viewed as a problem are often focused around physical, social and psychological risks to the mother and child. However, the extent to which the pregnancy becomes a problem often depends on what steps are taken by parents, health and social care agencies involved to offer support to the young women to reduce these risks. Many young women, despite the odds, do take their parenting responsibilities seriously, and have proven that they are good parents.

In addition, as Geronius (1991) cautions, we need to be mindful of the dangers of providing simple explanations to answer complex questions. Within this context, a growing body of evidence has challenged this automatic association between teenage mothers and socioeconomic disadvantage, and between teenage mothers and poor childcare. This evidence suggests that the dominant and widely held view that teenage pregnancy automatically equals long term economic and social disadvantage, has been exaggerated and even misleading (King & Fullard, 1983; Furstenberg et al, 1987; Phoenix, 1991). Some studies have been unable to demonstrate marked differences in parenting skills between teenage and older mothers (Bierman & Streett, 1982).

This critique is not intended to dismiss the research findings of an association

between teenage pregnancies and socioeconomic disadvantage. However, to lay these ills solely at the door of teenage pregnancies which as we have seen in chapter one, some newspaper writers and government officials are inclined to do, is quite misleading and futile. It takes attention away from the urgent need to address the root causes of these problems.

In addition, Hayes (1987; Abrahamse et al (1988), and Rindfuss et al (1988) have argued, that prior to their pregnancies, a significant number of these young women often do less well academically than those teenagers who do not become teen mothers. Is it then strictly accurate to blame early pregnancies for socioeconomic disadvantage? Could it be that the factors that lead to disadvantage in inner city neighbourhoods and extremely isolated rural areas, are more likely to be responsible for disadvantage in later life, than an early pregnancy? With the exception of Furstenberg et al's work, the limitation of most studies in assessing outcomes, stems from the fact that they are not longitudinal, and therefore can only report their findings in relation to the immediate years following the birth of the first child and subsequent children. As a result, relatively less is known about the long-term effects of teenage childbearing.

I am inclined to agree with Furstenberg et al (1987:8) who argued after reviewing the evidence in relation to social and economic disadvantage, that although:

'the evidence that early childbearing increases the risk of social and economic disadvantage is compelling. However, it is less clear whether this risk is sufficiently high to justify social stereotypes of the teenage mother that has emerged from social science research and its portrayal in the mass media' (Furstenberg et al, 1987:8).

An encouraging note to conclude this section is the findings that suggest that teenagers who receive early and adequate ante-natal care should be at no greater risk of experiencing adverse medical outcomes than older women from similar socioeconomic backgrounds (McAnarney, 1983).

3. RACE DIFFERENCES IN RELATION TO AGE AT FIRST BIRTH AND REPEATED TEENAGE PREGNANCIES

Racial differences have always featured prominently in the early literature relating to teenage pregnancies in the United States. Black women have been shown in several studies to have a higher fertility rate than white women (Bolton, 1980;

Washington, 1982; Lundberg & Lenroot, 1984; Kuziel-Perri & Snarey, 1991). Ford (1983), also found that repeat teenage pregnancies were much higher among black teenage mothers with low income in the United States. Similarly, in terms of repeated teenage pregnancies, some reported evidence to suggest that black women also begin childbearing at a much younger age than is generally the case with white women (Trussell & Menken, 1978; St. John, 1982). As a result of this earlier age at the time of first birth, black women are said to be at risk of multiple repeat pregnancies, and a higher incidence of unwanted births at earlier ages than is the case for white women (Ryder & Westoff, 1971; Westoff & Ryder, 1977).

Two main views have emerged in an attempt to account for the reported differences in fertility between racial and ethnic groups of young women. The first and earlier view often hypothesized that there are unique characteristics of black culture which have been reported to have a marked impact on both attitudes to fertility and rates of fertility (Goldscheider & Uhlenberg, 1969). These concerns about black fertility date back to 1965 with the publication of Moynihan's Report entitled 'The Negro Family: the case for National action (Williams, 1991). One of the suggestions of this report was that the black family is matriarchal and therefore operated outside the norm for most families. Illegitimacy, including teenage pregnancies, therefore becomes an acceptable phenomenon of every day life for such families. The drawback with these explanations is its speculative nature. No clear evidence has been provided to isolate the unique characteristics among black women, that are supposed to be responsible for maintaining this different effect on fertility rates and pace.

It is not surprising therefore, that the second explanation which has often challenged the first explanation, attributes differences in fertility between racial and ethnic groups and the white population, not to racial characteristics, but to differences in socioeconomic status (Thomlinson, 1965; Bogue, 1969; Presser, 1971; St. John, 1982; Williams, 1991). Moynihan for example, failed to explore the links between 'black female-headed households and poverty' (Williams, 1991).

No compelling explanations have been given for the earlier age of first births among black women. Additionally, as St. John (1982) argues, another serious shortcoming of these research studies is the fact that they focus almost

exclusively on the number and age of first pregnancies, rather than on the factors that impact on the final outcome. Therefore to make such speculations credible, research needs to focus on the factors contributing to the earlier age at first pregnancy and the pace and number of first pregnancies in order to isolate where differences identified in relation to race, are solely due to cultural and racial characteristics.

Mott's (1986) longitudinal study of 6078 teenage women, which spanned an eight-year period, highlighted the complexities inherent in isolating the distinct relationship between race and fertility differences. The study found 'important racial and ethnic differences in the likelihood of rapid repeat childbearing'. Among white teenagers, age at first birth had no marked effect on the proportion of teenagers who have a second birth quickly (12 per cent). On the other hand, among black teenagers, 'it has a significant inverse effect', with younger black teenagers (aged 16 and under), more likely than older black teenagers to have rapid repeat pregnancies. In addition, the oldest white mothers (ages 19-22), have a higher likelihood than the oldest black mothers of the same age range, to have rapid repeat pregnancies. At nearly all ages, at first birth, Hispanic mothers have an increased likelihood than either white or black teenagers, to have a repeat pregnancy soon after the first birth. The pattern for Hispanic teenagers was described by the researchers as 'U-shaped', with the greatest tendency towards rapid repeat childbearing found amongst the youngest at first birth (Mott, 1986:5). Mott acknowledged that in evaluating the findings of this study, it needs to be borne in mind that the relatively small sample size for Hispanic teenagers produced somewhat 'unstable estimates' and therefore make statistically definitive comparisons more difficult. However, on a whole, the data suggest that Hispanic mothers are generally more likely than white or black teenagers to have a second birth soon after the first.

These varied findings in the rate of repeat pregnancies, in particular, between black and white teenagers, would suggest an underlying marked difference between these sub-groups in their orientations towards the future, as well as socioeconomic characteristics. However, despite Mott's earlier association between racial differences and repeat pregnancies, he also reported that within each age group, black teenagers are 'significantly more likely' than white teenagers to have expectations of having fewer than two children. These black teenagers also report 'surprisingly high educational aspirations'. This gap

between the aspirations and the end result, I believe, clearly suggests that there are other factors apart from racial characteristics which affect these racial sub-groups differently, and which impact on the differences in findings in relation to rapid repeat pregnancies between these groups. These differences therefore, cannot be attributed purely to racial differences alone. What factors for example, mitigate against the realization of the aspirations and the reality? These are just some of the issues that need further exploration.

These complexities are further compounded by the fact that some studies found no significant differences between black and white teenagers, and in some respects, Hispanics teenagers. Where differences were reported, the maximum difference in birth rates by race occurs among girls under 15, the most vulnerable teenagers (Edelman & Pittman, 1986). In addition, Ford's 1983 study on repeated pregnancies, found that seventeen per cent of all teenage mothers became pregnant again within a year of the first birth, but the rates were the same for white and black teenagers.

The possible exception to this rule is in the case of Hispanic teenagers, where it would appear that there is a clear link between ethnic differences, cultural values and repeat pregnancies. For example, Mott's (1986) study also reported that young Hispanic mothers have a lesser likelihood to have any expectations of higher education. Unlike both black and white teenagers who report lower fertility expectations as their age at first pregnancy increases, Hispanic mothers report expectations that 'vary relatively little with age at first birth'. Thus the women who begin childbearing at aged sixteen or younger, are just as likely to expect to have a large family, as women who begin childbearing at age nineteen. These data also suggest, that young Hispanic mothers often hold more traditional values about education, motherhood and childrearing. This would also help to explain one finding of the study that they are more likely than young white and black mothers of comparable age, to report that the first child was wanted. These findings have also been supported by other studies (Dore & Dumois, 1990).

These diverse findings suggest that like many of the areas looked at so far, the conclusions reached have been conflicting, and lack contextualising. When challenged and tested, only partial support for such assumptions has been found. While different ethnic groups may indeed hold distinct cultural values about pregnancy and motherhood, given the deprived socioeconomic conditions under

which these teenagers often live, the distinction between cultural differences and socioeconomic status becomes increasingly blurred and difficult to isolate. Additionally, these reported contributory variables are never consistently fully explored. In many respects, it could be argued that this lack of exploration is due to the limitations imposed to a large extent by the methods of data collection used in the majority of these studies which have been mainly quantitative. For example, the reported link between racial differences and repeat pregnancies has not been clearly demonstrated beyond the presentation of statistical data. These data leave many unanswered questions. Reasons for the reported differences are still unclear and are not as straightforward as the findings would suggest at a glance.

Additional evidence to strengthen the argument for further exploration in terms of racial differences also comes from Mott's study which has shown that rapid transition from single to repeat pregnancy status is affected by several factors beside race and ethnicity (Mott, 1986). One such factor is the 'socioeconomic background, as represented by the level of parental education'. The study showed that compared with young mothers whose own mothers completed high school; those teenagers whose mothers dropped out of school were more likely to have a second birth within twenty-four months of the first birth. Among the young women ages sixteen or younger, 28 per cent of those whose mothers dropped out of high school have a second child within two years, as against 19 per cent of those whose mothers were graduates. Among the seventeen to eighteen age group, 22 per cent compared with 16 per cent respectively have another child within two years.

4. STRATEGIES TO REDUCE REPEATED PREGNANCIES

There is some evidence to suggest that delaying the occurrence of a first repeat pregnancy can have a positive impact on delaying further pregnancies as well as avoiding the negative outcomes of repeat pregnancies (Furstenberg et al, 1987; Horwitz, Klerman, Kuo & Jekel, 1991). As a result, a number of researchers have focused their attention on the effectiveness of postnatal intervention services for teenage mothers, as it has been generally agreed that antenatal services alone have not been proved to be effective in preventing repeat pregnancies (Jekel, Tyler & Klerman, 1979; Bertrand et al, 1986). A more comprehensive provision of postnatal services offered in schools have been reported in some studies to produce encouraging results in reducing repeat pregnancies in teenage mothers.

It is not always possible however to reach firm conclusions about the effectiveness of these services, as most intervention programmes are not evaluated beyond the immediate post natal intervention period (Seitz & Apfel, 1993). This makes evaluation of their long-term impact difficult. Nevertheless, some of these studies often provide reports of a significant decrease in the rate of repeat teenage pregnancy for up to two years following intervention (Olds et al, 1988; Seitz & Apfel, 1993). It is therefore not surprising that researchers often argue that such service provisions can help in the prevention of repeat teenage pregnancies.

In Klein's (1974) study which evaluated the success of an 'Interconceptive Care Clinic', significantly more girls returned to school after attending the programme than before attending the programme. Despite the fact that these programmes are more expensive to run when compared with adult contraceptive services, they prove to be more cost effective in the long run when compared to the cost of a repeat pregnancy.

In addition, Furstenberg (1976) and Furstenberg et al (1987) provide evidence of the benefits of the provision of services for pregnant teenagers in specialized settings in reducing repeat pregnancies. They reported that poor 'African-American' teenage mothers who received post-natal care at an 'Adolescent Family Clinic', very often continued to keep in contact with the staff for sometime after the birth of their babies. This contact developed into the provision of some form of informal post-natal service. It was found that these teenagers were more likely to use contraceptives on a regular basis than those women who attended the regular post-natal clinic of the hospital. In their follow-up study (Furstenberg et al, 1987), 39 per cent of the young mothers who attended the clinic did not have a repeat pregnancy, compared with 25 per cent of those who attended the regular post-natal clinic. These differences are significant given the large sample size, about four hundred teenagers of two comparable cohorts who were assigned randomly to two clinics.

In spite of the reported successes of these programmes mentioned above, researchers are not always in agreement about their effectiveness in preventing repeat pregnancies. For example, Polit et al (1986), found that despite the fact that seventy five per cent of the sample of 675 young mothers in their study, had participated in special teenage parent programmes to discourage repeat

pregnancies, half of those teenagers went on to have a repeat pregnancy during the two year study period.

For those studies that reported successes, there is a lack of clarity about the range of intervention approaches that are potentially effective in reducing unwanted repeat pregnancies, since the length of time of the services that are provided vary from programme to programme. It is encouraging to note however, the reports that relatively brief post-natal intervention with first time teenage mothers, significantly reduces the likelihood of subsequent pregnancies over a five-year period (Seitz & Apfel, 1993).

SECTION TWO

ADDITIONAL KEY THEMES - TEENAGE PREGNANCIES IN GENERAL

Family dysfunction and discord

Numerous studies have identified a number of variables commonly viewed as 'risk factors' associated with family dysfunction and discord that have an impact on teenage pregnancy. These include factors such as the experience of growing up in a one parent family (Miller & Moore, 1990); experiencing the trauma of sexual abuse (Boyer & Fine, 1992; Miller & Moore, 1990); being in care for a number of years (Oz & Fine, 1988) and leaving care (Gamet, 1992); growing up in a large family, particularly if one or more siblings were also pregnant as a teenager and there is a lack of stability (Oz & Fine, 1988; Konje et al, 1992); or parental divorce (Kiernan, 1996; Oz & Fine, 1988, Curtis et al, 1988). In an attempt to place some of these risk factors in context, I have focused on two issues – the role of family support and gender attitudes.

The role of family support

Closely linked to mother/daughter relationship looked at in section one is the role of family support in relation to teenage pregnancy. Research indicates that the previously identified negative effects of teenage pregnancy, can be overcome where there is parental support. This support significantly affects the ability of pregnant teenagers and teen mothers to cope successfully with the demands of their changed status. This view is also supported by Furstenberg & Crawford, (1978), when in reference to their seventeen year longitudinal study of young mothers in Baltimore, they suggest:

'the assistance rendered by family members significantly alter the life chances of the young mother, enhancing her prospects of educational achievement. It may also contribute to the well-being of her child...' (Furstenberg & Crawford, 1978:338).

Indeed the importance of family support is a theme that has been consistently echoed in research over three decades (Hopkinson, 1976; Furstenberg &

Crawford, 1978; Furstenberg, 1980; Manlove et al, 2000).

It is important to note however, that while these researchers frequently acknowledge the importance of family support, there is often little effort to explore the impact of providing this support on the family system as a whole. The notable exception however, is Furstenberg (1980), who had examined the role played by the family in an attempt to define the tasks that the family were actually accomplishing. He concluded that the family played a vital role in easing the transition to parenthood by the provision of childcare instruction, as well as financial and other assistance to their daughters. The role that is played by the extended family therefore substituted for some of the same advantages that are provided by 'conjugal units' when both parents play a part in socializing their child.

Gender attitudes

While there is no underestimating the impact of the family variables mentioned above, there is evidence to suggest that the picture so far painted in terms of the impact of family variable on teenage pregnancy is incomplete. Another often-overlooked, but important factor may also have considerable impact on teenage pregnancies in different ways. The beliefs and attitudes that young women hold towards the role of women in society, are likely to be highly influential contributory factors and influence upon early teenage pregnancies. For example, young women who reject traditional family roles may be more likely to engage in sexual activities if they reject the 'double standard' imposed by society in relation to gender differences in expectations of sexual intercourse. However, because they have stronger career aspirations, if they engage in sexual activity they are more likely to be diligent in using contraceptives (Morrison, 1989; Plotnick, 1992).

In some cases teenage girls who hold 'egalitarian views' about the role of women in society are less likely to engage in sexual activity as career aspirations feature prominently in their list of priorities (Cvetkovich & Grote, 1980). They have a greater awareness that early sexual activity could interfere with their future goals, and therefore are able to see the need for postponement of sexual activity. However, in some instances having career goals does not necessarily mean the postponement of early sexual activities, as some young women are prepared to have abortions if they become pregnant. As research cited earlier has suggested, this is particularly the case among young women from more affluent areas.

Additionally, if they decide against having an abortion, they are much more likely to opt for single parenthood (Brazzell & Acock, 1988; Plotnick, 1992). In this regard, single parenthood is seen as a conscious positive choice rather than the tragedy that is so often associated with teenage pregnancies. Therefore it would appear that the relationship between teenage pregnancy and the views that some young women hold about their respective roles in society, will depend on their particular interpretation and acceptance of various aspects of these views.

Teenage sexuality

Researchers have made a clear association between teenage pregnancy and the increasingly earlier age of commencement of sexual activity. This could be linked to the fact that the age of first menstruation for girls, has decreased from around the age of 14 in 1900 to about age 12 (Bury, 1984; Hudson & Ineichen, 1991). However, Russell (1983:159) argues that 'the lowering of the age of menarche cannot have had more than a marginal effect' on the increased sexual activity among teenagers. He further argues that a more 'plausible explanation is the effect of the widespread portrayal of the apparent advantages of sexual liberty in the press, in women's magazines, on the radio, and on television'.

Reports of early sexual activity in the Caribbean are clearly linked to social and economic factors. This is evident in the reasons given by teenagers for early sexual activity. These reasons include: the need to show love for their partner, (more commonly expressed by girls than boys), peer pressure, pressure from adult males with the offer of money as an incentive for sex; and to feel 'grown up' (Brody, 1981; Jagdeo, 1986; Aymer & Pichery, 1993a & b; Russell-Brown, 1988).

The extent of early sexual activity in the U.K and USA has been confirmed by studies which show that around half of the sixteen year olds and about 80% of nineteen year olds are now considered to be sexually active (Ford, 1983; Breakwell & Fife-Scraw, 1992; Wellings et al, 1994, Johnson et al, 1994). It is therefore not surprising that in addition, there is also evidence which points to the fact that pre-marital sex is approved by almost all teenagers (Wellings et al, 1994).

Self concept and self esteem

Having looked at gender attitudes and teenage sexuality, the issues of self esteem and self concept become pertinent. A number of researchers have suggested that a relationship exists between the incidence of teenage fertility, self-esteem and self-concept. Before looking at the evidence, it is necessary to have some clear working definitions of these concepts. Self concept has been described as a set of beliefs and images derived from a range of factors that impact on these beliefs such as race, social class, sexual preference, educational achievement etc., that individuals hold about themselves (Sandford & Donovan, 1993). In contrast, our level of self esteem is a measure of how much we like and approve of the concept that we hold of ourselves (Rosenberg, 1979). These definitions suggest that because of the way we construct our self concept from these factors, it is therefore possible to have a positive self concept and still have a lack of self esteem. This lack of self esteem is manifested in feelings of inadequacy to cope with day to day problems, feelings of incompetence and ineffectiveness (Zongler, 1977; Paik, 1992). Many researchers argue that for some young women with low self esteem, pregnancy may be one way of improving their self esteem by conferring identity and status. In this regard low self-esteem might therefore play a large part in pregnancies and births among teenagers (Russell, 1983; Hudson & Ineichen, 1991). As a consequence, teenagers with low self-esteem are more likely to become sexually active at an early age, and if they do become sexually active, will fail to use contraceptives. These actions will inevitably result in unwanted teenage pregnancies.

While there may be a link between self-esteem, self-concept and teenage pregnancy, the findings are far from conclusive and make it necessary to question the extent to which self-esteem plays a significant part in teenage pregnancies. For example, Paik's study on a sample of 148 teenagers, concluded that:

'indeed, teenage pregnancy and self concept seem to have a definite association or relationship (with teenage pregnancy), it is not certain, however, how and under what conditions these factors are related' (Paik, 1992:106).

The extent to which low self esteem and self concept is seen as a contributory factor to teenage pregnancies, would also depend on whether one views teenage pregnancy as negative, and in particular, on how teenagers themselves view their pregnancies. If it is viewed as a conscious positive decision, then the concepts of

low self esteem and low self-concept in this context become redundant, or at the least are open to question.

To add to the complexities of these issues, Robbins et al (1985), have argued that the relationship between self-esteem and teenage pregnancies is weak, as in certain circumstances, some teenagers with low self-esteem and intense feelings of powerlessness, had little risk of becoming pregnant. Similarly Paik (1992), found that in her study, the teenagers who had repeat pregnancies had slightly higher self-concept in general than teenagers who had only one pregnancy. Other researchers report little or no connection between self-esteem and teenage pregnancies (Cvetkovich & Grote, 1980; Vernon et al, 1983; Robbins et al, 1985; Morrison, 1989; Plotnick & Butler, 1991). Ford's (1983) study also reported that although low self esteem was found to be an important contributory factor for both first and repeated pregnancies, this relationship is not as straightforward as it appears on the surface, and is compounded by a number of additional factors. For example, young women trapped in a cycle of poverty have limited life opportunities despite any career aspirations that they might have. This can result in a sense of hopelessness (Cobliner, 1981; Smith et al, 1982; Stark, 1986), and as a consequence, the opportunity of becoming a mother is the reality that replaces the limited life opportunities.

Some research evidence portrays pregnancy as a very stressful and isolating experience for many teenagers. This experience is compounded if the teenager finds herself isolated from her friends and family. Consequently, high levels of social isolation or loneliness, have been reported in early research studies about teenage pregnancies (Curtis, 1974; Johnson, 1974; Curtis et al, 1988).

Additionally, these teenagers are reported to have more difficulties in socializing and forming meaningful relationships with other people (Roberts, 1976; Cobliner, 1981; Falk et al, 1981; Paik, 1992). When these factors are taken into account, it becomes highly plausible that these teenagers would experience their pregnancies as being a frightening and lonely experience as already fragile social networks become increasingly weakened (Havighurst, 1972). These experiences can impact negatively on the teenagers' self esteem and self-confidence.

It is interesting to note however, the evidence to suggest that the tendency towards teenagers viewing their pregnancies as frightening and undesirable occurrences in their lives is being replaced by increasingly more positive views

about pregnancy (Falk et al, 1981; Barth et al, 1983; Phoenix, 1991). These young women may feel more in control and therefore less likely to settle for any partner, and therefore more prepared to face up to the challenges of single parenthood (Robbins et al, 1985; Hanson et al, 1987).

While it may be feasible to argue that there is some link between self-concept, self-esteem and teenage pregnancies, as a number of studies do point to this link, however the conditions under which the factors of self esteem/concept are manifested in relation to teenage pregnancies remain inconclusive. For example, Paik (1992) has argued that 'antecedent variables' such as a broken home environment, or poor family relationships may influence both self-esteem and self-confidence. Poor self-esteem may influence other variables such as peer group influence and sexual activities, which in turn may affect the incidence of teenage pregnancies.

Peer influences and pressures

Among the other factors that have been said to have a contributory impact on teenage pregnancies, is peer pressure. A lot of this pressure comes from sexual partners, where sex is portrayed as a very important part of the relationship and a sign of love for one's partner (Brody, 1981; Bury, 1984; Jagdeo, 1986; Russell-Brown, 1988; McAnarney & Hendee, 1989; Rudat, Ryan & Speed, 1992; Aymer & Pichery, 1993a & b). Additional evidence suggests that early sexual activity is 'prompted partly by peer pressure and partly by the need for affection' (Corlyon & McGuire, 1997:57). Some pressure also comes from girls who often try to convince their peers that sex is a normal part of the relationship and it is desirable to engage in sexual activities as everyone else is also having sex (Mellanby et al, 1992). As Williams (1991) points out, the powerful impact of peer group influence becomes even more understandable, if we accept Erikson's assertion that one of the most difficult tasks that adolescents have to undertake is the avoidance of role diffusion and the establishing of personal identity (Erikson (1968) cited in Williams, 1991). In order to succeed in this task, a certain amount of distancing from their families who have been their main reference group before adolescence becomes necessary. As adolescents increasingly distance themselves from their parents, the identification with their peer groups also increases. The peer group therefore becomes the 'natural laboratory for accomplishing these tasks'. As this dependence on the peer group increases, parents inevitably lose some of their

usual authority and parental control over the actions of teenagers (Williams 1991). This helps to explain why peer pressure and influence on the behaviour of teenagers is so powerful.

While teenagers might be susceptible to negative influences from their peers, there is also a growing body of evidence that shows that teenagers are equally susceptible to positive influences from their peers. The evidence for this claim comes from studies of peer led programmes and projects that have yielded encouraging results. For example, reviews of a peer led education programme for young people in the United States, indicate that those young people who attended peer facilitated groups showed a greater increase in knowledge and awareness of risk factors, than was the case with other young people who received no counselling (Rickert, Gottlieb & Jay, 1991). Peer counselled groups demonstrated greater changes in terms of their attitudes towards sexual activities than adult facilitated groups. This increased awareness was attributed to the fact that young people found it far easier to ask questions of their peers than was the case with the adult counsellors.

The influence of alcohol and drug use on teenage pregnancy

There has been a long-standing and commonly held belief that the use of alcohol and drugs contribute to sexual risk-taking behaviour. Of particular relevance to this review is the evidence which cites alcohol and drug use as 'situational factors which may influence pregnancy risk-taking' behaviours in young women (Flanigan et al 1990; Flanigan & Hitch 1986; HEA 1997). However, while 'there is little doubt that the use of psychoactive substances often coexists with sexual behaviour' (Rhodes & Stimson 1994:210), the precise relationship between the use of drugs, alcohol and sexual behaviour has not been clarified. For example, as Rhodes & Stimson (1994:209) point out following a critical examination of the literature, that while research provides evidence of a link between 'drug-taking and sexual risk behaviour, the determinants of the relationship between drug-taking and sexual risk remain unclear'. These researchers did not find it easy to establish from the studies reviewed, whether the use of alcohol and drugs reduce inhibition in relation to sexual activity, or whether there is a greater tendency among those who drink or use drugs to take risks. (Rhodes & Stimson 1994). This led them to conclude that 'understanding of the relationship between drug-taking and sexual risk rest as much upon commonsense understanding as on empirical evidence'.

Similarly, Flannigan et al (1990:206) in their research which explored the relationship between alcohol use, risk-taking and teenage pregnancy, reported that the use of alcohol prior to intercourse was found to be 'a frequent and common practice'. However, they did not find 'a statistically significant relationship between contraceptive nonuse and drinking when compared to nondrinking women'. These researchers found that a combination of factors, including alcohol use, may have resulted in a 'complex web of reasons for pregnancy risk-taking', rather than alcohol use per se. Nevertheless, alcohol use, 'while not necessary or sufficient to deter a woman from protecting herself against pregnancy, may be a significant element among other causal factors' (Flannigan et al 1990:213).

Sex Education

For many years there has been an on-going debate about the value and effectiveness of sex education. It would appear that there are two main aspects of this debate. On the one hand there are those who argue that the provision of information related to sexual activities would equip young people with the necessary skills to make more informed decisions about avoiding unprotected sex, unwanted pregnancies and diseases. On the other side of this debate, is a relatively small, but nevertheless powerful and influential lobby against sex education in schools, on the grounds that it can encourage promiscuity and early sexual activity. This is in spite of abundant evidence to the contrary which shows that the arguments for sex education far outweigh the arguments against sex education. Evidence from the Netherlands, the USA and Sweden (Boethius, 1985; Hayes, 1987; Trussel, 1988; Stout & Rivara, 1989; Francis, 1994) clearly indicates that sex education does not encourage promiscuity or precocious sexual behaviour.

These studies suggest that comprehensive good quality sex education is an important strategy in reducing unwanted teenage pregnancies and sexually transmitted diseases. For example, research shows that 'the Netherlands has the lowest figures for teenage pregnancy of all developed countries' (Francis, 1994:27) The government is fully committed to sex education, which is provided by private family planning agencies funded by government. 'There is widespread coverage of human sexuality (including sex education) issues in the media' (Francis, 1994:28; Jones et al, 1985; Trussell, 1988), which as we have seen in chapter one, is quite

the opposite approach to what happens in Britain. Similarly, Sweden has one of the lowest teenage pregnancy rates in the world, where the level of sexual knowledge among 5 - 15 year olds is better than children of a similar age in the UK and the USA (Boethius, 1985).

Research in the Caribbean suggests that there are various reasons why young girls become pregnant. Prominent among these reasons is lack of understanding about conception and related factors. That is, although teenagers often understand that sexual activity leads to pregnancy, they frequently fail to understand the connection between sex, the menstrual cycle, contraception and pregnancy (McNeil & Olafson et al, 1983; Powell & Jackson, 1988; Russell-Brown, 1988; Chevannes, 1993; Jagdeo, 1994).

In the United States, there is also evidence pointing to the lack of adequate knowledge about sex and sexuality by the average teenager, regardless of cultural differences. Learning about sex is usually influenced by misconceptions and misinformation obtained almost entirely from peers, since puritanical attitudes which generate intense national debates in the wider society and cultural factors often inhibit open discussion about the subject with parents, adults or teachers. This therefore means that if unwanted teenage pregnancy, and all the reported associated adverse consequences are to be avoided, there must be comprehensive programmes of sex education and counselling (Onyehalu, 1983). These findings would suggest that there is an urgent need for education authorities to review their approach to sex education.

Also worthy of note is the fact that issues relating to sexuality are not discussed as openly in the United Kingdom, compared to other countries such as Denmark, the Netherlands, Holland and Sweden (Boethius, 1985; Ashton & Seymour, 1988; David et al, 1990; Lindahl, 1991; Nyman, 1993; Francis, 1994; Williams, 1994). These countries are said to be generally much more open and pragmatic about sex, and sex education, and they have lower conception rates than is the case in the United Kingdom. To compound this issue, research points to the fact that:

'attitudes to sexual behaviour in Britain are confused and contradictory. Sexual images and situations are used frequently for commercial reasons, but there are negative public attitudes towards education about sexuality and contraception.... This ambivalent public attitude is partly due to lack of knowledge and partly a desire not to offend a vocal but small minority who oppose effective sex education' (Royal College of Obstetricians and Gynaecologists, 1991 :50)

The double standards and secrecy surrounding issues related to sex in the UK serve as an added inhibiting factor for young people to discuss sex with their parents, teachers or with some adults in the agencies they approach in order to access information to prevent unwanted pregnancies. One basis of the argument against sex education in schools which is vehemently promoted by the anti-sex education lobby, is that sex education is best left to parents. Should the responsibility for sex education be left to parents as many advocate? As we have seen in chapter one, there is evidence to suggest that many parents find it difficult and embarrassing to discuss sex with their children (Ray, 1994; Social Exclusion Unit, 1999). As a result, most parents would like their children to receive sex education in schools (Morgan, 1994).

Given the arguments so far, there should be no doubt that well designed and executed sex education in schools has an important role to play in increasing knowledge and to a certain extent, change attitudes in reducing unwanted teenage pregnancies, and also in reducing the incidence of sexually transmitted diseases. Chief among them is HIV and AIDS which can have life threatening consequences. However, it has to be acknowledged that as Winter & Breckenmaker (1991), and Kirby et al, (1991), point out, sex education in schools alone is unlikely to lead to a postponement of sexual intercourse. It also does not appear to lead to any significant decrease in unsafe sexual practices, or a reduction in the number of pregnancies (Kirby, 1992; Stout & Rivara, 1989). I would however, view these findings with caution. The existing research studies on sex education are replete with evidence which points to the inadequacies of current sex education provision, in terms of poor quantity and quality. I would therefore argue that under these conditions, it is difficult to assess the true impact of the contribution of sex education on a reduction of both unwanted teenage pregnancies and sexually transmitted diseases. It is also important to note, that most studies point to the fact that sex education is likely to be more effective if it is addressed in a climate of more openness about sex, as is the case in Sweden and the Netherlands (Francis, 1994; Jones et al, 1985; Bothius, 1985; Hayes, 1987). In addition, it is also likely to be more effective if included as part of the wider context in which young people view their sexuality and their sexual relationships.

The reasons for this reported lack of success in relation to sex education have

been investigated by some researchers, and a number of explanations for this failure have been advanced. Among them is the fact that young people often lack the skills and confidence needed to enable them to use the information effectively. There is also a tendency to distance themselves from the information received (Frankham & Stronach, 1990). As stated before, young people are the recipients of the double messages delivered by society. Therefore knowledge imparted by such programmes is unlikely to change behaviour if this information is not reinforced in a positive way by the messages portrayed in the various information media such as television, the cinema, popular music and commercial advertising (Stout & Rivara, 1989). There is also evidence to suggest that young people believe that schools are only covering the biological facts and are failing to provide opportunities for meaningful discussions about sex, their feelings, fears, ignorance and so on (Alcorn, 1991; Social Exclusion Unit Report, 1999).

Additionally, a significant numbers of teenagers of both sexes become involved in sexual activity before they have had a chance to have sex education (Marsiglio & Mott, 1986). Therefore, this strengthens the point made in chapter one, that the age at which sex education begins in school needs to be re-evaluated. This view is also substantiated by research which makes the point that for sex education to be successful it needs to start much earlier and should be appropriate to the age and developmental stage of the young person (Marsiglio & Mott, 1986; Massey, 1990).

Other reasons for the reported failure of sex education are related to inconsistency of provision as the quality and the quantity of sex education can vary widely between different schools (Marsiglio & Mott, 1986; Allen, 1987; Thomson & Stout, 1992; Social Exclusion Unit Report, 1999). In addition, a significant number of teenagers criticize sex education for being too theoretical in approach (Segest, 1992; Social Exclusion Unit Report 1999). Some young people also feel that the information is provided in a boring and unimaginative manner, and teachers may lack adequate training to teach sex education effectively (Thomson & Stout, 1992; Davis, 1994; Morgan, 1994). It is therefore understandable that there is also much uncertainty and lack of confidence among teachers about talking to young people about sex and contraceptives (Ray, 1994; Social Exclusion Unit Report, 1999).

Conclusion

As the burgeoning literature on teenage pregnancies, which spans several decades has shown, on the whole teenage mothers fare badly in comparison to women who become mothers later in life. Becoming a mother during adolescence, can in certain circumstances, impact negatively on intellectual, emotional, psychological and social well being of these adolescents, hence the strong emphasis on the portrayal of teenage pregnancy as a social problem. However, the findings in regard to the outcomes of pregnancy are far from conclusive. What is encouraging is the increasing evidence that has emerged in the 90s that shows that teenage childbearing, although not ideal, does not always have to end in disaster if steps are taken to minimize the potential risks.

There are a number of gaps in the literature, among the most obvious being that which relates to the role of men and boys in teenage pregnancy. Boys need to be targeted as well. Statistics from the Public Health Laboratory Service (August 2000) showed that sexually transmitted infections increased dramatically in 1999 among teenagers aged 16-19. In addition, could the changing attitudes towards the role of women in society, women's sexuality and childbearing have an impact on the role that men and boys play, or are expected to play in teenage conceptions? How do men and boys perceive their role? These are all largely unexplored and unanswered questions, which point to the need for further research.

Other notable omissions from the literature, are studies focusing on repeated teenage pregnancies, in the United Kingdom and the Caribbean. Despite the apparent drawbacks of rapid repeat pregnancies highlighted in this review, there has been relatively little contemporary research on the conditions that influence it. The bulk of the existing research on repeated teenage pregnancies dates back to two decades ago. However, the socioeconomic and cultural environments of the teenagers of the nineties and beyond differ in many respects from the environments of the seventies and to a certain extent, the eighties in which the majority of the studies of repeat pregnancies were conducted. Among these differences are, a greater availability of contraceptive services, increased access to legal abortion provision, changed attitudes towards the role of women in society which in turn have impacted on their attitudes towards marriage and

concepts of family, relatively more opportunities to complete an education after confinement. These changes could potentially affect the conclusions drawn about the probability and outcomes of repeat pregnancy among teenage mothers.

The numerous research studies reviewed in this chapter have provided an overall comprehensive understanding of the variables that have a bearing on teenage pregnancies in general. This is less true in relation to repeat teenage pregnancies. There is no under-estimating the contribution to our knowledge base of gaining an understanding of the factors that predict which teenagers are likely to have repeat pregnancies, or the consequences of repeat teenage pregnancies. Nevertheless, there is a danger of an over reliance on predictors of repeat pregnancies in understanding the phenomenon of these pregnancies as it often underestimates the complexity of these factors. Consequently a weakness of such studies, is a failure to fully explore and evaluate the deeper and more complex underlying relationships between these predictive factors and the phenomenon of repeat teenage pregnancies. This omission has therefore left a large gap in our understanding of the interrelatedness and interconnectedness of these factors and the impact of these connections on repeat teenage pregnancies. Thus the meanings that lay beneath these variables are still poorly understood. I believe this omission is due to the fact that a significant proportion of the research reviewed in this chapter has relied heavily on the use of quantitative research methods like surveys, structured interviews and use of various inventory scales. While these approaches have proved useful in unearthing a breadth of information about the variables that impact on teenage pregnancies, they have often failed to adequately explain the relationships between these variables. One reason for this failure may be due to a predominance of what Williams (1991) referred to as the 'outsider perspective' in these studies, and a lack of 'the insider perspective', that is, the voices of the teenagers themselves. To truly understand the complexities of teenage pregnancies, we need to develop insights into the feelings, fears, hopes and internal struggles of contemporary teenagers as they confront the daily realities of life during their teenage years and their transitions into motherhood and adulthood.

It also has to be highlighted that in view of the prevailing negative images of teenage pregnancies, research findings in this area, with very few exceptions, have often failed to acknowledge the diversity and strengths of teenage women

as individuals. There is therefore an urgent need for research studies which utilize research methodologies that facilitate the unraveling of these complexities by exploring beneath the surface variables to develop a clearer and deeper understanding of the underlying factors and motives for these pregnancies. Without such knowledge our understanding of the issues will remain incomplete, and by implication, ineffective in our intervention strategies to address the issues, hence the focus of this research on seeking to understand the meanings behind repeated teenage pregnancies. This therefore requires in-depth exploration of the meanings that these young women ascribe to their pregnancies, by giving the young women a voice in evaluating the reasons for their actions. These are some of the questions and issues that have influenced the conception and execution of this research. To a large extent, these will also be the issues which this research will now go on to explore by the use of a qualitative approach, utilizing the process of in-depth interviews to get to the heart of the meanings that lie beneath the apparent complexities of repeat teenage pregnancies.

CHAPTER THREE

Research methodology and method

Introduction

This chapter presents a detailed account of the methodological approach to the design and execution of this research. It begins by outlining the aims and objectives of the study and discusses the research paradigms that have both informed and influenced the method of data collection, and looks at how these relate to the aims and objectives of the research. It then outlines and explores the rationale for the identified data collection strategy, illuminating its strengths and drawbacks. It also expands on the rationale for an international comparative approach to the study, outlined in chapter one. It briefly looks at some of the potential drawbacks and complexities of an international comparative approach as it relates to this study, and the steps taken to minimise these complexities. The chapter then goes on to address the issues of sampling and the sampling processes, as well as, issues of validity, reliability and generalizability in qualitative research, and particularly in relation to this research. It discusses the ethical considerations encountered and how attempts were made to address these concerns. It outlines the piloting and interview processes and following from this, the issues that had to be considered and addressed as the research progressed. The chapter concludes with an account of the data analysis process used in this study. Not only is this an account of the methodological approach and processes in relation to this study, but it also locates myself firmly within the framework of the research, and thus reflects the process of my own learning and development that occurred throughout the study.

As outlined in chapter one, an understanding of why teenagers have repeat pregnancies and what meanings these teenagers ascribe to their pregnancies was central to the aims and objectives of this research. In order to achieve these objectives successfully, it was felt that a qualitative approach would be the most appropriate method, as it allows me to get beyond the mechanical causes of repeat teenage pregnancies. It also allows the facilitation of the exploration of

the respondents' own construction of their experiences in a way that a quantitative approach would not have been able to facilitate. I am however, mindful of the fact that the term qualitative research is sometimes viewed 'as an umbrella term that covers a variety of styles of social research' (Denscombe, 1998:207). It is therefore important to be precise about what is meant by qualitative research in this study. The definition used by Hakim, (1987) fits well with the methodological approach used in this study. In this regard:

'qualitative research is concerned with individuals' own accounts of their attitudes, motivation and behaviour. It offers richly descriptive reports of individuals' perceptions, attitudes, beliefs, views and feelings, the meanings and the interpretations given to events and things, as well as their behaviour.....' (Hakim, 1987:26).

As this thesis unfolds, the use of this approach throughout this study will become more evident.

Paradigmatic influences

In keeping with the aims and objectives outlined above, a number of research paradigms have had an impact and influence on my approach to the design and execution of this research. The overriding sphere of influence comes from a 'co-operative inquiry' approach. This is 'an overall term used to describe the various approaches to research with people' (Reason, 1988:1) The distinctive feature of this approach acknowledges that there are numerous ways of viewing the world and gaining knowledge about the world. In the context of this research, this means a recognition that the knowledge gained from my years of practice and contextual experience as a social work practitioner and manager, is also highly valuable to the development of theoretical knowledge and insights into social phenomena and realities. This approach therefore works from the premise of 'multiple realities' and as a consequence, there can be no one objective reality. Instead there is the perceived reality, where each person's stance is a personal view of a wider picture and is therefore incomplete (Heron, 1981).

The aim of this approach is to empower, and where possible, makes efforts to involve the research subjects in formulating the questions that need to be researched. In the process of attempting to make sense of their meanings, they

are better able to understand their experiences and actions (Reason, 1988). Making these efforts on the part of the researcher give value to the subjective experiences of the teenagers whose lives, circumstances, behaviours and actions this research seeks to understand. These efforts also give equal value to the telling of their stories and therefore to the knowledge base which will be gained from this research exercise, thus acknowledging them as true experts of their experiences (Stanley & Wise, 1983).

The protagonists of this approach argue that, in the 'fullest form' of co-operative inquiry, 'the distinction between the researcher and the respondents disappears' (Reason, 1988:1). The aim is that all those who are involved, should contribute to both the conception of the research, that is, making decisions about what has to be researched, the most appropriate data collection method(s) for the aims and objectives of the study, as well as in making sense of the data.

In keeping with a co-operative inquiry paradigm, the design and execution of this research was particularly influenced by the philosophy of a participative approach, also referred to as 'dialogic inquiry' (Randall & Southgate, 1981). As the aim was for the respondents to play a central role in the formulation and generation of knowledge, which emerges from the study, through the medium of telling their own stories, a participative approach seemed logical as it places emphasis on the creation and facilitation of dialogue between the researcher and the respondents. This dialogue is important in order to develop an understanding of the numerous and complex ways in which the young women in this study 'create', 'modify' and make sense of their life experiences (Cohen & Mannion, 1985).

It has to be acknowledged that the execution of this research does not conform to a fully co-operative/participative approach. For example, the respondents, for various reasons, were not involved in all stages of the research process, notably in the areas of conception, design and data analysis. However, the approach to interviewing, and as will be shown later, the goal of generating theory from the data rather than the testing of a particular hypothesis, was clearly intended to feed into a co-operative/participative philosophy.

There also has to be further acknowledgement, that the goal of achieving a fully co-operative/participative approach to research, where the boundaries between researcher and respondents are blurred, is not always easily accomplished in every case for a number of reasons. First, in relation to this study, the fact that respondents are young mothers or mothers to be, struggling to make ends meet, and therefore understandably pre-occupied with their own agenda of their daily lives, makes it unlikely that they would be prepared, willing or able to devote the time and the energy that the concept of co-researcher and co-subject demands in its fullest sense. Secondly, as Humphries (1995) states, the reality in most research is that the person most passionately interested in the research topic is usually the researcher, and therefore by implication, is likely to be the most influential and committed participant in the process. Consequently, this is usually the person who pushes and perseveres to see the process to its logical conclusion. These factors tend to mitigate against full participation. This does not mean however, that if full participation on the part of the respondents is not possible, that the co-operative inquiry philosophy becomes redundant. As Reason goes on to state, in co-operative inquiry the emphasis is on adopting a method which allows people to be heard, and which values what they have to say. It is a new paradigm model that helps to shift the research perspective from that of doing research 'on people', to that of doing research 'with people'.

Feminist approaches to doing research have also had an impact on the philosophy and data collection strategy of this research. The emphasis of a feminist approach within the context of this study, is on giving the young women a voice, thereby attaching value and importance to their experiences of their lives from their own unique standpoints, and to explore how these experiences are shaped within the context of the wider social and political realities (Smith, 1987).

In feminist research, gender is seen as an important social variable that impacts on the research process. It therefore follows that the gender of the researcher and the respondents is of primary concern. In keeping with this philosophy, this research is conducted by a woman for the benefit of women, in that both the process of conducting of the interviews, and the presentation of the findings of the research, are intended to be ways of indirectly helping the women to improve their daily lives. This can be accomplished through the interview process, by

enabling the women to relive their experiences. In doing so, it is hoped that they will begin to gain some insights into their motivations and actions that may help them to begin the process of reshaping their lives. These are important objectives of this research, as the quest to find ways of helping to prevent unwanted teenage pregnancies has been an almost constant pre-occupation of professionals working with teenage mothers. This is particularly the case over the last 20 years where teenage pregnancies have received constant coverage and attention, though not always in helpful and positive ways. In addition, it is also my hope, that ultimately the knowledge gained from the women's life stories will provide greater insights into the helping processes and strategies which various professionals will use, in their attempts to help pregnant teenagers and teenage mothers who may require their help. The factor of a woman conducting research with women, is also an important consideration when we come to address issues of validity later in this chapter.

Factors influencing the design of the study

In designing this study, I was mindful of three issues, the first is the pervasiveness of a largely negative ideology and values in the ways in which we see and perceive teenage pregnancies. Chapter one shows that these views, to a large extent, have been fuelled by the last two decades of 'right wing' propaganda and ideologies that have sought to put the spotlight on teenage pregnancies in general, and single parenthood in particular, as phenomena that threaten to weaken or destroy the moral fibre of society. The second was my awareness of the complexities of teenage pregnancies, derived from my extensive search of the literature, and from my experiences of working with pregnant teenagers and teenage mothers. Third, the relatively under-researched and poorly understood nature of repeated teenage pregnancies. Awareness of these issues led to a deliberate decision not to approach the research from the point of view of seeking to test a particular hypothesis. In this respect, the study was informed by a grounded theory approach (Glaser & Strauss, 1967).

The essential element of this approach is the purposeful discovery of ideas from data. In the words of Glaser & Strauss (1967:14), to 'theorise from data rather than from the armchair'. This approach, as Glaser and Strauss argue, therefore

involves generating theory and doing social research as two sides of the same coin. In transferring this concept to this study, the aim was to attempt to understand and explain the nature of repeated teenage pregnancies from the data gathered rather than from the dominant methodological paradigm of prior theory through hypotheses testing. A grounded theory philosophy therefore, fits well with this research, where the goal of data collection was to allow the young women to speak in order to understand the nature of their experiences. It was therefore paramount to exercise empathy, in attempting to understand their experiences and feelings from their points of view, rather than to impose pre-conceived notions upon their experiences.

This is an approach with which, as a former practising social worker and now social work lecturer, I have a certain degree of familiarity and comfort. As Gilgun (1994) noted, grounded theory approach has a certain degree of compatibility with the ways which social work practitioners conceptualise and approach their practice, particularly in the ways in which social workers draw on social work theory and methods in the first instance to inform their practice. As practice proceeds, these theories are modified in light of new knowledge gained from the client. It must be acknowledged however, that this study did not follow all the steps of a grounded theory approach as outlined by Glaser and Strauss (1967). However, one aspect of a grounded theory approach that was used is the collection of data to 'saturation point' within the targeted sample. This point will be developed further in a discussion of generalizability.

In general, the main sphere of influence of a grounded theory approach was in shaping the generation of concepts, theories, explanations and connections between them. Adopting this approach to fit with the aims and objectives of this study, is in keeping with Glaser & Strauss's intention, as they stressed in their earlier work and subsequent writings, that because research is conducted in different settings by researchers who bring very different personal and professional knowledge and skills to the research process, it follows therefore, that research has to be flexible, and not constrained by a set of methodological rules to be followed precisely on all occasions. In the words of Strauss, 'a standardisation of methods swallowed whole, taken seriously, would only constrain and even stifle social research's best efforts' (Strauss, 1987:7).

The decision to employ a grounded theory approach is not to suggest that I have had no broad questions in mind, or grounded understanding of teenage pregnancies. The construction of the set of themes for example, suggests an indication of some level of awareness of prior constructed factors that I consider relevant and meaningful to the research topic. It follows therefore, that however unintentional, the highlighting of such factors results in the imposition of some form of direction and focus. Mindful of this possibility, throughout the interviews, attempts were made to ensure that the use of the set of themes did not dominate the interview process. They were used flexibly to ensure that the collection of data was as far as possible, a process of discovery for both myself as researcher and for the respondents as participants, and not clouded by my preoccupation with the testing of a prior hypothesis and any pre-conceived notions that I may hold.

A grounded theory approach is not without criticisms. For example, some researchers have challenged the idea that external reality can be uncovered by an outside observer (Charmaz, 1983). Similarly, others like Bateson (1990:28) have stated, 'it is invention that we do, not discovery, for what we search for does not exist until we find it'. My response to such criticisms within the context of this research is to put forward the argument that an outside observer can uncover external reality when the right conditions are created in seeking to understand the behaviour, motives and actions of the young women who will be the focus of the study. (The ingredients of these conditions have been discussed elsewhere in this chapter.) I would also challenge the notion that we can invent without discovery, as discovery is inextricably linked with the process of invention, each action feeding into the other. This is a process which is compatible with the philosophy of a grounded theory approach. This requires the researcher to remember that the quest for discovery is of necessity an interpretive exercise. For interpretations to be valid and meaningful, it must pay attention to the views of the people whose actions the researcher seeks to understand and analyse.

This therefore places a certain amount of responsibility on the shoulders of the researcher, who has to be acutely aware that the role of interpreter in interpreting what is observed and heard, requires more than simply reporting the views and feelings of the young women. It is also equally important to contribute towards the making of theoretical interpretations. In this way, these theoretical

interpretations ultimately also contribute to the knowledge base of policy makers, practitioners and academics, without losing sight of the fact that there is a clear obligation to the respondents to give voice and meanings to their feelings and experiences.

Design of the study

I agree with the widely held belief that the aims and objectives of any study should be the overriding determining factor in choosing a methodological approach. This approach should be appropriate to enable the researcher to achieve the identified aims and objectives of the study. This, within the context of this study, is to get to the heart of what the young women feel and think about their pregnancies, as well as the ways in which it has relevance for them. In order to achieve this, the methodological approach needs to be 'user friendly' and empowering. It needs to facilitate the young women's expression of feelings without imposing too much, the views of the researcher by the questions asked. Therefore, in view of these aims and objectives as well as the theoretical paradigms previously outlined which have influenced my approach to the study, it was felt that these objectives would best be met by the use of an unstructured to semi-structured in-depth approach to interviewing. This decision was made in order to allow as far as possible, the feelings, fears and experiences of the young women to flow freely in telling their stories.

At first glance, it might appear to be slightly unorthodox to use an unstructured to semi-structured approach to interviewing. In defence of this strategy, I put forward the argument that one drawback of qualitative open-ended in-depth approach to interviewing, particularly in the case of teenagers, is that it is not always easy for those who are less articulate to express their feelings freely in a truly unstructured way. As a result, there are occasions when the researcher may have to encourage the respondents to provide depth. It was therefore felt, that the use of a 'flexible format' open-ended set of themes (see appendix 1) could minimise this drawback, as the themes would aid as a tool to facilitate dialogue and further probing or exploration, or to raise important issues which the respondents can then develop in their own unique ways (Bolton & Fitzpatrick, 1994). I am also in agreement with Jones (1985) when she questions whether it is possible to conduct a truly unstructured interview, as the researcher

needs to clearly indicate the aims and objectives of the research. This communication of the aims and objectives, in some way, however small, imposes a certain amount of structure, as it signals to the respondent, the direction in which the interview should proceed. This is necessary however, to achieve the complex balance between restricting a previously imposed structure and restricting ambiguity which comes from a totally non-directive, non-interactive approach, which more often than not, simply results in encouraging the respondent to ramble aimlessly at best, and at worst, to provide any kind of rhetoric in the absence of any kind of direction. Furthermore as Denscombe (1998:113) states, 'semi-structured and unstructured interviews are really on a continuum and, in practice, it is likely that any interview will slide back and forth along a scale'.

Not only does the use of a set of themes help to enable the respondents to speak freely, but the 'flexible format gives the respondents considerable control over what issues are raised and the terms in which they are discussed' (Bolton & Fitzpatrick, 1994:20), in a way that the use of formal pre-determined questionnaires and standardised instruments (used in a significant number of studies on teenage pregnancies) make impossible. Several factors influenced the choice of the themes that were used. The most influential factor was the knowledge gained from the literature review, which provided relevant information about the variables that have been shown to impact on teenage pregnancies. The second factor was the knowledge gained from my own experiences of working with pregnant teenagers. Finally, I drew on my knowledge and experience gained both from working with young people infected and affected by HIV & AIDS and from the teaching of a module on HIV & AIDS for the past nine years. The themes were designed to ensure that I obtain depth, detail and nuances through the interview process. They were also designed to take into account the wide number of variables that might have impacted on the subjective experiences, meanings and actions of these young women in relation to repeated teenage pregnancies.

Drawbacks and complexities of an international comparative approach

As there is an international comparative element to this study, this chapter on methodology and method would not be complete unless it attempts to

acknowledge and address the question posed by Oyen (1992:4), of 'whether comparisons across national boundaries represent a new or a different set of theoretical and methodological challenges'. Or whether international comparative research can simply be 'treated just as another variant' of the numerous and well-documented problems that are already common to social research.

Sztompka (1988) (cited in Oyen, 1992) argues that the traditional emphasis of international comparative research was focused on the search for uniformity and attempting to establish generality of findings across national borders. However, in critically reviewing international comparative research, he argued that there should be a fundamental shift away from these traditional models of comparative research that have been outdated by rapid changes in the social realities to models which embrace more variety in comparative approaches.

He went on to propose a number of alternative approaches. One such approach that fits well with the comparative element of this study, was his proposal that there should be a greater move towards the search for uniqueness and comparisons that highlight the peculiarities of a country, by singling out a certain category of people by contrasting them with other people. In this regard, he argues, the focus would then be shifted to that of the search for attitudes and beliefs that are not typical. This shift in focus is likely to yield more meaningful results as the export and import of social and cultural practices across national borders continue to flourish. In addition, as Ragin (1987) argues, this approach is likely to reduce the levels of complexities encountered in international comparative studies, because if the aim is uniformity, then the complexities increase threefold.

There are of course, no easy answers to the issues posed above, however, one area of difficulty for me was the scarcity of literature that focuses on issues relating to international comparative research, particularly in relation to studies that focus on a specific phenomenon within a given society. All the available literature on comparative methodology tended to focus on issues of comparison in relation to nation states as a whole. As a consequence, the areas explored and problems identified were more relevant to comparative research on a macro level. Nevertheless, there were important lessons to be learned from an examination of the issues covered in the available literature.

One important lesson learnt from an examination of the literature on international comparative approach, was the importance of approaching any comparative research by conducting an initial assessment of any potential problems that are likely to emerge. This is particularly important when there are marked differences between the societies being compared. With this lesson in mind, I anticipated the possible differences in the approach to ethical issues in research between some professionals in the Caribbean and between some professionals in London. This was particularly so in terms of the issue of the principle of ensuring that respondents were facilitated in the process of giving informed consent. I know from my experience of working in the Caribbean that some professionals in positions of trust have a tendency to pay scant regard to confidentiality, even where clear procedures are in place. It was this awareness that led to alertness on my part, to ensure that respondents were fully aware of the aims and objectives of the research and were happy to participate in the process before they were interviewed.

Among the documented problems of international comparative research highlighted in the literature, was the need for appropriate translation of common concepts in the language of the cultures involved (Feldman, 1981). This signalled the need for vigilance about similar potential complexities at a micro level. As a result, care was taken in the design of this research, to minimise the potential complexity posed by the issues of dialect and nuances of meanings between London and the Caribbean. This was particularly important in relation to the set of themes previously discussed. Therefore, in addressing these issues, particular focus was given during the pilot stage and thereafter, to ensure that the language used would accurately convey the points that I was trying to communicate and vice versa. During the interviews where it was identified that it was necessary to modify language or resort to the use of dialect, this was done by interpreting, paraphrasing, summarising, feeding back in the dialect with which the particular respondent was most comfortable, and which most closely approximated to the standard English usage equivalent of the language of the set of themes.

In addition to attention to language or in the case of this study, dialect, complexities can emerge when the researcher has little or no, in-depth

knowledge and understanding of one of the societies being compared. As Fontana and Frey argue:

'respondents may be fluent in the language of the interviewer, but there are different ways of saying things, and, indeed, certain things should not be said at all, linking language and cultural manifestations' (Fontana and Frey, 1994:366).

In the case of this research, my understanding of the structures and cultures of both London and the Caribbean, was an added factor that considerably minimised such potential drawbacks.

Another factor taken into consideration was my awareness of the fact, that the use of a comparative group can strengthen the causal elements in the argument in reporting the findings of the study. To ensure the validity of this argument, care has to be taken to demonstrate that as far as possible, the groups compared are comparable in order to be able to argue convincingly that any differences in the findings found between the two groups are unlikely to be due to any marked differences between the two groups. Therefore in the sampling process, the same eligibility criteria for prospective respondents to participate in the study were used in both London and the Caribbean.

One very notable benefit of a cross national study, is that it provides a very useful tool for 'establishing the generality of findings and the validity of interpretations derived from studies of single nations' (Kohn, 1989b:77). It was therefore important to ensure that the respondents are likely to be representative of the population to which the researcher wishes to generalise the results. As will be shown in the sampling process, careful thoughts and efforts were made to ensure representativeness of the sample as far as possible.

The sampling process

The sample consisted of 52 respondents, 26 from London and 26 from the Caribbean Islands of Jamaica and Barbados. With the exception of two respondents who had reached the age of 20 just prior to the interview, all were aged 19 and under, from all racial backgrounds, and had had two or more pregnancies, irrespective of the outcome of the pregnancies. I made a conscious

decision to exclude all potential respondents who would not be able to communicate fluently in English. To do otherwise would lead to a reliance on interpreters, which from my own experience, would be likely to lead to an added layer of meanings, biases and interpretations that would in all likelihood, adversely affect the validity of the findings.

Questions about validity were uppermost in my mind from the outset, as well as my awareness of the fact that rigorous attention to sampling in qualitative research is as important as in quantitative research. The principles differ however, in qualitative research, the emphasis is not so much on randomness, the emphasis is placed more on obtaining a sample that represents the full range of possible observations in order to allow conceptual generalisations to be made. Therefore, close attention was paid to theoretical sampling, on the basis of my theoretical understanding of the subject of teenage pregnancies gained from practice experience and from the literature review. I was to a certain extent, able to determine what factors could maximize variability in the responses received and in the observations made during the interviews.

It can be argued however, that the sample may not be representative in terms of numbers. To compensate for this potential drawback, a decision was made to focus on, selecting a sample that incorporates a wide range of possible variables to minimise bias and ensure representativeness, thus taking diversity into account in the frame of analysis. Therefore concerted attempts were made to target a wide cross section of respondents both in London and in the Caribbean. This was a conscious decision to eliminate the possibility of institutional biases that could arise through targeting respondents solely from the caseloads of social workers.

This process also attempts to counteract the failure of several studies on teenage pregnancies to take into account individual differences between respondents in both their reasons for becoming pregnant and their subsequent management of their lives. As a result, it is therefore not surprising that these studies tend to portray an overly negative picture of the phenomenon of teenage pregnancies. A varied sample allowed me to gain insights into how some teenage mothers appear to overcome some of the many obstacles that they encounter as young mothers, against all odds. These insights could prove to be

useful information for policy makers and practitioners in focusing their interventions.

Timing of interviews was another factor that was taken into account. From my experience of working with pregnant teenagers, I was aware that a state of crisis can often result immediately following confirmation of an unplanned teenage pregnancy, and as a result the teenagers' self reports of their own experiences might be clouded by anxieties generated from the crisis. Therefore in order to avoid any potential source of bias that could arise from conducting interviews during this potential period of crisis, a decision was made that all pregnant respondents interviewed, should be at least six months pregnant at the time of the interview and those who are not pregnant at the time of the interview, should have given birth at least six months prior to the interview.

In London, the majority of respondents were recruited mainly from teenage and other antenatal clinics, the remainder came from voluntary social work agencies, teenage mothers' support groups and social services departments. In the antenatal clinics and other settings, respondents were given information about the research by the staff, aided at times by a specially prepared letter (see appendix 2) addressed to prospective respondents. Once potential respondents agreed to be interviewed, their names, addresses and/or telephone numbers would be passed on to me with their consent. I would make follow up contact within the same week in most cases, as I very quickly learnt that delays in this follow up process would lead to respondents losing interest, or changing addresses, particularly if they were in temporary accommodation at the time of the referral. Once contact was established with the young women, in order to be satisfied that respondents were giving informed consent to be interviewed, I repeated details relating to the purpose of the research. I also provided further assurance of confidentiality and gave a clear indication of the process of the interview and also of how the data would be used. The importance of their contribution to the research was stressed. At this stage if they were still happy to be interviewed, the interview would commence.

It was theoretically possible to draw the sample from a wider array of settings in London, due to its much larger geographical area and a greater number of agencies and ante-natal clinics, compared to the two Caribbean islands. In

practice, however, it proved to be considerably more difficult and time consuming to gain access to a wider number of relevant officials to seek approval for their staff to co-operate in identifying potential respondents. In many instances, once permission was given by senior personnel to approach the antenatal clinic staff and co-operation was assured in theory in helping to locate respondents, in practice it proved more difficult to enlist the help of staff. These reasons seemed to be centred around workload pressure, and at times due to changes of staff. This meant that a lot of time was spent on making telephone calls or visits to agencies to remind the staff to identify prospective respondents.

