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YOUNG PEOPLE IN LONDON: ABORTION AND REPEAT ABORTION

RESEARCH REPORT



LESLEY HOGGART AND JOAN PHILLIPS
POLICY STUDIES INSTITUTE
WITH ANGELA BIRCH AND OFRA KOFFMAN

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Executive summary

Despite some progress towards the government's aim of halving under-18 conceptions between 1998 and 2010, the rate of teenage pregnancy in England and Wales remains the highest in Western Europe (Population Action International, 2007). An increasing proportion of these conceptions, however, are ending in abortion, not teenage motherhood. In the UK around 50% of under-18 conceptions in 2007 ended in abortion. In London the figure was higher at 63%. In addition, compared to the rest of the country, relatively high proportions of London teenagers had already experienced one or more abortions and were thus undergoing a repeat abortion. Teenage pregnancies ending in abortion are likely to be unintended pregnancies that might have been avoided. For a variety of reasons these young women have not used contraception or emergency contraception effectively.

This research set out to explore factors that might lead to a greater understanding of what might reduce unintended and unwanted teenage pregnancies in London. This required gathering data on sexual behaviour leading to such teenage pregnancies; on teenage experiences of abortion; and on post-abortion sexual behaviour. A qualitative research methodology was adopted and a wide range of interviews were conducted with young people and professionals.

Key findings

Teenagers continue to have unprotected sex when they are fully aware of the possible consequences, and when they do not want to become pregnant.

Underlying issues that can help explain this include: feeling out of control, maybe because of drugs or alcohol, or because of the dynamics of the sexual relationship; reliance on user-dependent contraceptive methods; problems young women experience negotiating safer sex. This finding has implications for young women's choices of contraceptive methods.

Young people struggled to use their preferred methods of contraception (principally condoms and the pill) effectively. These methods are relatively user-dependent, and the condom – primarily a male method – requires young women to have the confidence to negotiate safer sex, or for her male sexual partner to take responsibility for preventing sexually transmitted infections and unintended pregnancies.

There is a poor understanding of fertility amongst young women, and this contributes to inconsistent contraceptive use. Teenagers in school-based focus groups talked about it being 'very easy' to become pregnant. This means that they might draw the wrong conclusion on any occasion when contraceptives have not been used. Young women who had terminated pregnancies told us that they had often failed to become pregnant after one or two incidents of unprotected sex, and this led them to think they may be infertile. They then assumed that they no longer needed to use contraception.

Abortion was viewed as ‘immoral’ by many young women, and this view makes abortion decision-making difficult and stressful. The way in which abortion is often covered as a discussion topic in Religious Education lessons within schools encourages such a framing of the issue. Feeling that abortion is ‘immoral’ contributed towards feelings of regret and/or guilt that some young women had following their abortion.

The mindset of pregnant teenagers and their degree of autonomy in making an abortion decision can influence their feelings and sexual behaviour following the abortion. We suggest that those young women who are able to make their own decision for their own reasons are more likely to establish an effective contraceptive regime following an abortion, than young women who may have been reluctant to end their pregnancies and do not have any plans for their own futures.

The myth that having an abortion may make you infertile still retains a hold. This was mostly evident in the school-based focus groups

Implications for policy and practice

The research findings indicate that policy developments around unintended teenage pregnancy and abortion should therefore have three main objectives:

- **Help young women avoid conceptions that end in abortion.** The main policy tools are Sex and Relationships Education (SRE), and local Contraceptive and Sexual Health Services.
- **De-stigmatise abortion.** This objective should inform developments in Sex and Relationships Education and Religious Education.
- **Help young women avoid repeat unintended pregnancies.** This could be facilitated through the further development of post-abortion services.

Improving education about abortion

Thought should be given to SRE being delivered by specialist teachers or specialist educators. All those responsible for the delivery of SRE should undertake continual professional development, and it would be helpful if this incorporated attitudinal work. No-one who is personally opposed to abortion should be involved in the delivery of SRE.

Separate messages are needed for STIs and pregnancy prevention. All methods of contraception should be discussed, including LARC and emergency contraception, and local services should be clearly signposted. All young people need to be encouraged to discuss which contraceptive methods are more effective for each purpose, and to consider the possible benefits of using more than one method. Misunderstandings about fertility should be addressed. Finally, consideration could be given to including the notions of self-respect and pleasure into discussions on negotiating safer sex.

A balanced, non-judgemental, discussion of abortion ought to be an integral part of SRE (preferably delivered by specialists). This should include accurate information on abortion, and be developed as part of an effort to de-stigmatise abortion. Religious Education (RE) is not an appropriate forum for this particular discussion to take place.

Avoiding conceptions that end in abortion

Commissioners need to develop world class commissioning for contraceptive and abortion services. Efforts need to be made by commissioners to collect data that will inform and support the further analysis of how services currently meet the needs of young people. London's Primary Care Trusts (PCTs) can refer to the recent London sexual health needs assessment and service mapping (MedFASH, 2008) and keep it up to date for their areas.

Access to, and use of, Long Acting Reversible Contraception (LARC) should be monitored at a local level. It should be available at all settings where contraceptives are available. Data should be systematically collected, and efforts made to try and ascertain how knowledgeable young women are with respect to all the different contraceptives available within this category. Services should also ensure that young women are given enough information and time to make an informed choice. Contraceptive counselling needs to include discussion of the possible side-effects of all contraceptives.

Further work is required to develop outreach, and confidential prevention services, for Black and Minority Ethnic groups that might currently struggle to access services. This study confirms other research that points out that one size does not fit all. The differing needs and preferences of diverse populations need to be taken into consideration.

Systems need to be in place for early identification of those who may be 'at risk' of teenage pregnancy. Innovative and effective 'early intervention' programmes should be developed for teenagers who are thus thought to be 'at risk'. Post-abortion services would need to consider engaging with such programmes.

Key service providers for vulnerable young people (e.g. youth workers, and social workers), ought to receive training in sexual health issues, and this should include pregnancy options, abortion services and a focus on local provision. They might then be able to help young people make informed decisions about their sexual health, as well as sign-post them to appropriate contraceptive and sexual health services. There also needs to be joint working with these services with respect to young people 'at risk'.

Young people need to be sign-posted to pregnancy and abortion decision-making support. Such support needs to be provided in a non-judgemental manner in a variety of settings. Post abortion support should be organised in these settings.

Avoiding repeat conceptions that end in abortion

Abortion provision needs to be considered by teenage pregnancy partnership boards (or the senior board responsible for teenage pregnancy) as well as sexual health boards. This should include monitoring the quality of the service available, and assessing whether it is 'young people friendly' applying the Department of Health You're Welcome Standards.

Young people need to be sign-posted to services which offer non-judgmental pregnancy decision-making support. These services should provide evidence-based information about all pregnancy options, and support access to ante-natal and abortion services. Some organisations offering pregnancy testing and counselling are not committed to providing non-directive support and oppose abortion. These should not be included in local information.

There is a clear need for high quality post-abortion services for young women to be developed. They should have three main purposes:

- 1. Post-abortion contraceptive counselling and support**
- 2. Post-abortion health and well-being follow-up**
- 3. Identification of young women in need of more intensive support**

Commissioners should consider funding a partly or fully dedicated post to providing individualised comprehensive contraceptive counselling prior to and following an abortion. Such a post could also involve one to one preventative outreach work with teenagers that may have been identified as being 'at risk' of teenage pregnancy.

In advance of the abortion, providers should organise a follow-up appointment, ideally two to four weeks afterwards. These follow-up appointments would cover both physical check-ups and contraceptive counselling.

Abortion referrers need to be able to keep track of the referral and have the follow-up appointment set up in advance of the abortion. Abortion providers need to check that their clients have a follow-up appointment organised and – if they do not - help them set one up. It should not be left for the teenager to take the initiative on this issue. The setting for this appointment should be agreed in consultation with the teenager. Intensive one-to-one support should be available for teenagers judged to be 'in need' of such an intervention. Where appropriate, they should also be referred on to other services.

Chapter 1 Introduction

This research project had two main aims. The first was to explore factors that may help explain what is currently viewed as a disproportionately high proportion of teenage conceptions that end in abortion in London.¹ The second was to try and shed light on what is currently viewed as a disproportionately high teenage repeat abortion rate in London.² The overall objective was to suggest ways in which local teenage pregnancy strategies might address these issues. The research did not seek to present teenage abortion as a problem to be dealt with, but rather to proceed from the assumption that, in the main, it would have been preferable for such pregnancies to have been avoided. We end the report by suggesting ways in which this might be achieved.

Methodology

In order to address the research questions, the research focused on an exploration of young women's attitudes towards sexual behaviour, contraception and abortion decision-making. It did this with groups of young women in schools, and also amongst young women who had terminated pregnancies. The research, however, also sought the views of Key Informants providing contraceptive and sexual health services for young people.

The study was mainly located in ten local health authorities. All Teenage Pregnancy Strategy Coordinators (TPSCs) from PCTs that had a higher than 17% repeat abortion rate³ were asked if they would like to take part in the research. The following agreed to participate: Barking and Dagenham, Brent, Greenwich, Enfield, Lambeth, Lewisham, Southwark, Tower Hamlets, Ealing and Wandsworth.⁴ The results from these districts have been combined in order to provide findings that should be useful for all London PCTs, and can also provide insights of value to the national teenage pregnancy strategy.⁵

¹ The research was not seeking to provide an explanation for why these rates are higher in London than elsewhere. This would have required complex quantitative and qualitative work. Rather the aim was to look at these issues in London and to try and suggest ways in which the numbers might be brought down.

² Unfortunately there is an inconsistency in the age ranges within which these statistics are reported. The conception rate is reported for under-18s whilst the repeat abortion statistics are calculated for under-19s. http://www.statistics.gov.uk/downloads/theme_health/conceptions2007/provisional_annual_conceptions_2007.xls In this research the term 'teenager' is used to cover both these groups.

³ This is the percentage of the total number of under-19 abortions that are for individuals who had undergone at least one previous abortion. This is the definition of repeat abortion employed in this project.

⁴ In one of these areas – Southwark – only key informants were interviewed for the study. This is because local officials did not approve the study until Research Ethics Committee approval for the project had expired.

⁵ Individual PCTs that participated are being given the opportunity for site specific feedback separately.

Data was gathered from three different groups of stakeholders:

1. Key Informant Interviews.

Qualitative interviews were conducted with teenage pregnancy strategy coordinators; service providers responsible for referring young women for abortions; and other key informants who work with young women that become unintentionally pregnant; and abortion providers. These were supplemented by two group discussions, and a short open-ended questionnaire sent to London TPSCs. The aim of this element of the work was to understand local service provision, abortion pathways, and access issues. A second aim was to collect data on what key informants felt influenced the behaviour and attitudes of teenagers with unintended pregnancies that ended in abortion. It was recognised that although this was second-hand information many of the key informants had years of experience of working with the teenagers whose views we were seeking to access. The research design allowed for this data to be compared with data from the young people themselves.

2. School-based focus groups.

One or two focus groups were conducted in schools in the study areas. The aim of this element of work was to explore what might be normative values and attitudes surrounding abortion, teenage pregnancy, sexual health, negotiation of safer sex, and issues around accessing services. The schools were selected by the research team, in consultation with the local education authority lead on sex and relationships education, or the teenage pregnancy strategy coordinator. The schools selected were comprehensive schools and, where possible, were located within teenage pregnancy 'hotspots'. They were all-girl focus groups with 8-10 participants either from year 10 (aged 14-15), or year 11 (aged 15-16).

3. Qualitative interviews with teenagers that had terminated pregnancies.

We had hoped to interview up to eight young women who had terminated pregnancies from each locality. We were not, however, able to recruit more than three respondents, in total, in this way. Key informants were sometimes reluctant to ask their client group to be interviewed, and, in other cases, the teenagers declined to be interviewed. We interpreted this difficulty as being partly due to what was often viewed as shame and stigma attached to abortion. We decided to adapt the research design, and interviewed extra key informants and also recruited teenagers who had terminated pregnancies through a central provider – BPAS.⁶ An additional seven teenagers were recruited in this way. The aim of this element of the project was to explore their views and experiences on a number of issues including: abortion, teenage pregnancy, sexual health, negotiation of safer sex, accessing services; as well as exploring their individual

⁶ Additional Ethics Committee Approval was granted from BPAS Research Ethics Committee, and an agreement to extend the study in this way was also secured from the original Research Ethics Committee (pan-London).

abortion decision-making. All these young women were over 16 at the time of the interview, and had experienced their abortion whilst a teenager.

These participants were not recruited as a representative sample, so conclusions are not drawn based on individual characteristics of the participants.

Nevertheless, the following information is given in order that readers may know a little more about the teenagers interviewed. Aliases are used.

Alias	Age at interview	Stated ethnicity	Stated religion
Nuru	19	Black African	Christian (not important to her)
Aisha	17	Bangladeshi	Muslim
Yasmeen	16	Cameroon	none
Anna	17	Black British (Jamaican)	Christian (not important to her)
Ella	19	White European	Catholic (not important to her decision)
Michelle	19	White British	none
Juliet	19	White British	none
Cara	19	Black British (mixed)	Christian (not important to her)
Lucy	16	Mixed race	Muslim (not important to her)
Katie	17	White British	none

Research Ethics

The research design gained pan-London approval from Wandsworth Research Ethics Committee. All the participants were given appropriate information leaflets, and were also given the opportunity to ask questions about the study and their involvement before being asked for written consent. All participants were thus able to make an informed decision about taking part in an interview. For the focus groups, where most participants were under 16, written parental consent was also gained. The research team assessed whether each participant understood what they were consenting to (Fraser competence), and continue to monitor this understanding throughout the interview. It was recognised that this was research in a sensitive, potentially distressing area and every effort was made to try and avoid any negative outcomes for the young women interviewed. They were informed that they were free to withdraw from the interview at any stage, and that they did not have to answer any questions that they felt uncomfortable with. In addition, probing was undertaken sensitively: participants were asked, for example, 'would you like to tell us a bit more about that' rather than 'please tell me a bit more about what happened'. It was recognised that although this approach may have limited the depth of the data obtained, it was a requirement for ethical research. The researchers also had the details of referral routes to sources of help and support and these were offered to participants at the end of the interview.

The anonymity of all the participants has been preserved in the report. This means that descriptions of people's work is kept to a minimum, and only used when needed for the analysis. The individual teenagers interviewed have, however, been given aliases. These aliases bear no relation to their real names, and have been used for stylistic reasons, mainly for ease in referring back to particular accounts at different points in the report. Unless otherwise stated, quotations are selected to indicate broader opinions, and patterns of behaviour, amongst the group rather than those of any one respondent.

Data Analysis

The report is based on an analysis of data collected at all stages of the research; and all the data sources:

- 10 interviews with Teenage Pregnancy Strategy Coordinators (TPSC).
- 14 interviews with providers responsible for abortion referrals, and other key informants working with young women that become unintentionally pregnant.
- 8 interviews with abortion providers.
- 1 discussion group with 13 London TPSCs.
- A short electronic questionnaire (open-ended questions) returned by 7 TPSCs who had not attended the discussion group.
- 16 focus groups in schools
- 10 interviews with teenagers that had terminated pregnancies.
- An expert deliberative focus group towards the end of the research process

A number of measures were taken in order to facilitate reliability and validity. The data was analysed independently by the two main researchers and authors, and the results were compared. In addition, the data was analysed in two different ways. First it was analysed thematically with the help of NVivo software: the interviews were first coded into broad themes, subsequently each theme was coded again. This facilitated comparison of issues across respondents and allowed emerging issues to be explored across the whole data set. Alongside this process, each transcript was re-read as a whole. This ensured that the emerging findings can be located within the context of the interview as whole, and allows researchers to check for inconsistencies in the narratives.

The use of multiple data sources also increases the robustness of the results. The data from all the sources has been triangulated, and findings from one group of stakeholders have been tested against the data from other sources. It should be borne in mind that each source of data by itself presents an incomplete view. The data from the Teenage Pregnancy Strategy Coordinators, and many other key informant interviews, for example, offers a partial view on a sensitive subject, and is influenced by the teenage pregnancy targets to cut teenage conception rates. For these informants all abortions contribute towards their rates, and can be seen as a failure of their prevention strategy. This sense of failure is magnified for repeat abortions. The interviews with the teenagers deliberately sought to explore some of

the findings emerging from the other data, as well as exploring how they felt about becoming pregnant if they did not want to become pregnant, and also their views on abortion. Finally, emerging findings were explored in a deliberative focus group towards the end of the project. Participants who held a number of different roles within contraceptive and sexual health services were purposively selected on the basis of their experiences of working with young women.

Some of the findings - those covering teenagers' sexual behaviour, for example - support the existing evidence-base developed by previous research. Other findings, however – most notably on post-abortion sexual behaviour - are more exploratory in nature and raise new ideas and suggestions. The qualitative research was primarily seeking views and attitudes of importance to a fuller understanding of abortion and repeat abortion amongst teenagers in London. It was not a formal needs assessment, nor an evaluation of existing services, nor a best practice guide. It would be useful for the report to be read alongside the recent London sexual health needs assessment and service mapping (MedFASH, 2008); the review of practice commissioned by the Teenage Pregnancy partnership in Hackney and the City (Hallgarten and Misaljevich, 2007); and the latest report from the Independent Advisory Group on Sexual Health and HIV (IAG, 2009).

The rest of the report comprises a further four chapters. Chapter two presents background information, discussing conception and abortion statistics, the teenage pregnancy strategy, and what is known about abortion decision-making from other research. Two chapters are then devoted to presenting the research findings. Chapter three looks at teenage sexual behaviour and addresses the question: what are the factors behind teenagers who do not want to be pregnant becoming pregnant? Chapter four moves on to consider teenage abortion decision-making and factors contributing towards repeat teenage conceptions. The final chapter draws conclusions and discusses the policy implications of the research.

