

# **WHAT ARE THE FACTORS UNDERLYING UNINTENDED PREGNANCY IN YOUNG WOMEN IN HULL?**

## **Executive Summary**

The recent public health white paper “Choosing Health” (2004) made significant commitments to sexual health and in particular the reduction of unintended teenage pregnancies, especially in areas with high teenage conception rates. Despite a strong local teenage pregnancy strategy and an active programme of activity to improve access to sexual health services (including family planning) and to provide education to help young people resist pressure to have early sex, Kingston upon Hull remains amongst the Local Authorities with the highest rates of teenage conceptions nationally. Although not all conceptions in young women are unplanned or unwelcome, an unintended pregnancy can have a long term impact on a young person in terms of well-being, education and life chances, in addition to the risk of poorer outcomes for the baby, should the young woman decide to continue with the pregnancy.

Both national policy and local strategy encourage innovation in designing and delivering interventions to reduce unintended conceptions. Nevertheless there is a lack of direct knowledge, nationally and especially locally, about the factors underlying unintended conceptions. Such knowledge is vital if we are to design programmes that are truly effective (i.e. what works for whom in what circumstances). That few published studies have focussed on the factors underlying unintended teenage conceptions is to be expected, given the sensitive nature of the subject and the current scarcity of qualitative research skills in the NHS.

The studies we identified concentrate largely on service delivery. For example a review from the University of York Centre for Reviews and Dissemination (1997) looked at the effectiveness of interventions such as school-based programmes and one-to-one interventions in community settings. However, virtually all the studies reviewed are from the US or Canada. Similarly, a review by the Health Development Agency (2001) was very much orientated towards service provision, drawing heavily upon material from outside the UK. There is a small UK literature in this area, for example, one study in the South West of England compared the use of family planning services and access to sex education between teenagers who chose termination with those who chose to continue their pregnancy (Pearson et al 1995). However we clearly need to know more about why unintended conceptions occur, if we are to provide appropriate education and support to young women who are at risk of conception, but wish to avoid it. This is an important question which can only be answered by those young women who have experienced an unintended conception.

The study presented and discussed in this paper was an exploratory qualitative study based on focussed interviews with young women who had recently had, or were waiting for, a termination. The findings suggest that young women have clear views about the value of the sex education they have received, and the way they think sex education should be presented, as well as how information about and access to contraceptive services is provided. In addition, the study sheds light on attitudes to

sexual behaviour and contraceptive use amongst both young women and young men, which suggests that to focus entirely on young women when discussing the avoidance of unintended pregnancy would be erroneous. The young women interviewed have strong opinions about “what works for whom in what circumstances”, and it is suggested that their views are of value in designing programmes and services for their age group.

## **Introduction**

The prime objective of the project was to investigate factors underlying unintended conceptions by interviewing young women between the ages of 16 and 20 who had experienced an unintended conception. The study was not intended to be statistically representative, but to be an exploration of young women's knowledge of and attitudes to sexual health, contraception, pregnancy and parenthood. By asking them to talk about their own experiences, as well as those of their friends, a broad insight into thoughts and attitudes of young people was obtained, and the result is a snapshot of one particular aspect of the lives of teenagers in and around Hull.

## **Background**

Reducing teenage pregnancy and lowering rates of young parenthood is a key government priority. The ten year national Teenage Pregnancy Strategy was launched in 1999, and the Teenage Pregnancy Unit was established to manage implementation of the strategy. The White Paper "Choosing Health" (2004) made significant commitments to sexual health and in particular to the reduction of unintended teenage pregnancies, especially in areas with high teenage conception rates. "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary care Trusts on Effective Delivery of Local Strategies ( 2006) and "Teenage Pregnancy: Accelerating the Strategy to 2010" (2006) continue to drive policy.

Since the launch of the Strategy in 1999, both under-18 and under-16 conception rates have reduced and both are at their lowest level since the mid 1980s; however, the UK still has the highest rate of teenage pregnancy in Western Europe, and Kingston upon Hull has one of the highest rates of teenage conceptions nationally.

Data published by the Office of National Statistics show that in 2005 there were 368 conceptions amongst women aged under 18 resident in Hull.. Of these 368 conceptions, 30% led to termination. The target is to reduce under-18 conceptions by 55% by 2010 from the 1998 baseline of 84.6 conceptions/1000, to 38.1 conceptions/1000. The most recent figures show that despite a blip in 2004 when conceptions increased after a number of years of decreasing, resulting in Hull having the third highest rate in the country that year, the downward trend returned in 2005 with conceptions being at a rate of approximately 71 conceptions/1000. A greater understanding of factors behind unintended conceptions may assist in achieving this target.

## **Methodology**

The study was designed as an exploratory qualitative study using semi-structured interviews. In this way, selected topics could be addressed, but the interviews had the flexibility to allow the participants to talk at length about topics that were of concern to them, and also to introduce relevant issues to the interview.

Interviewees were recruited from day patients at Hull Women and Children's Hospital, Dr Kate Guthrie's Surgical Termination of Pregnancy (STOP) list. The

initial recruitment process set out in the protocol was for Dr Guthrie to explain the project to patients, and ask them to agree to be contacted by telephone about 4 weeks after the termination in order for an interview to be arranged. Consent forms were then passed to the researcher, who rang potential participants to ask them if they still wanted to take part, and if so, to arrange an interview.

At this stage, the response was entirely negative. Respondents:

- said they had changed their minds;
- said they no longer wished to think about the termination;
- said they regarded the hospital as the end of the process and had no wish to revisit the experience;
- didn't answer the phone, and didn't return calls when messages were left.

As a result, an amendment bringing the time lapse down to a week was obtained. However, this only resulted in one interview.

