TEENAGE PREGNANCY IN SOUTH LONDON

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ABSTRACT

The increasing proportion of teenage girls of West Indian origin presenting for legal NHS abortions at the two teaching hospitals in a district of South London prompted the setting up of this study (1979-81, funded by the DHSS).

The study's main aims were to ascertain whether, in fact, the proportion of girls of West Indian origin was higher than would be expected in the district, which has a sizable population of long-settled West Indian immigrants; if so, to identify the most important contributory factors and to make appropriate recommendations for changes or improvements in the services, in order to bring about a reduction in the number of unwanted pregnancies.

In all, 550 teenage girls were interviewed: 220 after termination of their pregnancies, and 217 after the birth of their babies; a small comparison group of 113 teenagers who had never been pregnant was recruited in the district's hospital and community family planning clinics.

Interviews were conducted using a semi-structured questionnaire and the results compared, where possible, with other similar studies. This survey data, together with systematic and non-systematic observations made throughout the period of the study, were used to give support to the hypotheses.

About a third of both groups of pregnant teenagers were of West Indian origin. This was higher than anticipated. Since socio-economic differences did not provide immediate explanations, certain hypotheses were tested which derived from the apparent importance of types of inter-personal relationships (specifically, mother-daughter and boy-girl) as predictors of the risk of a teenage girl experiencing an unplanned and initially unwanted pregnancy.
The method of contraception (if any) used by a teenager at the time of her first sexual experience, provided a useful indicator of the type of relationship a young couple had. Girls of West Indian origin appeared to find themselves when they became sexually active, in "segregated" relationships with their partners (as opposed to "integrated" relationships), relationships typified from the study's viewpoint, by the non-use of any form of contraception, at least in the relationship's initial stages.

Once having identified what seemed to be a key to the problem (exemplified in the classification of relationship types devised) the question of how best to utilise this knowledge arose. It was suggested that the study's classification of relationship types could provide a useful frame of reference for those health professionals most closely concerned with young women and young men. Recommended changes in the services centred upon changing the attitudes of service workers towards young people, in the hope of improving their image and making them more approachable. It was suggested that a lay visitor on the wards who would also be available to give advice during those family planning clinic sessions directed specifically at young people, would provide invaluable support for teenage girls who had experienced an unplanned pregnancy.
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This study of teenage pregnancy is of a special, local population, carried out in a strictly defined geographical area, at the time of the study (1979-81) called the King's Health District, but in 1982 redesignated the Camberwell Health District. (See Plan of District at Appendix 1.)

The district straddles broad sections of two London boroughs, Lambeth and Southwark, encompassing to the east and south such pleasant and prosperous residential suburbs as that of Dulwich Village, with its tree-lined avenues, green parks and large well-tended gardens, and to the west and north the grey tenements, austere council estates and bleak terraces of a decaying inner city area, typified by many parts of Brixton. The nature of this study, focusing as it does on the characteristics and experiences of pregnant girls aged between 13 and 19 years, has emphasized far more frequently the backgrounds of teenagers from these latter areas and those between the two extremes, than it has those of the middle-class populace on the far side of the district.

Nevertheless, if this study does not follow a well-worn path, relating social and economic deprivation to all of the major disadvantages and dissimilarities that are to be found in a largely immigrant and working class urban population, it is not because these relationships do not exist for our group or because they are not extremely important. The district is characterised by its high proportion of substandard housing; its high unemployment; a notoriously high crime rate, particularly for street crime, burglaries and other crimes of violence; and by its youthful population, extremely mobile (within a fixed area), a large proportion British born but of West Indian origin, alienated and searching for its roots in the West Indian traditions of its parents.
The main reason for the different emphasis of this study is quite obviously our viewpoint: our interviews were entirely with young women. Looking at society from their perspective, some of the main disadvantages were confirmed. The differences resulting from racial discrimination in the experiences of young black men and women were evident, and within this (black) sub-group, too, there were differences. The male counterparts of our British born young women of West Indian origin have types of lifestyles infrequently shared by their partners.* This is less often the case with indigenous young couples, whose lifestyles bear a much closer similarity.

Other features of economic and social deprivation, such as standards of housing and levels of unemployment, were more difficult to discern from the viewpoint of teenage girls. The young British born West Indian girls in the study were more likely than the indigenous girls still to be living in their parental (or maternal) homes, so that their family circumstances reflected a standard probably achieved after years of hardship for middle-aged parents; and while a much higher proportion of the girls in the study aged under 18 were of West Indian origin, and theoretically still in education, those West Indian girls who were 16 or over appeared to be less likely to suffer discrimination in employment than their black partners.

The focus of any study largely reflects the personal bias of its researchers. Several hypotheses were explored in the initial stages of data collection, such as the proposition that the apparently greater likelihood of black teenage girls than indigenous girls experiencing unplanned and unwanted pregnancies was a transitional phase in the family building behaviour of women migrating from a developing (high fertility) society to an industrialized (low fertility) society. This could not be substantiated from our findings. Instead, throughout the study all hunches and gradually, certain evidence, pointed to the importance

* For variety and description, see Pryce (1979) pp.267-278; and Wood (1974).
of the types of sexual relationships young couples have as providing an explanation for the increased likelihood of some of these teenagers experiencing an unplanned and unwanted pregnancy.

Against this background, and with these limitations, 550 teenage girls, the majority residents of the King's Health District, were recruited consecutively and interviewed in either one of the district's two teaching hospitals, King's College Hospital and Dulwich Hospital, or in one of the district's hospital or community family planning clinics.

Interviewing had hardly been completed when in April 1981, the streets of Brixton exploded in an orgy of violence. The release of tension displayed a grim exuberance, a pride in the ability through sheer physical might to attract the country's attention to the longstanding, systematic humiliation and degradation the predominantly black community believed it had been suffering.

The protagonists were in the main young men. During the disturbances, in the kitchens and on the wards of King's College Hospital the predominantly middle-aged black domestic and nursing staff buzzed with this one topic of conversation. The black youngsters, formerly so roundly condemned by their elders for their supposed promiscuity and laziness, were at last a source of pride of the black community. Outspoken criticisms rarely heard before among these women were openly voiced against "whitey"; the bitterness and resentment of years of turning the other cheek were finally too much to bear.

The officially commissioned Scarman Report and the numerous other post-mortems, including those by police and community groups, did their best to illuminate the events leading up to the riots and to make proposals which might help alleviate the disadvantage and discrimination regarded as being at the root of the season of violence.
The findings of this study will give no hint of the tensions building up among young black men in the community, although our teenagers referred to partners who were "away at Dover" (and other borstals or prisons) with surprising frequency - in fact a number had served sentences in the past themselves; and while girls were not asked directly whether they had or had ever had a social worker, references to social workers were quite commonplace. Racist comments were not infrequently made by both black and white girls - occasionally a young white mother would be heard to object to sharing a room with black mothers on the maternity wards. Despite these expressions, inter-racial relationships between white teenage girls and young black men were quite common, though the reverse, black girls with white boyfriends, were comparatively rare.

King's College Hospital lies near the centre of the two extremes of the district it serves, one extremity running into Coldharbour Lane, leading to Loughborough Junction and Brixton, and the other crossing Denmark Hill and winding its way into the attractive surroundings of Dulwich.

The hospital is a conglomeration of buildings stuck together haphazardly by halls and corridors, different coloured dotted lines painted on the ground to guide the patient from one department to another. Papers and debris blow about its entrances. Its ground level has none of the hushed atmosphere, the awe-inspiring features of the super-white hygienic hospitals of films and TV (or, indeed of more affluent parts of London). The maternity wards in the new block are warm and friendly with visitors wandering in and out at all hours of the day; but the long drear corridors in the older building have a chill about them even on warm days, and the wards there seem more forbidding.
Dulwich Hospital, the other teaching hospital in the district, though of an aloof appearance, dark brick mock-Gothic, is considerably smaller and more compact; it is buffered from the outside world by an expanse of shrubbery and a porter's lodge by the gates. It exudes a familiarity and friendliness from its neat wards.

For a sociologist, the prospect of carrying out a study of a substantial number of healthy people within the confines of hospital walls is likely to be rather formidable. Inevitably, in a study of several hundred teenage girls, the volume of work involved simply in interviewing restricts the bounds of one's "community", making it impossible systematically to follow up teenagers in their own homes, with their boyfriends and families. For the future, in order to substantiate the hunches and hypotheses which resulted from this hospital-based study, it is essential that our teenagers' wider social networks be investigated, against the background of everyday life in the district.
ACKNOWLEDGEMENTS

This study was the brainchild of Dr. John McEwan of King's College Hospital. Without his inspiration and support, it would never have been extended or completed as it has been. Those who have experienced the isolation of the social scientist working in a hospital setting will appreciate the particular debt I owe for his encouragement and enthusiasm during the gradual formulation of ideas into hypotheses (and perhaps even theories). This is not to say that the time I spent working in the hospitals was not agreeable - it was a particularly happy period, thanks to the friendliness and helpfulness of the staff of the Helen Brook Department of Family Planning and the Area Family Planning Training Unit where I was based, and the willing assistance of staff in the two hospitals and in the family planning clinics. I also wish to thank the consultants for allowing us to interview their patients.

I am extremely grateful to Professor Margot Jefferys of Bedford College for the encouragement, advice and discipline which preparing this report for submission as a thesis required; and to Dr. Ann Cartwright and Madeleine Simms of the Institute for Social Studies in Medical Care for their kindness and guidance during the early stages of the work. John Simons of the London School of Hygiene and Tropical Medicine is also thanked for his, perhaps less direct, help. Without his confidence and encouragement I would never have become so involved in the nitty-gritty of fertility studies.

The DHSS provided the funds for the research and I am particularly grateful to them for this and for financing its extension.

Throughout this report I have tended to use the collective first person rather than "I". This is mainly because I wish to acknowledge the support given to me during
the different stages of the study's progress - to Dr. McEwan and Professor Jefferys and particularly to the interviewers who shared with me the painful, stimulating and nerve-wracking experience of interviewing 550 teenagers and converting it all into numbers - they were Alison Gould, Inga Jones and Janet Teale-Daniel. Nevertheless, while recognition is due to so many people, the responsibility for all the peaks and troughs of this thesis is solely mine.
INTRODUCTION

Study setting and sample

The King's Health District* is generally acknowledged as providing "above average" contraceptive services - through general practitioners, National Health Service and charity family planning clinics, and widespread commercial outlets, backed up by a "liberal" abortion policy at its two hospitals. Sex education of varying standards is almost universally available in its schools.

The district provides the setting for a study, carried out between 1979 and 1981, of 550** sexually active teenage girls. Interviews with the majority of these teenagers (80% or 437 girls) revolved around the experience of pregnancy: 220 were recruited immediately following the termination of their pregnancies in the district's two teaching hospitals, and 217 were interviewed in the hospitals' maternity wards within a week of giving birth to their babies. A small comparison group (113 girls) of sexually active teenage girls who had never been pregnant, was recruited in the district's hospital and community family planning clinics. Although private patients were not excluded, all our teenagers were National Health Service patients or clients, except for one young mother from the Sudan who was a private patient. Interviewing took place between May 1979 and July 1981.

The district's population includes a substantial number of long settled immigrants from the West Indies, the majority from Jamaica. The peak of immigration from the West Indies occurred in the early 1960s and so most West Indian teenagers recruited to the study were the children of immigrants. They had been born in the district and had attended (or were attending) local schools. In this thesis, these girls are distinguished

* From 1981 redesignated the Camberwell Health District.
** Six girls were not yet sexually active at the time of the interview, but were planning shortly to become so.
as UK Black girls, from indigenous UK White girls, and Jamaican girls (those born in the West Indies). West Indian girls is a general description and includes both those born in the West Indies and those born in the United Kingdom to West Indian parents.

Some earlier studies with particular reference to the district's UK born West Indian population

In 1966, a West Indian doctor, Dr. Violet Moody, interviewed 100 West Indian women attending the antenatal clinics at King's College Hospital. She was concerned about the living conditions in which many of these women who were single parents had to bring up their babies, and recommended that they be given financial assistance in the form of loans to buy their own flats (Moody and Stroud (1967)).

In the early 1970s, Dr. Margaret Pollak, then a GP in the Brixton area with a particular interest in Paediatrics, carried out a study of 3 year old children - 75 children of indigenous parents and 75 children of West Indian parents. Dr. Pollak reported a much higher than expected proportion of the West Indian 3 year olds as language retarded and attributed this in part to the different child-rearing practices of their mothers and the fact that so many mothers were working, leaving the children in the care of other siblings or with childminders (Pollak (1972) pp.116-7; pp.124-5).

Dr. Pollak followed up her 3 year olds when they were 6 years older (1979). At 9 years of age, she found that the differences between the two groups of children persisted, and she concluded that "cultural differences, particularly in child rearing practices, do appear to influence level of achievement" (p.167).

In 1974, Professor Michael Rutter from the Institute of Psychiatry and his colleagues published a series of
three articles about 10 year old children of West Indian immigrants. They found that West Indian children showed more behavioural difficulties at school than the indigenous children and that West Indian girls showed "rates of behavioural deviance much nearer to that in the boys, compared to "white" girls whose rates of deviance were much lower than that in the boys ... and when disorder or deviance was present in W.I. girls it was likely to involve conduct disturbance rather than emotional disturbance" (Rutter et al (1974)).

Rutter has also described the child-rearing patterns of the West Indian population in this area of London. There is, he suggests, "some lack of understanding of the developmental importance of play communication and parent-child interaction in the early years". Rutter quotes Fitzherbert's suggestion that "some parents believe that providing an income is a more responsible kind of motherhood than providing personal care" (Rutter and Madge (1976)).

Many other studies relating to immigrants and to racial disadvantage have concerned themselves with the West Indian community, but the studies above are mentioned particularly for their chronology and specific geographical location. The girls in our study were born in the 1960s; women who could have been their mothers, attending the hospitals' antenatal clinics attracted attention for a variety of medical and social reasons, as a result of which Dr. Moody recruited 100 of them for her study. In the community, Dr. Pollak, as a GP, became aware of the apparently slow progress some West Indian children were making compared with indigenous children, and so she recruited her 3 year olds. At school, the behavioural differences of West Indian children also attracted attention and Professor Rutter and his colleagues studied their 10 year olds.
It will not be surprising then to find that one of the promptings for this research was the hospital staff's concern for the young West Indian women who were requesting abortions in what appeared to be increasing numbers. In 1973, Dr. John McEwan and his colleagues recruited 54 girls aged 16 and under who were attending hospital antenatal clinics either to request an abortion or intending to continue with the pregnancy, in what was to be a preliminary study for the present research (McEwan et al (1974)).

Our two teaching hospitals have a formidable reputation for excellent research leading to innovation in many fields of medicine. They are unique in appointing a Consultant in Family Planning and have, through the efforts and interests of a few exceptional people, added significantly to the growing literature on the social aspects of fertility control (McEwan et al (1974); McEwan and Kingsley (1977); McEwan (1978); Reading and Newton (1977); Newton et al (1971); Lewis et al (1971); Beard et al (1971) etc.).

The roots of the "problem" - socio-economic or cultural?