In some cases, where prospective respondents were contacted by staff in antenatal clinics or by social workers, agreement was given for their details to be passed on to me. The respondents later proved impossible to trace, because they had either left home, or were never at home at the times of pre-arranged visits. This was frustrating but in some ways understandable, as keeping appointments arranged with a researcher is the least on their list of priorities. In some cases I suspect that they had simply forgotten to write down the dates and times of pre-arranged interviews. Later on in the process, armed with the experience gained from these frustrated efforts, I would telephone the evening or morning before the arranged visit to remind the young women of our appointment. On a few occasions, even in spite of these reminders, some young women were not at home when I called. Usually in cases where respondents were not at home for two pre-arranged visits, for ethical reasons, I made a decision not to pursue them, as I felt that this may be a clear indication that they had changed their minds about being interviewed. All of this meant that the conducting of the London interviews took much longer than I had initially anticipated. In spite of these experiences and being forced to postpone the research for a while as a result of illness, my commitment and belief in the worthiness of the research, as well as the enthusiastic reception I received from a number of professionals about the nature of the research, helped to sustain my efforts through these frustrations and delays.

Locating the sample in the Caribbean was in many ways easier than was the case in London. In Barbados, due to the small size of the island, (166 square miles), with a population of 265,000 people, it was possible to locate respondents from all over the island. This was done by concentrating my efforts

on finding respondents through the Medical Social Work Department of the island's only general Hospital and from the Barbados Family Planning Clinic. Both of these institutions cater to the needs of a wide cross section of the island's population.

The young women were first contacted by workers from the departments mentioned above, either by telephone or during occasions when they visited the departments for other appointments. They were given brief, but relevant information by the staff, about the nature, purpose and process of the research. If they were happy to be interviewed, I would follow up with a telephone call, or by direct contact when they visited the hospital for other appointments. Similar to the London respondents, pre-interview information would be given and if they had not changed their minds about being interviewed, the interview would be conducted on the same day if convenient, or at a mutually convenient later date or time within each three weeks time span.

In Jamaica, due to the relatively larger size of the island, compared to Barbados, (4,411 square miles) and a total population of 2.5 million people, with over one quarter of those living in the capital city of Kingston, the majority of the respondents were recruited from the ante-natal clinics of the two large public teaching Hospitals in Kingston. Others were also recruited through the Family Planning Clinic attached to the University of the West Indies, Mona campus. This clinic was located very close to the antenatal clinic of the University College Hospital, one of the two hospitals targeted. The other hospital targeted, was the Victoria Jubilee Hospital. These two hospitals cater for the vast majority of the population of Kingston and the adjoining parish of St. Andrew and some residents from the nearby parish of St. Catherine.

Attempts were also made to recruit respondents from polyclinics in Kingston, the Women's Centre* in Kingston, and the Medical Social Work Department of the University College Hospital. In the time available to conduct the interviews, I was only able to recruit respondents from two of the polyclinics targeted and none from the Women's Centre or the Social Work Department. Two respondents

* The Women's Centre of Jamaica Foundation is a voluntary organisation that was established in 1978 to reduce the incidence of repeat pregnancies and to deal with interrupted education caused by early childbearing.

recruited by the staff of the Medical Social Work Department, failed to keep their appointments for interviews, and time did not permit for further follow up as the interviews were planned to take place over two periods of three weeks in each island.

My first and usually only contact with the respondents coincided with the times of their antenatal clinic visits. The nursing staff in the clinics would first of all, identify from their records, those young women who fell within the framework of the research. They would then inform them about the presence of the researcher and the reasons for the interviews. If they expressed no objections to being interviewed, they would then be referred to me. This process raised some ethical concerns for me. I was acutely aware of the pressures on staff time in a clinic setting. I was also aware of differences in approach between the staff in the amount of time spent informing the young women about the research, in terms of its purpose, process and nature before they were referred to me. In order to be satisfied that respondents did not feel pressured in any way in consenting to be interviewed, I would ensure that before the interviews, each respondent was given as much detail as possible, about the purpose of the study. As with the London respondents, I also explained why their views were important to the findings of the research, how the interviews would be conducted, how the information would be used, and its confidential nature, particularly the process of ensuring confidentiality. They were also given the option without pressure to withdraw from the process if they so wished. All respondents agreed to participate after they were fully reassured.

The decision to focus attention only on the capital city of Kingston, in Jamaica might be perceived to potentially introduce an element of bias and could be said to have a limiting impact in terms of generalising the findings to a wider area. However this decision was taken for the same reasons used for singling out London from the rest of England for close scrutiny, that is, the relatively modest scope of the research project, as well as, the anticipated difficulties for one researcher recruiting respondents from such a wide geographical area. It also has to be highlighted that although respondents were living in the capital city of Kingston and adjoining parishes previously mentioned, at the time they were interviewed, many of the respondents had spent the

formative years of their childhood in other rural parishes, some had first become pregnant while living in these parishes.

Others had come to live in Kingston only within six months to one year before the time the interviews were conducted. They had come to the capital in search of what they perceived to be better life chances, in terms of opportunities to find employment that was unavailable to them in rural parishes. There is also an added bonus in selecting respondents from the two teaching hospitals in Kingston. This provided an opportunity to see a slightly wider cross section of people, as those young women attending the Victoria Jubilee Hospital were among the poorest people living in Jamaica in general, and the capital city in particular. Those young women attending the University College Hospital, were a more varied group in terms of socio-economic and educational status. These factors therefore introduced a further element of representativeness.

In Barbados, it could also be argued that by targeting the Medical Social Work Department as one of the main sources of recruiting respondents, this could introduce an element of institutional bias. This argument is countered by the fact that routinely, all women, the vast majority of whom are teenagers, seeking a termination of pregnancy for social reasons at the hospital, are referred to the Medical Social Work Department for interview followed by the submission of a report to the gynaecology clinic. For the majority of these women, this is the only reason for contact with the social worker. They have never been on the caseloads of social workers for any other reason. Secondly, young pregnant women are also referred to the social workers for routine psychosocial assessments, because they are pregnant teenagers who appear to the staff of the antenatal clinic to be unsupported by family, putative fathers and friends. If this is the case, they are targeted for early intervention and support, in the hope that this support will reduce the potential for child neglect when the baby is born, or be referred to other social work departments outside the hospital, for assistance in kind or cash.

In adhering to the principle of including a wide range of variables in the sampling process, it was decided that in London, distinctions based on ethnic differences would not be made. To the best of my knowledge, there are no studies on teenage pregnancies carried out in the United Kingdom, which make

comparisons on the grounds of ethnicity. However in the United States, there has been a marked tendency, particularly in the earlier studies, to view teenage pregnancies as being a 'black problem' (Goldscheider & Uhlenberg, 1969; Moynihan, 1965). This view stems from the reported higher fertility rates among certain ethnic groups in the United States (Bolton, 1980; Washington, 1982; Lundberg & Lenroot, 1984). The literature review of this research also showed that a growing number of research studies on teenage pregnancies carried out in the United States have increasingly challenged these assumptions (Thomlinson, 1965; Bougue, 1969; Presser, 1971; St. John, 1982; Williams, 1991). This latter group of researchers have argued that there may be a link between ethnicity and teenage pregnancy among certain ethnic groups. However, because these ethnic groups are often also socially, educationally and economically disadvantaged, it is difficult to identify whether the reasons for high pregnancy rates among these groups can be located in ethnicity, socio-economic and educational disadvantage, or a combination of factors. (see the literature review chapter, pages 86-90 for a fuller discussion of these issues). The link therefore, between ethnicity and teenage pregnancies has not been conclusively demonstrated. In any event even if the US evidence proved to be strong, one cannot automatically assume that the same evidence holds true for the UK.

This is not to suggest conclusively that in the United Kingdom there are no differences in teenage pregnancies that can be attributed to differences in ethnicity, cultural norms and values. According to Phoenix (1991), some researchers have expressed the view that there is a link between cultural norms and values of black 'West Indians' in the United Kingdom and a predisposition to early pregnancies. Similarly, later research evidence points to an over-representation of some ethnic minorities among teenage parents in the United Kingdom. For example, data from a National Survey of Ethnic Minorities (1997), and from the Health and Lifestyle Surveys (HEA 1994) point to a greater risk of teenage parenthood among these ethnic groups than the national average. These groups are Bangladeshis, African-Caribbeans and Pakistanis. Several factors may be cited as possible contributory factors to these differences. These factors include, social and economic disadvantage, which places ethnic minorities at a greater disadvantage in society. They also include factors such as traditions of early childbearing, over-representation of young people from ethnic minority communities in the care system and among those being excluded from

school, racism and religious differences. (Family Policy Studies Centre 1999; Social Exclusion Unit Report 1999). As the Social Exclusion Unit Report (1999) points out however, the reasons for these ethnic differences are very complex. Additionally, while ethnicity can have an impact on these different fertility rates and sexual practices, because these issues were unexplored in these studies, we have no way of knowing whether the reported fertility differences are attributable to ethnic differences, or are the result of socio-economic factors.

To compound these complexities, some studies have stated that in the United Kingdom, there is no evidence to suggest that young black women become teenage mothers for different reasons from white young women (Phipps-Yonas, 1980; Phoenix, 1988b & 1991). In addition as Phoenix (1991) argues, the justification for a comparative approach on the grounds of ethnicity would suggest that there are marked 'cultural similarities within groups of black women and groups of white women and clear differences between them' (Phoenix, 1991:16). In addition, black young people of:

'Afro-Caribbean origins are predominantly British born and have parents who come from a range of countries. Cultural homogeneity within a black British group and difference from a white British group cannot, therefore, be assumed' (Phoenix, 1991:17).

Nevertheless, these reported trends that we do not fully understand, do make a case for research to be undertaken in order to fully understand these differences. It is also needed to ensure that any identified differences in the sexual needs of young women and men from ethnic minority communities are addressed. The argument for research is further strengthened when viewed in relation to the points made by Zalduondo & Bernard (1995:157) that:

'At a theoretical level we know that the substance and meanings of sexual knowledge, perceptions and behaviours all are culturally constructed and socially reproduced. That is, they are learned, in a particular context, through experience with people and institutions which pressure, express and enforce a particular system of ideas and values. Since learned cultural beliefs and meanings are both individually held and collectively shared by members of the same cultural groups, sexual culture affects behaviour, both as an "*internal*" (intra-individual) and as an "*environmental*" determinant of sexual feelings, expectations and behaviours'.

Ethical considerations

In addition to the ethical concerns that I expressed earlier, it is also important to point out that I made efforts to ensure that in every case, permission to gain access to staff in ante-natal clinics and other agencies was granted from the appropriate personnel in these agencies. These are personnel who occupy the offices of Heads of Departments or sections in London and the Caribbean, Hospital Directors and Permanent Secretaries in the Caribbean. In some cases approval had to be sought and gained from ethics committees. In order to ensure that the staff who would be in contact with prospective respondents were fully briefed so that they could provide initial accurate information to these respondents, where possible, I made arrangements to meet them in person to conduct this briefing. I continued to maintain contact with them on a regular basis by telephone. These visits were also useful in making the most of the opportunities to discuss preliminary findings with professionals in the field where possible, as one means of ensuring validity.

After discussing my research methodology with a friend and former colleague who was also engaged in research in the area of children and families, another key ethical dilemma arose for me. This was how to address the question of handling sensitive information such as child abuse issues that might emerge from the interviews. Should I inform the young women that if situations were uncovered which indicate that a child was at risk, I would be obliged to report this to the relevant Child Protection Agencies, after informing them of the risks and my intention to disclose information? If I took this action, would I risk being viewed as a social worker working under cover?

I was already aware from my practice experience that many young women have very negative stereotypical views about social workers, particularly in a British context. This was also borne out by the comments made in some of the interviews. If I took this risk, I was almost certain that the quality of the relationship and rapport that developed between the young women and myself in the role of researcher would be adversely affected, and ultimately the quality of the information. These issues forced me to deal with the question of which hat I was wearing, that of a social worker or researcher? I pondered these issues for

a while and came to the conclusion that there was no doubt in my mind that I was wearing the hat of a researcher, but with clear responsibilities as a citizen. After grappling with the pros and cons of raising the issues at the start of the interviews, I decided that as the prime focus of the interviews was on the experiences of teenage women about the meanings that they ascribed to their pregnancies, it was highly unlikely that child protection issues would emerge. I also had to grapple with the question that if the research population were any other groups of respondent, would I have such concerns, after all older women often abuse their children, the answer was unreservedly no.

A further deciding factor was that the sample would not be drawn predominantly from the caseloads of social workers, and in such cases, where there were child protection issues, the authorities would already be aware of these issues. This was the case of one respondent referred by a social worker. I realise that this decision would not fully address the dilemma if child protection issues should emerge. I therefore resolved in my mind that if at anytime during the interviews, there was any indication of child protection issues beginning to emerge, bearing in mind my responsibilities as a citizen, I would at that point make it clear to the respondent that if she proceeds to disclose such information. I would have a duty as a citizen to treat the child's well-being as paramount. Before taking any action, I would also attempt to persuade her to report the matter to the authorities herself. If she failed to do so, I would have no other choice but to report it myself. Such warnings would hopefully give the young women the option to proceed to disclose information or not. In this way, the child or children would be protected if the need arose, without unnecessarily risking the quality of the information provided by the respondent.

There are no easy and straightforward answers to such questions when researching sensitive topics. There are few studies that address these issues (Renzeitti & Lee, 1993) and a scarcity of guidelines on how to deal with such dilemmas (Gallagher et al, 1995). In addition, the numerous research studies on teenage pregnancies did not offer any guidelines as to ways in which these ethical dilemmas could be resolved to the mutual satisfaction of everyone concerned. In fact, to the best of my knowledge, ethical issues relating to child protection concerns that may surface in teenage pregnancy research are seldom ever addressed. This provides a clear indication that the debate needs to be

widened for the benefit of both researcher and respondent, particularly as increasingly social workers and other health and welfare professionals are venturing into the world of research. These encounters will inevitably bring the researcher into contact with disadvantaged groups of people.

Piloting process

The piloting process was undertaken with four interviews, two in London and two in the Caribbean to assess the usability of the set of themes in both settings, as well as to unearth any unforeseen problems or issues. As a result of this process, I very quickly came to the realisation that I would have to adopt a flexible approach to the way in which the interviews were conducted. This is both in terms of the use of the set of themes, and in terms of the stage of the interview at which factual/biographical questions could be asked or introduced.

To ensure that each respondent was able to give their own account of their experiences and make sense of their pregnancies in the most mutually productive way possible, I found it necessary during the piloting process to dispense with certain well-known research conventions. For example, opinions differ about the point at which factual or biographical questions should be asked or introduced during the interview. Many factual questions are relatively easy to answer and for some, relatively non-threatening, which make the argument for opening the interview with factual questions very compelling. On the other hand, some research manuals clearly advise against starting the interview with information gathering about biographical details, as such questions often require a “yes” or “no” type of answer, or very short answers, which can mislead the respondent into believing that only brief and staccato responses are required. This view therefore, supports the argument for introducing factual questions at the end of the interview. In support of this argument, there is also another issue that needs to be borne in mind, the fact that not all factual questions are non-threatening. For example, I anticipated that questions surrounding the timing of sexual activity, could prove to be very threatening, anxiety provoking and intrusive for some respondents, thus supporting the argument for such questions to be introduced later.

During the piloting process however, it quickly became apparent that the argument for introducing some less intrusive factual questions at the end of the interview, though valid in some respects, would not always hold true for the less articulate respondents. Therefore introducing factual questions at the beginning of the interview became one very important means for allowing some respondents to feel more relaxed and in control, as they often felt a lot safer initially answering questions that were less intrusive. This process allowed them to gradually open up and talk about the more personal and intimate details of their lives, which often involved a lot of feelings and emotions. It gradually evolved that some respondents who initially found it difficult and intimidating to respond to an open invitation to share their experiences, had no difficulty in discussing highly personal issues. These included the number of sexual partners and sexual activities, when such questions developed naturally from the flow of providing more factual information. For example, a question about number of siblings could easily lead to an expression of feelings about being left out in the family. It could also lead to a discussion about difficulties in communicating feelings or fears about the pregnancy with a respondent's own mother because other siblings were always competing for mother's attention.

The piloting process also reinforced the need for flexibility in the use of the set of themes, so that they could serve the purpose for which they were intended, as outlined previously in this chapter. Therefore in cases where the young women were very articulate, the need for introducing the set of themes almost became redundant, as the respondents would have already covered most areas of the themes. In such cases, they were often only used to gain hard data such as age, housing circumstances, education etc. Or used to pick up on areas not already addressed to ensure that there was a certain level of consistency in the areas explored for each respondent, or to probe other areas further.

The piloting process further reinforced the need to use language that was compatible with the respondents' own everyday use of language, or understanding. Having worked with pregnant teenagers over a number of years, I was already very much cognisant of the necessity to tailor the style of language in a way that would be readily understood by the young women with a variety of experiences and backgrounds. The piloting process confirmed that the uncomplicated style of language and its usage that I employed was easily

understood, as there were very few instances when I was asked to explain the meanings of terms used.

An added bonus in relation to the Caribbean, is that having spent my formative childhood years in Kingston, Jamaica, with frequent return visits since I left the island, and having lived in Barbados, and worked with hundreds of pregnant teenagers in that island over an eight year period, I had knowledge, understanding and the ability to use local dialect in each island. This meant that where it was necessary to use substitute terms that closely approximate the terms used in the themes, I could readily adjust and use dialect with utmost ease. Judging by the rich quality of the data obtained, this ability, I am sure, must have contributed to the process of putting the respondents at ease. At times, I rephrased and translated their responses audibly to ensure that there was congruence and also for the benefit of the transcriber. Having completed this stage, with the lessons learnt from the piloting process uppermost in my mind, the next stage was to embark on the interview process.

The process of conducting the interviews

Efforts were made to collect data from Barbados and Jamaica over two six week periods spanning a period of two years. The process of collecting data was less concentrated in London and spanned a longer period for reasons already outlined in this chapter. A total of fifty-two semi-structured to unstructured interviews were conducted. The interviews focused on the life stories of the young women interviewed, using the set of themes in a flexible way, either as a trigger for discussion, or to facilitate further exploration. Regardless of the ways in which the themes were used, the overall aim was to gain a broad understanding of how the factors listed in the themes may have had an impact on, or contributed to the life experiences of the young women, and the link between these factors and repeat pregnancies.

The interviews began with providing some background information about myself. For example, for the Caribbean respondents, I gave a brief account of my connections with the region. It was also important to convey my understanding of some of the issues and familiarity with the customs, beliefs, norms, values and dialect. I had to face the real possibility that in a cultural context, if the

respondents perceived that I lacked understanding of their issues and the culture, they may have been inclined to leave out certain types of information that they felt I might not understand. For the London respondents, I provided information about my years of working with pregnant teenagers in London as well as some indication of my knowledge of living and working in London.

For both sets of respondents, I explained the aims, objectives and purpose for conducting the interviews. I repeated further assurances of confidentiality, that is, to inform them that their names would not be used in the final report, therefore maintaining anonymity when the information is shared with my supervisor and ultimately with other academics and professionals. At this stage, some respondents in the Caribbean asked further questions about the intended outcome of the research, for example how the data will be used, and in what ways they would benefit. In such instances, I explained how their own information could be used to gain further insights and understanding of repeat teenage pregnancies, and therefore to contribute towards more enlightened and improved ways of responding to their needs. I welcomed such questions, and viewed these requests for additional information as an indication of their interest in the research, and of their need to use such information as a way to gauge the type of responses that they would give.

All interviews were tape-recorded. In seeking their permission to use the recorder, I explained that it was important to record the interviews in order to ensure that I obtain an accurate record of what was said. I also explained that freed from the task of taking notes during the interview, I could concentrate more fully on their accounts of their experiences. These explanations were accepted in every case and permission was thereafter, willingly granted. In using the tape recorder, I did not get a sense that the presence of the tape recorder, was in any way inhibiting. It was unobtrusively used. I got the distinct impression that the respondents were only momentarily aware of the presence of the recorder at three points during the interview. Firstly, at the start of the interview when the tape recorder was switched on, and secondly, during the interviews when it was necessary to pause to turn the tape. After a pause, to ensure that the point that was being made before the pause was not lost, I would recap on where we had left off before the tape was switched on again. I also saw this as an important opportunity to communicate that what was being said, was being intensively

listened to, in view of the essentially interactive nature of the interview. The third point of awareness was at the end of the interview in turning off the recorder.

All respondents were given an initial estimated duration of the interview, particularly when the interviews took place during their clinic visits. This was to ensure that they would be able to take their time during the interview, without hurry or pressure if they were quite clear about the duration of the interview before they began the interview. This also served to minimise the adverse effects of a sense of intrusion on their time.

I found that the time spent on the opening statements, or dialogue with the respondents also served the added purpose of helping to bridge the divide between the respondents and me. It also helped to create a relaxed and comfortable atmosphere in which to provide what was often painful and sensitive information. This rapport building process was crucial to the interview process, as during the interviews it was necessary to ask private and often delicate questions. This therefore requires the researcher to gain the trust of the respondents (Cicourel, 1974).

To ensure that the stimuli used at the beginning of the interview was the same for all respondents, a standard opening statement was used at the beginning of all the interviews. This also helped to ensure that as far as possible, all respondents had similar understanding of the aims and objectives of the interviews, and, most crucially, similar understanding of the contribution expected from them. This is discussed further in the section on validity.

Before the interviews commenced, I incorporated the lessons learnt from the piloting process and gave the young women a choice as to how they wished the interview to proceed. I explained that at some point during the interview, I had a number of factual questions that I needed to ask. I sought their views as to which approach would make them feel most comfortable, either to begin the interview with those questions, or to introduce them at a later point. The women would respond by indicating their preferences, which varied from respondent to respondent. This process also helped to signal to the respondents that they had a degree of control in the way in which they told their stories of their experiences and can be ultimately empowering. On many occasions respondents indicated

that their preference was for the interview to begin with factual questions. In order to avoid staccato responses and to signal to these respondents that the type of answers required for factual questions were different from the kind of dialogue required to make the telling of their stories viable and meaningful for themselves and for me, careful attention had to be paid to my opening statement. For example, **‘before we get to the main conversation, I would just like to clarify some facts, so that I can fully understand your situation’**. Where respondents had indicated that they would prefer factual questions to be introduced at the end of the interview, this was prefaced by saying, **‘before we finish, I would like to be clear about certain facts’**.

Depending on the respondent’s degree of articulation, the set of themes was also used in a very flexible way. Either immediately following the factual questions at the start of the interview with questions stemming from some of the factual questions, or introduced during the course of the conversation when it was relevant to do so. They were used as a means of getting the respondent to elaborate or expand on a point made during the conversation. This was a particularly useful approach to questions relating to the beginning of sexual activity that would have been experienced as threatening if introduced in isolation. For example, **‘lets see when was that?’** or **‘was that before or after you were aged 13, or after you left school?’** Generally, such questions were introduced during the interview when the respondent was most comfortable and a rapport was already established between the young woman and myself. This required me to be well tuned into the context or mood of the interview, as well as to be observant in reading non-verbal clues that indicate shyness or discomfort. As I reflect on these interviews and on my experiences as a social work practitioner, I note the similarities with conducting difficult social work interviews on sensitive issues and the ways in which I was able to readily draw on these skills and experiences.

The Caribbean interviews

In Jamaica, the majority of the interviews were conducted at the antenatal clinics of the two hospitals previously mentioned. They were conducted in a room provided by the hospital. Where interviews were conducted in the Family

Planning Clinic or at a polyclinic, interviewing rooms were provided by the staff in these settings. In Barbados, the majority of the interviews were conducted in a room in the Medical Social Work Department. Others were conducted in a room in the Barbados Family Planning Clinic, or in the apartment in which I stayed while in Barbados. These arrangements ensured that we were uninterrupted and provided privacy for the young women. The majority of the interviews conducted in such settings in Jamaica, coincided with the young women's visit to the clinic for their appointments, either during or after the times of their appointments. In most cases they occurred while waiting for appointments. This did not place pressure on the women's time, as the common practice is for long waiting times in such clinics.

These arrangements proved to be most acceptable to the young women, as they were able to speak freely and quite frankly, in a relaxed and non-pressured way about their experiences and feelings. This would not have been possible in their own homes, as the majority lived in varying conditions of overcrowding. In homes where overcrowding was not so pronounced, it was nearly always the case that other relatives would be around. This meant that privacy could not be assured, particularly in houses where partition walls between rooms were very thin.

For about half of all the respondents interviewed, there was very little need for in depth probing by me, as they spoke spontaneously about their life experiences and feelings. For those who were more inhibited and less articulate, as indicated before, they tended to more comfortable with a semi-structured thematic approach. This proved to be most effective in maintaining a relaxed flow of dialogue, with no periods of unduly long uncomfortable silence for the respondents. In addition to allowing the women to speak freely about their own unique feelings and concerns, the themes also ensured that common ground was covered in all the interviews.

The interviews lasted between fifty minutes to an hour and a half, depending on the young women's style and flow in conversation and the level of ease in which they could recall events. The respondents spoke about a wide range of experiences, including their feelings and experiences of becoming pregnant on the first and subsequent occasions. They spoke vividly about their experiences of dealing with the reactions, and at times rage and rejection from parents, and

in some cases from friends and putative fathers. They spoke about the indifference and sarcasm of some teachers and the rejection by the school system in general, the sense of loss, isolation, and at times, despair that they felt as a result. The vast majority spoke about the sense of humiliation they had experienced as a result of the derogatory manner in which they were spoken to by some nurses and doctors in the antenatal clinics and on the postnatal wards. Some of these examples I had witnessed firsthand while I was present at the clinics.

Throughout all of this, they spoke with an intensity of feeling and emotions that were at times quite surprising. Many were tearful during the interviews. After the interviews many respondents willingly expressed their sense of relief and gratitude at being allowed to express those feelings and emotions that had haunted them for some time. Feelings that they were unable to express before because there were no opportunities to do so, as parents, friends, relatives and some professionals, either openly discouraged painful dialogue, or were totally lacking in understanding about the grounds for their feelings and the need to express such feelings. This ventilation process was in many respects for the respondents, also a process of gaining insights into their feelings and actions. This occurred as they attempted to put the pieces together either currently or retrospectively, in a way that would make sense to them and to alleviate some of the confusion and despair that they felt.

As previously indicated, even though I am currently not resident in the Caribbean, I felt that my Caribbean origins and understanding of the dialect and other issues were also instrumental in putting the women at ease, so that they could share painful feelings. My understanding of the dialect and social situation enabled me to understand what was being said without interrupting the flow of their dialogue for clarification of words and terms used. This also meant that in many respects, I was not regarded as a total outsider. This is an important observation in terms of assessing the authenticity and validity of the information provided, as the quality of the data would have been adversely affected if my presence was seen as an inhibiting factor.

The London interviews

In London, in all except one case where the interview was conducted in an antenatal clinic in a room provided by the staff, interviews were conducted in the respondents' own homes. This was relatively easy to arrange as the majority lived in rented accommodation, with their children, sometimes with current partners, and/or the putative father. In most cases where partners were present when I arrived for the interview, I enlisted their co-operation in minding the toddler or baby while the young woman was being interviewed. I did this by explaining to their partners about the aims and objectives of the research, how the interviews would be conducted. This helped to reassure them that the process would not be threatening to their relationships. In the majority of cases, partners were reassured and co-operated with caring for the toddler or baby in another room during the interview. However, in one case, I sensed that the young woman's partner felt threatened and demonstrated this by his constant interruptions on the slightest pretext. This was in spite of the fact that during the interview the respondent had stressed that her partner was supportive to her needs by regularly caring for the baby when she required time to go out alone. Her partner's behaviour did not reflect this statement. When this was pointed out to her, she maintained that he was supportive and his action on this occasion was more indicative of an off day occurrence rather than the norm.

In the instances where the young women lived in their parental homes, where relatives were around on the day of the interview, they would help to care for the baby in another room to give the young woman some time alone to be interviewed. In cases where no such assistance was available, we were able to conduct the interviews without too much distraction. I drew on my experiences of having cared for small children and having worked with young children, and the young woman's knowledge of her child's temperament. Together we found ways of keeping the toddler occupied during the interview.

My experiences of conducting the London interviews were in almost every respect similar to the Caribbean experience, in that about half of the young women spoke freely and in most cases spontaneously about their experiences. With the other half, I also had a similar experience of the need to exercise flexibility in the use of the themes. Where respondents had been in the care

system, they spoke passionately about these experiences, at times openly criticising the local authority system in particular for its failure to meet their needs, while at other times reflecting on some positive experiences of being in care. This was with an equivalent degree of passion and in some instances, annoyance, which was similar to the cases when respondents in the Caribbean spoke about the treatment that they received from teachers and schools. However, there did not seem to be the same level of concern about being excluded from school after they became pregnant, as was the case in the Caribbean. This could be because there were more facilities for continuing their education after school in London than in the Caribbean. Therefore this lessened the sense of loss in relation to interrupted education experienced by the London respondents.

Like the Caribbean respondents, the majority of these young people reported that it was the first time that anyone had bothered to take the time to listen to their views and feelings particularly in relation to the loss of a baby. These declarations further signalled to me that the data collection method used in this study was congruent with the aims and objectives of the study. It facilitated the kind of listening, which has been referred to as a 'transformation'. The kind of action that conveys respect for the other person's point of view and restores 'dignity and self esteem', and sends a message that their views are worthy of being heard (Ledwith, 1994).

Comments on the interview process

A wide range of opinions exists about how a researcher should approach the research interview. Survey research literature for example, suggests that research should be scientific, objective and controlled by the researcher. Others reject this approach to interviewing because they acknowledge the essentially interactive nature of the interview and embrace the subjective dimension of the interview process (Oakley, 1981).

Others advocate an 'emancipatory social science' in which research is designed and conducted with empowerment of the respondents as a main goal (Lather, 1988). My approach to all the interviews essentially acknowledges the inherently interactive quality of interviewing, and sees the empowerment of the young

women as a main goal. Therefore, it was impossible to avoid a certain amount of interaction. We laughed together when we could both see the humour in some of the experiences and feelings expressed. I commented when I felt a comment was in order and remained silent when it was necessary to do so. I used skills in communication, for example, nodding to indicate that I heard and understood what was being communicated to me. I used probes and follow up questions to elicit further details and to introduce other themes. I empathised as they described feelings, experiences and beliefs where I felt empathy. I saw these actions as an essential part of this interactive process. Nevertheless, I was mindful of the need to follow certain wise research conventions. For example, during the interviews I focused my attentions on the young women's experiences and did not share any of my own views or politics with them, in order to avoid my own issues/views clouding or influencing their responses. I wanted their insights/experiences and portrayal of these experiences to be at the centre of the analysis. The only exception to this rule, was in relation to those views that were shared deliberately to facilitate their participation in the process; such as my strong belief that people are the experts on themselves, their feelings and responses. They therefore bring to the research encounter a degree of knowing about themselves which researchers will never totally have. This is very much in-keeping with a co-operative inquiry approach and also with the growing demand in recent years for research that gives the consumer a 'voice in developing services' and I wholeheartedly embrace this view.

In view of the fact that considerable opportunities were given to the respondents to expand on their responses, this could be criticised on the grounds of subjectivity, as some responses are unavoidably framed by the questions asked to probe further, and as a result significant data might have been missed. I do acknowledge this possibility, and in response to such concerns I would argue that the prime focus of the interviews was the young women's accounts of their experiences. Where probes were used, they were used to illuminate issues raised to facilitate a fuller understanding, and to make sure that I fully understood the experiences that the women were trying to convey to me. In other words, the questions asked during probing bore a direct relevance to the feelings and experiences expressed by the women. In addition, in responding to probes, there was ample room for respondents to introduce new material whenever they so wished, and this was in fact what took place. Furthermore, the

themes that were covered were very comprehensive in scope, encompassing a wide range of variables that could have impacted on their first and subsequent pregnancies.

I also have to acknowledge that some of the women's account of their experiences was given retrospectively and in this respect, it could be argued that these instances were records of what the women choose to recall and present. Where this was the case, I would argue that this is also valid as one of the aims of the research was to understand the meanings that the women ascribe to their pregnancies, that is, how they made sense of their pregnancies. Therefore the knowledge that comes from the women's past, lived and felt experiences are equally as valid as current feelings and experiences.

A number of questions have also been asked by some researchers about the validity of the storyteller's point of view, in other words, how can we be certain that what the storyteller perceives to be the truth of his or her experiences is really the truth? How does the researcher know if the respondents' accounts of the experiences conveyed to the researcher are really accurate and how can the researcher be sure of the objectivity of the respondent?

While I am mindful of the need to pose such questions, I share the view expressed by Ledwith (1994) that, if as researchers, we are really interested in understanding the reality of people's experiences, then it is important to adopt a method that clearly enables those we interview to be heard. In the context of this study, this means a methodology that values the ways in which teenagers make sense of their experiences and the conscious or unconscious meanings ascribed to these experiences in general and their pregnancies in particular. To do otherwise would be oppressive and disempowering.

Towards the end of the interviews, a summing up question gave the respondents a further opportunity to introduce their own emphasis into the interviews, for example, **'if you were asked to state what the pregnancies meant to you, or how you make sense of your pregnancies, what would you say?'** This was followed by an opportunity in the form of an invitation to add anything further to the interview. If the interview was particularly painful, in order to wind down the process, I found it helpful to ask the respondents to comment on their

experiences of the interview. It was usually at this point that statements such as, 'nobody listened before' or 'I didn't have anyone to sit and talk to me', were made.

Number of interviews

It has been suggested that reports based on one quick interview with each respondent, should be treated with suspicion as the possibility of the interviewer getting beyond the 'public account' or rhetoric is not high (Cornwell, 1984:10). After the pilot stage, I felt confident that only one in depth interview per respondent would be necessary to meet the aims and objectives of the study as previously outlined. In general, the depth and breadth of the issues covered by the respondents, or raised by the set of themes, and the feelings expressed during the interviews, were so full and rich that there was a very real sense of completion of a process and nothing to be gained from further interviews. In addition, as stated before, the opportunity provided at the end of each interview to explore any issues/feelings that they felt were not addressed, was often not taken up. In relation to this study, these factors, I felt, put a strong case for one interview being enough to get beyond the point of rhetoric. In any event, locating all respondents for a second interview would prove to be extremely difficult, as many would have moved since they were first interviewed. In the case of the Caribbean respondents, a second interview would mean attempts to locate them at home, and as indicated before, this would not be a wise course of action. Like some of the London respondents, there was also a high probability that some would have changed their addresses since they were first interviewed.

Validity and reliability

Very close attention was paid to issues of validity and reliability throughout this study, from its conceptualisation to design, data collection and analysis. Qualitative research has been the subject of much debate surrounding the issues of validity and reliability. On the one hand, there are those who criticise this approach as being impressionistic and non-verifiable (Allen & Skinner, 1991). Others pose the question of whether it is feasible to generalise from the findings of more personalised and intimate investigations. While on the other hand, there are others who have attempted to dismiss such claims, by

countering with the argument that the goal of any interpretist study is primarily to gain an in-depth understanding of the issues and not validity.

Given that this study is influenced throughout by an interpretist framework, and, given the previously outlined aims and objectives of this study, it would be tempting to be inclined to ignore the arguments and concerns of those who dismiss a qualitative approach as non-verifiable, or those who assert that validity is not relevant in qualitative research. Instead, I will subscribe to the argument that for any piece of research to contribute meaningfully to the existing body of knowledge on the subject or area of focus, it has to be able to demonstrate that it can stand up to the rigours of scrutiny, in methodological terms.

With this goal in mind, considerations regarding validity and reliability were carefully addressed, in the design of the study and in its approach to data collection. The lack of a previously imposed rigid structure afforded me the flexibility and freedom to explore and examine the young women's experiences as seen through their own lenses. These factors make it more likely that the results can be accepted as authentic reports and accounts of the young women's experiences and feelings.

To make these assertions more credible, I was mindful of the need to avoid researcher bias, and to minimise and monitor the issue of 'interviewer effect' on data collection. This was done in several ways, I had to hold in mind, the knowledge that my own responses and interpretations could be a potential source of bias. In order to minimise this potential bias, I constantly reflected on my responses to ensure that where prompts were used, they were not used in a way that could lead the interview in one direction to the exclusion of all other factors. For example, I paid attention to emerging themes during the interviews only to the extent that these would also help me to listen for patterns of association between the emerging themes, particularly when they are not explicitly stated but implied. However, I was careful that attention was not paid to such themes to the extent that I would become oblivious to other factors or later themes.

One example of this was in the case of the theme of 'loss' which began to emerge from the pilot stage. I immediately picked up on this theme and began to

listen for patterns of association of both explicit and implicit issues of loss. When it was necessary to probe further into issues of loss, I was careful to monitor these probes to guard against reactivity, that is, if such themes emerged I would explore them, if they did not, I would not deliberately introduce them. This was to ensure that such probes were appropriately used to further exploration and illuminate, rather than to impose direction in order to consciously or unconsciously find what I may have been seeking to find. These actions would not only affect validity and reliability but would not be in keeping with a grounded theory approach that also influenced this study.

In in-depth interviewing, the quality of the data received depends to a large extent on the building of the relationship and on establishing rapport between the respondent and the interviewer. This introduces the possibility that the findings, to a certain extent could be specific to the quality of the relationship, or created by something the researcher might have said or done (Abbot & Sapsford, 1998). In order to guard against this, the process of constant reflexivity in the research was also used, that is, to discuss the emerging themes with professionals in the field such as health visitors and midwives, who have had many years of experience of working with pregnant teenagers. This was an attempt to corroborate these emerging themes and to reassure myself that these themes were not emerging as a result of some influence on my part.

This was done throughout the duration of the research whenever an opportunity was presented for doing so. For example, in the Caribbean, between the periods of data collection on the islands, I used the opportunity to discuss the emerging themes with family planning workers, medical social workers and other professionals. In London, whenever I visited an agency to try to enlist their co-operation in the research, I would also use the opportunity to appraise them of these emerging themes and invite feedback. On completion of the data collection exercise and analysis of the findings, I presented the findings to various groups of health and social care professionals. In every case, the responses received would lead me to believe that the emerging themes were highly likely to be accurate indicators of the phenomenon of repeat teenage pregnancies.

Issues of validity were also uppermost in my mind when I went to great lengths to ensure that the respondents were clear about the nature and purpose of the research, how the findings would be used, as well as the form that issues of confidentiality would take in order to ensure full and meaningful participation. Attention to these factors is crucial to validity, as we all have a myriad of ways in which we account for ourselves, and depending on our experiences in life, a range of different 'life trajectories' to impart (Abbot & Sapsford, 1998). These vary from the well-rehearsed answers, the overly simplistic responses to direct questions that come from frequent telling, to minimal, polite, safe, problem avoiding accounts and 'public accounts' (Cornwell, 1984). It follows therefore, that the extent to which respondents provide an honest and as far as possible, accurate accounts of their life experiences will depend on the extent to which the researcher is able to convince them of his or her sincerity and integrity in carrying out the research.

There were certain factors that also convinced me that the women's stories were not carefully rehearsed accounts of their life experiences. Once the respondents were fully appraised of the purpose of the research and were made to feel that their stories were worth telling and worth hearing, their accounts of their experiences emerged, in most cases, willingly and at times spontaneously. In addition, I believe that the fact that a significant number of respondents expressed their gratitude for being allowed the opportunity to ventilate their feelings in such depth, for the first time since their pregnancies began, are strong indicators that signify the high likelihood that their stories were genuine accounts of their experiences. There were also my own observations of their body language and extent of feelings demonstrated.

I have to acknowledge that the degree of rapport that I was able to establish with these young women, in many ways, comes from my own degree of knowing and understanding of some of the issues facing these young women. This therefore in some ways could be a potential source of influence. On the other hand, as Ellis (1995) argued, if, as a researcher, I was not involved in, and had no knowledge of the situation being researched, then it would have been almost impossible for me to interpret the information provided with any degree of accuracy. In addition, the fact that I am of the same sex as the respondents, increased the likelihood that the women would feel more comfortable and

relaxed in discussing the intimate details of their lives, than would be the case if I had been male. This also increases the likelihood of their accounts being valid. Indeed this observation was confirmed by the degree of ease and openness in the ways in which they spoke about their intimate experiences of sexual intercourse, of contraceptive use and at times, of abortion.

One suggested way of ensuring validity is to let the respondents read the transcripts of their interviews. It was not possible to do so in this study, particularly in relation to the Caribbean respondents, as the interviews were conducted over a two-year period and considerable time had elapsed between the interviews and the transcribing of the tapes. In addition, given the transitory nature of the living arrangements of a large number of the respondents, particularly in Jamaica, it would not be possible to trace them to send transcripts, let alone receive feedback from them after they had read the transcripts. There was also the high likelihood that posted transcripts would fall into the wrong hands. I could also not take it for granted that all of the young women would be able to read the transcripts. This would also lead into issues of breach of confidentiality, as well as privacy considerations that had to be taken into account.

To a certain extent, some of these concerns also apply to some of the London sample, and I could not see the wisdom of providing only a small number of respondents with transcripts. In view of these factors, I have to acknowledge that these may contribute to a potential weakness in this study. However, in order to counter this drawback, at the end of each interview and during the interviews where relevant, I would employ the skills of reflection, summarising and feedback to ensure congruence. On other occasions, where time permitted, I would also rewind the tape and playback random sections of the recording in order that the respondents could confirm that accurate accounts of their stories were recorded. This was also one way, however small of making them feel involved in the process. Having given an account of the measures taken to ensure validity, I will now turn my attention to issues of reliability in qualitative research in general, and within the context of this study in particular.

Within the context of qualitative research, the concept of reliability takes on a new meaning. In its classic sense, the criteria for reliability is the extent to which

the research instrument, in the case of this research, the set of themes, are neutral in their effect. In addition, there should be a high probability that this instrument would measure the same results when used on other occasions, with the same intent, or objectives. This presents some difficulty in qualitative research, as the researcher's self or degree of knowing, as I have so far repeatedly argued, is an integral part of that research instrument. It follows therefore, as Denscombe (1998) states, the question has to be asked in a different way, that is, if another researcher undertook the same research, what is the likelihood that he or she would arrive at the same conclusions.

This question could not be answered with absolute certainty in this research or in any other qualitative research. However, in order to increase the likelihood of others being able to replicate this study as far as possible, I have, attempted to ensure that the aims and objectives of the research have been clearly outlined. I have also provided a detailed account of how the research was undertaken, including an explanation and the rationale for the decisions made about the sampling process. Attention to the methodology was another way of increasing the possibility of replication. In other words, I have, I hope, in the words of Lincoln & Guba (1985), attempted to provide an 'audit trail'.

Generalization

As previously explained, care was taken in sampling particularly in terms of targeting a wide geographical area of London, and as far as possible, the Caribbean. Among the reasons for this, was to ensure that I would have access to respondents from multiple sectors in society. A quick glimpse at the characteristics of the sample however, would indicate to the reader that respondents came mainly from the lower socio-economic echelons of the respective societies. I am however, not too concerned that this will affect generalizability of the findings to a large degree, as the sample characteristics are consistent with a large proportion of the research on teenage pregnancies. These characteristics are also consistent with my experiences of working with pregnant teenagers in London and the Caribbean.

This is not to say that teenagers from more affluent sectors of the societies under scrutiny do not become pregnant. My experience suggests that they

simply do not surface for consideration and debate in the same way as their less affluent counterparts. A number of reasons account for this difference in focus. For example, teenage pregnancy among this group tends to be managed as a closely guarded secret within the confines of their families and support networks, which include many doctors, hence the focus on teenage pregnancies as a phenomenon of the lower socio economic strata of society. Therefore economic considerations tend to be the predominant factors that dictate the level of outrage and concern expressed, as outlined in chapter one.

I have already indicated that the sample is not statistically representative and as a result, generalizability could be said to be limited due to the lack of random sampling. In addition, the sample was confined to London as opposed to all of England to a greater extent, and to a lesser extent in Kingston as opposed to all of Jamaica, and in Barbados and Jamaica, as opposed to the whole of the Caribbean. These factors have to be borne in mind when interpreting the findings. In these regards, the findings could be said to have an inner city bias in the case of England, and regional bias in the case of the Caribbean, and as such, representative only of the geographical areas of focus. I am therefore, forced to urge caution in making judgements about generalizability of the findings. However, I feel that these methodological shortcomings have been overcome to a large extent by two principles of qualitative interviewing which have been extensively applied to the process of conducting the interviews in this research. These increase the likelihood that the findings could be viewed as representative of larger geographical areas in England and in the Caribbean.

The first, is the principle of '**completeness**' (Rubin & Rubin, 1995). This requires the researcher to keep interviewing until there is a feeling that what is learned from the interviews provide an overall sense and understanding of the phenomenon, or concept being studied. You therefore cease interviewing when there is the realisation that successive interviews do not add to the knowledge base you have already gained from previous interviews. This is what Glaser and Strauss (1967) referred to as 'saturation point'. In this principle, what becomes the important factor in determining generalizability, is not confined to the numbers of people interviewed, but the extent to which the knowledge gained provides a sense of completeness.

The initial research proposal was to interview a sample of about seventy respondents, thirty-five from London and thirty-five from the Caribbean. However, during the Caribbean interviews, I felt that saturation point was reached after about twenty interviews, when it became apparent that the themes which emerged after the first seven or eight interviews were constantly repeated in subsequent interviews both in Jamaica and Barbados. This led to a point where it was felt that no new knowledge was being discovered.

The second principle requires the researcher to take this process a step further by testing for **'similarity and dissimilarity'** of the themes and concepts which emerged from the first interviews. This is done by conducting additional interviews with a second group of respondents in another location or setting, who have background characteristics which are different from the first set of respondents, but who have similar life experiences to the first group. This is to see to what extent the themes discovered from the interviews with the first group, still emerged in these very different situations (Rubin & Rubin, 1995). I transferred this principle to this study in the case of conducting interviews in the Caribbean. I observed that similar themes were emerging in Jamaica that emerged from the Barbados interviews. This was in spite of any potential differences brought about by distance. After the completion of the Caribbean interviews, I also looked for similarity and dissimilarity of themes across international borders, in the case of the London interviews. Again I found that with a few exceptions, the same themes were emerging from the London interviews. As Rubin & Rubin state when respondents from diverse backgrounds or situations express the same set of themes, or in the case of this research, ascribe similar meanings to their pregnancies, the level of confidence about the generalizability of the findings can be increased.

The international comparative aspect of this study provided an ideal arena for putting these principles to the test. I carried out the interviews in London and the Caribbean in the same manner, using the same techniques as previously outlined in this chapter. The only exception was the slight adaptation of use of dialect in a Caribbean context. What is noteworthy, is that despite the overall differences and similarities of age, race, background circumstances and geographical location of all the respondents, as stated before, the emerging themes from the data collected in many instances were surprisingly very similar.

In view of these factors, I therefore feel that it is reasonable to argue in favour of the generalizability of findings over a wider area.

In spite of all the attempts made to ensure that issues of generalizability were addressed, I nevertheless have to acknowledge that in this study as well as other qualitative studies, as Hakim (1987) points out, the:

'main weakness (of a qualitative study) is that small numbers of respondents cannot be taken as representative, even if great care is taken to choose a fair cross section of the type of people who are the subjects of the study' (Hakim, 1987:27).

Therefore in view of this, I urge the reader to be cautious in generalising the findings.

Analysing the data

As the approach to this study is qualitative in nature, it therefore follows that the presentation of its findings would be the end result of a qualitative method of data analysis, focusing on the young women's accounts of their experiences. Where statistical information is presented, it will only be used to illustrate some of the issues raised, for example, to give the reader an indication of what numbers of the respondents expressed certain themes, and not primarily for the purpose of analysis, as in any event, a sample of fifty-two respondents is generally considered far too small to allow any in-depth, meaningful statistical analysis. Numbers, rather than percentages are used, as the sample is relatively small, the reader can get a clearer picture by simply presenting the numbers.

As anticipated before the data gathering process, a breadth of rich information was collected, facilitated by the in-depth semi-structured to unstructured approach to interviewing. As a result, I decided to use a method of analysis based on a 'framework' approach. This approach is described by the authors as:

'an analytical process that involves a number of distinct, though highly interconnected stages..... It involves a systematic process of sifting, charting and sorting material according to the key issues and themes' that emerge from the data (Ritchie & Spencer, 1994:177).

This approach to analysis also has similarities with other approaches to qualitative data analysis, such as those of Glaser and Strauss (1967); Miles & Huberman (1984); and Strauss (1987).

The first stage of the process – **'familiarization'**, began with my attempts to obtain a broad overview or grasp of the general content of the data. To achieve this, I had to listen to the tapes repeatedly to recapture the context of the interviews, carefully relating these to any notes made from my observations during the interviews. This process of listening to the tapes began from the point of conducting the first interview and continued in stages, that is, periodically after completing a number of further interviews. One advantage of doing this, was in enabling me to begin to identify themes, issues and concepts as they gradually emerged. This also had the added impact of stimulating me to focus and examine in more detail, the themes that were emerging as the interview process continued over the ensuing months. For example, as themes of loss began to emerge during the Caribbean interviews, I was able, where necessary, to explore issues of loss in greater detail in subsequent interviews.

The logical next stage, **'identifying a thematic framework'**, was to set up a thematic index of issues raised by the young women and the themes that emerged from the recurrence of particular views and experiences. To identify these themes, the transcribed interview notes were meticulously read, at the same time, carefully highlighting each time a particular word, idea or phrase was repeated. These activities were on-going throughout the data collection process, and as further ideas and recurrent themes emerged, these would be noted.

A numerical coding system was used to link to the index of emerging themes, and these were carefully recorded in the margins of each transcript. For example, the word loss was explicitly used at times, and at other times, implicitly implied within the context of the interview when words such as 'sadness', 'emptiness', 'loneliness' etc were used repeatedly. This process of indexing was very helpful in focusing my attention to begin to observe patterns of association of themes emerging from the data. However, as the authors of this approach state, there needs to be an acknowledgement and constant awareness that this process of interpretation when themes are not explicitly stated but implied, can be very subjective. The process involves the researcher in making judgements

and reaching conclusions about meanings, relevance and the importance of certain themes and issues raised, as well as the connections between them. In order to minimise these potential drawbacks, while analysing the data, I had to keep these issues at the fore of my mind when interpretations were being made. This was done by clearly documenting the analysis process, and using examples from the data to illustrate interpretations made, in order that the reader can reach their own conclusions and make judgements for themselves.

In the next stage of the process I focused on building up an overview of the data, by rearranging data from its original form and context around identified themes - a process referred to as '**charting**'. Here charts were drawn up with headings and sub-headings drawn from the list of identified themes from all respondents and also for each geographical location of the study. Having completed this process, the next stage was to group all the ideas around identified themes for all the respondents from each geographical location in categories closely linked to ideas that will be presented in the findings chapters. For example, having identified the core themes of loss, cycle of poverty/exclusion and differences in approach to career vis a vis reproductive cycle, the data was then rearranged according to these themes.

The final and ultimate stage of this process is referred to as '**mapping and interpretation**'. As the term suggests, in this process I attempted to put the themes in context in order to make sense of the emerging themes. I compared and contrasted the various accounts of experiences between the respondents from London and the Caribbean as well as making attempts to define and interpret the emerging concepts by developing explanations. This involved making associations between the themes identified above and their relationship to repeated teenage pregnancies.

The data was further compared within the categories identified to try to identify any apparent variations in meanings. Comparisons were also made across categories to search for connections between the themes. For example, to search for the connections between the themes of loss, cycle of poverty and differences in career pathways and their relationship to the phenomenon of repeated teenage pregnancies. As the findings chapters will show, there appears to be an implicit connection between experiencing a sense of loss that

is further exacerbated by being trapped in a cycle of poverty from which it may appear impossible to escape without external help. This can in turn lead the young women to re-formulate the order of their agenda in favour of motherhood preceding an education and a career.

Having clearly outlined the method and methodological approaches to this study and the rationale for choosing these approaches, the next stage of this thesis is to present the findings that have emerged as a result of utilizing these approaches.

SECTION TWO

RESEARCH FINDINGS

INTRODUCTION

In this section, the findings from the data collection process will be reported. It will be presented in three chapters. The first chapter reports on the Caribbean findings, the second chapter will present the London findings and the third and final chapter will explore the similarities and differences between the Caribbean findings and the London findings. It will also explore the meaning of the findings and its implications. The first two chapters will begin with the presentation and analysis of the characteristics of the sample. The chapters will then go on to present the findings in the form of the main themes, which have emerged from the study. There will be an attempt to structure the presentation of the themes according to the way in which they emerged. For example, there are some themes that emerged spontaneously from the women's accounts without prompting, and some themes, which as outlined in the methods chapter, were introduced by me in view of their level of prominence in the findings of other research studies on teenage pregnancies. The conclusions reached from the findings will form the basis of discussion of the final chapter and therefore no attempts will be made to draw conclusions at the end of the first two chapters.

In keeping with one of the aims and objectives of the study outlined in chapter one – that of giving the young women a voice in telling their stories and by so doing, attribute meanings to their experiences - the voices of the young women will be a prominent feature of these findings. This will take the form of direct quotes from the interviews.

These quotes will be reported exactly as spoken. Given the infinite variety of ways in which English is interpreted, substituted and spoken in the Caribbean, and indeed in London, the quotes will not be reported in standard, grammatically correct English. Therefore all readers will not be familiar with some of the expressions used by the respondents, but nevertheless should have no major difficulties in understanding the central points and meanings being conveyed.

CHAPTER FOUR

The Caribbean findings

This chapter presents the findings from interviews conducted with 26 respondents, of equal numbers from both islands. The findings will be presented in three sections. Section one focuses on the socio-demographic characteristics of the sample while section two will provide an indication of the extent and patterns of repeat pregnancy. In section three, the themes that emerged from the study will be provided.

Section one

Contextualising the findings - socio-demographic characteristics

In this first section a profile of the sample is provided.

Table 1 - Age of respondents

Age of respondents	Jamaica	Age of respondents	Barbados
Age 15	1	Age 16	1
Age 16	1	Age 17	4
Age 17	1	Age 18	4
Age 18	5	Age 19	4
Age 19	5		

As the table above shows, overall, each age band from 15-19 years was represented in the sample, with higher numbers of young people aged 17 and above.

Ethnicity

With regard to their ethnicity, All respondents were black. The majority of the population of both islands is of African descent. This ethnic group represents 91% and 70% respectively of the populations of Jamaica and Barbados (Ferguson, 1997). Historical reasons are influential in the fact that poverty and other social disadvantages feature prominently among this racial group. The racial make-up of the sample is therefore not surprising, since there has been a

well-established link between socio-economic disadvantage, deprivation and teenage pregnancies. The racial characteristics of this sample are also similar to other studies on teenage pregnancy in the Caribbean, which identify a link between the incidence of teenage pregnancies and 'working class peoples of the Caribbean' (Jagdeo 1984). However, anecdotal evidence from my own experience of work with pregnant teenagers in the Caribbean, would caution us not to conclude that teenage pregnancies occur only among this racial group in these societies. The absence of other groups from the statistics in the Caribbean is also a reflection of the fact that the wealth and social networks of these groups make it more possible to conceal such pregnancies, or to resort to private abortions within these networks. Therefore their numbers are seldom ever truly represented in the general statistics on teenage pregnancies in these islands.

Marital status

At the time of the interview none of the respondents were married. The question of marriage simply did not feature on their list of priorities. For the relatively few who had considered marriage, this was generally seen as a goal for the future, rather than an immediate concern, as they were preoccupied with more pressing issues of day-to-day survival. This finding is noteworthy and seems to be explained by the point made in chapter one, that historically marriage was not generally the norm among members of the lower socio-economic sectors of Caribbean societies. This historical legacy has remained intact in contemporary Caribbean societies, though there are some signs of a gradual change emerging. However, most respondents were in the type of union described in chapter one as 'visiting unions' with the father of one or both of their children, or with current boyfriends. This practice though very common within the lower socio-economic echelons of Caribbean societies, is not uncommon among other groups. Marriage in the Caribbean is linked to economic prosperity. Since these respondents and their partners were all poor, it is hardly surprising that marriage was the last thing on their list of survival priorities.

Table 2 – Formal qualifications obtained at secondary school level

	Barbados	Jamaica
Number of respondents with formal examination passes	2	1
Number awaiting results of examinations	Nil	1
Number without formal examination passes	11	11

At the time of the interviews, as table 2 shows, this sample was clearly educationally disadvantaged. All, except two respondents were at school at the time they first became pregnant. For the vast majority of respondents, this meant the end of formal education for a complex range of reasons, which will be discussed later. In Jamaica only 1 respondent had achieved any formal qualifications (CXC*), and another was awaiting the result of the 5 subjects she had taken at GCE/CXC level. In Barbados, this pattern was not too dissimilar, as only 2 respondents had achieved formal qualifications –(CXC). This lack of formal qualifications among the respondents in both islands was not surprising, given the fact that 98 per cent of all respondents did not return to school after the first pregnancy. The reasons for this widespread failure to return to school will be explored later in this, and the final chapter.

Two respondents in Jamaica had the opportunity to attend the Women's Centre. This is a voluntary agency whose main aim is to allow young women to continue with their education after the first pregnancy, as well as to prevent early repeat pregnancies. The women who said that they had attended the centre became pregnant again for a variety of reasons, including the failure to use contraceptives between the time of the first birth and their referral to the centre. Data from published material about the centre and from my own interview with centre staff, would suggest that these failures were in the minority, as in the majority of cases, the centre has been successful in meeting their aims and objectives. One respondent in Barbados was about to commence her 'A' level studies at the time of the second pregnancy. As we will see below, this pattern of low formal educational achievements mirrored the educational histories of their own parents.

Grandparents' Education

With the exception of two sets of grandparents in Barbados who were educated to a professional level, all parents of the respondents had only reached the level of a basic education. This resulted in insecure, unskilled jobs, which often left them exhausted and consequently, with very little time to devote to the demands of parenting. The importance of these factors in the incidence of repeat teenage

* Caribbean Examinations Council

pregnancies cannot be underestimated. The level of educational achievements of these parents also has a bearing on their very inadequate accommodation arrangements that will be described later in this section. The fact that these grandparents were either unemployed or were employed in very low income and insecure jobs also further compounds this situation.

Table 3 - Employment/Income

Barbados		Jamaica	
Number in employment	2	Number in employment	1
Number in receipt of welfare benefits	2	Number in receipt of welfare benefits	0
Number relying on family and putative fathers for financial assistance	9	Number relying on family and putative fathers for financial assistance	12

A similar picture emerges from an analysis of the respondents' income and employment profiles. This is brought out very clearly from table 3. These respondents were vulnerable in terms of their income and job profiles. In Barbados only two of the thirteen respondents were employed at the time of the interviews. Two were in receipt of welfare benefit - \$48 per fortnight, a British equivalent of about £16. There was no automatic right to such benefits that were stringently means tested. The level of welfare benefits in Barbados does not compare to British state benefits in amounts and comprehensiveness. In Jamaica, two respondents were previously employed but had to give up work after the second pregnancy. In Jamaica there are no equivalent state welfare benefits for unsupported mothers. Given these circumstances, the vast majority of Caribbean respondents were forced to rely almost exclusively on financial assistance from an often unpredictable variety of sources. These sources included support from the putative fathers, either occasionally or in some instances, on a regular basis. In some cases the young women received no support from the putative father of the first child, or occasionally no support from both fathers. The main source of support, where a young woman was unemployed, was from her mother, often placing further financial burden on already very limited resources. This lack of income also impacted on the precarious accommodation circumstances described on the next page, as without income, the chances of being able to secure suitable accommodation became virtually impossible. As we will see when the themes are presented, this

lack of income and access to other financial assistance is one of the factors that is directly related to the theme of 'the journey of search' which emerged in the Caribbean.

Accommodation

With few exceptions, the general pattern was for respondents to live in overcrowded accommodation, with one or rarely two parents, and three or four siblings, some of whom also had children of their own. Some of these home circumstances could be described as unstable, because there was no sense of permanence about these living arrangements. This was apparent when the young women often spoke readily about their feelings of uncertainty, which came from living under the threat that they could be asked to leave the parental home at short notice if there was a deterioration in the relationship with their families. Some were forced to live with relatives, friends or putative fathers on a semi-permanent basis, after they were asked to leave the parental home as a result of becoming pregnant, either after the first or second pregnancy, and in some cases, after a third pregnancy. This lack of security often has a direct relationship with repeat pregnancies.

Section two

The extent and pattern of repeat pregnancies

Number of pregnancies

All the respondents in this study had a minimum of two pregnancies. Some respondents however, had more than two pregnancies. For example, seven of the Barbadian sample had more than two pregnancies, including one with four pregnancies. Only one of the Jamaican sample had more than two pregnancies. The number of respondents with more than two pregnancies, therefore represent just under one third of the sample. This is a high proportion of such pregnancies and gives rise to cause for concern. In addition, when we look at the pattern of repeat pregnancies in tables 4a & 4b that follow, there appears to be a connection between early age at first pregnancy and rapid repeat pregnancies.