To try to make the interview less daunting, the researcher then began to accompany Dr Guthrie when explaining the project. This resulted in one consent to interview, but the interviewee then changed her mind on the day.

As a result of these difficulties in recruiting, where it seems that young women are enthusiastic about talking when on the ward, but no longer wish to think about the experience once they return home, a further amendment was obtained to allow interviews to take place once the patient has been admitted but before they go to theatre. Although initially the concern was that this might cause distress, in fact the young women are keen to talk on the day, and it was felt that it actually causes more distress to bring up a subject that they consider "closed" after the event.

In addition, it was intended that interviewees would be recruited via TPSS. It was agreed that the TPSS team would probably be able to find interviewees from their client base, who would be able to discuss:

- experiences of unintended conception;
- decision-making about whether or not to proceed with the pregnancy;
- knowledge and awareness of sexual health services prior to becoming pregnant.

In the event, this was not possible due to changes within TPSS as a result of staff vacancies and budget restrictions.

In total, then, 23 face to face interviews took place, plus one short telephone interview. The face to face interviews lasted between 9 and 35 minutes, depending on how talkative the respondents were. One interview was cut short because the interviewee was called for theatre. Of the 23 face to face interviewees, 19 lived in Hull, 2 in Beverley and 2 in Cottingham. Two of the 19 who lived in Hull did not grow up in the region, moving to Hull for University. The one telephone interviewee grew up in Hull but had moved away since, and partly as a result of, the termination.

Age profile of interviewees:

16	17	18	19	20
6	3	11	2	2

Five of the interviewees already had a child, two of them having given birth at the age of 15.

Interviews were recorded and transcribed. The transcripts were analysed using a grounded theory approach of emerging thematic categories being refined and saturated using an iterative process. Three overarching themes emerged, into which the categories could mostly be grouped; these were Knowledge, Access To Services, and Use of Contraception. The discussion on Findings which follows is based around these three key themes, with a further section discussing decisions around terminating or continuing with a pregnancy, and a section putting forward young women's views about actions that could be taken to improve services in this area for their age group.

## Findings

This section presents the results of the analysis, and is illustrated with quotes from interviewees. The quotes are labelled with the respondent number and age, i.e R1/16 refers to Respondent 1, who is 16 years old.

### Knowledge

The interview began by asking what the respondent remembered about the sex education they had received at school, and what they thought of it. A quarter of respondents couldn't remember having sex education at school or claimed never to have had any; only one respondent said that her lessons had been good. Most respondents could remember having lessons, but had not found the content particularly useful:

*Can't really remember. They told us about STIs and stuff, and then showed us how to put condoms on. Not much really. (R6/16)*

*It was a bit of a joke really (R5/20)*

Sex education often seemed to have taken place in science lessons, or in a scientific context, which was felt to be of limited use:

*Just the brief scientific outline. It wasn't anything I didn't know. To be honest, I think it was rubbish, because they're so scared of explaining it to you, that, like I said, they tell you it, like, scientifically. (R20/18)*

*They only talk about the reproductive stuff, they don't talk about how you'll feel, or hormones or anything, and they should (R23/18)*

None of the respondents mentioned lessons that had covered anything other than basic facts of reproduction and disease, apart from one interviewee who had gone to school in the south west of England. At no point had lessons dealt with issues around relationships, and feelings, or empowered girls at all, for example, in how to talk to boyfriends about using condoms.

Information about contraception had been included in lessons, but in a limited way:

*Just condoms and pills. They don't really explain it when you're at school (R14/18)*

*They mentioned condoms and .. can't remember what other ones they mentioned. But there's quite a lot, aren't there? ((R18/16)*

One issue for those who could remember was the way the information had been presented, either because it had been by a teacher they felt uncomfortable with, or who was perceived to be embarrassed themselves, or because they had been shown a film but not been given any opportunities to discuss anything:

*Our form tutor was a man, a male, and got out this wooden model of a penis and just quickly put a condom on it and said there you go (R8/17)*

*Had a little video of puberty, in year 6. (R22/18)*

*I had it in year 6 but it was just like a little session, like a video, but I reckon we should've done more, and they should do it in year 5 then 6 then again in High School (R3/17)*

It was felt by some respondents that it was better if someone from outside school had come in to give a talk, as that avoided potential embarrassment on the part of the teachers. It was also easier to talk to someone about personal issues if the student was not going to see that person every day at school.

Another key issue was the context of lessons; surrounded by friends, or in mixed groups of boys and girls, it was not a subject that was taken seriously:

*I don't think it makes much difference, if somebody's trying to talk to you seriously about sex when you're in a classroom with all your mates, that's all it'll be, a giggle. (R5/20)*

*I just think, like if they do it at school, at that age, they're daft then, aren't they, especially the lads. A room full of people, some people just aren't going to want to sit there and listen, and other people, they think people will start laughing at them and that. I don't know, they get real childish, lads. (R9/16)*

*I wasn't really interested, I mean I should, I listened, but you think you know all about it at the time, don't you? People make a laugh out of it at school more than take it seriously (R9/16)*

In that situation, it is difficult for individuals to raise issues that concern them, discuss worries, or even ask questions:

*Its like at school, we were all together, and nobody's saying owt, you know in front of the lads as well. I don't think I'd say anything. I don't think you'd get people talking in front of a class, do you know what I mean? (R4/18)*

The family was also a source of information, although this meant mothers, and occasionally sisters or aunts, but not fathers – where fathers were mentioned, it was

specifically to say that they couldn't talk to them about this kind of subject, whereas for many of the respondents, mums had been a major source of information;

*Oh, I'd known since I was younger, my Mam had gone through stuff like that, I can't even remember how I found out, but I knew, I just always knew about it (R15/19)*

*But whatever I don't know, my mum, you know, I can speak to my mum about it. (R7/16)*

Other sources were friends at school. This had drawbacks as well as benefits:

*And they'll tell you you can't get pregnant if you do it standing up, or if you pull out, or if you go to the toilet afterwards (R23/18)*

*There's loads of myths, isn't there? If you're on your period and stuff (R7/17)*

Several of the respondents mentioned common myths around getting pregnant, and said that younger teenagers still passed them on, and still believed them, but that they, being older, now knew better.