Chapter 2 Background

Introduction

This research is concerned with abortion among the teenage population of London. This phenomenon is the outcome of a range of factors affecting a diverse population of young women whose life experiences are extremely varied. The assumption made in this report is that the majority of teenage conceptions that end in abortion do so because the pregnancy is unintended and unwanted. For various reasons some young women do not manage to use contraception or emergency contraception effectively. This report seeks to address several key questions on this issue, namely: Why are young women who do not want to be pregnant becoming pregnant? What processes are involved in their decision whether or not to terminate a pregnancy? What might lead young women who have had an abortion to become pregnant again and seek a second abortion?

The literature presented in this section was compiled by a search of the Applied Social Sciences Index and Abstracts (ASSIA) database; the Science and Social Science Citation Indices via the Web of Knowledge, and the internet search engine 'google scholar'. The terms searched were 'repeat conception', 'repeat abortion' and 'teenage' or 'adolescent abortion'. In addition, the Zetoc database which provides access to the British Library Electronic Table of Contents was used in order to supplement the bibliography. The review is confined to UK based studies, as the context for the research studies was felt to be an important consideration.⁷

Teenage Pregnancy Statistics

According to the latest available comparative statistics, the rate of teenage pregnancy in England and Wales remain the highest in Western Europe (Population Action International, 2007). The latest national figures published in February 2009 on the rate of under-18 conception in England and Wales revealed an increase from a rate of 40.9 per 1,000 in 2006, to a rate of 41.9 per 1,000 in 2007. This is the first time since 2002 that the rate of conception in this population had risen. However, this figure should be contextualised. The increase in the rate is small and is lower than the rise in conception rate in the general population of women.⁸ Furthermore, there was an increase in the percentage of under-18 conceptions that end in legal abortions: in 2006 48.4% of conceptions ended in abortion, while in 2007 the figure

⁷ This means that an interesting study of repeat abortion in the United States is not discussed (see JONES, R. K., SINGH, S., FINER, L. B. & FROHWIRTH, L. F. 2006. Repeat Abortion in the United States. *Occasional Report No.29*.)

⁸ The general population of women of reproductive age defined as women aged 15 to 44.

had risen to 50%. As a result of this increase there was a reduction in the number of under-18 live births between 2006 and 2007.⁹

The 2007 under-18 conception rate in London was 45.6 per 1,000, and therefore above the national rate.¹⁰ However, the London percentage of under-18 conceptions which end in abortion was also above the national figure and stood at 63%¹¹. As a result, London's under-18 live birth rate was lower than the rate in England and Wales as a whole: the London rate was 17.1 per 1,000, whereas the rate in England and Wales was 20.9 per 1,000.¹² It is interesting to note that London's relatively high teenage abortion ratio (63%) resembles that found in European countries which have low teenage fertility, such as Norway and France (Daguerre and Nativel, 2006).¹³

The Government's aim of reducing the rate of conception among under-18 by 50% by 2010 (1998 used as the baseline) has prompted interest in improving the contraceptive and sexual health services available for young people.

The teenage pregnancy strategy; contraception and abortion policy

The Teenage Pregnancy Strategy, launched in 1999, has influenced policy developments in contraceptive and sexual health services. The Teenage Pregnancy Unit has coordinated efforts to improve sex and relationships education and contraceptive services, and there is little doubt that national sexual health policy has

⁹ A similar pattern is found in the under-16 population. The under-16 conception rate increased from 7.8 per 1,000 girls aged 13-15 in 2006 to 8.3 per 1,000 girls in 2007. However, since this increase was accompanied by a rise in the percentage of conceptions ending in abortion, the rise in fertility has been very limited: there were 3,164 such births in 2007 in comparison with 3,145 births in 2006.

¹⁰ As in the under-18 population, the London under-16 conception and abortion rates differ from the national average. The rate of under-16 conception and the percentage of conceptions ending in legal abortion were higher than in England and Wales as a whole. The London conception rate was 8.7 per 1,000 while the rate for England and Wales was 8 per 1000. However, the abortion rate in London was 5.9 per 1,000 while nationally it was 4.7 per 1,000. As a result the fertility rate in London, calculated as 2.8 per 1,000 in 2005-2007, was *lower* than the corresponding rate in England and Wales.

¹¹ Office for National Statistics, "Conception statistics in England and Wales 2007 (provisional)", Table 7: Under 18 conceptions: numbers, rates and percentage leading to abortion by LAD1 area, 2007, http://www.statistics.gov.uk/downloads/theme_health/conceptions2007/provisional_annual_conceptions_2007.xls

¹² Office for National Statistics, "Conception statistics in England and Wales 2007 (provisional)", Table 5: Under 18 conceptions: numbers and rates by area of usual residence and outcome, 2002, 2006 and 2007, http://www.statistics.gov.uk/downloads/theme_health/conceptions2007/provisional_annual_conceptions_2007.xls

¹³ These countries' teenage conception rates are lower than those of England and Wales, however, they also have a higher abortion ratio, i.e. a greater proportion of teenage conceptions end in legal abortion. For example, in France in 2001 there were 4845 live births to teenagers aged under 18, compared to 10,153 abortions (Daguerre and Nativel, 2006 p.117). Thus London's higher than average abortion ratio brings it closer to the pattern found in European countries that enjoy low rates of teenage fertility.

prioritised young people (IAG, 2009). There have also been related initiatives to improve young people's health more generally. In 2006, the Department of Health announced a new initiative to support the development of health services that would be easily accessible for young people and suited to their needs. The Teenage Health Demonstration Sites Programme was launched in four pilot sites, including Hackney, East London. In these localities, adolescent health advice and information will be made available to young people in sites they regularly visit such as youth clubs and sports centres.¹⁴ More recently, in February 2009, another initiative aimed at improving sexual health provision for young people was announced. A new media campaign which will raise awareness of the different contraceptive choices available, including the Long Acting Reversible Contraceptives (LARCs) has been launched. As part of this initiative, contraceptive services will be made accessible through a variety of sites, including further education colleges, all of which will be required to meet the 'You're Welcome' quality criteria that set out principles for young-people-friendly services.¹⁵

There have been some indications that the teenage pregnancy strategy has been partly successful. The number of teenage conceptions peaked in 1998, then began to decline after the implementation in 1999 of the teenage pregnancy strategy. Under-18 conception rates fell by an average of 2.0% per year between 1998 and 2003 (below the rate, however, needed to achieve the target of 50% reduction by 2010). An early study (Wellings and Kane, 1999) showed that fluctuations in the teenage fertility rate seem to track intervention-related factors such as access to, and use of, contraceptive services and initiatives to improve the sexual health of young people. This was supported by a study that looked at changes in under-18 conception rates between 1998 and 2003 and found that declines had been greatest in areas receiving higher amounts of strategy-related funding (Wilkinson et al., 2006). The evidence also suggests that targeted interventions may help as the change in the number of conceptions was greater in deprived and more rural areas, and in those populations with lower educational attainment.

There continues, however, to be significant variations in local area performance. In 2006, for example, almost half of under 18 conceptions occurred in the most deprived 20% local authority wards (DfES, 2006). The continuing wide geographical variations in patterns of teenage pregnancy and abortion – indicate the need for a small area approach. This has been highlighted by the Teenage Pregnancy Unit, in its identification of teenage pregnancy hotspots, and call for targeted work with 'at risk' groups (DfES, 2006). A number of local initiatives have been trialled.¹⁶ It is argued

¹⁴ Department of Health press release 31 August 2006, <http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID223809&NewsAreaID=2&NavigatedFromDepartment=False>, accessed May 2009.

¹⁵ See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

¹⁶ One of these was the Young People's Development Programme (YPDP), an innovative health programme for young people in England funded by the Department of Health which ran from 2004 to 2007. The aim of YPDP was to address risk behaviour in relation to teenage pregnancy, substance misuse and educational attainment

that the rate can come down in these 'hotspot' areas - generally areas of high social deprivation - if further resources are appropriately targeted.

Improvements in contraceptive and abortion services, however, have been uneven, and not as significant as many professionals had hoped (IAG, 2009). There is continuing disparity in abortion provision, including different restrictions according to geographical location (MedFASH, 2008). Policy efforts are set to continue, and have a dual approach: to establish a universal minimum standard of service in contraception and sexual health services; and to target specific interventions and efforts towards recognised teenage pregnancy 'hotspots'. Additional funding of around £27million annually (2008/9 and 2009/10) with further funds expected in 2010/11 has been allocated to improve women's access to contraception and to help reduce the number of teenage pregnancies, abortions and repeat abortion (IAG, 2009).

In recent years, a push to improve abortion provision, and accessibility, has been an important objective of sexual health policy. The National Strategy for Sexual Health and HIV (DOH 2001) imposed a duty on NHS Trusts to ensure that local abortion services meet local need, and the Royal College of Obstetricians and Gynaecologists has set a target of three weeks waiting time between referral and procedure (RCOG, 2004). Furthermore, there is a current effort to provide quick access to abortion;¹⁷ and in order to reduce the occurrence of repeat abortion, abortion providers are required to discuss and provide contraception at the point of abortion.¹⁸ There have therefore been improvements. One further way in which the teenage conception rate can be targeted is to further investigate those conceptions that end in abortion.

What more can be done to reduce unintended teenage conceptions?

The relationship between socio-economic deprivation and teenage conceptions has been well-documented. The more deprived an area is the greater the likelihood that young women from this area will become pregnant (Sloggett and Joshi, 1994, Sloggett and Joshi, 1998a, Sloggett and Joshi, 1998b, Smith, 1993, Social Exclusion Unit, 1999). Socially disadvantaged individuals experience greater difficulties in accessing contraception and are less likely to use emergency contraception (Jewell et al., 2000). They also start engaging in sexual intercourse at a younger age than those

through a long-term, broad-based developmental programme for young people aged 13-15. Twenty seven pilot projects in different locations in England took part in the programme. This programme has been evaluated by The Social Science Research Unit at The Institute of Education, University of London, but unfortunately the results are inconclusive. The evaluation found that the intervention may have increased teenage pregnancy risk but it also questioned the quality of the implementation of the programme. WIGGINS, M., BONELL, C., BURCHETT, H., SAWTELL, M., AUSTERBERRY, H., ALLEN, E. & STRANGE, V. 2008. Young People's Development Programme Evaluation. Social Science Research Unit, Institute of Education, University of London.

¹⁷ Department for Children, Schools and Families on 26/2/09 stated "Data for 2007 shows that progress is being made to increase early access: 68 per cent of NHS funded abortions took place at under ten weeks, compared with 51 per cent in 2001."

¹⁸ http://www.dcsf.gov.uk/pns/DisplayPN.cgi?pn_id=2009_0041

from advantaged backgrounds (Smith and Elander, 2006). However, it is important to note that deprivation does not solely explain variations in the rate of pregnancies among young women, as areas with similar levels of deprivation vary in their teenage pregnancy rate (Bradshaw et al., 2005, Social Exclusion Unit, 1999). Another factor which was found to affect the conception rate is the availability of contraceptive and sexual health services that are easily accessible for young people. As noted earlier, areas where there had been a high level of investment in sexual health provision through the teenage pregnancy strategy frequently had lower rates of conception (Ingham et al., 2008, Wilkinson et al., 2006).

Research which focuses on individual decision-making offers further insights into the processes involved in differing conception rates. At the centre of the analysis are complex and varied factors leading to the failure to use contraception effectively. The choice of contraceptive methods affects the likelihood that a young woman would become pregnant. User-dependent methods such as condoms and oral contraceptive pills have lower efficacy than LARC (Garg et al., 2001), but are the most popular methods of contraception in the UK.¹⁹ In a recent study of women presenting to Marie Stopes International for abortions, 78% of the women claimed to have used a regular method of contraception, with the most commonly used methods being the male condom (48%) and the pill (45%) (Bury and Ngo, 2009). Since young people are most likely to use these user-dependent methods,²⁰ they are faced with a higher risk of contraceptive failure.

Hallgarten and Misaljevich (2007) point out that some women have difficulties negotiating condom use. This may be because they lack self-esteem, or are in a relationship with a partner who is older and on whom they are economically dependent. They also note that for some young women an unwanted pregnancy is one problem among a few they are struggling with. They may be living a 'chaotic' lifestyle, be in a violent relationship, or have problems of alcohol or drugs abuse.

Other research has shown how some women develop a pattern of repeat non-use of contraception during intercourse (Williamson et al., 2009). This often occurs within a long-term relationship where, at first, unprotected sex takes place due to difficulties in accessing contraception or because intercourse was unintended. When a woman realises that she did not become pregnant as a result of the first occasion, she is likely to continue to engage in sexual intercourse without contraception. Her failure to become pregnant following those occurrences leads a woman to misperceive her risk of pregnancy. Consequently, she does not seek emergency contraception after such occurrences. A similar group of women identified by Hallgarten and Misaljevich (2007) are those who wish to 'test out' their fertility. Like the women who developed

¹⁹ Omnibus Survey Report No 41, Contraception and Sexual Health 2008/9.
http://www.statistics.gov.uk/downloads/theme_health/contra2008-9.pdf

²⁰ Omnibus Survey Report No 41, Contraception and Sexual Health 2008/9.
http://www.statistics.gov.uk/downloads/theme_health/contra2008-9.pdf

a pattern of non-use of contraception, these women may have at first failed to use contraception on one or more occasions. When they realise that they had not become pregnant as a result of these occurrences, they begin to doubt their own fertility. They subsequently develop a pattern of engaging in sexual intercourse without using contraception, in part as a result of their wish to find out that they could indeed become pregnant. Such patterns of behaviour are likely to be undermined if young women had better knowledge regarding fertility and consequently greater confidence that it is normal not to become pregnant following a single sexual intercourse.

Williamson's research also suggests that a young woman's attitude to becoming pregnant is an important influence on their use of emergency contraception. Whereas some women have a 'just-in-case' approach to a potential pregnancy, seeking to use emergency contraception in order to ensure that a pregnancy does not occur, others adopt an attitude of 'wait-and-see' to the possibility that they are pregnant. Such fatalism in young women has been noted in other research (Hoggart et al., 2006, Free et al., 2002). The different approaches appear to be associated with a young woman's socio-economic background: those from advantaged backgrounds tended to adopt the 'just-in-case' approach whereas those from disadvantaged backgrounds were more likely to adopt a 'wait-and-see' approach (Williamson et al., 2009). Jewell et al (2000) also suggest that early pregnancy and young motherhood are more acceptable to disadvantaged young women, even when unintended.

These findings could help explain the relatively small impact that the availability of emergency contraception has had on the rate of teenage conception. Emergency contraception was expected by researchers and practitioners to contribute to a reduction in the number of abortions. The availability of emergency contraception might be expected to enable young women who did not wish to become pregnant to avoid recourse to abortion. The UK National Survey of Sexual Attitudes and Lifestyles (NATSAL) 2000 found that 7% of 16–19 year olds reported using emergency contraception in the preceding year. By 2008/09 the figure was 17%.²¹ The question regarding the failure of emergency contraception to affect the number of abortions has become even more pertinent since, in 2001, it became available for purchase without prescription to those over-16. Although further research is required in order to fully explore this issue, it seems that availability of emergency contraception has not resulted in a significant impact on the conception or abortion rate (Williamson et al., 2009).

Negative encounters with health professionals, while obtaining emergency contraception (for instance feeling that practitioners were judgemental or disapproving) could have a negative impact on the likelihood that a young woman

²¹ Omnibus Survey Report No 41, Contraception and Sexual Health 2008/9.
http://www.statistics.gov.uk/downloads/theme_health/contra2008-9.pdf

will seek emergency contraception in the future (Williamson et al., 2009, Free et al., 2002).

It has also been suggested that a negative 'spiral relationship' around contraceptive use and health services could develop. Women who fail to establish an effective contraceptive regime and who then have negative experiences when they access health services seeking an abortion, are likely to continue experiencing contraceptive difficulties leading to a second pregnancy (Meyrick, 2001).

A particularly vulnerable group of young women are those who have difficulty using contraception due to their families' cultural or religious background. When a young woman's parents do not approve of sexual intercourse before marriage, she is likely to face several barriers to the use of contraception. She is likely to be living with her parents and be anxious that they will discover condoms or contraceptive pills in her possession. Young women might also be anxious that a parent will notice a change in menstrual patterns as a result of using LARC. Practitioners involved in the provision of contraceptive and sexual health services report that children of strongly religious parents of various faiths are frequently reluctant to use contraception (Hallgarten and Misaljevich, 2007, p. 30).

There are similarities between the experiences of young people from BME communities and those of the general British population of young people in their sexual and contraceptive decision-making processes and in their timing of sexual encounters (Higginbottom et al., 2008). Nevertheless, patterns of teenage fertility vary across Britain's ethnic communities. Among women of Pakistani, Caribbean or Bangladeshi origin the teenage fertility rate is higher than in the white population, while among young women of Indian origin, the rate is lower than in the white population (Berthoud, 2001). Furthermore, the relationship between early parenthood and economic disadvantage found in the white population does not apply to BME communities. In these communities, the negative impact of early parenthood is small or non-existent (Robson and Berthoud, 2003 quoted in Higginbottom et al., 2008). Many BME young people do not believe that early parenthood is a barrier for resuming education or developing a career later in life. Furthermore, in some BME groups the distinction between a birth in wedlock and out-of-wedlock has a significant effect on how a teenage pregnancy is perceived (Higginbottom et al., 2006b). Such views are likely to impact on abortion decision-making.

Abortion Decision-making in Britain

While the rate of teenage conceptions is associated with high levels of deprivation, the rate of teenage abortion is negatively associated with deprivation (Social Exclusion Unit, 1999, McLeod, 2001). In other words, teenagers from more affluent areas are more likely to terminate pregnancies than those from deprived areas. In Smith's study of Tayside, for example, around a quarter of pregnancies in deprived areas ended in abortion, compared with two-thirds in the more affluent areas (Smith, 1993).