Table 4a- Pattern of repeat pregnancy among respondents in Jamaica

Age at first pregnancy	Age at second pregnancy	Age at third pregnancy
14	15	
14	15	
14	17	
15	16	
15	17	
15	18	
16	17	
16	17	
16	17	
16	17	19
17	18	
17	18	
17	18	

Table 4b- Pattern of repeat pregnancy among respondents in Barbados

Age at first pregnancy	Age at second pregnancy	Age at third pregnancy	Age at fourth pregnancy
13	16	17	
14	15		
14	16		
14	16	17	19
15	16		
15	16		
15	16		
15	17		
15	16	17	
15	17	18	
15	18		
16	18		
16	18	18	

The data presented in Tables 4a and 4b above show, that there were no significant differences between these two islands in terms of the pattern of repeat pregnancies. A closer examination of this data also shows that the majority of first pregnancies occurred between the ages of 14 and 15 years. 15 of these respondents had a second pregnancy one year later, while 11 had a bigger gap between pregnancies. The larger gap between pregnancies would suggest that these respondents might have been more diligent about using

contraceptives in between pregnancies. However, in view of the fact that the majority of these respondents reported very inconsistent and irregular use of contraceptives, and some failed to use contraceptives, this explanation does not hold. As there were different fathers for some of the respondents' children, one possible explanation is that this bigger gap could be related to the intervals between relationships for some respondents. Also noteworthy, is the fact that those respondents with relatively short intervals between each pregnancy also showed a pattern of earlier age at first pregnancy. This finding is therefore consistent with the research findings in chapter two of an association between early age at first pregnancy and rapid repeat pregnancies.

Table 5- Age at first sexual activity

Age of respondents when first became sexually active	Jamaica	Barbados
Age 11	None	1
Age 12	3	3
Age 13	3	2
Age 14	3	4
Age 15	3	3
Age 16	1	None

Age of first sexual activity was similar for both Jamaica and Barbados. This finding is consistent with data provided in the literature review that the majority of both men and women aged 15-24 in Jamaica, have had sexual intercourse (Contraceptive Prevalence Survey 1993). Although I do not have similar published evidence in respect of Barbados, I would hypothesize from my experience of working with teenage women in Barbados, that the same finding also holds true for Barbados. These characteristics are significant because they provide further evidence of the link between early sexual activity and repeat pregnancies discussed in the literature review, as well as a link between early age at first pregnancies shown in tables 4a and 4b.

Table 6 - Planned and unplanned pregnancies

Number of pregnancies	Number Planned Jamaica	Number unplanned Jamaica	Number Planned Barbados	Number unplanned Barbados
First pregnancies	1	12	1	12
Second pregnancies	4	9	2	11
Third pregnancies	0		3	3
Fourth pregnancies	0		1	0

A number of research studies place a great deal of stress on the negative aspects of the unwanted nature of teenage pregnancies. However it is important to note, that although the vast majority of the pregnancies in this study were unplanned, the distinction must be made between unintended pregnancies and unwanted pregnancies. Section three will show that all respondents accepted their pregnancies after they had overcome the initial shock brought about by the knowledge that they were pregnant. All attached a great deal of importance to their ability to have children, and had therefore planned to have children at some time in the future. Therefore it could be argued that in the case of these pregnancies, it was the timing that was unplanned, and not the pregnancies, and in this regard these pregnancies could not be viewed as unwanted pregnancies.

Given the fact that the majority of first pregnancies in this study were reported as unplanned, the extent to which the young women valued their pregnancies was also evident by the fact that they all took good care of themselves during their pregnancies, to the best of their abilities.

On the one hand, these findings differ in some respects from other research into repeat teenage pregnancy, which states that teenagers who reported that the first child was wanted have a 'significantly increased overall probability of having a second child within two years' (Mott, 1986). However, in view of the distinctions made above between unplanned, unintended and unwanted pregnancies, on the other hand, it could also be argued that because these pregnancies were unintended but accepted, there is an element of wanting in these pregnancies, and in this respect, these findings could be said to correlate with Mott's findings.

An important feature in the respondents' attitude to their pregnancies was the amount of attention they paid to attending antenatal clinics on a regular basis for antenatal care. This investment of their time and effort towards their care could be said to have paid dividends, because with the exception of two respondents, who developed complications of pregnancy, generally all respondents reported good health during pregnancy. Additionally, with the exception of one minor case of infantile jaundice, and one case of a stillbirth and another case of a neo-natal death, all respondents also reported that their babies were in good health. These findings are noteworthy in view of the generally adverse reports of poor outcomes in maternal and infant health and mortality related to teenage pregnancies particularly in third world countries, presented in the literature review. They are also worthy of note in view of the relatively poor socio-economic circumstances of the majority of respondents interviewed. In this respect, these findings do not bear out some of the evidence provided in the literature review, that shows a correlation between third world countries, age of mother, complications of pregnancy and high infant mortality rates.

The putative fathers

In every case the putative father was older than the respondent. Their ages ranged from age 17 to 35. In the majority of cases, they were on average between 8 to 10 years older than the respondents. Some putative fathers were also in other relationships, or had children from other relationships. 10 putative fathers were employed. For 12 out of 26 respondents, the putative fathers were different for the first and repeat pregnancies. In some cases, respondents relied exclusively on their boyfriends for emotional and financial support. These factors are closely linked to the journey of search on which these respondents embarked in their quest for love and fulfilment in their lives, which will be looked at in more depth later on in this chapter.

Table 7 - Number of respondents with pregnancies among siblings

Barbados	6
Jamaica	6

It is noteworthy that just under half of the respondents had siblings who were also pregnant as teenagers. In the case of one respondent, all four of her sisters became pregnant as teenagers. These findings are in keeping with the literature review where evidence was provided that teen pregnancy among siblings was a contributory factor to teenage pregnancies. In terms of how these factors apply to this study, the evidence remains unclear. However, this pattern may be related to the tradition of visiting relationships and its implications seen in chapter one.

Overall it can be seen that this group of young women were vulnerable socio-economically. They typically had low educational levels and were poorly placed with regard to future prospects. In many respects, this sample was also very characteristic of the prevalent pattern of the 'visiting union' described in chapter one. These issues will be explored further in section three.

Section 3

Emerging Themes

As these themes are presented it will become apparent that there are some similarities with the phenomenon of single teenage pregnancies reviewed in chapter two, to the extent that, like single pregnancies, repeat pregnancies are also the direct result of a complex set of interrelated factors which have their origins in the circumstances leading up to the first pregnancy.

SPONTANEOUS THEMES

The loss factor

From the very first set of interviews and throughout the interview process, a recurrent theme which I have termed the **loss factor** emerged as having a significant bearing on the phenomenon of repeat pregnancies. This is a broad theme which encompassed a wide range of losses, not only those losses which are most obviously and commonly associated with death and dying such as stillbirths and neonatal deaths, but also the types of loss which are not so obvious, such as loss of positive nurturing relationships with parents and peers, lost educational opportunities, life chances and many more.

Before looking at these loss factors, which have emerged, a brief look at the reactions and responses to different categories of loss may help to improve our understanding of the impact of these losses. Frears and Schneider (1981) identified three different types of loss- **Apparent loss, loss as part of change and unnoticed loss**. As the term suggests, apparent loss includes all those losses, which are obvious, such as death of a family member, illness and injury. Loss as part of change are those losses which occur in the normal run of life changes, such as leaving home, having children and so on, which are normally

referred to as 'life transitions', and in the normal scheme of things, the experiences gained from dealing with these losses, prepare us for coping with later losses.

One type of loss, which featured prominently in this study, and to which I want to direct attention, is, **unnoticed loss**. These are the types of loss according to Frears and Schneider, which are not immediately obvious to everyone, but they nevertheless trigger loss responses in the individual. They are often more difficult to deal with as the individual's response is not easily understood, and consequently they fail to generate the same degree of support, empathy and facilitation of expression as more apparent losses. As the evidence will show, this failure to recognise and work with such losses often manifests itself in repeat pregnancies. It is important to look at each of these categories of loss separately before attempting to make the connections between them.

Loss following stillbirths, abortions, neonatal deaths

These losses featured in **12** out of **26** respondents interviewed. Feelings of loss were expressed in painful terms. For many respondents, this sense of loss was a very isolating experience, as the loss went unnoticed by family members and professionals. The young women spoke directly and indirectly about the enormous sense of emptiness, which they felt after losing the first baby. Terms such as '**I felt lost**', '**I felt bad**', '**I couldn't stop studying it**', were frequently used when expressing their emotions about their reactions to the loss. Many spoke about their sense of blame for the loss, particularly those losses which came about following stillbirths and miscarriages. In the case of stillbirths and miscarriages, the respondents became even more distressed and bewildered, as they were given no medical explanations for the loss; consequently, they felt they must have contributed in some way to this loss. This sense of guilt and blame was even more poignant where the feelings of loss had come about following an induced abortion. As we will later see, these strong feelings link directly to commonly held anti-abortion views among the vast majority of the respondents from both islands.

As the following quotes show, the second pregnancy often occurred as a result of trying to replace the first child, which they had lost. For example in the case of this respondent age 18 from Jamaica:

'Me baby was 8 months when he die suddenly. I was at home. I put him into the house. He was playing on the floor. I went to sweep the veranda, when I went back into the house, he was foaming froth and he die same place. I didn't even get to take him to the hospital or anything. They did a post mortem. Them said it was a little cold like pneumonia or something. All like now, I can't get that still. I think about him a lot. I can't get over it. I am still sad'.

This mother had previously indicated that although she initially felt that the second pregnancy was 'accidental', when her motives for the second pregnancy were explored, in hindsight she felt that the pregnancy was a substitute for the loss of her first baby. Her response to the question of whether the second pregnancy was to replace the first child that was lost, was: 'Yes definitely, because I keep on thinking on it so much, I didn't take any precaution or anything, so I get pregnant'.

When asked if she felt that the reason for not using any contraceptives after the death of the first baby, was because she wanted to get pregnant again, she emphatically replied:

'Yes, I want him or she a lot, because it would help me stop crying bout the first one so much. When I have this one now, I will feel more comfortable. Sometimes I fret and stress a lot, and so this one will make me more comfortable. I will feel better'.

In some cases there was evidence of hidden or masked motives at work, when some of the respondents claimed that although they were not initially conscious of their attempts to replace the child that they had lost, in retrospect they felt that the loss had a strong bearing on the second pregnancy. Among the reasons that they gave for arriving at this conclusion, was the sense of joy and fulfilment that they felt when they became pregnant again. This sense of achievement was still felt, even though in reality nothing had changed in socio-economic terms, and their circumstances were in many ways, just as desperate if not more so, than before. For example in the case of another respondent from Barbados, aged 19 who was pregnant for the third time, at the time of the interview, she informed me that she had secretly terminated her first pregnancy without her mother's knowledge. She had taken this action because she was frightened of her mother's reaction if she became aware of the pregnancy. When asked how she

felt about having this termination, she replied, 'I didn't feel good..... I did never want to do that there right, but I had to... It felt like taking a life, right'.

When asked why she felt she became pregnant again the second time, despite her fears about her mother's reaction, she was quite clear that she did not abort the second pregnancy because 'I didn't want to kill more children'. Although this respondent had not articulated that the second pregnancy was a deliberate attempt to replace the first pregnancy, it was likely that on some level at least, though not immediately apparent to her at the time, that there was some motivation to become pregnant again. This observation is made because she had been prescribed the pill following the termination, she had in fact started to take them, but had failed to follow the strict regime which taking the contraceptive pill demands to make it an effective means of protection against pregnancies. Given her strong sense of fear of her mother's reaction and the fact that she became pregnant again despite those fears, the notion of a masked motive to become pregnant again to replace the loss of the first becomes highly plausible. This hypothesis was confirmed when she was asked if she felt that the second pregnancy was in any way an attempt to replace the first, and she replied, 'Yes', she was feeling a sense of relief because 'I had she'.

M, aged 16 from Jamaica who first became pregnant at aged 15, had discovered during a routine antenatal clinic visit that her baby had died in her womb following an ultra sound. She expressed her sense of sadness, which ensued as a result of the loss. When asked during the course of the interview if the second pregnancy was planned or unplanned, she replied: 'Not saying planned and not saying unplanned'.

When asked to explain what she meant by this statement, she replied:

'First my baby father told me it was time for me to see if I could try to have a next baby because everyday I would say the baby would be this month old and that month old, so he said O.K. would you like to be pregnant again, and I said yes, and he said O.K. so I just do it'.

When asked if she was feeling this sense of longing for another baby because the first one had died, and whether she felt that a second pregnancy would make up for the one she had lost, she had no hesitation in replying, 'YES', the first pregnancy, I did not feel the baby moving this active, but now I feel it, so like I can say yes".

The extent of her loss was very evident as she generally appeared very sad and repeatedly made reference to the loss throughout the interview.

In the case of this respondent age 17 from Barbados, when she was asked if she was aware why she became pregnant the second time, she replied: 'I want to become pregnant again because I lost the first one, I did want one to make up'.

The sense of blame and guilt were even more acute where the loss had come about following an induced abortion. At the time of the interview, this respondent's second child was 10 months old. She was still breast feeding, and was also 4 months pregnant again. She was considering her second abortion. Throughout the interview, her sense of despair was quite evident. A major reason for her distress, was the deep sense of ambivalence felt about the fact that on the one hand, her socio-economic circumstances forced her to consider another abortion, and on the other, as her previous feelings about abortion suggest, she held strong views against abortion. She explained that after the abortion, although the decision to have the first abortion:

'was a joint decision with my boyfriend, but I did not feel good about it. I felt sad after I had done it. I would have liked to talk to someone. I felt bad for a long time. I feel bad now because I am pregnant again and I am thinking about a termination, but I can't help it. It brings back feelings about the one I lost'.

Another respondent aged 19 from Jamaica spoke of her multiple losses when she informed me that after becoming pregnant for the first time at age 17, she was put under great pressure by her mother to have an abortion, to which she eventually succumbed. During the interview, she became very tearful as she expressed her profound sense of loss following the abortion. Her sense of loss was further compounded by the fact that her boyfriend at the time, with whom she had a very close relationship, very much wanted the baby and was strongly against her having an abortion. He has subsequently broken off the relationship with her and no longer speaks to her because he is unable to forgive her for having the abortion. Her own mother now feels very guilty for having pressured her into having an abortion against her wish. During the interview, she spontaneously admitted that the second pregnancy was planned, because:

'After the abortion, I tried all the time to get pregnant. I became upset, as it seemed like I could not get pregnant again. I was being punished. I was relieved when I did' (become pregnant).

The extent of the sense of guilt which the majority of the respondents felt following a termination, was summed up by this 19 year old respondent from Barbados who tearfully said:

'I was pressured a lot (to have an abortion). I feel kind of sad, bored and sometimes I think about it and ask myself what I did.....I feel young girls like my age should not get rid of children because it is not a good thing to do and sometimes when you get rid of it, you have many thoughts. I would like to tell all the young girls out there, don't get rid of babies'.

The respondent quoted above had three pregnancies. She was quite clear that these pregnancies were to be replacements for the pregnancy that was terminated. She openly stated that the second and third pregnancies were planned because:

'I say after the first one was got rid of. I said I was always thinking about it and saying to myself. I don't think I am going to do that anymore. I don't think that's nice to do, so I say to myself it would be nice having children and stuff, so I told my boyfriend about it and he said o.k.'

It was interesting to note that in all the examples given above as well as in others not quoted, in spite of the anticipated response that the second pregnancy would fill the void left by the loss of the first pregnancy, many found out to their dismay that this void was still present when they were even more distraught halfway through the second pregnancy, as they gradually began to realise that the initial feelings of overcoming the loss by becoming pregnant a second or a third time, was short-lived and did not diminish their pain. During the interviews, these respondents were the first to admit that their feelings of sadness still prevailed to a greater or lesser extent, as they were still feeling sad after the second and in some cases, third pregnancies.

In the vast majority of cases, the respondents were expressing these feelings for the first time. In one case the gravity of a statement which was made could not be ignored, as in the case of the respondent mentioned above who had had three pregnancies, when she mentioned that 'I keep my feelings bottled up. I have no one to talk to. I feel like dying. I feel very unhappy'.

This expression prompted me to refer her for counselling and other socio-economic support, with the respondent's permission.

For some respondents, although there were opportunities to express these feelings with friends and family, as the following quote from one respondent shows, this was often not enough to dull the pain. After the loss she had spoken to her common-law sister-in-law and her own mother, but the sadness was still there. As she explained, 'I still feel it, because I said they didn't lose any of theirs and I lose mine, so they would not know what's inside, what I am feeling'.

The anti-abortion theme

Closely linked to the theme of loss was the very distinct and forcefully expressed anti-abortion views, which were expressed by **19** of the **26** respondents interviewed. Views about abortion either arose spontaneously following routine questions about the outcome of the first or subsequent pregnancies, or when asked at an appropriate point during the interview if they had ever considered the option of abortion at any time during their pregnancies. Statements such as: '**I hate it**', '**It's just not right**'; '**I bitterly regret doing it**' were frequently expressed. One respondent, when asked why she had made the decision not to have an abortion as suggested by her mother, replied, 'Because my mother did not throw away any of us'. The term 'throw away' is most often used in Jamaica to refer to abortions. It also has strong connotations of wastage and is also linked to prevalent views about the importance of fertility in women, which were held by all respondents. As this respondent aged 18 from Jamaica explained:

'It was my first, sometimes you throw away the first and you never know if you will have another one. You get pregnant you give it up. Sometimes when you do really want a child you can't make one. Sometimes that is the only one you could make'.

These views would also help to explain why despite the unplanned nature of the majority of their pregnancies, as shown in tables 3a and 3b, in the characteristics of the sample, the pregnancies were so readily accepted by the respondents. The importance attached to the first child became very evident when the respondent quoted immediately above was asked why she had terminated the second pregnancy. Her response was, 'I was young and had one already'. Nevertheless, her ambivalence about having terminated the second pregnancy was clear when she expressed her unhappiness about the termination, despite her perfectly well thought out rationale for the termination. She went on to say, 'I

didn't really feel too good about it, but the prices nowadays, and all these things at such a young age'.

The notion of wastage was also apparent when another respondent was asked if she had ever considered having an abortion. Her response was:

'Not really because if my parents had an abortion. I wouldn't be here right now. So I don't see why I should put a next child life in jeopardy by doing that.....It shouldn't happen at all. Government should not allow anybody to have an abortion'.

She went on to forcefully express views which clearly suggest that she thinks abortion should be treated as a crime, and considered to be murder. As she explained: 'any doctor who does that should go to prison for it. It shouldn't happen'.

This respondent was so adamant about the unacceptable nature of abortion that she would consider no cases of exception to her rule. As she emphatically stated:

'No exceptions. Even if it is rape. Have the child and give it up if you going to kill a child inside you. What happens when you meet a next man and you get pregnant? You are going to think of doing the same thing. You are not going to tell him that you get pregnant, because you love the life that you live, and I don't think that should happen. Any doctor who does that should really be in prison. You have nuff (a lot of) girls just love the street, but if you kill at first you are going to do it again'.

When she was asked if her constant use of the word 'kill' could be taken as an indication that she viewed abortion as murder, she replied:

'Yes I do think so because if there is a life inside of you and you abort it by killing it, its murder. Don't you think its murder? That should not happen at all, because if it should happen to them, they would not be here right now'.

Another respondent from Barbados, aged 18 remarked:

'I don't feel that people should kill something that they don't really know about. Well I feel that if you are pregnant and you are constantly bleeding or whatever, you would let nature take its course. If it is to die it would die. If it is to live it would live, but that's nature. I wouldn't like to interfere because the Lord said, thou shall not kill, so why should you take a life you don't know about'.

This association of abortions with the act of 'killing' was frequently expressed. Even where an abortion was felt to be the best course of action, the feeling that it was a process of killing someone, taking of a life, still lingered on beneath the surface and as these quotes show, can often weigh heavily on the respondents' state of mind. As this respondent aged 19 from Barbados explained, 'Well I think

it was the best thing but I didn't really want to do that because I didn't really thought about killing something'.

In some cases a distinction was reluctantly made between abortions that were felt to be necessary, as in the case of a pregnancy which happens as a result of rape, and those, which were not the result of rape. As this respondent from Jamaica stated:

'Some teenagers get rape and if them get disease, that baby will be born with disease and that need abortion'.

For this respondent, these were the only circumstances under which she would consider an abortion to be acceptable, because, like many other respondents, 'a woman should bring her first child, she don't know when she can have anymore, so she supposed to bring her first child'.

One respondent would support abortion in the case of rape but not in the case of a first child. As she explained: 'I don't believe in that, a lady supposed to bring her first child. She don't know that she can have any more. She supposed to bring her first child'. Here the importance attached to fertility took precedence over a case of rape.

Another respondent from Barbados, aged 18, when asked if she had considered an abortion as a response to the third pregnancy, explained:

'I got the money for the abortion and at the point when I was going to do it, I couldn't do it anymore... because I wasn't brought up to do that sort of thing. Well I wouldn't feel good within myself if I go and terminate a pregnancy. That is me, other people would go and do it and they won't think about those things you know, but that is me'.

As we have seen before, religious influences also feature in these strongly held anti-abortion views, as in the case of this respondent aged 19 from Jamaica who in expressing her disapproval of abortion, stated that, 'them always say people who kill baby a cemetery, time judgement day, them a go run backa (behind) them and bawl (cry). These words strongly suggest the notion of a day of judgement to be faced and the notion of having to be punished for one's sins. In this case, the sin of killing a baby. Views such as these as we will see later, are also closely tied to religious quotes expressed by some respondents in relation to the futility of trying to prevent teenage pregnancies, as the 'bible says children will have children'.

These quotes clearly show, that these strong anti-abortion views held by the respondents have their origins in a range of complex cultural and societal views about fertility, religion, the role of women and many more. Therefore when such rigid anti-abortion views are held, it is conceivable that such an intensity of feelings of loss is experienced by respondents who have had an abortion. Following from this, it becomes all the more understandable why having an abortion for the first pregnancy, or even a stillbirth, would result in such a powerful incentive to have a repeat pregnancy.

The journey of search as a symptom of loss

In keeping with the theme of loss, was a kind of loss as part of change, which took the form of an endless, often painful and fruitless search for fulfilment, love and nurturing which have been absent throughout the lives of the respondents. In all cases, this was a search which began before the first pregnancy and later manifested itself into repeat pregnancies, as their attempts to find the object of this search repeatedly failed. As the respondents struggled to ascribe meaning to their lives and to understand their repeat pregnancies, they often spoke poignantly about their experiences on this journey.

These losses as part of change did not adequately prepare them for dealing with later losses. The experiences of these young women provide evidence that these losses took place within a vacuum, without the benefit of a nurturing environment to enable them to learn from these experiences, and to make the vital life transitions which are characteristic of loss as part of change.

17 respondents often described their understanding of their repeat pregnancies as the end result of this search, which they would continue when the first attempt to find a loving and supportive relationship failed. In an attempt to ascribe meaning to her three pregnancies, this respondent aged 19 from Jamaica explained:

'I would say it was lack of love or something. Like you trying to find a person who love you and who ended up continually telling you that them love you, love you and you believe the person, so that's the person like you want to spend the rest of your life with that person, and get commitment and it ended up that's the person who breaks your heart. You want to find a next one who would push out more interest and the same thing happen again, till you get fed up. I am finished'.

These words are representative of the views and feelings of many other respondents. They are clearly the words of a disillusioned young woman who had pinned all her hopes of finding what she had lost, on the men in her life. The void remained unfilled and in the process of her search she has become too exhausted to search any more. She was aged 13 when she consciously began this search. When she was asked why she started searching at such a young age, she replied:

'I wasn't getting much attention because my father him leave me about the same day as I born. I found out from my mother that him didn't really want me, because him give her money for abortion, and she ended up carrying me. I find out that it was lack of love from both my father and my mother because the treatment I get from my mother it wasn't nice. She have six of us, one die, so she raised five of us by herself. She alone have to struggle, so she wasn't showing much attention or love. I was looking for love from my mother and I ended up getting three pregnancies'.

Similarly, this respondent aged 17 from Barbados ascribed meaning to her pregnancies in the following way:

'When I needed a father he wasn't there. So I guess when I got pregnant on both occasions, I guess I was looking for a man's love in place of his because I didn't feel needed or wanted by him. Everything else was important. Everything else in his life apart from me'.

When she was asked in what way she needed her father and he wasn't there, she explained:

'Like when we were going to school. Everything in terms of lunch money and that kind of thing. He would always say he never have it. I don't know why, even with my mother he didn't really give her money the way a husband should give his wife to look after the children..... I don't know what he used to do with his money, but I still feel he had a right to give her money to support us. The majority of the time she had to look for everything she wanted for us herself'.

This quote also indicates that financial support, or lack of financial support, also featured highly in the lives of the respondents and the subsequent choices that they made, and as we will later see, these factors have direct relevance to repeat pregnancies.

Another respondent from Barbados, aged 17, who had three pregnancies, when she was asked why she became sexually active at age 13, she replied:

'Friends and seeking attention. I guess you know when your friends talk about these things and you don't know you become curious. And when you didn't get certain things because my father could only show me a little attention because he was busy at work, and when he got his wife (stepmother) she didn't really like me, and there

was a lot of conflict. And when I met the fellow (boyfriend), he was real supportive and I was looking for a kind of closeness, so I guess that was my problem'.

In an attempt to further understand this search she went on to reflect on, and to explain the reasons for the meanings she had already ascribed to her pregnancies, she paused for a moment before she thoughtfully stated:

'Yes, I think that because at the age I got involve with M, the second little girl father, if I was not looking for something serious, I would not be with him all like now. I would have been here, there and everywhere'.

This quote like the last two, is representative of the views of 70 per cent of respondents which were expressed so frequently during the course of the interviews, and which are very closely linked to the next theme which emerged quite spontaneously during the interviews.

Loss appears to be not only a cause of repeat pregnancies, but also an effect of repeat pregnancies. Almost all of the young women spoke of the impact of repeat pregnancies in terms of multiple losses. For example, loss of previous relationships with friends, educational opportunities, loss of innocence and adolescence, were among those losses frequently mentioned. While young women with single pregnancies often felt these multiple losses, the arrival of another baby had the impact of widening the gap between setting goals and achieving those goals. In other instances, the sense of isolation and responsibility almost seemed to be compounded. There was a greater feeling of being trapped as it was often more difficult to get a babysitter for one baby than it was for two. Already very limited financial resources had to be stretched further. Loss of privacy becomes more acute as overcrowded homes became more crowded.

Loss of opportunities linked to school dropout

School dropout was cited in the literature on teenage pregnancies as a predictor of repeat teen pregnancies (Klein, 1972). This finding has been confirmed in this study, where all but two of the respondents were at school at the time of the first pregnancy. Some studies have also made links between early pregnancies and school drop-out (Card & Wise, 1978; Mott & Maxwell, 1981; & Hayes, 1987). As

we saw in the literature review chapter, numerous reasons have been cited to explain such links.

In this study, only one respondent was able to return to school after the first pregnancy and as we will see, this lack of opportunity to return to school also featured prominently in the respondents' sense of loss in terms of lost educational opportunities. It could also be argued that this factor had a direct bearing on repeat pregnancies in the sense that the rationale to have another child becomes even more attractive in the absence of the school in fulfilling a major role in their lives. A number of the young women said that one of the negative effects of early pregnancy was the lack of opportunity to continue their education once it became known by the school authorities that they were pregnant. They reported that the reaction from teachers varied from sympathetic but not very helpful in allowing them to continue their education, to downright insulting and outright refusal to allow them to return to school. 9 respondents reported that the head teachers of their schools refused them permission to return to school. In some cases, the girls simply stopped attending school in anticipation of being asked to leave.

A, aged 17 from Barbados angrily expressed her feelings of not being allowed to return to school in this way:

'It was just after the time when I had my son (first child), and I was trying to get back into school. The head teacher asked my mother if she couldn't find another school to send me to because the other girls at the school would tell me that I am young and I got pregnant and that kind of stuff. It didn't really matter to me because everybody makes mistakes and I really wanted to go back to school, but after that and she wouldn't take me back, or I couldn't go back, my education was finished from there'.

She went on to explain that she felt:

'Really angry, rather angry because I know I made a mistake. I was young but I was still to the age of going to school and my feeling is that she had a right to take me back in school whatever the case would have been. Some people were telling us that we should have gone to the Ministry of Education or something like that, because she just looks after the school to a certain extent, but it's not hers, so she should not be telling me to find another school to go back to or anything like that. She should have taken me back, so my education was just finished there'.

When asked how she was doing at school, she replied:

'Very well, all of my subjects were just great, English, Spanish, everything. I was doing great and that one mistake made my life, my educational life just stop like that. I guess it was my fault too, there is no rule in the school saying that when you get

pregnant you can't go back to school. The Ministry of Education should have facilities for young girls who get pregnant, where everyone would be the same, and after a few weeks or months you could go back to school. Everything in life depends on your education'

The quotes above show the impact of being refused re-entry into schools following the birth of an early unplanned pregnancy, that of loss of educational opportunities to develop and lead a meaningful and fulfilled life. Becoming pregnant as the last respondent so convincingly articulated, should not be a reason for being denied the opportunity to recover from that first mistake. From her discussion and insight shown into her experiences, I was left in no doubt that she had the ability to do well at school. In this respect, she was not an isolated example.

13 respondents reported that they enjoyed their experiences at school. They also spoke with pride about the progress they were making at school and the plans for their future prior to their pregnancies. However, after they were not allowed to return to school, and with very little to look forward to, lack of money and job prospects, no means of support, as in many cases their own mothers were the sole providers for the family and were unable to take on the responsibility for another child, they very quickly drifted into a second pregnancy, and in some cases, a third or fourth pregnancy.

Another respondent aged 18 from Barbados, in commenting on her experiences at school, said:

'I use to get on normal, (at school), good. I was friends with the teachers and children and so on. Yes I was very bright. Usually, I used to come first, second, third or fourth. I never went past fourth yet'.

And about leaving school :

'Well I felt real bad after I was talking to some of my friends and they say they do O'levels and their CXC's and what they got back. I did feel real bad that I didn't get to do them. I ask my father how he stopped me from doing exams and so on. But he say he can't do nothing bout that. He would like it, but he couldn't do nothing about it'.

Other reasons for not returning to school were not as clear-cut as the above examples indicate. In some instances, respondents spoke about the fact that

they did not enjoy their school experiences. Among the reasons given was the failure of the school to help to develop their full potential. This was particularly the case where some respondents were not academically able in the conventional sense of the term, but had the potential to develop in a vocational sense, as this quote from a respondent aged 18 from Barbados shows:

'I didn't use to get treat good so I guess that is why I leave school before. I always promise myself I would do well. When I first went there I used to get a lot of tension and I fail and I drop back in some subjects. And the teachers used to mostly pay attention to the children who are doing good all the time. So lack of attention cause me to fail the majority of my subjects and that is why I left school. There wasn't no reason for me to go back to school because I know I wouldn't pass the CXC subjects, because the majority of the time I would get put out of the classroom and things like that. I couldn't ask the teacher anything. They would always shout at me. When people shout at me I feel uncomfortable and cause me to retaliate, and I shout back at you'.

This young woman like many others interviewed, had given up on the prospect of gaining an education.

Other reasons for school dropout were closely linked to parental attitudes towards education. The data provided by the respondents showed that many parents were not fully committed to education for their daughters, and in some cases capitalized on the first pregnancy as a way of not supporting the continuation of that education. In one case the respondent informed me that the Education Welfare Officer had failed to visit her after she dropped out of school as a result of the first pregnancy at age fourteen. When he eventually visited the family, he advised her that:

'the best thing for me to do was to go and look for work. It didn't make sense for me to go back to school and have two children to support...in a way I was sad knowing that I couldn't go back to school to learn further, but then I still had like to think about the children. It was real hard'.

The parents of this respondent had simply accepted this advice without question. In such cases it appeared as if a conspiracy of silence existed. These issues will be explored further in chapter six.

The role of sex in the lives of respondents

In speaking freely about their feelings about sex, there was clear evidence to suggest that public perceptions and the popular image portrayed in the media of teenagers engaging in early sexual activity to fulfil their need for pleasure and

excitement, was far from the reality for the vast majority of the teenagers interviewed. 23 out of 26 respondents said that they did not enjoy sex. Their early engagement in sex was strongly rooted in a number of factors, beginning with their need to find love and a substitute for the close parental relationships that were missing from their lives, a part of the searching syndrome discussed earlier. Another motivating factor in relation to early sexual activity was clearly linked to the need for financial security, which will be looked at in the next section. With the exception of the need to find love and substitute for close parental relationships, in other respects, these findings validate the research evidence presented in chapter two which makes links between early sexual activity and social and economic factors (Aymer & Pichery 1993a & b; Russell-Brown 1988; Jagdeo 1986; Brody 1981). In many cases teenagers were sexually active for very long periods and could not report that there was any enjoyment in sex. These words from respondent aged 17 from Barbados who had been sexually active for four years, provide a good example of this reported lack of enjoyment in sex. 'Most people enjoy it, but I just can't find myself really enjoying it'.

Or, in the case of this respondent aged 18 from Jamaica, 'I hate it.....yes even now. It's too much hackling (trouble)...like you feel pain or something always go wrong...I am just pleasing him and not myself. I just give in. I am a person I don't like to hurt people's feelings'.

These quotes are typical of the feelings expressed by the respondents on a whole. It was also clear from the interviews that these young women are very rarely the ones to initiate sexual activity. A significant number were persuaded by older men to have sex. It is seldom the case, as the characteristics of the sample show that their sexual partners are of similar ages. What then leads a young girl, often from age 11 or 12 into early sexual activity? The next theme attempts to throw some light on the reasons for early sexual activity which emerged from these interviews.

The theme of economic dependency

This theme featured prominently in the case of 16 respondents. One of the main reasons given by respondents for engagement in early sexual activity was financial. It was also important to note that the monetary motive in all cases had

nothing to do with seeking to obtain money for the purchase of luxury or designer named goods. It was often to provide basic necessities for survival. For example this point was summed up in an illuminating statement made by a respondent aged 19 from Barbados who at the time of the interview, was speaking about her experiences from the age of 14:

'They (boyfriends) had to do so much for me because your mother give you something and then take everything she give you, you have to start from scratch, including panties, brassieres. You have to start from scratch and somebody pulling their pocket. You ain't washing, cooking and living at them, you don't have to do anything for them. I thought that (sex) was a way to repay them....some young people would not look at it that way, but that was one of the reasons I got pregnant. No money, nobody to give you anything like no adult. No mother, no father, no uncle, nobody that you could say if you are hungry you want \$5 to buy something. So in a case like that you turn to your boyfriend, and once you had sex so, its like something that got magnet that will pull you back again like dope, even though you don't enjoy it'.

This respondent aged 19 from Jamaica expressed similar views. In this case, although the second pregnancy was clearly associated with the loss of the first pregnancy following an abortion, socio-economic reasons also featured prominently in her reasons for early sexual activity. These factors again point to the interrelated nature of the factors that impact on repeat teenage pregnancies. When she was asked why she began sexual activity at 13, She replied:

'I didn't have anybody to back me as a strong mother and a strong father or so, I was almost on my own. My mother couldn't afford to support me. Me was living in the country at that time with my grandmother and I don't know my father. He was living in the same parish and his bigger children came for him and carry him away. From that I don't see him....when I reached about 7, I had to send myself to school, so that is some of the things why I have to have sex before... yes someone to support me'.

Yet another respondent aged 18 from Barbados in speaking about her lack of opportunity to accomplish her goals, attributed this to:

'The way how my family treated me and get along. If I needed something they would not give me, and sometimes my mother would send me to school without lunch money or anything. Sometimes I used to have to call my boyfriend out of his bed to bring money for me to get to school and get lunch and everything. It was a very, very hard experience I went through. Sometimes I try to forget it, but I can't'.

This quote like the others above, shows how financial need manifests itself into loss of power and dependency, which is so closely linked to the journey of search discussed earlier, and which ultimately results in repeat pregnancy as the financial need continues year after year.

Unsatisfactory parent /child relationships

There was evidence to suggest that poor relationship with parents is central to some of the themes that have been identified so far. A recurring issue in the respondents' reports about the poor quality of the relationships with their parent, was that of poor, or at times, non-existent communication between the young women and their parents. Even in the relatively few instances where relationships with parents were reported as 'good', certain topics of conversation were often censured by the respondents, as the young women appeared to work out for themselves at a very early stage, which subjects were taboo, and these were generally related to matters to do with sex, contraceptives and pregnancy. Since in the majority of cases, the parent in question happens to be the respondent's mother, mothers were singled out for a lot of criticism about the nature of the relationship. At times the blocks to communication were related to the fact that the young woman had had very little contact with her own parents, particularly her mother, from a very early age, as the respondent was raised by another relative, usually grandmother or an aunt. These factors frequently served to widen the gap between the respondent and her parent. However as we will later see, the young women's ability to learn from good as well as poor experiences was one of the influential factors in their approach to the parenting of their own children.

In some cases parents used children as pawns in their disagreements with each other, totally oblivious of the needs of the young women. As a result, these young women lost valuable opportunities for meaningful relationships with one or both parents, as the next quote from respondent aged 19 from Barbados shows:

'Well I must say I love my mother a lot but I was never shown love. My mother never use to show me love, so I use to always tell she I feel I was a mistake. Maybe that's the reason why she didn't love me. She would say she do but she never show it. But my brothers and sisters the same thing, I never use to get on with any, none of my family. The only family I used to get on good with was my father and as a result of that I was a child and my mother stopped me from going over their house because she didn't like them, so I had to stop. The communication broke up when my other family was there'.

Another reason most frequently given for lack of open communication with parents, particularly mother, was lack of trust in their mothers' ability to maintain confidentiality in relation to what was discussed between mother and daughter. This was most often the case with respondents from Barbados, as these quotes

show, 'I couldn't really talk to her because if I talk to her she would go and talk to her church friends. She would tell this body and the next'.

Similarly with this respondent, when asked who does she talk to in her family if she has a problem, she replied:

'No one, cause when I tell my mother something she talk to her sister, then her sister tell her children and then they go and spread the word all around, so I don't talk to no one'. In the case of another respondent aged 19: 'If I does tell her anything, somebody know about it. I don't know what prompts her to tell people, or it's just that she likes to talk, but you can't talk with her. The first time I was about 13 and I miss my period but I was sexually active and I told my mother, a good friend of hers come to my grandmother and told my grandmother something pertaining to the same thing. And my grandmother told my mother that she was wrong because if I, as her child told her something, that shouldn't have been told to her friends because it was none of their business, which is true'.

These circumstances left many respondents disillusioned about discussing any problems with their mothers, and in some cases, other members of the family, if it was the case that they also felt that some sisters, brothers, aunts could not be trusted to keep information on a confidential basis. Where this happened, it was frequently reported by these young women that they would turn to their boyfriends if they had a need to discuss personal issues, thus widening the gap even further between the young woman and her mother. This respondent summed up this situation very well when she said of her boyfriend: 'You know we can communicate and we can understand each other and all of that'.

When she was asked to whom would she turn if she had a problem. She did not hesitate in replying: 'No, no, not my mother, with my boyfriend. I would go to my boyfriend first'. These comments were by no means isolated. It was therefore not surprising that with this level of dependency on boyfriends, coupled with other factors that included lack of use of contraceptives, which will be explored later, the incidence of repeat pregnancies then becomes a reality. This level of dependency was also reinforced because as the next theme will show, this lack of trust also extended to their peers.

Before moving on to the next theme, it is very important to make the point that poor parenting approaches and unsatisfactory parent/child relationships have to be viewed within the context of social and economic deprivation that these families experienced. In the majority of cases the respondents' mothers were often burdened down by the sole responsibility of supporting the children, both

financially and emotionally, as many fathers, though not all, abdicated their responsibilities towards their families. There is also the added factor that some parents simply do not know what to do or say to their children before and during times of crisis, either as a result of their own experiences, or as a result of having been raised at a time in society when there were different sets of expectations of the parental role. This point is summed up very well by an 18-year-old respondent from Barbados who stated:

'I feel that parents should be more open, talk to their children, because there are some mothers that will sit down a child and tell a child what to do and what not to do if you are doing it. But some parents don't know what to do or what to use (contraceptives) and things like that. Other parents because they didn't grow up with that sort of thing, they would let the children do and pretend the child ain't doing'.

While these factors alone do not excuse poor parenting, they are issues that have to be borne in mind when criticisms are levelled at the mothers of these respondents.

'I don't keep friends theme'

Next to the themes of loss and lack of enjoyment of sex, the recurring theme '**I don't keep friends**' was another of the genuinely surprising findings of the study. This was surprising because as we will recall from chapter two, many studies on teenage pregnancy point to the influence of friends on the incidence of teen pregnancies. **22** out of **26** respondents reported that they did not 'keep friends' as they had little faith in such friendships. As this respondent from Barbados explained:

'I don't keep friends as my boyfriend always say and my grandmother, your best friend is your worst enemy, because you talk to friends and before you look around, your friends speak out and then people look at you bad, like a dog. Men does look at you stink. That's why I don't really keep friends because they are the worst things to have. You go somewhere with friends, they do something wrong and the first name they call is yours'.

Similarly in the case of this respondent aged 17 from Jamaica:

'I don't really keep friends with them there (other young people in her district). The least little thing they say you and them a friend and you and them talking and everything, and by the time you and them finish talk them bring back your name'.

As was the case with their mothers, for these respondents, like so many others interviewed, lack of faith and trust in peer friendships were clearly evident. The implications of this lack of trust in friends will be explored further in chapter six.

The importance of motherhood and fertility.

Another prominent theme that emerged from 20 interviews, is the importance attached to the concept of motherhood and fertility. This became apparent where as previously stated, pregnancies that were unplanned or unintended were accepted with ease once the initial fears and concerns about the pregnancy subsided or were less acute. Many later became quite pleased about being pregnant and information from probing suggested that this sense of satisfaction and pride, against all the odds, was closely tied to their views about the importance of being able to bear a child. In many ways it was seen as a confirmation of their ability to fulfil an important role for women. Closely linked to the respondents' feelings about their ability to have children, were the feelings held by some putative fathers in terms of their views about the more children they could father, the greater the proof of their 'manhood and virility'. In many ways these views impacted forcefully on some of the young women's decision to have a second pregnancy. There was a feeling that if they could have a child for this new man in their lives, this would generate a sense of pride in the man and consequently, a greater degree of commitment to them. As this 17-year-old respondent from Jamaica explained about her boyfriend's reaction to her pregnancy, 'Him feel proud, him didn't want a next guy to make me pregnant before him'.

In some cases this willingness to please was on one level, also closely linked to the respondents' lack of power and a sense of control in their lives. It was also related to how they viewed themselves in relation to the men in their lives. On another level, perhaps a more important level for them was the pressing need for economic survival, which as we have seen, is so closely tied to their dependency on the putative fathers.

These young women demonstrated a strong sense of their ability to survive, and in many respects, to turn what could be viewed by many observers as a personal

tragedy, into a sense of achievement. As this 16 year old respondent from Barbados explained:

'It (the pregnancy) did upset me a lot, but I wasn't vex because I was pregnant right, but because it affect my schooling and so on, but eventually I was happy with the birth of the baby and so on, and at this present time, I am happier'.

When she was asked what made her happier, she replied: 'because by seeing the joy of her, that alone makes me happy'. The extent of these strong survival skills was evident in the fact that this respondent's happiness was not marred by the reality that her first child was 6 months old and she was pregnant again. Her unstable and unpredictable socio-economic circumstance did not appear to adversely affect her feelings of satisfaction about her pregnancies. This is therefore a good example of the role that pregnancy plays in the lives of these respondents and the importance attached to the ability to become pregnant, which in their eyes, compensates for all the other disadvantages of early pregnancy.

In the case of this 18 year old respondent from Barbados, who took repeated risks in the form of unprotected sex for quite sometime before she eventually became pregnant again, she explained that when she did not become pregnant immediately, she felt 'a little bit sad cause if I couldn't get pregnant in the long run, I couldn't get children'. Getting children was very important because, 'I know I love little children'. This respondent became 'really excited' when she discovered that she was pregnant at aged 14. This excitement would suggest that on some level at least, the importance of fertility was a major priority for her, influenced by the fact that her four older sisters all became pregnant during their teenage years, including one with a repeat pregnancy. In the absence of a close relationship with her mother, the importance of fertility takes on new meaning in her life. The need therefore for a child to become the object of her affections became in her eyes at least, justifiable. In these circumstances, repeat pregnancy fits neatly into her frame of reference.

In addition to the young women's acceptance of their pregnancies being linked to their views about the importance of motherhood and fertility, there was also the frequently expressed view that in retrospect it was not such a disaster after all. This is despite the mostly unplanned nature of their pregnancies shown in the characteristics of the sample (tables 4a and 4b). They believed that it was

better to have all their children while they were still young and fertile. In some ways, it was as if the young women were saying, this was not what I wanted initially, but now that I have started, I might as well get on with it. Later, having completed this task, I can then go on to pick up from where I had left off in terms of career aspirations. What was less clear however, is any sense of how they would make this transition possible. Some researchers have suggested that early pregnancy could be considered by many young women as an alternative career (Phoenix, 1991). I am not disputing this finding because there is also some evidence from this study to suggest that this view is valid in certain contexts. However, as will be shown when we come to look at the theme of goal orientation, this was not the case for the majority of these young women. Pregnancy was seen very much as one of the roles they had to fulfil. Nevertheless, completing this task did not limit their views of the need to also fulfil other roles in their lives.

Respondents' approach to parenting

One example of the respondents' efforts to make the most of their pregnancies was the sense of pride in which they spoke about their parenting skills. It was remarkable to note that these respondents reported that the poor parenting relationships which a significant number of them had experienced, had not, at least at that point in their lives, adversely affected their approach to the parenting of their own children. It is important to point out here that despite their current reported parenting successes, there are no guarantees that these successes will continue in the future. These issues will be explored further in chapter six. They made a point of stressing that their current successes were not because of the good parenting experiences which they had, but in spite of these experiences. Additionally, in many ways they had learnt from these negative experiences in order to ensure that they did not repeat the same mistakes with their own children.

They made reference to their parents' mistakes such as the failure to talk to them about sex and failure to be supportive. One respondent aged 17 from Barbados said, 'I am a nice mum, I take care of my little girl, I talk to her, I read to her. I did not have this relationship with my own mother'. Another aged 18 also from Barbados said of her father, 'when I needed a father he wasn't there. I was looking for

a man's love as my father wasn't there'. Similarly, in the case of this 18 year old respondent from Jamaica:

'I would say I am a good mum for this young age... well I try to do the best I can to protect my baby from anything. I try to keep him clean and so forth, make sure he eats right, take him for his check-ups at the clinic and so forth. He has never really been admitted to hospital or anything like that. I am trying not to do the same thing my mother did, like leaving my babies with somebody else, them not knowing who their mother is. I am trying to grow them the best way I can.....'.

The importance of education for the next respondent, also from Jamaica, was clear, she explained that if she had another chance to live her life over, one thing would be a priority, that was to go to school. She went on to say, 'Me never go to school the right way. I will have to try and see if them (her children) can go to school the right way, so they can learn what I never learn'.

The respondents were all adamant that they would initiate discussion with their daughters and sons about sex at a very early age. Age nine was the age most often given as an example, though others said as young as age five or six would be the age that they would begin. They felt that this was particularly important because if their own parents had been more open with them, they may have been more informed about delaying pregnancy until they were financially and emotionally more ready to undertake the role of parenting. One wonders how realistic this view is in some cases, given the scarce financial resources in the family, and the important role that lack of financial support plays in the cycle of repeat pregnancies. Other mistakes they would avoid were their parents' failure to listen to their points of view, or providing the opportunities for open and honest dialogue.

In many cases, these convictions were so strong that they were willing to make sacrifices. For many, priorities simply changed, in order to fulfil the role of parenting in a more successful way than their own parents were able to. These feelings were summed up very well by this 19-year-old respondent from Barbados, who explained that she was forced to put the achievement of her goals on hold because:

'She (her daughter) is walking now and she is at the stage where you have to spend time with children at that age, because no one showed me that kind of love, so I want to do that for my children. I want my children to be able to, even if I teach them the right way and they had to decide. I want to be a good mother. To study now, can't make it. Less time with the children, more time in books is where neglect would

come and I won't like that. Sometime in the future maybe, when the children get older or if I go overseas.....I would like to be able to teach her certain things. I don't feel anybody could do it like I could do it because she is my daughter. I didn't have it from my mother, so I would like to do it for them. I don't want them to say I wasn't good'.

As we have seen in chapter one, there is often a feeling among members of the public, including parents, that if you are too open in talking to young people about sex, this could be a way of encouraging premature sexual activity. These are similar to the views expressed by some people in relation to young people and discussions about condoms. It is a classic case of the ostrich syndrome at work because in many cases the young women expressed disdain regarding their parents' attitude in this respect, as simple mathematics had enabled them to work out that their own parents were also sexually active at an early age. This point is conveyed forcefully by a respondent aged 19 from Barbados:

'My mother had five children just as young as I. Her first was at 14, second at 15, third at 17, and when she was much older she had the other two. I would always say to myself and my grandmother, she shouldn't condemn me because she was worst, I know when you have children you don't like to see them fall into the same category as you, but I feel it is wise to go about it the right way. Sit them down and talk to them. I can't look at my mother and tell her to let us talk, she ain't got no time'.

Some of the young women said that in other instances, their mothers were aware of their sexual activity but chose to ignore this, thus indirectly sanctioning this early sexual activity, because they felt that their daughters' boyfriends, who were often older than they were, would provide some sort of financial assistance. Sexual activity therefore becomes a means of economic survival. This finding validates the point made in chapter one, of a greater degree of acceptance of teenage pregnancies among certain sectors of Caribbean societies.

Goal orientation

Contrary to widely held beliefs among many professionals in the health and social care fields, and by some researchers cited in the literature review, about the link between poor self esteem and unwanted teenage pregnancies, I found very little evidence to suggest that these respondents were lacking in a sense of 'goal orientation' which was the term used by one study. **All except one**, of the twenty-six young women interviewed, had some form of goals for the future. The degree of goal orientation differed from individual to individual. Some were fairly basic, while others had high expectations of the future, such as the young

woman from Barbados who had obtained eight O 'levels and had begun to study for A' levels when she became pregnant again. She also had hopes of becoming a paediatrician. Another respondent, age 18 from Barbados was very clear about the fact that:

"I see myself prospering, like starting my own business, building my own home and other things. I would like to become an independent young woman, bring up my son into the right way, be able to educate him good and so on'.

These young women had not lost sight of their goals even when the possibility of realising these goals seemed to be slipping further and further from their grasp. For example in the case of the young woman who wanted to become a paediatrician, she was adamant that she had no intention of letting her dream die, when she said in a determined manner, 'somehow I will make it possible'. Similarly, in the case of this 19 year old respondent from Jamaica who was expecting her third baby, as she explained, 'although I am on my third pregnancy, I still see my life as how I pictured it.....to have this baby finish up my sewing class and become a fashion designer'. Her plan was to achieve this goal by working part-time and going to evening classes.

In spite of this determination on the part of these respondents, given their present socio-economic circumstances, including problems with child care services, it was difficult to see how they were going to achieve these goals without some form of assistance, financially, emotionally and practically, such as day care facilities and opportunities for participating in work experience schemes. Many hoped to return to some form of education and training, but could not see how this would become a reality, as this often meant having the money to pay for this education.

Some were simply overwhelmed by the enormity of the task. For example, as this respondent aged 18 from Barbados explained when she was asked what would prevent her from achieving her goal:

'The children, it is not easy to be studying and having two children to cope with, but I would have to try. If I try to become a secretary now I would have to start from scratch. It is not to say that I had any previous experience like I just finish school and going to further my studies. I don't feel that I could get it do, having to cope with children problems at home and books. It would set me mad'.

Some observers may point to the fact that because these young women often turn to men to fulfil their need for love, or to provide nurturing relationships, this could be construed as evidence of poor self-esteem and self-concept. This is not as straightforward as it may appear on the surface, and there are many difficulties with this argument. First, views about self-esteem cannot be divorced from the social and economic realities of the community/society in which these respondents live. Secondly, if we take the definition of low self esteem cited in the literature review that low self esteem is said to be manifested in feelings of inadequacy to cope with day to day problems, feelings of incompetence and ineffectiveness (Brown, 1977; Zongler, 1977; Paik, 1992), then it can be argued that these young women are not lacking in self esteem, as there was a great deal of irrefutable evidence of their abilities to survive and to cope, to learn from the mistakes of others, particularly in respect of their views about their own parenting. They were certainly aware of their self worth and need for a loving, nurturing relationships in their lives. Their approaches to meeting such needs may not meet with conventional approaches by other groups in society, but these approaches appear justifiable to these respondents, and we have no evidence to the contrary.

Pregnancy as a form of escape

In the case of 5 respondents, the journey to repeat pregnancies began when having a baby was seen as a way out of the physical and emotional abuse they were experiencing in the home and in one case, at school. Somehow in conjunction with their boyfriends, it was felt that a pregnancy would be a way to put an end to the abuse. It was felt that pregnancy would confer on them the status of womanhood and therefore they would no longer be subject to such abuse. Inevitably however, this was seldom the case and in many instances their pregnancies led to even further or different forms of abuse, and further compounded their sense of loss and isolation. In the case of this 16-year-old respondent from Jamaica, she explained that she became pregnant the first time because:

'I had some problems so I just say o.k. I am going to have a baby and see if that will help (this decision was made at age 15). I wasn't living with my mother, I was living with my guardian and I wasn't happy there. When I go to school they keep on following me like I am not going to school, and I start to get miserable. One day I

came home and pack up my things and go down by my baby father (her boyfriend at that time). And then the police keep on looking for me, and then I say I am going to get pregnant and see if it would stop and I just went on and get pregnant. I felt if I get pregnant, the police would stop looking for me, and even if the police saw me they couldn't do nothing about it.'

She later discovered that becoming pregnant was not the solution to her problems, as after she became pregnant, 'I was feeling sad because I leave school and I didn't want to, so I was feeling sad but I had to do it'.

In the case of another respondent aged 18 from Barbados who informed me that her decision to become pregnant the first time was as a result of the pressures she experienced at school, as she explained:

'All the time the headmaster used to pick on me, every time I came to school and thing, he want to see me in his office, and I had to go into his office and thing. And then he gave me a send home paper and all that time I get send home I told my mummy, look I ain't standing for it anymore.....I did feel bad cause all the teachers were against me telling me that I pregnant and all these things when it wasn't so. So that is the reason why I come out of school. All the confusion and thing had me....well I was home my boyfriend use to come round and I go by him and thing, so we decide we going to have a child. (This decision was made at age 15). It's a case of saying they are accusing me of doing this and I am not doing it, so maybe I should do it'.

She subsequently became sexually active, became pregnant and gave birth at age 15. The pregnancy led to severe medical complications of high blood pressure, which remained high after the birth. She became pregnant again at age 16. The complications worsened to the extent that the doctors warned her that she would lose her life if she had any further pregnancies, and suggested a sterilisation operation to prevent further life threatening pregnancies. The level of emotional damage, which this respondent experienced, was evident from comments she made later. There was a strong sense of fatalism when she said: 'I feel upset and messed up and confuse, that's all I can say'. When she was asked why she felt so 'messed up', she replied:

'because if I had somebody to sit down and talk with me and all this confusion in school, I wouldn't have any children at the moment. I didn't have anyone to sit and talk to me and tell me right from wrong..... That is why I feel so corrupt today, and my mind turn from everybody'.

In one notable case, the first pregnancy led to an increase of severe physical abuse and triggered off a cycle of repeat pregnancy and multiple losses, as in the case of this 18 year old respondent from Barbados who spoke at length about the severe beatings she received from her mother. She explained that:

'My first pregnancy was when I was 15 and my mother used to beat me with a dog hunter hose piece of 2x3. After that my boyfriend and his mother carry me by the doctor and I got a termination. After that my mother started quarrelling and getting on bad if my boyfriend don't give me money. She used to fret. It was a lot of confusion and problems. And after that I came out of school, then she started beating me again, so my boyfriend said it can't work because he can't let that happen. So all the time he just decided that we would get another baby.....so I got pregnant again and my mother went again and got a termination when I was 16..... that is when I left my mother and went with my boyfriend. ... One night I was outside talking to somebody and when she came home from work, she beat me naked as I born with a hose and took the iron she had just finished using and hit me on my foot. And the blood start spouting out of my foot and I ran outside to the next door neighbour who gave me clothes to put on, and she tell me call the police and the ambulance. And when they came for me, I told them I was not going back there.....so they took me to the hospital... They said that if I was not underage they would let me file charges because that was child abuse. All of my back was cut up. I couldn't lay down. I couldn't sit down, nothing'.

This respondent pointed out that no child protection proceedings were instituted. An example of the conspiracy of silence, which as we have so far seen, is so closely interwoven in teenage pregnancies. Professionals from a number of key agencies- the police the hospital and the school were aware of this abuse, yet the respondent reports that no action was taken. When asked if the school was aware of this level of abuse, she went on to say that:

'When I was at primary school I used to get beat, sometimes I couldn't sit down and the form teacher she called the welfare and tell the headmaster to check me and said she didn't know how a mother could treat me so, and they took me before somewhere, but I don't know what was going on'.

It seems plausible that no action was taken on the part of the professionals, as this abuse had been going on for many years, culminating with mother's response to the first pregnancy. If earlier action was taken the severe form of abuse, which occurred after the first pregnancy, could possibly have been avoided.

Themes which did not emerge spontaneously but explored by the researcher as a result of their prominent feature in the literature on teenage pregnancy

Contraceptive use

As evidenced by the literature review, much has been written about the link between teenage pregnancies and the use or lack of use of contraceptives among young girls. As a result, during the interviews a considerable amount of

time was spent on exploring the theme of contraceptives use, both in terms of their knowledge base of contraceptives, and the use of contraceptives. 19 respondents stated that they had no real knowledge of contraceptives, prior to becoming sexually active. This was particularly the case among the Jamaican respondents. Many had been lulled into a false sense of security because they had had several sexual encounters before becoming pregnant, and these experiences conveyed a feeling of invincibility in terms of becoming pregnant. 4 said that they had some knowledge, but were reluctant to use contraceptives because of suspicions about their effectiveness and the effects on their bodies of prolonged use. This was a concern that was frequently expressed by respondents. For example for respondent aged 17 from Barbados:

'After I had the baby, I decide to go on the depo injection, and after I had the injection, I started having so much problem cause I had a period. I went for six weeks and I got check out and everything, and then the doctor told me I was o.k. And then so I went back and got the injection, After the injection for a couple of days everything was o.k. and then all of a sudden I had a period for something like a month which I never had before. So I went back to the doctor and I was real worried. I was working like the Christmas week and I was real weak, and I went back to the doctor, and he told me he didn't know what was going on. And so he called over by the hospital and he got advice from somebody. And they told him to give me another shot now. It sort of made things worse, so then he had to give me tablets and stuff like that'.

And in the case of this 18 year old respondent from Jamaica:

'I was on the pill but I had to stop off it because I was getting a lot of backache and a lot of problems with the pill, so I had to come off it, so that's how it (the pregnancy) must have happened'.

It was also interesting to note how many respondents simply stopped taking the pill while remaining sexually active. There was also evidence to suggest that when respondents expressed their concerns about a particular method of contraceptive on their health, these concerns were not taken seriously, or just ignored by some health care professionals. The respondent quoted above was one example of this finding. As she explained: 'When I told her (the nurse) about the problem, she gave me the same pill'. This statement was fairly representative of a sizeable number of respondents. Failure of professionals to address the concerns of young people does little to allay any fears that they may have surrounding contraceptives. There was evidence to suggest that such fears are well established, particularly, but not only in Jamaica and do affect the attitudes and approaches which a significant number of young people hold about

contraceptives. For example, as this respondent aged 18 from Jamaica stated, 'I was going on the copper T but I had people discouraging me not to use it. It leaves you with a foul smell, and it rusts inside you'.

And in the case of another respondent from Jamaica, aged 18:

'Me never use to take no form of contraceptives because me afraid of them..... Because them say you can take the pill and you still get pregnant and turn the baby handicap and them sort of thing'.

The fact that such views were deeply rooted within the minds of the older members of certain sectors of the community and were passed down to the younger generation, was evident from this typical reaction when respondents were asked to state where they picked up these rumours: 'Older people say so, and through me young, me say them know more than me'. (Respondent aged 18 Jamaica).

The level of suspicion was at times surprising. In the case of this respondent from Jamaica, aged 17 who claimed that she did not use contraceptives, the reason given was also linked to fears derived from rumours:

'because it hurt some people. They used to say that it was made from animals and humans not supposed to take it and so. She was making reference to the pill which 'block up your womb and so when you want a baby now you have problems'.

Given the importance attached to the ability to have children among these young women, as was also clearly evident from this quote, and given the level of fear surrounding contraceptive use, it is not too difficult to see why so many young women gave up on a method of contraceptive at the first sign of any sort of problems. In the case of this 18 year old respondent from Barbados:

'Well, most pills and injections don't really work for some people. Some people say the copper T smell, the injections don't work it gives you bad belly, but from my point of view, I never try them so I don't really know anything about it'.

Not all reasons given for lack of contraceptive use were as complex as the above reasons. Other reasons included pressure from their boyfriends not to use contraceptives, particularly if the method chosen was the condom. There was also the fact that many young people are not very reliable in their approach to taking the pill, as they often forgot to take the pill as prescribed. This was the main reason why so many respondents favoured the depo injection as a means of contraceptive, as summed up by this respondent from Jamaica who explained her preference for the injection:

'because the injection a three months time before you get a next one, we wont have to slip up. Me will mark down the date, but the pill now, it is easy to slip up on the pill, because sometimes me no remember that the pill in me bag and me have to take it'.

Other reasons relate to the 'risk and be dammed syndrome' discussed in chapter two (Moore & Rosenthal, 1993). In this case, if a young woman has unprotected sex on a number of occasions without becoming pregnant, the temptation to take further risks increases. In such instances they often fail to think of the consequences of their actions, as in the case of this young woman from Barbados who was not using contraceptives at the time of the interview, and who already had two pregnancies. Her response to the question about the risk of further pregnancies was, 'I would try not to get catch. I don't know, since I had my little girl, I had sex more than once, unprotected sex and I was never caught'.

At times they expressed a sense of being too preoccupied with other more immediate problems of survival to think about long-term consequences of not using contraceptives.