*I don't think so much at our age, because you know, but probably in the younger years they believe them, because I believed them when I was younger. (R7/16)*

The benefits of talking to friends came from sharing information about contraception:

*I only know about the implant the other day because the friend I was on about at school had it. She told me about it. And I was like 'I didn't even know you could do that'. And I had sex education at school and I didn't even know (R20/18)*

Others had been encouraged to use contraception by their friends, or were encouraging their friends to use it:

*Now I've got pregnant a lot of my friends have gone on the pill, in case it happens to them (R6/16)*

However, although young women found out about different types of contraception because of the methods their friends were using, they were divided evenly between those who took up certain forms of contraception as a result of friends' advice, and those who chose not to use long term reversible contraception (LARC) in particular, because of friends reporting undesirable side effects:

*I don't like the idea of having like the injection, it's stuck in you for however long, and the same with the implant. And I've got friends that have had bad reactions to both. (R5/20)*

Other sources of information were leaflets, the GP, and Conifer House. (GP services and Conifer House are discussed further below). Most respondents felt that they knew enough about contraception and sexual health; their information had come from

a range of sources and they felt that school could not be relied upon to provide enough information.

The main issues were felt to be:

- the way in which information was presented;
- the age at which lessons were held;
- having large groups or mixed groups of boys and girls;
- the limited amount of information provided, particularly about the range of contraception available, and about wider issues of sexual health and behaviour.

Several of the respondents felt that the lessons had been poor because of an attitude that giving teenagers too much sex education would encourage them to have sex, and that the point of sex education, from the school point of view, was to scare them away from having sex. However, this approach was seen as counter-productive:

*Like if they'd done more with you, and did it like a full topic of a term of what you did it on, then you'd know more about it, cos, like, with kids, if they don't know, they'll go try. The less you know about it, the more you wanna know about it. (R14/20)*

*To be honest, I think it was rubbish, because they're so scared of explaining it to you, that like I said they tell you it like scientifically. (R20/18)*

All but one of the respondents felt that sex education should be provided from around Year 5 or 6, and carried on regularly throughout school. They also felt that boys and girls should have separate lessons, as well as some lessons together, and that the topics should cover more than a biological approach to sex and reproduction. Several respondents suggested having visits from young women who already had babies, to talk about what it was like to have a child at a young age. One respondent, who already had a baby, had done this herself:

*I think like people should go into schools, all years really, people should go into schools and explain it. Cos when we were at schoolgirl mums unit we went to a high school, and we talked to year 6 I think it was, about what it was really like having a baby. And they was all shocked, you know "(gasps) oh no I didn't think it was that hard!" you know? I think they should have more of that, like people who've had kids young, then people explaining like not to get pregnant. (R3/17)*

Others felt that presenting fairly bleak life stories would shock people into thinking more about using contraception:

*You could do a life story, I suppose, show a life story of this young girl who's real nice, and falls pregnant, and her life's gone downhill since then. You know what I mean, like, she can't go out, got to slave to look after the kid, the dad's gone off, she doesn't know where he is, he doesn't give her any support. Because that's what happens. That's what a lot of the time happens. Exaggerate it a bit ... just, look, this is what happens, do you really want to go*



*through that? They'd be like "no!" (laughs) Shock! "Where's your condom?" (R17/18)*

Both young parents and non-parents felt that sex education should incorporate lessons such as these, that emphasised the difficulties and hardships caused by having a baby at a young age, and that having visits from young women with that experience would reinforce the lesson.

Making information more widely available, by having leaflets and posters in places young people go, such as school, college, pubs and clubs especially on "under 18s" nights, was also suggested, as was making sure young people knew about a wider range of contraceptive options.

### Access to Services

For most respondents, access to services, mainly for contraception but also for information, advice, and testing for pregnancy and for disease, was either Conifer House, or the GP. A few expressed a preference for Family Planning Clinics, but reported that access was difficult due to limited opening hours or there being few sessions a week. Where Family Planning Clinics were preferred, it was often because the respondent knew they would see a female doctor.

R13/20 talking about her GP, and why she prefers Family Planning:

*And he's a man, isn't he? And all them are women (R13/20)*

Convenience was another issue; R2/18 talking about her friends, and whether they go to Conifer House:

*But I think they'd just rather go to the clinic in Cottingham (R2/18)*

On the whole, respondents liked Family Planning where they had access to it, but found access was a problem.

Less than half of the respondents used their GP for contraceptive services; most of those that did were happy with the experience, but some used the GP because they had no other option:

*I did think where else can I go but the doctors, cos there isn't anywhere else (R20/18)*

This was particularly an issue for young women living outside Hull, or where access to Conifer House in the city centre was difficult.

For those who were happy with their GP, the reasons they liked them were friendliness, helpfulness, and because they had a long-standing relationship with them as the family doctor.