This correlation is weaker than that between teenage conception and deprivation (Bradshaw et al., 2005). This means that variations in abortion rates are less likely to be explained by deprivation, than conception. Whilst variations in the conception rates cannot be explained solely by deprivation, this is even more the case with variations in the teenage abortion rate. Deprivation accounts for **more** than $\frac{3}{4}$ of the area variation in teenage conceptions, and about $\frac{3}{4}$ for abortions.

Higher rates of abortion are also associated with better abortion provision and accessibility. This has been confirmed by a recent study of national variations in teenage abortions, in which statistical modelling indicated that abortion proportions are related to socio-economic circumstances and availability of services. Relatively high proportions of abortion are to be found where family planning services are more developed, where there is a high proportion of female GPs and a greater independent sector abortion provision (Lee et al., 2005).²²

Inter-personal factors, such as familial relationships and local cultures also play an important role in abortion decision-making and therefore abortion rates in a certain locality (Henderson, 1999, Hoggart et al., 2006, Lee et al., 2004). Lee et al. (2004) found a strong association between abortion proportions for all women and those for the under-18s, even after controlling for service provision. This finding indicates that community and familial cultures may also play a role in shaping individuals' attitudes and beliefs, and therefore their decision-making processes. Further insights gained through qualitative research support the suggestion of differing attitudes and approaches to abortion across different localities.

As noted earlier a distinction is likely to be made between teenage parenthood in and out-of wedlock. In some communities, particularly those of a Muslim faith, teenage parenthood within marriage is not considered a problem (Higginbottom et al., 2006b). Moreover, young people from an Indian or Bangladeshi origin believe that an out-of-wedlock birth will be seen by their community as unacceptable. In certain instances young people expressed the fear that if their parents discovered a pregnancy, they would be forced to marry (French et al., 2005, iii). As a result of these perceptions, many young women from these communities state that if pregnant they would seek an abortion (French et al., 2005, p.48). This is true even for those who express negative views of abortion. In contrast, young women of Jamaican origin tend to have a more positive view of teenage pregnancy and feel that if they became parents, they would be supported by their family and friends (French et al., 2005). Nevertheless, it is hard to fully gauge the impact of ethnicity on abortion decision-making as a woman's ethnicity is not recorded in abortion statistics. The study of ethnicity and abortion has consequently been limited to individuals' accounts of their attitudes and behaviours (French et al., 2005).

Teenagers are also affected by political, social and local discourses around teenage pregnancy (Greene, 2006) although there is no evidence that peers had influenced

²² It should be noted that provision – especially independent sector provision – will often follow demand.

their behaviour (Arai, 2007). Studies have found negative attitudes to abortion and an acceptance of early motherhood in socially deprived areas (Turner, 2004, Tabberer et al., 2000). However, rather than deciding to become pregnant, young women often became pregnant accidentally, and then chose to continue and carry their pregnancy to term. As Turner phrased it: '*... it would seem that some form of acceptance [of maternity] does exist, but that this acceptance is not one that encourages young women to conceive but rather maintains them on the pathway to motherhood once they are pregnant*' (Turner, 2004, p.237). Like older women, a key factor effecting a woman's decision whether to terminate a pregnancy is the nature of her relationship with her partner. Young women who felt that they were in a secure relationship in which they will be supported tended to opt for motherhood (Hoggart et al., 2006, Lie et al., 2008, Pearson et al., 1995). This experience of an unintended pregnancy can contrast sharply with the experiences of young women who choose to undergo an abortion. Many may feel a 'loss of control' as a result of becoming pregnant but the process of arranging and undertaking the abortion can be experienced as a pathway for reinstating control over their lives (Harden and Ogden, 1999).

The stage of the pregnancy at which women seek an abortion affects the ease with which they are able to obtain one: women who seek an abortion in the second trimester of their pregnancy are more likely to encounter difficulties than those at an earlier stage of their pregnancy. Young women under the age of 18 are likely to delay their request for an abortion as a result of confusion, anxieties regarding the undertaking of an abortion and concerns about their parents reaction (Ingham et al., 2008). These findings appear to support the suggestion that there is a gap in advice services during the early period of the pregnancy. Counselling or advice during this time could help teenagers through the difficult decision-making process (Tabberer et al., 2000).

Thus, previous studies indicate that women vary considerably in the way in which they experience and respond to the possibility of an unintended pregnancy, which in turn corresponds to the way in which they experience a confirmed pregnancy. Some are extremely anxious not to become pregnant. They seek to use emergency contraception in response to a perceived risk in order to ensure that they do not experience an unintended pregnancy. It can be hypothesised that these women are likely to be those who associate an unintended pregnancy with a 'loss of control' over their lives, and who will seek to have an abortion upon the discovery of a pregnancy. Others, more frequently those from an economically disadvantaged background, adopt an approach of 'wait-and-see' to the possibility of an unintended pregnancy (Williamson et al., 2009). Some of these women, as Turner shows, do not plan to become pregnant but have an implicit acceptance of motherhood which underpins their decision to carry the pregnancy to term (Turner, 2004). This is also the case with young women (Hoggart et al., 2006, Tabberer et al., 2000). Others terminate their pregnancies.

Young women from BME communities who seek an abortion have specific needs and concerns. Healthcare professionals who work with BME groups report that they

often wish to travel outside their locality for their abortion. Extremely anxious to keep their pregnancy a secret, they prefer travelling to a clinic or a hospital in another area (French et al., 2005).

Some BME young women prefer to be seen by health professionals who are not a member of their own ethnic minority. They fear that a member of their own community may be judgemental or even breach their confidentiality. This is seen to be particularly significant for young women of South Asian origin whose GP is a member of their ethnic community. French et al found some support for young women's fears in their discussion with parents and health professionals, pointing to a need to explore this issue further (French et al., 2005, p.86). This research also found that for some women, the wish to hide their pregnancy from their family is compounded by a lack of knowledge of how to access abortion services, leading to a great sense of anxiety. Although these young women may need considerable support, the wish to protect their confidentiality makes it difficult to contact them at home or arrange follow-up appointments after the abortion (French et al., 2005). The difficulty in arranging post-abortion follow-up is of particular importance for the prevention of repeat abortions.

Finally, it should be recognised that there are BME communities that have received relatively little attention from researchers and policy makers. Although there are some notable exceptions (for instance Higginbottom et al., 2006a, Saxena et al., 2006), by and large, the Somali and Turkish minorities, for example, have not been closely studied. These ethnic backgrounds are likely to be prevalent in certain London boroughs, and local practitioners should be able to recognise the specific needs and concerns that young women from these ethnic groups have with respect to contraceptive and sexual health services, including abortion services.

Repeat Abortion

A recent study (Collier, 2009) found that there had been a rise in the number of under-20 repeat abortion between 1991 and 2007. The proportion of abortions that are subsequent to a previous abortion had risen by 68%, from 0.081% to 0.134%. It is important to note that these figures refer to a very small number of abortions, which tend to result in high figures for percentile increases.

However, beyond the statistics, relatively little is known about women, particularly young women, who have more than one abortion. As with the first unintended pregnancy, a repeat conception can be the result of failing to use contraception effectively or not using contraception. Repeat conceptions that end in abortion are also most likely to be pregnancies that were unintended and unwanted. Health professionals have expressed a range of views regarding which repeat abortions they considered problematic: some highlight consecutive abortions taking place within a short period of time, others have drawn attention to very young women or those who appear to experience emotional difficulties (Hallgarten and Misaljevich, 2007).

There is only a limited amount of available literature on the factors affecting the incidence of repeat abortion and an even more limited amount of research examining the incidence of repeat abortion among young women. It is clear that establishing an effective contraceptive regime following the first abortion is necessary in order to prevent further unwanted pregnancies. Targeted contraceptive counselling at the pre-abortion assessment visit has been shown to improve the contraceptive uptake immediately after abortion. Women who participated in Yassin and Cordwell's study received full and detailed advice regarding various contraceptive methods at the pre-abortion meeting and in many cases started their new contraceptive regime on the day of their abortion (Yassin and Cordwell, 2005). Another study found that women who experienced repeat abortions were found to be motivated users of contraception immediately following their abortion. Initially, when they were given advice regarding various contraceptive devices they made optimum choices. However, they did not comply with the contraceptive regime over a period of time. Thus, the study concluded that there was a need for a structured programme of follow-up in order to monitor the effectiveness of the contraceptive regime initiated after the first abortion (Garg et al., 2001). This appears to be supported by a recent study which notes a rapid decline in contraceptive compliance, particularly with LARC, amongst women presenting for repeat abortions (Das et al., 2009). It has been argued that responsibility for the peri-abortion contraceptive consultation should be clearly defined among the professionals and organisation involved and that it should not be left for patients to arrange follow-up appointments (Kumar et al., 2004). The historical division between contraceptive and sexual health services and abortion provision, is unhelpful from the point of view of enabling contraceptive provision to be combined with abortion provision (Cohen, 2007).

The suggestion that some women develop a 'spiral relationship' around contraception and sexual health services might be particularly important when trying to understand repeat abortions (Meyrick, 2001). A group of women, who might have a 'chaotic' lifestyle, are likely to struggle to establish a successful contraceptive regime. They may seek help from health services, but feel that they are viewed negatively by health professionals. This is likely to lead to an unwanted pregnancy that ends in abortion. Rather than constitute a turning point, which leads to the establishment of an effective contraceptive regime, the abortion could escalate young women's communication difficulties with health professionals. As a result their contraceptive difficulties are not resolved and they eventually become pregnant again.

Some initiatives are currently being developed in order to tackle repeat pregnancy among teenage girls in the UK; as is work to help teenage mothers avoid unintended second pregnancies (Perrow, 2004). These initiatives have yet to be evaluated.

Conclusion

Despite some progress towards the government's target of halving under-18 conceptions by 2010, the target looks increasingly ambitious. In London what is seen

as a relatively high proportion of teenage conceptions have ended in abortion. This indicates that pregnant teenagers in London are able to access abortion without too much difficulty, and this should not be viewed negatively. It would, however, have been better for the teenage pregnancy strategy, and arguably for the teenagers themselves, had these pregnancies been avoided. Our review of the research has indicated that there is still much to be done in terms of targeting contraceptive and sexual health services towards 'hot spot' areas; to engage young people who may be fatalistic about whether they become pregnant or not; to reach out to more vulnerable groups of young people; and, finally, to tackle misunderstandings and misconceptions around women's fertility. In terms of abortion decision-making, it is reasonably well-established that young women from non socially deprived backgrounds, with their own aspirations, are more likely to terminate pregnancies than proceed. Qualitative studies have also shown the importance of inter-personal factors as well as community and familial cultures of abortion. Relatively little is known about the relationships between sexual behaviour, abortion decision-making, and post-abortion sexual behaviour, especially from the perspectives of young women themselves. In the following two chapters we discuss the extent to which our research results confirm or challenge previous research, and present findings that add new insights to existing knowledge.

Chapter 3 Research Findings: teenage sexual behaviour and becoming pregnant.

Introduction

This chapter focuses on the question: why are teenagers who do not want to become pregnant becoming pregnant? It explores the sexual attitudes and behaviour of teenagers from a number of different perspectives. The findings are based on three iterative stages of analysis. Firstly, we analysed factors influencing teenage sexual behaviour from the perspectives of both young teenagers (drawing on data from the focus groups in schools), and also providers of young people's contraceptive and sexual health services. Secondly, we looked at factors behind the unintended pregnancies of the teenagers interviewed using in-depth interviews. Thirdly, we compared these data sets, looked for patterns and inconsistencies. Alongside this, we explored the extent to which services and programmes currently meet the sexual health needs of young women in London.

It has been recognised that some teenage pregnancies are intended (Cater and Coleman, 2006, Hek and Hoggart, 2004). This chapter has a focus on what might influence teenagers to engage in sexual activity that may result in unintended and unwanted pregnancies. The first section looks at the views of the study participants on why and when teenagers develop sexual relationships. Our analysis supports existing evidence in the literature which, whilst stressing the significance of socio-economic deprivation, also draw attention to a range of socio-cultural factors that may influence the sexual behaviour of young people (Smith and Elander, 2006, Social Exclusion Unit, 1999, Sloggett and Joshi, 1998a). Young women's views and decisions about sex were seen to be, in the main, influenced by a variety of different factors. These are likely to include: peer pressure, pressure from their partners, the influence of the media, sexual stereotyping, their hopes and aspirations for the future, as well as their own sexual desires. We then consider why some of this sexual behaviour may result in pregnancies that end in abortion. According to our analysis the main factors are clustered around difficulties (or indifference towards) negotiating 'safe' sexual encounters; poor knowledge about the full range of contraceptive methods available coupled with inconsistent contraceptive use; and misperceptions about fertility. Finally, we consider the extent to which local contraceptive and sexual health services were dealing with these types of issues. We argue that there is evidence of uneven provision and limited reach in meeting the sexual health needs of young people in the study.

Teenage Sexual Activity

Key informants pointed to a number of factors that they felt contributed towards young people feeling under pressure to engage in sexual activity that, in their view, they might not be adequately prepared for. As sexual health professionals, they would like to see controlled 'safe' sexual behaviour amongst teenagers, and this may

require an element of planning. There is a tension between this aim, and much teenage sexual behaviour.²³

Young women's known difficulties in engaging in controlled sexual encounters was of concern to key informants interviewed, and confirms understandings of adolescent sexual behaviour as generally being spontaneous rather than controlled. As one key informant explains *'they are being swept along on a kind of wave, of this is what we do and it's beyond our control'*. An element of spontaneity is evident in many of the accounts of sexual activity, for example, Aisha's description of her first sexual encounter. Although it seems that she was not expecting to have sex with her boyfriend that day, and she also appears unprepared, there is actually no indication that she would have preferred to abstain:

I was fifteen years old...I didn't realise that does he really want me to have sex or not and that's how we got into it so much. He took me to his brother's house and we went upstairs, well he asked me to take off my clothes, so I did and then you know, I didn't say no...I didn't mind.

Both key informants and young people thought that the media influenced teenage sexual behaviour through establishing normative views on sexual behaviour. The portrayal of teenage sex as spontaneous, romantic and fun in the media was seen to be important. Young people felt bombarded by messages about sex, as television programmes like *Hollyoaks* and *Gossip Girl* normalise teenage sexual activity. The general consensus felt by many was *'that is to say, if you are not doing it something is wrong with you'*. In a focus group discussion, for example, teenagers referred to the influence of the media as playing a crucial role in influencing their decision to have sex:

on television as well and stuff like that they explain it being so good like, so obviously you're going to be thinking yeah, I want to try it...

Becoming involved in sexual activity was also influenced by peer pressure, although not in a straightforward way. The claim that by a certain age (most often seen as around 16 or over) *'all their friends are doing it'* was seen as a central point in deciding whether to have sex, particularly when the young person was perceived to be in an established relationship. Older girls in the focus groups talked about feeling pressured not only to maintain their relationship with boys but their reputation as well, by having sex. Lucy explained that although she did not simply want to follow what she thought everyone else was doing, her own desires were, in a sense, legitimised by her perception that *'everyone else is doing it'*:

No, not that everyone else was doing it, 'cause I felt like why am I following everyone else, but at the same time I wanted to do it, and at the same time it was like yeah, everyone else is doing it why not me?

²³ This tension is not confined to teenagers.

The influence of the 'slag versus frigid' dichotomy of female sexual behaviour was also noticed. Indeed, not wanting to be labelled in either of these ways made decisions about whether and when to have sex inherently difficult. Many of the girls in the focus groups talked about being in a 'no win' situation:

Yeah, if they don't call you frigid then they call you a 'sket' or a 'ho', then you have done something.

Reluctance to being labelled 'frigid' often contributed towards young women feeling they ought to engage in sex. This was more likely to be the case when young people felt that they were in a long term relationship. A recent study has highlighted the prevalence of violence and coercion in teenagers' intimate relationships (Barter et al., 2009). In this research, girls in the focus groups talked about girls being pressurised into having sex by their boyfriends, drawing on sexual stereotyping and coercion:

Yeah you get pressured and then if you're saying no they're like what's wrong with you like, and you get called frigid and things like that and then it's you are embarrassed.

Perceptions of uneven power interactions in teenage relationships contributed towards girls finding it difficult to be autonomous in their sexual relationships.

All these circumstances can be examined within a framework of general teenage risk-taking and spontaneous behaviour (Shoveller and Johnson, 2006), in which sexual encounters fuelled by alcohol, often happened after or during parties; and in which young people were likely to experience greater difficulties controlling sexual encounters:

people do that stuff you know, some people go out, like I've been at a party before, yeah and like a girl and boy would go out anddo whatever and then come back to the party.

I was 16 and it was just with a friend and we were both really drunk.

One key informant also made the case that our understanding of teenage sexual behaviour and decision-making processes involved must be framed within the particular context of the challenges of living in highly cosmopolitan London. This challenge provides a further contextual base for our discussion and understanding of teenage sexual behaviour.

Young people have their lives incredibly difficult in London, it's a hard place to be brought up with incredible pressures.

There are, therefore, a whole range of influences that combine to make sexual decision-making a complex process for young people. Not surprisingly, therefore, the teenagers in the focus group expressed a wide range of opinions on whether, and when, young people might be 'ready for sex'. In addition, we found that a small number of young women in the focus group discussions, particularly from religious

and black and minority ethnic backgrounds, expressed strong views about abstinence and not engaging in 'at risk' sexual behaviour. These young women perceived sexuality as something that could be 'controlled' until marriage. For them, engaging in 'at risk' sexual behaviour, and drinking alcohol, were perceived as bringing 'shame' and lowering the family's status in the neighbourhood. These views corroborate previous research (French et al., 2005), that points to the role that ethnicity and culture can play in the decision-making processes around sex and the complexity of the issues involved, particularly with respect to the influence of family and religion on teenage girls' experience of adolescent relationships and engaging in at risk behaviour.