The present study is undertaken from a purely female standpoint, since only young women were interviewed. It began with a question: "If there really are more West Indian girls having unplanned, unwanted pregnancies, are the reasons socio-economic or cultural?" The expectation (and to some extent hope), was that the root causes of the high induced abortion rate would be found either to lie in "social deprivation" and so be shared by the indigenous teenagers from similar backgrounds, or to be a transitional phase, experienced particularly by the West Indian girls as their first UK born generation adapts its fertility behaviour, following their parents' migration from a high fertility (developing), to a low fertility (developed)
society. Either of these findings would be amenable to practical recommendations such as improved provision of family planning services and sex educational resources. Strictly cultural explanations are much more controversial and difficult to deal with, particularly when couched in negative terms by the host society and viewed as a "problem", as is the case with unwanted pregnancy and language retardation.

The fact that survey research is particularly conducive to the collection of data on socio-economic variables and less readily adapted to the identification of cultural factors also ensures that in this type of research emphasis falls on the socio-economic category of explanations.

While our sample of pregnant teenagers was virtually complete, permitting comparisons from the data capable of revealing real differences or similarities between teenagers in a defined area of South London who had become pregnant during the same period in 1979, socio-economic explanations for the higher proportions of UK Black and Jamaican teenagers requesting abortions could not be supported from the survey data.

About a third of our pregnant teenagers were girls of West Indian origin. These black teenagers not only shared many of the features of the indigenous girls, in a number of respects they exhibited characteristics which would be anticipated to indicate a reduced likelihood of experiencing an early unwanted pregnancy. They showed a greater interest in improving their knowledge of contraception through independent reading, a higher proportion had some academic qualifications, and there was a less distinct difference in the characteristics of those black teenagers having abortions and those having babies than was the case with these two groups of indigenous teenagers.

From the outset, the "feel" of interviews with the black teenagers gave cause for optimism - these girls were
generally alert, intelligent and ambitious. Nevertheless, the flexibility of our interview conversations provided opportunities for unanticipated features of these girls' family and sexual relationships to emerge.

Explanations for the type of social phenomena we were observing during the study are extremely difficult to derive from social survey research. Other sociological tools are required. It seemed important, therefore, that other lines of investigation be pursued in conjunction with the survey data, so that by broadening our knowledge of the sample through non-systematic observations, other possible explanations for the high proportion of black teenagers being recruited might become evident. The hypotheses which were developed as a result of this approach were therefore largely untestable, but the evidence which it has been possible to present in this thesis does lend support to our particular line of investigation into unwanted pregnancy.

The initial approach to the analysis of our data was suggested by the work of Elizabeth Bott (1957) and the studies her work has inspired which have shown that types of relationship between spouses influence types of parent-child relationships and, ultimately, types of relationships between children and their partners. Bott's theory of joint and segregated conjugal role-relationships has provided this study with, if not a theoretical base from which to work, at least some stimulating ideas.

In his Preface to the second edition (1971) of Bott's "Family and Social Networks", Gluckman says: "... a close-knit network of kin (i.e. where there is a segregated conjugal role-relationship*) ought also to lead to more

* With independent and complementary activities - where there is a sharp division of labour.
segregation of parents and children from one another than a loose-knit network does (i.e. where there is a joint conjugal role-relationship*). I would expect that in families with close-knit networks young persons would associate with their own age-mates, and it is from these age-mates that they would derive parts of their moral codes...".

Gluckman refers to Allcorn's (1954) study of young men with close-knit networks in a London working-class suburb. Allcorn "found that those young men who did not become mobile and move out of the local area to attend school and then university, grew up with...a 'peer group' of equals. This group became a powerful influence over the young men during the period between their leaving school and becoming engaged to marry...the peer group encouraged, by boasting and reciprocal teasing, temporary liaisons with young women, but opposed the forming of permanent attachments to them, since these would destroy the group" (p. xxviii).

Farrell's national survey of young people (1978) (which examined the sources of information encountered by young people during their early years which helped or hindered them in their acquisition of knowledge about sex and birth control) gives oblique support to these views, when she says "it looks as if those who do not attempt to control their fertility are the young working class boys who are not as likely to be involved in stable relationships" (p.32).

Bott (1971) reports Walter Miller (1958) defining 'lower class' by "...its use of the 'female based' household as the basic form of child-rearing unit and of the "serial monogamy" mating pattern as the primary form of marriage". "He describes", she says, "the 'focal concerns'

* With shared activities and interchangeable tasks.
of this subculture, stressing its emphasis on masculinity and toughness, excitement, smartness, and the ambivalent mixture of objection to any authority combined where control will be stringent. Miller makes it clear that segregation within the family is marked and that boys and men have groups of male peers. Adolescent girls evidently have gangs too...". (p.254)

One of the most important studies of family life in the West Indies (Jamaica) was written by an anthropologist, Edith Clarke, about her own society and called "My Mother Who Fathered Me" (1957). Clarke describes the great attachment children have for their mothers, in spite of considerable physical "control" in the form of strappings etc.,* and the economic importance, especially very young children have, in running errands and doing housework (pp.156-164). The book's title is particularly interesting for we know from many sources how much more difficult children find communication on "important matters" with fathers than mothers. Farrell (1978) reports that "boys and girls find it easier to communicate with mothers than fathers, and maternal-child relationships appear to be easier and closer. This may partly explain why mothers have a more active role as sex educators within the family" (p.121). And perhaps one of the reasons why, with West Indian girls, they may not. However, Farrell goes on to say that "sexually experienced working class girls were also less likely to say they found it easy to talk to their mothers about things that were important to them..." (p.102).

Dr. Pollak's study of child-rearing practices in Brixton (1972) revealed, though the sample was small, that of 75 indigenous 3 year olds, only one was language regarded, while 6 of the 75 West Indian 3 year olds were language

* Rutter (1979) notes the "consistent observation that attachment still develops in the face of maltreatment and severe punishment" (p.290).
retarded. The study has been criticised by the Commission for Racial Equality (London) in a pamphlet in which it evaluates some of the literature available on minority groups: "Despite the fact that the author is explicitly making a cultural comparison in child-rearing methods, no attempt is made to develop measures reflecting how West Indian mothers and fathers express attention and caring to their children, or to develop a West Indian scale of adequate/inadequate mothering. There is therefore no investigation of how English parents would compare with West Indians when judged by such standards."

West Indian mothers value tidiness and cleanliness in the home, and a disciplined, quiet child. Dr. Poliak made it clear that these were not criteria she used. It mattered little to her if a family and home were in disarray; what did matter was her assessment of the warmth and caring of the environment as evidenced by her assessment of the happiness and adjustment of the child.

The difficulty here lies in describing as "retardation" observed differences in speech development. In societies which put a high value on a quiet child, early speech development may well be given a comparatively low value. It is also questionable, therefore, to assert that differences in speech development are due to differences in warmth and caring, if the happiness and adjustment of a child is to some extent judged by his speech development.

Instead of focusing solely on West Indian mothers and their child-rearing practices, we also need to look at networks of social relationships which are what may differ in West Indian society. If West Indian mothers are actually behaving like fathers, perhaps West Indian grandmothers (or older sisters or aunts) are mothers. Perhaps if Dr. Pollak does see evidence of the behaviour of institutionalised children in the behaviour of the deprived West Indian 3 year olds, this is because they in fact lack a "mother", for they have no grandmothers in this country.
It may be that the position of children born today to the UK born daughters of West Indian parents will be different. The children described by Dr. Pollak are now teenagers and some of her sample will have been pregnant already. The question is - will their mothers be prepared to act as "mothers" to these grandchildren, now that they live in a society where they have a choice, given contraception and a "liberal" abortion policy, and they are able to work to earn a living? Or will these teenagers become more personally involved in their own children's lives?

We interviewed West Indian girls whose mothers were willing to bring up their babies for them. A 17 year old mother we met already had a 5 year old son, but as far as she was concerned, he was not her son, the baby she had just given birth to was her first child. A West Indian woman, unaware that her 16 year old daughter was pregnant until she gave birth to her baby at home, told nurses on the ward that she would be bringing up the child - "that's our custom".

Other West Indian teenagers having abortions were adamant that they did not want babies who would be brought up as their own brothers or sisters and would call their mothers "Mum".

Some girls' mothers refused outright to bring up their grandchildren and the lonely young mothers living in isolation in council flats were no better off than their own mothers had once been, struggling alone with their children. Very few West Indian girls in the study were married and only a small proportion were living with their partners.

One 15 year old West Indian girl became something of a cause célèbre at the hospital when she was referred by
the pregnancy counsellor of a local charity family planning clinic. Her older sister's baby was already being brought up by her parents, who were now refusing to accept this girl's baby, although they also refused to give their consent for her to have an abortion. She must bear the consequences for her behaviour, they said, and she was told to leave home. Her second trimester abortion was performed at the hospital without parental consent.

Sue Sharpe's survey of teenage girls in Ealing, West London (1976) makes particular mention of West Indian girls. "Many of their answers to questionnaires about the concern and interest of their parents implied that although parents were concerned with their progress at school, personal problems and worries were seldom discussed and even everyday experiences at school were frequently left untold ..." (p.238). The girls told her how they would try to treat their daughters when they became parents themselves: "Growing up in my family is hell, my parents just don't have any understanding at all and through their mistakes I'll make my family's life different"; "it will be better and I will want my kids to be more truthful and closer to me than I am with my parents"; and "I tell you, if my daughter got pregnant I wouldn't chuck her out of the house I wouldn't. I'd more or less try to understand, I don't want to make mistakes like parents do today. I want to try and understand her. I don't want them to think that parents never understand them" (p.245).*

Rutter and his colleagues had difficulty in recording birthplace of some of their West Indian 10 year olds, similar to problems we encountered with the West Indian partners of some of our teenagers. Teachers of Rutter's 10 year olds had in 14 cases (of 100) recorded their birthplace as the West Indies, although

* Rainwater (1970) found that black teenage girls living in a ghetto area of St. Louis were less likely to start sexual activity early (at 13 or 14 years) and less likely to engage in casual affairs and to have illegitimate children by their late teens if their relationships with their families were strong enough to over-ride the influence and pull of the peer group (pp.306-8).
10 of the children (4 could not be checked) had been born in the United Kingdom. Rutter suspected that "when teachers were in doubt about a child's place of birth, they (presumably unconsciously) used knowledge of behavioural deviance to come to a decision. It is apparent that this introduces a self-fulfilling element into the hypothesis that children born abroad have greater educational and behavioural disturbance" (Rutter et al (1974)).

We found a disproportionately large number of our teenagers (the majority of them West Indian girls) describing their West Indian partners as born in the West Indies. We had anticipated that similar proportions of partners as there were respondents would have been born in the West Indies. One explanation for this discrepancy may be that the emphasis on dialect and the external trappings of their inherited culture is more commonplace among groups of young West Indian men than among young West Indian women, giving the impression that their Jamaican origins are more recent. But in fact birthplace of their partners was not the only area of ignorance on the part of particular young women. They were also less likely to know about other general characteristics of their partners and their partners' families, about their own mothers' marital status at various stages of their lives, their parents' ages, and so on. We were concerned about this apparent lack of knowledge and about the communication difficulties we experienced ourselves (although these were even more noticeable when interviewing African girls).

The young women in our study are not a representative sample of the teenage population as a whole. Certain limitations imposed by our sample, in particular by the comparison group of girls recruited in the family planning clinics who had never been pregnant, are evident and have been referred to (see, for example, p. 261). A control group of sexually active teenage girls who had never been
pregnant, recruited from the community, would have elicited a much more diverse response. However, financial and time constraints, and the practical difficulties anticipated in undertaking such a recruitment programme meant that only clinic attenders could be recruited. Therefore, young women who had not been pregnant who, for example, had only ever approached their GPs for contraception, those who had only used commercial outlets and those who had never used contraception and had taken risks but who had not become pregnant, were not represented among our teenagers.

The foregoing chapter describes in outline some of the recent relevant research in the study district and that carried out on a national scale and notes the background to the setting up of this particular research project. The perceptions of the "problem" of those who initiated and sponsored the study, and those who formulated its broad outline, and the limitations of the sample and the interests and biases of the researchers have all been influential on the outcome.

In Part I which follows, the practical difficulties encountered in data collection by social survey are discussed, together with the limitations and advantages of the method and our efforts to supplement the data obtained by using a combination approach.
PART I

METHODOLOGICAL ISSUES

2 Social Survey Research

Data collection

Social survey research has an important place in providing a certain type of data. Nevertheless, extreme wariness is essential in interpreting data, since the observation of many types of social phenomena may actually be hindered by survey procedures (Busfield and Paddon (1977) p.98), and observations of cultural differences between sub-groups masked by these techniques.

Social scientists who have been faced with the practicalities of social survey research will be aware of the limitations of the method in reflecting a realistic picture of their subjects, methodological theory very often only serving to emphasize the deficiencies of the method in practice.

The aim of the social survey is to produce statistically significant results which are then used to validate the findings of the research. This entails the selection of a sample of such a size that findings for a particular group may be regarded as being applicable also to a much larger similar population. These ends are achieved by the standardised collection of data on a substantial number of individuals - standardised, that is, by the format of the questionnaire (usually structured, with pre-coded replies) and by interviewing techniques (questionnaires administered by trained interviewers, in strictly laid down situations).

It would, however, be naive to believe that simply by showing statistical significance in data collected in this standardised manner and establishing an association
between variables, or establishing the type and extent of a relationship between variables, it is possible accurately to reflect the type or pattern of behaviour, events or attitudes which are the primary concern of the sociologist, and so to provide explanations for the social phenomena observed.

While statistical tests may provide proof of a degree of association which has already been observed between variables, or which is believed by the researcher to exist between them, it is important to ensure that the information from which variables are derived has the same context of meaning for all respondents; that their ranking or scaling does justice to the meaning of replies; and that the overall pattern of relationships between variables has the same importance and meaning for all cases.

The process leading to the making of empirical generalisations involves a series of procedures: having selected a suitable sample, one needs then to construct discrete variables which, upon aggregation and measurement, will fairly reflect readily identifiable and straightforward "facts", even when taken out of their immediate context.

In reality, ensuring that the context of meaning of data from which variables are derived is common to all subjects and for both interviewer and subject is extremely difficult. Its achievement is complicated by the introduction into the interview situation of various influences external to the questionnaire material itself.

From the start, the possibilities of introducing misunderstandings and biases are strong, even in the task of recruiting the sample population. In order to obtain information from as many of the individuals who constitute the sample as possible, the interviewer must devise an approach and proffer an explanation which
are attractive to potential respondents and at the same time accurately and honestly set out the aims and methods of the research. The additional biases introduced by interviewers' appearance and manner (sex, age, social class, dress, accent, tone of voice) are well-known and can be minimised to some extent (Mitchell (1970); Hyman et al (1954); Cicourel (1964) and (1967); Busfield and Paddon (1977) p.93; pp.99-100).

The sterile conditions of the laboratory can never be achieved by the social scientist, the quality of whose data will vary with every interview experience. The actual circumstances of the interview may differ on every occasion, according to a variety of external influences. These inputs, over which the social scientist has only limited control, are broadly covered by four headings: situation (including the "location" and "presentation", i.e. the manner in which interviewer and respondent present themselves to each other and to those around them); needs; aims; and rapport of interviewer and respondent.

These inputs overlap in varying degrees, and for some groups of respondents one input may dominate all others in its influence. In our experience, rapport between interviewers and abortion patients was often noticeably better than that between interviewers and young mothers. The abortion patients were sympathetic to the aims of the study and at the same time felt a greater need to discuss their feelings and experiences.