*Yeah, fine, no problem. I went to see my GP for this, and I think he's brilliant, really brilliant (R8/17)*

*I can talk to him about anything, and the doctor you can trust them, cos they aren't supposed to give out any other thingy, so that's quite good as well, isn't it? (R17/18)*

However, the long-standing relationship was also seen as a problem by many respondents, especially where the GP was the doctor for all or most of the family:

*Well, cos it's the family doctor and I don't really want my parents to find out (R11/18)*

Many respondents had fears about confidentiality, or were uncertain whether the GP was truly confidential:

*I wouldn't have liked to go to my GP because - is it on your records? Your doctor's records? - cos like at Conifer House its private, and nothing can be said about anything. So I'd rather go to Conifer House than the doctors. (R7/16)*

*Yeah cos they think that their parents go there [to the GP] so they might find out. They don't find out, it's just the thought in your head that they might do. That scares people. (R10/17)*

The issue of confidentiality is not a straightforward one of guaranteeing that a GP will not divulge information to parents, because parents may discover a trip to the GP in other ways:

*That's another thing. Every time I've been to my doctor, I've always seen somebody I know. So, like, you could be there, and they'd want to know why I was there. (R7/16)*

*Cos like if your Mam found out you were going to the doctor's, cos sometimes they ring you and say "are you coming for your appointment?" and your Mam gets like "why, what are you going to the doctors for?" cos usually like when you're at school your Mam does your doctors for you, doesn't she? (R19/18)*

*You could see one of your Mam's friends or summat, and the nurse comes and shouts out your name and your number, and like your Mam's friend could think, could say to your Mam, 'oh, I seen your daughter at the clinic on Tuesday'. Mam says to me, 'what were you at clinic for?' (R16/18)*

The major issue for teenagers, then, with regard to visiting the GP, was being seen by someone they knew, and it getting back to their parents. This did not necessarily mean that they did not discuss things with their parents, but that they wanted to tell them in their own time.

*I mean, I know talking to your Mam is a good thing, but there is some things that you don't like to tell your Mam. I mean, as I say I tell my Mam everything, but I can think of a couple of things I haven't told her (R16/18)*

Another issue mentioned by some respondents was the difficulty in getting an appointment, and having to wait. One respondent had had a three day wait for an appointment when she first thought she might be pregnant, which had added to her anxiety.

To summarise, then, most of those who used their GP were happy with the service, but most teenagers preferred to go elsewhere.

The most frequently used, and popular place for contraceptive services and general advice about sexual health was Conifer House. All but two of the respondents had heard of it, the two who lived in Beverley being the exceptions. Most respondents also said that their friends went there. The main reasons for the popularity of Conifer House were friendliness of the staff, the feeling that it was for teenagers, and most importantly, confidentiality and being able to get in and out without being seen by family members or family friends.

*Yeah, cos it's out the way, and no-one knows, there's different floors for different things, so you can just walk in and no-one knows which floor you're going to really. (R10/17)*

*I thought they was real helpful, cos they don't just, erm, talk to you about that. They help you, ask you what you're doing with your life, get you back, cos I was at college, they get you back into college, you know, they're real helpful. And it's all confidential there, and you're all in a room together, with all other women, and they just come and sit with you and talk just quiet, and I think you feel more comfortable with other women, don't you? Or other teenagers your age (R16/18)*

*Yeah, it's good, it's good. They give you a lot of help, and they talk to you about everything, and give you options about contraceptives, and tell you what's going on, so I think it's good there (R19/18)*

Most respondents felt it was easy to get to, with it being in the town centre and near several bus stops, and had not found access to be a problem. However, some said they had found it difficult to get there when it was open. This applied particularly to young women from the outskirts of the city, who may have to take one or more buses after school or work in order to get there.

Although people were happy with the services they received at Conifer House, there was some nervousness on the part of some respondents about actually going there:

*Some people don't like going. Everyone knows what Conifer House is for, but some people don't like to go in. I don't mind, I go in for people (R23/18)*

One issue for some people was due to Conifer House offering testing for Sexually Transmitted Infections (STIs) and the thought that if they were seen there, people might think they had an STI:

*Just the people, d'you know, seeing you there, because it's for diseases and everything, and you think 'Oh God' (R15/19)*

*I was a bit uncomfortable at first because there was like a lot of weirdos there. I was just like, oh that's not my type of scene, only come for a couple of condoms (R17/18)*

The reluctance to attend was overcome by going with friends, which several respondents said they had done, or, as above, asking a friend to go instead. However, despite this reluctance, and feelings of awkwardness or embarrassment, Conifer House is clearly the most popular choice of service provider for sexual health services for this age group.

A suggestion made by several respondents was to have more centres like Conifer House, but spread around the city, either just for teenagers, or as drop-in centres where appointments were not needed. This would ease the problem of having to catch buses into Hull after school, and possibly tell parents where they were going, and also address the need for “someone to talk to” that many respondents voiced, and not just for themselves. There was an awareness that some young people were not getting the support and advice they needed:

*Just like a drop-in centre where you can just go and talk to somebody if you need to. Cos like some people haven't got anybody. I mean, I'm lucky, I've got my Mum and my friends, but some people haven't, have they? They haven't got somebody to talk to but if you had, like, a centre like that then they can just go and see somebody (R14/18)*

The main issues, then, as far as access to services is concerned are:

- confidentiality – not only in terms of fears about information being passed on, but being able to obtain sexual health services and contraception without other people finding out;
- being “teen friendly” – young women wanted someone to talk to, who was helpful and friendly, and would not be judgemental;
- ease of access – this includes journey times, opening hours, and cost.

### Use of contraception

The respondents fell into two categories, those who were pregnant due to contraceptive failure and those who were pregnant as a result of not using any contraception at all.

Those who were pregnant as a result of contraceptive failure were mainly on the pill, which had usually failed due to sickness:

*The reason I think I got pregnant is because I wasn't very well, and I had sickness, and I think because of that ... (R5/20)*

One respondent felt that her GP had rushed her into being prescribed the pill, and said that no-one had talked to her about it; she had had a stomach upset and not realised that this affects the effectiveness of the pill:

*They didn't tell me I'd have side effects and that it gives you stomach upsets. I'm worried that maybe I didn't take it properly (R24/16)*

Those who said they used condoms also often mentioned the fact that they offer protection from STIs as a reason for choosing them, as well as protection from unwanted pregnancy.