I know the dangers of sex, I know what the Bible says about sex outside marriage and everything and I've had, because I have the fear of God inside me so I wouldn't think to have sex outside of marriage, that's it so I don't need to ask anyone about advice.

Exactly yeah there's like, you know if you have one of those highest state of people and then your daughter does something, your state is going to go low so it's just going to be 'no I can't afford to take the blame for my parent's state going down', if you understand.

It is likely that such expressed beliefs in favour of abstinence leave these young women poorly prepared for situations in which they may find themselves under pressure to engage in sexual activity, or in which they decide the 'time is right' for them.

There is thus a tension between controlled behaviour desired in order to practice 'safe sex', and the way in which many young people experience sexual encounters. The teenagers often present a complex picture in which there is some kind of understanding of what might be the most sensible way to behave, but which is likely to be overtaken by circumstances that are difficult to control, including their own feelings. This can also be located within the context of the unorganised, or even 'chaotic', lives that some young people sometimes lead (Hallgarten and Misaljevich, 2007, Hoggart, 2007). This is an important part of the context that helps explain 'risky' sexual behaviour. Sometimes such behaviour will lead to unintended pregnancies. The following section considers the more immediate factors behind unintended pregnancies that end in abortion.

'Risky' Sexual behaviour and Unintended Pregnancy

Teenage pregnancy is a complex issue, and with respect to underlining factors influencing unintended pregnancies, we argue that these are multi-factorial and interconnected. The different data sources indicate that unintended pregnancies in teenagers can be understood as the result of three - often interconnected - factors. Firstly, lack of confidence and power imbalances affect young women's ability to negotiate safer sex in relationships, and this can lead to an unintended pregnancy. Secondly, erratic use of the condom and the pill meant that these methods of

contraception often do not protect young women. Thirdly, the research demonstrated that misperceptions about infertility can be a major factor in unintended pregnancies.

Negotiating safer sex

The factors that have been considered as important when considering what might influence young people to engage in sexual activity, are thus also an important part of the explanation for why they might experience difficulties with contraception. Young people in the focus groups expressed worries about STIs and becoming pregnant, and – in the main - they had knowledge about safer sex and safer sex practices, particularly about the importance of protecting themselves through using a condom. There was, however, very limited knowledge of forms of contraception other than the condom and the pill. In addition, many expressed anxieties about the technique of using a condom, and differing views were expressed around their ability to negotiate 'safe' sexual encounters. Some participants felt the boys could be presented with a statement such as *'if you don't want to use one then you're not doing it'* but others talked about the pressures they might be put under and thought that being able to do what they wanted to do was easier said than done, saying, for example, *'you get scared, you get scared of the boys, the boy you're with'*. What this indicates is that although these teenagers recognised the importance of negotiating safer sex practices with their partners, whether they would always be able to succeed could well be a different matter.

Relationship patterns of young teenagers were explored with key informants, in the focus groups, and in the teenage depth interviews. A recurrent theme expressed in all the data was that of power imbalances among female and male teenagers in relationships. This inequality appeared to be combined with a lack of self confidence. The inequality and lack of confidence were important factors contributing towards a limited ability to negotiate safer sex with their partners. This was made even more difficult when drugs or alcohol were involved. The teenagers described a number of sexual encounters in which they appeared to be out of control, either because of power imbalances, or because of the effect of alcohol. Sometimes it was a combination of the two.

The gap between intentions and sexual practice was an important theme in the interviews with the older teenagers. They pointed out that 'being safe' was difficult to put into effect even when they were fully aware of the possible negative consequences to themselves of not using contraception. Anna, for example, who had not wanted to become pregnant, talks about feeling unable to interrupt sexual activity in order to ensure that condoms are used:

I do think about it but it's difficult just to interrupt it or think, oh we've got to get that or stop it so you can get a condom and also if I don't say something the guy doesn't usually say something and it's just weird.

Such patterns of behaviour were evident in a number of the descriptions of sexual encounters. These descriptions sometimes reflected a lack of control over the encounters, or at other times an ambiguity of intentions and corresponding lack of thought about the possible consequences of actions. All these are illustrated in Cara's description of her first time:

that was a night of drunkenness. He was like my primary school crush so I kind of allowed him to get away with it, I let a lot of guys get to me emotionally, I didn't think about the consequences of my actions and allowed my emotions to be messed about with.

She thus begins by connecting what she has experienced as a loss of control to being drunk. However, this is ambiguous as she also states that she 'allowed him to get away with it' indicating that – to a greater or lesser extent – it was something that she had also desired, maybe because he was her 'primary school crush'. With the benefit of hindsight she sees this as the beginning of a pattern of sexual behaviour in which her feelings and desires lead her into sexual encounters and relationships in which she lets 'guys get to me emotionally'. Later in the interview she talked about her feelings of exploitation in a relationship with an older man:

He kinda, he did a lot of things that he shouldn't have done ... like he made me feel small so I did anything for him, I was young so I didn't really know about relationships and stuff.²⁴

Such difficulties were evident in a number of the accounts, and were particularly significant for girls from BME backgrounds who, because of their strict religious and moral backgrounds, said that anything to do with sex (including accessing services and information) would bring shame on their family. These young women demonstrated very little aptitude and the skills to negotiate safer sex with their partners.

Difficulty around negotiating safer sex, was also, in some cases, accompanied by a lack of concern, or fatalism, about the possible consequences of their actions. This helps explain inconsistent or erratic use of contraception. One other factor that needs to be taken into account, however, is misperceptions around fertility.

Contraceptive usage and perceptions of fertility

In the main, the teenage girls – especially in the focus groups – thought it was very easy to become pregnant. Running alongside this view was the assumption that if you had unprotected sex and did not become pregnant then you were probably infertile. Given the strong emphasis on condom use in most SRE (where condom use

²⁴ Cara did not want to expand on the things 'that he shouldn't have done', but from the context of the discussion it seems likely that she was coerced into sexual activity and might have been a victim of partner violence. See Barter et al., (2009) for a discussion on partner violence amongst young people.

is promoted as the contraception that protects against both STIs and pregnancy) and young people's known difficulties with this method of contraception, there are going to be instances of unprotected sexual intercourse. If there are a number of teenage girls who believe they are infertile because they don't become pregnant on these occasions, they are highly likely to continue the activity. This is more likely to be the case if they have a regular partner. Such a pattern of behaviour noted in previous research (Williamson et al., 2009) was certainly evident amongst the teenagers interviewed who had terminated pregnancies.

With the teenagers that had terminated pregnancies, misunderstandings about fertility followed a typical pattern. Contraception was often used during initial sexual encounters when the teenagers were worried about becoming pregnant and – crucially – thought that becoming pregnant was 'very easy'. Cara's description of her first sexual encounter demonstrates her great fear of pregnancy:

I was scared! When I broke my virginity, as soon as it was over I was like 'oh my God I'm pregnant', he was like [laughs] 'no, used a condom', and I was secretly buying pregnant tests, all of them came out negative, I was like 'whoa!'

In this example, her partner had taken contraceptive responsibility, though she had been unaware of this.

However, what happened in a number of these relationships was that as sexual relations continued and situations occurred in which no contraceptive was used, or it was used improperly, and such situations did not result in a pregnancy a (mis)perception emerged of being at low risk of pregnancy, or even of being infertile. This emerging belief led these young women either to stop using contraception, or use it in a haphazard manner, because they believed they would not become pregnant. Their own experiences led them to internalise the common 'it won't happen to me' attitude. Although in some cases they may have been testing their fertility, the dominant message in the narratives was that they did not need to be careful because they thought they could not get pregnant. Their resulting pregnancy came very much as a surprise.

I just thought that I couldn't get pregnant because I think there was one time when I was 15 and I didn't get pregnant with [boyfriend], that's probably what I thought 'I can't have babies' sort of thing.

(Katie)

No not really 'cause the few times I had had sex with him, I never got pregnant so I thought, like I said before, 'there must be something wrong with me why I can't conceive or carry a child', so that's why, that's another reason why I didn't think about contraception.

(Cara)

[Interviewer]: What did you think about the times that you did have sex and you didn't get pregnant?

I thought 'is there something wrong with me?' [laughs] At first I was happy and that but then I was thinking that way, was there something wrong with me, even though we did it why is nothing happening, and things like that.

(Yasmeen)

Taking the focus group data and the narratives of the young women who had terminated pregnancies together, therefore, it appears that young women who do not want to be pregnant continue to take chances. Although explanations for this behaviour are often complex and multi-faceted, we have highlighted difficulties around negotiating safe sex and misperceptions about fertility as being particularly important. Both of these factors increase the likelihood of inconsistent use of contraceptives, and that has also been evidenced in this research. There are two areas of policy with a remit that includes improving young people's practice of safer sex, and reducing teenage pregnancy. These are Sex and Relationships Education (SRE), and contraceptive and sexual health services.

Sex and Relationships Education

The study findings demonstrate that the provision and quality of contraceptive and sexual health services including SRE provision, for young people were uneven and patchy, across the various research sites. Focus groups explored the views mainly of Year 10 girls (and some year 11 groups), with respect to SRE. The majority of the girls expressed negative views about the timing, delivery and content of SRE in their particular school. Young teenagers felt that SRE should have been delivered earlier (than years 9 and 10) since by then (certainly by year 10) many were already thinking about engaging in sexual activity and had questions about sex and relationships that they would have liked to discuss before they had SRE in their schools.

Most people here like knew stuff from like Year Nine and Ten so like if you teach them from earlier then it might help to prevent Chlamydia or they know what they're doing before it's done because we're in Year Eleven yeah and then you come to teach the Year Eleven and they've already done sex and they've already gone through stuff so like it will be too late, not too late to teach but they would just think to themselves like if you taught me this when I was in Year Nine then maybe I would have thought twice about having sex.

The prevailing sentiment expressed by the girls in focus groups was that the SRE curriculum was also incomplete because lessons were generally limited to the medical aspects of reproductive health. Girls felt that there was too much emphasis on a limited range of contraception, particularly the condom, and STI prevention was the primary focus. They would also have liked more time to discuss the emotional and socio-cultural aspects of sexual relationships. Respondents wanted the content of SRE to explore issues around pregnancy and abortion; views of readiness to

engage in sex; self esteem and confidence in sexual relationship; and access and availability of contraceptive and sexual health services.

Like actual relationships, they talk about oh use a condom, don't have sex too early blah, blah, blah but like actual relationships and how to like keep one good if you like, like have sensible, safe sex within a proper relationship, they don't teach you anything about that, they just, the whole lesson go on about use a condom and this is what a condom looks like and if don't you'll get gonorrhoea, that's all they go on about the whole time.

In the case of the delivery of SRE, teenagers also often felt reluctant to engage in discussions for a number of reasons. These included: the teacher's delivery of the lesson, which young people felt was often awkward and uncomfortable; the teacher's gender when a male teacher delivered SRE to girls; and when SRE was delivered in a mixed sex grouping which, in their view, served to ignore the different needs of boys and girls. Concerns relating to confidentiality were also raised.

Based on the views and experiences of SRE, it is not surprising therefore that the older teenagers who had already left school had poor recollection about the content of their SRE lesson or thought that it was very limited. This view from Ella is typical of the responses that we received on SRE in schools:

I don't really remember being taught about it, there was just posters up about 'want respect, use a condom', but they never really gave classes about it, they never sort of said if we need anyone to speak to they're there.

Teenagers and providers also highlighted pockets of good practice with respect to SRE and its delivery. Both providers and young teenagers all talked positively about the content and delivery of SRE in circumstances when it was outsourced to a specialist sexual health provider.

The issue of abortion was generally not discussed in SRE in the schools, although the girls in the focus groups thought such a discussion would have been useful. As a result, there was a lot of confusion and uncertainty about what abortion entailed, and how the service might be accessed. A number of 'myths' about abortion, such as that having an abortion makes you infertile, were also evident.

If abortion had been discussed it was likely to have been within religious education (RE), where there was no opportunity for the girls to discuss what it might mean for them as an individual. One of the girls argued that the main problem with learning about abortion in RE was that they were not given the opportunity to discuss their feelings and attitudes. In their essays they have to try and have a balanced view:

so you have to compare this to that, so you know it's not really us saying how we feel about it and when you're doing an essay you can't actually express your feelings in an essay because there's specific things that you need to have

in your essay and if we do more of what you think it doesn't really get you the mark.

As discussed in the following chapter, the way in which abortion was discussed at school – as a moral rather than a sexual health issue - was likely to lead to misunderstandings and moralistic views on abortion. These were evident in the focus groups.

Contraceptive and sexual health services

Despite the government's intention to improve sexual health provision for young people and make services more young people friendly and accessible, the findings from the research demonstrates that there is still uneven and patchy provision of contraceptive and sexual health services for young people including LARC and emergency contraception. In some of the areas studied, examples of good practice were evident, whilst in others the provision was patchy or minimal. This finding chimes with the recent London sexual health needs assessment and service mapping (MedFASH, 2008), and the latest report from the Independent Advisory Group on Sexual Health and HIV (IAG, 2009).

It was evident that contraceptive and sexual health services were not fully meeting the needs of young people, and many were not accessing the services that were available. Young people that we interviewed were often unaware of how to access services; and they also revealed a lack of knowledge with respect to the full range of contraceptives. This quote by one of the key informants provides an analysis of young people's sexual health services, including SRE provision, in her area:

I know there's been lots of work but I don't know if the average 13 year old in the local school knows where to go for contraception, yes she might have had you know sex education in school and know about the methods and stuff but does she actually know how to get it, where to go, who she can talk to, I mean I think, as I say there are pockets of really excellent practice. I mean there are school nurses doing wonderful things you know and I think that's what it needs to be, you need, there needs to be somewhere at school where they can go and get contraception, why not.

As noted by this key informant, school nurses often play a vital role in providing sexual health information. This was confirmed in the focus groups where the girls had easy access to this service. Other sources found to be especially valuable were primarily those that were targeted at young people, such as a travelling bus.

In some circumstances, however, in which the school offered the services of a school nurse, teenagers highlighted problems of access and a lack of awareness of the service. In some cases, girls were unaware of school nurse service provision. One of the major problems with the school nurse programme was the fact that students were unaware of the times that they were available and generally felt that the nurse was difficult to access:

Apparently there's a nurse in our school and the nurse, we don't really see her, she's invisible.

Exactly, well apparently there's some school nurse that we're allowed to go and talk to if we think there's any problems with our health, sexually or something like that and I had no idea about it.

There was also a great deal of confusion about where to go locally for contraceptive help and advice.

What is the Clinic?

In some areas providers talked about specially targeted young people's services, including contraception, emergency contraception and sexual health advice, and making sure that such services were available through the 'You're Welcome' criteria. Elsewhere, however, providers talked about such services disappearing as part of cost-cutting measures, and very little provision being on offer for young people. It is not surprising therefore that data from interviews and focus group discussions with young people revealed a pattern of uneven access, and difficulties accessing the services. Many young teenagers interviewed were unaware or unsure of the location of their local clinic and services offered:

I want to ask you about the sexual health services you know about. Do you know about any? Where to go to get any information?

R1: Not really.

R3: All I know is that you can go drop in centre or talk to someone in the NHS clinic or something?

R1: What is the clinic?

In other instances, young people were reluctant to use the clinic services because of feelings of being scrutinised and not feeling very welcome:

Yeah, it's embarrassing, because when you go there, there's a lot of people sitting in the reception, and if you talk, there's people sitting like right behind you that can hear you, so I think that's not a good thing. It's really embarrassing, it should be confidential. They should like keep the people a bit far away from, because they're really close, they're really close, 'cause like you're talking there to the receptionist, there'll just be people right behind you. Even if you're speaking low, they'll still be able to hear you, and obviously because he's written STI for woman and stuff like that, if you go there, everyone just knows why you're there. It was embarrassing.

(Yasmeen)

Young people from some BME communities, in particular, expressed reluctance to access contraceptive and sexual health services. Rather, they sometimes tended to associate sexual health clinics with a base sexuality. Further, accessing these services was also an acknowledgement of one's intention to engage in sex and was therefore bound up with bringing 'shame' to the family. Such reluctance often led to low take-up of services that contributed to an unintended pregnancy, as in the case of Lucy.

I felt very ashamed when I thought I had to go to the clinic, I thought 'only dirty girls go there', and I'm like 'I'm not a dirty girl so I don't think I should go to the clinic', that was my thinking at the time.

Conclusion

This chapter has discussed what might influence the sexual behaviour of teenagers, and explored reasons behind unintended and unwanted teenage pregnancies. The research adds to a growing body of qualitative work that understands the sexual behaviour of teenagers within the context of what many see as a normalisation – and maybe desirability - of teenage sexual activity by the media, and by young people themselves. We have also argued that it is also important to acknowledge the tension between safer sex needing an element of control and the desire for sexual spontaneity. This has the potential to make effective contraception problematic for many women, regardless of age. Negotiating sexual relationships, however, is likely to be more difficult for younger women, who may lack confidence as well as experience. With respect to unintended pregnancies, young women's misperceptions about their fertility emerged as an important consideration that has not attracted sufficient attention, and that cannot be ignored.

The research also highlights the unevenness with which local contraceptive and sexual health services are meeting the needs of young women in particular. The findings of the research showed that young people were often unaware of how to access services; and they revealed a lack of knowledge with respect to contraception and contraceptive use. There is also clearly a tension between the emphasis in SRE on the use of condoms and the difficulties young people have with this method. The messages for young people need to be more complex, and – crucially – separate messages are needed about pregnancy prevention and STI prevention. We also found that young women are poorly prepared for the possibility that they may become pregnant as a result of sexual activity, and that they will then have to decide whether or not to terminate their pregnancies. This issue is discussed in the following chapter.