It is interesting to note that in spite of the long tradition of family planning in these two countries*, and the tremendous strides, which have made in educating the public about the use of family planning services, a significant number of young women interviewed showed a worrying lack of awareness about family planning methods and use. In situations when the young women said that they were knowledgeable about contraceptive use, as we will see later when the theme of sex education is explored, when they were asked to indicate the extent of their knowledge, their knowledge base emerged to be very superficial. Considerable gaps were identified between their stated knowledge and demonstrated actual understanding. For example, when they were asked about different methods of contraceptives, they were unable to provide reasonably accurate answers. This issue has important implications, because of the high levels of suspicion among some respondents about certain methods of contraceptives, it was important that they should be aware of alternative contraceptive choices.

* Barbados for example, was the first country in the Caribbean hemisphere to establish an official family planning programme in 1955.

Many respondents did not seem to be very informed about where they could obtain contraceptives. This was again particularly marked in Jamaica. For those who had used some form of family planning facilities, there was a tendency to start to use a particular method which was recommended by the clinic or hospital, and then they would later discontinue using this method while sexual activity continued, either because they felt that this method was not suitable for them due to adverse physical reactions, or lack of money to purchase further supplies. Often this action was taken without approaching the clinic to seek further advice. This is also another classic example of the 'risk and be dammed' attitude. These factors would suggest that when professionals are providing information and advice about contraceptive use, they should take the time to check that these young people fully understand the information being provided. In other words, they should pay attention not only to factual knowledge which the young women are able to relay back to them, but to also check that they truly understand this information.

A number of respondents stated that the first time they received any advice about contraceptives was after the first pregnancy, during the brief period between delivery and discharge from hospital. I would like to suggest that the timing of this advice needs a certain amount of rethinking. Usually sex is the last thing on the minds of these young women after delivery, when they spoke of being more concerned with providing food and shelter for themselves and their babies. In fact many spoke about being put off sex after delivery. I would think that in view of these factors, they are hardly in the frame of mind to be receptive to any advice about contraceptives, particularly if this is the first time they are receiving this information. This point is further strengthened by the fact that during the interviews when many of the young women were asked if they were currently using contraceptives, they responded by saying that they are not 'doing anything at present', that is, not currently sexually active.

Sex education

22 respondents were highly critical of both the quantity and quality of the sex education that they received at school. The majority felt that sex education had started too late (average age for starting was aged 13). They were almost unanimous that it should have started at a much earlier age, at the primary

school level, because it was their experience and the experience of their peers that sexual activity among young people started much earlier than many adults believed, or are prepared to accept. As we have seen from the characteristics of the sample, many of the respondents readily admitted to becoming sexually active at ages 11 and 12 years, and they also reported that this was not an unusual experience among their peers.

They felt that it was vital for schools to play a more central role in their development by improving the frequency and content of sex education to make it more relevant to the needs of young people, given the fact that today's young people mature much faster than their parents did. They were also clear that their parents for one reason or another, were not meeting their needs for information and guidance relating to their sexual development. Only **2 out of 26** respondents reported that they had any form of sex education at home. Many parents were embarrassed to initiate any sort of discussion about sex, or in responding to their daughters' queries. We have already seen evidence of these young peoples' adeptness at sensing when certain subjects are off limits for discussion, even in family situations that have been described as 'good' by a minority of respondents. Once they sensed this reluctance to discuss the subject, they would make no further attempts to obtain advice from parents. They felt that ideally their parents should play a bigger part in their sex education. However, if parents are unable or unwilling to talk to them openly and honestly about the subject, the school was the next best forum for this sort of discussion. The quotes that follow illustrate these points very clearly, and also validate many of the research studies which look at the crucial role of sex education in schools, discussed in the literature review and also in chapter one. As was also shown in the literature review, messages about abstinence, on its own do not work. This is particularly the case in poor societies, where as the evidence from this study suggests, early sexual activity is a complex phenomenon, which is closely tied to loss, socio-economic and other interrelated factors.

Respondent aged 19 from Jamaica, clearly expressed her dissatisfaction with the quality and quantity of sex education in her school, and demonstrated the link between early sexual activity and socio-economic factors when she forcefully stated:

'They should start to teach about contraceptives. Messages about not having sex pass through one ear and out the other. They should start to teach about sex from 11'. If you ask your granny (she was brought up by her grandmother), they think you too little to know about sex, what some 11 year old know some older women don't'.

For another respondent aged 17 from Jamaica, it was a case of:

'The teacher tell us not to have sex, leave it till later, but they never discuss if you want to have sex you could use a method....I think they should discuss it. They talk about one must bathe, use a roll-on, but never talk about sex, leave it till later. This is no use, because nuff children, they mother can't afford it. They have no father, you have to have a little boyfriend to give them some lunch money, school book fees. Sometimes the boyfriends want to make love to them, They (the school) should talk about protection'.

The following quote from a 16-year-old respondent from Barbados suggests that the age at which sex education commences in school is very important in preventing unwanted teenage pregnancies. It also highlights the fact that sex education cannot be left to parents alone. In her view, sex education should start:

'as early as possible. From the time the children reach first form because even first formers are having sex who don't know, because some mothers nowadays don't care about the children. I know a girl for instance who is about 15 or 16 now. She had her child at 14. She is actually prostituting on the road and her mother is at home and know'.

These respondents, as we have seen from the above quotes, spoke openly and often quite critically of the schools' input in terms of sex education which varied from no input, to sporadic attempts mainly focused on 'human biology' and 'general hygiene'. This supports the point made by Sargeant (1994) in chapter one about the inadequacy of the sex education curriculum in many Caribbean schools. Additionally, as many said, 'we did not talk about sex'. Schools need to approach the subject openly so that 'young girls would not make the same mistake'. This was a clear indication that the information provided in sex education was out of date and not in keeping with the respondents' level of sexual maturity. Others said that the teacher was often embarrassed and as a result, the students seldom took the information provided seriously. The general consensus was that the content of the sessions was limited and in no way met their needs for frank and open information. One young woman said in relation to the teacher's approach to sex education:

'What was missing was information about how you become pregnant, sometimes all they used to do was put the tape in and go along, we sit and watch, we had no opportunity for discussion'.

As discussed before, not all respondents claimed that they had not received sex education. 10 out of 26 said that they had received some form of sex education. However, where this was the case, there was evidence to suggest that there was a large gulf between what they said that they were taught and their actual levels of understanding. This gap showed up repeatedly, when during the course of the interviews, respondents would mention a list of areas covered during sex education class or classes at school. However later on in the interview, stated that they had not used contraceptives before their first sexual activity because they did not know that they would become pregnant so soon. This inconsistency is demonstrated very well by a respondent aged 17 from Jamaica, when she was asked how much knowledge she had about contraceptives before she became sexually active, she stated:

'I didn't know much only what I learned at school. I learnt in school that from the time you start to see your period and you have sex, you can get pregnant'. And what did she learn about preventing pregnancy? 'I learn that you can take the pill or injections to prevent yourself from getting pregnant'.

This respondent stated that she was taught all of this from age 13. Nevertheless she stated that although she was sexually active since age 13, the fact that she did not see her period until age 15, she did not think that she would become pregnant. When her period started she failed to use any form of contraceptives. When asked why, she stated, 'because I wasn't living with him (her boyfriend). When I go up to his house I don't spend more than a night or so'. This response brings the issue of regularity of sexual intercourse into the frame, as what she like so many other respondents was implying, is the fact that if one is not having sex on a regular basis, the possibility of pregnancy is not acknowledged. Given the relatively poor economic conditions among the lower socio- economic sectors of these societies, one may question whether the issue of costs of contraceptives might be an important factor in the lack of contraceptive use, particularly in Jamaica where there is a small charge for contraceptives. This factor may well have an impact, however, there was very little evidence to suggest that lack of use of contraceptives is linked to the fact that respondents cannot afford to pay for contraceptives.

Nevertheless, I would suspect that given the levels of relative poverty identified among respondents, the impact of lack of money to purchase contraceptives should not be discounted. While the cost of purchase of contraceptives in

Jamaica is relatively low as it was often subsidised, in many cases by international funding agencies, cost becomes an important factor where individuals are already existing at levels of absolute poverty. It is not too difficult to understand that if a young woman finds herself in a situation where she has to make a choice between food for her baby and the purchase of contraceptives, it is highly likely and reasonable to accept that the choice will be food for her baby. It is important to note from my discussions with health care providers, that as this funding for family planning agencies was often under threat of being cut, lack of contraceptive use may become even more widespread, with disastrous social and educational consequences.

HIV & AIDS

Among the health risk identified in the literature, was the risk of HIV & AIDS from unprotected sex. There was a surprising lack of adequate knowledge about HIV & AIDS 18 out of 26 respondents were found to have no significant knowledge of HIV & AIDS. Many respondents were able to say that they were aware of the fact that they could become infected from unprotected sex and that they were also aware of the need to use condoms. Nevertheless, as with other contraceptive methods, there were marked differences between stated knowledge and their real understanding of issues relating to transmission of HIV. One respondent aged 18 from Barbados was quite emphatic that:

‘It was a waste of time using condoms because although you make love to them, you make love and sweating and your pores open up, the sweat can get into your pores and you can get infected’.

Many respondents spoke about the difficulty in raising the subject of condom use with their boyfriends, because any such initiation of this type of discussion would lead to questions about their own fidelity. As this Barbadian respondent puts it: ‘because he may feel that I am running about with somebody else’. In the meantime, the respondents were left carrying this enormous burden of fear and uncertainty. Some respondents had themselves bought into this dislike of condoms for reasons such as the ‘condom smells’, or it can ‘slip off’ during intercourse and loss of sensation during intercourse.

The notion of trust also featured prominently in their responses about preventing infection. For example, for this 19-year-old respondent from Jamaica, it was a case of: 'I am not worried about HIV because my boyfriend don't go with anybody else...me trust him'. For another respondent, also aged 18 from Jamaica who does not live with her boyfriend:

'through I have been with one partner for so long.....I am absolutely sure about him.....at first I didn't trust him, but just because when he is not at work he is at his house, I can trust him, and I know where he works I can go there and check up on him, so I know'.

At times this lack of understanding was evidenced by their beliefs that HIV somehow only infects a certain type of woman. This view was clearly evident in the next quote from this respondent from Jamaica, when in justifying her trust in her boyfriend she explained: 'Them (her boyfriends, past and present) don't go with no dirty girls'. When asked to explain her definition of 'dirty girls', she replied, 'you know girls who go round, walk round and have sex with men, like girls who have more than one man, have 3 or 4 men at the same time'.

When these beliefs were explored, she admitted at least in theory that HIV does not only affect those having sex with '3 or 4 men' at a time, but there was still an observed cognitive reluctance to accept this.

It was often the case that respondents were concerned about the possibility of being HIV antibody positive in view of their involvement in unprotected sex, sometimes with more than one partner over a relatively short period of time, many to the point of being fearful. These fears about HIV however, were not matched by attempts to prevent infection. As this 18-year-old respondent from Barbados explained:

'Sometimes I don't want to go to the doctor to have a check because I might be frightened of the results I get back. It might say you are HIV positive and it would be what I am going to do if people find out. Them going to have my name all over the place and what not. And sometimes I pray to the Lord and ask him if I have it to send me a sign or something.... Sometimes I think I might be infected because I had sex with my first child father and I don't know who he had sex with. And the second one, I don't know who he had sex with. So it's the same thing all the way'.

For some respondents, it was the opposite approach, what I have termed the **check-up** approach, where their fears about HIV were dealt with not by preventative action, but by requesting an HIV antibody test when their doubts

about their partners' sexual behaviour became overwhelming. However, a negative test was not interpreted as an indication of the need to take precautions to avoid them being in the same situation of fear and uncertainty in the future. Instead, the pattern of unprotected sex and requesting a test to put their minds at ease would be repeated constantly. This practice in many respects, is similar to the approach used by many respondents in relation to contraceptive use and prevention of pregnancy, and in this regard, is not surprising.

Peer counselling

The vast majority of respondents, **(18)** felt that peers had an important role to play in preventing teen pregnancies. Of particular attraction was the notion that other teenagers who had been through similar experiences were more likely to get through to them because they would be perceived as knowing what they are talking about. As this 17 year old respondent from Jamaica in explaining why she thought it was likely that peer counselling would be effective explained, 'Yes because them will listen to somebody them size and them age more than bigger heads, because sometimes bigger heads them can get real miserable'.

Here her reference to 'bigger heads' clearly indicates that some older people were not receptive to discussion of such subjects. Or, it was the case that respondents are often reluctant or afraid to approach older people in their search for information. Additionally, as this 19-year-old respondent from Jamaica states: 'because young people will be easier to listen to, because maybe they are afraid to talk to somebody older than themselves'. Here the factor of fear is identified as being a common block to parent/child communication. These quotes were typical of the reasons given by respondents for their support of the idea of peer counselling. They were not being unrealistic however, because they were also eager to caution that some teenagers may not listen to anyone, regardless of whether the counsellor is older or of the same age as the majority of teenagers in this situation, as some teenagers may adopt an attitude of cynicism, a sort of **"who are you to preach to me, you have done the same thing yourself"** approach.

This 16-year-old respondent from Barbados was also in favour of peer counselling 'because they (teenagers) have experience, so I would know that it is something that they really know and not just go out and read about'. These findings are

similar to those of other research discussed in chapter two, that have looked at the issue and value of peer counselling for adolescents.

Knowledge of professional services

17 respondents said they were unaware of the types of agency that they could turn to for professional advice if they were in need of such advice. This was particularly marked in Jamaica, but was not related exclusively to Jamaica, but to Barbados as well. This response from an 18-year-old respondent from Jamaica was typical of the responses received to the question of knowledge of agencies: 'No, I don't know any at all'.

This finding in Barbados was all the more surprising, because all respondents were referred either by the Medical Social Work Department or the Barbados Family Planning Association. When this discrepancy was explored with the Barbadian respondents, it became clear that they had a limited understanding about the role of these agencies. Or in some cases, even confused about the nature of the services that these agencies provided, as this 18 year old respondent in responding to the question about her knowledge of services, replied, 'I only know about the family planning that's all I know about'. However, when asked if she had ever attended the Family Planning Clinic, she replied, 'No mam, I never had any cause to go there'.

In the case of the Medical Social Work Department, the respondents' perception of the services which the department provides, was limited to termination of pregnancy requests. For these respondents, this was the place where they (doctors) sent you to if you were thinking about an abortion. In the case of the Family planning Association, this was the place you went to for contraceptives only. The implications of this lack of knowledge cannot be ignored, given the poor levels of communication between respondents, their parents and their peers, it is of vital importance that they are aware of other avenues to which they could turn for advice and support in times of crisis, thus lessening their almost exclusive dependence on their boyfriends for emotional support.

Experience of interactions with professionals

Given the findings immediately above, it is also important to spend some time looking at the respondents' reports of their experiences with the professionals

that they encountered. With the exception of some agencies in Barbados, notably the polyclinics, the Family Planning Association, the Medical Social Work department and some ante natal clinic nurses, the general feeling was that their experiences though at times positive, were for the most part negative. 18 respondents reported having negative experiences in their interaction with professionals. Where there was discontent, the respondents expressed their discontent in very graphic terms. This 19-year-old respondent from Barbados spoke about an incident in the antenatal clinic where she alleged that a nurse quite loudly in the presence of other patients, asked a teenager on her arrival at the clinic, 'you bathe this morning? Go home and have a bath. She said it real hard (loud), and that wasn't anything to say in front of people so hard'.

Another respondent aged 17 also from Barbados, remarked: 'When you go for examination, the nurses throw insults at you'. The criticisms from the Jamaican respondents were equally scathing. As this respondent aged 18 from Jamaica explained:

'The nurses are very rough because with my first child, when I came here (the hospital), and I was in a lot of pain, and I call out to the nurses, they would let me know that when I was having sex if it didn't hurt as much as when I am having a child. To tell you the truth, them don't have any manners here, especially in the delivery ward, anything come to them mouth them tell you. If them past and you say doctor please help me, them wouldn't turn around and look at you, them just past as if them don't hear you'.

Fortunately however, not all accounts of interactions with professionals were negative, as evidenced by the following accounts from respondents. This account from a 19 year old respondent from Barbados, reported on both the positive and negative aspects of her experiences, when she explained:

'Well in the antenatal clinic most of them were alright. I used to go in there on mornings, sit down till I dose off to sleep and someone come and wake me up, make jokes, and if I am in the way, they would say these sorts of people always in my way (jokingly). That is how I like it to be, but there are some, when you come you have to sit down, you are not supposed to stand on your feet just because you are pregnant,

Nobody should treat you like dirt, they should be treated like normal human beings. You don't have to treat people so because they are not your relatives or friends'.

Another respondent aged 19 from Barbados added these positive comments:

'with the nurses at the hospital and Social Services, I would say that they talk to me and they are very nice people. Like if you are in need you can really sit down and speak to them, and they would talk to me the way a mum would talk to a daughter, they would talk to me that way'.

This quote clearly illustrates the vital role that professionals can play in bridging the communication gap between parents and respondents so frequently identified in this chapter.

The role of governments in preventing unwanted teenage pregnancies

A remarkable number of respondents, **12** in Jamaica, and **8** in Barbados, felt that governments were powerless in preventing teenage pregnancies, unless they were prepared to adopt policy initiatives that addressed the socio-economic needs of their teenage citizens. This 18 year old respondent from Jamaica summed up these views when she stated:

'Sometimes if they can support them when parents abandon them and so forth, to provide what they need, so that they don't really go astray... Sometimes they have to find food and so forth and they might see somebody and they offer them, and in return they want back something, and they end up getting pregnant'.

In response to the question what do you think governments can do to reduce the number of teenage pregnancies, the issue of socio-economic factors was very clear in this Jamaican respondent's reply:

'I don't know how they are going to do that you know. They would have to walk around to poor people who can't support their daughters and give them money, and I don't think they would want to do that. A lot of girls having sex is to do with money'.

The economic importance was also evident in this Barbadian respondent's comments:

'Maybe they should make more jobs available for teenagers and start teaching Family Life Education in schools at an earlier age than what they do now... teenagers and young people would have a better understanding about it'.

Response to criticisms from the public, professionals, governments etc.

20 out of 26 respondents were highly critical of the kind of generally negative and unsympathetic remarks made by older people about pregnant teenagers. It was felt that they were judged too harshly and at times older people's responses to teenage pregnancies were highly hypocritical because, as summed up by this 17 year old respondent from Barbados:

'Everybody don't see things the same way, but older people does be telling young people about getting pregnant, and when you look back, you find some old people that had 16 or 17 children and I don't feel that they had them from the time they were 20. I feel older people had children from the time they were young teenagers too, but everybody blames young people, but younger people, I feel they do the majority of the things that older people used to do, but I feel they do it a lot braver, because older people weren't as brave as young people like myself are now'.

CHAPTER FIVE

The London findings

This chapter presents the findings from interviews conducted with 26 respondents. The findings will be presented in three sections. Section one focuses on the socio-demographic characteristics of the sample, while section two will provide an indication of the extent and patterns of repeat pregnancy. In section three, the themes that emerged from the study will be provided.

The London respondents were drawn from a wide variety of inner and outer London boroughs and included both boroughs identified by the Office of National Statistics (2000) as having high rates of social deprivation indices, as well as areas identified as being 'more prosperous'.

Section one

Contextualising the findings – socio-demographic characteristics

In this first section a profile of the sample is provided

Table 8 - Age of respondents

Age of respondents	Numbers
Age 16	2
Age 17	2
Age 18	7
Age 19	13
Age 20*	2

As the table above shows, overall, each age band from 16-20 years was represented in the sample, with higher numbers of young people ages 18 and above.

* These two respondents at age 20 although slightly older than the upper age limit of 19 years stated in the methods chapter, had their pregnancies by age 19. They were included in the interviews because it was felt that they could make a significant contribution to the understanding of the factors impacting on repeat pregnancies. Their inclusion should in no way affect the outcome of the findings.

Table 9 – Ethnic composition of the respondents

Ethnic groups	Number of respondents
Asian	3
Black (includes Afro-Caribbean and African origins)	10
Mixed race	3
White	11

As indicated in the methods chapter, the final composition in terms of the ethnic characteristics of the sample, occurred randomly and not as a result of any deliberate attempts on my part to target any particular ethnic groups.

Table 10 - Marital status

Number married	1
Number unmarried	25

Similar to the Caribbean respondents, the vast majority of these unmarried respondents had no plans to get married, either currently or in the future. The one respondent who was married, opted for marriage for cultural reasons after she became pregnant, as it was not considered appropriate to have children out of wedlock in her own culture. Two respondents however had cited marriage as a future goal. One of these respondents was adamant that she would under no circumstances get pregnant again without being married. Marriage was particularly important to her because, 'no one else in my family has a stable relationship with someone, they just have kids and then the men leave them, I am going to change this'. These findings, along with the Caribbean findings on marital status discussed before, contrast sharply with those of Scott (1983) who pointed out that many teenagers in her study became pregnant because of 'sentiments of "love" and "aspirations for marriage"'. Additionally, these respondents in Scott's study were hoping to marry their sexual partners in the near future following the birth of their babies. While these findings may well be representative of the population of respondents studied by Scott, they were not corroborated by the findings from this study, and may well be related to the

changing views of young women in contemporary societies about the role of marriage in their lives.

Table 11 – Formal qualifications obtained at secondary school level

Number of respondents with formal examination passes- GCSE	11
Number with GCSE and GNVQ examination passes	4
Number preparing for A'level examination	2
Number without formal examination passes	9

As we can see, close to half of the respondents had passed some form of formal examination, either just before leaving school or at a later date as a result of attending a further education course. The General Certificate of Secondary Education (GCSE) passes ranged from three to ten subjects, mainly ranging from grades A to C. Those respondents with no formal examination passes had stated their plans to return to education at a later date in order to be able to take these examinations. Some were already in the process of preparing for exams around the period of the interview. The significance of these results and the marked differences between the level of formal qualifications obtained by the London and the Caribbean sample, will be explored in the final chapter.

Table 12 – Grandparents' education

Number educated to professional level	3
Number educated beyond the basic primary level	20

Unlike the Caribbean sample, the majority of parents had been educated beyond the basic primary level and three parents had obtained professional qualifications. The employment opportunities are on a whole, much better for the London grandparents than is the case in the Caribbean. As a consequence, all grandparents with the exception of those who were experiencing long term chronic illnesses such as alcoholism, were employed in a wide range of jobs. These included a nurse, a social worker and a teacher. This meant that they were much more able to offer financial and other levels of support to their daughters than was the case in the Caribbean, and accordingly, with vastly different end results. These issues will be discussed more fully in the final chapter.

Table 13 - Employment/income

Number in employment prior to first pregnancy	6
Number in receipt of maternity benefits	3
Number in receipt of income support or awaiting the outcome of their applications for income support	16
Financial maintenance from husband	1

The young people in London did indeed need financial support. As can be seen from table 13, the majority was dependent on income support. This ranged from £35 to £111 per week. Others were awaiting the outcome of their applications for income support. For the sole respondent who was married, her only source of financial support came from her husband's income. However, those who were in employment prior to their first pregnancy held a range of jobs, some of which attracted a reasonable level of income, such as shop assistants and secretaries, including one legal secretary. At the time of the interviews the three respondents who were in receipt of maternity benefit, were expected to go on to claim income support after the period of maternity benefit expired. The majority of the respondents were also receiving child benefit.

Table 14 - Accommodation arrangements

CATEGORY	NUMBERS
Living in council accommodation with sole tenancy	4
Living at home with parents	8
Living in council accommodation with husband	1
Living in council accommodation with boyfriends/putative fathers	10
Living in privately rented accommodation	1
Living in a mother and baby home	2

Contrary to a widely held belief that all pregnant teenagers receive council housing, the table above shows, that just under one-third of the respondents were living at home with one or two parents at the time of their interviews. These respondents did not seem overly eager to change these living arrangements. For the four respondents who were living as single occupants in council accommodation, there was a pattern of frequent visiting by their boyfriends who lived elsewhere – this is similar to the pattern of visiting relationships seen among the Caribbean

respondents. On the whole, these accommodation arrangements provided a greater measure of security for these respondents, than was the case for the Caribbean respondents.

Section two

The extent and pattern of repeat pregnancies

Number of pregnancies

All respondents in this study had a minimum of two pregnancies. Like the Caribbean sample, some respondents also had more than two pregnancies. However, unlike the Caribbean sample, a greater number of respondents had more than three pregnancies. These included: three respondents with five pregnancies, two with four pregnancies and four with three pregnancies. This is a very high proportion of respondents with multiple repeat pregnancies. However, in most cases these multiple pregnancies were attributable to repeat miscarriages following successive attempts to become pregnant. There were also two cases of repeat abortions. The significance of these repeat miscarriages to our understanding of repeat pregnancies will become evident later in this chapter when the themes are discussed.

Table 15 - Pattern of repeat pregnancies

Age at first pregnancy	Age at second pregnancy	Age at third pregnancy	Age at fourth pregnancy	Age at fifth pregnancy
14	18			
14	18			
15	15	16		
15	16			
15	16			
15	16	19		
15	16	19		
15	16	17	19	
15	16	18	19	
15	16	17	18	19
15	16	17	18	19
15	16	17	18	19
15	17			
15	17			
15	17			
15	18			
15	18			
15	18			
15	19			
16	17			
16	17			
17	18			
17	18			
17	18			
17	18			
17	18			
18	19			

The table above shows that in many respects, there was a marked similarity with the pattern of repeat pregnancy shown among the Caribbean respondents. In this sample, the average age of first pregnancy was also aged 15. 1 respondent had a second pregnancy less than one year after the first pregnancy, while 16 had a second pregnancy one year later. This relatively short duration between the first and second pregnancy fits the pattern of rapid repeat pregnancy described in the literature review chapter. While 10 respondents had a bigger gap between pregnancies, it is noteworthy that for some of these respondents, this gap was as much as four years. This is explained by the data provided in table 17, which show that 8 respondents had planned their second pregnancies.

Table 16- Age at first sexual activity

Age when respondents first became sexually active	Number
Age 11	1
Age 12	2
Age 13	5
Age 14	9
Age 15	3
Age 16	4
Age 17	2

The median age for first sexual activity for young people between the ages of 16-24 in the United Kingdom, is 17 years. (Wellings et al 1994). The data above show that except for six respondents, sexual activity started much earlier than the median age for first sexual intercourse. This is further evidence of a connection between early sexual activity and repeat pregnancies. It also links to the pattern of repeat pregnancies shown in Table 15. A number of reasons were provided for early sexual activity. These issues will be explored as they become relevant later in the chapter.

Table 17 - Planned and unplanned pregnancies

Number of pregnancies	Number planned	Number unplanned	Planned/unplanned
First pregnancies	3	22	1
Second pregnancies	8	17	1
Third pregnancies	1	3	
Fourth pregnancies	2		
Fifth pregnancies	3		

Similar to the case of the Caribbean respondents, the majority of these pregnancies were unplanned, but again no evidence was found to suggest that these unplanned pregnancies were 'unwanted' even in those instances where there was a certain

element of ambivalence. These respondents viewed their pregnancies as **unintended**, in the sense that while they had all planned to have children at some point in the future, for the majority, there were no plans to have children at this point in their lives. As will be seen later in this chapter when the theme of **normative acceptance** is explored, the relative ease with which respondents accepted their pregnancies is further supporting evidence of the fact that it would be misleading to view these pregnancies as unwanted. In addition, like the Caribbean respondents, the importance that these respondents attached to the concept of **motherhood and fertility** puts a very compelling case for challenging the common view portrayed in the literature on teenage pregnancy of the unwanted nature of these pregnancies. This 19 year old respondent captures this notion well when she stated, 'no none of them were planned, but they were certainly not mistakes. They were all very much wanted'.

This acceptance of their pregnancies was also evident from the meanings that these respondents had ascribed to their pregnancies. In discussing the importance of their baby or babies in their lives, many respondents frequently used terms such as 'I couldn't see life without her now', or, 'my pregnancy is the most important thing in my life'. For example, although this respondent's pregnancies were described as unplanned, when asked to speak about what her pregnancies meant to her, she stated:

'It means a lot to me, I have always wanted children but I didn't want to become a single mum. I love children to pieces. I think because it will be me own. It will be great really. Probably my insecurities will get more better'.

Here her words suggest that so much hope in so many areas, is pinned on this pregnancy that it would be misleading to describe her pregnancy as unwanted. Similarly as another respondent in trying to ascribe meaning to her pregnancies, remarked, 'My life is so content. I can't imagine myself ever being without them. I am so content. I can't ever remember what it was like before because it just feels as if I have always had them'.

Like the Caribbean respondents, these respondents also demonstrated the importance of their pregnancies to them by the excellent ways in which they took care of themselves during pregnancy. They had all attended antenatal clinics on a regular basis. They had taken a very keen interest in their pregnancies, which was

evident from the very knowledgeable ways in which they could discuss the progress of their pregnancies, and their general abilities to ask the relevant questions during routine visits to their doctors. Early in the data collection process, with the respondents' permission I had observed some of these interactions between some of the young women and the antenatal staff. Given the interest taken in their pregnancies, it was not surprising therefore that except for anaemia, which seemed to be a common health complication among these respondents, in most other respects, and with few exceptions, they had remained healthy throughout their pregnancies. The vast majority also reported that their babies were healthy. With the exception of the finding related to anaemia which correlates with some other research studies (Bury, 1984; Hudson & Ineichen, 1991), the findings about the respondents' health in other respects do not correlate with the findings of other research, which point to a link between teenage pregnancies and complications of pregnancy (Simms & Smith, 1984; Nord et al, 1992; Klein, 1994). This is not to suggest that concerns regarding the health of teenage mothers should be minimized, or that vigilant measures to ensure good health during pregnancy should be relaxed, but rather to caution against making sweeping generalizations about teenage pregnancies in relation to health complications.

The description **planned/unplanned** is used to denote a certain degree of ambivalence on the part of respondents in relation to whether they wanted to become pregnant. For example, in response to the question of whether the pregnancy was planned or unplanned, the reply was: '**I can't say planned and can't say unplanned either**'. This ambivalence is often evident where in some cases, although the respondent did not deliberately seek to become pregnant, it would appear that on some level at least, there was a hidden desire to become pregnant. This is in view of the fact that while they were fully aware of the possibility of becoming pregnant because they were engaging in unprotected sex, nevertheless they still took no action in the form of contraceptives to prevent pregnancy. This practice was often seen in the case of some repeat pregnancies.

The Putative fathers

The London findings provide noticeable similarities with the Caribbean sample, in the sense that the majority of the putative fathers were also older than the respondents, with age differences between the respondents and putative fathers ranging from 5 to 14 years. Two of the older putative fathers also had other children from previous relationships. In one case, a putative father aged 30 had five other children from 5 previous relationships. In only 4 out of 26 respondents, the putative fathers were different for the first and repeat pregnancies. Twenty were employed. Four were in prison for a number of offences ranging from being in possession of illegal drugs to robbery. The majority was supportive both emotionally and financially. However, the level of dependency on the putative fathers was much reduced compared with the Caribbean sample and the implications of this finding will be discussed in the final chapter.

Table 18

Number of respondents with pregnancies among siblings	8
--	----------

Some of these sibling pregnancies also led to repeat pregnancies. In the case of one respondent, five out of six siblings became pregnant during their teenage years. Similar to the Caribbean sample, the number of sibling pregnancies is also relatively high. In this sample, these pregnancies represent just under one-third of the sample. As the findings will show, some of these sibling pregnancies had an influential effect on the decision of some of the teenagers interviewed to become pregnant themselves.

Section 3

Emerging Themes

As with the Caribbean findings, the London findings will show some similarities with the phenomena of single and repeat pregnancies reviewed in chapter three, but in addition, many new themes have also emerged. Together these old and new themes provide evidence of a complex, interrelated set of factors which have a bearing on repeat pregnancies, most of which have their origins in the experiences of the respondents prior to the first pregnancy.

Spontaneous themes

The loss factor

The theme of loss identified in the Caribbean sample, which for the purpose of this research has been termed '**the loss factor**', also featured prominently among the spontaneous themes that emerged from the data analysis process of the London sample, and was also found to have a significant bearing on repeat pregnancies. These feelings of loss were often expressed in detailed and very painful terms. These losses included '**apparent loss**' as described in the Caribbean chapter to denote the intense grief reaction that occurred following abortions, stillbirths and miscarriages. Three respondents had experienced multiple losses in the form of multiple miscarriages that further compounded their sense of grief and isolation. In addition to the more **apparent loss**, many respondents also experienced '**unnoticed loss**'. These are feelings of loss that have been triggered by the respondents' previous earlier experiences of **sexual, physical and emotional abuse**. In one case this unnoticed loss was brought about as a result of the respondent having a child received into the local authority care within a few days of birth. In each of these examples, these are experiences where the loss factors are not readily recognized and acknowledged, but nevertheless have been shown in this research to lead to symptoms of grief and loss which have had a significant impact

on these respondents' journey of search for love and security, culminating in the phenomenon of repeat pregnancies. (see chapter four for a fuller discussion of the manifestations of loss).

Loss following stillbirths, abortions, neonatal deaths

Losses which were experienced as a result of stillbirths and abortions, featured prominently in 11 out of the 26 respondents interviewed. These respondents spoke about their pain and their sense of blame and guilt in graphic and moving detail, which conveyed forcefully to me the extent of the depth of their pain. The link between such losses and their desire to have a repeat pregnancy was clearly evident when the respondents, in explaining the full extent of their loss, spoke clearly of the compelling need to fill the emotional void created by the loss by becoming pregnant again as quickly as possible. Some of these feelings and emotions have been captured in the quotes that will follow. S aged 16 years as she tearfully traced her experiences from the start of her pregnancy to the point of her stillbirth; she summed up the feelings of many respondents when she told the following story:

'I was going for an abortion (following first pregnancy) and everything was booked in for the abortion, we went to the abortion clinic and I just couldn't go through with it... I didn't like being there and it just felt totally wrong to be there... I thought I don't want to get rid of my baby. I thought it was growing inside me, my child and that's a part of me and I can't go through with it'.

In reference to the final stages of the pregnancy, she went on to say:

'I was a week overdue and I went down to the hospital just for a normal scan and they done all the tests and the man said to me "oh the heart monitor ain't working. I am just going out to get another monitor". But I knew then because I had seen the scan that there wasn't a heartbeat and I knew that my baby had died, so he went out and got the consultant. And he came in and done a scan and said to me like I am so sorry but your baby has died, we can't find a heartbeat and that... .. And I had to be taken upstairs to be induced to have the baby... So I went up to the maternity and I got taken round the back of maternity, so I wouldn't be with people having babies and hearing that. And I was induced at 3'oclock and gave birth to my baby at a quarter to eight that night. And they done all the tests and said that there was nothing wrong with me. And they have never found any reason why it had happened. They just said it was one of those things that happen. But to me a 15-year-old girl that was heavily, heavily pregnant, they should have induced me. The baby was fine a week before...'

And with emphasis she said:

I AM VERY ANGRY ABOUT IT...there must have been something that they could have done you know, they could have induced me earlier before this happened... It was awful, it was terrible to think that I had been through a pregnancy 9 months... I had been through so much during my pregnancy, to come away from it at the end of it with nothing, was the most awful experience I have ever had. And to give birth and not to hear that baby cry once it's come out of you... especially like that you have felt that baby move and you have seen it growing, and all the scans it was fine you know, and just for a week overdue it had to die never to be explained, is the most awful thing in the world to happen to anyone. I just blamed myself, cause I thought I must have done something wrong, or there must have been something I could have stopped from doing. But you know there is nothing. I didn't do anything you know. I wasn't smoking, I wasn't on drugs. I didn't even have an infection when I was pregnant you know. There was nothing wrong with me physically, which made it even harder to accept... We had everything for that baby and we was all looking forward for the baby coming you know. And when that happened, it was just like someone had ripped out your heart you know. Like the whole world sort of came to an end you know and it was awful'.

Given her experiences and the strength of feelings described above, the need to fill the void created by her loss was not difficult to grasp, as she stated:

'As soon as I lost the baby I thought that's it I am going to have another baby.... It's because you have lost something and you want that baby so much that you just straight away think that's it. I am going to get pregnant and have another one. I will never stop hurting and wanting that baby, but it is just something I wanted. I wanted a child, but it will never replace her'.

Another respondent aged 18 described her feelings of loss after having an abortion as:

'Gosh I went through a depression, really, really bad depression you know, guilt, everything. It took me a while, a good six months before I got myself back to normal.....I just felt so guilty in my head. I felt that I had killed my own child.....I wanted to turn back time, I really, really regretted doing that, I really did'.

And this respondent aged 20 years in describing her feelings derived from her experiences of multiple losses following three miscarriages explained:

'I felt like a part of me was gone.... Whether you are 15 or 25 or 50 it doesn't matter. If you know you have got something growing inside of you, the feeling is out of this world and when to be told that it's not there or the baby is dead, or you have miscarried, it's heart rending. I mean like with my first one (miscarriage), I just sat and cried for two days solid. My foster mum was like "you are mad, you don't want kids so early, this young", and I was like, you just don't understand, which I think a lot of people don't'.

The extent of her loss becomes even more understandable when you take into account, the fact that her desire to have a baby arose out of her earlier childhood

experiences of unnoticed loss which began many years before she first became pregnant, as she explained:

'When I was younger, I was quite the person who couldn't wait to have a baby. I wanted something to love and something that will love me back, which is something that I have never had, so I suppose in a way I sort of yearned for it (a baby) you know'.

Therefore when she became pregnant it was like:

'all my prayers had been answered, when I lost it, that's why I felt empty because it was something that I wanted so much and it's been given to you. I felt like it had been given to me with one hand and taken away with another'.

For this respondent, her sense of loss had been compounded by the fact that she was sexually abused as a child. She had spent periods away from her family following reception into care as a result of the abuse, and her own mother had turned against her in refusing to believe that her stepfather sexually abused her. This abuse and lack of affection and support from her mother, have in many ways led to a kind of search, which is in some respects similar to the **journey of search** described in the Caribbean chapter.

The strength of the need and determination to have a repeat pregnancy following a loss of the magnitude quoted above often meant that some respondents, in an attempt to avoid a repeat of that painful experience, would go to great lengths to conceal a repeat pregnancy from relatives and sometimes putative fathers, to avoid being pressured into a second termination. As this 17 year old respondent remarked:

'I felt really bad about what happened last time (she had an abortion), when I found out that I was pregnant again I thought I am going to keep it a secret, because I knew that everyone was going to pressure me to have an abortion again, and I didn't want to do it. I thought I am not having an abortion this time because I felt really bad about what happened the last time, but I told my boyfriend. He wasn't very happy about it, but I said to him that I was gonna have the baby anyway and if you wanted anything to do with the baby then I wanted him to be there, but if not, I was going to have the baby regardless'.

In the case of another 17 year old, when she discovered that she was pregnant for the second time, she explained that she:

'felt kind of happy but then it was a kind of shock as well, because it was just a short space of time. I thought oh my gosh, how am I gonna tell my family again. I thought I will

leave it. I won't tell anyone because I knew what they are gonna want me to do, and I thought, I am not going to do it (have an abortion) again this time'.

The London respondents, like the Caribbean respondents quickly found that having a repeat pregnancy did not always live up to the perceived promise of filling the void created by the loss of the first pregnancy. Many respondents found that the strength of feelings of loss was not diminished by the fact that another baby was on the way. For example as this 19 year old respondent stated when asked if she has ever come to terms with losing her first baby, 'No, I still think about her now, whether it would have been a girl or a boy and how old it would have been and things like that'.

For another respondent aged 19 when she was asked if she felt the second pregnancy in any way substituted for the one that she had lost, she responded, 'No, it's like having a step-father, can't make up for the real thing'.

In some cases just as the respondents appeared to be coming to terms with their loss, they were plagued by guilt about the baby that they had lost. This is similar in a way to a kind of survivor's guilt seen among the partners of AIDS victims (Alcorn, 2000). In this instance, the presence of another baby increases the guilt in term of a feeling of having chosen to keep one over the other. As this respondent explained:

'I still think about it (the first pregnancy), especially now that I am pregnant again, because I think I am keeping this baby and my last pregnancy I didn't keep it, so I feel kind of wrong in a way, it's only been a year or something and what's changed in a year really'.

Many of these experiences of loss were further compounded by the fact that some respondents were unable to share their pain with close family or friends. As this respondent stated, during the earlier pregnancies (which were terminated), there were times when, 'I felt sick and upset and wanted to tell me mum, but I knew she would be horrified and want me to keep them, and I would have to fight her'.

Loss as a result of having a child taken into care by the Local Authority has been found to generate similar feelings of loss and grief to that experienced by those who have had stillbirths and abortions. This became very evident in the case of a 19-year-old respondent who had her first child taken into the care of the local authority from birth because there were doubts about her ability to care for her child. She explained:

'I was never given a chance, that's something that really annoys me, that I never got a chance with him for people to see how capable I was. It is terrible. It is something you can't even explain because it runs deep. I was just devastated carrying a baby for nine months and feeling it move, going through labour and everything and seeing him for the first time and him just going. It was horrible. He went to foster carers within days after birth'

She had been in and out of local authority care between the ages of 8 to 17 years. She was first received into care when her stepfather physically abused her. After the experience of abuse she 'got with the wrong crowds and got into trouble with the law a lot'. At the time of the interview she was living in a mother and baby home with her new baby, aged four months, and her son aged four years who had been in care. This was an attempt to assess her parenting skills in relation to both children. She explained that she was receiving counselling, so she was 'glad to be here, because things that happened in the past, I can talk about now'. She went on to explain that she was happy to be given a chance to 'turn my life around'. This respondent had also had a previous miscarriage and described the sense of loss as similar to the miscarriage, an 'empty feeling. I just felt lost really'.

Unnoticed loss

Many respondents experienced what was described in the Caribbean chapter as **unnoticed loss**. Termed **unnoticed** because their connection with feelings of loss and grief was too often easily overlooked by outside observers. These respondents had often experienced many different forms of abuse, and in some cases, a combination of different forms of abuse - **emotional, sexual and physical**, often starting from early childhood. The impact of these experiences of abuse quite often went unrecognized, but as will be seen, they had powerful emotional and psychological consequences nevertheless, resulting in feelings of lack of worth and being unloved. As a result, these respondents often embarked on a journey of search to find fulfillment and to give meaning to their lives, similar to that seen in the Caribbean respondents, albeit for different reasons.

The link between sexual abuse and early teenage sexual activity leading to teenage pregnancies was particularly evident among this group of respondents. In some cases, their responses to any recent experiences of loss as well as their approach to

sexual relationships have been found to be very closely interconnected with their earlier experiences of abuse. 5 respondents had experienced sexual abuse, 1 had experienced physical abuse and 3 had experienced emotional neglect. Among those respondents who had experienced one or several forms of abuse, was one respondent who had suffered sexual abuse at age 6 by her father and again at age 13 by her stepfather, which led to her first pregnancy. Another had suffered sexual abuse at age 13 by her father, a brother and a family friend. Her mother was a chronic alcoholic who was drunk most of the time and was therefore unable to protect her daughter from the abuse, so there was no place of refuge for this respondent. In discussing her subsequent early sexual activities she remarked:

'I was sexually abused when I was younger by my father, family friend and my brother and like it was natural as far as I was concerned. If my father could do it then anyone could do it as far as I was concerned. In my eyes it was natural whether it was like with a guy that I was going out with for two months let alone two years. It was natural to me'.

This respondent's experience is a classic example of someone who had experienced multiple forms of abuse. In addition to sexual abuse, there was a very powerful element of emotional neglect and abuse, which together conditioned her responses and attitude towards sex later on. When she was asked about her mother's whereabouts while this sexual abuse was going on, she replied:

'she was at home. She was an alcoholic. She didn't protect us or anything like that. We (her brother as well) used to have to scrape for food. Steal out of her purse to scrape for food. Penny for the guy. Do that down the pubs. We got picked up by the police at half past twelve at night. They asked, "where is your mum"? She is at home sleeping on the couch. There was no boundaries, nothing. It was like we were allowed to roam round the streets till God knows what hour trying to scrape some money to go down to McDonalds, or go down to the chippie and get some chips or something like that. And when we did ask for food we would get a slap across the back with a broom or something. So it was like scraping for love, scraping for food, scraping for this. It was like that all the way through life, so me expecting something from someone else, I had to give in return. To get food from my mum, we would have to get her up, get her sober and get her to make us food. It was us giving something to someone else to get something back. That's what we learnt when we were children'

Another respondent had asked to be received into care at the age of 11 after it had emerged that her stepfather had sexually abused her for 2 years. She was subsequently in and out of care for the remainder of her teenage life. As we will see, the following words convey a sense of confusion and loss that resulted in a period of rebellious behaviour in her attempt to understand and cope with the pain she felt. For her like so many others, these emotions had led her on a journey of search to find

what she felt was missing in her life. This search was dictated by her earlier experiences which had impacted powerfully on so many areas of her life – in her search for love, her choice of partner, her feelings about having a baby, her miscarriages and feelings attached to motherhood among others. As she explained:

'I didn't know whether I was coming or going.....it took me a long time to understand what happened. And I didn't understand until I was about 17... At the time I was confused. I was young. My mum had basically said no it didn't happen. She completely took his side and that broke my heart knowing that my own mother would take a bloke's word over her own daughter's. And that kind of threw me out a bit. I was quite an extrovert, but at the time I went very inward somewhere in my mind because of what my mother had done when she chose my step-father over me, I just basically felt that there had never been any love in my life, even from my own parents. I didn't know who my father was. My mum didn't really care less and if your own parents can't give you love, who the hell can? So when I found out that I was pregnant the third time, and I had a bloke who wanted to stand by me, I basically felt for the first time in my life, wanted and needed. A bloke who wanted me and a baby who needed me and when that was taken away from me, (miscarriage) my whole world just fell apart and then when it happened again six months later, it was like I am not gonna have kids, and when I was told I wouldn't have children, it broke my heart quite a lot'.

Quite often a pregnancy was seen to be one element that would somehow right all the previous wrongs. If the first pregnancy ended in a miscarriage, the sense of loss was compounded and the process of repeat pregnancies continued until that void was perceived to be filled, as in the case of the respondent quoted immediately above, who had been abused as a child and had suffered four miscarriages before eventually carrying a pregnancy to term.

There was evidence to suggest that the experience of sexual abuse resulted in a period of excessive and extremely risky sexual behaviour, as in the case of this 18-year-old respondent who was sexually abused at aged 10. She attributed her early sexual excesses to the abuse. She had four pregnancies by age 19. After the sexual abuse and the subsequent insensitive handling of the issue by her mother who chose to tell all the family, she explained, 'I just went a bit wild.....And I just rebelled, that's when I started getting in with the wrong crowd'. During this period she became involved in numerous short-lived unprotected sexual encounters, some of which led to unwanted pregnancies, which she terminated, and some which did not result in pregnancy, a fact which caused her to worry whether she was infertile. As a result, on several occasions with her latest boyfriend she explained that she did not use condoms in order to test if she was infertile. Here the importance of motherhood and fertility, another theme that will be discussed later in this chapter, becomes evident. These

examples of sexual abuse correlate with the evidence provided in chapter two of a link between sexual abuse and teenage pregnancy.

Perceptions about abortion

Closely linked to the intensity of the feelings of loss, were views about abortion, which were in most respects quite negative. 21 respondents expressed negative views about abortion, while 5 reported that they were not particularly for or against abortion. Many respondents spoke of their sense of guilt and disgust in some cases following an abortion. They made it clear that their felt wish or masked wish to become pregnant again was also linked to the abortion they had had- a way of atoning for one's sins. As this 19 year old respondent who had three pregnancies explained:

'I got pregnant at 15. We (includes partner) both thought that it was best that I have an abortion, so I went through with it and that destroyed me inside. I felt really cut up inside, I can't really explain it. It was terrible; I didn't get any counselling or anything like that. I don't know if it would help. I didn't feel happy about that, so that's when I decided, no I really want kids, so that's when I planned to have my daughter'.

When her responses were explored to see whether her decision to become pregnant again was in any way linked to having the abortion, in order to emphasize the link between this feeling of loss and the decision to become pregnant again, she stated:

'Yes, it definitely was, because the first pregnancy was a mistake, but to be at the age of 15 and planning to become pregnant again, doesn't quite sound right unless there was a reason for it. It usually does happen by mistake you know. The first one was a mistake you see, but then I had the abortion and that made me determine to have one you know. It was like if in a way I had lost the one, and wanted one to replace that one. But I couldn't you know, I was having nightmares and crying all the time. Every night I would cry about it and get really upset. I was really happy before. That's when the arguments started with my boyfriend because I just changed. I was really moody and I was just terrible, that was the stage when I would do everything to annoy everyone. I ran away from home. My mum didn't know where I was. When I returned, she grounded me and I would climb out of the window, wouldn't go to school. I mean I would argue with her all the time. I was just a right pain really'.

When asked if she felt this change in behaviour was attributed to her having had the abortion, she replied: 'Yea, I mean I wanted to take it out on everyone else'.

The feeling that an abortion represents the taking of a life dominated the thinking of most respondents, even in cases where respondents were not being judgmental

about other people's decision to have an abortion. This notion of taking a life was so emotionally powerful, that they felt unable to make this decision in their own case. As this 19 year old respondent pointed out:

'I got nothing against people that chose to do that, but me personally, I just couldn't do it. Well I mean it's a baby, a life. It's something I couldn't do, because I mean you would have those thoughts you know, just like when I had the miscarriage and I suppose with me having a miscarriage, I know how I felt when that was not my decision. I just couldn't imagine how I would feel if it was my decision to get rid of a baby. So it's just something I couldn't and wouldn't do'.

The strength of some of their views against abortion and the impact on repeat pregnancies is summed up by this quote where M aged 19 attempted to explain her feelings following the two abortions she had had. Here she stated:

'I felt like I had murdered somebody, guilt, really guilty and it was my own fault. I was also thinking about my own body, what things I would get later in life (by having the abortions). I felt this even more after the second one because I also thought I had put my lower regions through so much hell. After I got pregnant the third time, it's no way that I could have had an abortion because it would have been three dead babies'.

At times the fear of anticipatory grief and loss proved to be a powerful, motivating factor in not having an abortion, as this respondent aged 18 showed in explaining why she could not go through with the abortion for her second pregnancy as suggested by her mother:

'I always thought that if I go through with an abortion, I will never forget about it. It would be always just haunting me. And people would always be reminding me about it, so it is not something I could really do.....In some ways it is my feeling that every time the due date (anniversary of the abortion) would be there it would be total depression, because just sitting here thinking about it, was getting me down and really stressed'.

The need for counselling was clearly evident in the words of the next respondent aged 19 as she described her experience and feelings about going to have the abortion:

'I just didn't want to go through that again because I had a hard time, when I had the abortion it was horrible emotionally, every single way, like knowing that you have to go to the hospital, because you know what you are doing, and you go downstairs in this little white room just you alone. I felt really bad and guilty. I felt like I was doing something bad that you are not supposed to do. I went in I was just sitting there and they said just take off your clothes and sit down and wait and that was it. Afterwards they asked if I was alright, gave me some leaflets and some pills and sent me home and that was it. They said if I had any problems I could contact them. I felt disgusting, dirty. I felt horrible. I didn't even want to see anybody for two weeks. I just locked myself away. I cried a lot. When I decided to have the abortion because I was still at college, I didn't have no one

to talk to about anything. It was really hard because my mum was in.....(out of the country) at the time and there was nobody there for me. So when I found out that I was pregnant again, I said no way I am not going there again. I wouldn't advise no one to have an abortion'.

The importance of motherhood and fertility

Views about the importance of motherhood and fertility were frequently expressed. Therefore it was not surprising that closely linked to feelings of loss and strong views about abortion, were concerns about fertility. As we can see from the quotes which follow, many respondents simply feared that repeated abortions and miscarriages would lead to infertility. Or to have an abortion would be tempting fate as they might not be able to become pregnant again, a situation which psychologically at least they felt unable to accept.

After several abortions, this respondent aged 19 explained, 'I kept on panicking that I would not be able to have children. I would have been devastated'. She went on to explain:

'You know like to have a family, that's what everyone wants, to be married, to have kids, to live somewhere nice, have a nice job whatever. That was my main worry that I wouldn't be able to have children and have a relationship like I have with my mum, and like you see people they have children and they are happy, that was my main worry'

Another respondent also aged 19 explained:

'after the second abortion my doctors told me that my chances of having kids would be slimmer because of the inflamed tubes and that. And so I was being a bit more careful thinking that I won't get pregnant again, but at the same time sort of hoping that I would be, because then I would know that I could have children'.

Similar to the Caribbean respondents there were times when the reluctance to terminate a pregnancy was tied up with the notion of the importance attached to having the first child. It was almost as if these respondents felt that it would be a bad omen to terminate the first pregnancy and they were not about to put this omen to the test. As respondent aged 17 explained, 'I thought about an abortion, but I didn't want one at all because it was my first child and I have always thought that if you have an abortion once, I might not be able to have another child again'.

The next respondent aged 18, in explaining why she wanted the second pregnancy following a termination of the first, she stated:

'I wanted B, maybe it is because I had the first one terminated and to be honest with you, I thought what if I have this one done as well and I can't have anymore. So I thought no. That first termination was definitely a big influence because what was going through my mind is what if I did this one and try again and I can't have more, then I think I would have gone do lally, because I do love kids. Yea, I know I would have gone mad if I found out I couldn't have kids'.

Filling the void

The importance of motherhood and fertility can also be contextualized more fully when another theme which emerged-**filling a void in the lives of respondent-** is explored. This theme was prominent in the responses of 9 respondents. There was evidence to suggest that for many respondents, having a baby was seen as an extension of the role, in some cases multiple caring roles that they had played for a significant portion of their lives. These respondents had spent considerable periods of their lives looking after younger siblings or younger relatives. For two respondents, this void was created by many years of emotional neglect as they strove to fulfill a parenting role to their own parents who were rendered incapable of parenting as a result of chronic alcoholism and mental illness. In each of these situations when their caring role came to an end, the compulsion to fill that void became almost inevitable. These were usually the respondents who had reported that their pregnancies were planned. They were also the respondents that in most cases were not achieving success in other areas of their lives such as in education. A good example of this need to fill a void was provided by the next respondent age 16:

'I always had kids round me, all my sisters babies, they were always round me'. And in relation to her mother: "I didn't go to school a lot because my mum was an alcoholic and I didn't want to leave her. It was very upsetting, definitely. She used to drink and everything. Anytime I went to school, I use to leave and come back because mum used to have blackouts and pass out and things like that, cuts all over her face, and people used to mug her because she was so drunk and everything like that. So that's why I never went to school because every time I used to come back, she would either have fallen down the stairs, or went to the shop and pass out, and I wanted to be there to keep an eye on her, so that's why I didn't go to school really. I used to cook her dinner, make sure she eats, because she was like anorexic as well. She went down to four stones. So I was like force feeding her and things like that, like she was my baby, so instead of me being her baby, she was my baby. From about 13, I was cooking my mum's dinner and like doing the washing, doing housework and take care of everything else'.

The planned nature of her first and subsequent pregnancies becomes more understandable, when she became pregnant very soon after she was removed from home by the social services and placed in Bed and Breakfast accommodation.

Having been separated from her caring role, the need to fill that void became more urgent. As she went on to remark:

'Yea I love children and I say to my mates, I want a baby, lets have a baby. And I met L (boyfriend) and I thought yea I want to be with him. I suppose I just fell pregnant because I didn't have no one there with me. I thought I wanted someone to love and take care of'.

When asked if she didn't feel loved at home she replied, 'No not really. I felt left out because my mum was never there, she was in hospital all the time'. In relation to her babies, she responded, "I do enjoy having them which makes me feel that I have someone to care for you know, to bring them up the way I wasn't brung up, so I can make them feel different from what I had done you know'.

Repeat pregnancies become inevitable in some cases because the need to have children is closely tied to the desire to feel needed and valued. Therefore at times when this need is equated with having a baby who is dependent for physical care, but makes very little emotional demands on you, the desire to keep maintaining this state of dependency becomes almost addictive. Therefore the need to have another tiny baby increases as soon as these babies reach a certain age when they begin to assert some level of individuality. This is quite evident in the next quote from a 16 year old respondent as she explained why she felt the need to have a repeat pregnancy, 'I was broody again after S. I love tiny babies. I love newborn babies. If I had a chance to have a baby again and it would stay a newborn baby, I would'.

Another respondent aged 17 explained:

'I always said that by the time I am 18 I would like a child, so I had her at 18. I have always been around kids. I have done babysitting and looking after other people's kids, you know the usual thing. Some people say at the end of the day when you baby sit you give back that child, but I never wanted to give back that child'.

It was not surprising then that this respondent left school at aged 14, in spite of the fact that she was a bright student. She had no career aspirations while at school, and still has no idea about what else she wants to do with her life apart from caring for babies.

For another respondent age 18, the sense of emptiness as well as the sense of purpose and of filling a void in her life gained by caring for her babies, was quite evident in this quote, 'having them is more important (than going to college) because when I

have no one to talk to, I have them to talk to and I don't feel bored. I have always got something to do'.

Approach to parenting

Given the importance attached to motherhood and fertility, how did these young women cope with the responsibility of parenting? What are their views about parenting?

The notion of a sense of responsibility was central to their views and approaches to parenting. Many respondents clearly took pride in their parenting abilities. This pride was evident in the responses from **20** respondents. As this 18-year-old respondent, in assessing her ability as a parent, remarked:

'I think I am quite good. I am responsible. I know how to look after her. I think I can show her a few things, not to go the way that I did. Or I will try because my mum tried with me, but I still ended up going the wrong way. So I guess I can only talk to her and tell her what I have been through, and then she will still have to make the decision for herself, whether she goes and do the same thing'.

Some respondents identified the mistakes that their own parents had made in parenting, and used these mistakes as a point of reference to ensure that they would not make the same mistakes with their own children. This was clearly evident in the words of this 19 year old respondent who stated:

'I won't be like my mum, especially like how I have a daughter. I have to have that good relationship with my daughter where she can come to me and talk about **anything** without having fear in her, thinking that oh I might kill her, and/or I might go mad whatever. That's very important, because I know for a fact that if I had that kind of relationship with my mum, the kinds of thing that I have done, or been involved in, I wouldn't have done. I think I was just rebelling against my mum. I don't blame her, but I am just sad that me and her didn't have that relationship you know, like what we have now. I am just sad that me and her didn't have that kind of relationship throughout my life'.

It is clear from these words that even though the relationship with her mother has now improved following the birth of her baby, there is still an element of loss, which prevails. It highlights just how crucial a good and open parent/child relationship is in the lives of these respondents.

In another example where the respondent had experienced neglect and abuse, she clearly took her parenting role seriously, in attempting to ascribe meaning to her pregnancies. With an air of conviction she stated:

'My kids are my world. They are brought up with a lot of discipline in their lives, which is something I lacked. I have tried and I will carry on trying to give them everything I didn't have. And they will grow up knowing at the end of the day that their mother loves them, which is a feeling that I never had. There is a lot of things I want to teach my children. I will never hide my past from my children'.

The impact of the sexual abuse she had experienced was very evident when she remarked:

'I am very protective of my kids. I am wary about who goes near them, who touches them.....I am especially protective over my little girl because of what I went through. If anyone ever touches my daughter, I will physically kill them. There is no way in the world that I would want her to go through what I went through. I will make damm sure that she never ends up in care, that she knows who her parents are, and that she knows who loves her and who doesn't'.

In some respects, contrary to the pregnancies leading to loss of hope and abandoning of goals, they had the reversed effect. The experience of becoming pregnant and having the subsequent responsibility of parenting had given these young women new hope or incentive for the future in terms of what goals they had set for their own lives. For example, this respondent in exploring the meaning of the pregnancy to her, explained:

'When I found out that I was pregnant with her, she forced me to do a lot of things. She gave me that motivation to get up and do things, because I was working in a store before I was pregnant. And then I thought to myself, working in this store wasn't getting me anywhere, or help me with the things I am gonna need, so I applied for a better job, and then she inspired me to start driving, because I am not getting on a bus with a buggy. Then I came back home because I thought it was a better place for me to be than out there struggling. I was settling for less so she inspired me'.

An additional factor in the reported successes of the respondents in their approach to parenting was the quality of the relationship between the respondents and their mothers. Except for those respondents who had experienced emotional and physical neglect and abuse, only a small minority of respondents reported that they did not have good relationships with their mothers. A recurring theme among many respondents is that their pregnancies had resulted in a kind of **rite of passage**, conferring on them the status of adulthood. This newly acquired status broke down any barriers of communication that existed between the respondents and their

mothers prior to the arrival of their babies. One area of communication that was reported to have significantly improved, was the ability to discuss intimate sexual issues with their mothers, which was previously an area of taboo. This 19-year-old respondent had left home prior to her first pregnancy because of her mother's overly strict manner in relating to her. In commenting on the current vastly improved quality of the relationship with her mother, she informed me that:

'It wasn't until I left home and got pregnant that I felt I could come and talk to her. I don't know why that was. She kind of like backed down a bit. From I left home the relationship got better. I felt I could speak to her about anything'.

Another 19-year-old respondent captured the essence of this point very well, when in discussing the quality of the relationship with her mother, she remarked:

'I never used to have a good relationship with my mother, but ever since I have had the kids we have had a wicked (street slang for excellent) relationship. I never used to be able to talk to my mum, but I can talk to my mum now about anything..... and it just draws me nuff (a lot) closer'.

It has to be acknowledged however, as we have seen in previous quotes from some respondents, that for those respondents who were not fortunate enough to enjoy good relationships with their parents, the impact of this poor relationship on their lives, can be traumatic and long lasting with far reaching consequences.