**Situation:**

Location: This may be on an abortion ward, a
maternity ward, in an anteroom to a ward, or in a clinic; the respondent may be wearing street clothes or disposable hospital gown, sitting or lying in bed, or sitting in a chair; the interview may be within sight or even earshot of other patients and visitors;

Physical condition of the respondent: At the time of the interview the girl may be feeling ill, in pain, depressed, tearful, relieved or even angry;

Interviewer's status: The reception and treatment by medical and lay staff, the title or description given to her will vary - she may be treated in a comradely manner, as an intruder or as a necessary evil;

Respondent's status: She may be treated as a recalcitrant to be punished by the "family planning lady", her differential treatment accorded on the basis of her age, marital status or colour.

Perceived Needs:

Interviewer's motives or "needs": As perceived by staff (as above) and influenced by the status of research in a teaching hospital;

Interviewer's motives or "needs": As perceived by respondent - she may feel she is being coerced into using contraception; believe her capability of caring for her baby is being assessed (particularly if she is young and single); or see the interviewer as yet another social worker;

Respondent's needs: An abortion patient may feel a need to talk over her experience while a young mother may be disinterested in, or even irritated by, attempts to discuss her experience, often having had a surfeit of attention in the preceding weeks.
Rapport:

Interviewer's perception of the respondent: Her appearance, age, ethnic origin and so on, may influence her attitude and initial approach;

Respondent's perception of the interviewer may be similarly varied; also, her own self-image (the interviewer's expectations of her, as she construes them) will influence her truthfulness and frankness.

Perceived Aims:

Interviewer's understanding of the aims of the interview as a social scientist will differ from

Respondent's understanding of the interview's aims, resulting in the replies she deems most appropriate (compared with her replies to the same questions when put by a doctor, nurse or social worker).

Recruiting in the hospitals

Choosing the most appropriate location and eliminating some anticipated sources of bias was most complex in the case of the abortion patients. Having "shadowed" several women through the system - from first interview at the hospital by a nurse counsellor and doctor, to admission on the ward and discharge after the operation - it was apparent that the only opportunity to spend about one and a half hours in relaxed conversation with the teenagers would be soon after the operation.

The waiting time at the first appointment in the hospital is a tense and stressful time for patients. It may be three or four hours before all formalities have been completed. It would have been unsympathetic and quite inappropriate to inflict any additional questioning at this time. In any case, the quality of the information
would have been poor: many girls make their request for an abortion with a well-rehearsed story. There might also have been the suspicion that the agreement to give the abortion might be related to one's performance at our interview.

Women requesting abortions, whether on the NHS or privately, are invariably quizzed about their past use of contraception, particularly the method used, if any, at the time of conception. The overtones of guilt attached to failure to use a method resulting in an unplanned and unwanted pregnancy are considerable, even before the abortion request is made. When this guilt is reinforced by those with the power to grant an abortion, the truthfulness of a woman's replies must often be suspect.

We hoped that by interviewing teenagers after they had had the abortion they would feel less need to fabricate replies to our questions about the use of contraception. Nevertheless, a girl's self-image must in some cases have necessitated her presenting herself as a user of contraception when, in fact, she has not been.

Not only could a history of contraceptive use be fabricated. One teenager we interviewed arrived at the hospital with her boyfriend deliberately dressed as shabbily as he could and with a prepared story of the dire consequences for them both if her (doctor) parents learned she was pregnant. Another teenager described herself as a "trainee housekeeper living at the YWCA" to both her GP and the hospital doctor. In our interview she told us she was living at home while working in the West End as a waitress.

Allen (1981), of her study of nearly 900 women and their contacts with the family planning, sterilisation and abortion services, has reported that "many of the
women having abortions described their encounters with doctors as "battles" in which they were trying to "convince" the doctors that they should be granted an abortion .... These women regarded the whole abortion-seeking procedure as an obstacle-race, which it very often resembled".

There were several different settings in which women requesting abortions might be seen at their first visit to the hospitals - in the antenatal or gynaecology out-patients clinics, or in an office on the ward where the majority of abortions were actually performed. The two completely different environments, clinic and ward, would also have biased the interviews if they had been held there and then.

At the time of the study there were four wards admitting abortion patients. Because of the different times of operating lists and different attitudes of doctors, women could have "early" abortions in the following ways:

As out-patients, under local anaesthesia, spending only a few hours in the hospital (only 2 of our teenagers had this type);

As day cases, admitted starved (of food and liquid from midnight) at about 8 a.m. and discharged in the late afternoon;

As overnight cases, many admitted as early as 10 a.m. the day before the operation and discharged in the late afternoon after the operation, or on the following morning (i.e. after 2 nights in hospital).

"Late" abortions were less predictable in duration. They could necessitate a stay of up to a week. Girls who experienced complications, or who were re-admitted with
complications, could have long stays in hospital (in our experience ranging from one or two nights to two weeks).

It was important that all interviews should take place at the same stage and after the operation seemed most appropriate for several reasons:

It was administratively convenient for us. We had time to locate all suitable girls and, since we were interviewing in two hospitals, a mile apart, ensure that we saw them all before their discharge;

We felt that some of the topics we wanted to cover might not easily be discussed before the operation, such as how girls felt about having an abortion and whether they had been at any time undecided, etc. We also hoped that having ostensibly got what they wanted, the girls would tell us their real feelings and experiences;

We wanted to be seen to be completely independent of the hospital staff and services.

Sometimes girls did not feel well after the operation. For some, the after-effects of anaesthesia, even of such a short duration as was used for these operations, had caused vomiting. When this happened, we usually left the girl and returned when she felt better. Often, however, girls preferred us to stay with them until they felt better.

By the time we began interviewing the abortion patients, we had already interviewed 113 girls (who had never been pregnant) in family planning clinics. It may be suggested that interviewing girls who had just, literally, woken up from an, admittedly minor, operation, will introduce biases into that group of interviews. However, we found the abortion patients even more eager to talk than the
girls in either of the other groups (except perhaps for the two young mothers who had had stillbirths) and they were undoubtedly more alert and interested in conversing with us than the majority of young mothers who were interviewed several days after the birth of their babies.*

Although most young women experiencing their first, normal, birth are detained for a week in hospital, this was not uniformly practised and sometimes we found that they were discharged 3 or 4 days after the baby's birth. This meant that we were unable to fix a particular day after the baby's birth on which to interview all young mothers, since some needed more than 3 days in which to recuperate from the birth (for example, the teenagers who had had Caesarian sections were detained for 10 days). Interviews took place wherever it was convenient for the mothers. If they were up and about and shared a ward with other mothers, it was usual to find a quiet corner away from the ward where there were fewer distractions. However, in most cases the interviews took place by the young mother's bed.

The distractions during interviews with the teenage mothers were far more than those we had experienced while interviewing the abortion patients. Babies cried, needed bathing, feeding or changing and there was an endless stream of visitors - physiotherapists, nurses, doctors, priests to bless the babies, trolley-ladies selling magazines and various odds and ends - and there was open visiting for fathers of the babies. A few of the girls were depressed, some were in considerable pain (after

* Black (1979(ii)) reported a different "feel" about interviews with abortion patients. "There was more evidence of disturbed family psychodynamics in those girls choosing termination. In general, they appeared more intelligent, outgoing and to have greater personal ambition for the future. It is unclear whether the disturbed family background should be seen as etiological, or influencing the outcome decision only".
Caesarian sections) but generally they were well and happy and anxious to go home. Seven days seemed a long time and the last few days they found boring. They became restless and sometimes ill-tempered with the nursing staff and those around them. Most young women shared rooms with three other mothers, giving them little privacy or quiet. This they found particularly difficult to adjust to, especially during the night. Some found the nights unexpectedly noisy, the night shift of nurses moving about as though it were daytime, chattering and busy, combining with the crying of babies to give them sleepless nights. We had to time our interviews quite carefully, avoiding early morning bathing of babies (and mothers), meal times and general visiting times, as well as the "quiet time" in the afternoon when all the mothers were expected to take a nap. However, once we were aware of the different routines of the wards, finding one or two hours usually in the late morning or early evening was not difficult. Once the nursing staff became used to us, our presence was accepted, even welcomed, and the mothers were usually left undisturbed while we were with them.

**Recruiting in the family planning clinics:**

Every clinic in the district was visited once every three weeks according to a planned timetable (prepared on the basis of the time of a clinic and its location), until the required number of young women who had never been pregnant had been recruited. This enabled us to visit those clinics which had only one session a week at least three times, while the bigger centres which ran several clinics a week (such as the hospitals, Brockwell, Lister and Loughborough) were visited numerous times during the two months approximately in which recruitment took place.
Appropriate permissions to interview in the clinics were obtained in advance and letters sent to the clinic secretaries at least a week before we first visited each clinic. Even so, letters were said to have been mislaid and on several occasions our presence was challenged.* Nevertheless, such incidents were isolated and our success at interviewing all teenagers who had never been pregnant who attended the clinics was almost complete, except for the rare occasions on which there were simply too many suitable girls to interview.**

Although the clinic interviews were considerably shorter than the interviews with the pregnant teenagers (since they excluded the substantial sections on the experience of being pregnant and having an abortion or having a baby), it was, nevertheless, found in the pilot of the study that young women were being seen so quickly by the doctors in the community clinics that we were delaying girls for quite some time afterwards to complete our interviews. To remedy this, we drew out a section of the interview and made it self-administered. This section, on contraceptive knowledge, was given after an explanation of the study to suitable girls to fill in while they were waiting to see the doctor. If possible, we then continued with the remainder of the interview beforehand, but in many cases the main interview took place after the girls

* These public challenges did not help our image if there were suitable young women already waiting at the clinic reception and we later approached them asking if they would agree to be interviewed. On one occasion, in a hospital clinic, a nurse who was new to that particular session demanded to know exactly what our interviewer (a familiar figure to all other staff in the clinic) thought she was doing there without permission and why she had not been informed.

** A problem peculiar to recruiting in the clinics was the refusal, without explanation, of some girls who did not know when we first approached them whether or not they were pregnant. Once aware of this problem, we would ask reluctant girls if this might be the case. However, about six girls who had agreed without hesitation to take part, returned after completion of the interviews to say that in fact they were pregnant.
had finished with clinic formalities. One of the advantages of interviewing young, usually single, women is that their time is fairly flexible and the majority were quite happy about staying longer and were interested in answering our questions.* Interviewing in the clinics was more difficult for the interviewers than interviewing on the wards because of the limitations on the time one could spend with a girl and the instant rapport which had to be established.

In a study such as ours, it is impossible to return to participants to verify their interviews at a later date. However, on several occasions girls were interviewed twice and it was then possible to compare the interviews; at other times sisters were interviewed and the information concerning their parents and families was then cross-checked to see how the two interviews differed. Some girls were interviewed in the pilot of the study and then appeared again in the main study. (One was a West Indian clinic attender and another a young Turkish abortion patient.) In fact, by minimising the number of interviewers and discussing all interviews, we were able to make links between families (through sisters), partners and friends and between the three groups.

Conduct of the interview:

The conduct of the interview itself posed a considerable challenge in the collection of our survey data. The first two segments administered by the

* On one occasion a young woman doctor refused to allow us to interview a 13 year old girl who had already agreed to take part in the study. (She would have been our youngest family planning clinic attender.) There was very little we could do in that particular instance, but in others where clinic staff had anticipated our approaches to young women with comments such as "there's someone here who's doing some interviews, but you don't have to agree if you don't want to", we nevertheless managed to recruit these girls ourselves by giving a more appropriate and attractive explanation of our purpose.
interviewer (ascertaining demographic details and sex education and knowledge) consisted in the main of short questions with pre-coded answers. However, there were also included, particularly in the latter segment, a number of open-ended questions. The inclusion of these questions had several aims: to assure the teenager that she would genuinely be contributing her ideas to our study; that her role was as important as that of the interviewer - that they were in fact equals; that she was not going to be bored for the next hour or so responding to dull impersonal questions; and also to create an alliance between interviewer and teenager through laughter and the discussion of intimate information by two young women (interviewers having memorized most of the questions to give the impression of spontaneity).

The third segment of the interview involved drawing a family tree. This innovation provided not only a great deal of data, but broke the formal pattern of questioning.

The fourth segment, the girl's sexual and reproductive history, was recorded in the form of a chart, divided into months and years, recording age at commencement of menstruation, previous and present pregnancies (if any) and their outcome, sexual partners and methods (if any) of contraception used.

The girls were shown the blank chart and were involved in its proper completion. In most cases, prompting was needed to pinpoint the exact month of a particular event (for example, onset of menstruation or first sexual experience), perhaps relating them to school term, time or season of the year (e.g. Summer, Christmas or birthday). Many girls enjoyed the opportunity to put these events in the past into perspective. The everyday nature of the promptings and the relationships used, the matter-of-fact questioning and the variety of questions asked ("how long were you going with Jim?", "where did you get the pessaries?") made the most personal questions less intimidating.
Emphasis on when, rather than whether also helped minimise any reluctance to talk, or any desire to fabricate.

The next segments, recording the experience of having an abortion or a baby, were only loosely structured. First reactions to the knowledge of the pregnancy of the girl, her mother, her partner and others were all recorded verbatim; her approaches to various sources for help, whether clinic, GP or hospital directly, were all recorded as she described them, together with her own interpretation of the attitudes of these sources and her treatment; and the actual experiences of abortion or childbirth.

The final segment of the interview dealt with attitudes, incorporating the type of light-hearted questions about men and relationships familiar to all readers of women's magazines. Its only drawback was that, unlike the magazines, on its completion we failed to offer our teenagers any solutions in the form of our interpretation of their character, their personality or their possibility of success in the future. Nevertheless, the majority of the girls found the interview both enjoyable and useful - many of them, on its completion, taking the opportunity to ask questions and seek advice about problems they had been either too ashamed or shy to discuss with others.

A major hurdle was winning over the minority of girls who were "not interested" in taking part in the study and at the same time managing to remain cheerful when confronted with young women who had no opinions to express on whole sections of the interview - who simply "didn't know" or "hadn't ever thought about", "weren't interested" or "weren't bothered" with questions on subjects which had never affected them personally. "I can't say, I've never used that" (about a method of contraception), "I
wouldn't know, it's not something I've thought about" were not unusual replies. We had interviewed over half of the whole sample of 550 by the time we began interviewing the mothers and had not come across more than isolated instances where opinions were so sparse. It was with this group that we encountered most difficulties.

In some interviews, to overcome barriers that became immediately apparent, we changed the order of the interview questions. This is a practice which is normally to be discouraged (Richardson, Dohrenwend and Klein (1965) p.43), but in the circumstances, it was preferable to the prospect of receiving an even higher proportion of refusals. When faced with particular reluctance, we avoided those questions about contraception which seemed to antagonise some young women until the mood of the interview had improved. In some cases, it was impossible to win girls over and in the young mothers' group we had the highest proportion of refusals.

As with the abortion patients, if one interviewer was unsuccessful with a particular young mother, another tried to talk to her later and frequently this proved successful.