*I've always used condoms, you see, unfortunate occasion it didn't work, but I've always used condoms for protection (R8/17)*

One respondent was doubly unlucky:

*I was using condoms when this happened, so, but the last time it'd happened I was on the pill. So, obviously, it's not foolproof, is it? (R17/18)*

Several were on the pill, but had forgotten to take it, or had taken it irregularly. Most respondents said that not only had they forgotten to take their pill, but said that they knew their friends forgot too:

*Forgetting is a problem, it's if you're busy, or you rush out, and you forget to take it, and it's like, 'oh God, I forgot to take it'. I've done it a few times where I've forgot and thought 'oh damn' and then I've been at work and thought 'I'll have to take it tonight' (R15/19)*

Forgetfulness is often linked to the lifestyles of this age group. Some young women do not have a regular routine, or are experiencing family breakdown and moving home; others are under pressure at school because they are doing GCSEs or A levels. In difficult or stressful circumstances, remembering to take a pill can sometimes slip from the mind.

All the respondents were now aware of LARC, mainly as a result of discussions they had had with doctors and nurses prior to their termination. They all agreed that it was a good idea in principle, and many of them were planning on taking it up:

*To be honest, I think why didn't I get it earlier? (R20/18)*

Some were taking it up despite having had reports about side-effects from friends:

*I'll just have to leave it in, won't I, whether or not I get fat (R13/20)*

However, some found the nature of the procedure to be too intrusive for them:

*I think that's quite good for some people, cos it lasts a lot longer doesn't it, and you can't forget it, but for me I'm a bit squirmish. I wouldn't be able to have summat like that in my arm (R9/16)*

And some had been put off by reports from friends:

*I don't like the idea of having like the injection, it's stuck in you for however long, and the same with the implant. And I've got friends that have had bad reactions to both. (R5/20)*

However, this was an area where there were a lot of mixed feelings. Some were reluctant to take up LARC because of things they had heard from friends, but some thought their friends would take it up once they knew someone who had it:

*Like, talking to my friends, like if they knew I was getting the implant today, then they might go for that, because obviously that is more reliable (R20/18)*

Those respondents who had not used contraception at all had a variety of reasons. Some respondents had had bad experiences with certain types of contraception, and had been "caught out" in the change from one method to another.

*When I got it took out I went away the next day. And that's when I got pregnant, when I was away for 2 weeks. So, yeah (laughs) if I hadn't gone away I don't think I would've got pregnant. (R3/17)*

Others simply hadn't used it:

*I just thought I won't get pregnant, but I did (R6/16)*

*Nothing. Yeah, I know, I'm stupid. I should've known. (R23/18)*

The reasons for this are varied and deserve further detailed exploration, as an understanding of failure to use contraception is a major concern in terms of reducing unwanted pregnancies.

For some young women, it was a case of thinking "it won't happen to me", and several respondents felt this was quite a common attitude amongst people they knew:

*I don't think they think they'll get caught pregnant real quick, or owt like that. They just don't bother using owt. And then when they do, it's like, oh God. (R15/19)*

It was suggested that young women did not realise how easy it was to become pregnant, and if they knew, they would take precautions. However, being rational about contraception is unlikely when in "the moment":

*Cos it's too much, err, time consuming, really, if you like want to do it straight away you don't think about a condom, can't you tell? (laughs) You just go for it, so you forget about them really, and then it's afterwards, you regret it and think oh god why didn't I use one? (R10/17)*

*They just get caught in the moment and they daren't say, "have you got a condom?" You just go on with it and think "oh, it'll be alright," then it's not (R19/18)*

Not stopping to think about using condoms is compounded by a number of factors, including embarrassment about discussing them, and having the confidence to ask a partner if he has a condom or will use one:

*I mean, cos I know them saying, like, "no, I aren't using one", then you should say no, obviously, shouldn't you, but not a lot of girls do. I mean, I've done it myself, so I can imagine other teenagers doing it. So, I think most of it's the confidence that you need. I think they feel a bit stupid saying no, you know (laughs) (R16/18)*

*Yeah, yeah, yeah definitely, because like, sometimes, like during sex they don't speak, so the girl is, like, scared to say "have you got a condom?", and the boy, well, the boy will just like get on with it won't he, really? He'll just think, "forget about it, oh it doesn't matter" (R19/18)*

Almost all the respondents said that young men did not want to use condoms, and tried to persuade their partner to have sex without one, because it would be better, or because stopping to put on a condom would spoil "the moment":

*I think most of it you feel stupid, you know, but erm, a couple of times I was saying "shall we use a condom?", cos obviously I don't want to be getting pregnant, like in the situation I'm in now. And they're just like basically, no. You know. No. no. Its crap, its crap. So I think a lot of it is if you're confident to ask the person to use one, and confident to say no, then you're alright. But I think a lot of it can be the, erm, boyfriends as well, or whoever you're sleeping with (R16/18)*

*Some of them whinge that it takes away the feeling, the sensation, things like that (R22/18)*

Some said that it was not so much that young men tried to persuade young women to have sex without a condom, but rather that they were lazy or just didn't think about it:

*A lot of boys say they don't like them, but I just don't think they think of it at all (R2/18)*

*But they're just lazy. They say it spoils the moment, but no, its not. It'll spoil the moment when there's a baby crying in the middle of it. (laughs) (R14/18)*

A significant aspect of young men's behaviour, as reported by young women, was that men assume women are on the pill, or think that they should be. Most respondents felt that young men saw contraception as a woman's responsibility:

*Mostly its lads, they think it's all up to the girls all the time (R9/16)*

*Yeah they do nowadays, cos it's just like, hit puberty go on the pill. That's what they're thinking. Loads of lads I used to hang round with thought that. (R10/17)*

*A lot of boys are stubborn aren't they? And they're like no, no, it's your job. (R17/18)*

This was partly because the consequences of unprotected sex could be more serious for girls than for boys:

*Cos they're not the one who'll have, they'll just think at the end of the day if they do get pregnant or whatever, at the end of the day its not really their problem. A lot of boys think that. (R18/16)*

*I think that they don't really care if they get a girl pregnant, because they think, oh well, she's got pregnant, I don't have to stick around, I can still go out, she has to stay home. I think that's what they think. So they don't care if she gets pregnant, cos they can still do what they want to do, basically (R3/17)*

However, this was seen by some as only applying to "one night stands", as once a relationship was established, contraception was something that would, or should, be agreed upon between both partners:

*I think in a couple of cases they probably just think they're on the pill. But that's maybe if they just have one night stands and things but if you're with somebody, they're obviously gonna know whether you're on the pill or not, so you'd both decide to use summat, wouldn't you? (R15/19)*

Having had unprotected sex, some young men felt that there were other ways for women to avoid pregnancy, either by taking the morning after pill:

*They just tell them to go and get the morning after pill. That's what they all say. (R1/16)*

Or with a termination:

*I've had that said to me, I mean, I've never been pregnant before, but I have had my ex boyfriend saying to me, before, its alright, if anything happens you can just do this, and I'm like, well, no its not as easy as that, its horrible, its not a nice thing to do either, but he's like, no its alright, you know. (R7/16)*

Alcohol appears to be a major influence on behaviour which leads to unprotected sex, with people not stopping to think or to discuss contraception:

*Yeah that's how I got pregnant with my first one. I got drunk, cos - it was my birthday, and my birthday was on a school night, so we went out on the weekend. That's when I got pregnant with him. Yeah, that's why (R3/17)*



*I know it sounds silly but at the time you aren't bothered, when you're drunk. Well you are, but you just seem to think you haven't got a condom, its doesn't matter this time round, I'll be alright (R16/18)*

Alcohol means people are less inhibited, and more likely to take risks:

*Yeah, cos it gives people more confidence, it makes them think, oh, it makes people more reckless. And if they were unsure about doing something, once they've been drinking they think, oh it'll be alright now. (R5/20)*

*Drinking and just forgetting about it, people go out on town and drink and forget about it, they lose inhibitions (R21/18)*

Parties or other occasions where young people are consuming alcohol were also settings for young men to avoid using condoms, not so much in terms of putting pressure on young women, but of taking advantage of situations where decision-making was impaired:

*I don't think they put pressure on not to use them, they just don't. That's what they're like. They don't use them. Cos boys I think do take advantage of girls. Like say if they're at a party and they're drunk, that's when they'll take advantage. (R14/18)*

*I mean, a lot of my friends, used to always go out on a Friday night, I mean even if it was like at a friends house, they'd end up getting drunk and end up sleeping with someone (R19/18)*

This issue was perceived as one which was becoming increasingly problematic as more people drank, at a younger age:

*There's more younger people drinking now than there was when I was like 14 .. and I think that's why more people are getting pregnant, because they're drunk, and they don't want to like talk about anything, they just go ahead and do it because they don't know what they're doing (R3/17)*

There was also a perception that club nights aimed at young people, especially under-18s nights, were an occasion for opportunistic sex or one night stands, whether or not alcohol was involved:

*They do have sex behind the Ice Arena, or behind Pozition, at under 18s, or in the toilets. Its disgraceful. (R10/17)*

*in under 18s they can't drink, and at Ice Arena you can only drink what's there. So its nowt to do with the alcohol. But at Pozition at under 18s, where we used to go if you smelt of beer you weren't allowed in. So its nowt to do with the drink. I don't know what its to do with really (R10/17)*

One respondent's suggestion for lowering teenage pregnancy rates was fairly direct:

*Tthey should put cameras or security round the back of Pozition. Or big billboards (laughs) saying about contraception. (R10/17)*

The respondents felt that young men and women had different attitudes to contraception, with women being the ones to think about it and take it more seriously, and men relying on them to do this:

*Yeah, cos the girls do think about it a lot cos of the fact that its them that's going to get pregnant. The boy's just the one that gets them pregnant. She's thinking what if I'm pregnant and the boy's just, she might be. Yeah I think boys should be spoke to more about it, cos girls have to think about it don't they? (R14/18)*

*Yeah, cos I think girls take it more seriously. To be honest (R18/16)*

Although a few respondents mentioned STIs, the issue of responsibility for contraception was usually discussed in terms of avoiding pregnancy, or the consequences of unwanted pregnancy and birth. One respondent said she always used condoms now because she had had an STI, and one said that she had ended a relationship because her boyfriend cheated on her and had not used a condom with the other girl. On the whole, however, STIs were not a major factor in the decision making process about whether to use contraception, and what method to choose.

Several of them thought that it would be difficult to change behaviours, especially those of young men:

*It's just getting people to use it, and especially lads. They're just - I don't know - they just don't seem like they're bothered. It's always got to be the girl who's got to do everything. Cos girls I know are sensible about it all, aren't they? (R9/16)*

However, although many respondents talked about being under pressure from young men in various forms, whether to have sex, have unprotected sex, or deal with the consequences later, pressure did not only come from men:

*When you're 15, you'll do anything to have a boyfriend, and everyone else is doing it, so you do too. That's why I did. Cos everyone else is doing it. (R23/18)*

Peer pressure from other girls, particularly at school, was a factor in making the decision to have sex:

*But it was even worse with it being an all girls' school. So you was like, it's full of lasses going 'I've lost my virginity, I've done this', and you was like 'whoa'. Time for you to do it. So you go out and do it (R10/17)*

The main issues, then, in terms of contraception are:

- finding a suitable form of contraception;
- information about side effects of the pill and LARC;
- forgetting the pill;
- reliability of chosen methods.