Reversed life course rationalization

A theme which emerged from **10** respondents, is the theme that I have termed a **reversed life course rationalization**. As will be seen from the following quotes, many respondents having had a first unplanned pregnancy, very quickly rationalized to themselves that it would make more sense to continue the process and complete their childbearing role at an early age, which would then enable them to pick up on other life interests and career developments later. This reversed rationalization is different from the reversed thinking which some Caribbean respondents used occasionally in relation to their repeat pregnancies, where it took the form of a way of rationalizing and accepting their fate after having a repeat pregnancy. In the case of the London respondents, this reversed thinking was used frequently to rationalize their decision to have a repeat pregnancy, rather than as a philosophy of acceptance

of their fate as in the case of the Caribbean respondents. When such rationale is used the journey into repeat pregnancies becomes inevitable. Although the rationale used by each respondent varies slightly, the overall essence of the points, which they have made, remains the same.

For this respondent aged 17, the decision to have a repeat pregnancy was simply rationalized as, 'I like it that I am young because as they grow up, I am growing up too you know. So get it over and you can get on with your life. Why wait three years before the next pregnancy'?

When respondent aged 18 was asked if there was anything about her life that she would want to change, or if given the chance to live her life over again whether she would have postponed having children until she was older, she replied:

'No because I have done it the other way round. My sister and my brother done it the other way round. They have their careers and then they got married and they had their lives for a little while and then they had children, but I don't think I would want to change it. It's hard and you are going to miss out on a lot in life. But now that I have my children the way that I look at it now is that other people they go to school, they go to college, they get a job, they have their career, they get married and then they have a baby. I have just done it the other way round. I missed out on school. I have no qualifications at all. I have my children when I am young and now I am at college and I am getting a career. So I have done it back to front'.

When respondent aged 17 was asked if she had any regrets about missing out on her education, she was in no doubt about her priorities as she replied:

'they say education comes first, but it's more important for me to have the children first because when you get your education, you go to university, you could be offered a job and you can't take the job because you are pregnant or something, and that would hold you back, but if you get all these out of the way first.....my mum had me early and she is in a good job now'.

This respondent aged 19 summed up the feelings of many others when she commented in relation to her pregnancy:

'It's just a path. Instead of going straight on my path, I have sort of gone backwards on my path. It's just that I had kids a bit early, so when I am 32 I am going to have a 14 year old and a 16 year old. That's when most people are actually having their kids. So my life will start when theirs is stopping'.

Normative acceptance of teenage pregnancy

Another theme, which is closely linked to the theme of **reversed life course rationalization**, and which in many ways could be said to be a pre-requisite to this

concept, is that of a **normative acceptance of teenage pregnancy**. As the interviews progressed, there was an increasing awareness on my part, that the pregnancies did not appear to generate a sense of extreme crisis or panic, which has been reported in other research studies of teenage pregnancy. There was almost a kind of matter of fact, *laissez-faire* philosophy about the pregnancies among respondents. It was in many ways a feeling of, this is not what I had planned, but now that it has happened, I will make the best of it.

There was also an increasing kind of sub-cultural acceptance of the normality of teenage pregnancies among all respondents, irrespective of race or age differences, in the sense that it was increasingly seen as the norm rather than a phenomenon which should generate a sense of crisis. Hence, as will be seen later in this chapter, there was a growing feeling among respondents that there is nothing that government and other agencies can do to prevent, or reduce teenage pregnancies significantly.

In view of the predominant negative views of teenage pregnancy largely portrayed by certain politicians and the mass circulation newspapers that were discussed in chapter one, there is an inevitable tension between these views of acceptance among the teenagers interviewed and the wider society's views about teenage pregnancies. In spite of this tension, I would nevertheless argue that these teenagers' changing perceptions in relation to the acceptability of teenage pregnancies, is ironically, a by-product of this persistent negative coverage. It is also closely interlinked with society's gradual changing views and growing levels of acceptance of teenage pregnancy as a more and more commonplace phenomenon. One reason for this increasing acceptance of teenage pregnancy could be linked to the extensive and persistent negative media coverage of teenage pregnancy over several decades. The public, including teenagers, as a result, have gradually become more sensitized about teenage pregnancies. Ironically, this same process of sensitizing the public could over time lead to the reverse process of desensitizing. The more they confront sensational headlines about teenage pregnancy, there is a corresponding lessening of impact, and consequently they are no longer reacting with the same level of shock and outrage, as once was the case.

This is not to suggest that the pregnancies did not generate any form of discomfort for these respondents, because in many cases it did. However, their initial discomfort was usually more related to uncertainty about how parents and boyfriends would react to the news of the pregnancy and was usually short lived. This cultural acceptance of teenage pregnancy might go some way towards understanding the persistent wide differences in the rates of teenage pregnancies between the UK and its European neighbours. This acceptance on the part of the respondents is also closely linked to the degree of parental acceptance of the pregnancies, in the sense that the more readily a respondent's parent views the pregnancy as a normal occurrence, the more pronounced the concept of acceptance became on the part of the respondent. This level of parental acceptance, which may not always be openly stated, is similar to what Rosenstock (1980) cited in Adler & Tschan (1993) refers to as a 'covert mandate' from parents. This is not necessarily a bad thing, as it has also emerged from this and other studies on teenage pregnancy that those respondents who coped most well with their pregnancies and subsequent child care responsibilities, were those who received the greatest level of support from their parents. The concept of acceptance may also be closely linked to the evidence cited in the literature review that pre-marital sex is approved by all teenagers (Wellings et al 1994), in the sense that if teenagers view pre-marital sex as a normal everyday activity, then it is not too difficult to see why they would accept teenage pregnancy as a normal extension of this activity.

Given the predominance of these views, the concept of **reversed life course rationalization**, looked at previously becomes increasingly more understandable. This theme of acceptance is illustrated clearly in the views of respondents cited below:

'When I was at school, I thought I was never gonna get pregnant until about 27. So it's not something I thought of. Just when it happened it happened. From my first pregnancy, I got attached to the idea of being pregnant and like seeing people in my family pregnant you know, I just kind of got fond of the idea of being pregnant. It's just what I want basically' (Respondent aged 17).

Acceptance was even more marked where early pregnancy was the trend among close friends. As this 18-year-old respondent stated, she became sexually active at aged 15 because 'all my friends and my sisters were having sex'.

The next respondent age 18 summed up the feelings of many other respondents when in a matter of fact way she commented in relation to her pregnancy, 'It wasn't a big thing because I wasn't the first in my school'.

Themes which for the most part did not always emerge spontaneously but were explored by the researcher as a result of their prominence in the literature on teenage pregnancy

Understanding and use of contraceptives

Given the importance accorded to the use of contraceptives in preventing unwanted teenage pregnancies explored in the literature review, a number of questions relating to contraceptives, were posed to the respondents in an attempt to gauge their understanding of and use of contraceptives, and the impact of this knowledge or lack of knowledge on both first and repeat teenage pregnancies. There was a fairly mixed response to the questions posed and the issues raised. **18** respondents claimed that they had no real knowledge of contraceptives. Although **12** respondents claimed that they were knowledgeable about contraceptive methods and use, their approach to the use of contraceptives, or their willingness to take risks by not using contraceptives, would call into serious doubt the true extent of their understanding. For example, many respondents despite the fact that they claimed to be knowledgeable about contraceptives, the typical explanations of why they became pregnant the first time were: **'It just happened'** or **'I didn't think that I would become pregnant'**, or in the case of repeat pregnancies, **'I didn't think that I would become pregnant so soon' after the miscarriage, abortion or first birth**. These responses do point to a gap between knowledge, levels of understanding and actual practice. It therefore becomes feasible to argue that some repeat pregnancies, particularly those where there is no other credible explanation, can be attributed to the fact that some respondents were genuinely unaware that they could become pregnant so quickly after the first pregnancy.

There was also compelling evidence to suggest that there were other factors at work apart from knowledge base, which determined whether some young women used, or did not use contraceptives. For example, some respondents who claimed that they

were knowledgeable about contraceptives could offer no explanation for their lack of use, but on closer probing, it became apparent that other powerful but silent emotional factors were at work. This was particularly evident in the case of one respondent aged 18 who stated that she knew about contraceptives but could not explain why she did not use them. After careful exploration it became clear that the concept of **filling a void in the lives of the respondents**, looked at previously in this chapter, was a significant determining factor in her lack of contraceptives use. It was evident from her responses that she viewed pregnancy as an extension of the role she had been playing for many years, in particular the last four years where as she quietly explained:

'I just wanted it, (a baby) I know because my mum had just had a baby, and like I was looking after him a lot and he went to the nursery, so there was nothing left for me to do, so I just wanted a baby and then I asked my boyfriend to get me pregnant'.

When she was asked why she was feeling so empty and lost at her age, she went on to explain that all her sisters had children as teenagers and she helped to care for their babies. Her mother's baby filled that void for a while until he went to nursery. She did become pregnant, but felt compelled to terminate the pregnancy after she was pressured by her grandmother to do so. It came as no surprise that when her grandmother died weeks later; she lost no time in becoming pregnant again.

Given these underlying factors, her failure to use contraceptives becomes understandable. The example given above, points to the fact that the use of contraceptives cannot be viewed as a purely mechanical act. It is inextricably linked to other factors at work and these factors have to be explored and fully understood if contraceptives are to be a significant force in reducing the rate of 'unwanted teenage pregnancies'.

For another group of respondents, the experience of having repeated unprotected sex without becoming pregnant, led to a certain level of complacency or in some cases, a genuine belief that they were somehow immune from becoming pregnant, as this 18 year old respondent explained, 'I mean the first time I had sex, I got away with it, but after the fourth or fifth time, I didn't'. She readily admitted that she didn't think she would become pregnant despite the fact that she had said that 'I knew all about sex

because my mum and my family are pretty open minded', and taught her all about contraceptives.

In some cases, pregnancy occurred not because a respondent had not bothered to use any form of contraceptives, but because of incorrect use. Some respondents reported that they were using contraceptives at the time of pregnancy, but they became pregnant because they had either missed taking a pill, or because there was an accident with the condom. The 'condom burst', was the expression frequently used, and in this respect, these findings are in keeping with other recent research into contraceptive use and teenage pregnancy (Hinkson, 1999). As this 19 year old respondent puts it:

'I went on the pill, but basically I didn't like being on the pill. I just kept on forgetting to take it and everything, so I stopped taking it and just used condoms, but the first time I got pregnant, one night we didn't use anything. I didn't think I would get pregnant'.

This response is typical of the views of many other respondents.

Like the Caribbean respondents, what seemed to be a frequent practice was respondents' failure to seek further follow up contraceptive advice when they felt dissatisfied with a particular method of contraceptive, or because of some adverse reaction. In the case of the respondent quoted immediately above, her doctor had prescribed the pill, and she did not think of going back to seek further advice about an alternative method. She was also aware of other contraceptive agencies that she could attend and claimed that she felt comfortable attending them, but still took no action.

There was also some evidence to suggest that where a young woman had experienced abuse, particularly emotional and sexual abuse, and had embarked on a journey of search for love, contraceptive use seemed to be the furthest from her list of priorities. Here the object of her search took precedence in terms of importance over the use of contraceptives. As in the case of this 18 year old respondent who had been emotionally neglected all her life, she explained that she 'started off using the pill but it made me sick and I didn't really know anything about it. And L was my first boyfriend, so I knew I wanted to be with him so I didn't really bother'.

In some instances, the experience of years of abuse of various kinds can also affect a young woman's attitude to the use of contraceptives. This 20-year-old respondent who had experienced sexual abuse, when discussing her reasons for not using contraceptives, stated:

'I was drunk a lot. I stored up a lot, rebelled against a lot of people. I had a lot of emotional problems, rebelled against anything and everything people tried to do for me, so when my foster mother tried to put me on condoms, I thought f it. I just threw them back at her and went out and get drunk'.

Most respondents who had opted to use contraceptives had knowledge of where they could go to access this service. They had also worked out their own preferences in terms of service facilities that would meet their needs.

Some respondents regrettably even after two or more pregnancies were still uncomfortable about contraceptive use. This discomfort sprang mainly from a number of misconceptions and misinformation about contraceptives that they had picked up along the way. Such fears, doubts and insecurities were hard to shift. For example as this respondent informed me, 'I used the pill but I stopped, the injections make you bleed, the coil can rot you out and make you stink down below'. She was so adamant about her views that no amount of attempt to convince her otherwise would have changed her mind. She was not an isolated example.

The remainder of the respondents, who claimed that they had no knowledge of contraceptives, cited several reasons for this lack of knowledge. Chief among them were lack of parental input in sex education and inadequate sex education at school, which brings us to the next theme to be explored.

The role of sex education

In view of the lack of understanding of and use of contraceptives prevalent among respondents, and in keeping with the importance attached to the availability of good sex education to prevent unwanted pregnancies cited in the literature review by numerous research studies (Jones et al., 1985; David et al, 1990, Boethius, 1985), the issues of the quality and quantity of sex education received by these respondents, as well as the impact of sex education on their lives were explored with all respondents. A small number of respondents, 2 in total, said that they had not

received any sex education while at school, and what little knowledge they had gained came from various sources, but mainly from friends. The remainder of respondents however, stated that they had received some form of sex education but apart from two exceptions, they were generally dissatisfied with the quality and quantity of the sex education received.

Sex education was one of the areas where respondents were most emphatic and vocal in expressing their views, which conveyed a sense of very strong feelings of disappointment in this area. The most frequent criticism of sex education at school relates to the quality of sex education received. 18 respondents reported that the quality was poor. These complaints often related to an inconsistent, unrealistic approach to the teaching, as well as the lack of detailed information provided. In this respect, the quotes of the respondents' views that will be provided next, are very representative of the views of the majority. Each of these quotes in its own way, provides very relevant information about the elements that in the opinion of these young women, should be included in sex education. Respondent aged 18 in discussing what she was taught at school, remarked:

'Nothing much, they showed you the methods of contraception and they didn't explain very much. It was a girl's class and a boy's class, and they just told you about the menstrual cycle, about periods and how you would get pregnant, but they didn't tell you anything more than that'

When asked what she felt was missing, she replied:

'the things that I read in magazines were more detailed than the school would tell you, more information about how people get pregnant, and how it exactly happens and what happens if you don't use contraception'.

She went on to say:

'there were only about four classes, and it was about once a week. I don't really understand why they separated the boys and the girls. I thought that if the boys and girls were together, then the boys would understand the same things as the girls go through, ...they should have got us all together so that the girls know what the boys go through and the boys know what the girls go through'.

Another respondent aged 19 stated:

'we had sex education at school but it didn't seem to explain much. It was just about periods and condoms. It didn't really get into it deep enough, for example, the gritty details. I mean at the age of 13 that's when it (sex education) starts. They think children at that age are young and stupid and they don't really understand, but really they do, they understand more than some older people think. So they have to explain how they would

like people to explain to them you know. Not oh this is a penis and you know what I mean. We used to laugh in class. It wasn't serious enough for us to sit down and go oh really, that's interesting. It was just a joke'.

When asked if she felt able to ask questions during her sex education classes, she replied:

'No because the teachers would be stuck up or something, not young and friendly enough for you to be able to talk to them. It would be like watch a video and questions, no'.

She was asked if she had an opportunity to advise schools about the content of sex education what message would she want to convey to them, she replied:

'just get more up to date videos, just be honest. Maybe if they don't feel embarrassed, talk about their own sexual experiences, or if that is too embarrassing, just give good examples. For instance speak about different type of relationships and what could happen, and what couldn't happen. Just go into it really deeply. I am sure that would help you know and people would listen if it is a teacher they respect, but if it is someone that doesn't really communicate well with them, then they wouldn't'.

A very important point made by another respondent aged 18 was:

'they don't tell you about the pressures you can be under from boys. They just tell you about the condoms and the pill. It was just about two lessons and that was it. They need to help us know how to say no'.

This 20 year old respondent forcefully stated her disgust at the quality of the sex education she received by describing it as:

'crap..... There was information, but just not enough. Not realistic. It needed single mums ages 15 and 16 to go into those schools to say this is my life, do you want the same. It is only the parents' responsibility to a certain extent, but parents can only do so much. A lot of people will talk about drugs, but sex is an inward thing. This country doesn't talk about sex enough and that's why we have got so many problems'.

This respondent in discussing what was missing from sex education in her school remarked, 'the graphic details and also about the emotional side as well. How much heartbreak it can cause. It's harder to say no than to say yes'.

In discussing what she learnt and what was missing from sex education, this 19-year-old respondent explained:

'It was very basic, pills stop you getting pregnant. Condoms stop you getting disease, but I don't think I learnt about crabs or warts or other horrible things. Sex education is all about preventing pregnancy and then in a Catholic school the pill is seen as not good. It's not openly enforced that way. They just sort of brush over it. Older people are saying to younger people if you go on the pill early it will make you promiscuous, but it is not only pregnancy you have to worry about, it's all the diseases'.

All of the above quotes point to the fact that the emotional and relationship components of sex education are equally as important as the purely biological aspects.

The message from the following quote has also been borne out by other research into teenage pregnancy (Davis, 1994; Morgan, 1994; Scott & Thompson, 1992), and suggests that expert knowledge, the sex of the teacher delivering the lesson, and an air of confidence in delivering sex education to young people are all important elements to take into consideration in order to ensure that crucial information is assimilated. These elements are also important to ensure that meaningful dialogue is encouraged, which is so very important in effective sex education. This respondent admitted that she did have sex education but it:

'Wasn't really kind of informative. We had this male teacher and he felt really uncomfortable talking about it, which is really stupid, really they should have got someone else. And he said we have to give this kind of talk and here are some leaflets, if you have any questions ask me, and because I went to an all girls' school, no one really said anything because he was a male teacher who felt uncomfortable in front of a whole group of girls and we felt uncomfortable with him as well, so it wasn't much of a sex education, just a few leaflets really. We was meant to have it for a few weeks but we didn't really talk about it because we could tell that he was uncomfortable'.

Her next point suggests that it was not the overall quality of sex education in that school that was poor, but the quality and skill of the person delivering the lesson because as she informed me, 'we had friends in other classes and when they told us what they talked about like different forms of contraceptives and we said we got a leaflet so he must have felt uncomfortable'.

There were only two respondents who felt satisfied with the quantity and quality of sex education, and it is equally important that their voices are heard as sex education educators need feedback on both good and bad practices in order to successfully gauge their presentations. One of these respondents did not provide detailed examples of what she felt was good about her sex education lessons, apart from stating that sex education, 'started at 9 years at school and covered everything'.

The other respondent aged 16 however, stated:

'Mine was actually quite good, they showed you how to put a diaphragm up this thing and condoms and that's good. We had PSHE classes and it was all about sex education and periods and the sperm meeting the eggs and AIDS. That is what schools should be doing. We had a right laugh doing it, but you learn how to do it, and at least you are learning what should happen'.

As we have seen from the literature review much controversy surrounds the question of whether it is the parents' responsibility to provide sex education or the schools' responsibility. The evidence from this research puts the main responsibility for sex education firmly at the door of the schools for many reasons, but chief among them is the fact that although the vast majority of respondents in this sample stated that they had very good relationships with their parent/s, they were nearly unanimous about the fact that this good relationship did not include discussions about issues relating to sex. 24 out of 26 respondents said that they had received no form of sex education from their parents.

The next three quotes from two 18 year old respondents and a 17 year old respondent respectively, point to several issues that need to be highlighted in the debate about sex education, (1) the unrealistic approach of some parents in relation to their daughter's sexuality, (2) the inadequacies of sex education as it is approached in some schools, and (3) one reason why the responsibility for sex education cannot be left entirely in the hands of parents:

'When I started seeing my first boyfriend, I said to mum I want to go on the pill, she said no, because that is just encouraging you, and look what happened, my daughter was born. I didn't know that I could have gone to my doctor's and get the pill without my parents knowing. I didn't know that. I think the school could have done a hell of a lot more. Because the school where I was at, a lot of girls from there got pregnant at 15 or 16. I remember having sex education at year 7 and it was more about making babies. There was nothing about contraception. Couldn't the school tell me that I could go to the doctor's. They don't talk about the dangers of diseases. When I think about the way I was brought up, my parents NEVER EVER spoke about sex you know. They were too embarrassed to. They never sat down and talk about it you know, so I think there definitely should be sex education in schools because of households like where I grew up in you know, they don't talk about it. There should be a lot more said about contraception and pregnancies, not just you have sex and you have babies when you are married. It's not reality, is it'?

The next respondent, so typical of many other respondents who were quite clear about the excellent quality of the relationship between them and their parents, when asked if her mother had ever provided sex education for her, she replied, 'My mum

thought I was too young to even talk about it you see. It just shocked her when she found out I was just 14 and having sex really. She wouldn't talk to me'.

When asked what she felt her mother's reaction would be if she took the initiative and approached her mother with a view to discussing sex, she replied:

'She would probably laugh. I mean she would think it's a joke really. I don't know, her parents didn't talk to her about it, and probably their parents didn't talk to them, so it wasn't seen as the thing to do. You just learn that's it'.

And as the third respondent also pointed out:

'well not all parents talk about it, like I say some parents think it is a dirty thing still. Some people are still living in the middle ages and thinking that their kids aint gonna do it you know, but kids are doing it. I think it is good that they are doing it in schools. They should be doing it in every school, giving proper lessons on it once a week and that. They keep going on about all these young pregnancies, there won't be as many. Fair enough you would get the odd accident and that, but a lot of people wouldn't be doing it. At schools they should be giving away condoms. At secondary schools in the PSHE lessons I think they should be giving those to the girls and boys there, because they are having sex. And you know even if they are not, it is still something good to carry around with them in case they do decide to have sex'.

Barriers to communication between parents and children about sex not only relate to parental neglect in addressing the issue of sex education with their children, but also to the level of comfort or discomfort experienced by young people in discussing such issues with their parents. As the 17-year-old respondent informed me:

'my mum doesn't talk about things like that, most of my sex education was from my dad and I used to feel really uncomfortable to talk about such things with me dad. Sex education should start at primary school because so many young girls get pregnant now. When you start at secondary school everyone is talking about boys, so the earlier the better'.

Similarly as this 18-year-old respondent explained, 'I couldn't talk to my mum about those things because you wouldn't know what to say when you speak to your mum about those things'. Unfortunately this was one of the two respondents who stated that they had received no sex education from school.

In some instances it is the case that in spite of the fact that in every other way the relationship between a young woman and her parents, usually mother, is good, when it comes to the topic of sex, the young woman often senses that this subject is off limits to discussion, and avoids any attempts to raise certain issues with her mother. When asked if she could approach her mother to discuss issues relating to sex, this

18 year old respondent replied, 'Well I think I could but I don't know if I would want to. There is a barrier when it comes to my mum that I don't want to cross. I prefer to ask somebody, maybe a nurse or somebody'.

She experienced such feelings in spite of the fact that she felt that one of the reasons why she had such a good relationship with her mother was because her mother had her when she was 16 herself.

Not only are some parents embarrassed, but it would also appear that there might be some misunderstanding on the part of parents about whose responsibility it is to provide sex education. As this 18 year old respondent stated:

'My mum was very embarrassed to talk about things like that when I was younger. I just don't think she did enough really. I think she thought as well that a lot of it was left to the school, I don't think it should be really, but it is. I was also embarrassed to talk to her. I had no knowledge about contraception, not really, only what I heard in the playground and discussed with friends and what not'.

As we have seen from the first chapter, there is often confusion about the role of residential and fieldwork social workers in fulfilling their duties under the Children Act, 1989 in providing adequate sex education for young people in their care. However, as the next quote from a respondent who had been in care following physical abuse shows, the importance of that role is quite evident. In recalling her experiences of being in care she remarked:

'It was the first time I understood what sex was because my mum was never there especially for me. She just never was. She was always working and when she came home, I was put to bed, simple. So I didn't really see a lot of my mum when I was younger and it wasn't until I was put in a children's home that everything was sat down and explained to me. What a period was, why they happened, how often they happened, you know, what sex was about, bits and pieces, it made me understand a lot'.

Regrettably not all respondents who had been in care were able to report such positive views about their experiences of sex education while in care.

Worthy of note by residential care staff is her follow up comment:

'But although they were giving me information, they wasn't giving me the support that I needed, which is quite difficult sometimes especially when you are in a children's home and you have to go downstairs to an office where there were about four or five fellows that are all on the same shift. There is not one female on and you have to walk in there and ask to go to the cupboard to get sanitary towels, especially when you are twelve years of age'.

To conclude this section, it is important for both schools and parents to understand a crucial point that all respondents were at pains to point out. That is, the fact that a sex education approach which focuses on the concept of 'avoidance of early sexual activity' will not be heard. One respondent summed up this point very clearly when quite emphatically stated, 'schools need to understand, messages of avoidance do not work'.

The role of sex in the lives of the respondents

In view of the commonly held perception in the minds of certain members of the public, the media and some politicians, of a teenage population that is obsessed with the pursuit of sexual pleasure and excitement, the role of sex in the lives of the respondents was among the themes explored during the interviews. A very small number of respondents, **2 in total**, claimed that they do enjoy sex but the majority stated quite clearly that they did not enjoy sex, or certainly not at the start of their sexual relationships. Some had very ambivalent feelings about their experiences of sexual intercourse. The reasons provided for their involvement in early sexual activity were many and varied, and have very little to do with being promiscuous. These will be explored later. A significant number of relationships had been in existence for over a year and some had lasted five years. This finding is in keeping with evidence provided in the literature review that most teenage sexual activity takes place within steady relationships (Bury, 1984). Quite often there are many other factors that come into play to influence a respondent's decision to have sex at an early age. For example, in a few cases, sexual activity began in an attempt to keep up with a perceived image among their peers of everyone being involved in sexual pursuits and there was pressure to withstand the feeling of being the odd one out.

This 17 year old respondent explained that she became sexually active at 14 because:

'It just seemed like the thing to do, sort of thing, all my friends were sleeping with their boyfriends. It was kind of like I am the odd one out and everything. It's like everyone talking about these boys and it was like my first serious boyfriend, no one else was really serious before'.

On the one hand, she had succumbed to the pressure to become involved in early sexual activity, but on the other hand, the fact that her boyfriend 'was someone older',

was also an influential factor. She had also taken the perceived serious nature of the relationship with her boyfriend into consideration before deciding to engage in sexual activity.

Similarly, another respondent in trying to make sense of why she became sexually active at aged 13 explained:

'my mum and dad weren't promiscuous. I didn't see anything there. I really liked him (her boyfriend) and that's the only reason I can think of. Everyone says it's peer pressure. I think only about 10% of it could have been peer pressure. When I hear my friends say it is because everyone is doing it, I thought no, I really loved him. I had loads of boyfriends in between but no one I wanted to do that with'. With a thoughtful expression she concluded by saying **'I think children are getting older a lot younger'**.

Evidence was also provided to suggest that in some cases early sexual activity was simply a means of responding to the hurt, anger and confusion felt by some young people who have been abused in one form or other. This respondent aged 19 had embarked on a journey of excessive sexual activities at aged 15 following sexual abuse at age 10. When asked whether she had enjoyed those sexual encounters, on reflection replied:

'At the time it was like wow yea, but when I sit back and look at myself when I was younger, I thought to myself what was I doing? I never enjoyed none of it. I was just pleasing them at the end of the day, nobody was pleasing me back'.

There was evidence to suggest that the experience of sexual abuse often has a negative impact on how a young woman views her sexuality, and can result in a very distorted view of any future sexual relationships that she may have. This respondent who had been abused sexually by her father, brother and a family friend, in explaining why she does not enjoy sex, quite clearly stated that:

'I don't even enjoy it now. I haven't even got a boyfriend now ever since I moved out (she had briefly lived with her boyfriend). Sex now doesn't interest me. Sometimes I would look at television, and there is a film and they are having sexual intercourse or something like that, I would turn it off, or anything like sexual abuse on the news I turn off, because it just gets to me'.

When she was asked why she engaged in early sexual activity if she didn't enjoy it. Her response was:

'To make someone love me. To get someone to love me because I didn't have that, so I didn't know what it was. So I thought if I do this they are going to love me aren't they? It was just basically to keep someone with me'.

Further evidence also suggests that at times poor communication, where for example a parent is being excessively strict in trying to protect a daughter from early sexual activity without fully communicating why certain actions are taken, can have the opposite effect than that which was intended. This 19 year old respondent who had experienced four miscarriages in trying to carry a pregnancy to term, spoke convincingly of her reasons for early sexual activity, which she attributed to the fact that:

'Because my mum was so strict, she just put the fear into me and you want to know why is she behaving like that. She wouldn't let me go anywhere, and I think that's why I got myself into a lot of things that I shouldn't have done you know, like starting to have sex early and just being rude. I wasn't searching for something, I felt that if I could have been more open with my mum, if at the time I could speak to her then I don't think that I would have gone and done that because I would have had the relationship where I would have sat down and let her explain certain things to me, you know what I mean. Because I didn't have that relationship, I was just basically doing and following other people....my friends were sexually active but I don't think I would have been influenced if I had that relationship with my mum. She just shouts sort of thing. She never sat down and had a proper conversation you know. She was just shouting and screaming, and you better don't do this blah, blah, blah, so it just automatically pushes you the other way'.

Goal orientation

The link between self-esteem, goal orientation and teenage pregnancies has been well documented in the vast literature on teenage pregnancies. In particular there is the suggestion that there is a link between poor self esteem and unwanted pregnancies (Russell, 1983; Hudson & Ineichen, 1991), and consequently, teenagers who have early pregnancies are lacking in self-esteem and goal orientation. However, similar to the findings from the Caribbean respondents, the data collected from the London respondents had not provided any marked evidence to suggest that these young women were lacking in a sense of goal orientation. In this respect, these findings correlate the findings of other research, which also found no marked link between low self-esteem and teenage pregnancies (Cvetkovich & Grote, 1980; Morrison, 1989; Robbins et al, 1987; Plotnick & Butler, 1991; Paik, 1992). Even where respondents had experienced abuse in their lives, their beliefs in themselves and their abilities, as well as their attempts in trying to overcome their painful past

experiences in order to make a success of their lives, were very evident. In their attempts to explore and analyse their experiences and to ascribe meaning to their lives, many respondents were very determined to make every effort to avoid the mistakes which their own parents had made in raising them.

The vast majority of respondents (**24 out of 26**) had, at some point given some thought to what they wanted to do with their lives. Their goals varied from the very basic but important life survival goals, to the very ambitious. Whatever the target, there were goals nevertheless. In focusing on their future plans, they were in no way underestimating the difficulties that they would experience in juggling parental responsibilities with future studies. In many respects they had given thought to how they would manage in terms of childcare arrangements. On the whole, they are to be commended on the ways in which they coped with their pregnancies and subsequent parenthood without losing sight of their goals.

Some were forced to postpone their plans until a later date because of the pregnancy, without abandoning their goals. This was the case with an 18-year-old respondent who had gained 9 GCSE passes at grades A-C and had got into sixth form College to do her A'levels prior to her second pregnancy. Her career plans were quite definite as she stated:

'I wanted to be an Educational Psychologist that's why I was studying A'level Psychology, English and Sociology. I am definitely going back to college. By September 2001 I definitely want to be back in college'.

As we can see her pregnancies in no way dampened her ambitions. She had no regrets about her pregnancy. This was quite evident when she went on to say, 'I am proud of myself because I think that I have done quite well and I am proud of my daughter, she is the best. Its made me want to pursue my goals even more, definitely'.

Another respondent who had also gained very good GCSE passes was attending college at the time of the interview, studying 'A' level Art and Sociology with plans to add media studies to the list of 'A' level subjects she was taking. She admitted that combining part-time study and raising her children was often difficult but as she explained:

'I want to become a teacher or social worker to help other kids. It's quite hard I must admit, but I see it as even if I don't do too well, at least I would have tried. I wanted to carry on because I did quite well in my GCSEs. My parents said I could have done better. I mean I probably could have, but I think in my condition, I think I did quite well. I think I probably did better than most kids in my school. So I did want to carry on not just to be like a stereotype you know, have kids young, sponging off the dole, sitting at home doing nothing. I wanted to show people that not all young people are just not worth it, they do want to help themselves.

Her determination was plainly evident when she emphatically stated: 'so I just thought carry on with college, even if it takes me five years. I am going to do it'.

The pregnancy and thoughts of the enormity of current and/or future parental responsibilities had injected a renewed sense of commitment and urgency in pursuing their future careers. This was true even where respondents stated that their main impetus for returning to college at a later date was to help them to be able to help their children with their schoolwork. For example, a respondent aged 18 years in speaking about her regrets in not attending school regularly, recalled that she:

'really enjoyed Maths and English so I want to do that again and get my GCSEs, so I am going to night classes. I want to go back to school while they are really young so that when they go to school I can at least sit down with them at night and help them with their homework and things, and if they ask me a question I can help them. If a job does come my way when I am older, I can take it because I do want to'.

In the case of another four respondents, their career goal choices were directly related to having experienced a great deal of abuse in various forms, and later using the experiences to ascribe meaning to their lives. Three of the four respondents had definite plans to work in the social care sector as a result of having experienced abuse and of being in the care system. As one remarked:

'When I was younger I didn't have the foggiest, just knew I wanted to do well. My plan is to return to education when my kids are old enough. Because of the experiences I have had, I am now gradually understanding my life now. I have turned the corner. I am interested in some kind of work in social care with young people'.

Responses to theme of welfare dependency and teenage pregnancy

Given the persistent and prominent media and political interests accorded to pregnant teenagers and the charge of teenage pregnancy leading to welfare dependency in Western countries (Bottling et al 1998; Burghes & Brown 1995; Polit & Kahn 1986), this was one theme which was raised only with the London respondents.

This was another one of the areas where respondents were particularly assertive in stating their views. In relation to the issues of whether teenagers deliberately make themselves pregnant in order to claim welfare benefits and gain access to housing, only 2 of the 26 respondents were in agreement with this view. However they were at pains to point out that they were only making reference to their knowledge of the local teenage population in their borough. The remainder of the respondents, were unanimously opposed to this view of the reasons for teenage pregnancies. Even where a few respondents felt that this might be the case with a small minority of young people, they were quite clear that this was certainly far from being the case with the majority of young people. Their remarks show the complexity of reasons for teenage pregnancy and the overly simplistic nature of such claims. These remarks also show that the idea of obtaining welfare benefits and housing was often the last thing on their minds in having a teenage pregnancy. For example, this 18-year-old respondent commented:

'I get so annoyed when I hear these things, maybe there are a few people out there, fair enough you know, but I get so annoyed when they categorize every young person as getting pregnant on purpose to get their house you know, to sponge off benefit, which I don't think it's true because the benefits people don't give you enough money anyway if you want to live in luxury. And as for doing it just to get a house, I think that's ridiculous. Who is going to go through all that pain or having a baby just to get a house? They can just put their names on the waiting list and wait three years, so what's the big rush.....A child is not something you say let's quickly have a baby and get a house, that's not how it works....the government should not categorize like that it's just not fair'.

Another respondent's comments show that being unemployed at this time in her life was a decision based on several factors which she had carefully taken into consideration, as she remarked:

'That's just stupid, really stupid. I grew up in a council house. I didn't need to have a baby to have me own council house. I have me mum's one. I worked for Abbey National for six months. I gave it up because it was really hard keeping up. My mum had the baby everyday. A was in nursery, by the time I rushed home and done dinner I was really loosing the bond with them and I just wanted them in bed and then do me housework..... I was ten pounds a week better off for going to work leaving them in other people's hands'.

In response to the claim that young people deliberately make themselves pregnant to access housing and benefits, this respondent emphatically remarked:

'That's crap. If you really want housing that bad you can go and get a house by saying that you have been kicked out of your home whether or not you are pregnant... My friend she has got a baby that is nearly two now and she has been living in a hostel in.... and it is bug ridden and she has been there for ages and she is classed as disabled because she has got....and they haven't done anything about her you know, they have left her and her two year old child who is being bitten.... so it's crap when they say you get homes quicker, they don't get them any quicker if you have got a child. And when they say about the social, you don't get hardly anything. A mean fair enough you get something, but it aint a lot. To have a baby just to get on the social and get a house is crap, you get a baby for life you aint got that for life you know. No matter what happens you have got to look after that child, so it is stupid what they say about that and it gets right on my nerves when they say that because it aint nothing to do with that'.

In a similar mode this respondent quite forcefully said:

'That's a load of codswollop, I know a couple of people who do that, but not many. I wish I was at home. Let's put it that way because getting your own place ain't nothing good, all you get is just bills upon bills, so I wish I was still at home. I didn't want to leave my mum's house in the first place'.

Throughout all these interviews I found no evidence to substantiate the welfare dependency claim. Overall, I got a sense of respondents receiving benefits because they genuinely felt that at that particular stage in their lives they had little choice, but it was seen as very much a temporary measure. As we have seen from the characteristics of the sample, many respondents were still living with their parents and there was no sense of urgency to leave. Some of those who were housed in council accommodation were generally not ecstatic to be there, and as the quote above suggests, some expressed a wish to be back at home. Having visited some of these council housing estates where some respondents live, I can fully understand this lack of enthusiasm. The overwhelming majority of respondents' feelings about being in receipt of benefits were summed up very well by this respondent who simply remarked, 'I am on benefit and I just can't wait to get off them and go out there and work'.

Can governments and other professionals take steps to reduce the rate of teenage pregnancies?

The most worrying element of these findings is the widely held view among the respondents that there is very little that governments and/or other agencies can do to significantly reduce teenage pregnancies. **15** respondents were quite adamant that there is nothing that government can do to reduce teenage pregnancies. **11** respondents expressed uncertainty in response to this question. These views are very closely interconnected to the theme of **normative acceptance** looked at earlier

in this chapter, where there is a sense that increasingly teenage pregnancies are accepted as a normal part of the culture and experience of more and more young people and therefore it is pointless trying to change that situation. The reasons advanced by the respondents in support of their beliefs were many and varied, and in some respects, based on their own experiences and their knowledge of their peers.

These views also showed quite clearly the rationale on which they have based their thinking, and reflects a certain degree of ambivalence about this issue. On the one hand they are saying that there is nothing that government can do to reduce teenage pregnancy, while on the other hand, their expressed anger about the quantity and quality of sex education both at home and at school, is also implying that they believe that effective sex education can have a positive impact on reducing the rate of teenage pregnancies. This ambivalence also points clearly to the fact that no unilateral approach to the reduction of teenage pregnancies is likely to be effective, and in many respects the eventual pregnancy is only a symptom of other underlying, often complex problems. It is also important for these views to be heard by those responsible for policy making if policies are to be effective. This 17 year old respondent was quite adamant that:

'Governments can do nothing. It doesn't matter what anyone says if a young person wants to do something they are gonna do it. We listen more to our friends more than people in your family. The way you see it is like my mum and so just want to stop me from having fun and doing what I want to do because maybe they are not as young as they used to be, whereas your friends are more on your side. So no young person is going to listen to government'.

K. aged 18 echoed the views of many respondents in relation to whether government and other agencies can develop policies to significantly have an impact on the rate of teenage pregnancies in the UK. As she commented:

'I doubt it. Sex education was o.k at school. What they told me is true. My sex education is good because they explained everything to me in every way. But sex education alone is not the answer. You can listen to what someone says but at the end of the day it is up to you if you listen, you have to make up your own mind'.

Another respondent stated:

'I don't know what they can do to reduce it, because it's like I say you make up your mind. If you are gonna have sex you're gonna have it. If someone tells you not to do something, you want to do it, because I am stubborn like that as well'.

The element of ambivalence in their thinking in this area was clearly evident from this next quote, where the respondent having quite clearly expressed her doubts about the likely effectiveness of current practices and policies aimed at reducing teenage pregnancies, she went on to say:

'But I really think they have to get into the schools, I really think they should, that's the best thing because I had to find out about family planning myself you know. Even if they give leaflets about family planning and condoms..... you don't get nothing'.

Similarly this respondent remarked, 'they can't reduce it because young people know about sex and because they know they want to try'. While she admits that young people will want to experiment, she also felt that 'no one should have sex until they are 18. I wished I had waited because maybe I wouldn't be pregnant now. Maybe if I was still at home and I didn't need the comfort'.

Here this quote further reinforces several factors, (1) that for this respondent and indeed many others, there are other issues leading to pregnancy which have to be taken into consideration in developing effective policies and strategies to attempt to reduce teenage pregnancies. (2) There is also the natural tendency among teenagers to take risks as part of their development and coping strategies to manage loss and change, and because of this risk taking element in normal adolescent development, the tasks of persuading teenagers to avoid risks in their sexual behaviour have to be a constantly reinforced activity.

This respondent was both very adamant and ambivalent when she said, '**NO they can't. They really, really can't. It's up to the girl**'. When her response was explored and she was asked if the high rate of teenage pregnancies is related to poor sex education, again as with the previous respondents, her ambivalence was apparent when she replied, 'I reckon it (sex education) should start from Primary school. Or what they are doing in America, where they give the girls dolls like babies for a week, that might help'.

This respondent saw the solution to reducing unwanted teen pregnancies in practical terms. Her advice was:

'Giving away condoms can reduce it if anything is spoken about and publicized often enough it can..... they should be talking about it more in schools and discussing it as young as possible and giving condom away in schools. It wouldn't stop it, but you know it would cut down, I reckon'.

Some responses point to the fact that access to contraceptives and embarrassment in accessing contraceptives may be an inhibiting factor in contraceptive use.

Therefore in terms of what governments and other agencies can do to prevent teen pregnancies and sexually transmitted diseases, this respondent felt that:

'There should be a room in school where boys and girls can get free condoms free contraceptives, anything, because most of the time it's the embarrassment of having to go into a petrol station, a chemist to buy them. So I think not a huge room just like your form room you have like once a week someone comes round with free condoms, or you have a set amount of condoms in that form room, so that they can give like three to each person, because then they haven't got to go and buy them. They haven't got to go through the embarrassment of having to go into a shop and sometimes ask for them, then perhaps it wouldn't happen'.

What can government do to help pregnant teenagers and teenage parents?

Following the views expressed above, the next logical question to pose to the respondents was if government cannot take steps to reduce the rate of teenage pregnancies, what then can government do to help those who become pregnant? The responses to this question were more mixed in terms of the support or services that they felt could be offered. However, the most frequently expressed need was for more help in relation to childcare facilities to enable them to go out to work, or in most cases to further their education, and thus improve their employment and financial prospects. This point was made by **16** respondents. This request links very closely to their responses in relation to questions asked about future goals. It also gives added credence to their rejection of the notion that young people simply want to succumb to a culture of welfare dependency.

This 16-year-old respondent summed up all of these issues when she pointed out that:

'More emphasis on allowing you to finish your education. Creche facilities to allow you to go and finish your education and go out and get a job, then you are off the social. Why don't they do things like that?'

This next respondent supports the view expressed above and gives a very clear message that incentive to work programmes have to ensure that childcare is accessible and affordable, otherwise young women having weighed up the pros and

cons of going to work or staying at home, are more likely than not to opt for staying at home and raising their children if it is felt that the disadvantages outweigh the advantages. As she stated:

'I don't think that this going back to work thing (the current government's New Deal for Lone Parents) that they started is very good because childcare costs is far too high. I would have to leave them with my mum, I couldn't pay childcare. When you are on this benefit you might as well stay at home and raise your kids, because when you get right down to it, you are only getting an extra twenty pounds. So for that extra twenty pounds you are out from nine to five, you probably don't get home until six . Just for that extra twenty pounds you could be home with your kids'.

This next quote from an 18 year old respondent who had obtained 9 GCSE passes and was now at college studying for A'levels, is effective in several ways. (1) It again challenges the welfare dependency claim. (2) It provides evidence of good self esteem and goal orientation. (3) It highlights the at times misguided approach of government and professionals to working with young people who for whatever reason or reasons, become pregnant and want to break out of that cycle of disadvantage, when she remarked:

'They could be more supportive I suppose. It took me a whole year and a half to get my nursery place. I was asking for it about a month before she was born, because I wanted to carry on. I applied to charities. I applied to the college for help. No one wanted to help me. And it is only now because I have got back problems did they say yes they would look after her. They are not going to say they would look after her for me to go to college, it was because of back problems and that really annoyed me. I had a social worker, other people I know have social workers and they get everything they want, yea. I had a social worker and I asked her for a placement for S, so I could carry on with college. What she said to me was, well the thing is, you shouldn't be going to college, you should be at home looking after your child. Well I though it's like a big circle, government are criticizing you for not trying, but when you want to try no one wants to help you. All I needed was for her to be somewhere then I could probably do my homework and do everything properly, so that I wouldn't be on the dole anymore, but they don't seem to want to help and that really drove me mad. It's like they are putting you down you know, saying you are not helping yourself, but when you want to help yourself they not letting you help yourself. So that is one thing that really, really annoys me....they should make it easier for someone to help themselves. If someone don't want to help themselves then let them have their seventy pounds a week and soon they would probably stop giving them money. If someone wants to really do something with their life, I think they should support them because then I would be paying back the money after I have a good job, wouldn't I? I would be paying back the money through taxes and stuff like that'.

Two respondents felt that more should be done in the schools in terms of sex education. As one of these respondents suggested, 'they can tell you what to expect. What will happen if you miss taking one pill and what can be done about it, like the morning after pill'.

The importance of clear and open communication about such issues was made apparent when she went on to say:

'I think they should have more people like you (the researcher) because at times I feel I have no one to talk to, even now I am pregnant. It would be nice to have more doctor advice when you are pregnant. Even somewhere to go to when you need advice to know what to expect for the first couple of months'.

While there was one suggestion of providing more benefits, two respondents felt that government is already doing enough, or at least as this respondent puts it:

'While I wouldn't say they are doing enough, but if they did anymore then you would get lazy about it. You would sit down and you would think oh well everything is coming to me, so I might as well not bother, so I think they shouldn't give too much. Because the money that I get (the small amount) just gives me more incentive to go out to college and get my education so that I can have a proper job'.

The role of peer counseling

An increasing amount of literature on peer counseling in relation to reducing unwanted pregnancies has emerged recently, therefore, following on from the question of what government can do, the question of peer counseling first popularized in the United States (Rickert, Goitllieb & Jay, 1991; Phelps et al 1994), seemed to be the next logical question to pose to the respondents. Indeed one respondent in response to the last two questions posed about whether the rate of teenage pregnancies can be reduced and also, what government can do to help teenage parents, made a suggestion, which closely fits in with the concept of peer counseling when she stated:

'They can't reduce teen pregnancies because they go about it the wrong way. Send teenagers to go and live with a single mum for two days to see what being a parent is all about. The government don't do enough, they really don't, they talk about go and use the condom, go and take the pill, but contraceptives isn't everything. The government don't get young people involved enough to find out where they (government) have gone wrong and they need to do it'.

The evidence from the interviews shows that the **22** respondents had heard about the concept of peer counseling and were for the most part supportive of it. This finding is in keeping with the findings from other research (Phelps et al, 1994). At least two respondents were already involved in peer counseling. For those respondents who had never heard of the concept, once it was explained to them, on

a whole they generally felt that there were likely to be positive benefits from using this approach in providing relevant information for and in working with young people.

Some were cautiously optimistic, however as this 19-year-old respondent remarked: 'It depends on whether the individual is prepared to listen. Sometimes you have to learn for yourself and experience it for yourself'.

The next view so clearly expressed below is very representative of the majority of the views expressed:

'I think that it is a good idea having people of similar age who have experienced it (pregnancy) talking to young people as they are more likely to listen to that person than to someone who just say don't do that, but have never experienced it. It's like they being a hypocrite or something, but if you have someone who had actually gone through it, they have more right to talk to you. They can actually tell you how it feels and things like that. I have had an abortion and I am going to have a baby as well, I would like to think that my sister can come and talk to me when she gets to my age. I can give her advice on both sides, like the advantages and disadvantages of having an abortion and of having a baby as well. I think she is more likely to listen to me than just to my mum and dad saying don't do that or do that. So I think it's better, yes'.

Among the few respondents who felt that peer counseling would not be effective was this 19 year old respondent who stated, 'To me all this is not going to work because it's just me explaining to someone what I went through, but they might go through something entirely different, so I don't think that would work at all'.

Knowledge of services and experience of interaction with professionals

The majority of respondents had some knowledge of one or more support and advice services. However, 5 respondents claimed that they had no knowledge of these services. For those respondents who had little or no knowledge of services that they could access for advice, we have seen from the evidence provided in this chapter that there is a need for accessible, user-friendly services which are well publicized and which have the confidence of these young people. This quote from a 19 year old respondent sums up very well this crucial need, particularly where young people feel that they cannot turn to their usual support networks in their environments such as family members, peers and other significant others for help and advice. In describing her feelings regarding her desperate need to talk to someone when she first became pregnant, she explained:

'Yes, I just wanted to talk to people but you know friends at school, I just felt a bit embarrassed to talk to them you know because I think oh God I am a bit young. My boyfriend, I didn't feel that right to talk to him. I really honestly didn't know him all that well, and my parents I didn't feel alright to talk to them, so at that stage I did feel I needed to talk to someone (outside the family). I couldn't talk to teachers. In a catholic school you have to be married before you can have sex. It's just not sex for the sake of sex; it has to be sex for the sake of having a child you know. You couldn't even mention that in our school you know'.

On the whole, respondents had come into contact with a fairly wide range of services such as family planning clinics, teenage antenatal clinics, voluntary social services organizations and statutory social service agencies. They were generally satisfied with the services that they had received, and for the most part, their experiences of interaction with professionals. (19 respondents expressed satisfaction with their experiences of receiving services from professionals).

The teenage antenatal clinics of Kings College and St. Georges hospitals enjoyed a high level of approval among those respondents who had used their services. For those respondents who had not had the opportunity to attend a specialist teenage pregnancy clinic, the general feeling was that they often felt uncomfortable in the usual antenatal clinic with a majority of older women in attendance, and would have preferred to attend a specialist clinic. When asked about her experiences of attending the Kings College Hospital Teenage Pregnancy Clinic, this respondent was full of enthusiasm when she said:

'lovely, lovely, before I had kids I was told not to have the baby at Kings, but I found that Kings was fine. The Bessemer Clinic was wicked man because they are so friendly. They know that you are young but they don't put you down. They just explain to you that now that you have had your first, it's better for you to go to college to help yourself, so they were fine'.

The voluntary social work agencies like Newpin and Welcare were singled out for special praise by those respondents who had benefited from their services, in particular, their group work services, which they found helpful in supporting them to cope with the challenges of being young single parents.

Midwives in other clinics attracted their share of praise as well. This respondent informed me that:

'the team of midwives were really nice and friendly and helpful, and they always spoke to me in a polite manner. And when I was in labour they were really good in helping me along, telling me how to cope with the pain'.

In relation to respondents experiences with social services, this respondent who had spent many years in care stated:

'I have been very lucky with social services. I have had very good experiences with social workers. There is only one that I couldn't stand. She drove me up the wall. I have been very lucky with the social workers I have had, they have always stood by me. They have always tried to understand. Never quite understood, but always tried which is a start'.

The next quote shows just how important it is for pregnant teenagers and teenage mums to continue to receive support until it is felt that they are now fully able to cope. For some respondents, this is particularly important where parental support is lacking. For example, this respondent, although generally satisfied with her social worker, still felt she could have been a little more supportive, when she remarked:

'I don't see the social worker anymore after my schooling finished, because everything seem to be fine between me and my mum and dad. But I think they could have done a lot more in terms of what are you going to do now Z now that you have had the baby. You still have an education to get. There was no encouragement. I needed a kick up the backside, but I didn't get that'.

All was redeemed however when she later said:

'When I took out an injunction against my boyfriend, the judge was concerned about the effect on S (her daughter), so I got a new social worker and he was excellent. He was really brilliant. He opened my eyes and let me see what a fool I have been. That is why I broke free completely. He helped me to get back into school. Got back into the 6th form. He helped me to get a child minder'.

Unfortunately, not all respondents were as fortunate in their encounter with professionals. 9 respondents provided examples of negative experiences of their interactions with professionals. The next respondent's account of her experiences of doctors and nurses in the antenatal clinic and on the labour ward was not an isolated account. Other respondents, fortunately a very small minority, have also reported similar experiences. Of her experiences she stated:

'Very bad. I was young and they were taking the mickey out of me. I didn't like them, none of them. As soon as I go to the doctors they used to say oh you are too young to have a baby, you are a child. I know that, so I didn't want to hear that. That time I didn't have a mouth to talk so sometimes I didn't want to go to the doctors. And the labour time as well, once when I was in labour they were arguing with me that I was not in labour

when I was. They said you are too young to have kids. I said I have two more at home and they started laughing at me, asking if I am sure they are mine. I felt bad'.

Another respondent who had had three pregnancies and who at the time of the interview was still unsure about the most appropriate method of contraceptives for her, spoke about her experiences when she attended the Family Planning clinic for the first time when she first became sexually active. These experiences as we will see, alienated her from the very professionals that she needed to interact with in a positive light, as she informed me:

'I went to a Family Planning clinic once, they just seemed to be really out of date, you shouldn't really be having sex at this age but, you know, putting you down straight away and then carrying on with the conversation. It made me feel even worse, like I was doing something wrong, so it made me want to keep it to myself even more'.

It is important that professionals hear these respondents' accounts of their experiences. Professionals do a very difficult job, often with limited resources and therefore positive feedback is important, but so too is the negative feedback such as the feedback provided immediately above. It is of crucial importance that pregnant teenagers are given all the support and encouragement they can, particularly at the antenatal stage when they are often very vulnerable. Unprofessional behaviour on the part of staff such as that reported above is most certainly alienating.

Also worthy of note, is the fact that there were two respondents who reported that they were wary of approaching professionals and agencies for help even if needed. These feelings were based on second hand accounts of other people's negative experiences with professionals and not on their own experiences. Nevertheless at such a difficult stage in the lives of pregnant teenagers, this element of suspicion among some young people has to be acknowledged and every effort made to counter this as much as possible. This means that attempts in publicizing the much needed services of various professionals in a variety of settings need to be coordinated and on-going in order to ensure that vulnerable teenagers in need of such services are aware of their existences and will feel confident in accessing them.

Knowledge of HIV & AIDS

It is now over a decade since the world first became aware of the existence of HIV & AIDS. Although some of us may have developed an unfortunate level of complacency about this deadly phenomenon, as the yearly statistics continue to show, the tragedy of HIV & AIDS becomes even more evident and urgent as the infection continues to spread in frightening proportions particularly among young people (Alcorn, 2000; PHLS, 2000). Given the fact that the practice of unprotected sex can make teenagers vulnerable to both teenage pregnancy and sexually transmitted diseases, HIV infection being the most deadly, it was important to also touch briefly on the respondents' understanding of HIV & AIDS transmission factors and prevention strategies during this study.

It was particularly worrying to discover evidence from the interviews which clearly suggests that young sexually active teenagers still have limited and inadequate knowledge of HIV & AIDS, and that misinformation and misconceptions still abound in worrying proportions. Similar to the Caribbean sample, there were also marked differences between respondents' stated knowledge and their real understanding of transmission factors and issues. Only 1 respondent out of the sample of 26 could be said to have adequate knowledge of HIV infection transmission factors and of AIDS. The response **'I don't know a lot'** was a fairly typical response from respondents in relation to HIV & AIDS, and the views of the respondents cited below certainly paint a very disturbing picture.

This 18 year old respondents in a matter of fact way simply said, 'young people don't think about preventing HIV. You don't think, you really don't. I don't really know about HIV and all of that. You got nothing in school'.

Another respondent stated, 'I can't remember it being included at school. I don't know a lot about it. I don't know nothing at all really, only that it is a sexually transmitted disease, that's it'.

The fact that she cannot remember it being covered at school gives even more credence to her next point, when she remarked, 'if it was spoken about, it couldn't have been in much detail, otherwise, I would have remembered something'.

The lack of knowledge and understanding of the issues was evident when this respondent aged 20 confidently stated, 'I know a lot, you can get HIV when you sleep with too many people'.

Similarly, this 19-year-old respondent remarked:

'I only know what I was told. I have the books but I don't really read them, because to me only when you sleep out and you have different boyfriends, and your boyfriend has different, different girls, to me that's the only time you can really catch it'.

Her next point shows a marked similarity to a frequent practice among Caribbean respondents, the practice of what I had termed in the Caribbean chapter as the **check-up** approach where respondents developed the practice of relying on frequent HIV tests rather than prevention strategies to give them peace of mind if they felt their partner was being unfaithful. She explained:

'I haven't really thought about HIV and AIDS and because I have always had general check-ups anyway. At certain times after I have had sex with him, I give it about two months and I go to the clinic to be checked out'.

The notions of transmission only linked to sleeping with **'too many people'** or **'the wrong person'** were also typical of the views of many respondents. These two concepts of HIV transmission are clearly represented in the views of the next respondent aged 19 when she stated:

'I don't know a lot. Having sex with the wrong person you can catch it. I started to worry about HIV when there was a time that I thought I had HIV. I was having dreams and scares about HIV. I had a blood test and was so scared to go for the results. When I became pregnant I panicked, what if I am infected? I realized that the guys I slept with and had unprotected sex I was being really careless. I realize that I have to settle down'.

The concept of HIV being a respecter of persons who are perceived to be **'nice and clean'** was another point of view that many respondents held. This is evident from the quote from this 17-year-old respondent who began by saying: 'I know the ways that you can get it'. She then proceeded to provide some good examples. However her next statement led me to question the true extent of her understanding when she remarked that she was:

'not worried about my recent partner because he is a nice, clean boy'. Her definition of 'nice, clean' was derived from the fact that prior to their relationship, her boyfriend

had had a long-term sexual relationship for six years and 'I don't think he slept about either'.

What all of these quotes show is the fact that although most respondents had some fairly basic factual knowledge about HIV transmission, however the extent of their levels of understanding, and of misconception and misinformation proved to be a significant factor in reducing the effectiveness of that knowledge, in terms of translating this knowledge into safer practices.

There is also an element of complacency in the approach of some respondents towards HIV & AIDS. In addition to this 18 year old respondent saying that she didn't know very much about HIV & AIDS as it wasn't covered at school, she went on to say that she had read a leaflet she was given while she was pregnant, 'but I am not interested in it. I can't say I won't catch it, but during the pregnancy they would have told me if I was positive'.

The evidence from these interviews points to the fact that schools appear to be failing in taking on a consistent health promotion role in the fight against HIV & AIDS, as previous quotes have shown and the next quote will show. For example, in reference to how much knowledge this respondent had in relation to HIV & AIDS, the response was:

'Not a lot. I am not quite sure what it does to you. I know it breaks down your immune system and stuff. Not very much was covered at school. You see they briefly had one or two lessons about STDs.....and AIDS came into it, but not very much.....there wasn't a set time for AIDS'.

In view of the numerous and complex emotional and personal factors that get in the way of assimilation and understanding of knowledge about HIV transmission and AIDS, information about HIV & AIDS cannot be taught as a one off session. Research has shown quite clearly that on average individuals have to hear information about HIV & AIDS at least five times before it begins to sink in because of those personal and emotional factors referred to above which interfere with the assimilation of information. This means that this information has to be provided on a consistent basis in a way that encourages meaningful dialogue to facilitate understanding, as well as to clarify misconceptions and misunderstandings, before young people will be able to confidently apply that knowledge to safer practices.

Experiences at school

As the characteristics of the sample show, the average age of first pregnancy was 15 years. This means that the majority of the respondents were at school at the time of their first pregnancy. However, the level of school dropout seen among the Caribbean respondents was not evident in this sample, though 2 respondents were not encouraged to return to school. For example, this respondent reported that:

'One of them (teachers) was very, very rude. My headteacher didn't want me there because I asked if I could wear leggings because my belly was growing and my school trousers were getting too tight. And I can't remember his exact words but what it meant was it would look too obvious, I would look pregnant, now I still wanted to get my education, but I couldn't because I couldn't wear the trousers that they wanted me to wear'.

In another instance it was a case of pregnancy being treated by the head of the school as if it were contagious and the image of the school came before the young woman's education and future. As this respondent explained:

'My headmistress was very snobbish and she said I had to leave and go somewhere else, so I did that and I went to another school part-time and I did my course work and everything and I went back and done my GCSEs afterwards, but she then pretended that there was no problem, she didn't ask me to leave or anything, but when my mum said about getting governors involved, it was a totally different story. It was all come back, very nice. The rest of them (teachers) were understanding about things and I only went back part-time. Two other girls fell pregnant after me and it was like see what you've done sort of thing. It was not nice'.

Fortunately however most respondents reported that once they had informed their teachers of their pregnancies, in most cases teachers were supportive.

There is some evidence from this study which points to a link between failure to do well or feeling alienated from school and teenage pregnancies. For example, one respondent had already left school just prior to her pregnancy. She had however, taken 4 GCSEs before her departure and was successful in all four subjects, nevertheless she felt she could have done much better but she 'was always in trouble and hated school' and could not wait to leave school.

Three other respondents reported that they also did not like school and were always in trouble, therefore it was not surprising that the pregnancy played a substitute role

in their lives, when they became pregnant the decision to leave school was like a wish that had come true. As this respondent explained:

'I didn't like school, I didn't get on with anyone there. I was always in trouble, so I didn't really go. I never enjoyed being at secondary school one bit. So I didn't go back when I found out (about the pregnancy) and decided I was keeping the baby'. When asked if there were any regrets about not going back, she replied 'No, that was the best thing that ever happened to me'.

Her next remarks proved however, the need to explore fully the roots of school phobia, because as she proved, her dislike of school was not related to a lack of interest in education, but more to her dislike of the particular school environment in which she was placed. She reported that since leaving school and having the baby she returned her attention to the business of learning. She informed me that, 'after I had the baby I go to a centre and I am doing my GCSEs'. And her reasons for hating school before? 'It was just the school I went to. I went to S girls' school and that was just like you are fighting for your life in that school and I didn't like it'.