Moodiness and depression, discomfort or pain may have been reasons for initial refusal. One 16 year old English mother was so depressed for the entire period of her stay in hospital that it was impossible to interview her at all. She wept continually, appeared to be in pain and lay curled up in her bed with her back to the baby in its cot. After spending over an hour with her, the interview questionnaire completely forgotten, trying to console her, it became evident that she was so severely depressed that it was beyond the ability of an inexperienced person to help her. Eventually
a social worker was called and she, in turn, asked for a psychiatric assessment to be made. The social worker contacted the community social workers and asked them to take over the girl's case when she was discharged. Our unhappy mother's own mother had disowned her when she became pregnant and she had gone to live with her West Indian boyfriend and his father and other brothers. She had been living in this all-male household for several months and expected to return there from the hospital. Although her mother was told of the baby's birth, she did not visit her daughter or the baby. This teenager's experience was a particularly sad one; fortunately it was the only case of severe depression immediately after the childbirth we encountered.

The interviewer's own mood could also increase the likelihood of her request being rejected by a potential subject, since approaching prospective respondents with even a slightly negative attitude could easily provoke a negative response. One of our interviewers had the shattering experience of having the first four young mothers she approached refusing point blank to take part in the study. Obviously it is necessary to strike a balance between informing and enthusing prospective respondents - informing them of the object of the study and their free choice to participate or not as they wish, but at the same time making the experience sound enticing.

Throughout the survey, emphasis has been placed on verbal communication. Discussion of each girl's relationships with a number of people (such as her partner and her mother) and each girl's experience with various professionals (such as her own doctor, the abortion counsellor and the hospital doctor) largely focused on her ability and/or desire to discuss with and communicate her feelings and problems to others. In fact, in multi-cultural societies such as ours, the importance of non-verbal communication has been surprisingly under-rated. Progressive medical educationists teach doctors how to elicit information, as
well as project sympathy verbally. Those professionals who communicate extra- or non-verbally appear to do so out of an instinctive awareness of the needs of their patients rather than as a result of their training. The possibility of the importance of non-verbal communication in a study concerned with a substantial culturally differentiated group is evident.

Bernstein's theory of elaborated and restricted codes (1965) suggests an analytical tool which takes into consideration social class as well as cultural differences in the ability to communicate verbally.

"As a child learns an elaborated code", Bernstein has explained, "he learns to scan a particular syntax, to receive and transmit a particular pattern of meaning, to develop particular verbal planning process, and very early learns to orient towards the verbal channel ... A child limited to a restricted code will tend to develop essentially through the regulation inherent in the code. For such a child, speech does not become the object of special perceptual activity, neither does a theoretical attitude develop towards the structural possibilities of sentence organization and there is little motivation or orientation towards increasing vocabulary."

Where there is a limited and perhaps rigid use of adjectives and adverbs, the verbal elaboration or intent is reduced and this then is given meaning through extra-verbal means. With the restricted code, Bernstein says "speech is not perceived as a major means of presenting to the other (person) inner states". He has argued that "children socialized within the middle class and associated strata can be expected to possess both an elaborated and a restricted code, whilst children socialized within some sections of the working class strata, particularly the lower working class, can be expected to be limited to a restricted code."
If a child is to succeed as he progresses through school it becomes critical for him to possess, or at least to be oriented towards, an elaborated code."

This study did not set out to test Bernstein's theory, indeed it did not provide material suitable for interpretation by this means. Nevertheless, our interviewing experiences seemed to lend support to his theory, although modifications would be required before applying it to ethnically differentiated groups and populations such as our West Indies born teenagers and the UK born daughters of West Indian parents.

Interviewers were recruited who appeared to be able to empathize (non-verbally) with our teenage respondents and every girl's behaviour and appearance were recorded as fully as possible. As a result of our interviewing experiences, our statistical findings were felt to give only a sketchy representation of "reality".

An awareness of the importance of non-verbal communication is essential when interpreting findings such as that UK Black girls are less likely to discuss their problems, even with their mothers, than are UK White girls. Our black teenagers generally told fewer people about their pregnancy than did their indigenous counterparts, although they did visit their GPs on average more times before being referred to the hospital for abortions. Unfortunately, however, these were not visits during which the girls' problems were discussed in depth with their doctors. On the contrary, it appears that it took them more visits simply to put across their feelings and to have their requests for referral granted.
Interpreting Social Survey Data

The social scientist, aware of her respondent's differing understanding and experience may need to take account of a number of factors in order to ensure that the data as classified accurately reflects its meaning. In interpreting social survey data, there are four main areas influencing results which require consideration when the significance of findings is discussed: the origin of the data (from the questionnaire itself or from observations of events outside the interview); the context of meaning of data; the classification of data (and validity of definitions used); and its aggregation.

A respondent gives the reply she believes is appropriate in a particular context. Any number of replies will be equally true. We asked all those teenagers who had at some time taken the contraceptive pill why they had stopped, a question also asked by nurse counsellors and doctors and usually recorded in a patient's hospital notes. A range of different responses will be elicited from women, depending on whether they are interviewed in hospitals or family planning clinics, by doctors, nurses or layworkers. We found that doubts (spread by the media) about the safety of the pill were a reason frequently given by patients to clinic or hospital staff to explain their failure to use contraception prior to becoming pregnant. But although this reason was noted by doctors or nurses in patients' records, it was never given by respondents as a reason for discontinuing use of the pill to our interviewers.

One of our abortion patients, a young UK Black woman who had been having the injectable contraceptive, told the doctor that she had not returned for the last injection because she had seen a programme criticising it on TV. In fact, in reply to the question why she wasn't using contraception she had told us a much longer story beginning with her flat being burgled a month before the injection was due, her fears about staying there alone and the difficulties she had had in arranging for the windows'
and locks to be repaired. Her boyfriend was being rather elusive and less dependable than she had hoped during this time. With all this on her mind, she said, everything had been too much for her and she simply never got round to visiting the clinic for the injection. She was also having some difficulty coping with her very lively young son as we witnessed ourselves. We had first noticed this young woman and her son while interviewing other girls in a family planning clinic. She had come for a pregnancy test and her impatience with the little boy had attracted everyone's attention.

**Difficulties with classification**

Classifying data provided us with our most serious problems.

**Rape**: Defining rape was particularly difficult. Our teenagers' experiences ranged from brutal and violent attacks by strangers to situations between couples which had gone beyond the girl's control. Only one abortion patient we classified as raped in her most recent relationship. Several girls were recorded in their hospital notes as having been raped, but they did not describe their experience to us in these terms.

One 15 year old English abortion patient refused to speak to the interviewer who went to see her. Not only would she not speak, she would not look at or acknowledge the interviewer in any way. A different interviewer approached her again later to see if she would agree, but she still remained silent. We, and the nurses on the ward, were convinced that we were being deliberately misled by the girl and her mother. Was she really so distraught after the rape that she could not look at or speak to anyone? The hospital notes recorded that she had been abducted for five days and raped. This was the girl's story to
her mother and the story her mother subsequently told the hospital doctor. In one lapse, the girl said to a nurse that her mother had told her not to say a word to anyone while she was in hospital. Her mother also ensured that her daughter left the hospital with an IUCD. A too strong reaction to the rape of one's 15 year old daughter - or just practical? We did not know.

In some cases where girls described their experiences as rape, we were able to classify it more satisfactorily after having viewed the experiences in their wider perspective. Nevertheless, we were sometimes confronted with problems in differentiating between situations. A 16 year old English abortion patient told us how she went to the off-licence in a black friend's car, "but we didn't go there ...". This girl was, however, another unusual case. She also did not regard her abortion (foetus 22 weeks) as an abortion - that was something that only other (bad) girls had.

In an inner city area such as ours, rape is almost commonplace, so that an observer hearing of girls' experiences gradually becomes immune to the shock of hearing their stories. One of our interviewers had herself been the victim of an attack on a local council estate some time before the study; a nurse was raped on a street by the hospital during the period of the study; and it was not unusual for our teenagers to refer to sisters or friends who had been viciously raped in the past. The most distressing story we recorded was that of a 15 year old abortion patient (see pp. 204-6).

Relationships with partners: Not only did the reliability of our classification of rape experiences cause us concern, the reliability of classifications of girls' relationships with their partners generally also troubled us.
Most definitions of the type of relationship a young couple has are based on duration of the relationship. The British Pregnancy Advisory Service (in its report Schoolgirl Pregnancies (1978) p.9) uses length of time to define three main types of relationship:

Casual relationships - lasting 1-2 days (where "intercourse is isolated and/or impulsive");

Temporary relationships - lasting no longer than 3 months;

Steady relationships - lasting at least 3 months.

In their questionnaire to head teachers for their report about pregnant schoolgirls, the Joint Working Party on Pregnant Schoolgirls and Schoolgirl Mothers (Pregnant at School (1979) p.66) asked teachers: "To the best of your knowledge, was the relationship - casual (or) steady?" On the basis of the teachers' replies, it was claimed that "most conceptions occur within a steady relationship". Nevertheless, the teachers must have used many different criteria in making their judgements.

Farrell (1978) used a different definition. "Although teenage sexual activity was not investigated in detail, there was little evidence of promiscuity. The majority of young people currently involved in a sexual relationship were having sex with someone they had been going out with for more than six months" (p.219).

In our experience the length of time a couple had known each other (or even the length of time they had been "going out together") was not a reliable indicator of the nature of their relationship. There were several reasons for this.
For most young people, particularly those still at school, their circle of friends or acquaintances has relatively fixed and long established boundaries: the family and relatives; the street or council estate; the school; the social club and church. Although mobile within the district, the majority of our teenagers had lived in their present area of residence for 3 or more years. Because of this, the majority of girls will probably have known their partners for some time at school or in the neighbourhood (for example, "his mother's stall is next to my mother's in the market"). Once girls leave school and take jobs outside the district, their opportunities to make frequent new social contacts increase.

Young teenagers, we found, were more likely to go about in groups than in couples. For many girls, group membership makes sexual activity less likely, even though a particular boy in the group may be regarded as a "sort of boyfriend".

In fact, when a girl does have intercourse and becomes pregnant in these circumstances, it can be a very unhappy experience. The immature "boyfriend" may, in fright, brazen it out by denying paternity and spreading the scandal, leaving the girl, with the help of her closest girlfriend, to laugh it off, to say she was only joking and to deny everything. How is such a relationship to be described? If it had not been ended by the shock of pregnancy, it may have gradually matured into a more caring partnership.

There would appear to be differences in behaviour according to age group. It seems likely that, as girls mature and become more experienced in handling social situations and surer of their judgement of the types of men they like, the shorter the preliminaries leading to a serious (and sexual)
relationship become. The fact that a girl says of a boy "I've known him all my life, he lives next door" says very little about the intensity of their relationship.

Essentially, what the majority of similar studies have done, and we have to some extent followed, has been simply to distinguish "casual/promiscuous" from all other relationship types. By using a calendar chart to build up a history of relationships, reproductive events and sexual behaviour, we were able to ask as many questions as were necessary to learn what we wanted to know. We were concerned to learn how old our respondents had been when they first had intercourse and how old their partners were, what contraception they might have used and where they obtained it, how long their sexual relationships had lasted, what other methods they had used later, and about any pregnancies which may have occurred and their outcome.

Completing the calendar chart was not always an easy exercise. If a girl could not remember her first partner's age, or only with difficulty, if she had not seen much of him, or exclaimed that "he wasn't a steady boyfriend!", or said that it was at a party and she didn't see him again, or if he was followed in quick succession by a number of sexual partners, we would probably describe the relationship as "casual". Comments like: "I hardly knew him", or "it was really a one night stand" were easy to interpret. Not so easy to interpret were the responses of adventurous and curious girls, intoxicated with the excitement of growing up and exploring the adult world. An abortion patient, a doctor's daughter, said of her first lover: "He was very handsome and rode a motorbike; he was much older than me and I was so crazy about him, I decided that I would have to find out what it was like with him". She idolised him, or what he stood for, and built a fantasy world around him, not unlike the groupies who were infatuated by older boys and frequently exploited by them.
Girls having abortions were more likely to have just ended a relationship than were our other teenagers. Eighty-three percent of the mothers had seen their partners in the week before the interview compared with 71% of the abortion patients. For some of the abortion patients, becoming pregnant had sealed the fate of their relationship. The decision to separate, however, was as likely to have been made by the girl as it was by her partner.

A young English girl, humiliated at the discovery that news of her pregnancy had become common knowledge in her circle, decided (once the abortion had been arranged) to tell everyone that it was just a joke. She asked her girlfriend to tell the boy that she wasn't pregnant at all. "As soon as I knew I was pregnant", she said, "I didn't want to know him." They had been going about in the same crowd for some time.

Nurses on the ward couldn't resist giggling when they read the notes of an English girl who had come home pregnant after a holiday in Spain. She was a serious girl with a steady boyfriend here. She had gone to stay in Spain with the family of a boy she had known and corresponded with for four years. He had even previously visited her family here. "I didn't expect to sleep with him at the time, but ...".

An English clinic attender (who had never been pregnant) had a steady boyfriend but said she still occasionally slept with her former boyfriend. In fact, it was not at all uncommon, as we found when recording sexual behaviour, for two serious relationships to overlap for some time.

None of these relationships could be regarded as strictly casual or promiscuous and they were, therefore, not coded as such but instead included under the broad category of "steady". However, they could not satisfactorily be described as the type of exclusive steady relationship
which is the popular view of what "steady" means. Some of these relationships could more accurately be described as "affairs" (or "love affairs"), since they were emotional experiences although of limited duration. There is also appropriately a hint of the illicit in the description of a relationship as an "affair". It was impossible to categorize relationships as specifically as this, but quite evidently, the present groupings into either "steady" or "casual/promiscuous" relationships are inadequate.

The loose-knit patterns of teenage social behaviour which characterised most of our indigenous girls' relationships were harder to discern in the behaviour we observed among West Indian teenagers. Exclusivity in a relationship, at least for the West Indian man, did not seem to be valued. An articulate West Indian girl attending a family planning clinic talked about the significance of bearing a man's first child in the way an indigenous teenager might talk about remaining a virgin until she met "Mr. Right".

Relationships between West Indian young mothers and their partners are described in the section dealing with young mothers. West Indian teenagers in the abortion group described partners' reactions which bore many similarities to those of the West Indian mothers. Initially delighted to hear of the pregnancy, many partners would become hurt and angry when the girls raised the possibility of having an abortion. Nevertheless, they often openly saw other girlfriends and many had children by other women. One West Indian partner already had three children by other girlfriends, but "he was pleased - he could have jumped over the moon". In fact, he called our respondent a murderer when she said she was having an abortion. "Now I've ditched him!"

A 19 year old West Indian abortion patient had already had her boyfriend's baby and had been going with him for three years. She saw him once a week, but he had another, younger, baby with another girlfriend. When she told her
boyfriend she was pregnant "he didn't say nothing. He never does. He said I must do what I think's best ... We don't get on very well. He's got a lot of girlfriends."

One of our young West Indian mothers was first seen when she was admitted for an abortion, but she changed her mind just before the operation. A few weeks earlier, another girl had given birth to her boyfriend's child and she thought that the other mother and her baby would receive all his attention. In spite of her apprehension, when she was interviewed several months later as a young mother herself, she was still seeing her boyfriend regularly and seemed very happy and optimistic for the future.

A West Indian abortion patient who had two men to contend with (the father of her first baby and a new boyfriend, the father of this pregnancy) decided that she had had enough of them both - "that's it, I said, no more men!" The more recent boyfriend intended to marry someone else, the mother of his 2 year old child, although he still wanted our girl to continue with the pregnancy.