Chapter 4 Research Findings: Abortion Decision-making and Repeat Abortion

This chapter analyses the research findings on abortion decision-making processes, and assesses the implications of these for policy and sexual health service developments. It focuses on the relationship between individual decision-making, and the broader social, cultural and political contexts within which decisions take place. The first part of the chapter looks at an important context for abortion decision-making, that is, what the research has learnt about different attitudes and beliefs towards abortion. We then consider what might influence individual decision-making and how these attitudes and beliefs are played out in this process. Third, moving on from the decision, we consider teenagers' experiences of abortion pathways – what is available for them, what happens to them, and what they feel about their experiences. Finally, we look at post-abortion experiences and consider what might influence post-abortion sexual behaviour and the possibility of subsequent unintended pregnancies.

Views and Understandings: abortion and abortion decision-making.

This section discusses the range of attitudes towards abortion expressed by respondents in this study. It is important to note here that the different interview groups were approaching the issue from different perspectives. The key informants were asked about their knowledge and opinions on what might be influencing teenage girls they were working with; focus group participants were asked about their general views on abortion and also what teenage girls might take into account when making a decision; and those teenagers that had terminated pregnancies were specifically asked about what had influenced their decision, and probed on their own attitudes towards abortion. We draw on the views of key informants with a wealth of experience of working with young people in a sexual health context, and compare these with views expressed by young people themselves, in the focus groups or one to one interviews.

It was evident that young people's personal attitudes towards abortion varied widely. The differences ranged from viewing abortion as absolutely wrong to an acceptance of abortion as a solution to the problem of an unwanted pregnancy. Differences of opinion were, as might be expected, most obvious in the focus group discussions. Taking all the data into account, although there was a diversity of views around what influences teenagers' abortion decision-making, a number of patterns and themes emerged. These are grouped under the following two broad areas:

- abortion 'myths', misinformation and lack of knowledge
- the morality of abortion

Abortion 'myths', misinformation and lack of knowledge

This research suggests that young women's views about abortion are critically shaped by their knowledge and understandings of what having an abortion entailed,

and what might be the possible consequences of having an abortion. In many cases this amounted to poor knowledge and misunderstandings. These included misperceptions about: the consequences of abortion on fertility; having to pay for an abortion; the gestational limit associated with having an abortion; and the abortion process itself. This misinformation helped to create the negative views that many of the young people held about abortion.

The most frequently mentioned myth was that abortion is likely to make you infertile. This was also raised by a number of abortion referrers who described it as one of teenagers' greatest concerns.

You know there are two questions that everybody asks at some point and if they don't I answer them anyway; and one of them is 'am I going to die'²⁵ and the other one is 'am I throwing away my chances of children', and I think that one of my key issues about repeat abortions is that if doctors and nurses and other people spent less time telling women they were risking their fertility by having an abortion there would be less second abortions, because it is still used as a way of kind of scaring them and making them feel awful in some strange way and the thing is that the vast majority of young women in this position that I've ever met feel so awful about their situation anyway that they can take a bit of information like that, feed it into their loss of self-esteem and you know general feelings of failure about being in that position and of course the ideal punishment to mete out to yourself is that you've thrown away your children, and I do think that is really quite important because you know I see people back pregnant just a few months after an abortion and they are really surprised that they are pregnant because the bit that's gone in has been the bit about you're going to be infertile.

This assessment by a very experienced family planning Doctor is reproduced at length because it sums up one recurring message from all the different data sources, and provides an important insight into what might help reduce rates of repeat abortion.

The 'myth' of infertility following an abortion was also evident in the focus groups. 'Well when you have an abortion you can't have any children', was not an uncommon refrain. Some girls said that they learnt that 'you can't have children after having an abortion' in the course that they did at school. And one of the teenagers we interviewed, Katie, told us that she had been told at the clinic that there would be a risk that she could not have babies after having an abortion. She thought that this was because she was anaemic.

A number of other myths, and evident lack of knowledge, were revealed in the focus groups: that you had to pay to have an abortion; that if you are under 16 then your parents have to be informed; that you have to have someone over 18 with you; and there was also confusion around the time limit.

²⁵ This was the only informant to mention this particular worry.

Q: You know there's a time limit on having an abortion, do you know if there's a time limit?

R1: I thought it was a couple of weeks.

R1: I thought it was 34 weeks.

R3: Yeah, that's what I was thinking.

R4: Is that four months?

R5: I forgot, it was in Eastenders.

This exchange in one focus group illustrates both limited knowledge, and the sources of information that the girls are calling upon.²⁶ The limited knowledge is not entirely surprising given that very few people can remember everything they might have been told about any particular subject, especially if they are unsure of the relevance of the information for their own lives. However, the uncertainty and poor knowledge about abortion contrasted starkly with the girls' knowledge about STIs and condom use. This is likely to be because, as discussed in chapter three, abortion is not generally discussed in SRE.

The girls also talked about what they knew about abortion procedures:

there's one where they put the hook in yeah, and they use the hook to shred the baby and it is nasty

sometimes if they give birth to the child they cry

they leave it to die

All the girls quoted above had been taught about abortion in RE, and they had been asked to do the research for an essay by themselves. They used the internet to gather information for the essay, and thus been exposed to a wide range of sources that they were likely to have had difficulty evaluating. The misinformation they had been exposed to would undoubtedly contribute towards them developing their own views on abortion within a framework centred on moral concerns.

By way of contrast, one group of year 11 girls had a targeted intervention whereby an outside sexual health educator had run a series of workshops with them. We held a focus group with these girls and this was the only group of girls that appeared to have discussed abortion 'myths':

²⁶ One of the abortion storylines in EastEnders saw Sharon becoming infertile following an abortion.

She taught us that because there's people always think that abortion can lessen your chance of having a baby, she told us that that's not true, plus like other facts about abortion like the time period you can have up till you have an abortion.

The morality of abortion

One of the central findings in this research is that the young women in this study, in the main, were concerned about the morality of abortion. Indeed, there was a tendency for them to view abortion as immoral in many ways.

Key informants also noted that young women often internalised a moral framework that made it extremely difficult for them to consider the option of abortion if they became pregnant unintentionally:

An interesting thing that I see that influences choices is that so many young girls, young women will think abortion is murder and they couldn't possibly do that so that will influence their choice.

The one that keeps coming up for me quite regularly is 'I don't want to kill my baby'. I then have to say, I can quite understand that, because I find that one hard to challenge. Because if they feel they're going to kill or murder their baby, who am I to say that they're not. But quite interestingly, one of my young ladies who had said that to me at one point, came in to see me another day with a friend of hers that was pregnant, and said the same thing, and I said to her, why do you view it like that if I can ask you that, and she said that in religious education, they learn that to have an abortion is murder, maybe it's not in those words, but maybe that's how they've kind of processed that.²⁷

Their own personal belief system and again in some ways this draws in on what they've been exposed to at school because some of them come with very, you know, it's wrong, it's killing a life. It's that sort of very strong view which then can be very difficult if they've got those views beforehand and then they find out that they're pregnant and they don't want to go on with the pregnancy, you know that is a very definite tension between a belief that they've held on to, perhaps never really questioned, but then they're pregnant and it's going to disrupt plans.

The consensus amongst key informants was that much of this influence was coming from SRE:

One problem we do find, is that some of the girls have had some quite heavy handed sex education - I don't know what you want to call it in schools -

²⁷ The same respondent also noted that this may be used as a moral justification for continuing a pregnancy that the young woman may have wanted anyway: *'it might suit their situation to say that as well, you know, they truly want to have the baby and to get around not having a termination they could say that'.*

about abortion and that does seem to have quite an impact on, you know they'll come in and they'll say 'oh we had', 'oh no I can't possibly', and they've obviously been exposed to something fairly dramatic in schools which has had quite an impact in terms of putting them off abortion.

Such views were certainly evident in the focus groups in the schools, and appeared to be connected to the way that abortion had been dealt with in SRE, especially the concern with the morality, or immorality, of abortion.

the same way murderers get sent to prison, people that abort their babies should get sent to prison as well because they're murderers as well, simple as ABC

if you have an abortion you've got blood on your hands

The prevalence of such beliefs, confirming the assessment of key informants, is likely to make abortion decision-making stressful if any of these teenagers were to become pregnant. In some cases, such stark views were challenged in the groups. There was also a clear tendency for the groups to try and develop a more nuanced moral framework. A number of different themes were evident when this was attempted. These themes included:

- taking responsibility for your own actions;
- innocence and blame;
- shame and secrecy; and
- horrible but necessary.

One popular view was that anyone who ended up being pregnant, who did not want to be, should not be seen as unfortunate or unlucky but rather as 'silly or 'stupid', and should consequently take responsibility for their actions: *'I say quick enough to open your legs, take the consequences for it'*. This sense of responsibility was also evident amongst those teenagers that had terminated pregnancies. One of these, Cara, explained why she had not terminated a previous pregnancy:

if I'm a big enough girl to lie down with a man, then I'm big enough to take the responsibility, so I thought why should I bail out of my responsibility when I was stupid enough to go there in the first place?

However, after having had one child, when she found herself pregnant again, other considerations over-rode this assessment: *'It would mess me up so that's why I went ahead with it'*. But she did feel regretful, and this was principally because she had gone against her own moral framework:

I'm not ever going to do that again, it's a horrible experience, like gonna be hanging over my head for a long, long time, that I killed a baby.

Noticeably, in the focus groups, rape was seen as an exception whereby the girl was not 'silly', or irresponsible, but innocent.

I think if you're silly enough to get yourself in that situation then, you know, I think in a way you should suffer the consequences, but whereas if you get raped or something then I would say it is acceptable.

An associated alternative view that also drew on notions of responsibility was that having an abortion was ok for teenagers, but not for older women. This was connected to the view that teenagers becoming pregnant could be an understandable mistake that they should not necessarily be held to account for because they might be young, and – by implication – careless and foolish. In other words, unlike adult women, teenagers are too young to take full responsibility for 'irresponsible' actions.

Another recurring theme in the focus groups was to view abortion as wrong because other women who would like children may be unable to have children:

I think it's wrong because you get older couples that try for years and years and years to have children and they can't.

In the focus groups, many of the girls also talked about how difficult the decision would be for themselves thus confirming the assessments of key informants. In these group discussions the decision was often posed as an individual dilemma and mixed feelings were also expressed: 'horrible but necessary' is a strong theme. One participant brought together a number of these concerns in one contribution, also illustrating how young people may have conflicting ideas. She is speculating about what she might do if she became pregnant.

Yeah I don't think it's a good thing to do but if it needs to happen then it needs to happen, like if you get raped and you can't live with having a baby then I think having an abortion, there are some circumstances where I think that's alright but it's still horrible but I reckon, I suppose at the moment if I got pregnant I think I'd have an abortion but I don't believe in abortion because it's just ruining somebody else's life.

Feelings of secrecy and shame would be expected to be associated with such individual dilemmas, and this was also a strong theme in the focus groups.

nobody tells anybody they've had an abortion

It was not always easy to disentangle the shame and stigma respondents felt was associated with abortion from that of becoming pregnant as a teenager. Girls in the focus groups referred to the stigma of people knowing at school that you had an abortion, and it was virtually universally agreed that becoming pregnant would be something that you would want to keep a secret because '*people are quick to call you a whore*'. Unlike continuing with a pregnancy, keeping an abortion secret is an option.

When, and where, it appears that abortion is generally accepted - maybe even commonplace – there seemed to be less concern about secrecy. Anna, for example,

talked about abortion being generally accepted by the young people that she knows, and certainly by her friends: *'I don't think they're the biggest taboo'*. This appeared to make a difference to how she felt about having an abortion herself, not seeing it as something to be ashamed of.

All these themes give snapshots of what were generally complex, thoughtful discussions in the focus groups. The desire to frame abortion as a moral issue has obvious implications for how any teenager that became unintentionally pregnant might feel. In general, in the focus groups the girls were much more confident about discussing abortion as a moral issue than they were about abortion as a sexual health issue. This is likely to be related to locating the discussion in RE.

The main attitudes towards abortion can therefore be grouped around two themes: one of these is the poor knowledge displayed and the associated persistence of abortion 'myths'. The second is the concern to place abortion in a moral framework. When abortion is seen as immoral, feelings of secrecy and shame, as well as the view that becoming pregnant somehow indicates stupidity or irresponsibility were evident. Both of these are influential when it comes to individual abortion decision-making.

Abortion decision-making

This section looks in more detail at what may influence individual abortion decision-making and, as part of this discussion, considers how the issues discussed above are played out in this process. Our review of previous research has shown that a number of factors – most significantly social deprivation, aspirations, availability of services, the views of significant others - are important (Lee et al., 2004, Tabberer et al., 2000). This study was designed to look closely at inter-personal factors as well as how the broader issues are played out at an individual level. Our interviews, in particular with key informants, substantiate previous research findings: although social deprivation and the aspirations of young people were seen as primary factors, it was acknowledged that multi-faceted explanations were required; and that there was no single explanation:

the teenagers that come in for abortion are more diverse than the ones who tend to have their babies.

Other research has shown that teenagers who become pregnant when they do not want to be are generally shocked; and often dismayed and scared. They mainly then think very seriously about the decision they have to make, and they may also take a while to reach their decision (Ingham et al., 2008). We also found this to be the case.

Our analysis of the data points to a range of different influences on individual decision-making. These include teenagers' own aspirations (connected though not reducible to social deprivation); the views of those close to them, and of their communities; their own views on the morality of abortion; and their assessment of the likely social support they may receive as a teenage mother. There is clearly significant variation in the extent to which the teenagers make decisions themselves, and the extent to which they are propelled towards a particular decision by their

own situation and/or the opinions of those around them. Our analysis suggests that the extent to which they make this decision themselves, and **for** themselves is an important influence on post-abortion feelings and behaviour. This section is therefore organised around the various influences on decision-making, beginning with those influences most closely associated with teenagers making these decisions with their own futures at the forefront of their minds.²⁸

Ambitions and aspirations for the future.

As discussed in chapter two, an acceptance of early motherhood is associated with social deprivation (Turner, 2004). Many of the key informants in this research noted that teenagers who have aspirations are more likely to terminate than continue pregnancies. Many of the young women interviewed, talked about their plans for going to college being an important consideration. Michelle, for example, first thought about her mother's reaction and then about her own future:

when I found out I was like my Mum's going to kill me, that came out of my head first and then I was like what am I going to do, and then I said to myself I'm not ready for a baby, just a lot of things were in my head and I just talked to the boy and he goes to me 'do what you want, whatever you choose I'll be there for you, whatever choice you make, whatever decision you make I'll be there for you'. And then I was like I'm not ready for a baby because I was thinking about my education.

She made up her mind to have an abortion immediately, as soon as she knew she was pregnant, and did not regret her decision.

Others, however, were more concerned with getting their own future sorted out in a broader sense, such as having a job and their own home before having a baby. This indicates that it may be a mistake to conceive of aspirations only in a narrow education-focused sense. For several, such as Juliet, it was often also about the aspirations they had for a future child and their vision of themselves as a mother. Not wanting to struggle financially as a young mother could be an important part of this:

I'd like to be able to give my children what they want and not struggle, I know it can be done, but I don't want to struggle, I want my kids to just have anything they want. I don't want them to be spoiled but I want them to have opportunities and have money really. So the reason why I did it was because I thought I need to get a job and make sure that I can have a child when I can support it. So that's the reasons why I did it, so it would have a better life ultimately in the future.

Of course, for most, a number of different factors were all taken into account, as with Nuru. She was thinking about herself and going to college, but this came

²⁸ Individual decision-making processes will often span a number of different influences.

together with a whole number of other concerns all of which influenced her decision. She also talked about how important it was to her for it to have been her decision:

I'm not ready for a baby because I was thinking about my education ... if I drop out of college what am I going to do, how am I going to look after the baby because my mum's going to throw me out, I'm too young, you know and I was thinking what if the boy he says now he's going to be there for me but what if he just goes and finds someone else.

Girls in the focus groups also talked about more immediate personal interests playing a role, as in the following exchange:

R3: cause if your friend is going to go out there, go partying every single night, go out there and have fun, do what teenagers want to do and then they're going to think about it, 'oh if I have a baby, I've got to sit in the house, take care of the baby, listen to it cry, can't go out'.

R2: Can't take a baby to the rave.

These more immediate concerns were not, however, mentioned by those who had terminated pregnancies.

Another set of influences can be viewed as being less about making decisions for themselves, but rather taking into consideration what other people might think they should do, as well as their own social circumstances.

Social circumstances and the views of significant others

The views of partners, family and friends were also important to the teenagers that had terminated pregnancies. Juliet, for example, had thought that she may have had support from her boyfriend and her parents had she decided not to terminate her pregnancy but they all still played a role in influencing her decision to terminate when she was very ambivalent about what she wanted to do:

For a while I decided that I was going to keep it just because I was really scared of having an abortion and we didn't want to do it. I don't know, I didn't want to live with knowing that I'd done that, I just really didn't want to have an abortion, so I decided that, and even though everyone around me was saying that they thought it was better to have an abortion I don't think they pressured me, they didn't want to pressure me but it did feel like pressure at the time just 'cause it felt like everyone was saying 'have the abortion then you can do this, this and this, and if you don't then you're going to have to do this, the second option'. I was like obviously I know it's not going to be great and I know it's going to be really crappy and I'm not going to have money and whatever, but also there would be some good bits of it. I don't know, just slowly I think I decided that I didn't actually want that and that even though it would be hard having the abortion it wouldn't be forever, whereas having a baby it would have been forever.

This lengthy quote illustrates the influences of 'everyone' around her, but also indicates how important it was for her to eventually make the decision herself, for her own reasons. This was also important to other teenagers.

As with previous studies (Lie et al., 2008), the relationship with the potential father was potentially an important factor. In most cases the teenagers had the support of their boyfriends for the decision they had made, and this had been important to them.

Data from all the interviews showed that it is not only the views of significant others that may push teenagers towards deciding to terminate a pregnancy, but also the knowledge that if their immediate family did not want them to have a baby this would be likely to signify a lack of support were they to proceed with the pregnancy. So the family is thereby important in two ways: as a potentially vital source of social support for young mothers, but also as a powerful force reacting against the pregnancy. In some cases this is because they would be shamed within their community.