At times the reasons for not liking school did not always lie at the door of the school but as a result of past or current emotional, sexual or physical abuse that the respondents had experienced, and in some cases were still experiencing during the times that they were enrolled at school. In this regard, the school became a focus for their anger and unexpressed emotions. As this 20-year-old respondent who had been physically abused by her father explained why she hated school at the time by saying:

'I was in my own little world then. Because people were telling me what to do, I hated people telling me what to do. I wouldn't listen to me mum. I would be out all night, and she would have the police out looking for me. But that's because I wanted to be at home with me mum, but I didn't want to be at home with me dad because of what he done to me. I just didn't like school. I hated it. I still resent him for what he did to me. I haven't spoken to him for seven years'.

The majority of respondents however, reported that they had enjoyed their school experiences. Those respondents who had enjoyed being at school proved that an early pregnancy or pregnancies does not have to mean the end of a young woman's educational experiences. These are examples well worth bearing in mind by schools that opt for the easy option of excluding a young woman from school because of early pregnancy. For example, this respondent had just finished her exams when she

found out that she was a pregnant –9 subjects at GCSEs. She reported that 'school was good. I wish I could go back'. Another respondent was determined to stay on at school and take her GCSEs when she discovered that she was pregnant. As a result she would not run the risk of being asked to leave because of the pregnancy, therefore she 'kept it (her pregnancy) a secret from everyone but one person which is my best friend at school'. Her plan and determination worked because she went on to gain 9 passes at GCSEs with grades A-C. Her love for education continued even when she went on to have a repeat pregnancy and enrolled for A'level courses.

CHAPTER SIX

Repeat teenage pregnancies-the meanings ascribed by teenagers in two cultures

Introduction

This final chapter has several objectives - to explore the similarities and differences between the London and the Caribbean findings and to evaluate the significance of these similarities and differences, by highlighting specific aspects of the characteristics of the samples and specific themes where these similarities and differences are particularly marked. The chapter will revisit the research questions raised in the first chapter. (1) Why do young women have repeat pregnancies despite the difficulties often inherent in a first teen pregnancy and what are the meanings that they ascribe to these pregnancies? (2) What are the links between teenage pregnancies and the development of a culture of welfare dependency?

Many powerful emotions and feelings derived from a variety of losses, deprivation and neglect, which are linked to the respondents' experiences of having abortions, stillbirths, neonatal deaths, physical, sexual and emotional abuses, have been expressed by both sets of respondents in this study. In order to attempt to develop a deeper understanding of these feelings, emotions and actions, it is necessary to turn to the theoretical literature for further sources of illumination. This chapter will therefore include a discussion of the theories of bereavement and loss and the theories of attachment as they relate to this study.

Before addressing the above issues, the chapter will begin with a brief look at my experience of carrying out the research. It will also revisit certain aspects of the methodological approach and the aims and objectives of the study. Finally, in keeping with a feminist approach as discussed in the methods chapter, the knowledge gained from the women's life stories should be used to provide greater insights into the helping processes and strategies of various professionals. The chapter will therefore conclude by exploring the implications of the findings for policy development and practice with the making of recommendations arising out of the findings.

The experience of carrying out these interviews proved to be a very exciting, enlightening and humbling experience for me. Throughout the data collection process it became increasingly apparent that in attempting to make sense of their experiences and in ascribing meanings to their pregnancies, the respondents had devoted a great deal of energy and thought to exploring and evaluating their experiences. This culminated in a narrative of their own lived and felt experiences. This was very evident from the rich and illuminating quality of the data provided. This process, I would argue, is a validation of the appropriateness of the paradigmatic frameworks that have influenced the approach to the study. It is also a clear indication of congruence between the method of data collection employed and the aims and objectives of this study.

The data collection approach was effective in bringing to the fore a wide range of complex, underlying emotional and psychological issues that the use of standardized questionnaires would not have uncovered. This was summed up very well by one respondent who commented at the end of the interview that she valued the interview process because, **'you see teenagers talking about their experiences on telly, they are asked a question and they answer, but often the answers do not tell you about what is underneath, they just touch the surface, and no one asks further questions to understand'**.

As a result of utilizing the combination of methodological approaches discussed in chapter three, the objective of giving the young women a voice was fully met. This is a very important aspect of this research, because it also meant that the spontaneous themes which emerged during the data collection process, arose directly out of the young women's accounts of their experiences, as opposed to the imposition of my own prior construction of categories. This imposition would have been contrary to the aims and objectives of this study discussed in the first chapter. In addition, the evidence from the findings also clearly suggests that in the process of ascribing meanings, the young women did gain considerable insight into their lives. There was evidence also that they were using these insights to begin or continue the process of reshaping their lives. In this respect, it was therefore a process of discovery for me as well as for the respondents.

Revisiting questions of generalizability, reliability and validity

In revisiting the above questions, my intention here is not to repeat issues in respect of the above which were addressed quite comprehensively in the methods chapter, but rather to extricate certain factors from the evidence to complement the points already made in that chapter. In particular, I wish to return to two principles in relation to the question of generalization, these are, the principles of '**completeness**' and '**similarity and dissimilarity**'. In conducting the interviews and later in analyzing the data, I felt increasingly confident that the views expressed by these respondents in London and the Caribbean were genuine accounts of their experiences. In Addition, the same themes emerged, time after time, by respondent after respondent in London, irrespective of their geographical location, age or ethnic differences, and in the Caribbean regardless of the age differences, or whether they were living in Jamaica or Barbados. This awareness added to a sense of completeness – a feeling that there would be little else to learn from conducting interviews on a larger scale. I would therefore argue that these findings could be generalized to a larger population.

The similarity of themes in London and the Caribbean such as **loss, views about abortion, the role of sex in the lives of the respondents, goal orientation, knowledge and use of contraceptives, sex education, the role of government in preventing unwanted teenage pregnancies and HIV & AIDS** was also quite remarkable. This similarity gives added weight to the causal nature of the findings. Where there were differences between the two sets of respondents in relation to emerging themes, these could be explained in terms of differences in the socio-economic realities of the two regions. These differences do have important policy implications for working both with pregnant teenagers and in the prevention of teenage pregnancies. In all these respects, the comparative element of this research has served to strengthen the case for validity and generalization. These factors have further served to increase my confidence that the views expressed by the respondents are authentic accounts of their own lived and felt experiences. Other factors have also contributed to this level of confidence. For example, during the interview process, observations and initial conclusions that I made on the basis of information provided by the respondents were repeatedly checked out with the respondents. This was to ensure that any conclusions drawn from the information

received, was received and understood in the ways that it was intended to be received and understood by the respondents.

Nevertheless there is one limitation in relation to some aspects of the findings that has to be acknowledged, and the reader needs to bear this in mind when the findings are evaluated. This limitation mainly relates to the fact that in view of the non-longitudinal nature of this study, certain themes have to be viewed within that context. This is particularly in relation to the respondents' approach to parenting and future outcomes in achieving goals. At the time of carrying out the interviews all indications suggest that the majority of these young women were coping well with their pregnancies and their parental responsibilities, however one cannot predict with any degree of certainty how they will fare in the future. The same caution does not apply however to evaluating the findings in relation to the reasons for repeat pregnancy and the meanings that these young women ascribe to their pregnancies. In spite of any changes in circumstances that may occur in the future for these young women, these future changes cannot detract from their reasons for repeat pregnancies at the time of conception, or the meanings that they ascribed to their pregnancies in relation to those reasons.

Similarities and differences in relation to the characteristics of the samples

On the whole the characteristics of both sets of samples were fairly similar in the sense that there were no marked differences in relation to certain characteristics like the age of the respondents, number of pregnancies among respondents, planned and unplanned pregnancies, age at first sexual activity, pattern of repeat pregnancies and marital status. This degree of similarity gives further credibility to the argument for validity. There were however, two marked differences that need to be explained:

1. Differences in educational achievement and outlook between the two samples

A number of factors could be said to account for these differences:

1.1 Many Caribbean respondents reported that their attendance at school was often always affected by lack of money for basic necessities such as lunch money and bus fares. This was not the case for the London respondents because of the higher standard of living in England and the availability of state benefits for families in need. Consequently, better school attendance increases the chances of obtaining higher levels of academic and vocational achievements.

1.2 There was an overall lower incidence in London of teachers refusing to allow the young women to return to school following teen pregnancies than was the case in the Caribbean. Therefore one could argue that in relative terms, a teen pregnancy in London stands less of a chance of adversely affecting a young woman's educational achievements than is generally the case in the Caribbean. As I have argued in chapter one, school dropout has particularly adverse social and economic implications for Caribbean societies. It is therefore important to spend some time commenting on the circumstances surrounding school dropout in the Caribbean before moving on to the next point.

My own professional experience from working with pregnant teenagers in the Caribbean makes it possible for me to be able to validate the young women's accounts of not being allowed to return to school after becoming pregnant. Many heads of schools simply refused to entertain any discussion about the young girls' return to school. In some cases, these young women were treated as if they had acquired some deadly infectious disease, which would spread rapidly to other pupils, if they were allowed through the school gates. With the exception of the possibility of some respondents attending the Women's Centre in Jamaica (see chapter 3), there was no other alternative provision for those girls who were asked to leave. Many of the young women felt that while they cannot lay all the blame at the school's door for a repeat pregnancy, had the school been more receptive and supportive towards them, they might have been able to prevent a subsequent pregnancy.

Given this closed-door response of many schools, particularly in the Caribbean, it is not too difficult to understand why the prospect of a second pregnancy would become an attractive possibility, particularly if there is a definite promise of financial support and 'love' as substitute rewards. I want to make it clear that this is not an

attack on all schools. I am also aware of many heads of schools who have been very encouraging to young girls following teenage pregnancy. These schools have allowed young pregnant girls to remain at school, in some cases during the pregnancies, for as long as it is feasible to do so, and after the birth of their babies.

Many respondents simply did not return to school because there was no one to take care of the baby after it was born. If the young women were living in single parent households, in many instances the maternal grandmothers were the sole providers for the family, and were therefore forced to work outside the home and could not provide childcare support. The characteristics of the sample show that these families were not financially well off and therefore could in no way afford to pay for day care facilities. This respondent sums up the circumstances of many other respondents when she explained, 'After I had my baby, I didn't have anybody to keep the baby, so I said let me stop home and care for the baby'.

Financial difficulties also played a part in the curtailment of education in other respects. This was particularly marked in Jamaica, where many respondents cited the fact that their parents could not afford school fees, books and lunch money on a consistent basis, as the main reason for school dropout. These financial difficulties in many instances started some time before the first pregnancy and continued with the advent of the repeat pregnancy. Taking all of these issues into consideration, the end result is that the Caribbean respondents, though full of hope for their futures and certainly not lacking in goal orientation, had far fewer avenues open to them to continue their education and to realize their educational goals.

1.3. The literature review chapter outlined the difficulties in relation to limited and inadequate provision for the education of pregnant teenagers (Dawson, 1989, 1996, 1997). Nevertheless, the existing provision, including out of school educational provisions, though limited, still increases the possibility for a young woman to continue in education after the birth of her baby. All of these factors mean that, there are more chances of the London respondents being prepared for and allowed to take their exams after they become pregnant. If they were unable to take these exams before leaving school, there are more opportunities to allow them to take these exams at a later date.

2. Accommodation

The vast differences in the accommodation facilities between the two sets of respondents are worthy of note in this chapter because of the different implications for each group. The lack of, or scarcity of state housing provision in the Caribbean, meant that many of these young women lacked security about the stability of their living arrangements. This lack of security has a distinct connection with the **journey of search** and ultimately with repeated pregnancies, as it often translates into lack of power that comes from the actual or perceived realities of having to rely on others for accommodation. When this reliance is on the putative father or future boyfriends, the power to make choices like saying no to unprotected sex or no to having other babies, becomes considerably weakened.

In contrasting this situation with the realities for the London respondents in terms of housing, the importance of the availability of housing provision for teenage mothers becomes even more crucial, as it makes them less reliant on the men in their lives to influence their choices adversely.

Similarities in themes between the London and the Caribbean findings

The loss factor

In view of the predominance of this finding in both London and the Caribbean, a link between loss and repeat pregnancies has been clearly established in this research. The concept of loss is not new, what is new however, is our awareness of the extent to which these experiences of loss brought on by the loss of a baby, or various forms of unnoticed loss, impact on the compelling desire for a teenager to repeat a pregnancy. One contributory factor to the findings in relation to loss, relates to the fact that unlike other studies of repeat pregnancies reviewed in chapter two, this study did not restrict its sample to teenagers who have had a first live birth. This made it possible to discover and evaluate the link between the experience of having a stillbirth, neonatal death or abortion and repeat pregnancy. These findings have convincingly demonstrated the extent to which we have underestimated the powerful

emotional and social impact of loss, which occurs after a young woman has terminated a pregnancy, or where the pregnancy has ended because of stillbirth and neonatal death. We have seen from the evidence that the emotions and feelings generated from this experience of loss is a powerful determining factor on the desire to have a repeat pregnancy, in an attempt to cope with the myriad of powerful feelings and the compelling need to fill the emotional void created by the loss. I must admit that the strength of these feelings and their link with repeat pregnancies came as a genuine surprise, even in spite of the fact that I have worked with pregnant teenagers for many years. The fact that this theme emerged in almost identical proportions for both sets of respondents, despite their different geographical locations and socio-economic circumstances cannot be dismissed as coincidence. In addition, the evidence derived from the voices of the respondents where they have in many instances, by their own admission, attributed their repeat pregnancies to their experiences of loss, also gives added weight to this finding.

In trying to explain this phenomenon, there is no underestimating the distinct possibility that society's ambivalent views regarding abortions have in some ways contributed to the strength of feelings of loss felt by the respondents who have had an abortion. However, these feelings and emotions were also experienced with the same degree of intensity by those young women who have lost a baby as a result of stillbirth, neonatal death or as a result of a child being removed from its mother immediately after birth. This suggests that these feelings derive their strength and intensity more from their connections with the young women's very strong feelings about their ability to reproduce, and the extent to which they believe in the importance of the concept of **motherhood and fertility**, rather than as a result of purely external societal influences. One may then ask, if these feelings of loss are to a certain extent inevitable and are likely to result in repeat pregnancies, is it not the case then that the inevitability of repeat pregnancies under such circumstances makes it pointless to try to work towards reducing multiple pregnancies in young people who have had such experiences? It has to be acknowledged that there may be some credence to this argument. This is particularly true in relation to those instances where we have seen respondents go through repeat pregnancy after repeat pregnancy (in cases of multiple miscarriages) in an attempt to quell that powerful urge to replace that which has been lost. However, we have also seen from

the evidence that respondents have indicated the need for adequate counselling before an abortion to prepare them for such feelings. They have also expressed the need for counselling after the abortion, to help them come to terms with the powerful feelings that occur after the event.

This suggests that this counselling is vital in order to help these young women to cope with the all-consuming and compelling emotions of the kind described in the last two chapters. The importance of counselling has been well documented in the numerous research and clinical studies which show conclusively the need for adequate pre and post counselling in cases of abortion, stillbirth and neonatal deaths (Dana, 1982; Stringham, Riley and Ross 1982; Clarke, 1989). In addition, feelings of loss have also been generated after a baby has been removed from its mother under the circumstances outlined in the previous chapter. We therefore, need to add reception into care to this list of those young women who need counselling. In these instances, identifying and responding to loss as a possible predictor of repeat pregnancies would alert professionals to the need for adequate validation and exploration of the feelings following the loss.

In none of those examples cited in the findings and also in those not cited, did the respondents have counselling. All except one respondent, who was supported by a close-knit family network, indicated that they would have welcomed this opportunity. Their responses to the opportunities that the interviews provided to express their pain were an added indication of their need for counselling. Whether counselling would have been successful in reducing this very compelling urge to repeat a pregnancy in order to fill a void, cannot be predicted with any degree of certainty. What is clear is that leaving these young women with no avenues for expressing their feelings is very likely to lead to a repeat pregnancy.

The subject of abortion needs special mention in this regard. The information obtained from the interviews, and from my own previous experience of counselling young girls seeking abortions, shows that quite often a young girl has an abortion as a result of either actual or perceived pressure from others do so, in order that she can 'get on with her life'. This view is also validated by evidence from other research studies. For example, Corlyon and McGuire's (1997) research on 'pregnancy and

parenthood among young people looked after by local authorities' also reported that 'considerable pressure was allegedly put on young women to have a termination. This came predominantly from parents, carers and group workers, and, to a lesser extent, from social workers'. At this stage I want to make it clear that I am not advocating an anti-abortion perspective, as I believe in a woman's fundamental right to choose whether or not to end her pregnancy. What I am advocating is that when a young girl becomes pregnant for the first time, that she is not pressured into having an abortion. This is particularly important in view of the very strong anti-abortion views, which these young women hold. These strong views about abortion have also been reported by other studies (Moore and Rosenthal 1993; Corlyon & McGuire 1997). In all of these studies the views were so all pervasive that it led Corlyon & McGuire (1997:64) to emphasize the fact that 'these views were not considered responses for the benefit of the interview, but firmly held beliefs'. Therefore, instead of pressure to terminate her pregnancy, she should be given adequate non-directional opportunity to explore her feelings, both prior to, and after the abortion for those who decide to have an abortion, in order to make, or not make this decision.

This view challenges certain commonplace notions about what is often viewed as the best course of action for a young woman when she becomes pregnant for the first time. It would appear from the evidence provided in this study that pressure or advice to have a pregnancy terminated in order for the young girl to get on with her life may not be so prudent in the long run. Instead, it may be far more productive, where a young woman is very clear that she wants to go ahead with her pregnancy, for all concerned to respect and accept this decision. Where this is the case, support needs to be provided from schools, parents, social agencies during and after her pregnancy, in order to create a more realistic opportunity for her to 'get on with her life' after the birth of the baby. This is opposed to undue pressure to terminate which as we have seen from the evidence in this study, so often leads to a deep sense of loss and a compulsion to replace that which has been lost.

This argument is strengthened by evidence from other research studies which suggests that when a young woman obtains the right kind of support, she can go on to overcome the adverse affects of early pregnancy (Jones et al 1985; Trussell 1988). One way of getting away from the temptation to dictate what action a young

girl should take on discovering that she is pregnant, is to rethink the notion of 'unwanted pregnancies' portrayed in other research studies. This means that observers should not readily make the assumption that the pregnancy is unwanted. It may very well be the case as stated before that the pregnancy is 'mistimed' or 'unintended' but certainly not always unwanted. As one respondent so insightfully pointed out, '**children are getting older a lot younger**', consequently, however young a girl appears to be in terms of chronological age and maturity when she first becomes pregnant, her views and wishes should be taken into account in relation to the outcome of her pregnancy. The deliberate lengths that some respondents who have been pressured into having an unwanted termination will go, in order to conceal a second pregnancy to avoid being pressured into a second termination, give added weight to this argument.

The evidence from both sets of respondents also places stress on the need for acknowledgement of any **unnoticed loss factors**, which may be linked either directly or indirectly to teenage pregnancies. In addition to this acknowledgement, there is also the need for counselling and support in cases of **unnoticed loss** generated by years of various forms of abuse and parental neglect. The respondents themselves, who had experienced these forms of abuse, made it clear, that they would have valued counselling. Therefore, these situations and experiences require the same degree of support as those who have experienced the more commonly recognized and accepted **apparent losses**. These **unnoticed losses**, as have been so vividly portrayed by the evidence, often lead some young women to begin a **journey of search** which results in being caught in a vicious cycle of deprivation, dependency, poverty, a repeated cycle of sexual and physical abuse and unintended or mistimed pregnancies. Without the opportunity, facilitation, time and space to reflect and understand the reasons for their pain and grieve appropriately, these young women succumb to the overwhelming need to dull their pain in whatever way that seems feasible at the time. This is often without the benefit of insight to understand and evaluate the impact of those actions until it is too late. In order to understand these feelings, emotions and actions of the young women more fully, I will now turn to the relevant theoretical literature for further sources of illumination.

Theoretical considerations

In view of the nature of the theme of loss in its various forms that have emerged from this study, two theoretical paradigms are of particular relevance to this study. The first are the theories and concepts of bereavement, loss and grief. The second relates to the theories of attachment derived from studies of attachment development and behaviour in infants. This section will now briefly look at the contribution of these theories to our understanding of the themes of loss in its various forms that emerged from this study, beginning with theories of bereavement and loss.

Understanding loss

A number of descriptive theories of bereavement and loss have been developed which attempt to explain how most people typically react to loss. They present different stages or phases to describe the experiences of people who are bereaved. Although these theories originated from attempts to explain the emotional responses of people who are dying and bereaved, their application is increasingly being widened to include the experiences of individuals experiencing other forms of loss. They are therefore quite relevant in helping us to make sense of, and validate the emotional responses of a significant number of respondents in this study. The earlier theories of loss (Kubler-Ross, 1969; Murray Parkes, 1972) have been subjected to considerable debate and controversies during the last decade. As a consequence, many alternative theoretical approaches of the manifestation of bereavement and grief have been suggested (Raphael 1983; Stroebe et al 1993; Walter 1994 & 1996). Later in this section, the contribution of Stroebe et al's work to our understanding of loss, particularly in relation to this study will be addressed. I will begin by drawing on two of the earliest and most well-known models of reactions to loss and death that I find to be particularly relevant to the nature of loss expressed in this study. The first was put forward by Kubler-Ross (1969) who categorised the experiences of the dying and bereaved into five stages, which she sees as defence or coping mechanisms to deal with loss. These stages are denial, anger, bargaining, depression and acceptance. The second model was developed by Parkes (1972) who also described a stages theory. These stages are alarm, searching, mitigation, anger, guilt and gaining a new identity. Similarly, others like (Speck 1978) identified three distinct

phases of shock and disbelief, developing awareness and resolution. From these theories it would appear that the responses to loss do follow a particular pattern of varied emotional manifestations and feelings. They also suggest that the adjustment to loss requires the individual to go through a process which facilitates the gradual accommodation to the changed realities of that individual's life.

At a glance, these stages and phases theories suggest a linear progression of experiences and emotions that the bereaved person goes through, and indeed this is one of the criticisms that has often been levied at them. For example, Corr (1993) argues that a stage model, in which an individual proceeds in a linear fashion from one stage to the next, has not been supported by subsequent research. He further argues that this type of model is a generalization from the experiences of some individuals, and as such does not represent the range of emotions and ways of expressing grief that exists among various individuals and cultures. As a consequence, these stage models should not be interpreted in a rigid and prescriptive way. It is important to bear in mind however, that both Kubler-Ross and Parkes have stated that these stages may not follow a clear order and at times oscillation between stages may occur. This oscillation was apparent in my own study when some respondents spoke about being plagued with feelings of guilt, just as they thought that they were coming to terms with the baby that they had lost. This gives added weight to the experiences of practitioners working with people experiencing loss, that the progression through stages as implied by these theories is never the same for any two people. Boundaries between stages can overlap and people can also move back and forth between stages. Perhaps a more realistic approach then, is to view these manifestations of loss, not in terms of stages, but in terms of reactions to loss and part of the normal grieving process.

Despite these observations, what these theories all have in common is their contribution in helping us to understand and validate the experiences of those experiencing loss. In the context of this study, applying knowledge of the grieving process, not only to those who are dying and bereaved, but also to other types of 'unnoticed loss', has helped to give meaning to the range of emotions and manifestations of loss expressed by these respondents. Furthermore, this application of knowledge also helps us to view the respondents' expressions of emotions as

normal reactions to their experiences of loss. These points are supported by Parkes (1996) in a later study, when he identified 'comparable features' of his stages theory responses to bereavement that were 'discernible in the reactions' of those experiencing other forms of loss. In chapters four and five I highlighted the cases of 'apparent' and 'unnoticed' losses and it is clear that the expressions of feelings and emotions such as guilt, anger, ambivalence, shock and disbelief, and depression were all present to varying degrees. In addition to understanding the feelings and emotions expressed by the respondents, these theories also provide a framework for us to make sense of some of the deeper conflicts involved in their experiences. For example, we saw evidence of the specific 'search' component, which is such an inherent feature of grief. This was described by Parkes (1996:200) as 'an urge to search for and to find the lost person in some form', convincingly displayed in the expressed actions of these respondents, as they sought to replace a lost child by repeating a pregnancy. Marris (1986:23) argues that 'of all the changes which beset a lifetime, bereavement is characteristically the change that we are least prepared for, and the hardest to accept'. Viewed within this context, it is understandable that the urge to search for, and find a replacement for loss therefore becomes a logical course of action for these respondents. This search component was also particularly evident in the endless quest to find fulfilment and meanings as depicted by the journey of search for Caribbean respondents. It was also evident in the compelling need to fill the void created by experiences of stillbirth, abortions, neonatal deaths and emotional neglect for a substantial number of respondents from London and the Caribbean.

These emotional symptoms of loss experienced and expressed by these respondents are typical of the reactions to grief, as they have been systematically observed and presented in the stages and phases theories of Kubler-Ross, Parkes and Speck. However, more recent theories of loss such as the 'dual process model of coping with loss' (Stroebe and Schut 1998 & 1999), provide an additional dimension to our understanding of the responses to loss adopted by these respondents. This model identifies two categories of feelings or experiences that the bereaved person has to cope with. These are the loss experience itself, and the changes and adjustments that result from the loss. This leads to two orientations - the 'loss orientation' and 'restoration orientation'. In the 'loss orientation' the

bereaved person will focus on what has been lost and also remembers the past, such as the case of those respondents who reported that they were almost always preoccupied with the feelings relating to previous miscarriages, stillbirths or abortions. This loss orientation process also encompasses the emotional responses of the stages and phases theories previously mentioned. However, in its notion of 'restoration orientation', it goes beyond the emotional responses of the 'loss orientation', to also place emphasis on the fact that the bereaved person has to deal with a number of new challenges and carry out new tasks, which have come about as a result of the loss. These challenges and tasks have to be addressed as part of the coping strategy to overcome loss. Undertaking these tasks is an attempt to deal with the present and the future rather than the past. It could be argued that the need to replace a pregnancy as a response to loss, is a form of restoration orientation – a task that has to be accomplished in order to put right what has gone wrong. In the final analysis, both of these orientations incorporate various aspects of the way in which the bereaved assimilate the change in their feelings and experiences following a major loss.

Other contributions from the literature on loss and grief are also relevant to the findings of this study. As we have seen in the preceding two chapters, the experiences of loss articulated by some respondents were related to their experiences of having a stillbirth, neonatal death and abortions. Lovell (1997:27) draws our attention to the fact that because stillbirths, miscarriages and neonatal deaths are not often viewed as "proper" bereavements, they tend to be devalued because there appears to be no person to grieve for.....Thus death at the beginning of life is a neglected area'. Similarly, Stringham et al (1982:322) point out that 'the death of a stillborn baby, as in any loss, requires a period of grieving, but because the baby is seen as a "non-person" and is largely unacknowledged by society, families are often left unsupported in their grief'. This neglect is often evident in the actions of many professionals and members of the public where a web of silence and secrecy often surrounds these deaths (Bourne, (1977 cited in Stringham (1982)). In Moulder's (1990) study of miscarriages, she pointed out that many women frequently complain about the insensitive and neglectful treatment, which they receive from many professionals. These actions on the part of professionals can intensify the negative feelings that follow the experience of a miscarriage (Clarke 1989). It is not surprising therefore, that the majority of these young women were speaking about their experiences and

feelings of loss for the first time, because characteristic of the phenomenon of unnoticed loss, many people often fail to understand the meanings and significance of such losses.

In turning our attention to abortion, Dana (1982) in her work with women who have had abortions, reminds us that abortion is a taboo subject, which is accompanied by the secrecy and silence that is often imposed on women who have had abortions. When this is coupled with feelings of guilt and shame which many women experience following an abortion, it becomes very difficult to express the feelings and emotions which they later experience. This shame is clearly embodied in the words of this respondent when she stated that, in relation to the abortion that she had had, 'me shame to tell the doctor me dash way one'. In addition, as we have seen in chapters four and five, even where the young women were prepared to express their feelings, there were often very few avenues open to them to do so, either within the family and social networks or from their interaction with professionals. It is not surprising then that these unexpressed feelings and emotions led to the need to find other avenues to respond to the loss, through actions that are perceived to bring some form of relief and reparation such as a repeat pregnancy.

In addition, Dana (1982) went on to say that in our day to day lives we often make major decisions that can be reversed or changed. Having an abortion however, is a final, absolute decision that cannot be changed or reversed. This irreversible nature of abortion can make it a frightening and overwhelming experience for many young women. It is therefore conceivable that some of the strong feelings expressed by these respondents could be linked to this irreversibility. Therefore as a consequence, the need to address this by the act of replacement with another pregnancy becomes all consuming, to the extent that these young women will go to various lengths to conceal a second pregnancy in order to fill the void created by the loss.

As we have seen, the lack of opportunities for expression of feelings does not diminish these feelings of grief discussed in the stages and phases theories of bereavement. All of these factors therefore strengthen the argument that appropriate grieving will normally require outlets of expression if bereaved people and those experiencing other forms of loss are to adapt successfully to these life changes.

Attachment

Attachment is of particular relevance to this study because of the debates around early childhood relationships and their impact on later life relationships. A number of respondents have reported experiences indicative of earlier attachment problems. Despite these problems, it would appear from the evidence that they have been making significant efforts to overcome the negative impact of these earlier experiences. I therefore wish to focus on two elements of attachment theory, which are of particular relevance to this study and would therefore help to improve our understanding of these experiences and subsequent attempts by the respondents to overcome these experiences. These are: (1) the link between the quality of early attachment experiences and its impact on an individual's later capacity to (a) form and maintain meaningful, fulfilling and mutually supportive intimate relationships, and (b) to form loving and secure attachments with any children that she may have. (2) the relationship between early adverse attachment experiences and the individual's capacity to overcome these early experiences – resilience. This therefore leaves out many other aspects of attachment theory, but they are not considered relevant to the issues that the study has raised.

Attachment has been described by Bowlby (1988:27) as 'any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world'. Similarly, Ainsworth & Stayton describe attachment as an 'affectional tie that one person or animal forms between himself and another specific one – a tie that binds them together in space and endures over time' (Ainsworth & Stayton, 1991:31). Attachment has been the subject of many disputes surrounding its origins, that is, how attachments are developed. However, despite these disputes, 'there is little doubt that attachment occurs, and that they are prominent features of many children's social environment' (Durkin 1995:81). The need for a child to enter into a loving and nurturing relationship with an adult in order to facilitate the development of a well-adjusted adult later in life is therefore well recognised. There is a school of thought among attachment theorists that the best predictor of future behaviour is past behaviour. For example, Bowlby (1969) hypothesised that early experience ultimately influences the individual's later ability to form attachment to her

own children. This is what is referred to as 'inter-generational transfer' of attachment behaviours – where children later draw on their own experiences or 'internal working models' of relationships with their parents to use as a 'template' for future relationships. 'It is through these internal working models that childhood patterns of attachment are carried through into adult life' (Holmes 1993:81).

However, as Aldgate and Bradley (1999) point out, attachment theory has been subjected to changes in its 'cultural context' since the writings of Bowlby in the 1950s. For example, Ainsworth (1969) built on and refined Bowlby's work and identified three main types of attachment using the 'Strange Situation' experiment, which was developed as a result of attempts to measure patterns of attachment in 1-2 year olds. This was a laboratory experiment in which the interaction between mothers and infants was observed prior to, and during and after a brief separation, when the child is left with a stranger. As a result of these observations, three categories of attachment have been identified. In 'secure attachment', the child actively approaches the parent as she returns. There are also two types of insecure attachments. These are, 'avoidant attachment', where the child is slow to approach the parent when she returns, and 'resistant attachment', depicted by angry and resistant behaviour, following the parent's return. Many reasons have been advanced for insecure attachments. For example, children placed in the category of 'anxious attachment' have been reported to experience rejecting and sometimes hostile interactions with their mothers (Belsky et al, 1984). Infants classified as 'resistant' are often difficult to comfort, they struggle or become rigid when attempts are made to comfort them. These factors make them more difficult to care for, and in turn their mothers may show lack of sensitivity to their needs. Research has also pointed to an association between abused and neglected children and insecure attachments. This abuse can adversely affect the child's later intellectual and socio-emotional development (Ainsworth, 1980; Belsky et al 1984).

This approach to the study of attachment behaviour is not without criticisms. For example, as Barnett (2000:89) argues, in carrying out these tests, it is usual to employ only one stranger. 'If a series of strangers is employed, even in children classified as 'secure', the earlier, less strange 'strangers' tend to evoke much the same response as the parent'. Single measures therefore, cannot reflect the complexities of caregiver – child

relationships even within the same culture. Additionally, in some cultures, an absence of closeness, exemplified by touching and hugging, does not indicate an absence of healthy relationships.

Later research by Main and Solomon, (1986), identified a new pattern of attachment classified as 'disorganized/disoriented attachment', signified by confused and contradictory behaviour towards the parent. Research suggests that this type of attachment seems to be more prevalent in samples of high-risk infants, hence the hypothesis that disorganized attachment is the result of extremely unpredictable behaviour from the person providing care for the child (Main & Hesse 1990). In such cases, parenting behaviour is unpredictable, and fluctuates between providing security and being abusive. This in turn, results in conflicting and confused behaviour from the child as the 'source of security is also the source of fear'. This might help to explain the confusing emotions expressed by some respondents in this study who at times indicated a sense of resentment towards their mothers and at other times expressed feelings of love, and a need to protect and care for an alcoholic mother who neglects and abuses them.

Other researchers have demonstrated the ways in which attachment patterns can be transmitted across generations. The Adult Attachment Interview (AAI) was devised by Main et al (1985), as a tool for assessing the 'inner world' of the parent with respect to their earlier attachment experiences. This interview took the form of a semi-structured psychodynamic interview in which the parent is encouraged to talk about her early attachments, feelings about parents, and to describe significant losses in her life and early childhood traumas. The interview transcripts are then rated and classified into four categories – 'free to evaluate attachment', 'dismissing of attachment', 'enmeshed in attitudes towards attachment', and 'unresolved/disorganized/disorientated attachment'. Several independent studies have demonstrated consistent correlations between the attachment status of infants in the Strange Situation and that of their mothers in the AAI. For example, Fonagy et al, (1991), administered the AAI to prospective parents and found that the results predicted infant attachment status in a Strange Situation at one year with a 70 per cent accuracy. Of insecure infants, 73 per cent were reported to have insecure mothers, and only 20 per cent of secure infants had insecure mothers. These and

other similar findings have been used to support the view that the attachment status is a function of parent-child relationship rather than temperament. Having looked at various attachment theories, I will now move on to further explore the 'intergenerational hypothesis' because of its relevance to this study.

Of importance to this study, is the fact that some early studies have reported that child abuse follows a 'generational pattern', that is a distinct link between the characteristics of those parents who abuse their children and early attachment disorders (Fontana 1973; Steele and Pollack 1968; Steele 1975b). Steele for example, found a pattern of abuse in three generations in some families. In addition, Steele and Pollack, (1968) from an examination of clinical records, reported that their entire sample of 60 parents in their study experienced abused as children. Fontana also found a history of abuse in the parents of 'abused or battered or neglected children'. However, the methodology of these studies has been subjected to criticisms. For example, Egeland (1988) points out that these samples were based on a retrospective analysis of case material or examination of child protection records of parents who abused their children. Other studies reported a lower rate of transmission of patterns of abuse (30 per cent). (Hunter & Kilstrom, 1979, Straus, 1979), cited in Browne, (1988). Egeland (1988:88) argues however, that these reported lower rates could be attributed to several factors. For example, in Straus' study, the sample consists of two-parent families with children between the ages of three and seventeen years, and excludes single parent families with children under three years of age. This therefore ignores the fact that 'much abuse takes place in single parent families and occurs prior to the age of three'. Other factors may include, faulty recall of earlier negative experiences or unwillingness 'to reveal to interviewers the fact that they have been abused or are abusing their children'. It is therefore impossible to determine the number of adults, who had similar early childhood experiences and have not abused their children. The evidence from these findings is therefore inconclusive. It has been suggested that in order to fully test the intergenerational hypothesis, longitudinal studies that examine on-going child rearing practices of a sample of adults who were abusing their children is needed (Kaufman & Zigler (1987) cited in Browne (1988).

This was precisely the aim of Egeland et al's study. They explored the intergenerational hypothesis through a longitudinal study of 47 'high-risk parents and their children'. The case histories, as well as 'objective data' of mothers who were abused in childhood and repeated the pattern of abuse with their own children were examined. They compared this data with mothers who were abused in childhood and did not abuse their children. They reported that 'a number of mothers in our sample who were abused as children are not abusing their children'. These are encouraging and important findings because they suggest that the cycle of intergenerational abuse can be broken. Of the 47 mothers in Egeland et al's study who were abused as children, only 16 were found to be abusing their children. Egeland concludes that factors other than the intergenerational hypothesis 'cause' abuse. He points out that in order to understand these issues more fully, it is also important to study those parents who were abused as children and have not repeated the pattern of abuse with their own children. The findings from the study show that :

' a major variable distinguishing the continuity (those who repeated patterns of abuse) from the exception group (those parents who did not repeat the pattern of abuse), was the mother's relationship with her parents and her current relationship with her husband/boyfriend. Most of the mothers who broke the cycle of abuse were currently in an intact, long-term, stable relationship with husband or boyfriend.....They described their relationship as more satisfying, were rated higher on emotional support and were significantly less likely to be in an abusive relationship with a mate. The husband/boyfriend was, in most instances, the father of the child, and he was emotionally supportive of his wife/girlfriend and was involved in the caretaking of the child. Those mothers who broke the cycle were also likely to have reported that foster parents, a relative or one of their parents provided them with emotional support'. (Egeland et al (1987) cited in Browne (1988:92).

Also noteworthy, is the fact that the abused parents in Egeland et al's study received some form of counselling during their 'adolescent or early adult years'. 'They were very aware of their past history of having being abused and were able to recall it in great detail. They spoke of their abuse with much emotion and they were generally quite verbal about the way they intended to raise their children'. In contrast, the mothers who continued to abuse their children, 'spoke in generalities about their history of abuse. Their recall was vague and they lacked understanding of the relation between their caretaking history and the care they provided their children'.(Egeland, 1988:94). As we will recall from chapters four and five, some respondents in my own study also spoke openly and with great emotion about their experiences of abuse. They were also quite adamant that they would make every effort to avoid repeating the abusive practices of their parents. The

findings from Egeland et al's study clearly highlight the fact that these respondents in their efforts to avoid repeating the pattern of abuse that they experienced, would require supportive strategies to help them to overcome their negative experiences.

Other research studies have also provided evidence to suggest that although a pattern of intergenerational abuse does occur, it does not occur in all families. (Kaufman & Zigler 1989; Rutter et al (1983).

Rutter and Madge's (1976) study of cycles of disadvantage also contributes significantly to our knowledge and understanding of intergenerational transfer of experiences. Many respondents in my own study have experienced disadvantage in various forms. How far does this disadvantage transfer from one generation to the next? Rutter and Madge (1976:303) argue that a cycle of disadvantage in relation to a number of socio-economic, environmental and other factors is transferred between generations. However, it was important to note that these 'continuities' are much weaker over a period of three generations than they are over two generations. In addition, although some 'familial' disadvantage are repeated from one generation to the next, these 'continuities for many aspects of family life are generally fairly slight, although they are substantial in the case of severe abnormalities in parenting such as child-battering'. Notwithstanding, 'at least half of the children born into a disadvantaged family do not repeat the pattern of disadvantage in the next generation'.

These views therefore, have not only helped us to understand some of the themes that emerged from this study, but have also provided the basis to look at the implications of some of the findings. In this study, some respondents spoke of their experiences of a variety of parental abuses and neglect. However, as the early parent-child interactions of their parents are not known, it is difficult to identify whether a pattern of generational abuse exists. Despite these early negative experiences, the respondents in this study attached a great deal of importance to the concept of motherhood and fertility in ascribing meanings to their pregnancies. Following from this, there were frequent reports of their persistent attempts to form good relationships with their own children, often describing themselves as 'good parents'. In the preceding sections I have discussed the theoretical link between dysfunctional parent/child relationships and the hypothesized impact on later

parent/child relationships. I have also discussed the link between other stress factors and abuse. In view of these findings, one could therefore question the likelihood of these reported positive mother/child relationships being sustained over time. One could also question whether these respondents who have experienced abuse would go on to repeat the pattern of abuse. In addition, given the negative early childhood experiences reported by some respondents in both London and the Caribbean, one may also hypothesize that some of these young women will later experience great difficulties in their personal and social relationships. These are issues that cannot be predicted with any degree of certainty.

Nevertheless, also worthy of note are the views expressed by many respondents that they have learnt valuable lessons and derived positives from the negative experiences of their early childhood experiences in their quest to avoid repeating the practices of their own parents. The evidence provided from Egeland et al and Rutter and Madge's studies, suggest that these aspirations and proposed actions are quite possible, despite earlier attachment difficulties. In addition, Belsky & Pensky (1988:195) in concluding their review of 'the inter-generational transmission of family relationships' state that there is evidence to suggest that although dysfunction is transmitted from generation to generation, this is by no means inevitable. Rutter (1987) also argues, that the presence of risk factors is not always a guarantee of negative developmental outcomes, but rather increases the odds or the probability of a negative outcome.

These conclusions have remained consistent in other studies. For example, Quinton & Rutter's (1988) study of women raised in group foster homes also provide some evidence that raising children of one's own appeared to have some reparative value for those socially damaged by early life relationships. Many showed psychological resilience in the face of adversity. What factors enabled these women to experience positive adult outcomes in spite of their earlier experiences? Among the reasons provided by Quinton & Rutter are, the presence of a supportive husband and good experiences at school. In addition, the presence of a close relationship in which one feels comfortable and able to confide in one's partner, is a protective factor against stress in adults of all ages, as well as in children (Rutter & Rutter, 1993). These findings are in many ways similar to Egeland et al's findings which were discussed

earlier. They further strengthen the evidence already provided that insecure attachments and relationships during childhood do not always inevitably lead to later social and behavioural difficulties (Belsky & Nezworski 1988b). Some people are able to develop reasonably well integrated, personality structures, where they are able to cope competently and appropriately with a range of social relationships (including parenting and with partners) in spite of experiencing adverse environments and poor quality relationships in childhood (Werner & Smith 1982; Fonagy et al 1994).

Not all the reported difficulties in relation to parenting are the result of poor attachment experiences. For example, DeLozier (1982:97) points out that a number of additional factors have been identified as important to the aetiology of abuse. These factors include environmental stress, unemployment and poverty, or circumstances related to individual parents such as prematurity. However, not all, or even the majority of families that fit any of these categories described above, are abusive parents. 'Most premature babies are not abused, most teenage parents are not abusers and so forth'.

This seems to be an important point at which to examine the concept of resilience. Resilience has been defined as 'normal development under difficult conditions' (Fonagy et al 1994:231). We have already looked at some factors that contribute to resilience. Other factors are also important. For example, Egeland, et al reported that the ability to cope with stress was also a factor in resilience. The abusive mothers in that study, were reported to have 'very high life stress scores and lived in chaotic and disruptive environments'. Therefore living in situations of 'poverty and experiencing large amounts of life stress appear to increase the likelihood of continuity of abusive patterns across generations' (Egeland, 1988: 94). A significant number of respondents in my study were living in situations of poverty and experiencing stress, particularly those in the Caribbean. As we recall, some respondents from both samples reported experiences of abuse from their own parents. However, there were no reports of these respondents repeating this pattern of child abuse with their own children. With regard to the impact of poverty on these respondents' parenting capacity, Egeland's findings were not confirmed. Of course the sample in this thesis is relatively small and would need to be followed through with further studies. Nevertheless, also of importance to this study, are the findings of Westlake and Pearson, (1997) who point out that many

parents show remarkable resilience and ingenuity. These parents try to manage inadequate resources to ensure that their children are cared for to the best of their abilities. Their coping strategies included activities like borrowing money, sometimes going without food themselves, eating unhealthy foods which gave them space or a sense of 'reward' to enable them to cope with day to day duties. These findings parallel the experiences of some of the respondents in this study, particularly those in the Caribbean, and may help to explain why these respondents are able to cope with their children, despite their experiences of poverty. Westlake and Pearson argue that although these strategies may be viewed as short-term measures, they are particularly important when options are limited.

Researchers in the field of children and family services have also made contributions to the knowledge base in relation to resilience. These researchers have identified a number of protective factors that contribute to resilience in children who spend much of their childhood in local authority care. These factors include the need to develop enriching and supportive friendships with peers. Special attention is placed on friendships because 'a child with no friends is an isolated child who is likely to become an isolated adult. Therefore helping the child to acquire the ability to make and sustain friendships is likely to significantly improve their quality of life' (Daniel et al 1999:9). However, it is important that attention is paid to the quality of these friendships. For example, Quinton et al (1993); and Ferguson and Lynskey (1996) cited in Daniel et al, (1999) placed emphasis on the need to avoid friendships with delinquent peers. Another important protective factor is good educational attainment (Rutter, 1991) cited in Daniel et al (1999). The role of the school however, is much wider than that of providing opportunities for obtaining an education. 'Schools also offer a wide range of other opportunities to boost resilience, including acting as a complementary secure base, providing many opportunities for constructive contact with peers and supportive adults' (Garbarino et al, 1992; Gilligan, 1998 cited in Daniel et al (1999)).

Other contributions to the knowledge base on resilience, come from a qualitative study which tracked the life stories of 40 young people between the ages of 18 to 30 who spent much of their childhood in family placements. In this study, Schofield (2001) found that a combination of factors contributed to resilience in these young people. Among these factors are supportive, emotionally nurturing, trusting and

committed relationships with foster carers, clear boundaries and the teaching of life and social skills. All of these factors contributed to what Rutter (1999) cited in Schofield (2001) referred to as a positive 'chain reaction' leading to rewarding and stable adult life.

In returning to the theme of unnoticed loss that emerged from this study, the concept of an 'internal working model' as a template for future relationships as hypothesised by Bowlby (1969) takes on particular significance. For example, in this study we have seen what appears to be some links between early experiences of sexual and emotional abuse during childhood and the respondents' approach to their sexual relationships later as adolescents. Attachment theories suggest that the need for intimacy and attachment relationships or 'affectionate bonds', remains a basic need into and throughout adulthood. This need to form 'affectionate bonds' throughout life was one of the factors that were particularly evident in the examples of the young women in the Caribbean, as they described and explained the reasons behind their journeys of search. The fact that many respondents cited their ability to talk to their boyfriends and/or putative fathers in the absence of opportunities to develop this kind of dialogue with their mothers also strengthen this point. Though for many respondents, economic necessity was clearly linked to early sexual activity, nevertheless, for some respondents, sexual activity was also closely interwoven with the need for intimacy. They did not however, often find the level of intimacy that they were searching for in the sexual act itself. This may help to explain their reported lack of enjoyment of sex. This also suggests that in many respects, the need for intimacy did not always equate to a need for sexual intercourse. It was the level of closeness surrounding the sexual act that was more meaningful than the sexual act. In view of the evidence from the studies of attachment and resilience that we have just seen, this opportunity for dialogue with their boyfriends/putative fathers, may very well have been one of the protective strategies that these respondents used to help them overcome their earlier painful experiences. This need to form 'affectionate bonds' was also clearly articulated in the examples of some young women in the London sample as they also strove to fill the voids in their lives created by years of emotional neglect.

These theories have undoubtedly strengthened the conclusions reached about the experiences and the impact of loss exemplified by the voices of the respondents. They have also helped us to understand the intricate dynamics between the respondents' early relationship histories and the nature of their current experiences. The evidence in relation to the capacity for resilience that human beings have in overcoming all sorts of obstacles in life is encouraging. Throughout the previous two chapters, there were numerous examples of the capacity for resilience shown among the respondents in this study. This therefore gives further strength to the argument that a teen pregnancy does not have to have a negative outcome if the right support structures and services are put in place to help these young women to overcome earlier disadvantages. In drawing this section to a conclusion, I am therefore encouraged by the point made by Bowlby (1988:136) that:

'although the capacity for developmental change diminishes with age, change continues throughout the life cycle so that changes for the better or for worse are always possible. It is this continuing potential for change that means that at no time of life is a person invulnerable to every possible adversity and also at no time of life is a person impermeable to favourable influence'.

Sex education

As indicated in chapters one and two, the question of sex education in schools in terms of its usefulness in teenage pregnancy prevention has long been debated. The strength of feelings expressed by both sets of respondents in relation to the sex education which they either did or did not receive, leaves us in no doubt about the degree of importance that these young women attach to sex education. Equally, their comments have also left us in no doubt that the quality and quantity of sex education that they received were inadequate. Inadequacy of provision is also demonstrated by the fact that sexual activity is a constant occurrence in the lives of these respondents, yet so many respondents had no definite long lasting memories of what was covered, particularly in relation to HIV & AIDS and to contraceptive use. The young women were however, unanimous in their views that schools should provide sex education of adequate quantity and of good quality. This is required to meet their need for the kind of developmental education that, as we have seen from this research and others cited in this thesis, is quite often not provided at home.

However, the inherent ambivalence demonstrated when on the one hand these young women are quite clear that the standard of sex education must improve, and on the other hand they feel that there is nothing that government or other agencies can do to prevent unwanted pregnancies, would suggest that the strong emphasis placed on sex education as a method of pregnancy and sexually transmitted diseases prevention, may need a certain amount of radical rethinking. Indeed, sex education may have only a relatively small role to play in reducing unwanted teenage pregnancies. This is particularly the case, because the evidence from the Caribbean respondents shows, that there are powerful economic considerations which impact on teenage pregnancy. Additionally, for both sets of respondents, there are often so many other underlying psycho-social and emotional contributory factors to both first and repeat pregnancies. On the other hand, the fact that these respondents all became pregnant repeatedly, and the majority had also reported that their experiences of sex education in schools were poor, would lend some weight to the view that sex education, realistically and intelligently executed, is likely to have a vital role to play in preventing unintended teenage pregnancies. This type of sex education however, must take on board all the issues raised by the respondents in this and other studies of teenage pregnancy.

Contraceptive knowledge and use

In teenage pregnancy research and practice, considerable attention has been focused on contraceptive use as the single most important factor in reducing the rate of unplanned teenage pregnancies. Certainly on a purely mechanical level this claim cannot be denied, consequently on the face of it, the link between incompetent use or non-use of contraceptives seems to be a likely explanation for the incidence of 'unwanted pregnancies' among teenagers. As a result, contraceptive failure has been frequently cited in the literature review as one of the main reasons why young women become pregnant (Bury 1984; Simms & Smith 1986; Jagdeo 1984; Chevannes 1993; RCOG 1991; Klein 1974). In this study we have also seen from the evidence provided that the level of knowledge and understanding about the use of contraceptives was poor among both sets of respondents. In addition, poor sex education is one contributory factor to this lack of knowledge and understanding. The

evidence provided from this study however, clearly suggests that to view contraceptive use or non-use among teenagers in purely mechanical terms is an oversimplification of a complex issue. This is because, there are a number of complicated underlying and often underestimated emotional issues that are at work in relation to both single and repeat teenage pregnancies. I am referring particularly to issues such as the levels of reasoning and emotional force at work in the concepts of **normative acceptance, filling a void, the journey of search and loss**. In addition to these issues, Holland et al (1990:336) draw our attention to the powerful impact on young women's sexual practices of social pressures such as the 'power relations within which sexual identities, beliefs and practices are embedded'. Although this power is employed in various social contexts such as age, class and ethnicity, 'what is particularly significant in the negotiation of safer sex in heterosexual encounters is the power which men can exercise over women' (Holland et al 1990:339). Therefore, 'the social pressures and constraints through which young women negotiate their sexual encounters impinge directly on their ability to make decisions about sexual safety' (Holland et al 1990:336). These social issues and pressures were so influential in relation to teenage pregnancies, that even where some respondents had proved that they were knowledgeable about contraceptives, and even where access to contraceptives was not an obstacle to its use, there was still a consistent failure to use contraceptives appropriately.

All of these factors show convincingly that, in many instances, contraceptive non-use was only the final manifestation in a chain of events and emotions that have a bearing on first and repeat pregnancies. Therefore I would strongly argue that in order for contraceptive use to become an integral part of the routines of teenagers who are sexually active, some of the emphasis directed to the importance of the mechanical act of taking or using a prescribed or non-prescribed method of contraceptive, needs to be urgently redirected. There should be a move to include a concerted focus on understanding the powerful underlying reasons and social pressures, why some young women either do not use contraceptives at all, or if they do begin to use a method, quickly discontinue its use, or have suspicions about contraceptive use. Consequently the provision of contraceptives requires more than an act of simply prescribing an appropriate method for a young woman. As far as possible there is also a need to provide opportunities for appropriate exploration of

any potential psycho-social and emotional barriers that would inhibit their use. Factors such as the young girl's general views about contraceptives, social and economic obstacles, old wives tales, pressures from men, misconceptions and misinformation regardless of the reason or reasons, or whether there is an underlying desire to become pregnant. As the evidence has shown, if these underlying issues are present and significant, and if they are ignored, then there is a strong likelihood of contraceptive non-use and failure becoming a reality.

This is not an easy task, but some of the groundwork can begin in sex education classes, which provide opportunities for these views to be aired and explored. Secondly, given the enormity of this task, with the exception of cases of emergencies, I would therefore question whether the General Practitioner should be the first port of call for contraceptive prescription in a clinic or surgery. Additional support for this claim comes from evidence cited in the literature review chapter which showed that a significant number of young women in one study failed to use contraceptives despite having visited their GPs for contraceptive advice and prescription (Churchill et al 2000). In view of these concerns, I would argue that in order to increase the possibility of contraceptives being used effectively, as far as possible, there is a need for adequate pre-prescription counselling or screening. This argument is further strengthened by the relative ease in which some young women dispense with the use of contraceptives, particularly if they feel that it is not a suitable method for them, or if they have some underlying fears about the impact of contraceptive use on their health. I do acknowledge that for some teenagers this screening may appear to be intrusive, particularly if enough care is not taken to minimize this sense of intrusion by the professional carrying out the screening. Therefore any attempts at this kind of exploration would have to be carefully integrated into the history taking which precedes contraceptive prescription in order to avoid the risk of alienating potential users.

No discussion of contraceptive use would be complete without also commenting on the findings in relation to HIV & AIDS in this study. For many respondents, particularly in the Caribbean, a lack of power in their lives and the realities of their level of dependency on the fathers of their babies, meant that although they were aware of the need to use condoms, they were in fact powerless to insist on condom

use if their boyfriends were against its use. This was the reason most often given for not using condoms. This point is summed up well by Zalduondo & Bernard (1995:177) citing Caravano 1991 & Mahmoud et al 1989) who point out that in the Caribbean 'women's low social status and economic dependency impair their ability to negotiate for safer sex'. In addition, Holland et al (1990:343) highlight the difficulties in negotiating condom use for all women, and the gap between having knowledge and the ability to put that knowledge into use, when they pointed out that:

'while public education campaigns which equate safer sex with condom use would appear to have been highly successful at the level of information, this connection, however, tells us nothing about whether the use of condoms can actually be negotiated in any given sexual encounter..... Condom use and safer sex more generally is not simply a matter of making rational decisions based on knowledge of the facts'.

These are the issues that are often ignored in sex education forums and also in public health promotion campaigns, and urgently need to be taken on board if both sex education and public education campaigns are to be effective in reducing the rate of teenage pregnancies and sexually transmitted diseases.

Differences between the London and the Caribbean findings

An element of search for a variety of reasons was one of the manifestations of repeat pregnancies, and in this regard, this element of search was evident in both sets of respondents. However the **journey of search** which emerged as a distinct theme among the Caribbean respondents and the sense of desperation and degree of urgency in which these respondents embarked on that journey to find emotional and economic support, was not seen among the London respondents to the same extent. There are many factors that contribute to this difference, and in order to understand these significant differences, we need to turn to the differences in socio-economic factors impacting on the lives of the respondents between the two regions. One reason relates to the absence of a comprehensive benefits system in the Caribbean which forces many young women to rely exclusively on the putative fathers for financial support and this often leaves these young women very vulnerable to exploitation by men when they become pregnant for the first time. However this lack of state support also takes its toll even before the first pregnancy occurs, in the sense that where there is little or no support from the state for poor parents in need of help,

the entire family becomes economically and socially vulnerable. It is usually at this point that the young women in these families begin to look for financial help elsewhere.

This further strengthens the point made in chapter one, section three, for policy makers in the Caribbean, to consider and address the contribution of poverty to the incidence of teenage pregnancies in the region. As is often the case, if there are additional factors such as an emotional void in the young women's lives, or other underlying motivations towards pregnancy, the **journey of search** intensifies. Chapter four provides clear evidence that the combination of the need for financial assistance and other underlying emotional factors are usually instrumental in propelling these young women on a cyclical journey which often leads to repeat pregnancies. There is some support for this argument from other studies on teenage pregnancies cited in the literature review. For example, Paik's (1992) study on repeat teenage pregnancy emphasized the importance of financial support from parents after the birth of the first baby in preventing repeat pregnancies. In addition, for poorer parents who received 'state aid', their daughters had fewer repeat pregnancies than those teenagers whose parents did not receive 'state aid'.

Another reason for the observed differences in the **journey of search** among the two sets of respondents, centers on the level of emotional support provided by the parents of the respondents in London, which has been shown to be better than was the case with the Caribbean parents. This is not to suggest that the Caribbean parents were less caring than their London counterparts. Several factors were important here, the vastly different employment opportunities open to the London parents and the availability of state help if and when needed, meant that in relative terms the London parents were less burdened with daily survival pursuits. Therefore, considerably freed from the stress of unemployment and poverty, they had more time and energy to be able to offer a more consistent level of emotional and financial support to their daughters. The more predictable and secure economic circumstances also helped to lessen the young women's dependency on the putative fathers. Many London respondents attribute this very good level of support from their parents as a significant contributor to the success they have made of their parenting tasks and to a decreased feeling of vulnerability. This support also fostered renewed

hopes. It generated a feeling that despite the pregnancies all was not lost. One could counter argue that repeat pregnancies occurred for the London respondents in spite of a lesser need to embark on a **journey of search**. However, in view of the level of support available to the London respondents, the chances of further continued repeat pregnancies become considerably less than is the case for the Caribbean respondents. Given their current deprived socio-economic circumstances, respondents in the Caribbean are more likely to remain perpetually in this cycle of dependency with increased likelihood of the pattern of repeat pregnancies continuing.

The issue of welfare dependency

Chapter one showed that, among the controversies surrounding teenage pregnancies in some western industrialized countries, notably Britain and the United States of America, is the issue of whether teenagers deliberately make themselves pregnant in order to gain access to financial benefits and housing not available to their childless counterparts. Additionally, there is the claim that this access to benefits and housing leads to a situation of dependency on the state with young women becoming increasingly less self sufficient. Although the issue of welfare dependency was not explored in a comparative sense with the Caribbean respondents, this theme when explored with the London respondents, exposed many differences between the two geographical areas. Consequently, this is one of the areas in which the process of making comparisons between London and the Caribbean proved to be a very valuable learning exercise for many reasons. Among these reasons is that the data obtained from the comparison helped to evaluate the role of the state in both a preventative and a supportive capacity in relation to young women who become pregnant as teenagers. It clearly highlighted the negative impact of economic insufficiency and the resulting dependency, on both first and repeat teenage pregnancies.

The London findings show that the majority of teenagers interviewed were either in receipt of benefits or were awaiting the outcome of their applications for benefit. In this regard, these findings are in keeping with other research studies on repeat pregnancy cited in the literature review, notably Polit & Kahn (1986) which found that

teenagers with a repeat pregnancy were more likely to be receiving welfare assistance than those who avoided subsequent pregnancies. Nevertheless, does the fact that these teenagers are in receipt of benefits constitute evidence that they deliberately make themselves pregnant in order to obtain such benefits? The overwhelming evidence from this study is that this is certainly not the case. As the teenagers' responses show, such reports conflict markedly with the young women's own accounts of their rationale for becoming pregnant. These teenagers become pregnant for a myriad of very complex and interrelated reasons, least of which is to become the recipients of housing and financial benefits. Furthermore, remaining in a position of dependency on welfare benefits was certainly not the intention of these respondents. For those who had commenced work prior to the pregnancy, few had no plans to return to work. For those who were at school at the time of the first pregnancy, they had plans to commence work at a later date. Some respondents had already returned to education with a view to adequately equipping themselves for the job market in the near future. This desire was very evident when the themes of **self-esteem and goal orientation and also what can governments do to help pregnant teenagers and teenage mothers** were explored. As we recall, in responding to the question of what government can do to remove the barriers to independence, the young women were quite clear about what was needed. These needs were: opportunities to continue their education both in terms of educational provision and crèche facilities, as they had no intention of remaining indefinitely in a position of dependency.

The London findings and indirectly supported by the comparisons with the Caribbean respondents, showed that far from access to benefits creating a situation of dependency, for many respondents, the availability of benefits and housing had provided the avenues for moving away from dependency and potential exploitation and abuse. Thus the level of reliance on the putative fathers for economic survival expressed so forcefully in the Caribbean interviews, was not seen in the London sample. The London respondents enjoyed and benefited from the confidence that their very existence and survival did not depend solely on the views and demands of the putative fathers. This rendered them less at risk of exploitation and abuse and in less danger of being trapped in a cycle of dependency. Their awareness and acknowledgement of this fact meant that during the interviews, they exhibited a level

of confidence in defying abuse from their partners that was not seen to the same extent among the Caribbean respondents.

In contrast, the Caribbean respondents, with no recourse to similar benefits and housing, found that in many respects they were often very reliant on the putative fathers to provide a form of 'welfare role' in the absence of this kind of service from the state. This resulted in being caught even further in a cycle of dependency on the putative fathers as they continued on the often-endless **journey of search** on which they were forced to embark in order to survive economically. The end result was repeat pregnancies, which in turn planted their feet even more firmly in this cycle of dependency. It is ironic that for the Caribbean respondents, lack of access to state benefits and housing created the very situation of dependency that British teenagers have been accused of in relation to the state. The only difference being that instead of being dependent on the state with more escape routes and possibilities, the Caribbean respondents were dependent on the putative fathers who for the most part, either could not, or would not help them to escape from this unhealthy degree of dependency. These factors challenge the political and media discourses of welfare dependency in relation to teenage pregnancies explored in chapter one. They also provide support for the claim that rather than developing an argument for a reduction in state help for these teenagers as has been repeatedly advocated by politicians and the media in England and the United States, there is a strong case for continued well thought out and purposeful state support for these teenagers to see them successfully on the path to independence. The evidence also puts a strong case for the intervention of the state in the Caribbean to help these young women escape from the desperate situation of dependency in which they find themselves.