The main issues as far as not using contraception are:

- being “in the moment”;
- thinking “it won’t happen to me”;
- embarrassment or lack of confidence to talk about condoms;
- young men’s reluctance to use condoms;
- young men’s reliance on women using contraception, and assumptions about who should take responsibility;
- the influence of alcohol.

### Other issues

The other main issue discussed in the interviews concerned the process of decision-making around whether to terminate or continue with the pregnancy. Most of the respondents who did not already have a child said that they felt they were not in a position to have a child as they could not support a family financially, and were at the start of their careers, or at college or planning on going to University:

*Because I can’t support it financially. He can’t, my Mum can’t. I’m hoping to go to Uni in September, and I want to get my career sorted out first, get some money, give it a life. Cos I know that I can’t now. (R2/18)*

*I can’t give it anything, like I want to be able to have a kid when I’ve got money to bring it up (R17/18)*

They felt that they would want children one day, but when they were in a position to provide for a family, when their careers were established and they had a house.

The other main reason was they were too young to have a baby:

*I’m too young. I’ve got loads of mates, well quite a few mates from school who’ve got babies, pregnant now, had miscarriages you know who wanted to keep them. I’ve messed up a bit at school, I don’t want to mess up any more and be on benefits and that. I’d rather wait til I’m a bit older (R9/16)*

Most had discussed the decision with their boyfriend, and said that they agreed with the decision not to continue with the pregnancy. However, for some, the deciding factor centred on the relationship they had been in at the time they got pregnant. For two respondents, the pregnancy had led to the end of the relationship, which had then led to the decision to have a termination:

*He doesn’t want to know, yeah. So I thought, I’m young, I’ve got a baby of my own, she’s just turned one, I’m just starting to enjoy myself again, I aren’t in a relationship with you, so I thought the best thing to do is to have a termination (R16/18)*

*Cos its not my partner’s, who I’m with now. So, we didn’t want a kid to another person, really, when we’re just thinking about moving in together. (R10/17)*

For those who already had a small child, the deciding factors centred around whether they could cope with another baby:

*I'm just not ready for another one yet (R14/18)*

*I just knew I couldn't go through with it again, not having already got one. Two babies, with two different fathers, at my age? Don't think so. I knew I just couldn't cope with it. (R23/18)*

Tiredness, lack of money, and the difficulty of life with a baby at a young age were influences in the decision-making process.

Families were also influential, both in deciding to continue with a pregnancy:

*Everyone knew, in my family, and they were all really excited, and wanted me to have the baby. So I did. And I know I shouldn't say I regret it, with her out there, but I do. (R23/18)*

*She [mother] was upset because she thought I was going to make the same mistakes that she had. Because she had my older brother when she was 15, so, and me nana had my mam when she was 15, it sort of like runs in the family (laughs). (R3/17)*

(Both respondents above had had a baby at the age of 15, and decided not to continue with a subsequent pregnancy.)

And in being supportive of the decision to have a termination:

*She (mother) said she's done it before, but she was made to do it. She said, I think that's why she's more supportive now, because her mam wasn't. When she was 16 she had to have an abortion otherwise she was kicked out, so I think, that's why, she said that's why I wanna talk to you about things, because I didn't have a mam to talk to like that (R16/18)*

It was far more common for mothers to be supportive of the decision to have a termination than to continue with a pregnancy at a young age.

The main issues, then, in deciding whether or not to terminate a pregnancy are:

- age;
- inability to support a baby financially;
- stage of life (i.e. studying or establishing a career);
- current relationship;
- inability to cope.

The interviews ended with respondents being asked what they would like to see, in terms of service provision for their age group, and whether they thought service providers could do anything to change people's attitudes, in particular with regard to having unprotected sex. Some respondents thought that it was unlikely that young people would change their behaviour or attitudes:

*I don't reckon there's anything, cos like if people don't want to go talk to anyone, people don't want to do things, then I don't think anyone can change them into doing things (R3/17)*

In those situations, sex education in whatever form was unlikely to have an impact:

*Cos no matter how many times you talk to someone about it, they can still not listen to you, like "I'll do what I want", cos you get people like that out there (R3/17)*

The issue was not that there was not enough information, but that people would choose whether to take notice or not:

*Like I said, I think it's just the person. They don't listen. I see it all the time, things about contraception, about diseases, get checked out, use this use that, but people don't. So. I think you put it across enough. You hear it everywhere but no-one does owt (R15/19)*

However, some respondents were clear about what they would like to see, in terms of changes in attitudes, even if they thought that was unlikely:

*I think you need a bit more respect off the boys, really, don't you? (laughs). Well, the boys I've been with anyway, haven't got a lot of respect. I mean, some of the boys, my ex boyfriend, he was real supportive and stuff like that. But some of them just don't care. So. I think if you got more of them to respect women a bit more, it might not happen as much. (R16/18)*

The two most frequent suggestions in terms of service provision were for better information, and better access to facilities that were designed for young people.

*More information in schools and stuff. For younger people. Dunno. Maybe give some contraception stuff out (R11/18)*

*Open more clinics and have them open longer (R12/18)*

*I don't think there's enough clinics for young people to go to (R14/18)*

Easier access to contraception, in a way that would avoid embarrassment and the risk of discovery was also mentioned:

*You could make it more open to people like, cos young people think its embarrassing to go and buy condoms or do this or do that, but its not, so I don't know really, there should be a less embarrassing way for them to do it, but I don't know how to do it (R10/17)*

*I think just let more people be aware that there is a morning after pill available, free, and where to get it from. And I think it should be in schools, telling them. (R21/18)*

On the whole, respondents felt that they knew enough now; however, this was due to the experience of becoming pregnant, and they often said their friends were not well informed, and that they had not known enough about sex and contraception prior to becoming pregnant.