Young women that had been reluctant to have the abortion and did so because of family pressure, or lack of family support, were unhappy and vulnerable following the abortion. Aisha, for example, wanted to keep her baby but did not have the support of her boyfriend or her mother, and she had an abortion when she did not really want to: *'If my mum would let me keep it, I would still keep it and still go to school and everything'*. Initially, she had been happy to discover she was pregnant because *'I do love kids'*. Whilst she stated that *'no-one forced me'*, she had had no support for continuing the pregnancy and also thought that having a baby whilst being unmarried would be embarrassing for her community. She was a Muslim girl from a large Bangladeshi community.

As noted in other research (French et al., 2005) the sense of secrecy and shame was especially pertinent in this community. As Aisha had commented, one important reason for her to terminate the pregnancy was the shame she might bring upon her family. This point was also raised by key informants, with the Asian Muslim community being noted as being especially sensitive towards the possibility of teenage girls having a baby whilst still at school. This was described as being 'socially unacceptable':

they shouldn't be having sex out of marriage anyway so it's a cultural thing and to be found out about that is far more frightening for them than to actually go through a termination.

A lot of the girls I see who have abortions, say 50% of them or maybe 60% say the reason why they're having one is because they'll be shamed by their family and that's coming from the Bangladeshi community most of all.

Key informants also pointed out that many pregnant teenagers do not have good social support systems, and may be trying to deal with other social problems, such as drug addiction, or abusive relationships. Such young women were described as

having 'chaotic lifestyles'. As has been pointed out in previous research, an unintended pregnancy is only one of their problems (Hallgarten and Misaljevich, 2007). At least three of our interviewees might have been described in this way. Katie, for example, had been sexually abused by a member of her family and had moved frequently between her mother's, father's and boyfriend's homes, managing to avoid school for many of her teenage years. She had one child and when she found herself pregnant again she felt that she had 'no option' but to end the pregnancy. At the time of the interview she was on the pill, as she had been before becoming pregnant, but said that whenever she felt ill she was not taking it.

The extent to which teenagers may be influenced, pressurised, or coerced into an abortion obviously varies.

Coerced

Some of the key informants pointed out that some of the teenagers they knew may well have little choice themselves. They had been persuaded or coerced to have an abortion by their families, or their partner. They may themselves have preferred to have proceeded with the pregnancy.²⁹

We do see a significant amount of women coming back later on who will say I was made to have an abortion at whatever age, and it's left such a huge damage to them psychologically, it's been so traumatic for them but I personally feel it's much better to support a young woman through having a baby if that's what she wants than to put her through a forced abortion and the psychological damage that that does in her life.

I know one young lady that was more or less made to have a termination when she was about 13, 14 and she was given the scan picture and she spent the next two years just crying, and subsequently her behaviour then became quite bad and she ended up pregnant, had her baby and has totally calmed down, turned her life around and is a very, very good mother and is now working as well. But she never got over the fact that she had been made by her mum to have a termination of a baby that she wanted.

Abortion providers noted that they tried to ensure that young clients were not being pushed into making decisions that they were not happy with, but they also said that it was not always possible to be certain. Indeed, one provider had been on the verge of going to court over just this issue. Their stated policy, therefore, was to see all women on their own at some point, regardless of their age.³⁰

The extent to which young women make these decisions themselves, taking into account all these influences, is important. All the factors mentioned can play a

²⁹ In this research we did not speak to anyone who said they had been made to have a termination. This may be a consequence of our sampling strategy, or accidental.

³⁰ One of our interviewees did say she had only been seen with her boyfriend (Juliet): 'I was surprised though that they didn't speak to me by myself to be sure this is what I wanted rather than sitting with your boyfriend there'.

greater or lesser role in decision-making processes. Understanding there will be no social support for you and your baby, or knowing that everyone around you thinks you should have an abortion, for example, are likely to incline young women towards having an abortion. They are often subject to direct pressure or persuasion to terminate their pregnancies. In other cases, the expectations upon them, and/or their cultural background may make them feel that they have little choice in the matter. The extent to which they make this decision **for** themselves may therefore vary.

Our analysis suggests that the extent to which young women feel a sense of autonomy in their decision-making processes is an important factor influencing post-abortion feelings and desire to establish a more effective contraceptive regime.

Before turning to look at post-abortion behaviour, however, we will consider the role of contraceptive and sexual health services; what is available to teenagers who decide to terminate their pregnancies? We then turn to consider teenagers experiences of abortion. The discussion begins by analysing the views of key informants on abortion referral pathways.

What happens? Abortion referral pathways and abortion services

Given the tensions and pressures that pregnant teenagers may experience, abortion services need to be readily accessible; abortion pathways should be easy to follow; and different forms of post-abortion support should be available. This research has identified areas of good practice, as well as a number of areas in which improvements could be made.

Abortion referral pathways

As noted in chapter two, there is still considerable unevenness in abortion access and provision (IAG, 2009). One issue that emerged in this research was the variety of abortion referral pathways, and what might be seen as the existence of a 'postcode lottery' with respect to access to abortion services. Different practices with respect to post-abortion follow-up were also evident.

I can phone the providers for an appointment for a [London PCT] woman and be given one in 5 days. I can phone the same provider on the same evening for a woman in the PCT next door and I can be told three weeks.

One PCT, for example, reported a situation in which the PCT contracted a local hospital for six abortions in any one week. If there was a seventh requested then the woman was turned away. That situation was turned around with the arrival of a new commissioner who ensured that there were no restrictions in abortions funded, and then *'hung on there while the rate went up and up and up, and then it steadied because there hadn't been enough capacity and she had to grit her teeth through the*

capacity catch up'. This anecdote is important because it suggests that a rising proportion of conceptions ending in abortion may be due to improvements in access.

The key informants were often critical of the way that abortion services were commissioned. This was most strongly expressed by the central abortion providers, one of whom talked about the range of different funding criteria they had to work with:

I would love to see a requirement on Commissioners by the Department of Health to provide abortion services the same as they have to do for cancer or anything else so that you have to provide abortion services to any woman who wants it, not so that Commissioners can pick and choose. There is a Borough in London somewhere where, as I said earlier, to get an NHS funded abortion you have to be either under sixteen or it has to be your first abortion, they won't fund second ones. You know some criteria in some areas are so tight that it's almost impossible for women to get an abortion. So I would like the Department of Health to be much more pro-active about abortion services and actually tell Commissioners what they should be providing.

Although providers did allow for self-referral, they still have to check whether the abortion is covered by the PCT, and whether that PCT allows self-referral or whether the client might be required to be referred through a GP or a contraceptive and sexual health clinic. We were told of some PCTs insisting that only abortions referred through GPs were funded. Other PCTs required that anyone requesting an abortion had proof of address in their area. Those women requesting an abortion might be asked for proof of identity and proof of residence. This may be difficult for teenagers, and for some vulnerable groups (such as asylum-seekers) may be impossible. In addition, not everyone is eligible for abortion. They have to be eligible for secondary care NHS funding because an abortion is not an emergency service. It was also difficult for centralised referrers, like Brook, to know what each young person is entitled to.

Unevenness was also evident with respect to whether or not abortion providers were commissioned to provide contraception at the time of the procedure: some PCTs commissioned this, others did not; and of those that did, some commissioned LARC and others did not. There were also questions raised by some key informants as to whether abortion providers are the best service for the provision of long-term post-abortion contraception. It was felt that continuity of support meant that young women needed to come back to their localities for continuing contraceptive consultation and support. Although the abortion providers do provide contraception following an abortion, at the time of the research they pointed out that they do not see themselves as specialist contraception providers in the same way as contraceptive and sexual health clinics, for example. Notably, they would struggle to find the time for a meaningful consultation, and to maintain contact. Also, abortion providers can provide only as much as they are paid for by the PCTs and this varies significantly across London. This is an area of confusion in London's sexual health

services. If the Pan-London Commissioning Guidelines for Abortion Services³¹ were implemented consistently then this situation would improve.

Examples of good practice were evident in this research where abortion referral and after-care are provided within an integrated sexual health framework. In these, the aim of monitoring the well-being and sexual health of individual teenagers following an abortion was viewed as an important part of their abortion pathway.³² It was pointed out that such continuity is important because if abortion is not considered as a journey with referral, assessment, procedure, and follow-up components all in place, then important intervention opportunities are missed. The most important aspect is the opportunity to use the referral consultation to start the work of supporting contraceptive choices after the abortion, and including this in the abortion assessment process. It is also important, as noted by Kumar et al (2004), for professionals to arrange follow-up which can then start on-going contraceptive provision and support.

The following section further considers post-abortion care in the context of findings on what might be done to help prevent repeat conceptions. Before doing this, however, it is important to examine what has been learnt about teenagers' experiences of abortion in London.

Experiences of abortion

This section considers the teenagers' experiences of the abortion process. The teenagers we interviewed that had terminated pregnancies had a range of experiences.

The attitudes of clinic staff towards the teenagers was an important factor influencing whether they had positive or negative feelings about their abortion. In the main, they were happy about the way they had been dealt with, often describing the clinic staff as 'nice', or 'understanding'. This was very important to them. Cara, made a point of commenting that at the clinic *'everyone was just lovely, they were really understanding, it's nice to know that people don't judge you for what you do'*. Indeed, when one of the abortion providers talked about their suggestions box they noted:

But a lot of people will comment on 'I didn't expect people to be nice', because I think the stigma and they think that the staff are going to be horrible to them, and that's especially true of younger people, they think staff are going to be judging them. So the comments would normally be along the

³¹ <http://younglondonmatters.org/uploads/documents/ylm2teenagepregnancypanlondoncommissioningguidelinesforabortionservices.pdf>

³² See Hallgarten and Misaljevich 2007 for examples of good practice in establishing abortion pathways in sexual health practice.

lines of 'I wasn't expecting people to be as nice as they were', which is good for us but it's a shame the expectations are low.

An important indicator for the teenagers was whether they felt they were being judged. Yasmeen had been expecting to be judged, and her sense of a lack of judgement contributed to the clinic experience being positive: *'they didn't judge me, they didn't do nothing, and I felt like I could tell them everything'*.

Juliet, however, described a mixed experience. Some staff had been very helpful and 'nice', but overall she felt that she had been rushed through the initial counselling meeting, and then the procedure itself. She felt that she did not have a chance to discuss how she felt about having the abortion, apart from a brief discussion with the clinic counsellor. This troubled her because at the time she was not sure whether she was making the right decision, and she would have welcomed the opportunity to talk through the issues as she saw them: *'I felt a bit like 'aren't you going to check that it's alright?' I think it's a massive thing to me but obviously they see many people a day'*. Also, she insisted that at no point was she seen by herself. She also described the doctor as 'horrible', and she thought she was very abrupt and judging her: *'I felt like she was telling me off almost'*. This young woman's account of her experiences at the clinic is instructive. It may well be that the doctor was not judgemental, and that the real issue was that she had an expectation of being judged. Nevertheless, the fact that she felt she was being judged is a reminder of the need to be especially careful to avoid such an approach.

The attitudes and approaches of referrers were also important and negative experiences of GP referrals were noted. Ella, for example, had wanted to talk to someone about the decision that she was making and saw a nurse at a GP surgery:

I wanted to talk to her more, she just seemed to want to get me out. I just wanted to talk through it and everything but she just sort of pushed me out. It was like take this number, do the termination, and have the coil fitted, and that's it, and I was like okay'.

In a number of cases, expressions of unmet need were evident in the teenagers' accounts. A strong theme was that many, like Ella, wanted the time and space to talk about how they felt before, during, or following, the day of the abortion.

These teenagers are expressing unmet needs that have the potential to be dealt with following their abortions. The following section explores the relationship between their post-abortion experiences, feelings and attitudes; and post-abortion sexual behaviour. This is an important relationship to discuss, in order to begin to understand repeat conception and repeat abortion.

Post abortion experiences, behaviour; and repeat abortion

Understanding what might happen to teenagers after they terminate pregnancies is an important part of developing a strategy in order to try and help them avoid repeat abortions. There are two aspects to be considered. First, the services and

support mechanisms in place; and second, the young women's responses to their abortion and consequent decision-making with respect to their sexual behaviour and their future more generally.

Post-abortion services

In this report post-abortion services are viewed as including services available immediately following the abortion, so this covers those services available at the abortion providers. The way that teenagers are dealt with at the clinic ought to be seen as an important element of post-abortion support. Sometimes teenagers feel support is lacking. Immediately after the abortion, Juliet had been upset by the Doctor's attitude and she was also surprised about the lack of human contact following her abortion: *'they just seemed to leave you there, which at the time I just wanted someone to hold my hand or something'*.

Other concerns centred on their physical health following the abortion. Some young women had experienced little pain and discomfort, whilst others had felt quite ill in the days following the abortion. Some of the teenagers that had originally agreed to be interviewed, later declined because they said they felt too ill, and several of the interviewees complained about prolonged pain and bleeding that they were worried about. Katie, for example, was interviewed about seven weeks after her abortion and had been in pain and bleeding since her abortion. She had been given a telephone number but did not have any after-care arranged. She did not call the clinic.

Some of the key informants who had worked with teenagers who had abortions talked about traumatic experiences that they had heard about.

I'm sure that there's a lot that I don't hear about that have done fine so you know this is not everyone. Another said she had an horrendous time with bleeding and pain and she couldn't get hold of anybody and she thought she must be dying and she was doing it on her own, she hadn't told anybody

This respondent also noted that, it is really only likely to be teenagers with post-abortion problems that go to see her. However, similar experiences were also recounted by teenagers we spoke to.³³ Although these accounts may not be representative of the teenage client group as a whole, there were enough accounts to suggest that there is an unmet need for abortion follow-up for a proportion of teenagers.

Key informants talked about poor engagement with contraceptive and sexual health services following an abortion, and about unclear care pathways. None of the

³³ It could be argued that teenagers who experienced problems were more likely, than those who had not, to volunteer to take part in a research interview. It should be noted, however, that most were asked if they would like to take part at the time of their first appointment at the abortion provider, before such problems developed. Also, as noted previously, other teenagers had agreed to be interviewed but later withdrew because they felt too ill or distressed to take part.

teenagers that we spoke to had accessed post-abortion care, though they had generally been given a telephone number. Most, like Katie, indicated that they may well have turned up for an appointment had it been planned for them. Katie was asked:

Q: What about if they'd asked you to go back in a couple of weeks or three or four weeks for a check-up after you had the abortion, would that have been something that you would have done?

R: Yeah, I would have gone back to make sure everything's alright

Most key informants were worried about a lack of post-abortion follow-up care for teenagers. They pinpointed two important reasons for intervention at this stage. Firstly, it was seen to be important to establish a good, effective, contraceptive regime following an abortion in order to prevent further 'unintended' pregnancies and repeat abortions. Secondly, as many providers pointed out, any social problems that may have contributed towards becoming pregnant are not likely to go away as a result of the abortion. It was therefore felt that intervention following an abortion might be important. In this research, many of the teenagers we interviewed were taking contraceptive chances following their abortions; and we also talked to teenagers with obvious social problems. It is clear that any post-abortion intervention would need to be tailored to the individual, to explore all the factors that may have contributed towards her becoming pregnant, and take into account her decision-making 'mind-set'.

Post-abortion feelings and behaviour

One of the most important findings in this study is the extent to which attitudes, understanding and beliefs about abortion appeared to be likely to influence post-abortion feelings and behaviour. A second and more tentative finding that merits further research is that the extent to which the young woman made the decision herself, and **for** herself, was also important. Taken together, we suggest that these two issues affect the mind-set with which teenagers experience their abortion and handle their post-abortion situation. This includes their sexual behaviour following the abortion. We look at these issues through re-visiting attitudes, understandings and beliefs; and decision-making; in the context of post abortion feelings and behaviour.

Attitudes, understandings and beliefs

One myth is particularly important in influencing post-abortion behaviour: the view that having an abortion might make you infertile. As noted earlier, key informants, in particular, when they talked about 'myths' that they had noticed in their consultations with young women, felt that the idea that having an abortion is likely to lead to infertility was deeply embedded. One consequence is likely to be rapid repeat pregnancies. As noted earlier, one of the teenagers we interviewed thought that she might be infertile following her abortion. However, in the main, the others were more affected by beliefs concerning the morality or immorality of abortion.

This was also acknowledged by key informants who were aware that teenagers that terminate pregnancies are sometimes left with difficult feelings to come to terms with:

I think they feel that they've done something wrong in the sense that they wouldn't like to be in that position, they feel 'guilty'

They were often worried about this aspect of abortion decision-making for young people, saying, for example, *'I don't think that guilt is ever a useful emotion'*.

One referrer noted that *'when I see girls who are having trouble deciding it's often much more about not wanting an abortion than wanting a baby'*. She thought this was often because of their religious background, and meant that if they terminated their pregnancies they were quite likely not to want to tell their families because of the shame of being pregnant. For many of the teenagers she dealt with she thought there was a sense of *'abortion is wrong but I don't want to have a baby'*. As she noted, such a belief system will leave girls with very mixed feelings that they are likely to need help to work through.

Young people in the focus groups also talked about how teenagers they knew had felt bad after having an abortion, and talked about the need to *'pick up the pieces'*.

From people that I know that have had an abortion, I think the government or doctors and stuff should provide the aftermath help if you know what I mean ... for the next two months the person who's had the abortion should come to see a doctor and just talk about it, a counselling kind of thing because if they keep it in, we as their friends have to pick up the pieces and it's a bit too much for us as well.

These assessments were reinforced by the accounts of the teenagers. Many of those that had terminated pregnancies talked about ambivalence, mixed feelings and there was, once again, a strong *'horrible but necessary'* theme.

'It's a horrible thing to do but I think it was the best thing' (Juliet)

'It's a horrible thing because I don't like killing it, because when my neighbour told me about how they die, it's like they put a pipe in you and they suck it out, that's how I feel bad about it, all bits and pieces come out. That's not nice.'
(Aisha)

This is important because it does indicate that some teenagers, at least, do not feel comfortable about the decision they have made, even when they feel it is the *'right'* decision for them.