I don't keep friends theme

Another important difference in the findings relates to the theme of '**I don't keep friends**', which was so prominent in the experiences of the Caribbean respondents, but did not emerge in any significant way in the London sample. In contrast, many London respondents reported that although their friends might have changed as a result of their pregnancies and enforced different lifestyle and priorities, they had friends nevertheless and often valued the support gained from old and/or new

friends. We have already seen evidence presented earlier in this chapter to suggest that the presence of enriching and supporting relationships with peers, is a contributory factor in the ability to develop resilience (Daniel, et al 1999). The presence of friends in the lives of the London respondents provided yet another avenue of support, and for lessening the exclusive hold that many putative fathers had on the Caribbean respondents. This level of distrust of friends seen among the Caribbean respondents is difficult to explain. The evidence provided in the literature review chapter of an association between pregnant teenagers, high levels of social isolation, a tendency to become loners and difficulties in forming meaningful relationships, (Curtis, 1974; Johnson, 1974; Curtis et al, 1988), may help to throw some light on this finding. However, it does not fully explain the reasons for the prominence of this theme among the Caribbean respondents but not among the London respondents. In addition, while the findings of the studies quoted above may to a certain extent, be related to the decades in which these studies were conducted, where the public forcefully condemned teenage pregnancy, this does not occur to the same extent today. I am therefore inclined to favour anecdotal evidence which suggests that the level of distrust of friends seen among the Caribbean respondents, could be a direct result of a certain level of competitiveness and single mindedness which is often required to survive under such desperate economic conditions. This is in the sense that the presence of friends far from being seen as another level of support, may be viewed as added competition for the affections and attentions of the putative fathers thus putting your means of survival at risk.

These findings have important significance in the scheme of repeat pregnancies, because this lack of faith and trust in friends could, and there is evidence to suggest that it does, increase the level of dependence on their relationships with the putative fathers. Consequently, if a young woman is unable to confide in her parents or relatives, or receive support from them, and if the same feelings apply to her peers, then the rationale for putting all her trust and faith in her boyfriend becomes even more inevitable. This is not to suggest that some level of dependency on their boyfriends is necessarily harmful, but when this level of dependency becomes all inclusive and excludes significant others, then the impact on the young woman's psycho-social development is likely to be negative. This situation perpetuates further dependency and loss of power. This can, and often leads to more isolation from

significant others in their lives and a mitigating factor against resilience. As a consequence, when, as so often happened, boyfriends let them down, there was no one else to turn to, particularly where conflict exists with their parents. Repeat pregnancies therefore become a real possibility as they embark further on their journey of search.

It is worth taking into account, the fact that because the young women in the London sample were not as dependent in a pathological and destructive way on the putative fathers, they reported better relationships with the putative fathers, and a greater sense of control over their own decisions. These putative fathers, with few exceptions, tended to be the same father for both pregnancies. This is another example of the availability of state provision in the form of benefits lessening the need for respondents to feel compelled to search for economic support in the same way as their Caribbean counterparts. This in turn, results in an alleviation of the intense pressures on the relationship. It also provided a greater chance of the relationship lasting, thus sparing the young women the trauma of having to deal with the experience of frequent partner changes which was so prevalent often among the Caribbean respondents, and validated by the literature on 'visiting unions' in the Caribbean.

The role of sex

There were similarities in relation to the role of sex in the lives of the respondents between London and The Caribbean, where with few exceptions, all respondents stated that they did not enjoy sex. The marked difference worthy of note here however, is the circumstances under which early sexual activity became a means of both emotional and economic support and survival for the Caribbean respondents and also became the means that kept these respondents firmly routed on their **journey of search**. This did not prove to be the case in London where the role of sex in the lives of the respondents, though at times it included the need to fulfill an emotional void, in other respects it took on a more multi-faceted nature. It is not surprising therefore that the putative fathers in the Caribbean were in many respects, considerably older than the respondents, as in addition to fulfilling an economic need, they often took over the role of providing a listening ear and a shoulder to cry on

which in many cases, was not available at home. As we recall from the voices of the young women in the Caribbean, there were many instances when they would state that their boyfriends provided both emotional and financial support. All of these factors viewed together therefore mean that:

'sex, as it is currently socially constructed in its various forms, cannot simply be understood as a pleasurable social activity, it is redolent with symbolic meanings. These meanings are inseparable from gendered power relations and are active in shaping sexual interaction' (Holland et al 1990:339).

The meanings which teenagers ascribe to their pregnancies

The term ascribing meanings, as defined in chapter one, denotes the process by which the teenagers themselves have attempted to make sense of their experiences in relation to their pregnancies and their lives, and as a result of this process, develop a narrative of their own lived and felt experiences.

The experience of ascribing meanings to their pregnancies and ultimately to their lives proved to be a very insightful experience for these respondents. Their narratives gave a clear indication that in spite of the difficulties and obstacles encountered as a result of their pregnancies, for the vast majority of these young women, the experience of their pregnancies and subsequent parental responsibilities have not been totally negative and detrimental to their lives. This was also the case even in situations of relative poverty as is the reality for the majority of the Caribbean respondents. Notwithstanding the difficulties encountered, in many instances these experiences have in numerous ways, enriched their lives and have helped towards their overall development and maturity. A similar finding was also reported by Corlyon & McGuire (1997:126) who pointed out that among the advantages of motherhood, reported by the respondents during the course of the interviews, were 'the changes in character and lifestyles experienced by the young women. Some young women felt that the responsibility associated with caring for a child had caused them to temper their excesses'. The fact that I found no evidence to corroborate the claim made by a number of researchers in the literature review chapter that the majority of repeat pregnancies are unwanted, may also be significant to the development of these later coping strategies. In most cases, these pregnancies were unplanned, but not unwanted.

The theme of **reversed life course rationalization** suggests that some teenagers may have a different life map of events that dictate their actions than that which is considered the norm for most people. Therefore for these teenagers, what may appear to outside observers to be a lack of goal orientation or self esteem, may simply be a different frame of reference which reverses the formula from education first followed by a job or career then motherhood, to one which puts motherhood first before further education and career. This concept suggests that for these teenagers, instead of viewing their pregnancies as an indication of failure or deviancy, they were able to ascribe positive meanings to their pregnancies. In this regard, and also from the evidence provided earlier in relation to resilience, the focus of government and professionals needs to be shifted to the use of strategies and approaches that concentrate on helping them to get the best from this reformulated life map. This is an acknowledgement that for many respondents, the extent to which pregnancy becomes a tragedy depends on a number of internal and external factors such as: (1) the young woman's feelings and level of acceptance of her pregnancy, (2) support from her family network which determines the extent to which she is able to continue with a reasonable life style, (3) the extent to which the young woman is supported by government and other external agencies, such as the school and other professionals, in providing opportunities to enable her to continue with her education or skills training.

Numerous themes emerged from this study that have been shown to have a distinct bearing on repeat teenage pregnancies. The same could be said about the meanings which the young women ascribed to their pregnancies. However, among the meanings that stood out as of special significance to these young women both in London and in the Caribbean, is the meaning attached to the concept of **motherhood and fertility**. It is ironic that so many studies have concentrated on the disadvantages of teenage motherhood, yet for the teenagers in this study, the importance that they attached to this concept, was seen to be instrumental and central to the ways in which they rationalized the acceptance of their pregnancies. It was also instrumental in the many decisions that were made in relation to their pregnancies. For example, this concept was clearly evident in the case of their views about abortions. It was also in some ways tied to the need to fill a void in their lives. It

was evident in their rationale for acceptance of their pregnancies. In many respects, it was seen as the most important role in their lives. It was not quite clear from where this level of importance that they attached to **motherhood and fertility** had originated, but it was often shown to be at the core of their thinking about their pregnancies nevertheless. Some respondents attached importance to this concept because they perceived that having their own children gave them the opportunity to correct their parents' mistakes, to right the wrongs that their parents had inflicted on them. Whatever the origins, it was a powerful determining factor in the decisions and sacrifices that they made.

The strong value placed on their ability to be mothers has been supported by feminist theorists who have argued that motherhood provides women with a valued identity and considerable emotional satisfaction (Phoenix, 1991). On the other hand, it could be argued that the high status value placed on the role of motherhood and fertility, is partly an adjustment to their perceived lack of power and relatively weak social and economic position in societies, because of limited access to educational, social and economic opportunities. Nevertheless, this view can be challenged by the observation among these respondents that the importance that they attached to their role as mothers, was not viewed by them as an end in itself, but as one aspect of their lives, as evidenced by their very clear sense of goal orientation.

Closely linked to the importance and meanings attached to the concept of **motherhood and fertility** for many respondents, were the meanings derived in relation to the notion of responsibility. This notion was particularly seen in relation to their parenting role, where respondents in weighing up what their pregnancies meant to them, in nearly every case spoke of their love for their children and gave an acknowledgement of the responsibilities that accompanied that parental role. Quite often it was this sense of responsibility that fuelled their ambitions for themselves and their children and in some cases, stimulated a change in the ways in which they conduct their lives. It was this sense of responsibility that also often determined their acceptance of their newfound status. For some respondents, clearly articulated meanings were often ascribed in retrospect, but in some cases, as the evidence shows, respondents had begun the process of ascribing meanings to their pregnancies even before they became pregnant. This was particularly evident in the

case of those respondents seeking to fill a void in their lives created by sexual abuse and various forms of emotional abuse, irrespective of the origins of that void. It was also evident in the case of those who had viewed pregnancy as a form of escape from various forms of abuse. In such cases it could be argued that meaning was derived from a sense of completion which the pregnancies have brought to an earlier process.

Why do teenagers have repeat teenage pregnancies?

There are many complex, interrelated, underlying psychosocial and emotional driving forces which are not often apparent, but nevertheless, have been shown to have powerfully fuelled a young woman's journey into repeat pregnancies. In addition, although some factors can appear on the surface to have a direct impact on a teenager's motive for a repeat pregnancy, on closer examination it has often emerged that a combination of variables are working together to propel a particular theme to the fore. In this regard, no single reason can be advanced for repeat pregnancies. However, some themes have been shown to have a distinct and powerful link with repeat pregnancies.

In addressing the question of why teenagers have repeat pregnancies, it is not my intention to repeat the evidence produced in the Caribbean and London chapters, but simply to highlight some significant aspects of the findings in relation to the reasons for repeat pregnancies. Certain themes such as **school dropout, lack of knowledge and use of contraceptives, inadequate sex education**, cited in the literature review to have a bearing on repeat pregnancy, have been corroborated by the findings from this study. Indeed these themes are not exclusive to repeat teenage pregnancies, they apply equally to single pregnancies and there is no need to single out these themes for special comment in this chapter. Similarly, other themes such as **filling a void, normative acceptance of pregnancy, the role of sex in the lives of the respondents**, are new themes that have emerged in relation to repeat teenage pregnancies. While not wishing to downplay their significance as they have been well covered in the preceding chapters, they could also be said to apply to first pregnancies. However, the evidence shows conclusively that certain new themes have emerged as having a significant bearing on repeat teen pregnancies. Their

prevalence among respondents both in London and the Caribbean further strengthens the evidence of their significant relationship with repeat teenage pregnancies. The theme of **loss**, and specifically **apparent loss in relation to repeat pregnancy**, is a new and important finding. It appeared as a factor in almost identical proportions among both sets of respondents. It is remarkable that respondents on opposite sides of the globe were expressing feelings of loss and making direct links between their experiences of loss and their decision to have a repeat pregnancy in very similar terms.

The insidious and often silent but powerful nature of the impact of **unnoticed loss in many guises** on repeat teenage pregnancies has also been established. Other themes such as **reversed life course rationalization** identified to a greater extent among respondents in London and to a lesser extent among the Caribbean respondents have also emerged as having a distinct and understandable link with repeat teenage pregnancies. It could be argued that the process of reversed life course rationalization also links to the findings of early age at first pregnancy as a predictor of repeat pregnancies discussed in chapter two. This is due to the fact that the earlier a first pregnancy occurs, the greater the likelihood of age being a factor in this rationalization process.

The theme of the **journey of search** in the Caribbean has been shown to be both a cause of repeat pregnancy and an outcome of repeat pregnancy. In the sense that the beginning of the journey in itself leads to repeat pregnancy, and once established on that cyclical journey, the likelihood of further repeat pregnancies increase. This theme has challenged the blanket notion that teen pregnancies lead to social and economic disadvantage (Gispert et al 1984). Rather the reverse has been shown to be true, in the sense that socio-economic disadvantage has a considerable bearing on whether a young woman embarks on this journey which leads to pregnancy in the first instance. Teenage pregnancy may compound socio-economic disadvantage but it is highly questionable whether it can take the blame for socio-economic disadvantage.

Some of the concerns commonly associated with repeat teen pregnancies have not been fully corroborated in this study. This is particularly related to the concern that

repeat pregnancies exacerbate the problems typically associated with early childbearing (Polit et al 1986). There is no denying the fact that an early teenage pregnancy results in a life changing experience for many young women. However as the evidence from attachment research discussed earlier (DeLozier, 1982; Quinton and Rutter 1983; Rutter 1987; Egeland, 1988), has shown, the extent to which this experience becomes traumatic and negative is not always as predictable as some research studies imply. In addition, these studies have also shown that individuals have extraordinary capacities for resilience in the face of adversity. The evidence from this research shows that, young women have repeat pregnancies for varied and multiple reasons, but on the whole they have coped with their pregnancies and parental responsibilities very well. Similar findings were reported by Corlyon and McGuire (1997:71) who stated that 'despite the lack of preparation and the absence of teaching on aspects of parenting, these young mothers appeared to be fairing as well as other mothers living in comparable surroundings'.

The vast majority of these teenagers have given every indication that they have adjusted well to their pregnancies and in some respects have adopted an almost philosophical outlook. This was clearly evident from the themes of **normative acceptance of pregnancy, reversed life course rationalization, and motherhood and fertility**. Their views about motherhood and fertility, their responses to the loss of a baby and their need to replace that loss, have all to varying degrees, provided evidence of their levels of adjustment and acceptance of their pregnancies. Some have even welcomed their pregnancies, as in the case of those seeking **to fill an emotional void** in their lives. One may argue that for some respondents the presence of an emotional void in the first place is evidence of a traumatic existence. This may well be true, but the fact that they have chosen to deal with this trauma through pregnancy is their right to decide, and therefore cannot be judged as disastrous by external observers. As we have seen before, many respondents in ascribing meaning to their lives have gone one step further than accepting their pregnancies and have gone on to identify the positive experiences and changed outlook in their lives that have come about as a result of the pregnancy.

Research cited in the literature review has also suggested that young mothers who have gone on to have a second child soon after the first birth, are likely to face

serious educational and economic problems (Seitz & Apfel 1993). The comparative element of this study has helped to put such claims in context. We have seen from the Caribbean findings that these young women for the most part experienced educational and economic disadvantage, but in every case the disadvantage was evident before their pregnancies. Other societal factors also helped to create or exacerbate these problems. For example, in the case of young women who are educationally able, who become pregnant and have every desire to return to school to continue their education in order to realize their goals, but are refused re-entry to school. In addition, there is also the case of the young women who feel so alienated from the school that an early pregnancy becomes a viable alternative. In this case, their educational and ultimately economic disadvantages can in many respects be attributed to the failure of the education system and not to their pregnancies. The pregnancies may be a symptom of those failures and/or as well as, other underlying problems. If we turn our attention to the London respondents in particular, we see evidence of a substantial number of respondents showing good educational potential as was evidenced by their GCSE and other examination passes. This is not an isolated finding, other studies have also reported similar findings. For example, Corlyon & McGuire (1997:121) also reported that many young women in their study 'acquitted themselves well in terms of both attendance and/or qualifications'. These successes can be attributed to the educational and other opportunities, which were previously open to them. Attachment and resilience research have provided convincing evidence to suggest that if these young women are given the support and assistance to realize their dreams, then there is no reason why they should ultimately be disadvantaged educationally or economically. All of these factors challenge the blanket view that teen pregnancies automatically equal personal, social and economic disaster.

Conclusion

The findings from this research have made a significant contribution to our knowledge and understanding of the phenomenon of repeat teenage pregnancies. For both the respondents and myself, the interview process was an unfolding of knowledge, for the young women as they struggled to give meanings to their lives, and for me as I struggled to gain an understanding of these meanings.

These findings are directly attributed to the research process, which facilitated the exploration and evaluation of underlying factors that have been shown to be linked to repeat teenage pregnancies. The process of allowing the young women the opportunity to tell their stories, and in making sense of their experiences, was very productive. It helped to unearth the potent impact of many frequently underestimated and poorly understood underlying emotional factors, that have been found to have a strong bearing on repeat teenage pregnancies. This is not to deny the importance of the approach of other studies in identifying factors such as predictors of repeat pregnancies, or the relationship between family background characteristics and repeat pregnancies. These approaches and findings have also added to our knowledge base. However, the significant contribution of the findings of this study is to demonstrate convincingly the powerful impact of both intentional and masked or hidden motivations for pregnancy. These findings also demonstrate the need for a full understanding of both the overt and the underlying motivating factors that impact forcefully on repeat teenage pregnancies. Unless as nation states we seek to address the economic factors that create a climate of loss, fear and displacement, many young women will feel compelled to embark on a **journey of search**. This journey is likely to keep them on the economic and emotional treadmill that ultimately leads to both first and repeat teenage pregnancies. Both the external social, economic, and the underlying emotional and psychological factors leading to early sexual activities and repeat pregnancies must therefore be acknowledged and addressed as part of a comprehensive package of measures which cannot be made in isolation from each other. These strategies must be coordinated and they must take into account all areas of a young woman's life, the social, the emotional, the psychological and the economic. Unless urgent attention is paid to these issues, the traditional and popular areas of focus in teenage pregnancy and sexually transmitted diseases prevention such as sex education, and contraceptive provision will have minimal impact in reducing teenage pregnancies.

In this chapter, as well as the preceding two chapters, I have repeatedly expressed concerns about the role played by putative fathers. These concerns include: lack of financial support for their children; the inability of some putative fathers to become involved in the day-to-day physical and emotional care of their children; putting their

desire for sexual fulfillment before the needs of their partners so that in some cases they refuse to use condoms. Given this rather bleak picture, does this mean that putative fathers have no role to play in the life of these respondents?

My concerns about the level of the respondents' dependence on the putative fathers are not to suggest that fathers do not have a positive role to play in both the lives of the respondents and their children. They relate to the circumstances where dependency on the putative fathers becomes destructive and oppressive. For example, there are cases where they exercise control over the young women's sexual and fertility practice, with detrimental effect. I am also concerned that in the absence of welfare benefit support in the Caribbean which these young women clearly need, men will continue to attempt to fill the gap left by the state, while at the same time furthering their own agendas. This is often without a sense of responsibility and duty.

Notwithstanding these concerns, in this research some respondents, particularly those in the Caribbean, attached a great deal of importance to the need to have positive relationships with their own fathers. This was evident from the palpable sense of loss expressed by many respondents who were separated from their fathers. In addition, they placed much value on fathers' love and attention, and attributed their search for love and affection, in part to the lack of fathers' presence in their lives.

The factors outlined above suggest that although this study has found causes for concern in relation to the role played by some of the putative fathers, it has also found important reasons for fathers to play an active role in their children's lives. In fact, the importance of father's role was stressed in chapter two by Gispert et al (1984) who pointed out that father's presence in the home was an important contributor to the prevention of repeat teenage pregnancies. Similarly, Selwyn, (2000) concludes following a review of research evidence on the effect of father's absence, that father's absence may be harmful for children. 'This is not because a sex-role model is absent, but because other aspects of father's role, such as providing economic, social and emotional support, go unfilled for families'. Research also suggests that fathers and mothers influence their children's upbringing in very similar ways (Lamb, 1997).

Warmth and close relationships are associated with positive child rearing outcomes, whether the parent is male or female (Selwyn 2000). What is now needed, are policies and practical support to help maximize their contribution.

The international comparative element of this study has contributed significantly to our understanding of the phenomenon of repeat teenage pregnancies. It has done so in several important respects. Firstly, from the point of view of the similarity of themes that have emerged from the countries compared despite their socio-economic differences. This has highlighted the universal nature of the factors that have been shown to have a bearing on repeat teenage pregnancies. These aspects have in turn strengthened the causal elements of the findings. Secondly, this comparison has also exposed the gross oversimplification of the practice of reducing the complexities inherent in teenage pregnancies to the purely economic motives of gaining welfare benefits and housing. While conversely, it has also served to highlight the intrinsic relationship between socio-economic deprivation and teenage pregnancies, and the crucial role that the state must play in minimizing the detrimental effects of economic stringency on teenage pregnancy.

It is fitting in drawing this chapter and research to a conclusion, to briefly return to a central concept of this study, that is the importance of the concept of **meaning** in relation to our understanding of the phenomenon of social action. As previously stated, endeavouring to understand the meanings ascribed by teenagers to their pregnancies, essentially meant attempts to understand what significance the respondents attached to their actions and the process by which they made sense of these actions in evaluating their experiences and ultimately their lives. This study has demonstrated clearly the value of utilizing this concept in social research, as without attempts to understand the meanings, motivations and significance of social actions, our understanding of social phenomena is bound to be incomplete and by implication invalid. This approach is very much in-keeping with the paradigm of a 'co-operative inquiry' approach (Heron 1981; Reason 1988) discussed in chapter 3, where the main aim of facilitating the understanding of the meanings of social action, is to empower respondents to develop a greater understanding of their experiences. In doing so, ultimately to give greater value both to the knowledge gained from the research and subsequent application of that knowledge. If as researchers, we make

attempts to empower our respondents to make sense of their actions, or ascribe meanings to these actions by attaching significance to the telling of their own stories, they as well as their observers will be better equipped to understand their experiences and actions (Reason 1988). The findings have shown that our increased understanding of the phenomenon of repeat teenage pregnancies would have been severely limited without the utilization of this central concept of meaning in the attempts to understand, as fully as possible, the reasons for repeat teenage pregnancies.

Recommendations

These recommendations are to be read and contextualized in conjunction with other recommendations made periodically throughout the London and Caribbean chapters. At the centre of these recommendations is a strong belief that although no one would argue that a repeat teenage pregnancy is an ideal experience for a young woman, nevertheless, a repeat teenage pregnancy does not have to lead to poor outcomes. It is within the context of this understanding that the following recommendations are made.

Sex education

The recommendations begin with sex education because so much of our hopes for reducing teenage pregnancies have been pinned on the provision of good sex education. It is clear from the findings and the arguments provided so far that sex education alone cannot prevent 'unwanted' teenage pregnancies. However, there is no denying the fact that sex education properly thought out, realistic and well delivered has a crucial contribution to make in reducing early teen pregnancies, in helping young people to make important decisions about relationships and in preventing STDs. However in providing sex education, there needs to be an acknowledgement that many young people have many and varied social interaction experiences and influences outside the classroom. Their views and actions are quite often shaped as much by these experiences as well as by the experiences they gain from the school environment. As a result, these young people may bring a different frame of reference with them into the classroom in terms of how they view certain issues relating to contraceptive use, sex and relationships, HIV & AIDS. It is therefore imperative that these experiences and views are not ignored. These experiences, feelings and views need to be acknowledged and validated, and opportunities provided for them to explore these issues in order to get young people to embrace other points of view, and in the process, separating out fact from fiction. We have seen the very powerful impact that underlying feelings and emotions, as well as social and economic pressures, can have on the actions of these young women. Sex

education therefore cannot be adequately delivered and would be meaningless unless any underlying issues for the young people are acknowledged and taken on board and explored.

The fact that controversies abound about the question of parental role in sex education is well known, there is no doubt that parents have a contribution to make to the sex education of their children. However, the evidence from this and other research studies points conclusively to the fact that in most instances parents are either unable or unwilling to undertake this crucial task for a variety of reasons previously explored, and this situation needs to be understood and respected. In addition, we know from research evidence from this and other studies that many young people will not approach their parents to discuss issues relating to sex, because of embarrassment and the barriers which they sense coming from their parents. The needs of these young people have to be acknowledged. They therefore need access to good quality sex education outside the home.

These issues call into question the right afforded to parents in the UK to withdraw their children from sex and relationship education in schools. They also call into question the plan outlined in the DfEE recent circular on Sex and Relationship Education Guidance to issue parents with an information pack on sex education as a substitute measure. There are no guarantees that parents will make use of this pack, particularly if their reason for withdrawal of their children in the first place is tied with their opposition to sex education. What of the rights of the child to a comprehensive education which covers all aspects of his or her development? What are the implications for the child who misses out on this education? These are issues that the government urgently needs to explore. Information provided by the Department of education suggests that about 1% of parents exercise this right to withdraw. If this 1% of children miss out on the right to this aspect of their education, it is 1% too many.

The evidence in relation to the lack of knowledge and understanding about HIV & AIDS is an indication of the failure of the schools to provide this information in sufficient quantity and quality. HIV & AIDS statistics have for many years consistently shown that young people are among the groups of people increasingly being infected

and affected by HIV & AIDS. This subject is far too important to be covered as a one off addition to the sex education curriculum as many respondents have indicated. As long as HIV remains an issue of life threatening reality, its inclusion in the curriculum should be on going and well integrated. We cannot afford to allow young people to become complacent and forget the need to protect themselves from infection and ultimately to save their lives. We also have to understand the many socio-economic and emotional barriers and difficulties highlighted in this and other studies, that they encounter in negotiating safer sex and provide consistent opportunities for them to discuss ways in which they can overcome or minimize these barriers.

Support services

The constraints on the schools' curriculum in terms of time and expertise have to be acknowledged. This means that even with the best of intentions, sex education may have to compete unfairly for space and time in terms of curriculum development. This does not however, absolve the schools from their responsibilities in relation to sex education, as I firmly believe that good sex education is an integral part of any comprehensive educational approach. It is an attempt to recognize these constraints and to seek to support and complement the schools' efforts in whatever ways possible. This requires stronger links between the schools and their communities. Therefore, as an adjunct to sex education, there is a need for more out-of-school support groups that cater not only to pregnant teenagers and teenage mothers, but also to all teenagers where the meanings and implications of sexual relationships can be explored and developed. This will ensure that where necessary young people can gradually get to ventilate pent up feelings and be offered reassurance, some of which they may not be able to express in a classroom setting. This requires meaningful dialogue with professionals, not the type frequently referred to in the Caribbean findings, and in some cases, the London findings, where some professionals by their actions, have deliberately or inadvertently alienated some respondents. Therefore professionals who come into contact with young people, particularly teenage parents, need to recognize the fact that they may be the only source of advice, support and guidance for some young people. They therefore need to be mindful of the crucial role that they can play in positively influencing the actions of these young women.

This can be achieved with sympathetic handling and well thought out advice, geared to the needs of the individual.

Professionals and relevant social care agencies should also make every effort to ensure that teenagers who may require their services and assistance are fully informed about the role of the agency and the nature of the services which they offer. This is particularly, but not exclusively, the case in the Caribbean, where the evidence provided suggests that respondents were not knowledgeable about the range of services on offer. Even where they had visited certain agencies, they held a very limited view of the role and services of such agencies. This situation needs to be rectified as we have seen the impact on the life decisions of some teenagers where there was an urgent need to communicate their feelings and they were prevented from doing so for several reasons, but significantly because of lack of knowledge about services.

Contraceptive use

The importance attached to contraceptive use, as a means of pregnancy prevention has been evident from the numerous studies reviewed in chapter two. The importance of contraceptives in pregnancy prevention is not in question here, but as we have seen from the evidence provided in this research, a purely mechanical approach to contraceptive provision is very unlikely to work for many young people. In this regard, I fully agree with Russell (1983:162) who points out that:

‘the argument that the number of unwanted pregnancies.....would be reduced if youngsters – girls and boys – were better informed about modern contraceptive practices is not convincing. My view has long been that this is a naïve oversimplification of what is an extremely complex, medical, social and cultural problem’.

Therefore, contraceptive providers both in London and the Caribbean need to widen their approach to ensure that there are opportunities for the many emotional and psychological barriers to contraceptive use, which have been identified in this study, to be explored and taken into consideration when prescribing contraceptives. There is no point in prescribing the pill to a young woman who feels that the use of the pill is, or will be in some way detrimental to her short or long term health. She simply is not going to take it, or will dispense with its use at the first sign of any real or

perceived problems. This approach therefore requires the development and use of empowering models for exploring any potential barriers to contraceptive use as well as to capitalize on potential strengths.

Caribbean societies have to acknowledge that provision of contraceptives and sex education will not have an impact unless the issue of economic deprivation which is at the root of the **journey of search** and dependency seen among Caribbean respondents is also addressed. I will also repeat the call made in chapter one for the role of men who neglect their responsibilities as fathers, and who readily capitalize on the vulnerabilities of these teenagers in furthering their quests for sexual intercourse, to be addressed. However, the role of men cannot be successfully addressed without first addressing the role of the state. As long as teenagers find themselves in positions where they see the need to have sex as a means of economic survival, it will prove exceedingly difficult, if not impossible to make any inroads into the reduction of the rate of teenage pregnancies through contraceptive use.

Contraceptive agencies under threat of funding cuts particularly in the Caribbean, need to have the confidence of secure funding to ensure that young people receive adequate and fully comprehensive contraceptive counselling and advice, including where at all possible, free contraceptives for those who cannot afford to purchase them. This is particularly the case in Jamaica where contraceptives are not issued free of cost. In view of their reported lack of knowledge about the availability of such services in Jamaica, young people need to be told on a consistent basis, in schools and by other public service announcements and campaigns, where they can access contraceptive services. I stress the need for consistency because it has too often been the case where social issues are taken up when they appear to be in vogue and ignored soon afterwards when the issue is no longer current. Unfortunately teenage pregnancies and sexually transmitted diseases like HIV & AIDS are current and on the rise, we therefore cannot afford this state of complacency, the consequences are far too great.

Teenage ante natal clinics

The evidence from this research suggests that teenage pregnancy does not automatically have to equate to long-term socio-economic disadvantage, therefore pregnant teenagers need all the support and help that they can get to help them to overcome any potential drawbacks of early pregnancies. They therefore need services where they can feel comfortable to participate fully in their care and future outcome, and these services do not necessarily have to be new. If we refer back to the London findings in this study, it is evident that the respondents who had the opportunity to attend specialist teenage antenatal clinics during their pregnancies had very positive experiences in these settings. We therefore already have a service that is popular with the teenagers who attend as evidenced by their excellent antenatal attendance record and comments about these services. There is therefore an opportunity to capitalize on the potential of these clinics and also enhance the role that these clinics can play. This can be achieved, first, by providing more teenage antenatal clinics, and secondly, by extending the role and function of these clinics to include services that go beyond the role of medical and nursing care. These services need to be multi-disciplinary, where expertise and skills are complementary rather than divisive. This range of services would be invaluable in meeting the multi-faceted needs of these teenagers in an attempt to prevent mistimed repeat pregnancy or pregnancies. This recommendation is equally relevant for the Caribbean as part of its strategy to address the needs of teenage mothers.

School dropout

The detrimental impact of school dropout, particularly among the Caribbean respondents, has been evident from the voices of the young women. In this and other studies, the importance of young women being allowed to continue their education during and after the first pregnancy, as was argued in chapter one, cannot be overestimated. In this regard educators should first consider their role in educating young people ahead of misguided and ill-founded concerns about preserving the reputation of the school. Attention also needs to be focused on a greater direction and commitment in policy making by the state to address these issues. A number of questions need to be asked and explored. For example: What role does the school

play in school dropout in terms of encouraging young people to make education a prime motive to prevent school dropout? In addition, what is the response from schools following school dropout?

These young women need all the help they can obtain in order to overcome any actual or potential disadvantages brought about by early-unplanned pregnancies. Therefore educators and policymakers should seek to ensure that young women who become pregnant are not excluded from school and that every opportunity is available for them to have an education of whatever type seems more suitable to their needs. This is a very important provision in ensuring their economic and social self-sufficiency in the future, as well as in equipping the young women to ensure that their own children are given every opportunity of not repeating the mistakes of their parents.

Support from the state

The comparison between London and the Caribbean has highlighted the importance of the provision of short-term state benefits in the lives of these young women. This means that the state should continue to support young women who become pregnant and are in need until they are able to support themselves. This is crucial if they are to avoid or escape from the potential damaging effects of being trapped in a position of dependency and disadvantage. However there is the recognition that as far as state funds are concerned, there is no endless pot of gold, and accountability to the tax - payers is mandatory. Therefore the provision of benefits should be purposeful and accompanied by a package of measures which include opportunities for continuing education and/or training, to ensure that young women in need do not remain indefinitely on benefits but should be supported to become self sufficient. As the respondents in this study have stated forcefully, chief among these measures should be adequate childcare, education and training facilities to enable them to be equipped to take their rightful places in society. The state owes this support to its young citizens and ultimately to the development of an economically and socially healthy nation. An early pregnancy or pregnancies should not be allowed to equate to a cycle of disadvantage and dependency.

On both sides of the Atlantic, the Caribbean and London, the clear messages from the voices of the teenagers are that there is very little that anyone can do to reduce teenage pregnancies. This suggests that a radically new approach is needed in the way we view and work with teenage pregnancy. There needs to be a shift from an approach that focuses almost exclusively on prevention strategies, to a two pronged approach which deploys strategies which focus on prevention, and simultaneously focuses on strategies to improve the life chances for those teenagers who become pregnant. The almost exclusive focus of governments and policy makers on pregnancy prevention tends to exclude and ignore the needs of young women who have already become pregnant. The absence of repeat teenage pregnancy statistics supports this concern. This situation needs to be rectified urgently, as this and other research studies on repeat teenage pregnancy have shown, the needs of these young women are just as great. Therefore if the young women are correct in their assumption that there is very little that governments can do to prevent teenage pregnancy, then at least these governments should take steps to ensure that those who do become pregnant are not deliberately or misguidedly condemned to a life of unfulfilled dreams and hopes, and of untapped and wasted potential.

Abortion services

Governments in the Caribbean, particularly in Jamaica, where very little opportunity exists for legal abortions in the public health sector, should take a more realistic and long term view about people's needs for, and rights to abortion if they so choose. Women of all ages will always seek and have abortions, therefore steps need to be taken to improve or provide abortion services in the public health sector. It is so often the case that these state policies and lack of provision affect those who are located amongst the poorest sectors of the society. There are other adverse consequences such as serious and at times, long term risks to the young woman's health. This is particularly the case where a young woman feels compelled to resort to illegal, unsafe back street abortions. As the Caribbean chapter shows, the sense of loss following an abortion is often compounded where the abortion takes place in secrecy. This situation further reinforces a young girl's sense of wrong doing, guilt and shame which is so overwhelming, that in order to atone for 'her sins', a decision to have another baby, regardless of the socio-economic consequences, seems the only

solution. This situation calls for policymakers and professionals to take a more long-term view in relation to the physical health of the young women. Additionally, given the mental health implications evident from the voices of the respondents that the research has so far uncovered, the need for pre and post abortion counselling cannot be over emphasized. This suggests that what practitioners should be aiming to ensure, is a state of affairs where a young woman can be given the opportunity to explore her feelings prior to making a decision about whether to terminate a pregnancy or not. If she decides to go ahead with the termination, follow up counseling is vital.

Managing other losses

The very important recommendation in relation to the need for adequate counselling following a loss of the kinds highlighted in this study has been extensively covered in chapters 4, 5, and 6. This constitutes another very important strategy in the prevention of unintended repeat teenage pregnancies. We have seen convincing evidence in chapter six to suggest that people can accommodate to loss, overcome the detrimental effects of abuse and deprivation of various kinds, if support and substitute opportunities are available. If they are deprived of that support, or those opportunities, the chance of failing to make an appropriate adjustment to loss, abuse and deprivation increases. It is essential that the approach to this counselling seeks to go beneath the presented surface issues and variables that traditionally have been shown to have a bearing on teenage pregnancy. There needs to be understanding of the core underlying issues that have not been so readily understood in the past, but nevertheless have been shown in this research to have a powerful impact on teenage pregnancies. The research on attachment and resilience conclusively suggests, that the more supportive and protective factors that are available to young people, the more likely they are to display resilient behaviour. The task therefore for governments, parents, professionals and significant others is to make every effort to ensure that these young people have access to as many supportive services and processes as possible.

Giving the teenager a voice

Finally, it is hoped that the methodological approach and outcomes of this research have provided strong proof of the value of allowing the voices of the young people to be heard and valued. This approach should not be restricted to conducting research; there is an urgent need for it to be transferred to direct working with young people in terms of facilitating greater consultation and communication between professionals and their young clients. More meaningful dialogue reduces the chances of alienation and will provide enhanced opportunities to develop a greater understanding of the needs of young people and ultimately more effective service provision.

Bibliography

- Abbot, P., & Sapsford, R. (1998). *Research Methods for Nurses and the Caring Professions*. Milton Keynes: Open University Press.
- Abrahamse, A., Morrison, P., & Waite, L. (1988). *Beyond Stereotypes: Who Becomes a Single Teenage Mother?* Santa Monica, California: RAND Corporation.
- Adler, N., & Tschan, M. (1993). Motivation for Pregnancy Among Adolescents. In A. Lawson & D. Rhode (Eds.), *The Politics of Pregnancy - Adolescent Pregnancy and Public Policy*. New Haven: Yale University Press.
- Ainsworth, M., & Stayton, D. (1991). Infant-Mother Attachment and Social Development: Socialization as a Product of Reciprocal Responsiveness to Signals. In M. Woodhead, R. Carr & P. Light (Eds.) (1999). *Becoming a Person*. London: Routledge.
- Ainsworth et al (1978). Patterns of Attachment: Assessed in the Strange Situation and at Home. Hillsdale, New Jersey: Erlbaum.
- Ainsworth, M (1969). Object Relations, Dependency and Attachment: A Theoretical Review of the Infant-Mother Relationship. *Child Development*. Vol. 40. 969-1025
- Ainsworth, M. (1980). Attachment and Child Abuse. In G. Gerner, C. Cross, & E. Zigler (Eds.) *Child Abuse: An Agenda for Action*. New York: Oxford University Press.
- Alcorn, K. (1999). *AIDS Reference Manual*. London: National AIDS Manual.
- Alcorn, K. (2000/2001). *AIDS Reference Manual*. London: National AIDS Manual.
- Algate, J. & Bradley, M. (1999). *Supporting Families Through Short-term Fostering*. London: The Stationery Office.
- Allen, I. (1987). *Education in Sex and Personal Relationships*. London: Policy Studies Institute.
- Allen, G., & Skinner, C. (1991). *Handbook for Research Students*. London: Falmer Press.
- Allen, I., & Dowling, S. (1998). *Teenage Mothers - Decisions and Outcomes*. London: Policy Studies Institute.
- Allen-Mills, T. (1997). US Agonises Over Soaring Teen births. *Sunday Times*, 12/1/97.
- Applewhaite, L. (1994). Feature Address. In G. Nicholson (Ed.) *Children Having Children: The Problem and Prevention of Adolescent Pregnancy*. Kingston: University of the West Indies. Canoe Press.
- Ashton, J., & Seymour, H. (1988). *The New Public Health*. Milton Keynes: Open University Press.
- Aymer, F., & Pichery, N. (1993a). *Knowledge, Attitude and Practice Survey of Secondary School Youth in Antigua*. St. Johns: AIDS Secretariat, Ministry of Health, Antigua and UNICEF.
- Aymer, F., & Pichery, N. (1993b). *Knowledge, Attitude and Practice Survey of Primary School Youth in Antigua*. St. Johns: AIDS Secretariat, Ministry of Health, Antigua and UNICEF.
- Babb, P. (1993). Teenage Conceptions and Fertility in England and Wales. *Population Trends*, 74, 8-17.
- Baldwin, W., & Cain, V. (1980). The Children of Teenage Parents. *Family Planning Perspectives*, 12, 34-43.
- Barnardo's. (1992). *Telling the Children?* London: Daniels.
- Barnett, J. (2000). Relationships. In M Boushel, M. Fawcett & J. Selwyn (Eds.) *Focus on Early Childhood - Principles and Realities*. London: Blackwell.
- Barth, R. P., Schinke, S. P., & Maxwell, J. S. (1983). Psychological Correlates of Teenage Motherhood. *Journal of Youth and Adolescence*, 12(6), 471-487.
- Bateson, M. (1990). *Composing a Life: Life as a work in Progress*. New York: Penguin.

- Bell, C. (1993). Single Mothers Lose Right to Leap Housing Queue. *Daily Mail*, 8/10/93.
- Belsky, J., Rovine, M. & Taylor, D. (1984). Pennsylvania Infant Development Project. III: The Origins of Attachment: Maternal and Infant Contributions. *Child Development*, Vol. 55: 718-728.
- Belsky, J. & Nazworski, T. (1988b). Clinical Implications of Attachment. In Belsky, & Nazworski. (1988a) pp. 3-17. Hillsdale, New Jersey: Erlbaum.
- Bertrand, J., Russell-Brown, P., Landry, E., Murray, D., Norville, S., & Rotchell, Y. (1986). *A Test of two Strategies for Delaying a Second Pregnancy in Teenage Mothers in Barbados*. Bridgetown, Barbados: Tulane University, New Orleans, USA & Ministry of Health, Barbados.
- Bierman, B., & Streett, R. (1982). Adolescent Girls as Mothers: Problems in Parenting. In I. Stuart & C. Wells (Eds.), *Pregnancy in Adolescence, Needs, Problems and Management*. New York: Van Nostrand Reinhold.
- Birch, D. (1987). *Are you my sister Mummy?* London: Youth Support.
- Boethius, C. (1985). Sex Education in Swedish Schools: The Effects and the Fiction. *Family Planning Perspectives*, 17(6), 273-279.
- Bogue, D. (1969). *Principles of Demography*. New York: John Wiley & Sons.
- Bowlby, J. (1969). *Attachment and Loss, Vol. 1: Attachment*. London: Hogarth Press.
- Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.
- Belsky, J. & Pensky, E. (1988). Marital Change Across the Transition to Parenthood. In R. Palkovitz and M. Sussman (Eds.). *Transitions to Parenthood*. New York: Hawarth.
- Bolton, F. J. (1980). *The Pregnant Adolescent: Problems of Premature Parenthood*. London: Sage.
- Bolton, M., & Fitzpatrick, R. (1994). Quality in Qualitative Research. *Critical Public Health*, 5(3), 19-26.
- Bottling, B., Rosato, M., & Wood, R. (1998). *Teenage Mothers and the Health of their Children*. London: Office of National Statistics.
- Boyer, D., & Fine, M. (1992). Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment. *Family Planning Perspectives*, 24(1), 4-11.
- Bradshaw, J., & Millar, J. (1991). *Lone Parent Families in the UK: Family Policy Studies Centre*.
- Brazzell, J., & Adcock, A. (1988). Influence of Attitudes, Significant Others and Aspirations on How Adolescents Intend to Resolve a Premarital Pregnancy. *Journal of Marriage and the Family*, 50, 413-425.
- Breakwell, G., & Fife-Scraw, C. (1992). Sexual Activities and Preferences in a United Kingdom Sample of 16 to 20 year-olds. *Archives of Sexual Behaviour*, 21(3), 271-293.
- Bridgeman, C. (1994). An Adolescent's Personal View. In G. Nicholson (Ed.) *Children Having Children: The Problem and Prevention of Adolescent Pregnancy*. Kingston: University of the West Indies. Canoe Press.
- Brindle, D. (1994). Health Risks Over Sex Lesson Option. *The Guardian*, 15/6/94.
- Brody, E. (1981). *Sex, Contraception and Motherhood in Jamaica*. Cambridge, Massachusetts and London: Harvard University Press.
- Brook Advisory Centres. (1991). *Annual Report 1990-1991*. London: Brook Advisory Centres.
- Brook Advisory Centres. (1997). *1964-1994 Thirty Years On*. London: Brook Advisory Centres.
- Brooke, C. (1993). Life on the Estate of Missing Fathers. *Daily Mail*, 5/7/93.
- Brooks-Gunn, J., & Furstenberg, F. J. (1985). Antecedents and Consequences of

- Parenting: The Case of Adolescent Mothers. In A. Fogel & G. Metson (Eds.), *The Origins of Nurture*. Hillsdale, New Jersey: Erlbaum.
- Brooks-Gunn, J., & Chase-Lansdale, P. (1991). Children Having Children: effects on the family system. *Paediatric Annals*, 20(9), 467-481.
- Bumpass, L., Rindfuss, R., & Janosik, R. (1978). Age and Marital Status at First Birth and the Pace of Subsequent Fertility. *Demography*, 15(1), 75-86.
- Burghes, L., & Roberts, C. (1995). Lone Parents. *Community Care*(1075).
- Burghes, L., & Brown, M. (1995). *Single Lone Mothers: Problems, Prospects and Policies*. London: Family Policy Studies Centre.
- Bury, J. (1984). *Teenage Pregnancy in Britain*. London: Birth Control Trust.
- Bury, J. (1991). Teenage Sexual Behaviour and the Impact of AIDS. *Health Education Journal*, 50(1), 43-49.
- Butler, M., Inechen, B., Taylor, B., & Wadsworth, J. (1981). *A Report to the DHSS*. Bristol: University of Bristol.
- Card, J., & Wise, L. (1978). Teenage Mothers and Teenage Fathers: The Impact of Early Childbearing on the Parents' Personal and Professional Lives. *Family Planning Perspectives*, 10(199).
- Charmaz, K. (1983). The Grounded Theory Method : An Explication and Interpretation. In R. Emerson (Ed.), *Contemporary Field Research*. (pp. 109 - 126). Boston: Little Brown.
- Chevannes, B. (1993). Sexual Behaviour of Jamaicans. *Social and Economic Studies*, 42(1), 8-16.
- Children Act 1989 Guidance and Regulations. (1991). *Vol 4. Residential Care*. London: HMSO.
- Churchill, D., Allen, J., Pringle, M., Hippisley-Cox, J., Ebdon, D., MacPherson, M., & Bradley, S. (2000). Consultation Patterns and Provision of Contraception in General Practice Before Teenage Pregnancy: case study control. *British Medical Journal*, 321(19th August), 486-489.
- Cicourel, A. (1974). *Theory & Method in a study of Argentine Fertility*. New York: John Wiley.
- Clarke, J. (1992). *Stillbirths - The Patient Speaks - A Study of The Psychosocial Effects of Stillbirths*. Bridgetown: Queen Elizabeth Hospital, Barbados.
- Clift, F. (1997) Barbados. In Ferguson, J (Ed.). *Caribbean Children's Law Project – The Law Relating to Children in Barbados, Jamaica, Guyana and Trinidad and Tobago*. London: Hornby Ackroyd & Levy. Solicitors.
- Coblner, W. (1981). Prevention of Adolescent Pregnancy: A Developmental Perspective. *Birth Defects: Original Article Series*, 17, 35-47.
- Cohen, S., & Young, J. (1973). *The Manufacture of News: Social Problems, Deviance and the Mass Media*. London: Constable.
- Cohen, L., & Mannion, L. (1985). *Research Methods in Education*. London: Croom Helm.
- Contraceptive Prevalance Survey Jamaica - 1993. 1V. (1995). *Sexual Behaviour and Contraceptive Use among Young Adults*. Kingston: National Family Planning Board.
- Corbet, M., & Mayer, J. (1987). *The Adolescent and Pregnancy*. Boston, Massachusetts: Blackwell Scientific.
- Corlyon, J., & McGuire, C. (1997). *Young Parents in Public Care – Pregnancy and Parenthood Among Young People Looked After by Local Authorities*. London: National Children's Bureau Enterprises.
- Cornwell, J. (1984). *Hard Earned Lives : Accounts of Health & Illness from East London*. London: Tavistock.

- Corr, C. (1993). Coping With Dying: Lessons We Should Not Learn From the Work of Elizabeth Kubler-Ross. *Death Studies*. Vol. 17. 69-83.
- Coyne, A. (1986). *Schoolgirl Mothers*. London: Health Education Authority.
- Cragg Ross and Dawson Ltd. (1999). *Young People's experiences of relationships, sex and early parenthood: qualitative research*. London: Health Education Authority.
- Currie, J., Jekel, J., & Klerman, L. (1976). Subsequent Pregnancies Among Teenager Mothers Enrolled in a Special Program. *American Journal of Public Health*, 72, 1606-1611.
- Curtis, I. (1974). Observations of Unwed Pregnant Adolescents. *American Journal of Nursing*, 74, 100-102.
- Curtis, H., Lawrence, C., & Tripp, J. (1988). Teenage Sexual Intercourse and Pregnancy. *Archives of Disease in Childhood*, 63, 373-379.
- Cvetkovich, G., & Grote, B. (1980). Psychological Development and Social Problems of Teenage Illegitimacy. In C. Chilman (Ed.), *Adolescent Pregnancy and Childbearing* (pp. 15-41). Washington DC: US Government Printing Office.
- Daily Mail Comment. (1990). *Daily Mail*, 19/7/1990.
- Dana, M (1982). Abortion and the Emotions Involved. Unpublished paper. The Women's Therapy Centre.
- Daniel, B. Wassell, S. & Gilligan, R (1999). "It's Just Common Sense isn't it?" Exploring Ways of Putting the Theory of Resilience Into Action. *Adoption and Fostering – New Developments in Child Care Research*. Vol. 23 (3). 6-15.
- David, H., Morgall, J., Osler, M., Rasmussen, N., & Jensen, B. (1990). United States and Denmark: Different Approaches to Health Care and Family Planning. *Studies in Family Planning*, 21(1), 1-19.
- Davis, A. (1994). The Role of Hormonal Contraception in Adolescents. *American Journal of Obstetrics & Gynaecology*, 170, 1581-1585.
- Dawson, N. (1989). Report on the 1987 Survey of Educational Provision for Pregnant Schoolgirls and Schoolgirl Mothers. *Journal of Adolescent Health and Welfare*, 2(1), 7-8.
- Dawson, N. (1996). Report on the 1994 Survey of Educational Provision for Pregnant School-girl and School-girl Mothers. *Journal of Adolescent Health and Welfare*. Vol. 9 (1). 12-24.
- Dawson, N. (1997). The Provision of Education and Opportunities For Future Employment for Pregnant Schoolgirls and Schoolgirl Mothers in the United Kingdom. *Children and Society*. Vol.11. No.4. 252-263.
- Deans, J. (1992). 'Lilley;s £500m crackdown on Benefit Fiddlers'. *Daily Mail*, 8/10/92.
- Deans, J. (1993). Tories Signal Twin Attack on Abuse of Welfare Benefits - Crackdown on Lone Mothers. *Daily Mail*, 8/10/93.
- Deans, J. (1995). 'Redwood Single Mothers Storm'. *Daily Mail*, 14/8/95.
- Dechesnay, M. (1986). Jamaican Family Structure: The Paradox of Normalcy. *Family Process* 25: 293-300. Family Process, Inc.
- DeLozier, P. (1982). Attachment Theory and Child Abuse. In C. M Parkes & J. Stevenson-Hinde (Eds.). *The Place of Attachment in Human Behaviour*. London: Tavistock Publications.
- Denscombe, M. (1998). *The Good Research Guide*. Milton Keynes: Open University Press.
- Department of Education. (1994). *Education Act, 1993 : Sex Education in Schools* (Circular number 5/94. Education Act 1993). London: Department of Education.
- Department of Education. (1994). *Education Act, 1993 :Education of Pupils Educated Otherwise Than at School*. (Circular number 11/94. Education Act 1993). London Department of Education.

- Department of Education and Science. (2000). *Sex and Relationship Education - The New Guidance* (DFEE 0116/2000): Department of Education & Science.
- Department of Health. (1999). *The Health of the Nation: A strategy for Health in England*. London: HMSO.
- Department of Health. (2001). *Implementation of the Teenage Pregnancy Strategy Progress Report*. London: Department of Health.
- De Zaluondo, B. & Bernard, J.M. (1994). Meanings and Consequences of Sexual Economic Exchange: Gender, poverty and Sexual Risk Behaviour in Urban Haiti. In R. Parker., & J. Gagnon (Eds.). *Conceiving Sexuality: Sex Research in a Post-modern World*. London: Routledge.
- Dickens, H., Hartshore, E., & Garcia, C. (1976). One Hundred Pregnant Adolescents. Treatment Approaches in a University Hospital. *Journal of Public Health*, 63, 794-800.
- Dore, M., & Dumois, A. (1990). Cultural Differences in the Meaning of Adolescent Pregnancy. *Families in Society: The Journal of Contemporary Human Services*(February 1990), 93-101.
- Doughty, S. (1990). Scandal of Absent Fathers. *Daily Mail*, 1/1/90.
- Doughty, S. (1999). One in five girls 16-19 admits having multiple partners - shock truth in teenage sex. *Daily Mail*, 13/3/99.
- Doughty, S. (1999). Give Up Babies Plea to Single Mothers. *Daily Mail*, 26/1/99.
- Duncan, S., & Edwards, R. (Eds.). (1997). *Single Mothers in an International Context: Mothers or Workers?* London: UCL Press.
- Durham, M. (1989). Britain's new underclass. *Sunday Times*, 26/11/1989.
- Durkin, K (1995) *Developmental Social Psychology – From Infancy to Old Age*. Oxford: Blackwell Publishers Ltd.
- Egeland, B (1988) Breaking the Cycle of Abuse: Implications of Prediction and Intervention. In K. Browne, C. Davies & P. Stratton (Eds.) *Early Prediction and Prevention of Child Abuse*. Chichester: John Wiley & Sons.
- Edelman, M., & Pittman, K. (1986). Adolescent Pregnancy: Black and White. *Journal of Community Health*, 11, 63-69.
- Education Reform Act. (1988). London: HMSO.
- Eldelman, M. (1987). *Families in Peril: An Agenda for Social Change*. Cambridge, Massachusetts: Harvard University Press.
- Ellis, P. (1995). Participatory Research Methodology and Process: Experience and Perspective of a Caribbean Researcher. In B. Humphries (Ed.), *Understanding Research - An Independent Learning Pack for Health and Welfare Professionals, Students and Others Wishing to Develop Skills in Reading and Doing Research*. London: Whiting and Birch Ltd.
- Ellwood, D., & Bane, M. (1984). *The Impact of AFDC on Family Structure and Living Arrangements*. Massachusetts: Harvard University Press.
- Faculty of Public Health Medicine. (1994). *Guidelines for Health Promotion No 37: Measuring the Effectiveness of Contraception Services*. London: Faculty of Public Health Medicine.
- Falk, R., Gispert, M., & Baucom, D. (1981). Personality Factors Related to Black Teenage Pregnancy and Abortion. *Psychology of Women Quarterly*, 5, 5.
- Family Planning Association. (1993). *Children Who Have Children*. London: Family Planning Association.
- Family Policy Studies Centre (1996). *The Employment of Lone Parents - A Comparison of Policy in Twenty Countries*. London.
- Family Policy Studies Centre (1999). Family Briefing Paper 9 – *Teenage Pregnancy and the Family*. London.

- Feldman, E. (1981). *A Practical Guide to the Conduct of Field Research in the Social Sciences*. Boulder, Colorado: West View Press.
- Ferguson, J. (Ed.). (1997). *Caribbean Children's Law Project - The Law Relating to Children in Barbados, Jamaica, Guyana and Trinidad and Tobago*. London: Hornby, Ackroyd and Levy.
- Fiigel, H. (1982). Late Social and Psychological After Effect of Pregnancy in Adolescence. *Journal of Adolescent Health Care*, 2, 209-212.
- Field, F. (1989). *Losing Out: The Emergence of Britain's Underclass*. London: Blackwell.
- Fine, M. (1988). Sexuality, Schooling and Adolescent Females: The Missing Discourse of Desire. *Harvard Educational Review* 58: 29-53.
- Flanigan, B., & Hitch, M. (1986). Alcohol Use and Sexual Intercourse and Contraception: An Exploratory Study. *Journal of Alcohol and Drug Education*. Vol. 31. 6-40.
- Flanigan B. McLean, A. Hall, C. & Propp, V. (1990). Alcohol Use as a Situational Influence on Young Women's Pregnancy Risk-taking Behaviour. *Adolescence*. Vol. 25. 205-214.
- Fleissig, A. (1991). Unintended Pregnancies and the Use of Contraception: Changes from 1981-1989. *British Medical Journal*, 302(6769), 147-147.
- Fonagy et al (1991) The Capacity for Understanding Mental States: The Reflective Self in Parent and Child and its Significance for Security of Attachment. *Infant Mental Health Journal*. Vol. 12: 201-18.
- Fonagy et al (1994). The Theory and Practice of Resilience. *Journal of Child Psychiatry and Psychiatry*. Vol. 35 (2). 231-52.
- Fontana, A., & Frey, J. (1994). Interviewing the Art of Science. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*. London: Sage.
- Fontana, V. (1973). *Somewhere a Child is Crying: Maltreatment- Causes and Prevention*. New York: Macmillan.
- Ford, K. (1983). Second Pregnancies among Teenage Mothers. *Family Planning Perspectives*, 5(15), 268-272.
- Ford, N. (1993). The Sexual and Contraceptive Lifestyles of Young People: part II. *British Journal of Family Planning*, 18, 119-122.
- Francis, C. (1994). Sex Education for Teenagers in Holland. *Nursing Standard*, 8(15), 27-31.
- Frankham, J., & Stronach, I. (1990). *Making a Drama out of a Crisis: An Evaluation of the Norfolk Action Against AIDS Health Education Play 'Love Bites'*. Norwich: University of East Anglia Centre for Applied Research in Education.
- Frears, L., & Schneider, J. (1981). Exploring Loss and Grief within a Holistic Framework. *Personnel and Guidance*, 59(2), 341-345.
- Furstenberg, F. (1971). Preventing Unwanted Pregnancies among Adolescents. *Journal of Health and Social Behaviour*, 12, 340-347.
- Furstenberg, F. (1976). *Unplanned Parenthood: The Social Consequences of Teenage Childbearing*. New York: Free Press.
- Furstenberg, F., & Crawford, A. (1978). 'Family Support: Helping Teenage Mothers to Cope. *Family Planning Perspectives*, 10, 322-333.
- Furstenberg, F. (1980). Burdens & Benefits: Impact of Early Childbearing on the Family. *Journal of Social Issues*, 36 Part 1, 64-87.
- Furstenberg, F. J., & Brooks-Gunn, J. (1986). Teenage Childbearing, Causes, Consequences and Remedies. In L. Aike & D. Mechanic (Eds.), *Applications of Social Science to Clinical Medicine and Health Policy*. New Brunswick, NJ: Rutgers University Press.
- Furstenberg, F. J., Brooks-Gunn, J., & Morgan, S. (1987). *Adolescent Mothers in Later Life*. New York,: Cambridge University Press.

- Furstenberg, F., Levine, & Brooks-Gunn. (1990). The Children of Teenage Mothers : Patterns of Early Childbearing in Two Generations. *Family Planning Perspectives, 22*(2), 54-66.
- Gallagher, B., Creighton, S., & Gibbon, J. (1995). Ethical Dilemma in Social Research: No Easy Solutions. *British Journal of Social Work, 25*, 295-311.
- Garnet, L. (1992). *Leaving Care and After*. London: National Children's Bureau.
- Geronius, A. (1991). Teenage Childbearing and Social Reproductive Disadvantage: The Evolution of Complex Questions and the Demise of Simple Answers. *Family Relations, 40*, 463-471.
- Gilgun. (1994). Hand in Glove: The grounded Theory Approach and Social Work Practice Research. In E. Sherman & J. Reid (Eds.), *Qualitative Research in Social Work*. New York: Columbia University Press.
- Gispert, M , Brinich, P., Wheeler, K., & Krieger, L. (1984). Predictors of Repeat Pregnancies Among Low-Income Adolescents. *Hospital & Community Psychiatry, 35*(7), 719-723.
- Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory : Strategies for Qualitative Research*. Chicago: Aldine.
- Golding, P., & Middleton, S. (1978). Why is the press so obsessed with welfare scroungers? *New Society, 26*(October).
- Goldscheider, C., & Uhelenberg, P. (1969). Minority Group Status and Fertility. *American Journal of Sociology, 74*(4), 361-372.
- Gribben, M. (1992). *Seeking out the Wounded Child*. London: Barnardos.
- Grice, A. (1999). Ministers to take a harsh line on single parents. *Independent, 10/2/99*.
- Griffiths, M. (1990). Contraceptive Practices and Contraceptive Failures among Women Requesting Termination of Pregnancy. *British Journal of Family Planning, 16*, 16-18.
- Gunn, S. (1990). 'Thatcher Acts on missing fathers'. *The Times, 19/7/90*.
- Hakim, M. (1987). *Research Design: Strategies & Choices in the Design of Social Research*. London & New York: Routledge.
- Hall, S., Critcher, C., Jefferson, T., Clarke, J., & Roberts, B. (1978). *Policing the Crisis: Mugging, the State and Law and Order*. London: Macmillan.
- Hall, S. (1980). Encoding/Decoding. In S. Hall & D. Hobson & A. Lowe & P. Willis (Eds.), *Culture, Media, Language*. London: Routledge.
- Hamburg, B. (1981). Teenagers as Parents: Developmental Issues in School-age Pregnancy. In E. Purcell (Ed.), *Psychopathology of Childbearing and Youth: A Cross Cultural Perspective*. New York: Josial Macy Jr. Foundation.
- Hanson, S., Myers, D., & Ginsburg, A. (1987). The Role of Responsibility and Knowledge in Reducing Teenage Out-of-wedlock Childbearing. *Journal of Marriage and the Family, 49*(241-256).
- Hardy, J., Welcher, D., Stanley, J., & Dallas, J. (1978). Long-range Outcomes of Adolescent Pregnancy. *Clinical Obstetrics & Gynaecology, 21*, 1215-1232.
- Harper, C. (1989). *Adolescent Pregnancy in Latin America and the Caribbean*. New York: International Planned Parenthood Federation, Western Hemisphere Region, Inc.
- Havighurst, R. (1972). *Developmental Tasks and Education*. New York: London Books.
- Hay, C. (1995). Mobilization Through Interpretation: James Bulger, Juvenile Crime and the Construction of a Moral Panic. *Social & Legal Studies, 4*(June), 197-223.
- Hayes, C. (Ed.). (1987). *Risking the Future Vol 1: Adolescent Sexuality, Pregnancy and Childbearing*. Washington DC: National Academy Press.
- Health Education Authority. (1997). *Health Update 4- Sexual Health*. London: HEA.