A 14 year old West Indian girl was banned by her parents from seeing her boyfriend. He had "made funny remarks - that he would cut me up" (if she had an abortion). Another West Indian boyfriend burned his girlfriend's nightdress in an attempt to prevent her admission to hospital for an abortion.

"Planning" a pregnancy: A concept which brought with it similar difficulties when it came to classifying our data was that of the planned or unplanned pregnancy. This subject is discussed in detail in the section dealing with young mothers.

Religious affiliation: Another problematical area was that concerning religious affiliation. Although patient's religion (if any) is recorded in all hospital notes, little or no apparent use is made of this information,
at least for the majority who are Christians, except perhaps for funeral purposes. The dietary requirements of immigrants of different religions may be an important use of this information in some other areas.

We found that West Indian women, if professing a religious belief more specific than "Christian", were most frequently Pentecostalists or members of one of the Protestant non-conformist sects which flourish in West Indian communities.

In the cards kept on the wards for all patients, on numerous occasions we noticed a young West Indian woman's religion recorded as "Rasta" or "Rastafarian", although it was very rare to have the same girl describe herself to us during the interview as a Rastafarian. She was more likely to say she had no religion or was simply a "Christian". Reasons for this difference may be that since a high proportion of the hospitals' nursing staff is West Indian, they have interpreted the girls' religion as Rastafarian, or that West Indian girls talking to other West Indians are more likely to describe themselves as Rastafarians. Since it is sometimes more aptly described as a political movement than a religion, they may feel it an inappropriate reply to give when questioned about religion by a white interviewer.

The reasons for asking about religion in fertility studies are very different from the reasons for which hospital officials record this information. Strength of religious conviction (and indeed, the particular religion practised) is believed to inhibit premarital sexual activity as well as the use of contraception, but it is doubtful if this would apply to more than a minority of people today and it usually occurs only where strong cultural traditions in a particular society reinforce these attitudes. Occasionally a Muslim girl would say she did not use contraception as it was against her religion. In fact, Islam's Koran does not prohibit the use of contraception, although some sects may use their own
interpretations of "hadiths" written later than the Koran to support their conservative traditions. If the same Muslim girl were asked if she practised her religion, she would find the question ridiculous, for she observes all the traditions and her personal beliefs are irrelevant. Irish Roman Catholic girls brought up and educated in the Republic or Northern Ireland may react similarly; after all, they dutifully attend mass and observe the religious festivals. But what of English Roman Catholic girls, educated at our state schools?

It is evident that samples the size of ours which include girls from various religions and cultures, when asking about religious affiliation, may confuse what is certainly a jumble of religious beliefs and practices. The questions only have value if viewed within sub-groups which have a similar understanding of the question, as, for instance, the Irish teenagers. The number of girls born in Northern Ireland or the Republic of Ireland was very small, too few to combine into a separate group (5 in the total, 2 in each of the pregnant groups and 1 clinic attender - 1% of each group). None of these Irish girls and none of the Muslim girls in the sample said that they did not have a religion.

Where religious affiliation is correlated with a distinctive culture (or nationality), it may be a significant factor in investigations of differential fertility. Compton (1982) commented in his discussion of fertility differentials which exist between the Protestant and Catholic populations in Northern Ireland that in most developed societies today "there is evidence that such differentials have narrowed as the strength of religious beliefs has waned and as cultural and social-economic differences between nationalities have become more blurred" (p.193).
Perhaps our most interesting finding concerning religion was the high proportion of the clinic group (30%) who were Roman Catholics, compared with the abortion patients (19%) and the young mothers (22%). A Catholic abortion patient was clearly very distressed after the operation. The guilt and anxiety she had felt about her sexual relationship and the shock of finding herself pregnant made any idea of a similar relationship in the near future completely repellent. She had told no-one about her pregnancy, including her now former boyfriend. Although she had insisted that she did not want or need any form of contraception when she was discharged from the ward, the sister, herself a Catholic, insisted loudly that she accept the pill before leaving. This fuss and insensitivity added to the girl's distress and also to her stubbornness. We left the ward together to find a quiet place for the interview. Later, in a more relaxed frame of mind, she went to the hospital pharmacy for the pills, having decided that by accepting them she was not committed to taking them, or to acting in a manner which she believed to be wrong.

Illiteracy: The number of illiterate girls we stumbled upon was disconcerting - stumbled upon because our use of the standard sociological variable, length of full time education, neatly camouflaged this serious disability. The difficulties surrounding apparently straightforward numerical data, such as the differing values of an additional year of education at age 16, compared with a year at age 18 (Busfield and Paddon (1977) p.102) were less important for us than the realization that some of our teenagers were unable to read or write after even 8 years at school.

Particularly memorable were the young mothers who had left school at very young ages or who had never attended school at all. Early in interviewing on the maternity wards, it was found virtually impossible to coerce or cajole many of the mothers into themselves completing the section of the questionnaire on sex education and knowledge. As a result, the section was included in the main interviewer-administered questionnaire. This problem did not arise with either the abortion patients
or the clinic attenders. It may be that some young mothers in the excitement and confusion of the first few days of motherhood found it difficult to concentrate; but equally valid reasons could be that the content (sex education and knowledge) was a deterrent to a certain type of young mother, or that the girls could not read or write well enough to answer the questions. An intelligent Pakistani mother who was interviewed through an interpreter had never been to school; three UK White girls talked quite openly about their illiteracy — one of these girls was sitting in bed colouring-in a child's colouring book with an array of different coloured felt-tip pens when we arrived to interview her. One of 18 children and living with an unmarried woman friend who had two children, she explained that she had lost confidence at school because she was always being teased. Illiteracy took many forms, but it was not always a source of shame, to be kept secret.

**Educationally subnormal girls:** It was even difficult to recognize girls who might have been ESN. A young mother who was described as ESN by the nursing staff seemed sensible and was easy to talk to. The interviewer noted: "I'm inclined to think she could read — she had magazines and volunteered the information that she had read all the pamphlets she had been given about pregnancy. It is possible that as she could not write, people assumed that she could not read either. She said she was taken out of school when she was 8 because she was behind the others. "They" said she had a hearing problem and she was sent to a special school. She spoke as if she had a hearing defect but didn't appear to be wearing a hearing aid."

"Schoolgirl" pregnancies: The most controversial teenage pregnancies are those of "schoolgirls" (girls aged 15 or under). The usual view taken is a negative one:
"everyone agrees that pregnancy in schoolgirls is totally undesirable" (Hemming (1979)); and "pregnancy in schoolgirls is in general so stressful and so full of risks to both mother and child that society has a responsibility to ensure that wherever possible, it should be avoided" (Pregnant at School (1979) Preface).

The description "schoolgirl" may be somewhat misleading. Several girls under 16 in our sample described themselves as "unemployed" (although we described them as "under 16 but not at school"); others were chronic truants. Over 20% of all the pregnant girls had already left school at 15 years or under, as had 17% of the clinic attenders. The implication that their education has been disrupted by the pregnancy is not always valid. For many girls the order of events is reversed - truanting and lack of interest in school followed later by pregnancy. Two young mothers were proud that their parents had paid fines imposed on them for not sending their daughters to school. One of these girls was already working when she was 15.

Sex education: Sex education also provided us with difficulties in classification. Over a quarter (28%) of the young mothers said that they had not had any sex education lessons at school, compared with only 6% of the abortion patients and 11% of the clinic attenders. Only 16% of the young mothers who had had some sort of sex education had it before they turned 12 years old, compared with over a quarter of each of the other groups (27% and 18% of the abortion patients and clinic attenders respectively).

In fact, a number of girls apparently did not understand what was meant by sex education or at least did not think that the information they had been given could be classified as sex education. This was not surprising, for when we asked what these lessons were called, an
enormous variety of descriptions emerged - in cookery classes, health and hygiene, social studies and so on. A great deal appeared to depend on the individual skills and interests of teachers. Farrell (1978) also reported difficulties in defining sex education.

In the pre-pilot research, a 15 year old West Indian girl told how she had learned most from her (male) English literature teacher. When the class had read Margaret Drabble's novel "The Millstone" (about a young woman who has an illegitimate child after first considering an abortion) he told the class about his mother-in-law's experience during the Second World War in trying to arrange an abortion. This teacher obviously had a particularly good rapport with his students and through literature raised and discussed many different social and personal issues. The 15 year old, who had an abortion, had gone first to him when she found she was pregnant.

It is possible that a number of those girls who denied having had any sex education, had received some but had not recognized it as such.

Qualitative and quantitative variability of data

All the difficulties described so far relate either to context or definition or a combination of the two, while some conventional data we know from our informal observations concealed important facts (such as the illiterate girls who had nevertheless spent up to 8 years in education).

Respondents' selective recall: Another type of inadequacy revealed in the methodology was the scarcity of data recorded on subjects which we would anticipate to be part of basic family lore.

There are several possible explanations for the difficulties we encountered in collecting information
about girls' families and partners. Although girls, when replying that they "didn't know", certainly appeared genuinely not to know or at least not to remember the answers to our questions, there may have been some girls for whom this was a defence against what they regarded as an invasion of their privacy. However, this explanation is not so acceptable when we note that the same girls were quite willing to answer personal questions about their own lives.

Another explanation is that there is a section of our sample for whom this knowledge is irrelevant and either for whom other aspects of family life are more important, or for whom family life has been non-existent or fragmentary (for example, those girls whose childhood has been spent in and out of care). However, we did not have a large enough number of girls from such disadvantaged backgrounds to account for the unexpectedly high proportion of "don't knows" we found ourselves recording.

This would, in fact, appear to be one of those areas where cultural differences have been concealed behind a screen of apparent ignorance. The construction of family trees and our interest in parents' backgrounds give to some extent an ethnocentric view of the family, with its excessive emphasis on biological ties. Had it been possible to extend the time and scope of our interviews we would also have recorded details of girls' social networks in order to learn more about their ties with other significant people who were not necessarily members of their nuclear families.

Legitimacy: Girls were not asked directly whether or not they were legitimate. This information was deduced, as far as was possible, from the family trees. The high proportion of "don't knows", especially amongst the abortion patients (18%) is accounted for by the number
of girls (mostly West Indians) who were first or second born who did not know if their parents were married when the eldest child was born or, indeed, when they were married, although they may have been married at the time of our interview; or because of situations where a girl's mother had a first child illegitimately to an unknown father and later, her present family to the girl's father. Our preoccupation with marriage seemed to some West Indian girls to be "nit-picking", occasionally drawing an irritated "oh, I don't know!". The complexities of their parents' relationships and the offspring they produced seemed irrelevant to their own lives.

Our legitimacy figures should be treated cautiously for two main reasons: Firstly, because of cultural differences. The implications of illegitimacy are different in a culture where marriage may involve the commitment of the husband economically to support his wife and family. For some West Indian groups, marriage, although not child-bearing, may well be delayed for many years, until the man is established in his work. A quarter of the West Indian mothers were illegitimate, as were two of the three mothers of mixed race, while only 7% of the UK White mothers were. (The West Indian girls also had the highest proportions for whom "dont know" had to be recorded). Only 5% of the UK White abortion patients were recorded as illegitimate (with 15% "dont knows") compared with over a third (36%) of the Jamaican girls (29% were "dont knows") and 15% of the UK Black girls (with 15% "dont knows"). Of the small group of girls of mixed race, almost a third (31%) were illegitimate and over half (54%) were "dont knows".

Of the entire clinic group, only four girls (4%) were illegitimate - one of these was UK Black and one of mixed race and there were only two "dont knows" among clinic attenders.
The second reason for treating the illegitimacy figures with care is that, particularly where our indigenous girls are concerned, our data may be inaccurate.

In the maternity wards at both hospitals, the staff called all mothers "Mrs." even when they knew a mother was unmarried (although the very young mothers were more likely to be addressed by their first names). This was not altogether a one-sided attempt to present an image of traditional morality, for many of the young single white girls interviewed were wearing ostentatious engagement and wedding rings. "People stare at you in the bus if you've got a baby - they look to see if you're wearing a ring", was a typical, perhaps feeble, excuse for their attempt to conform, to avoid the discomfort and censure many teenagers still feel at being single mothers.

At the time of coding the interviews with the young mothers, marital status was found unexpectedly to have caused considerable confusion. The married teenagers had been asked if they had conceived before they were married, and if they would have married then, or even at all, if they had not become pregnant. Whether or not we asked this question depended on the stage at which we learned that a single girl was only pretending to be married; or whether we had not become confused ourselves about the girl's marital status when, although admitting to being single, she consistently called her partner her husband; or whether she called herself a common law wife and her partner her husband. In almost all of these cases of confusion, the girls were white.

Black girls were much more likely to be frank about being single - indeed, they did not seem to be at all concerned for themselves. Occasionally, when talking about their mothers they might say how upset she was because the neighbours would talk about her daughters "having kids and not being married". 
Communication between the generations: The differences in attitudes of black and white girls towards illegitimacy may mean therefore that the data on marital status of respondents' mothers at the birth of their first child, on legitimacy and on the marital status of the young mothers themselves may not be as reliable for white as for black girls. Data collected on the girls' mothers originally promised to be very rewarding. It seemed that in spite of its being second-hand in nature, our teenagers were an ideal source of information about their mothers, knowledgeable, unbiased (at least as far as our factual questions were concerned), reliable informants because we posed no threat. They were open, frank, even talkative; they read us their boyfriends' letters, told us their secret fears, of their fathers or brothers in prison, the family fights and other problems. However, the amount of data we were able to collect concerning mothers depended on a number of factors, among them the girl's age, cultural background and whether or not she had been pregnant before.

The relationship between a mother and daughter changes when the daughter becomes a mother herself. A young Turkish Cypriot (Muslim) mother described the sharp transition she experienced. Her mother and older sisters had many secrets from the young girls - they often whispered or sent the young ones away when they were talking. They never spoke to the younger girls about periods, intercourse, pregnancy or childbirth - until they too were married. (These Muslim girls would have been virgins until they married.) Then suddenly they became members of the "women's club", with no subject taboo, so that when our young mother had her baby, she was quite worldly, her head filled with the tales she had been told by her mother and sisters.

For other girls, becoming pregnant, even if ending in abortion, may be the catalyst changing the relationship between mother and daughter. A Jewish girl having an abortion had suddenly become her mother's close confidante.
Her mother had become pregnant before marriage and she, with her husband-to-be, decided to have an abortion (he was a student, unable to support her and she feared the disgrace a rushed marriage would bring on both their families). The (then illegal) abortion was a desperately unhappy, messy and painful experience. Every detail of her secret of so many years poured out and was shared with her daughter. Our patient's bedside table was covered with boxes of chocolates, fruit and flowers brought by her family (not her "boyfriend", whom she easily talked about as a "one night stand", but an aberration, a mistake, definitely "not the sort of thing I normally do!").