## **Discussion**

This study is unusual in that whereas most published research on teenage sexual behaviour and pregnancy focuses either on sexual activity or on the experiences of young parents, this report considers, as it were, an interim stage between sex and parenthood, and asks why, if they did not want to be pregnant (which they clearly did not otherwise they would not be having a termination), did they get pregnant? This section of the report discusses the findings set out above in a wider context, and considers whether Hull teenagers are different to teenagers in other parts of the world, and whether this might influence rates of teenage conceptions.

In a small American study, Spear (2004) found that teenagers had limited knowledge about contraceptive methods, but that inconsistent use was “not strongly related to lack of knowledge or access to contraceptives”. Like the American teenagers, the respondents in this study were often only aware of condoms and pills prior to coming into contact with GDU staff, after which they were much more informed about the range of contraceptives available, particularly LARC.

Stanley (2005) describes the visibility of teenagers seeking contraceptive services in small towns as a factor that makes young people reluctant to access services, and this study is consistent with that finding. Even in a city such as Hull, individual communities within it, particularly housing estates, have an element of risk of visibility for young women. Confidentiality was also identified as important in both Stanley’s study and this one, with young women being uncertain about whether or not a visit to the GP would remain confidential, whether that confidentiality related to the consultation itself, or to people “finding out” in other ways. Hillier, Harrison and Warr (1998) had similar findings for Australian teens.

Young women want services that they perceive as friendly towards them, that are understanding of their needs and non-judgemental. The need for “someone to talk to” was often expressed, either for themselves or for teenagers generally. The need for more information, made available in places where young people would be able to get it easily, was widely expressed, as was the need for easily accessible contraception, and better information about the range of methods available. Many thought that more information about LARC would encourage young women to take it up, despite stories about side effects being quite often related amongst their friends. The findings of this study are consistent with the results of the BMRB tracking survey (2003) which identified opening hours, convenience, not being seen by anyone they knew, being seen by a staff member of their own sex, friendly staff, and confidentiality as the most important attributes for services providing advice on sex and relationships.

An Australian study looking at condom use and safe sex in rural settings (Hillier, Harrison and Warr, 1998) found that although teenagers were aware of condoms and messages about safe sex, condom use was not a simple matter, as “the rational approach to safe sex, which regards safe sex as a choice, overlooks the importance of the context of sexual encounters”. This was often because condom use involved negotiation, which either because of girls’ lack of confidence or the actual timing of it (i.e. the idea of being “in the moment”) did not take place. Similarly, respondents in this study reported difficulties in discussing condom use, notwithstanding male reluctance to use them.

Hooke, Capewell and Whyte (2000) found in their study of 13-15 year olds in Ayrshire that boys “possess a considerable sense of responsibility on sexual issues, although this is not as well developed as for girls”. However, a 2001 study commissioned by the Teenage Pregnancy Unit (Counterpoint, 2001) found that young men “felt that contraception was really something for young women” and that they found it “a hassle, and were quite happy to avoid using it”. For the young women interviewed for this study, there were clear gender differences in attitudes to use of and responsibility for contraception. Young women described themselves as being expected to take responsibility, and said that young men often assumed that they would. This was often because the consequences were seen as falling entirely on the girl, the emphasis being very much on pregnancy as a result of unprotected sex, and not STIs. Further research is required to discover young men’s views about use of and responsibility for contraception.

Coleman (2002) reviewed international literature on interventions to reduce teenage pregnancy, and found that “most intervention programmes have focussed on teenage pregnancy risk in “isolation” rather than in “combination” with other behaviours” with most promoting use of contraception, most specifically condom use, rather than looking at teenage pregnancy alongside alcohol and drug use. Coleman (2001) suggested that there is evidence that general levels of alcohol use are statistically associated with high risk sexual behaviour, i.e. those who drink more are also more likely to report risk-taking sexual behaviour, but that evidence from “event analyses” that look at alcohol use leading to sex on specific occasions did not show a conclusive link. However, the findings from this study suggest that alcohol consumption does lead to risky sexual behaviour, in the form of unprotected sex, with several respondents saying that they had done that themselves, and many saying that their friends had also had similar experiences. Thus it can be argued that measures to reduce teenage pregnancy should be linked to an alcohol strategy, and address risky behaviours in combination.

On the whole, then, attitudes of young people in Hull are similar to those elsewhere; there may be differences in young men’s attitudes to contraception, and in the influence of alcohol on sexual activity. Both these issues would benefit from further exploration.

## **Conclusions**

This study set out to explore factors leading up to unwanted conceptions in young women aged 16 – 20. The key factors centre around education and information, service access, contraceptive use, and pressures from partners and peers.

They clearly express a wish for more, and better, sex education in schools, which is delivered in a way that extends beyond mere biology. This should not only address emotions and confidence around relationships, but also tackle the realities of having a baby at a young age. Peer education was strongly supported by those young women who already had a small child.

Gender was a key issue, with the respondents feeling that they were expected to be responsible for contraception, and generally taking on that responsibility not necessarily because they felt they should, but because they felt that young men would not.

Better access to services that are designed for their age group and are friendly and non-judgemental would make it easier for them to obtain contraception, and to be fully informed about the range of methods available. However, when it came to encouraging people to use contraception and not take risks, they were not optimistic that service providers could do much to change attitudes. Alcohol, the excitement of “the moment”, and not wanting to stop (or feeling awkward about asking a boy to stop) meant that rational decisions about contraceptive use were unlikely.

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