- Health Education Authority. (1994). *Analysis of Health Education and Lifestyle Survey*. London: HEA.
- Health Education Authority. (1998). *Reducing the rate of Teenage Conceptions, Towards a National Programme*. London: Health Education Authority.
- Heron, J. (1981). Philosophical Basis for a New Paradigm. In P. a. R. Reason, J (Ed.), *Human Inquiry: A Sourcebook of New Paradigm Research*. Chichester: John Wiley and Sons.
- Hinkson, J. (1999). *The Research Papers into Teenage Pregnancy in Lambeth*. London: Lambeth Welcare.
- Hofferth, S., & Hayes, C. (Eds.). (1987). *Risking the Future Vol. 2*. Washington DC: National Academy Press.
- Hogan, D., & Kitagawa, E. (1985). The Impact of Social Status Family Structure and Neighborhood on the Family of Black Adolescents. *American Journal of Sociology*, 90, 825-855.
- Holland, J., Ramazanoglu, C., Scott, C. Sharpe, S., & Thomson, R (1990) Sex, Gender and Power: Young Women's Sexuality in the Shadow of AIDS. *Sociology of Health and Illness* Vol.12 No.3.
- Holmes, J (1993). *John Bowlby and Attachment*. London: Routledge.
- Horwitz, S., Klerman, L., Kuo, H., & Jekel, J. (1991). School-age Mothers: Predictors of Long-term Educational and Economic Outcomes. *Pediatrics*, 87, 862-868.
- Hudson, F., & Ineichen, B. (1991). *Taking It Lying Down - Sexuality and Teenage Motherhood*. Basingstoke: Macmillan.
- Hughes, D. (1999). Welfare the Crackdown. *Daily Mail*, 10/2/99.
- Humphries, B. (1995). *Understanding Research - An independent Learning Pack for Health & Welfare Professionals, Students & Others Wishing to Develop Skills in Reading and Doing Research*. London: Whiting & Birch Ltd.
- Hyman, J. (1999). *Teenage Motherhood - Identity and the Child Adult/ Dichotomy*. Unpublished Research Paper, Brunel University, London.
- Ibbotson, S. (1993). Teenage Pregnancy in the UK - a multifactorial issue demanding a multifactorial solution. *Fertility and Control Reviews*, 2(3), 13-18.
- Ireson, C. (1984). Adolescent Pregnancy and Sex Roles. *Sex Roles*, 11(3-4), 189-201.
- Jagdeo, T. (1984). *Teenage Pregnancy in the Caribbean*. New York: International Planned Parenthood Federation, Western Hemisphere Region/ Caribbean Family Planning Affiliation, St Johns Antigua, West Indies.
- Jagdeo, T. (1986). *Myths, Misconceptions and Mistakes - A Study of Trinidadian Adolescents*. Port of Spain, Trinidad: Family Planning Association of Trinidad and Tobago and UNICEF.
- Jagdeo, T. (1994). Teenage Pregnancy: A Caribbean Perspective. In G. Nicholson (Ed.), *Children Having Children: The Problem of Prevention of Adolescent Pregnancies*. Kingston: Canoe Press.
- Jekel, J., Klerman, L., Bancroft, R., & P, D. (1973). Factors Associated with Rapid Subsequent Pregnancies Among School Age Mothers. *American Journal Of Public Health*, 63(9), 769-773.
- Jekel, J., Tyler, N., & Klerman, L. (1979). Continued Childbearing Among Women who were Pregnant as Adolescents. *Journal of Population*, 2, 328-337.
- Johnson, C. (1974). Adolescent Pregnancy: Intervention into the Poverty Cycle. *Adolescence*, 9, 391.
- Jones, E., Forrest, J., Goldman, N., & al, e. (1985). Teenage pregnancy in developed countries: determinants and policy implications. *Family planning perspectives*, 17(2), 53-63.
- Jones, S. (1985). Depth Interviewing. In R. Walker (Ed.), *Applied Qualitative Research*.

Aldershot: Gower.

- Jones, E., & Guttmacher, A. (1986). *Teenage Pregnancy in Industrialized Countries: A study sponsored by the Alan Guttmacher Institute*. New Haven; London: Yale University Press.
- Jones, M. (1992). Teenage Pregnancies: Who is Responsible? *Education & Health*, 10(2), 21-26.
- Kalmuss, D., & Namerow, P. (1994). Subsequent Childbearing Among Teenage Mothers: The Determinants of a Closely Spaced Second Birth. *Family Planning Perspective*, 26(4), 149-153.
- Kari, J., Donovan, C., Li, J., & Taylor, B. (1997). Adolescent Attitudes to General Practice in North London. *British Journal of General Practice*, 47(415), 109-110.
- Kaufman, J. & Zigler, E. (1989). The Intergenerational Transmission of Child Abuse. In Cicchetti & Carlston. Pp. 129-50.
- Kiernan, K. (1996). Lone Motherhood, Employment and Outcomes for Children. *International Journal of Law, Policy and the Family*, 10(3), 233-249.
- King, L. (1997). Jamaica. In J Ferguson (Ed.). *Caribbean Children's Law Project – The Law Relating to Children in Barbados, Jamaica, Guyana and Trinidad and Tobago*. London: Hornby Ackroyd & Levy. Solicitors.
- King, T., & Fullard, N. (1983). Teenage Mothers and Their Infants: New Findings on the Home Environment. *Journal of Adolescence*, 7, 171-190.
- Kirby, D., Barth, R., Leland, N., & Fetro, F. (1991). Reducing the Risk: Impact of a New Curriculum on Sexual-risktaking. *Family Planning Perspectives*, 23(6), 253-263.
- Kirby, D. (1992). School-based Programs to Reduce Sexual Risk-taking Behaviour. *Journal of School Health*, 62(7), 280-287.
- Kitchan, C., & Marsh, B. (2000). £60m to tell girls that it is ok to be a virgin. *Daily Mail*, 10/10/2000.
- Klein, L. (1974). Early Teenage Pregnancy, Contraception and Repeat Pregnancy. *American Journal of Obstetrics & Gynaecology*, 120(2), 249-255.
- Klerman, L., & Jekel, J. (1973). *School Age Mothers : Problems, Programs and Policy*. Hamden, Connecticut: Linnet Books.
- Klerman, L. (1980). Adolescent Pregnancy: A New Look at a Continuing Problem. *American Journal of Public Health*, 70, 776-778.
- Koenig, M., & Zelnik, M. (1982). Repeat Pregnancies among Metropolitan Area Teenagers: 1971-1979. *Family Planning Perspectives*, 14(6), 341-344.
- Kohn, M. (1989b). Cross National Research as an Analytical Strategy. In M. Kohn (Ed.), *Cross National Research in Sociology*. Newbury Park: Sage.
- Konge, J., Palmer, A., Watson, A., Hey, M., Imrie, A., & Ewings, P. (1992). Early Teenage Pregnancies in Hull. *British Journal of Obstetrics and Gynaecology*, 99, 969-973.
- Kubler-Ross, E. (1969). *On Death and Dying*. London: Tavistock.
- Kurtz, K. et al. (1995) Adolescent Fertility and Reproductive Health: A Needs Assessment in the English Speaking Caribbean for Pew Charitable Trusts. Washington, DC: International Centre for Research on Women.
- Kuziel-Perri, P., & Snarey, J. (1991). Adolescent Repeat Pregnancies: An Evaluation Study of a Comprehensive Service Program for Pregnant and Parenting Black Adolescents. *Family Relations*, 140 (October), 381-385.
- Lamb, M (1997). *The Role of Fathers in Child Development*. New York: Wiley and Sons.
- Landy, S., Schubert, J., Clelanad, J., Clark, C., & Montgomery, J. (1983). Teenage Pregnancy: Family Syndrome. *Adolescence*, 18(71), 679-694.
- Lather, P. (1988). Feminist Perspectives on Empowering Research Methodologies. *Womens Studies Intemational Forum*, 11, 569-582.

- Lawson, A., & Rhode, D. (Eds.). (1993). *The Politics of Pregnancy: Adolescent Sexuality and Public Policy*. New Haven: Yale University Press.
- Ledwith, M. (1994). Listening as Emancipatory Research. *Critical Public Health*, 5(3), 15-18.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Enquiry*. Newbury Park CA: Sage.
- Lindahl, K. (1991). The Swedish Experience. *Teenage Parenthood Network*, 4, 19-22.
- Lister, R. (1996). In Search of the Underclass. In R. Lister (Ed.), *Charles Murray and the Underclass; The Developing Debate*. London: IEA Welfare Unit.
- Local Government Act. (1988). London: HMSO.
- Lovell, A. (1997). Death at the Beginning of Life. In D. Field, J. Hockey, & N. Small (Eds.) *Death, Gender and Ethnicity*. London: Routledge.
- Lundberg, E., & Lenroot, K. (1984). *Illegitimacy as a Child Welfare problem*. New York: Arno Press.
- MacFarlane, C., & Warren, C. (1989). Contraceptive Prevalence Survey: Jamaica. Kingston: National Family Planning Board.
- MacIntyre, S., & Cunningham-Burley, S. (1993). Teenage Parents as a Social Problem: A Perspective from the United Kingdom. In A. Lawson & D. Rhode (Eds.), *The Politics of Pregnancy - Adolescent Sexuality and Public Policy*. New Haven: Yale University Press.
- Main, M. & Hesse, E. (1990). Parents' Unresolved Traumatic Experiences Are Related to Infants in Disorganized Attachment Status: Is Frightening and/or Frightening Parents Behaviour the Linking Mechanism? In M. Greenberg, D. Cicchette & E. Cummings. (Eds.) *Attachment in the Pre-school Years, Theory, Research and Intervention*. Chicago, Illinois: University of Chicago Press.
- Main, M. & Solomon, J. (1986). Discovery of an Insecure, Disorganized/disoriented Attachment Pattern: Procedures, Findings and Implications for Classification of Behaviour. In M. Yogman & T Brazelton (Eds.) *Effective Development in Infancy*. New York: Ablex.
- Main, M. Kaplan, K & Cassidy, J. (1985). Security in Infancy, Childhood and Adulthood. A Move to the Level of Representation. In, I. Bretherton, & E. Waters (Eds.) *Growing Points of Attachment Theory and Research. Monographs of the Society for Research in Child Development*. Vol. 50: 66-104.
- Manlove, J., Mariner, C., & Romano, A. (1998). *Positive Educational Outcomes Among School-age Mothers*. Washington DC: Child Trends.
- Manlove, J., Mariner, C., & Romano, A. (2000). Subsequent Fertility Among Teen Mothers: Longitudinal Analysis of Recent National Data. *Journal of Marriage and the Family*, 62, 430-448.
- Marchant, C. (1993). Single minded. *Community Care*, 5/8/1993(978).
- Marris, P. (1986). *Loss and Change*. London: Routledge and Kegan Paul.
- Marsiglio, W., & Mott, F. (1986). The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancies Among American Teenagers. *Family Planning Perspectives*, 18(4), 151-162.
- Maskey, S. (1991). Teenage Pregnancy: doubts, uncertainties and psychiatric disturbance. *Journal of the Royal Society of Medicine*, 84(December), 723-725.
- Massey, D. (1990). School Sex Education: knitting without a pattern? *Health Education Journal*, 49(3), 134-142.
- Maughn, P. (1994). Teenage Pregnancy. In G. Nicholson (Ed.) *Children Having Children: The Problem and Prevention of Adolescent Pregnancy*. Kingston: University of the West Indies. Canoe Press.
- Mayer, J., & Timms, N. (1970). *The Client Speaks - Working Class Impressions Of Casework*. London: Routledge & Kegan Paul.

- McAnarney, E. (Ed.). (1983). *Premature Adolescent Pregnancy and Parenthood*. New York: Grune & Stratton.
- McAnarney, E., & Hendee, W. (1989). Adolescent Pregnancy and its Consequences. *Journal of American Medical Association*, 262(1), 74-78.
- McCarthy, J., & Menkell, J. (1979). Marriage, Remarriage, Marital Disruption and Age at First Birth. *Family Planning Perspectives*, 11, 21-30.
- McCormic, M., Shapiro, S., & Sarfield, B. (1984). High risk mothers: Infant mortality and morbidity in four areas of the United States, 1973-1978. *American Journal of Public Health*, 79, 18-23.
- McNeil, P., Olafson, F., Powell, D., & Jackson, J. (1983). *The Women's Centre in Jamaica: An Innovative Project for Adolescent Mothers*.
- McQuail, D. (1969). *Towards a Sociology of Mass Communication*. London: Collier-Macmillan.
- Mellamby, A., Phelps, F., & Tripp, J. (1993). Teenagers, Sex and Risk Taking. *British Medical Journal*, 307(6895), 25-25.
- Metson, D. (1988). Lessons From an Audit of Unplanned Pregnancies. *British Medical Journal*, 297, 904-906.
- Miles, M., & Huberman, A. (1984). *Qualitative Data Analysis : A Source of New Methods*. Beverley Hills & London: Sage.
- Miller, B., & Moore, K. (1990). Adolescent Sexual Behaviour, Pregnancy and Parenting: Research through the 1980s. *Journal of Marriage and the Family*, 300, 1026-1027.
- Milman, S., & Hendershot, G. (1980). Early Fertility and Lifetime Fertility. *Family Planning Perspectives*, 12(3), 139-149.
- Moore, K., & Caldwell, S. (1977). The Effects of Government Policies on Out-of-Wedlock Sex and Pregnancy. *Family Planning Perspectives*, 9, 164-169.
- Moore, K., & Waite, L. (1977). Early Childbearing and Educational Attainment. *Family Planning Perspective*, 9(5), 220-225.
- Moore, S., & Rosenthal, D. (1993). *Sexuality in Adolescence*. London: Routledge.
- Morgan, R. (1992). 'Lilley targets scroungers'. *The Times*, 8/10/92.
- Morgan, J. (1994). *What parents think their children know - what their children say they know*. Harrogate: Northern and Yorkshire Regional Health Authority.
- Morris, L. (1994). *Dangerous classes: The Underclass and Social Citizenship*. London: Routledge.
- Morrison, D. (1985). Adolescent Contraceptive Behaviour: A Review. *Psychological Bulletin*, 98, 538-568.
- Morrison, D. (1989). Predicting Contraceptive Efficacy: A Discriminant Analysis of Three Groups of Adolescent Women. *Journal of Applied Social Psychology*, 19, 141-152.
- Mott, F. L., & Maxwell, N. L. (1981). School-Age Mothers - 1968 and 1979. *Family Planning Perspectives*, 13(6), 287-292.
- Mott, F. L., & Marsiglio, W. (1985). Early Childbearing and Completion of High-School. *Family Planning Perspectives*, 17(5), 234-237.
- Mott, F. (1986). The Pace of Repeated Childbearing Among Young American Mothers. *Family Planning Perspectives*, 18(1), 5-12.
- Moulder, C. (1990). *Miscarriage: Women's Experiences and Needs*. London: Pandora.
- Muncie, J. (1999). *Youth and Crime: A Critical Introduction*. London: Sage Publications.
- Murray, C. (1990). *The Emerging British Underclass*. London: IEA Health and Welfare Unit.
- Musick, J. (1993). *Young Poor & Pregnant: The Psychology of Teenage Motherhood*. New Haven: Yale University Press.

- National AIDS Trust Youth Initiative. (1991). *Living for Tomorrow*: National AIDS Trust.
- National Curriculum Council. (1990). *Health Education Curriculum Guidance 5*: National Curriculum Council.
- National Health Service Reorganisation Act. (1973). London: HMSO.
- Nicholson, G. (1991). *The Medical and Health Related Implications of Adolescent Pregnancy*. Paper presented at the Teenage Pregnancy, Barbados, West Indies.
- Nord, C., Moore, K., Morrison, D., Brown, B., & Myers, D. (1992). Consequences of Teenage Parenting. *Journal of School Health*, 62(7), 310-318.
- Nyman, V. (1993). Going Dutch - a pipe dream? *British Journal of Family Planning*, 19, 200-203.
- Oakley, A. (1981). Interviewing Women : A Contradiction in Terms. In H. Roberts (Ed.), *Doing Feminist Research*. London: Routledge & Kegan Paul.
- Oakley, R. (1988). Nuclear Power is 'greener' says Thatcher. *The Times*, 26/10/88.
- Oakley, R. (1990). Plan to Make Fathers Pay. *The Times*, 17/1/90.
- Oakley, R. (1990). Permissive Age Attacked. *The Times*, 18/1/90.
- Oakley, D. (1994). Rethinking Patient Counselling Techniques for Changing Contraceptive use Behaviour. *American Journal of Obstetrics & Gynaecology*, 170(5), 1585-1590.
- Office of National Statistics. (2000). *Population Trends 102*: Office of National Statistics.
- Olds, D., Henderson, C., Tatelbaum, R., & Chamberlain, R. (1988). Improving the Life Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation. *Journal of Public Health*, 78, 1436-1445.
- Onyehalu, A. (1983). Inadequacy of Sex Knowledge of Adolescents: Implications for Counselling and Sex Education. *Adolescents*, 18(71), 627-630.
- Oppel, W., & Royston, A. (1971). Teenage Births: Some Social, Psychological and Physical Sequelae. *American Journal of Public Health*, 61, 751-756.
- Osofsky, J. (1978). Teenage Pregnancy: Psychological Considerations. *Clinical Obstetrics and Gynaecology*, 21(4), 1161-1173.
- Oyen, E. (Ed.). (1992). *Comparative Research Methodology - Theory and Practice in International Social Research*. London: Sage Publications Ltd.
- Oz, S., & Fine, M. (1988). A Comparison of Childhood Backgrounds of Teenage Mothers and their Non-mother Peers: A New Formulation. *Journal of Adolescence*, 11, 251-261.
- Ozawa, M. (1989). Welfare Policies and Illegitimate Birth Rate Among Adolescents: Analysis of State by State Data. *Social Work Research Abstracts*, March, 5-11.
- Paik, S. (1992). Self Concept of Pregnant Teenagers. *Journal of Health and Social Policy*, 3(3), 93-111.
- Pan American Health Organisation. (1994). *Health of Children and Adolescents: Health Conditions in the Americas*. Washington DC.
- Parker, H. (1995). *Taxes, Benefits and Family Life*. London: Institute of Economic Affairs.
- Parkes, CM. (1972). *Bereavement – Studies in Grief in Adult Life*. London: Tavistock.
- Parkes, CM. (1996). *Bereavement – Studies in Grief in Adult Life*. London: Routledge.
- Peach, E., Harris, J., & Bielby, E. (1994). *Teenage Pregnancy - A Community Issue. A Literature Review*: Nuffield Institute for Health.
- Pearce, D. (1993). Children Having Children. In A. Lawson & D. Rhode (Eds.), *The Politics of Pregnancy : Adolescent Sexuality and Public Policy*. New Haven: Yale University Press.
- Peckham, S. (1993). Preventing Unintended Teenage Pregnancies. *Public Health*, 107, 125-133.
- Phelps, F., Mellanby, A., Crichton, N., & Tripp, J. (1994). Sex Education: The Effect of a

- Peer Programme on Pupils (aged 13-14 years) and Their Peer Leaders. *Health Education Journal*, 53, 127-139.
- Phipps-Yonas, S. (1980). Teenage Pregnancy and Motherhood: A review of the literature. *American Journal of Orthopsychiatry*, 50(3), 403-431.
- Phoenix, A. (1988b). Narrow Definitions of Culture: The Case of Early Motherhood. In S. B. Westwood, P (Ed.), *Enterprising Women: Home work and Culture among Minorities in Britain*. London: Routledge.
- Phoenix, A. (1991). *Young Mothers*. Cambridge: Polity Press.
- Phoenix, A. (1991). *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
- Plotnick, R., & Butler, S. (1991). Attitudes and Adolescent Non-marital Childbearing: Evidence from the National Longitudinal Survey of Youth. *Journal of Adolescent Research*, 6, 470-492.
- Plotnick, R. (1992). The Effects of Attitudes on Teenage Premarital Pregnancy and its Resolution. *American Sociological Review*, 57(December), 800-811.
- Policy Studies Institute (1997). *Fourth National Survey of Ethnic Minorities*. London.
- Polit, D., & Kahn, J. (1986). Early Subsequent Pregnancy Among Economically Disadvantaged Teenage Mothers. *American Journal of Public Health*, 76(2), 167-171.
- Population Reference, B. (1992). *Adolescent Sexual Activity and Childbearing: Risks and Consequences in Latin America and the Caribbean*. Washington, DC.
- Powell, D., & Jackson, J. (1988). *Young Adult Reproductive Health Survey*. Kingston: Jamaica National Family Planning Board.
- Presser, H. (1971). The Timing of First Birth, Female Roles and Black Fertility. *Milbank Memorial Fund Quarterly*, 49, 329-362.
- Presser, H., & Salsberg, L. (1975). Public Assistance and Early Family Formation: Is there a Pronatalist Effect? *Social Problems*, 23, 226-241.
- Public Health Laboratory Services. (2000). *Data on Sexually Transmitted Infections in the United Kingdom 1995-2000*. London: Public Health Laboratory Services.
- Quinton, D., & Rutter, M. (1988). *Parenting Breakdown. The Making and Breaking of Inter-generational Links*. Aldershot: Avebury.
- Ragin, C. (1987). *The Comparative Method: Moving beyond Qualitative & Quantitative Strategies*. Berkeley, California: University of California Press.
- Randall, R., & Southgate, J. (1981). Doing Dialogical Research. In P. Reason & J. Rowan (Eds.), *Human Inquiry : A Sourcebook of new Paradigm Research*. Chichester: Wiley & Sons.
- Raphael, B. (1983). *The Anatomy of Bereavement*. New York: Basic Books.
- Ray, C. (1994). *Sex Education. Highlight No. 128 (28)*. London: National Children's Bureau.
- Reason, P., & Rowan, J. (Eds.). (1985). *Human Inquiry - A Sourcebook of New Paradigm Research*. Chichester: Wiley.
- Reason, P. (Ed.). (1988). *Human Inquiry in Action-Developments in New Paradigm Research*. London: Sage.
- Renzetti, C., & Lee, R. (1993). *Researching Sensitive Topics*. London: Sage.
- Rhode, D. (1993). Adolescent Pregnancy and Public Policy. In A. Lawson & D. Rhode (Eds.), *The Politics of Pregnancy: Adolescent Sexuality and Public Policy*. New Haven: Yale University Press.
- Rhode, D., & Lawson, A. (1993). Introduction. In A. Lawson & D. Rhode (Eds.), *The Politics of Pregnancy: Adolescent Sexuality and Public Policy*. New Haven: Yale University Press.
- Rhodes, T., & Stimson, G. (1994). What is the Relationship Between Drug Taking and Sexual Risks? Social Relations and Social Research. *Sociology of Health and*

- Illness*. Vol. 16 (2). 209-28.
- Rickert, V., Gottlieb, A., & Jay, M. (1991). Effects of Peer-counselled AIDS Education Program on Knowledge, Attitudes and Satisfaction of Adolescents. *Journal of Adolescent Health*, 12, 38-43.
- Rickford, F. (1992). Baby Boom. *Social Work Today*. November 5th.
- Rindfuss, R., St. John, C., & Bumpass, L. (1984). Education and the Timing of Motherhood: Disentangling Causation. *Journal of Marriage and the Family*, 46, 981-984.
- Ritchie, J., & Spencer, L. (1994). Qualitative Data Analysis for Applied Policy Research. In A. Bryman & R. Burghes (Eds.), *Analysing Qualitative Data*. London & New York: Routledge.
- Robbins, C., Kaplan, H., & Martin, S. (1985). Antecedents of Pregnancy Among Unmarried Adolescents. *Journal of Marriage and the Family*, 47(3), 567-583.
- Roberts, R. (1976). *The Unwed Mother*. New York: Harper and Row.
- Rosenberg, M. (1979). *Conceiving the Self*. New York: Basic Books.
- Rotchell, Y. (1983). Teenage Pregnancies. In H. Fraser & M. Hoyos (Eds.), *Adolescent Medicine in the Caribbean*: University of the West Indies.
- Royal College of Obstetricians and Gynaecologists. (1991). *Unplanned Pregnancies - Working Party*. London: Royal College of Obstetricians and Gynaecologist.
- Rubin, H., & Rubin, I. (1995). *Qualitative Interviewing - The Art of Hearing Data*. Illinois: Northern Illinois University.
- Rudat, K., Ryan, H., & Speed, M. (1992). *Today's Young Adults*. London: Health Education Authority.
- Russell, J. (1983). School Pregnancies- Medical, Social and Educational Considerations. *British Journal of Hospital Medicine*, 29(2), 159-166.
- Russell, J. (1983). School Pregnancies: A Theoretical Analysis of a Social Problem. *Adolescence*, 24(93), 19-28.
- Russell-Brown, P. (1988). *Teenage Sexuality, Perceptions and Attitudes of the Youth of Tobago*. Port of Spain: Family Planning Board, Trinidad and Tobago.
- Rutter, M., & Giller, H. (1983). *Juvenile Delinquency: Trends and Perspective*. Harmondsworth: Penguin.
- Rutter, M. (1987). (Temperament, Personality, and Personality Disorders. *British Journal of Psychiatry*. Vol. 150. 443-58.
- Rutter, M. & Rutter, M. (1993). *Developing Minds*. Harmondsworth, Middlesex: Penguin.
- Rutter, M. & Madge, N (1976). *Cycles of Disadvantage*. London: Heinemann Educational Books.
- Ryder, N., & Westoff, C. (1971). *Reproduction in the United States, 1965*. Princeton: Princeton University Press.
- Sandford, L., & Donovan, M. (1993). *Women and Self Esteem*. London: Penguin Books.
- Santelli, J., & Beilenson, P. (1992). Risk Factors for Adolescent Sexual Behaviour, Fertility and Sexually Transmitted Diseases. *Journal of School Health*, 62(7), 271-279.
- Sargeant, H (1994). Strategic Planning. In G. Nicholson (Ed.) *Children Having Children: The Problem and Prevention of Adolescent Pregnancy*. Kingston: University of the West Indies. Canoe Press.
- Scally, G. (1993). Confidentiality, Contraception and Young People. *British Medical Journal*, 307, 1157-1158.
- Schofield, G. (1994). *The Youngest Mothers: The Experience of Pregnancy and Motherhood Among Young Women of School Age*: Avebury.
- Schofield, G. (2001). Resilience and Family Placement – A Lifespan Perspective. *Adoption and Fostering – New Developments in Child Care Research*. Vol. 25.

(3). 6-19.

- Scott, L., & Thomson, R. (1992). School Sex Education: more a patchwork than a pattern. *Health Education Journal*, 51(3), 132-135.
- Scott-Jones, D. (1991). Educational Levels of Adolescent Childbearers at First and Second Births. *American Journal of Education*, August, 461-480.
- Scott, J. (1983). The Sentiments of Love and Aspirations for Marriage and Their Association with Teenage Sexual Activity and Pregnancy. *Adolescence* Vol. 18: 889-897.
- Segest, E. (1992). It Requires Knowledge, Insight and Skill. *Teenage Parenthood Network*, 7, 4-6.
- Seitz, V., & Apfel, N. (1993). Adolescent Mothers and Repeated Childbearing: Effects of School-Based Intervention Program. *American Journal of Orthopsychiatry*, 63(4), 572-581.
- Selwyn, J (2000) Infancy. In M. Boushel, M. Fawcett and J. Selwyn (Eds.) *Focus on Early Childhood - Principles and Realities*. London: Blackwell Science.
- Sex Education Forum (1998). *Let's Talk About Sex and Relationships: A Policy and Practice Framework for Working With Children and Young People in Public Care*. London: National Children's Bureau.
- Sharpe, S. (1987). *Falling for Love: Teenage Mothers Talk*. London: Virago.
- Sheldon, T. (1998). Diary of a Sex Education Class - Dutch Courage. *Guardian*, 11/2/98.
- Simms, M., & Smith, C. (1985). *Teenage Mothers and Their Partners*. London: HMSO.
- Skinner, C. (1986). *Elusive Mr Right : The Social and Personal context of Contraception*. London: Carolina.
- Singh, S., & Wulf, D. (1990). *Today's Adolescents, Tomorrow's Parents: A Portrait of the Americas*. New York: The Alan Guttmacher Institute.
- Smith, P. B., Nenny, S. W., Weinman, M. L., & Mumford, D. M. (1982). Factors Affecting Perception of Pregnancy Risk in the Adolescent. *Journal of Youth and Adolescence*, 11(3), 207-215.
- Smith, D. (1987). *The Everyday World as Problematic : A Feminist Sociology*. Boston: North Eastern University Press.
- Smith, T. (1993). Influence of Socio-economic Factors on Attaining Targets for Reducing Teenage Pregnancies. *British Medical Journal*, 306, 1232-1235.
- Social Exclusion Unit. (1999). *Teenage Pregnancy*. The Stationery Office Ltd.
- Speck, P. (1978). *Loss and Grief in Medicine*. Balliere Tindall.
- St. John, C. (1982). Differences in Age at First Birth and the Pace of Subsequent Childbearing. Implications for the Minority Group Status Hypothesis. *Demography*, 19(3), 301-314.
- Stanley, L., & Wise, S. (1983). *Breaking out: Feminist Consciousness & Feminist Research*. London and New York: Routledge and Kegan Paul.
- Stark, E. (1986). Young, Innocent and Pregnant - Teenagers Get Pregnant for a Variety of Reasons, from Ambivalence and Ignorance About Sex to Wanting to Fill a Void in Their Lives. *Psychology Today*, 20(10), 28-29.
- Steele, B.(1975b). *Working With Abusive Parents from a Psychiatric Point of View*. Washington DC: Government Printing Office. (U.S Department of Health, Education Publications No. (OHD) 75-70.
- Steele, B., & Pollack, C. (1968) A Psychiatric Study of Parents who Abuse Infants and Small Children. In R. Helfer & C. Kempe (Ed.). *The Battered Child*. Chicago: Chicago University Press.
- Stevens-Simon, C., Parsons, J., & Montgomery, C. (1986). What is the Relationship Between Postpartum Withdrawal from School and Repeat Pregnancy Among Adolescent Mothers? *Journal of Adolescent Health Care*, 7(3), 191-194.

- Stout, J., & Rivara, F. (1989). Schools and Sex Education: Does it Work? *Paediatrics*, 83(3), 375-379.
- Strauss, A. (1987). *Qualitative Analysis for Social Scientists*. Cambridge & New York: Cambridge University Press.
- Stringham, J., Riley, J., & Ross, A. (1982). Silent Birth: Mourning a Stillborn Baby. *Social Work*(July 1982), 322-327.
- Stroebe, M., Stroebe, W., & Hanson, R. (Eds.). *Handbook of Bereavement: Theory, Research and Intervention*. Cambridge: Cambridge University Press.
- Stroebe, M., & Schut, H. (1997). The Dual Process model of Coping with Bereavement: Rationale and Description. *Death Studies*. Vol. 23. 197-224.
- Stroebe, M., & Schut, H. (1998). Culture and Grief. *Bereavement Care*. Vol.17. (1) 7-11.
- Taylor, B., Wadsworth, J., & Butler, N. (1983). Teenage Mothering: Hospitalizations and Accidents During the First Five Years. *Archives of Disease in Childhood*, 58, 6-11.
- The Children Act. (1989). London: HMSO.
- Thomlinson, R. (1965). *Population Dynamics*. New York: Random House.
- Thomson, R., & Stout, L. (1992). *An Enquiry into Sex Education*: Sex Education Forum, National Children's Bureau.
- Toynbee, P. (1998). Why Kids Have Babies. *Guardian*, 26/8/98.
- Toynbee, P. (1999). Mixed-up teenagers need more than this botched job. *Guardian*, 16/6/99.
- Trussel, J., & Menken, J. (1978). Early Childbearing and Subsequent Fertility. *Family Planning Perspectives*, 10(4), 209-218.
- Trussel, J. (1988). Teenage Pregnancy in the United States. *Family Planning Perspectives*, 20(6), 262-272.
- Turner, T. (1994) Childbearing and Teenage Pregnancy in Antigua. In G. Nicholson (Ed.) *Children Having Children: The Problem and Prevention of Adolescent Pregnancy*. Kingston: University of the West Indies. Canoe Press.
- Upchurch, D., & McCarthy, J. (1989). Adolescent Childbearing and High School Completion in the 1980s: Have Things Changed? *Family Planning Perspectives*, 21(5), 199-202.
- Upchurch, D., & McCarthy, J. (1990). The Timing of First Birth and High School Completion. *American Journal of Sociological Review*, 55, 224-234.
- Ventura, S., Matthews, T., & Curtin, S. (1998). *Declines in Teenage Births 1991-1997: National and State Patterns* (47): National Vital Statistics Report 47.
- Vernon, M., Green, J., & Frothingham, T. (1983). Teenage Pregnancy: A Prospective Study of Self-esteem and other Socio-demographic Factors. *Paediatrics*, 72(632-635).
- Walker, A. (1996). Blaming the Victim. In R. Lister (Ed.), *Charles Murray and the Underclass: the developing debate*. London: IEA Welfare Unit.
- Walter, T. (1994). *The Revival of Death*. London: Routledge.
- Walter, T. (1996). A New Model of Grief: Bereavement and Biography. *Mortality*. Vol.1 (1). 7-25.
- Washington, A. (1982). A Cultural Historical Perspective on Pregnancy Related Activity Among U.S Teenagers. *The Journal of Black Psychology*, 9, 1-28.
- Webster, P. (1988). Lawson Faces Censure Over Lobby Briefing. *The Times*, 10/11/88.
- Wellings, K., Field, J., Johnson, A., & Wadsworth, J. (1994). *Sexual Behaviour in Britain*. London: Penguin.
- Werner, E., & Smith, R. (1982). *Vulnerable but Invincible: A Longitudinal Study of Resilient Children*. New York: McGraw-Hill.
- Westlake, D & Pearson, M. (1997) Child Protection and Health Promotion, Whose

- Relationship? *Journal of Social Welfare and Family Law*. Vol. 19 (2) 139-58.
- Westoff, C., & Ryder, N. (1977). *The Contraceptive Revolution*. Princeton: Princeton University Press.
- Weymouth, W. (1998). *News as Discourse*. Hillsdale, New Jersey: Lawrence Erlbaum.
- Williams, C. (1991). *Black Teenage Mothers Pregnancy and Child Rearing from their Perspective*. Lexington, Massachusetts: Lexington Books.
- Williams, E. (1994). Contraceptive Compliance Among Young People. *British Journal of Sexual Medicine*, 3, 12-15.
- Wilson, S., & Heslop, C. (1991). Do We Need Local Family Planning Clinics? *British Journal of Family Planning*, 17, 49-52.
- Wilson, S., Brown, T., & Richards, R. (1992). Teenage Conception and Contraception in English Regions. *Journal of Public Health Medicine*, 14(1), 17-25.
- Women Centre of Jamaica Foundation. (1994). Annual Report. Jan-Dec.
- Winter, L., & Breckenmaker, L. (1991). Tailoring Family Planning Services to the Needs of Adolescents. *Family Planning Perspectives*, 23(1), 24-30.
- Wintour, P. (1993). Portillo Conjures up Christian Lessons for Welfare Cutback. *Guardian*, 16/9/93.
- Wood, N. (1994). Lone Mothers Reject Jobless Young Men as Husbands - Lilley. *The Times*, 21/6/94.
- World Health Organisation. (1991). Women, Health and Development Progress Report by the Director General.
- Wright Mills, C. (1959) *The Sociological Imagination*. New York: Oxford University Press.
- Zabin, L., & Sedivy, V. (1992). Abortion Among Adolescents: Research Findings and the Current Debate. *Journal of School Health*, 62(7), 319-324.
- Zelnik, M., Kanter, J., & Ford, K. (1981). *Sex and Pregnancy in Adolescence*. Beverly Hills: Sage.
- Zongler, C. (1977). The Self-Concept of Pregnant Adolescent Girls. *Adolescence*, 12(48), 477-488.

Appendix one

Outcome of second pregnancy:

.....
.....
.....

Source of income:

.....
.....
.....

Family composition:

.....
.....
.....

Other pregnancies among siblings?

.....
.....
.....
.....
.....
.....
.....

Single or two parent family?

.....

If single, male or female:

.....

Parents' education and occupation:

.....
.....
.....
.....

Housing circumstances:

.....

.....

.....

.....

Themes To Explore

Education:

- Age at leaving school.
- Exams passed and/or courses attended/skills training.
- Feelings about school in particular and education in general.
- If currently not at school, are there plans to return to school or other form of educational institution/project? If not, why not?
- Attitude of teachers towards pregnancy.
- Attitude of teachers/schools towards continuing education.
- Experience at school.
- Performance at school.
- Parent's/guardian's views about education.

Family Relationships:

- Relationship with parent or parents.
- Relationship with siblings.
- Extent to which these relationships are viewed positively or negatively, factors influencing this perception.
- Extent to which you can confide in a family member(s).
- Relationship with mother. Was mother the first person you told about the pregnancy? Was mother aware of the sexual relationship, if so what were her views?
- Was there agreement between mother and daughter about the outcome of the pregnancy, use of contraceptives, educational goals.
- Degree of supportiveness/condemnation.
- Feelings of family members regarding the pregnancy.
- Reactions of family to pregnancy, first and subsequent pregnancies.
- How have these reactions affected you and your relationship with the family or individual members?
- To what extent are issues of sexuality, contraception discussed openly in the family or with individual members.

Other Relationships:

- View of friendship/relationships in general.
- Importance of relationship with boyfriend/putative father. Importance of stable relationships.
- Importance of relationship with peers. Influence of peers, their feelings about teenage pregnancies, about sexuality and relationship.
- What part can peers play in teenage pregnancy and prevention?

Boyfriend/Putative Father:

- Age of boyfriend/putative father(s).
- Education and socio-economic status of boyfriend.
- Boyfriend's attitude towards pregnancy, first and subsequent.
- His feelings and attitude towards any goals/plans you may have.

Professional Services - Voluntary & Statutory:

- Knowledge of various services for teenagers aimed at supporting pregnant teenagers of preventing teenage pregnancies.
- If aware of such resources, feelings regarding them.
- Feelings about the approach of professionals/volunteers offering such services.
- Degree of perceived usefulness of such services.
- Should there be separate services for teenagers, particularly pregnant teenagers?
- Quality of relationship(s) with such professionals, factors influencing this perception

Financial Factors/Employment:

- Whether employed or not. If not, source of financial support.
- Did lack of income have an influence on first and subsequent pregnancies - if so, in what way?

Health:

- Health prior to the pregnancy.
- Health during the pregnancy and currently, if not pregnant?
- Baby's health.
- Ante-natal and post-natal care. Feelings about the quality and approach to such care.
- Perceived gaps in these services.
- Was ante-natal care commenced at the recommended time? If not, why not?

Abortion:

- Views/feelings about abortion. Who and/or what has helped to shape these views?
- Was abortion a consideration at any time? If so, why? If not, why not?

Contraceptives:

- Knowledge/views about contraceptives.
- Where did this knowledge come from?
- Extent to which contraceptives were used before first pregnancy/after first pregnancy.
- Knowledge of where and how to obtain contraceptives.
- Boyfriend's attitude towards contraceptives.
- Parent's attitude towards contraceptives.
- Peers' attitude towards contraceptives.
- Attitude of professionals to your request or enquiry about contraceptives.
- What are the factors likely to influence contraceptives use? Attitude towards contraceptives.
- Feelings regarding the views held by some older people including parents and teachers, that use of contraceptives encourage promiscuity among teenagers.
- Regularity of use.
- Type of contraceptives used and reasons for this choice.

Sex/Sexuality:

- The extent to which the young women received sex education. If so, where, by whom, at what age it was offered?
- Feelings about the content/quality/approach to sex education by the teacher/counsellor/advisor etc.
- Other sources of knowledge about sex, views about these.
- Experience of sex, what factors led to sexual activity was this coerced, or freely entered into?
- Feelings about sex and relationships.
- Attitude and influence of peers towards sexual activity.
- Frequency of sexual contact.
- Views and influence of siblings, parents towards sexual activity.

HIV:

- Knowledge about HIV transmission and prevention.
- What effect has this had on your views/feelings about sexual activity?
- Views of peers, parents, boyfriends, siblings etc.

Self Perception Re: Pregnancy:

- Feelings about the pregnancy, first and subsequent.
- Influential factors on becoming pregnant.
- The extent to which the pregnancy was planned or unplanned.
- If unplanned, what factors could have prevented it? Feelings about the unplanned pregnancies.
- If planned, factors which influenced this decision.
- Feelings about teenage pregnancies in general.
- Coping strategies in respect of the pregnancy. Fears, hopes.
- What can governments/agencies do to prevent unwanted/unplanned teenage pregnancies?
- Effects of pregnancy on socio-economic factors.
- Influence of socio-economic factors on pregnancy.
- Factors which influenced repeated pregnancy.

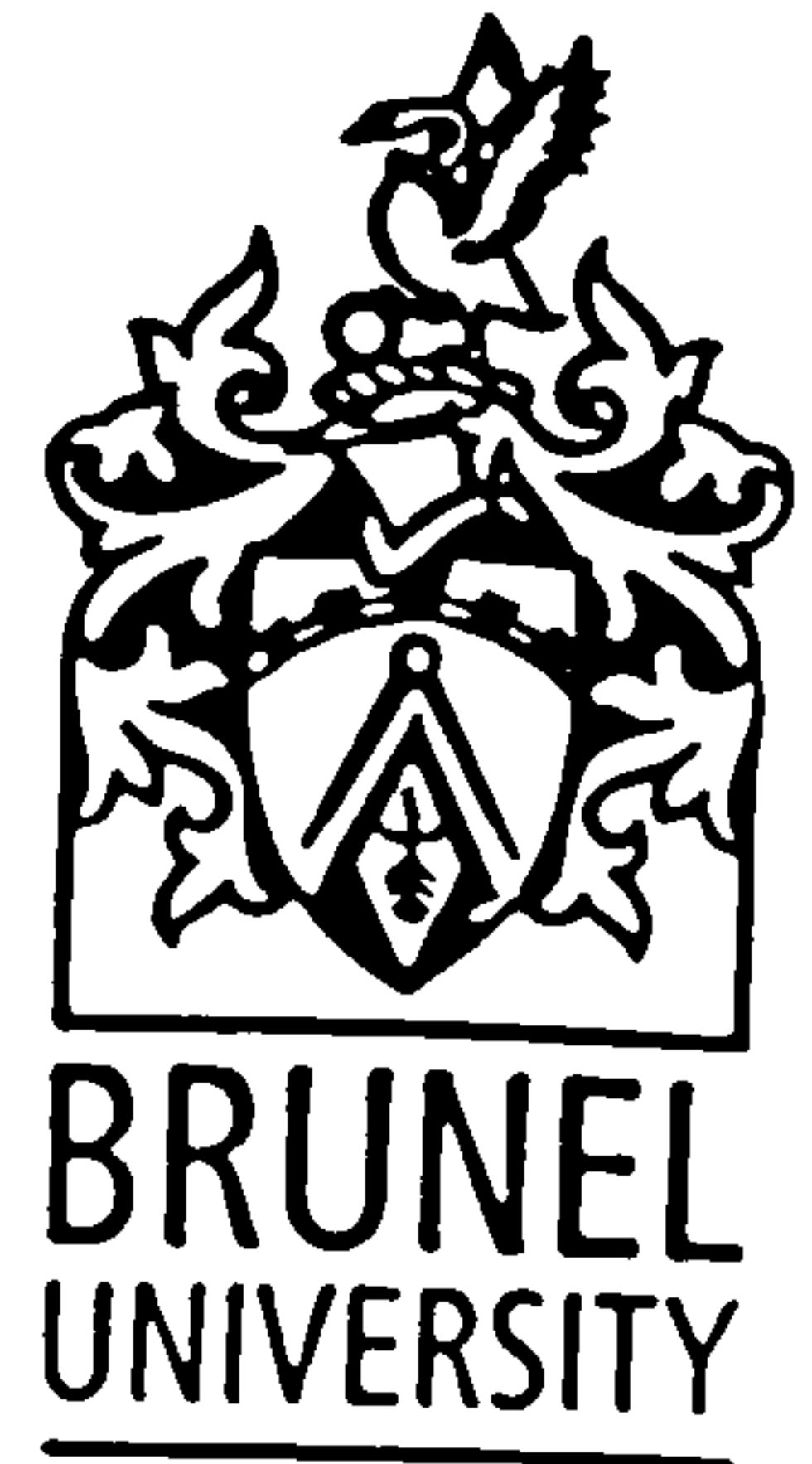
Aspirations/Future Plans/Goals:.

- The extent to which there are goals and what factors influenced these.
- What needs to happen to make these possible, by self and others?
- If there are no goals, what factors influence these?
- What are the perceived factors that stand in the way of achieving these goals?
- Feelings about self (self esteem) prior to, during and after first and subsequent pregnancies.

Appendix two

Appendix two

Department of Social Work
Direct fax number: 0181 891 8266



Sample letter to potential respondents

Date as postmark

Twickenham Campus
300 St Margaret's Road
Twickenham, Middlesex TW1 1PT
United Kingdom
Telephone (0181) 891 0121
Fax (0181) 891 8270

Dear

I am a lecturer at the above college and am currently carrying out research into repeated teenage pregnancy. The research will focus on those young women aged nineteen and under who have had two or more pregnancies.

The aim of the research is to give teenagers such as yourself a chance to tell their own stories, about their reasons for becoming pregnant, their experiences of their pregnancies, the reactions of schools/teachers, family, friends, boyfriends as well as health and social care professionals. It will also provide an opportunity for you to talk about the impact on your life.

It is hoped that the information you provide, will be extremely useful in providing information for professionals, which will help them to determine what are the best ways in which they can help teenagers such as yourself, during the times when you may be experiencing distress as a result of your pregnancy.

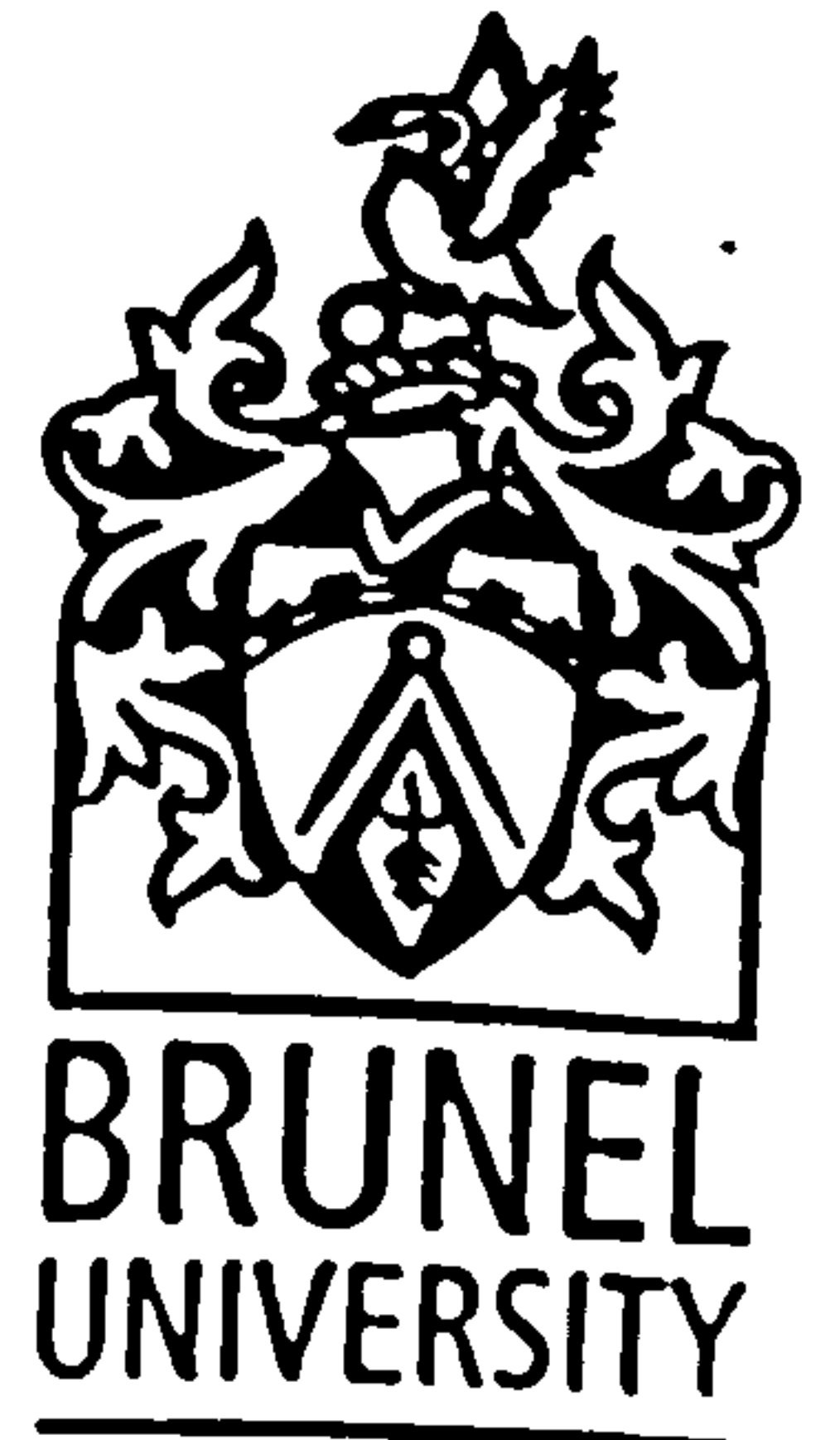
I would be very pleased to be given the opportunity to talk to you. The information which you will provide will be treated with the strictest confidence. Your name will not be used in any report(s) which will be written.

I am hoping that you will be able to meet me at a convenient time and place for you. If you do decide to meet me, you can let me know either by writing to me at the above address, or telephone me on 0181 287 8772 on weekdays between 7 p.m and 10 p.m., or at weekends; or there is an answer machine on this number for you to leave me a message and a number where I can return your call. I look forward to hearing from you.

Yours sincerely

Jean Clarke
Lecturer

Appendix three



Sample letter to professionals and agencies

Twickenham Campus
300 St Margaret's Road
Twickenham, Middlesex TW1
United Kingdom
Telephone (0181) 891 0121
Fax (0181) 891 8270

I have recently commenced M Phil/PhD research into Repeated Teenage Pregnancies-Comparisons between London and two Caribbean Islands.

I am interested in interviewing young women aged 19 and under, known to your Department, who have had two or more pregnancies.

I am therefore requesting your co-operation in identifying young women who fall within the category outlined, and who would be willing to participate in the study. Once the women have agreed to participate in the study, I will make arrangements to contact them directly.

The young women will be assured confidentiality and their identities would remain anonymous.

Benefits Of The Research

A strong and influential current in contemporary political discourse in both Britain and the USA, maintains that the Welfare State offers incentives to teenage women to become pregnant.

The Welfare State, it contends, offers teenage mothers levels of social benefits and an enhanced opportunity to become householders in their own right, which are unavailable to their childless contemporaries. Beyond this, these benefits, it argues, render marriage to the putative fathers an economically non-viable option, since this would reduce significantly their eligibility for such benefits.

The study therefore aims to compare behaviour, motivation, values and attitudes of young women who become pregnant in a 'Welfare State' such as England, with those living in countries in which benefits of this type and access to independent state provided accommodation are not available, such as Jamaica and Barbados.

The study attempts to establish the meaning of repeated teenage pregnancy for the young women who experience it, and the ways in which they manage their lives. To date very few studies have attempted this in-depth analysis into teenage pregnancy.

The only comparative research on teenage pregnancy has been carried out between developed countries. Repeated pregnancy is a relatively neglected area, and all existing studies have been undertaken in the United States of America.

A clearer understanding of how teenagers view pregnancy will have implications for educational, social, health and economic policies. It will also have implications for the practices of health care workers, social workers, teachers, probation officers and parents, as it will seek to highlight the ways in which services may be adapted to make the most effective responses in terms of the needs of the teenage mother, her child and her family.

Background Experience of the Researcher

I have had over 15 years experience of generic and medical social work in London and Barbados. I have also specialised in work with teenage mothers in both countries.

Period of Research

The research is expected to take place over four years. The fieldwork in Jamaica and Barbados has already been carried out. I am currently in the process of conducting interviews in London.

I look forward to hearing from you in the near future.

Yours sincerely

Jean Clarke
Lecturer

Appendix four

Appendix four



HOSPITAL (KINGSTON REGION) MANAGEMENT BOARD
AT VICTORIA JUBILEE HOSPITAL,
KINGSTON,
JAMAICA

January 2, 1996

Ms Jean Clarke
Senior Lecturer
Brunel University College
Twickenham Campus
300 St. Margaret's Road
Twickenham
Middlesex TW1 1PT
England

Dear Ms Clarke:

RE: RESEARCH INTO REPEATED TEENAGE PREGNANCIES.

Thanks for your letter dated December 4, 1995 re pursuing your research on "Repeated Teenage Pregnancies" at this institution.

We would be willing to have you between the 11th and 26th of July 1996 and will assist you as best we can.

Please contact me again during the first week of June so that I can put things in place.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'G. Wesley Bernard', written over a horizontal line.

.....
G. Wesley Bernard, J.P.
F.I.C.S., F.A.C.O.G., F.R.C.O.G.
Senior Medical Officer
Victoria Jubilee Hospital

In Replying the Number and
Date of this Letter should be
quoted.

A14:258

Ministry of Health
Barbados

11P/T31



June 15, 1995

Mrs. Jean Clarke
Senior Lecturer
Department of Social Work
Brunel University College
Twickenham Campus
300 St. Margaret's Road
Twickenham, Middlesex TW1 1PT
ENGLAND

Dear Mrs. Clarke,

Your letter dated Mach 10, 1995 addressed to Mr. Neville Millington, Hospital Director, Queen Elizabeth Hospital, and concerning your interest to conduct research into "Repeated Teenage Pregnancies - comparisons between two Caribbean Islands" was sent to me for comments and advice.

I write to inform you that the proposal was reviewed by the Medical Research Advisory Committee and there are no objections to you conducting the research at the Queen Elizabeth Hospital. It would be wise and desirable to obtain written consent particularly in relation to confidentiality.

I believe that the findings of your research will benefit our services especially those areas which address the needs and health of young people. In view of this, I look forward to receiving a copy of the research findings as soon as they are available.

Best wishes and I hope that I will see you in July.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "B. Miller".

(B. MILLER)
Chief Medical Officer

*Ministry of Health
Barbados*



In Replying the Number and
Date of this Letter should be
quoted.
No.....11/06/T13.....

.....1995-06-16.....

Ms. Jean Clarke
Senior Lecturer
Department of Social Work
Brunel University College
Twickenham Campus
300 St. Margaret's Road
Twickenham, Middlesex TW1 1PT
ENGLAND

Dear Madam,

I am directed to refer to your letter dated March 10, 1995, and to inform you that approval has been granted to conduct research on Repeated Teenage Pregnancies in Barbados.

A copy of the questionnaire should be submitted as soon as possible to the Ministry, and you should contact either the Chief Medical Officer or the Senior Medical Officer (South) on your arrival.

The delay in response is very much regretted.

Yours faithfully,

H. PAYNES-DRAKES (Mrs)
for Permanent Secretary

St. George's Hospital

Blackshaw Road, London SW17 0QT

Telephone: 081-672 1255

Fax:

Ext:

CF/sjg/a162

16th January, 1996

Jean Clarke,
Senior Lecturer,
Brunel University,
Twickenham Campus,
300, St. Margaret's Road,
Twickenham,
Middlesex,
TW1 1PT

Dear Ms Clarke,

Re: Repeated Teenage Pregnancies - Comparisons between London and two Caribbean Islands

Your letter was passed to me by Sr. Anderson to see whether I would allow you to undertake this research at St. George's.

I have checked this out with the relevant departments, and I find no reason why you cannot undertake this research.

Please can you make the necessary arrangements with Sr. Anderson as to your needs and the dates that you will be requiring her input.

The only requirement that I ask of you, is that when your research is finished that you will actually come back to the Maternity Unit and tell us what you have found out, or in fact, send me a completed copy of the research that you have undertaken.

If I can be of any further assistance, please do not hesitate to contact me.

I wish you all the best in your research.

Yours sincerely,



Charlene François (Mrs),
Director of Midwifery & Gynaecology

cc: Sr. Anderson

Appendix five

Appendix five

CONSENT TO BE INTERVIEWED

Re: Repeated Teenage Pregnancy Study

This is to confirm that I have agreed to be interviewed in relation to the above study. I have given of Homerton Hospital, Antenatal Clinic, permission for my name, telephone number and/or address to be passed on to Jean Clarke, the researcher.

I understand that Jean will be contacting me to arrange a suitable date, time and place to be interviewed.

Name:

Address:

Appendix six

Appendix six

Ref:

MLASG

Date:

7th November 1997

Forest
Healthcare 

Jean Clarke
Senior Lecturer
Brunel University College
Twickenham Campus
300 St Margaret's Road
Twickenham
Middx TW1 1PT

Whipps Cross Hospital
Whipps Cross Road
Leytonstone
London E11 1NR
Telephone 0181-539 5522
Fax 0181-558 8115

Dear Ms Clarke

re: **Repeated Teenage Pregnancies - the meaning Ascribed by Teenagers -
Comparison between London and two Caribbean Islands**

I am sorry it has taken some time to reply.

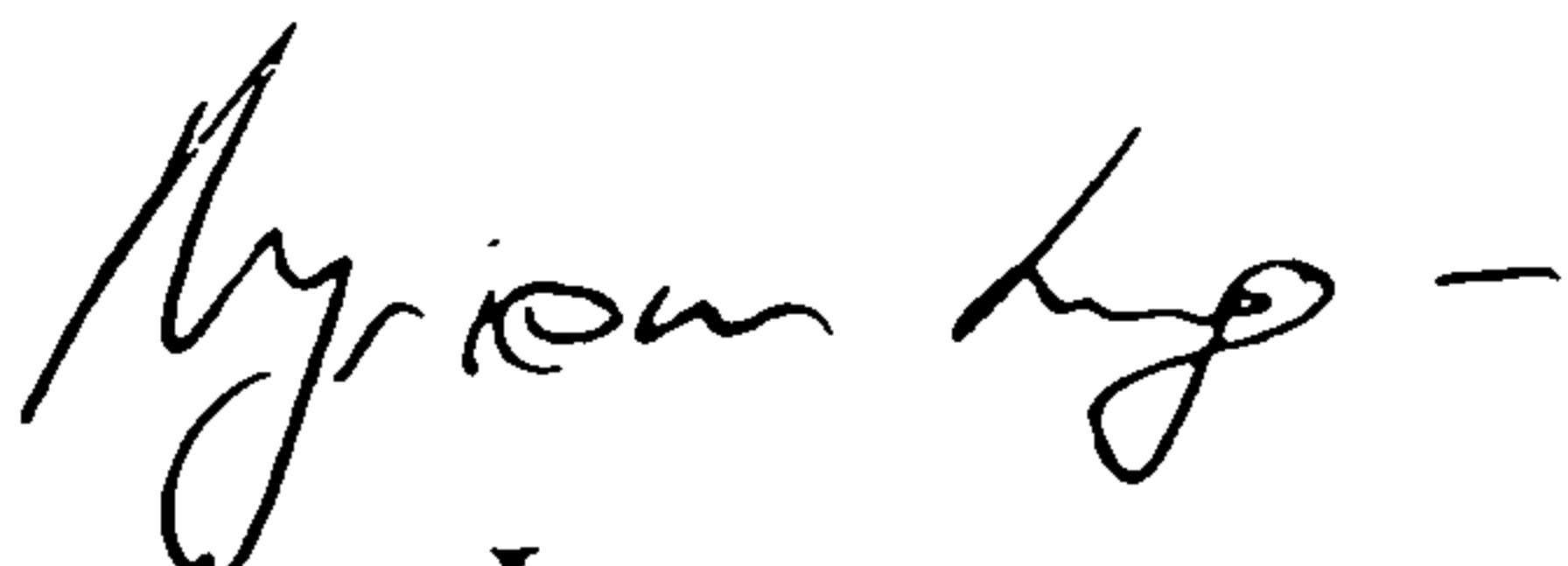
The research proposal has been sent to the Ethics Committee but I had to ask the service in August whether they were happy about the issue of interviewing minors in the absence of parents consent. I have had a reply from the Service Director who discussed this with the people within the service. The linkworker for pregnant schoolgirls and one of the midwives met and talked at length with yourself, the project and field worker and feel the right degree of sensitivity would be used in dealing with the young women in the study. I am therefore very happy for it to go ahead.

I would be grateful if you could let me have a copy of your report once this is completed.

I have notified the Local Ethics Committee to this effect.

Best wishes.

Yours sincerely



Myriam Lugon
Medical Director

c c Kate Smook

Chairman
The Right Honourable
the Lord Jenkin of Roding

Chief Executive
Bryan Harrison