A 15 year old West Indian abortion patient seen during pre-pilot research was the youngest child in her family. She became pregnant the very first time (and up until the interview, the only time) she had had intercourse. Her mother, a very upright and attractive woman, stoutly built, brought her to the hospital to request an abortion. They sat well apart, Lucy in her school uniform, quite silent, looking at her hands. Her mother looked away from her and said: "I don't know what's happened to Lucy, I just can't talk to her any more." She went on at length about how Lucy had let her down, how she had failed to live up to the high standards she had set and how she had no idea that "such things" were going on. Mother and daughter could not speak - there was a wide emotional gap between them. Later the mother brought her daughter to the hospital for the operation and we met again when she came to collect Lucy after the operation. Not only was all forgiven, but they were now close and understanding friends. Mother had been amazed to learn that Lucy had become pregnant the very first time she had had intercourse. She had too, and at the same age. The birth of her eldest daughter (to a different father than Lucy's), now a graduate and working abroad, had meant the end of her ambitions of becoming a nurse, which she deeply regretted, proud as she was of her successful eldest daughter.
All girls in the study were asked: "How do you normally get along with your mother?" The difficulty with this question was that it implied the present and gave no inkling of earlier conflict or disharmony. In fact, some girls did enlighten us with their replies:

"Like sisters in a way - now that we're older."

"Terrible! But getting better since the baby's birth (her mother's grandchild)."

"At first, when I was growing up, we didn't get on, but when I had the baby we started to get on very well."

"Great - now!"

There is also a problem in comparing the replies of UK Black and UK White girls. Undoubtedly, West Indian and indigenous girls' expectations of what a mother-daughter relationship should be, differ. West Indian girls probably expect their mothers to be strict, and probably do not think that an indication of a good relationship is being able to discuss personal problems - particularly about sex and boy-girl relationships.

But while it may be that many West Indian girls do not expect to be able to define a mother-daughter relationship in the same terms, Sue Sharpe's young friends' comments (see p. 24) are evidence of changing views. Being brought up in the same society and educated in the same system as the indigenous girls has probably influenced the expectations of the West Indian girls.
Part of the explanation for the difference in knowledge of their mothers' lives may be youthfulness and the fact that some girls will not have told their mothers of their present pregnancy. The girls having abortions have not yet achieved the necessary maturity in their mothers' eyes to become privy to the secrets surrounding their mothers' own first births.

The age of the girls' own mothers at the time they gave birth to their first children was calculated by deducting the age of the eldest (known) child from the mother's present age. In acquiring information about mothers from daughters, we had to accept that there would be certain inadequacies in the data. Some teenagers, mostly young mothers, could provide us with vivid details of every miscarriage, infant death and even induced abortion their mothers had experienced - but these were exceptional. The majority of the girls did not know and probably would never know such intimate details of their mothers' lives. Because of this, our figures are not of the teenagers' mothers' ages at their first pregnancies, but at the birth of the first children acknowledged by their families. Because of society's more conservative views a generation ago, comparisons between our teenagers' and their mothers' reproductive behaviour is bound to be flawed. Nevertheless, even among our teenagers we can find numerous cases where in the future, girls will almost certainly deny this particular pregnancy, whether they had an abortion or a baby. For the majority of our abortion patients, the pregnancy they had just had terminated would eventually fade into the past and be almost forgotten. One of the young mothers was Irish, from a rural community. Only her mother knew she had had a baby. The baby was privately adopted and she returned home after ostensibly "trying out working in England for a bit". It is doubtful that her future children would ever know about her son. A 17 year old West Indian mother said
she had never been pregnant before. In fact, the nursing staff knew well, from her hospital notes, that she already had a 5 year old son (born when she was only 12).

Sylvie, a 16 year old UK Black girl, an abortion patient (her second, she had had her first at the age of 15) told a long, complicated and very amusing story when asked if her mother had had any other children before her. Sylvie said that for years she had nagged her mother, saying she wanted an older sister and her mother always said, "all right, all right, one day you'll have one!" One day, when Sylvie was about 14, a 19 year old girl just turned up - she lived not far away, down at Peckham, with her boyfriend, and Sylvie's mother, who hadn't seen her for a long time, said "you wanted a big sister Sylvie, well this is your big sister". Sylvie was delighted. Not long afterwards, Sylvie and her mother and young brother went on holiday and her mother told the long-lost sister that she could use their flat while they were away. When they returned, they found the flat in chaos, things were missing, the gas meter had been broken open and the money taken and sister and boyfriend had disappeared. "That's it!" shouted Sylvie's mother, "Just you get one thing clear Sylvie, you never had no big sister, you hear! That's the finish of her!"

In our national statistics, premarital births are known to be under-reported. Dunnell (1979) estimated that only half of the premarital births in the longitudinal National Survey of Health and Development had been reported (pp.9-11).

Any estimate of size of family of origin based on number of siblings will be totally misleading, particularly for the abortion patients and the young mothers. In fact, numbers of siblings and numbers of children of our girls' mothers make an interesting comparison. For the clinic
attenders, there is a close correspondence between the two — for example, 38% of these girls' mothers had had only 1 or 2 children and 44% of the clinic attenders were only children or had one other sibling. But while 15% of the young mothers' mothers had had only 1 or 2 children, a quarter of the young mothers themselves were the only child of a particular mother and father or had one other sibling from the same parents. Twenty-two percent of the abortion patients' mothers had had 1 or 2 children, but almost a third (31%) of the girls were the only, or with one other sibling, offspring of the same father.

Because of the large numbers of girls with step-siblings amongst the abortion patients and the young mothers, with whom they may or may not be living, birth order has little significance. Many of our teenagers were the eldest of a particular group of full siblings, but they had an older step-sibling who lived with them. In fact, this was a feature of many West Indian families, reflecting a type of family pattern common in the West Indies — in rural areas and among the urban working class. The first, illegitimate, child often the result of a brief liaison, is followed a few years later by several children, born in quite quick succession, the children of one stable partner, the first of whom may be illegitimate and the latter legitimate. In this family pattern, there is then a dilemma for the first-born child and the second as to who is head of the pecking order. A similar situation arises even with children of the same parents in the relationship pattern which has been called the migration pattern. A child born in the West Indies may be left with relatives, only joining his or her parents when they have become established here, which may be after several years. In the meantime, the parents may have had more children and the eldest, on arrival, finds his or her place usurped by the second born. (The social worker's view of these problems is described by Wood (1974).)
Many more West Indian than indigenous girls amongst the abortion patients and the young mothers had step-siblings; 21% of the UK White abortion patients had step-siblings, compared with 57% of these UK Black girls and 64% of the Jamaican girls. These proportions were similar for the young mothers - a fifth of the UK White girls had step-siblings, compared with 63% of the UK Black girls (numbers of Jamaican girls in this group were very small).

Mixed race (West Indian) teenagers: Almost 6% of our abortion patients (13 girls), almost 3% of our clinic attenders (3), and 1.4% of our young mothers (3) were of mixed race, usually with West Indian fathers and white mothers.*

Teenagers of mixed race created a dilemma for us. These girls were, obviously, immediately visibly different from the indigenous girls, so that we asked them the questions appropriate to the West Indian teenagers, such as about ties with the West Indies and having white friends. Some of them were the only child of their mother's relationship with a West Indian and had other younger white half or stepbrothers or sisters and had been brought up in a white household. Their numbers are too small to be of any significance if treated separately. Benson (1981) in a study of mixed race marriages in Brixton, recorded these parents' views about their children's ambiguous ethnicity, for "while culturally the mixed-race child might have much in common with his white peers, the fact of his colour distinguished him from them" (pp.135-6); and "colour, and the attitudes respecting it held by a significant section of the English population, placed a barrier between the mixed-race child and his white peers" (p.138).

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* There are also mixed race teenagers (not West Indian) concealed in our "other" category for ethnic origin - girls one of whose parents was of European or African origin.
It seems inevitable that our mixed race teenagers will be treated by society generally as West Indians and so, partly as a result, will be more likely to identify with and behave like West Indian girls.

Partners' backgrounds: Data on the birthplace of the teenagers' boyfriends or partners was inconsistent with our expectations. (Reference has already been made to Rutter's difficulties with the birthplace of his 10 year olds in the Introduction.)

Partners of the clinic attenders were in the main born in the U.K., the Republic of Ireland or Northern Ireland, or Europe. Only 5 partners (3%) were born outside these areas, all of them in the West Indies. The majority (83%) of the clinic attenders' partners were Caucasian; one was Asian and the remainder (16%) were Negro West Indian. Of these 17 West Indian partners, only 5 were born in the West Indies - the majority having been born and educated in this country. This proportion born outside the U.K. is, in fact, a little higher than we would have expected to find in these age groups in the West Indian population generally, since the peak of West Indian immigration occurred in the early 1960s and so most teenage West Indians and many in their early 20s would have been born in the U.K. Only 17% of our West Indian abortion patients, 11% of our West Indian mothers and 9% of our West Indian clinic attenders had been born outside the
U.K. However, when we looked at the place of birth of the West Indian boyfriends and partners of our pregnant teenagers, we found that over half were said by the girls to have been born outside the U.K. - 53% of the abortion patients' partners and 56% of the young mothers' partners.

If the information given to us is correct, then the figures are of interest. However, it is more than likely that they are completely unreliable and this may in itself be noteworthy, particularly when we look at relationship types. It could be that the exceptionally large proportions of partners born outside the U.K. are to some extent accounted for by the fact that they are, generally, slightly older than the girls. However, it seems more likely that the girls have just assumed that their partners were born in the West Indies. Perhaps they do not know their backgrounds well; perhaps because young West Indian men are more affected by racialism and unemployment in this country they have become alienated from the rest of the population, even their own women, and for this reason have put more emphasis on their West Indian origins and heritage.
Matching researcher and researched

Many of the practical difficulties associated with fertility studies have been ably and critically discussed by Busfield and Paddon (1977). Other researchers have dealt with specific problems or have reacted more emotionally and personally to the frustrations of social survey research (Sharpe (1976): "By the time I had completed the research and was getting into complex data analysis, I had become increasingly alienated from the work. The warm and living nature of the feelings, ideas and hopes of the girls who had participated had been frozen somehow and lost within long computer sheets covered with endless statistics and calculations" (Preface)).

Nevertheless, there are those sociologists who believe that it is only through the large social survey that a properly "scientific" understanding of social phenomena may be achieved. Where these studies confine themselves to the most straightforward and factual data, readily aggregated and most conducive to analysis by statistical procedures, they are largely successful. Some noteworthy proponents of this type of research, those particularly concerned with fertility studies, are Cartwright (and her colleagues) (1976; 1978; 1979); Bone (1978); Dunnell (1979) and Farrell (1978).

Those researchers who profess to find social survey research least palatable usually do so for two main reasons: they are concerned about the fluctuating quality of data collected by a number of different interviewers (necessitated by the size of these studies), most of whom are not closely, intellectually involved in the research project and so cannot easily share the understanding and intentions of the senior researcher; and they are concerned about the rigid standardisation of data collection - the assumptions that interviewer and
respondent share the same viewpoint and life experience and that discrete facts, pre-coded responses and the context of meaning of certain variables are commonly understood by all."

Undoubtedly, too, the personality of the researcher and the type of research work he finds himself involved in provides part of the explanation for the wide range of views about and criticisms of social survey research among sociologists. A certain gregariousness and desire to become closely involved in another individual's experiences and to share confidences, together with the ability to develop a rapport and to identify with (and be identified by) one's subjects - will probably mark those sociologists who feel that social surveys fail to note important variations and complexities.

Naturally, this identification and involvement of the researcher can only take place in appropriate circumstances - a middle-aged male researcher, for example, would have some difficulty in identifying with and being taken into the confidence of schoolgirls having abortions. A middle-aged middle class woman may well have similar difficulties. So very often the sociologist's approach to social survey research will be coloured by personality and particular research opportunities. Sociologists, just as social anthropologists in the field, need to exploit those avenues open to them. While women researchers may have access to certain quarters in a society traditionally barred to men (such as domestic

* Powellmaker (1967) referred to a sociologist working in a Balkan village who expressed confusion and resentment at finding that "the sociology methods I have been teaching in the classroom do not work out as easily in practice and are rather difficult to carry out"... "Even in the survey on which she was engaged, it was not possible to work on people as if they were chemical or physical elements, to be arranged according to a predetermined plan" (p.10).
groups in Muslim communities), they may well be excluded from all-male activities such as meetings of headmen of the community. Husband and wife teams have successfully worked together to surmount sexual barriers. The Pehrsons, in their study of the Marri Baluch, attempted to duplicate anthropological data each from the sphere of their own sex, she running a native household and participating in the activities of the women, he acting as the head of the household, working with the men and entering into community life (Pehrson (1966)).

Very often informants who are members of the host community are able to close some of the gaps in understanding. Where sociologists work in a team there is the possibility of a complementarity of contributions to the theoretical and practical expertise required when confronting a particular problem.

Location, too, may have a marked effect on the extent of the observations of social processes feasible in a particular society. Western urban communities frequently posing greater difficulties than those encountered in the more traditional fields of anthropological research. Frankenberg (1966) has related: "When I went to Glynceiriog I was always conscious of my anthropological colleagues' anecdotes of how they sat in the centre of African villages while life went on around them and encompassed them. They could not avoid becoming part of the social processes they wished to observe. In my early days in the village I would often climb a hill and look sadly down upon the rows of houses of the housing estate and wonder what went on inside them.... Had I studied Bethnal Green or the Sheffield housing estate the observation of social process would have presented even greater difficulties.... Students of areas of this kind try to devise techniques to get over this problem. By and large, however, they can only deduce social process from the information they can collect by questioning people in their homes or elsewhere ....." (p.16).
Comparisons with other studies

One of the main advantages of social survey research is being able, whenever possible, to make comparisons with the findings of other, similar studies. Although our study is local and special, it is, nevertheless, important to be able to comment on its findings in relation to those of the national studies which form the basis of most of our present knowledge of teenage sexual behaviour. The studies most relevant to us are Schofield's (1965) which aimed to provide the basic information which is the essential first step before suitable educational measures can be developed. This involved measuring the extent of teenagers' sexual experience and identifying "some of the sociological and psychological factors associated with sexual experience". Farrell's more recent study (1978) was of the sources of information young people encountered during their early years, which helped them (or hindered them) in the acquisition of knowledge about sex and birth control.

Dunnell (1979) describes a survey of the marriage and fertility-family formation patterns of 6,589 women in England, Scotland and Wales.

No recent research, however, has been carried out into the fertility behaviour of the U.K. born children of immigrants. The large proportion of girls of West Indian origin in our sample provided us with an opportunity to make a contribution in this area.

Social survey and observer participation:
A combination approach for the medium-sized study

In retrospect, the organization of research into teenage pregnancy in the district over the past few years could perhaps have provided more rewarding results. The chronology of this research has a typical pattern, a small pilot study followed by a larger survey.

The conclusions reached in the small preliminary study of 54 pregnant girls under 17 years which was carried
out at King's College Hospital in 1973 (McEwan et al (1974)), provided the impetus (and indeed justification) for this larger, more expensive study. The findings of this research will necessarily overshadow and out-date those of the 1973 study. This might have been avoided if, in 1973, a much larger, more superficial aggregation of data on pregnant teenagers (a brief questionnaire completed by teenagers on admission and perhaps incorporating an analysis of information taken from hospital notes, a rich though sometimes poorly validated source of data) had been carried out, followed by a smallscale, intensive study of 50 teenagers over a period of time, say 12 months. This approach would have utilized best the different interests and abilities of social scientists (the survey researcher followed by the sociologist- anthropologist) and techniques of research (survey followed by observer participation).