Young women's feelings and their mind-set when having an abortion can also affect their take up of post-abortion services that may be on offer. One strong theme in the key informant interviews was that teenagers would often disengage with them following an abortion because *'you're a reminder of something that has happened'*

and that is something they want to ‘disassociate’ themselves from. Some key informants talked about young women’s desire to put the abortion behind them and move on without being in contact with services. This last point is important and fits with the notion of abortion as something ‘horrible’ that most people would simply want to forget about.

Decision-making

The extent to which young women make the abortion decision themselves also forms part of their mind-set. All the sexual health providers we spoke to were certain that they should not play any part in the decision-making process.

You can’t, that wouldn’t be ethical ... we don’t influence the decision-making either way, we can’t.

No I mean the one thing we don’t do is tell them what to do, we’re involved in facilitating the decision but there’s never any question of being involved in the decision-making.

I’m not there to change anyone’s mind.

The relationship between women making this decision themselves and their post-abortion psychological well-being has also been noted by the women’s counselling service at St George’s Hospital.³⁴ It is important to note that the moral framework that the teenagers we interviewed drew upon influenced the way that they felt about their decision-making. In these cases, it has not prevented these teenagers terminating pregnancies, but had made some of them feel uncomfortable about the decision they had made.

It is therefore important for the decision to have been their decision, and for their own reasons – for themselves. The implications of this for contraceptive and sexual health services are that those young women who are not really making the decision for themselves and may be feeling guilty and negative about themselves may need extra help in trying to turn their situation around so something positive does come out of the experience. As one key informant put it: *‘try and make the abortion a positive experience’*. She was referring to the abortion itself, but the sentiments are also relevant for post-abortion support.

Our analysis has indicated that there is a likely relationship between the pre-abortion mindset of young women and post-abortion feelings and behaviour. Those young

³⁴ In an unpublished paper, the team have explained that they set up a counselling screening service of all abortion patients in the recognition of the stress that may be experienced at times by pregnant women around abortion decision-making. They feel it is important to assess *‘if the patient is at risk of subsequent negative psychological effects arising from her decision to terminate the pregnancy’*, and note that *‘shame, guilt and at times regret may be repressed for a long time, but may eventually reappear at some point’*.

women who had been comfortable with their decision were less likely to feel regret or guilt following their abortion, than those who for one reason or another were not convinced that they had made the right choice. This is clearly central to the issue of repeat pregnancy and repeat abortion.

Repeat abortions

Many of the key informants struggled to find a pattern when they were asked for insights into teenage repeat abortions. They were aware that repeat conceptions were not uncommon. The St George's team also noted that teenagers that have had an abortion frequently become pregnant again within two or three years after the procedure. Other key informants had more experience of repeat conceptions ending in maternity, following an abortion, and found these easier to explain than repeat abortions. They did this largely in terms of looking at the reactions of the teenagers to their abortion and pointed out that if they had not wanted the abortion themselves and/or they felt guilty about the abortion they were more likely to become pregnant again and decide to keep their babies. This is indeed one of the reasons why the sexual health professionals were so worried about 'guilt'.

However, some ideas were put forward. One pattern noted was that following an abortion:

the girls that don't have those sorts of aspirations or any real idea of what they want to do in life, they're much more laid back and relaxed and irresponsible about their contraception, so in some ways if they've got a very clear I want to do this, you know even if you know I want to be a singer or a dancer, or, it doesn't have to be any particular profession but having a very clear idea of what you want out of life seems to be even if they've had one abortion, you know if they're pregnant and they need an abortion seems to be enough to make them be more responsible about contraception.

Our review of previous research has shown that whilst teenagers with aspirations are more likely to decide to terminate a teenage conception, the issue is actually more complex than it first appears. A diverse range of teenagers decide to terminate pregnancies. What this abortion provider is noting is that of the teenagers who have abortions those with aspirations are more likely to try harder not to become pregnant again than those who don't '*have any real idea of what they want to do in life*'. This is likely to be related to the factors underlying individual decision-making: is the decision primarily coming from the young woman and is it something that she has chosen to do for her own interests?

Other key informants talked about girls who led 'chaotic' lifestyles being less likely to establish an effective contraceptive regime following an abortion. Of these teenagers some will become pregnant a second time. At that decision-making point some will 'keep their baby' but for others their social circumstances may still be against this, or they may not want to become mothers, and they will have another abortion.

Of the teenagers that we interviewed those who had made the decision to terminate their pregnancies because of their own aspirations, who had made the decision for themselves, were very concerned to establish an effective contraceptive regime following their abortion. This was also true of some of those who were ambivalent. As seen above, abortion providers did not want to play any role in influencing anyone's abortion decision-making. One of the reasons given for this was to avoid problems following an abortion: *'however old a client is she's got to be able to take responsibility for that decision afterwards'*. This is important for post-abortion feelings and behaviour.

When Yasmeen, for example, is asked why she decided to terminate her pregnancy she talks about her own future before she mentions the other influences on her decision.

I just thought I can't have a baby at this age, I'm too young, I've got my college, I have to go to college and study. I've got studies and I just don't – my mum wouldn't be happy either

Her boyfriend thought that she should have the baby but:

I had to do what I wanted to do, so I told him: 'this is not you, this is me, me, what I want to do in the future'.

She made her decision as soon as she knew she was pregnant. Although she did say that she did not 'believe in abortion' she is certain that she made the right decision and has no doubts or regrets:

I don't doubt myself. I mean I didn't doubt myself in the first place anyway and I still don't.

Yasmeen had plans for the future, and she wanted to ensure that she did not become pregnant again. She would have liked to have an injection at the clinic:

I think they shouldn't send you anywhere else. I think after that they should just give it to you straightaway, 'cause they're giving you condoms, that's one of the contraceptions, they should be able to give you the other one as well. They are sending you somewhere else, and I don't even know where that is.

Anna had also made the decision to terminate her pregnancy primarily for reasons to do with her own future. She began by being adamant that she had no regrets and asserting her control over the process. Her feelings are however quite ambivalent, and indicate that expressing an absence of regret does not necessarily imply absence of sadness.

Q: How did you feel after the abortion then?

R1: I actually felt good, I actually felt alright, I felt relieved, I felt like I could be in control of what I wanted to do, so I didn't regret it at the time.

Q: Now that a couple of months has sort of gone by, how do you feel about your decision now?

R1: I don't regret it, I don't regret it. But, I mean, it's... I do think about how it would have been nice to have something of my own to love'

Anna, however, later reflects on the complexity of her feelings:

I said I don't regret it before, it sounds a bit too firm I suppose. I think I could have done with some counselling or someone to talk to about it to understand what my feelings were.

Her mixed feelings, and ambivalence about her decision, are such that she feels that if she was to become pregnant again she would not have another abortion: *'Next time I get pregnant I'm going to have the child'*. For this reason she is very concerned to establish an effective contraceptive regime following her abortion.

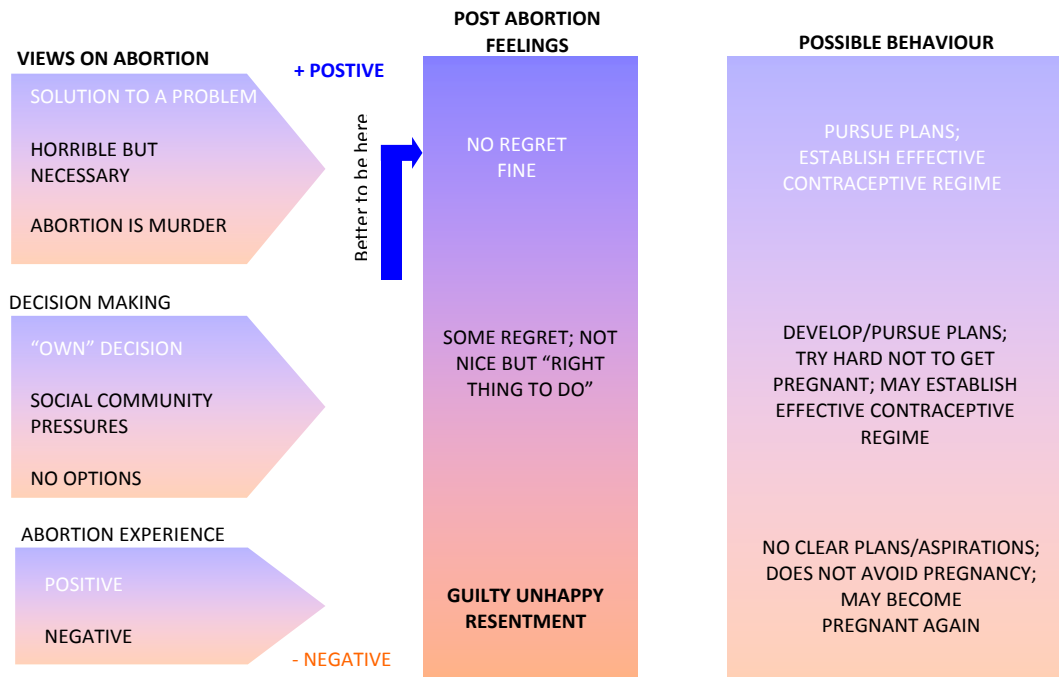
For others the decision had been more complex with a range of factors. We have described the family pressure on Aisha, for example. Although she felt she had made the right decision, and that she had been too young to have a child, the expectations of her family and her community had been significant factors propelling her towards an abortion. She also had strong reasons for establishing an effective contraceptive regime following the abortion. She had been pleased to get a contraceptive implant on the same day as the abortion.

The teenagers with other social problems appeared to be less concerned about another pregnancy.

The following diagram illustrates the different stages of the abortion decision-making process and possible pathways through and beyond that process. The first three multi-coloured boxes represent the main factors that might influence post-abortion feelings and sexual behaviour. The top box represents the range of views on the morality of abortion. We have shown how teenagers' feelings about their abortion have been influenced by their personal views on abortion, whether they see it as 'horrible but necessary', or as a straightforward solution to their problem of an unintended pregnancy. The second box - 'decision making' - represents the differing extent to which teenagers are making the decision for themselves, taking into account influences, such as their families' and communities' attitudes towards becoming a teenage mother (for example), on their decision. After this decision the abortion experience itself is important. Following this experience, the first multi-coloured column - 'impact of decision' - represents the range of post-abortion feelings that may be experienced. These range from feeling fine with no regrets to feeling guilty and unhappy about having had an abortion. The second multi-coloured column - 'possible behaviour' - indicates a range of possible post-abortion behaviour.

Although this is a simplified model of complex and diverse attitudes and behaviours, and progress through these stages should not be seen as linear, we would suggest that there is a relationship between where teenagers begin this process and their

end-point. Those starting in the blue-shaded areas of the boxes, for example, are more likely (though not certain) to end in the blue area. We would also suggest that where teenagers end this process is an important indicator of the type of post-abortion support they might need.



Three Examples:

Yasmeen had clearly made the decision to have an abortion primarily based on her hopes for her own future. She emerged from the abortion process with those aims at the forefront of her mind and she also wanted to try to avoid becoming pregnant again. During the course of the interview she had also said that although she had always tried to ensure that her boyfriend used a condom she was not always successful, particularly if they were both drunk. Her preferred contraceptive choice following the abortion was LARC, specifically the injection. However, she was having difficulty accessing this method.

Anna expressed more ambivalence about the decision that she had made. However, because she also has plans for her own future she wants to ensure that she does not become pregnant again.

Juliet had at first wanted to continue her pregnancy. However, she was convinced by everyone around her that it was not a good idea, and she came to believe that it was not a good idea for her own reasons. She did not want to struggle financially, and wanted a reliable income before she had children. She does, however, feel regret following her abortion and wants an implant because she wants to be sure that she will not get pregnant again *'I really don't want it to happen again, and in my head if I ever do get pregnant there's no way that I'd have an abortion again'*.

Although these three teenagers have travelled on slightly different pathways, avoiding a second unintended pregnancy was important to all of them. However, at the time of their interview none had been successful in accessing and beginning to use the contraceptives of their choice. They would have had to have been proactive and they did not feel ready to make such an effort. Outreach post-abortion services could have helped these teenagers establish the effective contraceptive regime they desired.

Post-abortion intervention

This research has shown an unmet need for post-abortion services for teenagers in London. Three issues are especially important to consider:

- Post-abortion contraception
- Post-abortion health and well-being
- Making a new start

Key informants generally agreed that trying to help teenagers avoid repeat abortions poses different challenges to that for the first abortion. As has also been suggested by Hallgarten and Misaljevich (2007), sexual health providers felt that repeat abortions indicated that there had been no change in behaviour and many thought that this represented a failure on their part. Providers, especially those responsible for referral, felt that presentation for a repeat abortion was an indication that services had failed to engage someone who may be 'at risk' of further unwanted

pregnancies. When asked to speculate about what might help, some key informants pointed to the need for a more holistic targeted service. It was felt that some teenagers that presented for repeat abortion were often likely to suffer from other social problems, to lack confidence, and have a disregard for their own self. These did not change as a result of the abortion. Following their first abortion, teenagers that may be in this category therefore need to be identified for a broader intervention: injunctions to use contraceptives more efficiently are likely to be ineffective. This re-emphasises the need to work with the whole person in a post-abortion service.

As pointed out by Rowlands, all women requesting abortion should be treated according to their individual circumstances, and as a minimum receive information and support; and some will require counselling (Rowlands, 2007). The interviews with teenagers that had experienced an abortion also showed that teenagers are likely to have different needs following an abortion. For some this may be a 'light touch' which simply involves ensuring that they have had good quality contraceptive counselling. For others a more intensive intervention may be called for.

Post-abortion contraception

One immediate issue is the need for post-abortion contraception. There were differences of opinion amongst the key informants as to where this might best be provided. Many felt that abortion providers, at the time of the research, did not have the time, or specialist skills, needed to provide a comprehensive contraceptive consultation, and that contraceptive support needed to be ongoing and was therefore best arranged locally.³⁵ Another view expressed was that it was difficult for teenagers to think about their future contraception when their minds were concentrated on their abortion experience. However, abortion referrers had also noticed that some teenagers coming back to them weeks after terminating pregnancies were having unprotected sex. A number of these had become pregnant and were requesting another referral. Some referrers were worried that these young women did not have adequate contraceptive counselling at the time of their abortion, and had been simply sent away with either condoms or oral contraceptives that they were not using effectively. One suggestion was the provision of LARC at the time of the abortion.

There were, however, also differences of opinion about the desirability of providing LARC following an abortion. It was pointed out by a number of key informants that young women are worried about returning to 'normal' following an abortion and this means that any contraception and its possible side-effects have to be fully discussed at the consultation. The key informants noted instances of young women asking for

³⁵ There are a number of comments on abortion provision reported in this chapter. It is not appropriate in this report to note which providers such comments applied to.

the implants to be taken out because they were unhappy that their periods had not returned to 'normal'.

We also heard, however, about young women who had wanted implants at the time of the abortion but were turned down. It is not clear whether this was because this service had not been commissioned by their PCT, or because the abortion provider was reluctant to provide LARC.

there was a young woman who was perhaps just fifteen who was sent to one of the independent providers, she had her abortion, she wanted an implant put in afterwards, they didn't do it they said oh go to your GP, by the time she got round to actually having the implant inserted she was already pregnant again so she came to us; so there she is not sixteen, she's had two abortions and we put the implant in the same time that she had the abortion, which is what should be happening you know particularly for vulnerable young women you have to get their contraception sorted out at the same time, they're not going to come back.

Post-abortion contraceptive counselling and provision is therefore a controversial and sensitive issue. Taking into account the views and experiences of the teenagers that had terminated pregnancies, alongside those of the key informants, the research evidence suggests that mechanisms are put in place to try and ensure that each teenager who terminates a pregnancy is offered two opportunities for a contraceptive consultation. The first needs to happen at the time and place of their abortion. However, it is likely that they would also benefit from a second consultation two to three weeks following the abortion. This could be at a place of their choice, but the research evidence suggests that this consultation should be booked for them at the time of the abortion.

There is also clearly a need for the providers to ensure that enough time is available for the consultation so that the young women are able to understand all the options available to them, and the positives and negatives of each method for themselves. As many key informants noted, this is especially important with LARC. The side effects of LARC would have to be thoroughly explained and continuing support offered in order to help young women feel comfortable with the method. NICE guidelines on LARC should be followed.³⁶ Hallgarten and Misaljevich (2007) have noted a number of examples of good practice for post-abortion contraceptive counselling: a central point of principle, highlighted in the case study of South Tyneside, is that

Honesty and commitment to facilitating a truly informed choice ensure that all young women are able to consider the best possible option for them. They

³⁶ See the NICE (2005) guidance on *Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception*.

<http://guidance.nice.org.uk/CG30/Guidance/pdf/English>

are given complete information about the best and worst case scenarios with a given type of contraception and asked to consider how they would cope if they experienced the worst case. (p.16)

At the time of this report there was a high take up of LARC in South Tyneside. If teenagers have a second consultation as a minimum provision, any anxieties about side effects could be discussed at that meeting. The interviews with the teenagers indicate that they may welcome a post-abortion follow-up appointment if it is arranged for them. This would be primarily to ensure that their physical health is 'back to normal' following the abortion, but general well-being as well as contraception could also be discussed.

Post-abortion health and well-being

The question of where the best place for a more general post-abortion intervention to take place was discussed in the key informant interviews and with the young women who had terminated pregnancies. Abortion providers do offer a phone line and sometimes a follow-up appointment; and referrers do generally offer a follow-up appointment. They noted, however, that these offers were not always accepted. As we have already stated, these services were not taken up by any of the teenagers we interviewed.