The present study would have been inappropriately treated by survey methods alone. However, because of its size, it was possible to combine these techniques with those more commonly used in micro-sociological research. It is not always possible to make this type of compromise between macro- and micro-sociological research, but in this study we have had a number of advantages. Although confined to a small geographical area, our 550 respondents are actually more than a third of Farrell's national sample of 1,556 teenagers, and yet, for several reasons (not least the circumstances and method of recruitment of the sample) it was possible to treat the collection of data almost as anthropological fieldwork. These were:

- Personal involvement of the researcher in all stages of the study, particularly in interviewing, and close co-operation between a small number of interviewers;
- The hospital and clinic settings provided the advantages of neutral territory, privacy, and the opportunity of later referral to hospital notes. The
hospitals are in many ways the hub of the surrounding community; local people work there and some have had continuing contacts over many years with the hospitals, as can be seen from very long histories in the notes;

The district is a compact geographical area and the teenagers interviewed were frequently seen on later occasions, in the street, visiting friends in hospital, in clinics etc.;

The flexibility and informality of the questionnaire (see copy at appendix), incorporating the drawing of family trees and filling in of charts, were comprehensible to the teenagers;

Not least, being a "fly on the wall", included in meetings and discussions, a part but apart, on the border of the hospitals' immediate interests and priorities; and the advantage of being attached to the hospital and being based there, so entrusted with the gossip in the department and on the wards, a vital source of information for the sociologist.

Nevertheless, such a combined approach, so logical when viewed with hindsight, was less apparent during the preparatory work of setting up the study. The combination of methods used was initially made in an effort to compromise: to discover the basic socio-demographic facts of our sample and at the same time to unravel the complex problem set before us. The compromise consisted of compiling a mainly semi-structured questionnaire, using the smallest possible number of interviewers working in close co-operation, observant also of influences just outside the interview itself, and the drawing on of a number of sources for each teenager in addition to the survey's interview data.
Data from sources other than the interview do not only provide the critical information which forms the basis for the general hypotheses. These non-systematic observations also provided an opportunity to check certain data which might never have otherwise been questioned, and certain data which has in the past been inadequately defined and frequently used uncritically.

The sources of information for each respondent, apart from the interview data, included:

Non-systematic observations of the researcher concerning:
- the respondent's health
- the behaviour of doctors and/or consultants

Non-systematic observations made by other respondents (girls having abortions or babies at the same time)

Casual conversations and observations of:
- other members of the respondent's family (e.g. sisters, both of whom were respondents)
- other medical personnel (doctors or lay-workers from other clinics, wards or schools)

Information obtained through access to hospital records hospital notes referred to one year after our interview.

The example of Julie and Linda: The following description of data collected for two sisters, Julie and Linda, gives an indication of the usefulness of combining these systematic and non-systematic observations, as well as some of the difficulties we encountered.
Julie was a young West Indian girl who had been born in London. She had a second trimester ("late") abortion a month before turning 16. She had just finished her CSEs, although she did not yet know the results and had left school (she was coded as "under 16 but not at school").

Linda was interviewed several months later. She was 14 years old and had been at school until leaving to have the baby; a home tutor had been arranged for her return home. At the time of the interview she expected to be returning home with her son, but she was instead discharged to a mother and baby home.

Julie told us that her father worked at "a security place, as a porter". Her sister Linda said he was a storeman. It is possible that he had changed jobs between our interviews. Julie described their accommodation as rented, with their own furniture, and agreed that "privately rented unfurnished" was the correct description. Linda said that it was a housing association flat. Her mother, Julie said, had left them when she was only 4 and they never saw her. While Julie said that her mother lived in Catford, South London, and had been born in England, Linda said that she didn't know where her mother was living now, but that she had been born in Jamaica (certainly both girls appeared to be daughters of Negro West Indian parents). Julie knew her father's age and told us about his two other children, her stepbrothers. Linda didn't know his age and said that he had six other children.

The different descriptions of the father's job were not problematical as the codes we intended to use to classify father's occupation into social class categories are the same, but the discrepancies in description of accommodation and the number of father's other offspring and place of birth of their mother are confusing. Except perhaps for father's other children, none of these would
seem to be sensitive issues which one or other of the girls would wish to conceal.

Julie's abortion, though second trimester, was completed comparatively quickly; she had only spent one night in hospital when she was interviewed, after it was over, but in fact she was detained two more days for several reasons.

She could not sit up to talk to me, so I sat close by her bed. She was a pretty girl with tightly plaited hair in braids pulled up and over the top of her head. She appeared extremely lethargic and yet she smiled and seemed pleased to talk. During our conversation, a group of doctors came to the foot of Julie's bed - the consultant, the hospital doctor on the ward and several medical students. My presence (a layworker, a visitor?) was ignored. The hospital doctor asked the consultant if it were not inadvisable for Julie to have an IUCD since she was anaemic and this method of contraception is known to produce a heavier menstrual flow. The consultant disagreed with the young doctor. "That's the price she'll have to pay!" He smiled pleasantly at Julie and spoke to her in a friendly, fatherly fashion, telling her that her boyfriend was only interested in one thing, but she ought not even to be having sex at her age. She should instead be like Sonia Lannaman (a black sportswoman). Julie was expressionless and completely silent. She had just told me that she had had intercourse three times in her life, the first time 8 months ago. The boyfriend, from her description did not appear to be putting a great deal of pressure on her to have sex with him. Apart from evidently hardly having the strength to walk, let alone run like Sonia Lannaman, Julie had been caring for her brother and sister since she was 4; she prepared the family's meals, did the housework and had just finished her school exams. She wanted to take the pill in future, she had said to me, but she did not voice her feelings to anyone else. She had the IUCD
inserted later that day. When asked in our interview about the doctors she had seen and how sympathetic and helpful they had been, Julie had no comment to make. They were "all right". Having seen her blank expression when the consultant spoke to her, one wonders if this was not always Julie's defence, making everyone "all right".

Another West Indian teenager, also an abortion patient in a nearby bed was interviewed a day later and talked quite spontaneously about Julie who, she said, "they" all knew, had a very hard time, trying to look after her family "especially when she's never well". A former boyfriend of this girl was the brother of Julie's boyfriend. "She (Julie) doesn't know it, but that boyfriend of hers has other girls everywhere - he's no good really, or his brother. That's why I dropped him!" Poor Julie! Julie had described her relationship as "steady" and said that she saw her boyfriend every day. (They could, of course, have been neighbours.)

The hospital doctor who had queried the suitability of the IUCD for Julie detained her that day and the next and treated her anaemia. She was given a supply of iron tablets when she was discharged.

A year after interviewing Julie, we referred to her hospital notes. Within a short time of her discharge, she had bled so profusely with her IUCD that it had been expelled. She was prescribed the pill to take instead. Shortly afterwards she was admitted to the hospital with an overdose of iron tablets; she was having boyfriend trouble and was depressed, she is noted as saying. This was the time when it must have been evident at home that her young sister Linda was about to have a baby. A short while later, Julie was admitted for another abortion - this time she was early enough for the aspiration type.

We did not know Linda was Julie's sister when she was first interviewed. Nevertheless, her interviewer was
just as concerned about Linda's apathy as I had been about Julie's. (I later asked a nurse on her ward if she was anaemic and was told that there was nothing about anaemia on her notes.)

Some time later, a school doctor who arranged home tuition for pregnant girls, mentioned to me that she had visited Linda at home just before she had had the baby. A woman in a dressing gown had slipped out of the flat and hovered in a nearby doorway just as the school doctor arrived. The doctor spoke to the girls' father and she felt that he was sincerely concerned to do all he could to keep the family together. In the circumstances, he had not managed to do this.

It would be some consolation to know that inaccuracies like those in our data on Julie and Linda were rare and insubstantial, but we do not know this. Because of the circumstances surrounding the majority of our interviews, where assurances of complete anonymity were always made, it was not possible to return to patients to check the accuracy of the original interviews.

Julie's experiences are referred to again in our conclusions and recommendations.

Three types of shortcomings inherent in social survey methods were of particular significance in this study: we were aware that the reliability of some of the data we were collecting was dubious; the quantifying of data describing complex situations required that it be forced into artificial and inadequate classifications; and cultural influences pervaded the data in differing and sometimes difficult to discern degrees.

As a result, those independent variables which are frequently relied upon to show a causal relationship with
outcome variables, were felt to be often suspect, since we had little confidence that they were reliably known or that they adequately reflected the social phenomena we were observing.

In view of these shortcomings in the survey data and our growing awareness of important themes emerging from our interview experiences (and being reinforced by other sources) which were actually being obscured by the survey procedures, it was necessary to reconsider the underlying beliefs with which the research had initially set out.

The process of re-evaluation of the techniques necessary and the emerging hypotheses are described in the next Part.
Talking with a girl on one occasion for just an hour and a half or two hours provided barely a glimpse of the real world from which she came, but as the interview experiences accumulated and began to reinforce each other, what seemed to be the most important influences in the girls' lives gradually became clearer.

The numbers of girls under 16 years actually becoming mothers has been gradually decreasing (OPCS, 1980). There are many pressures on very young girls to have abortions: from their families, from their doctors, as well as from society's general condemnation of early motherhood. The sight of a 14 or 15-year-old girl nursing her baby with the care and confidence of a woman twice her age is at once moving and sad. She is only a child, but there she sits, a mother with her own child.

The circumstances applying at the precise time a girl finds she is pregnant are particularly important in the decision-making process - whether to continue and have the baby or have an abortion. The process of events also tells us a great deal about the types of relationships she has with her mother and her partner. This was an extremely interesting area which was not explored with the girls who had never been pregnant as their relationships had not been "tested" in the way the pregnant girls' had.

However, all the clinic attenders were asked what they would do if they should become pregnant. Two girls
who were interviewed in the clinics did in fact become pregnant and were interviewed for a second time. The girl who had said she would have an abortion, had her baby, and the other girl, who had said she would have the baby, decided instead to have an abortion when the real-life situation arose.

These examples only emphasize the variability in particular intentions, even when viewed over a short timespan. Married couples' intentions regarding family size, for instance, may vary for several reasons: according to how firm the intentions are; over a period of time; and according to the different stages in their marriage relationship (Cartwright (1976) pp.19-24). How much more problematic then is assessing the intentions of single girls who by their attendance at a family planning clinic are indicating an unwillingness to become pregnant, at least in the immediate future?

Possibly the most stimulating, but at the same time tiring, infuriating and distressing period of the research was the time spent actually talking to teenagers, on the wards and in the clinics. This was an unexpectedly rewarding time for the amount of material we were able to record at each interview, but it was also on occasion extremely harrowing. The degree to which our young subjects (particularly the abortion patients) were willing, even anxious, to share every aspect of their experiences, led us to feel that this need to "talk it out" was not being filled by other people in their lives, either the professionals they had so far encountered, or more importantly, their mothers and their partners. It was not surprising then to find that many of the teenagers' relationships with these two very important people were frequently marked by disaffection and mistrust.
It seemed important to look more closely at certain recurrent features in order to explore the possibility that there is not only a connection between these two relationships, but that the type of early relationship a mother and daughter have will have a direct influence on the type of boy-girl relationship a young woman will find herself in when she becomes sexually active.

While intuition played a not inconsiderable part in the formulation of the "types" which follow, they nevertheless have support in many substantial aspects from the survey's empirical findings as well as from other sociological research (already referred to in our Introduction) which encouraged us to take this direction. Nevertheless, our hypotheses should be seen as no more than tentative at this stage, inviting further critical examination and testing.

Mother–daughter relationships – types of mothering

As interviewing progressed, several features began to emerge which were frequently inter-related: disrupted family life, physical separation of mother and daughter, poor communication between mother and daughter, solitariness or loneliness of the teenager, and the enforcement of self-reliance at a very early age.

We encountered numerous examples of relationships between mothers and daughters suggestive of an extreme type of mother-daughter relationship epitomised for us in the disciplinarian or distant mother. This type of mother appeared to enforce her authority by threats and physical punishment. As her daughter grew older, these threats would largely lose their power and their relationship would be left in a vacuum, mother and daughter leading independent lives with minimal inter-
personal contact. There would be little sense of loyalty here for the family unit, individuals instead acting autonomously.

Even a distant mother, however, may be ambitious for her daughter and idealistic. She may view the responsibilities of motherhood as, above all, the provision of discipline and material benefits.

Such distant mothering would be in every respect opposed to that practised by another type, the companionable or close mother. This type of mother would value interpersonal communication above unquestioning obedience and strict discipline. She would combine her role of mother with that of teacher and confidante. Mutual support would be given in times of crisis and there would be a high value placed on loyalty and respect for the family unit.

These are ideal types, relationships in reality occurring somewhere between the two extremes. In sociological analysis, ideal type constructs do not correspond to an "average" type in a statistical sense. They are ideal in a logical sense, any given social phenomenon permitting a variety of different abstract constructs, depending on which elements are made the focus of interest. Ideal type analysis is associated with the work of Max Weber (Henderson and Parsons (1947)).

Our observational data lends support to the view that the relationships with their mothers of girls who experience the trauma of an unplanned and unwanted teenage pregnancy tend to cluster nearer the distant extreme of the continuum.

In all likelihood, where there is a distant mother, there is also a distant father and the conjugal
relationship between distant mother and distant father will also have some of the characteristics of the mother-daughter relationship described, particularly the strict segregation of roles and low value on (or perhaps expectation of) companionship between spouses. The close mother, on the other hand, would be likely to share her parental role with a close father and the couple's conjugal relationship will bear a similarity to Bott's joint conjugal role relationship (1957). These are untestable hypotheses from our data, requiring closer examination in any follow-up study.

The statistical findings of the study give some support to our observations on the different types of mother-daughter relationship. There were several opportunities in the interview for us to learn something about our teenagers' relationships with their mothers, particularly in the case of those girls who had been pregnant. There were differences between all groups in whose mothers had first told them about periods and "where babies come from". Girls who had never been pregnant, the clinic attenders, were more likely to have learnt initially from their mothers than the girls who had become pregnant. Mothers were also an important source when we discussed who it was girls had talked to most often about sex, and who had been most helpful, talking to about sex. Again, the clinic attenders generally, UK White girls generally, and those girls who were already using the pill at the time of their first sexual experience were all most likely to have talked to and been helped by their mothers.

For the pregnant girls, we learned about their mothers' reactions to their pregnancies, who had first told her and what she had done; we also asked how
mother and daughter normally got along together. We learned where the mothers were living, if our teenagers were living away from home, and how frequently they met. When we asked about educational achievements, we also asked the girls if they had been encouraged by their mothers or fathers to stay on at school.

Boy-girl relationships - devising a typology

Alerted initially by observations and encouraged later by the analysis of certain data, we explored the possibility that two hypotheses, together forming the basis for a typology of relationships, might prove to have foundation.

Six of the girls interviewed in our group of clinic attenders were not yet sexually experienced, but intending shortly to become so. They were all involved in serious relationships with boyfriends and all requested, and were prescribed, the pill on their first visits to the clinics.

The first hypothesis is, therefore that:

The degree of risk of an unplanned pregnancy varies directly with the degree of risk taken (indicated by what, if any, contraception the couple is using) at the time of first sexual experience.