The most successful account of post-abortion appointments that we were told of was by a family planning consultant who arranged follow-up appointments after two weeks. Although we do not have figures for this clinic, or any figures to compare this case with, this account was corroborated by another key informant who noted that *'she always insisted that they went back so she made sure they got the aftercare'*. It seems that in this example a follow-up meeting was expected, and there was a high rate of attendance. There was a planned process from initial meeting through to post-abortion support.

Some of the areas were trialling post-abortion follow-up for under-18s. Mostly those developing this post-abortion service were looking to *'tapping them back directly into their local sexual health services'*. Their perception – and indeed the perception of many key informants - was that teenagers do not want to stay in contact with the service that has terminated their pregnancy: *'people want to get away from there quite quickly, it's not the right forum for any kind of follow-up'*. We did not find this to be the case with the teenagers that we interviewed, but this may be a consequence of the research sampling strategy. These were teenagers that were prepared to discuss their experience with researchers and therefore not wanting to turn their back on the experience as soon as possible. It is likely, taking all the evidence into account, that some teenagers would not welcome follow-up appointments at the abortion clinic; others (maybe fewer), however, might welcome the anonymity of the setting and prefer a follow-up appointment there. Follow-up appointments could be used to identify those teenagers with 'chaotic' lifestyles, may have multiple problems, be especially vulnerable and felt to be at risk of another pregnancy. Such young women could be signposted to other appropriate services,

but they could also be followed up through their local contraceptive and sexual health services.

Making a new start

It was generally felt that intensive one-to-one support by a sexual health professional, possibly an outreach nurse, would be the most effective approach for teenagers assessed to be 'at risk' of another pregnancy. This view was expressed by many key informants and also supported by the expert focus group. It is an approach that has been tried in Hackney and is seen as being largely responsible for reducing repeat teenage pregnancies in that borough.³⁷ It is too early to comment decisively on the likely broader success of this strategy, but our research findings suggest that this might be a promising approach. A need for intensive, individualised post-abortion follow-up has certainly been identified.

More intensive post-abortion support is especially important for teenagers who might be located in the middle, or towards the bottom of the diagram presented earlier. For these teenagers an intervention should not only be concerned with contraception, or working through post-abortion feelings, but more of an individualised intervention that seeks to help them think more about their own futures. It is also especially important for teenagers that may be left with feelings of guilt and shame.

Anna talked about how being able to talk about themselves at the time of the abortion might be helpful:

Like I said at the stage when I was spoken to for the pregnancy, if I'd had counselling to just work on the things that I wanted, or it should be a time where a girl can really think about what they want to do and what's best and take control of their life, and I think a lot of people whatever situation they're in, whether they're in a council house or whether they're from rich backgrounds or poor backgrounds, I think it's helpful to get advice at that stage. Because you are in a really shock point and a defining moment in your life and you should be forced to really think about what you're doing.

Her reference to abortion as a 'shock point' and a 'defining moment in your life' is important. The point she is making indicates that for some young women, at least, there may be a window of opportunity to help them re-define their lives.

³⁷ City and Hackney NHS Press Release 12 July 2007
http://209.85.229.132/search?q=cache:nC3jbUF88pgJ:www.chpct.nhs.uk/trust_documents/doc_click_count.asp%3Fid%3D483+press+release+young+people+in+hackney+lead+the+way+in+reducing&cd=1&hl=en&ct=clink&gl=uk

Conclusion

This analysis of abortion pathways and abortion decision-making has shown a need for clearer pathways of care; for improved and consistent post-abortion support; and the need for contraceptive and sexual health services to be more proactive in engaging young women in follow-up care. It has also shown how teenagers struggle with the morality of abortion and how damaging framing abortion as an [im]moral issue can be. It is also important that teenagers make these decisions themselves, and with their own futures in mind.

The teenagers interviewed expressed the need for varying degrees of support. Some stated they had no need for any additional support; others simply wanted help accessing 'more reliable contraceptives'; others talked about needing to discuss their feelings. Some appeared to need support to set their lives in a more positive direction, whilst for others this was clearly not necessary. In terms of where they wanted post-abortion support, they struggled to express preferences beyond generally preferring somewhere local. They mostly would have preferred to have an appointment set up for them so that they did not have to take proactive steps themselves. They did not express strong views on whether or not they would prefer to see someone already known to them. The implications of all the research findings for policy developments are now considered.

Chapter 5 Conclusions and Policy Implications

The main findings on abortion and repeat abortion in this research are as follows:

- **Young people continue to have unprotected sex when they are fully aware of the possible consequences, and when they do not want to become pregnant.** For many, this is likely to continue to be the case. Underlying issues that can help explain this include feeling out of control, maybe because of drugs or alcohol, or because of the dynamics of the sexual relationship. In many respects, however, such behaviour is not confined to teenagers, and is a sign of an underlying tension for all women between the perceived desirability of sex as a spontaneous act and the control that may be necessary to avoid risk. This finding has implications for young women's choices of contraceptive methods.
- **Young people struggle to use their preferred methods of contraception (principally condoms and the pill) effectively.** These methods are relatively user-dependent, and the condom – primarily a male method – requires young women to have the confidence to negotiate safer sex, or for her male sexual partner to take responsibility for preventing STIs and unintended pregnancies. The primary responsibility for pregnancy avoidance remains with women, and young women's reliance on a male method is therefore fraught with difficulties. Because these are the methods most often used by young people there will continue to be instances of unprotected sex.
- **Many teenagers who are not sexually active believe that it is 'very easy' to become pregnant.** This means that whilst they are less likely to 'take chances' during their initial sexual encounters, they may draw the wrong conclusion on any occasion when contraceptives have not been used.
- **Young women's failure to become pregnant after they have had unprotected sex is likely to lead them to think they may be infertile.** They may then seek to test their fertility, or – as seen in this research – assume that they no longer need to use contraception. This is more likely to be the case if they are in a steady relationship and do not feel the need to take precautions against STIs.
- **Abortion is viewed as 'immoral' by many young women, and this view can make abortion decision-making difficult and stressful.** The way in which abortion is often covered as a discussion topic in RE lessons within schools encourages such a framing of the issue. Feeling that abortion is 'immoral' is likely to contribute towards any feelings of regret and/or guilt that young women may have following an abortion.
- **The mindset of pregnant teenagers and the extent to which they make an abortion decision by and for themselves may influence their feelings and sexual behaviour following the abortion.** We would suggest that those young women who are able to make their own decision for their own reasons

are more likely to establish an effective contraceptive regime following an abortion, than young women who may have been reluctant to end their pregnancies and do not have any plans for their own futures. These issues would need to be explored around the time of the abortion in order to offer an appropriate individualised post-abortion service.

- **The myth that having an abortion may make you infertile still retains a hold.** This was mostly evident in the focus groups. It has obvious implications for post-abortion sexual behaviour, so it is encouraging that it was not such a strong theme amongst those teenagers who had an abortion.

Policy Implications

- Policy developments around abortion should therefore have three main objectives:
 - Help young women avoid conceptions that end in abortion.
 - The main policy tools are improvements in SRE and improving young people's access to a full range of contraceptives.
 - De-stigmatise abortion.
 - This objective should inform developments in SRE.
 - Help young women avoid further unintended and unwanted pregnancies.
 - Through the development of post-abortion services.

The following issues have emerged from this study, and are raised for consideration. Some of the suggested developments are already taking place in a number of areas. It would be helpful to the teenage pregnancy strategy if these developments were to be rigorously evaluated.

Strategy and commissioning issues

- 1. Local data should be gathered, and analysed in order to develop a local strategy, as well as to monitor, and target appropriate interventions.** As the Independent Advisory Group has recommended: *'PCTs should develop world class commissioning for contraceptive and abortion services with effective performance management based on rigorous comparative data'* (IAG, 2009). The data ought to be shared within the Teenage Pregnancy and Sexual Health Boards, and used to identify local needs and commission appropriate services. In particular, more data should be gathered on rapid repeat pregnancy; and on ethnicity. It would also be helpful to gather data on abortion followed by conception resulting in motherhood. Addressing repeat abortion could be considered as part of the strategy of reducing teenage conception rates.
- 2. Commissioners need to consider how to commission services at each stage of the abortion pathway.** Referral, assessment, procedure and follow-up components are all important, and should be considered individually, as well as forming a coherent whole.

3. **Sexual Health Commissioners need to consider where the gaps in local contraceptive and sexual health services are.** Efforts need to be made by commissioners to collect data that will inform and support the further analysis of how services currently meet the needs of young people. A comprehensive service mapping is needed as a basis for a full picture of local provision and usage of the services (IAG, 2009). London PCTs can refer to the recent London sexual health needs assessment and service mapping (MedFASH, 2008) and keep it up to date for their areas. PCTs also need to ensure that they have a sufficient number of trained staff to provide comprehensive contraception and abortion services. A workforce development strategy would help with this.
4. **Abortion provision needs to be considered by teenage pregnancy partnership boards (or the senior board responsible for teenage pregnancy) and not left to sexual health boards.** This should include discussing the quality of the service available, and whether it is 'young people friendly' applying the Department of Health You're Welcome Standards
5. **Efforts need to be made to monitor the quality of abortion provision.** We have suggested that feelings of regret following an abortion are likely to be exacerbated by any negative experiences at the abortion provider (as well as during the referral and follow-up stages). Interviewees also talked about the importance of non-judgemental attitudes towards them in their experiences of abortion. Monitoring should include visiting clinics, and encouraging feedback from users (maybe in follow-up appointments at GPs or clinics). This does not need to be confined to teenage experiences.
6. **Access to, and use of, Long Acting Reversible Contraceptives (LARCs) needs monitoring at a local level. It should be available at all settings where contraceptives are available.** Data should be systematically collected, and efforts made to try and ascertain how knowledgeable young women are with respect to all the different contraceptives available within this category. These forms of contraception should be readily available as part of the range of methods any woman can choose from.
7. **Commissioners should consider funding a post partly or fully dedicated to providing comprehensive contraceptive counselling prior to and following an abortion.** Such a post could also involve one to one preventative work with teenagers that may have been identified as being 'at risk' of teenage pregnancy.

Contraceptive and Sexual Health Services

8. **Local teenage pregnancy strategy coordinators, and sexual health commissioners, need to think about the ways in which contraceptive and sexual health services can be improved for young people:**
 - Are the services 'young people friendly' and accessible?
 - Could contraceptive and sexual health services be developed in secondary schools, as in policy recommendations for extended school health services? This would almost certainly require more school nurses.

- Could a case be made for emergency hormonal contraception (EHC) to be provided in advance for young women known to rely on condoms or the pill?

- 9. Systems need to be in place for early identification of those who may be 'at risk' of teenage pregnancy.** This is already taking place in many areas. It clearly needs to involve joint working of a number of services. This research would support Recommendation 6 of the 2007/8 Annual Report of the Teenage Pregnancy Independent Advisory Group (DCSF, 2008) which calls for partnership work to improve the skills of all those working with children and young people so they are able to identify risk and '*respond appropriately to their emotional and sexual health and well-being*' (p.25).
- 10. Services need to ensure that a full range of contraceptive methods - including LARCs - are easily accessible to women of all ages.** They should also ensure that young women are given enough information and time to make an informed choice. Contraceptive counselling needs to include discussion of the possible side-effects of all contraceptives. Further support may be needed to help maintenance of the selected method, or movement to another method.
- 11. Young people need to be sign-posted to services which offer non-judgmental pregnancy decision-making support.** These services should provide evidence-based information about all pregnancy options, and support access to ante-natal and abortion services. Some organisations offering pregnancy testing and counselling are not committed to providing non-directive support and oppose abortion. These should not be included in local information.
- 12. Further work is required to develop outreach, and confidential prevention services, for BME groups that might currently struggle to access services.** This study confirms other research that points out that one size does not fit all. The differing needs and preferences of diverse BME groups need to be taken into consideration.
- 13. Young men can, and do, take responsibility for contraception and this should be encouraged.** However, it is important that they understand female, as well as male, contraceptive methods. Any interventions, or publicity materials, aimed at young men should also encourage them to think about their role in preventing unintended pregnancies.
- 14. Key service providers for vulnerable young people (eg. Youth workers, and social workers), should continue to have the required training in sexual health issues, and this should include abortion services and a focus on local services.** They might then be able to help young people make informed decisions about their sexual health, as well as sign-post them to appropriate contraceptive and sexual health services. There also needs to be joint working with these services with respect to young people 'at risk'.

15. Innovative and effective ‘early intervention’ programmes should be developed for those who may be ‘at risk’ of teenage pregnancy. This has been prioritised by the Teenage Pregnancy Unit in the Teenage Pregnancy Assessment Framework. The research to date suggests that that these would need to be targeted holistic programmes. There are examples of interventions that do seek to engage this client group and work with them on a number of different levels. The teenage pregnancy prevention strategy is likely to benefit from an expansion and an evaluation of targeted interventions. Post-abortion services would need to consider engaging with such programmes.

Post-abortion services

There is a clear need for high quality post-abortion services for young people to be developed.

16. Abortion providers are now required to provide post-abortion contraception.

This should include the full range of contraceptives and adequate time should be allowed for comprehensive contraceptive counselling. All doctors and nurses working in this sector would therefore need to be adequately skilled for this provision. Abortion providers should also take steps to try and ensure that their follow-up care is accessible.

17. All teenagers should have a post-abortion follow-up appointment. This should be made for them at the time of their abortion, or at the time of their referral.

This appointment ought to be made by an appropriate professional, in consultation with the teenager. It should not be left for teenagers to take the initiative on this issue. Follow-up appointments would cover both physical check-ups and further contraceptive counselling. Consideration ought to be given in each locality to where would be the preferred place for post-abortion follow-up appointments, but teenagers can be given the choice of re-visiting the abortion provider, or consulting local services. All contraceptive methods ought to be available at all possible settings. Patient Group Directives may be needed to facilitate this. Abortion referrers need to be able to keep track of the referral and have the follow-up appointment set up in advance of the abortion. Abortion providers need to check that their clients have a follow-up appointment organised and if they do not, to help them set one up.

18. Interventions aimed at reducing repeat abortions need to address the whole person. Individualised and intensive one-to-one support should be available for teenagers judged to be ‘in need’ of such an intervention.

Interventions could be developed in a number of different ways, including: outreach nurses specifically for TOP follow-up; and arrangements being made for follow-up clinics. Some of the districts are already involved in developments in this area. Post-abortion work would need to develop a bespoke service spending an appropriate length of time with each young woman to understand the factors behind her pregnancy, and her decision to terminate that pregnancy. It will need to be recognised that the intervention is likely to be different for each young woman, and may include

contraception advice and support, connexions/youth worker support and education. It would include the recognition that some teenagers will not want or need such an intervention.

Sex and Relationships Education

In most schools, Sex and Relationships Education could be improved in a number of ways. Many of these issues are already addressed in the Young London Matters SRE Guidance.³⁸

- 19. Thought should be given to SRE being delivered by specialist teachers or specialist educators.** All those responsible for the delivery of SRE should undertake continual professional development, and it would be helpful if this incorporated attitudinal work. No-one who is personally opposed to abortion should be involved in the delivery of SRE.
- 20. Separate messages are needed for STIs and pregnancy prevention.** All methods of contraception should be discussed, including LARC and Emergency Hormonal Contraception (EHC). Young people need to be encouraged to discuss which contraceptive methods are more effective for each purpose, and to consider the possible benefits of using more than one method.
- 21. A balanced, non-judgemental, discussion of abortion should be an integral part of SRE (preferably delivered by specialists).** At the very least there ought to be an opportunity for teenagers to discuss ‘what do you think you might feel/do if you (your girlfriend) became pregnant?’ This is important for the prevention strategy, plus it could also help young people make more informed abortion decisions, if necessary. The discussion ought to be facilitated in such a way that should a young woman will, as far as possible, feel comfortable about the decision she makes. This should be viewed as part of an effort to de-stigmatise abortion. RE is not an appropriate forum for this discussion to take place.
- 22. Boys should be encouraged to consider the consequences of accidentally making someone pregnant.** The research has shown how important the support of boyfriends can be in young women’s decision-making processes. However, because of the potential for discussions on abortion to be reduced to disputes about competing rights, this is one area of SRE that would be better taught in single gender sessions. Young men also need messages about condom use to avoid accidentally causing a pregnancy as well as for STI prevention.
- 23. Accurate information on abortion (availability, methods etc) needs to be included.** PSHE is due to become a statutory subject, and as the TPIAG report

³⁸ <http://www.younglondonmatters.org/uploads/documents/srecorecurriculumforlondonapracticalresourcepdfdocument.pdf>

noted: *'contraception, abortion and homosexuality are all legal in this country and therefore all children and young people should be able to learn the correct facts'* (TPIAG, 2008). The Young London Matters SRE guidelines also recommend including discussion of abortion in the curriculum.

- 24. Efforts need to be made to enable young people to have a better understanding of their own likely fertility.** Confusion around fertility is likely to be undermined if young women had better knowledge regarding fertility, and understood that not becoming pregnant following a single instance of unprotected sexual intercourse is not unusual.
- 25. Contraceptive and sexual health services should be clearly signposted in SRE.** It would also be helpful for local services to undertake outreach work in schools and colleges.
- 26. Further efforts need to be made to develop sex and relationships education for out of school settings.** This is especially important given that the research evidence suggests that poor school attendance is associated with teenage pregnancy. This ought to include developing SRE programmes in FE colleges, recognising that older teenagers may have significant gaps in knowledge.
- 27. Consideration could be given to how to increase coverage of self-respect, self-confidence and pleasure in SRE.** This might be one way to begin to address issues of difficulties negotiating safer sex, and lack of autonomy that many young women experience in sexual encounters.
- 28. Thought could be given to how to make connections between actions and possible outcomes.** A useful way of introducing a discussion in a group setting may be: 'do you think that if someone is having sex without using contraception they must be trying for a baby?'

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CONTACT INFORMATION

Government Office For London
Riverwalk House
157-161 Millbank
London
SW1P 4RR

www.younglondonmatters.org

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