And the second:

The use of a(n effective) method of contraception at the time of first sexual experience varies directly with the degree of integration of certain aspects of their relationship (that is, the extent to which activities and responsibilities are shared and their ability to communicate
with each other.*

The method of contraception a girl or couple used at the time of the girl's first sexual experience is shown on p. 129. While only 28% of the clinic attenders used no method at all on the first occasion, 63% of the abortion patients were in this category and 68% of the young mothers. Twenty-two percent (27% if we include the six girls who had not yet but were about to become sexually active) of the clinic attenders could be described as "initial pill users", compared with only 5% of the abortion patients and 11% of the young mothers.

If our two hypotheses are combined, the following sequence emerges:

The degree of integration influences (effective) which risk of of a couple's contraception dictates unplanned relationship pregnancy

* Communication here implies either tacit or verbal exchange. There are various means couples use to communicate their feelings without explicitly discussing contraception. For young single women, it is usually important not to become pregnant and so the inability to deal with the problem of using contraception and to communicate with her partner would indicate that their relationship does not embody the characteristics of our integrated relationship (see over page). Some young women in relationships we would describe as segregated (also see over page) told us that they had been reluctant to tell their partners that they were not using contraception. Some partners had simply assumed that the girls were "on the pill".

Chamberlain (1976) has questioned the importance of the desirability of verbal communication frequently emphasized by social demographers. Nevertheless, in her study of highly fertile women with six or more children, she does record the women expressing difficulties in talking to their husbands about birth control.
If we consider the four following aspects of a young couple's (sexual) relationship, two extreme models or ideal types of behaviour emerge. The four aspects are:

1. (Degree of) sharing:
2. (Degree of) understanding:
3. [Use of effective] activity
4. Sexual communication contraception
   activities, with each
   experiences, other
   responsibilities, outlook

At one extreme of the axis is the highly integrated type of relationship and at the other the segregated relationship.

The integrated model requires that all four aspects of the relationship be fully operative and that they take place in this sequence. This means that the third aspect, the use of effective contraception, cannot precede the initiation of the relationship, but must follow the first and second aspects and precede, not follow, the couple's first sexual experience together. Couples falling within the integrated relationship model would regard effective contraception as an integral, premeditated part of their sexual relationship. The integrated model should exclude those teenagers who begin taking oral contraception before becoming sexually active without being involved in a close relationship, for example, those who are pressurised into using oral contraception by a member of their family, a social worker, while they are in care, or by their GP, because they are thought to be at risk of becoming pregnant.
The model emphasises the importance of a couple's relationship in the use of effective contraception and the avoidance of unplanned pregnancy. We would expect, in this view, that the breakdown of a relationship would usually coincide with the cessation of use of contraception (unless, of course, the cessation followed on an agreement by both partners to have a child). This would mean that the same cycle of events would begin at the commencement of a new relationship. Since responsibility is shared, teenagers in a completely integrated relationship probably very rarely take risks.

The segregated model occurs when one or more aspects are inoperative or out of sequence. Teenagers in segregated relationships view contraceptive use as a separate activity not directly related to the circumstances of their sexual activity or relevant to their particular relationship.

While the first aspect of the integrated relationship is typified by the high degree of sharing of all activities and responsibilities, the segregated relationship is typified by the segregation of activities and responsibilities.

In the segregated model we would find teenagers engaged in casual and semi-casual sexual relationships; teenagers who perhaps because of their extreme youth are still at the stage where their activities are group orientated, rather than couple focused; teenagers whose parents (and therefore they too?) observe quite strict divisions between male and female roles and duties; and West Indian teenagers whose female/mother centred culture excuses and sometimes even excludes West Indian men from the responsibilities of contraception and upbringing of children.
Intermediate relationships are those which lie between the two extreme models of relationships and are those in which the first or second aspects are not fully operative. This would lead to the use of the less effective methods of contraception (obtained anonymously and comparatively easily) or withdrawal, which requires no advance planning. (There will probably be a sizeable proportion of West Indian teenagers in this group.)

Couples in intermediate or segregated relationships, who, after using a less effective or no method initially, have progressed to using an effective method (for example, the 28% of the clinic attenders who had used nothing initially, but had progressed to using an effective method, as evidenced by their attendance at the clinics) may on the reinstatement of a temporarily broken or unstable relationship, succumb to the temptation of taking a risk. Although only 5% of the abortion patients were initial pill users, 40% of these girls had, at some time in the past, taken the pill. If our hypothesis is correct, it would follow that these teenagers, at the start of a new relationship would be likely to repeat their former pattern of beginning sexual activity before using contraception - only progressing to the use of a method as the relationship becomes closer to the integrated model. The experiences and behaviour of small groups of teenagers in both the abortion and young mothers groups support these views. Data and observations which give support to our hypotheses are brought together and discussed in Part V.
PART III

COMPARISONS

Introduction

From the hypotheses which were developed while the study was in progress, we move to the main survey data and the comparisons we were able to make, illustrating the similarities and the differences between our three groups of teenagers; between the indigenous girls and those of other ethnic groups (particularly the UK Black girls); and between the teenagers in our sample and those observed by other researchers.

In general, the differences between our clinic attenders and young mothers were the most marked, with findings for the abortion patients tending to lie between these two extreme groupings. Cultural differences introduced to the groups in differing degrees by the daughters of immigrants, for the most part West Indian or Irish, added another dimension to our material. Because of this, and the nature of our sample, findings strictly comparable to those of other, particularly national, studies are meagre, although where we do have appropriate data, that for our indigenous girls tends to support that of Wilson (1980), Kiernan (1980) and Black (1970)(i).

Wilson (1980), referring to a teenage population in Aberdeen, attempted to predict which girls were at risk of becoming pregnant before the age of 16 years using a risk score allocated on the following criteria: serious academic under-achievement at the age of 11 years; a court appearance before 16 years, referral for child guidance or to a psychiatric clinic; 5 or more siblings;
mother who was under 20 when her daughter was born; and illegitimacy.

Wilson reported that "it proved possible to use a combination of these characteristics to create a crude risk score which is capable of distinguishing a group of girls who were known to have become pregnant before they were 16 years old" from the rest of the population.

Kiernan (1980) noted that the teenage mothers in her study (based on data collected by the National Survey of Health and Development's longitudinal survey of people born throughout Britain in the first week of March 1946) "often have less propitious backgrounds than their peers ... they were likely to come from less advantaged families in which parents had tended to marry at young ages and had large families ..."; they "were, on average, the least able academically, unambitious and left school at the minimal age".

Black (1979)(i) in her study of pregnant teenagers summarised the etiological risk factors for those completing the pregnancy as "low socio-economic status, poor educational achievement, large families of origin, with a family history of premarital conception; and close identification with a grand multiparous non-contracepting mother".

In this Part, comparisons between our groups of teenagers are dealt with in four broad sections: social characteristics; sexual and reproductive histories; contraceptive use; and knowledge and attitudes.
A. Social Characteristics

Ethnic Origin

Teenagers of West Indian origin formed substantial proportions of the two groups of pregnant girls. Using 1971 Census figures to estimate, rather crudely, proportions of teenage girls of West Indian origin expected to be in the population from which our sample was drawn, we anticipated that if these girls were similarly represented in our study, they would account for about 13% of the pregnant teenagers. In the pilot, however, we recruited about twice this proportion and in the study itself, their proportions in all three groups of teenagers well exceeded expectations.

On the basis of 1975 hospital clinic attendance figures, we anticipated that we would not recruit any West Indian girls in our group of clinic attenders (girls who had never been pregnant). In fact, we recruited 10 UK Black teenagers (9%), 3 of mixed race (3%) and one Jamaican girl (1%).

The proportion of West Indian abortion patients was slightly higher than expected. From the experiences of the pilot and from hospital records of all women requesting abortions, we had expected about a third of the group to be of West Indian origin. In fact, 69 girls were UK Black (31%), 14 were Jamaican (6%) and 13 were of mixed race (6%), in total 44%. In the group of mothers, the three comparable figures were 62 (29%), 8 (4%) and 3 (1%), totalling 34%.

Overall, the distributions by ethnic origin in the two pregnant groups were similar, Asian girls being the
only group which was not represented at all in the abortion group. No African girls or Asians from the Indian subcontinent were recruited in the clinic group.

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK White</td>
<td>83 (37.7)</td>
<td>92 (42.4)</td>
<td>75 (66.4)</td>
</tr>
<tr>
<td>Irish</td>
<td>11 (5.0)</td>
<td>11 (5.1)</td>
<td>11 (9.7)</td>
</tr>
<tr>
<td>European</td>
<td>8 (3.6)</td>
<td>10 (4.6)</td>
<td>2 (1.8)</td>
</tr>
<tr>
<td>African</td>
<td>4 (1.8)</td>
<td>5 (2.3)</td>
<td>-</td>
</tr>
<tr>
<td>Asian</td>
<td>-</td>
<td>4 (1.8)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>UK Black</td>
<td>69 (31.4)</td>
<td>62 (28.6)</td>
<td>10 (8.8)</td>
</tr>
<tr>
<td>Jamaican</td>
<td>14 (6.4)</td>
<td>8 (3.7)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Mixed race</td>
<td>13 (5.9)</td>
<td>3 (1.4)</td>
<td>3 (2.7)</td>
</tr>
<tr>
<td>Other</td>
<td>18 (8.2)</td>
<td>22 (10.1)</td>
<td>10 (8.8)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>220 (100%)</td>
<td>217 (100%)</td>
<td>113 (100%)</td>
</tr>
</tbody>
</table>

Age

While adolescent girls are not regarded as a high obstetric risk group, they do have a greater risk of anaemia and pre-eclamptic toxaemia and are more likely than older women to have low birth weight babies (Russell (1969); Underhill and Atkins (1978)). Evidence in general points to a greater risk of complications in girls under 17 years than in pregnant women 20-29, but at less risk than pregnant women over 30 years. The same is true of the children of these women (Pregnant at School (1979) p.17), children born to girls under 17 years being at greater risk than those born to women 20-29, but at less risk than those born to women over 30 years.

Many more pregnancies to girls aged 15 and under end in an abortion than a live birth. We interviewed 39 girls
aged 15 or under - 30 had abortions and 9 of them had babies. Two of these girls were 13 years old - one was an abortion patient and the other a young mother. Of the 9 mothers, 7 were UK Black girls and 2 were of mixed race. There were no UK White girls in this very youthful group. Of the 30 girls 15 or under who had abortions, over half, 17, were UK Black girls, one was Jamaican and 3 were of mixed race; 7 were UK White girls and one was recorded as "other".

The most marked difference between the two groups of pregnant girls was in the proportions of very young girls clustered in the abortion group, and older girls in the group of young mothers.

<table>
<thead>
<tr>
<th>Age (%)</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>1 (0.5)</td>
<td>1 (0.5)</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>7 (3.1)</td>
<td>3 (1.3)</td>
<td>-</td>
</tr>
<tr>
<td>15</td>
<td>22 (10.0)</td>
<td>5 (2.3)</td>
<td>7 (6.2)</td>
</tr>
<tr>
<td>16</td>
<td>39 (17.8)</td>
<td>17 (7.9)</td>
<td>24 (21.2)</td>
</tr>
<tr>
<td>17</td>
<td>56 (25.4)</td>
<td>43 (19.8)</td>
<td>23 (20.4)</td>
</tr>
<tr>
<td>18</td>
<td>47 (21.4)</td>
<td>60 (27.6)</td>
<td>31 (27.4)</td>
</tr>
<tr>
<td>19</td>
<td>48 (21.8)</td>
<td>88 (40.3)</td>
<td>28 (24.8)</td>
</tr>
<tr>
<td></td>
<td>220 (100%)</td>
<td>217 (100%)</td>
<td>113 (100%)</td>
</tr>
</tbody>
</table>

Figures from the OPCS show that between 1972 and 1979 there had been a considerable drop in the rate of pregnancy in unmarried girls aged 16 to 19 years, from 60.4 to 46.9 (per 1,000 unmarried women), while that for girls aged 11 to 15 years remained unchanged at 1.8, except for a slight increase to 2.0 from 1973 to 1975. "Schoolgirls" (that is, girls under 16) increased as a proportion of total pregnancies in unmarried teenage women from 2.6% to 3.2%.
Marital Status

Almost all the teenagers having abortions were single (94%), with an additional 3% describing themselves as "common law" wives. Just over half of the mothers were single (51%), with a further 9% describing themselves as "common law" wives.

Just over half of the married mothers said that they had conceived, on this occasion, after marriage. Some of these girls had been pregnant before and the earlier pregnancy had precipitated the marriage; some mothers were from cultures where virginity at marriage is mandatory and so the possibility of premarital sex was not ever entertained (for example, a Pakistani Muslim girl and Muslim girls of Turkish and Cypriot origin).

Marital Status (%)  

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>4 (1.8)</td>
<td>84 (38.7)</td>
<td>3 (2.7)</td>
</tr>
<tr>
<td>Separated</td>
<td>2 (0.9)</td>
<td>3 (1.4)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Single</td>
<td>192 (87.3)</td>
<td>101 (46.5)</td>
<td>92 (81.4)</td>
</tr>
<tr>
<td>Common law</td>
<td>7 (3.2)</td>
<td>19 (8.8)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Engaged</td>
<td>15 (6.8)</td>
<td>10 (4.6)</td>
<td>16 (14.2)</td>
</tr>
<tr>
<td></td>
<td>220 (100%)</td>
<td>217 (100%)</td>
<td>113 (100%)</td>
</tr>
</tbody>
</table>

All births to the girls under 16 years were illegitimate. Even though none of these girls could legally marry under 16 in the U.K., we might have found girls under 16 who had married elsewhere. Proportions of illegitimate births were 88% to those girls under 16, 77% to those aged 17, 58% to those aged 18 and 43% to those girls aged 19 years.
Our proportion of illegitimate births was very high (69%) when compared with national figures.* Few of our UK Black mothers were married (only 3 of 62 girls), none of the 8 Jamaican mothers was or the 3 mixed race girls having babies. However, even among our UK White mothers, only 58 (56%) were married at the time of the birth.

Iliffe (1975) has shown the changes in marriage patterns of West Indies born women in England by comparing them with women born in Jamaica:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>92.52</td>
<td>95.27</td>
<td>98.62</td>
</tr>
<tr>
<td>20-24</td>
<td>52.92</td>
<td>67.28</td>
<td>88.21</td>
</tr>
<tr>
<td>25-34</td>
<td>19.75</td>
<td>20.04</td>
<td>66.28</td>
</tr>
<tr>
<td>35-44</td>
<td>11.70</td>
<td>14.40</td>
<td>48.22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36.68</strong></td>
<td><strong>35.26</strong></td>
<td><strong>72.97</strong></td>
</tr>
</tbody>
</table>

There are no figures for UK Black women. The suggestion that a much higher proportion of women of West Indian origin marries in the U.K. than in the West Indies could not be substantiated from our findings. (In any case, we are dealing in our sample with some young women who could not legally marry.)

* In England and Wales in 1980, 43% of all births to women aged 19 and under were illegitimate. Proportions illegitimate by mother's age were 99% at 15 years, 75% at 16 years, 58% at 17 years, 41% at 18 years and 30% at 19 years (OPCS (1980)).
Among the clinic attenders, 7 (6%) were aged 15 years. The age distribution and marital status of this group bore a much closer resemblance to that of the abortion patients than it did to the young mothers.

Only 4 girls (4%) in the clinic group were married and one of these was already separated from her husband. However, this group contained, significantly, the highest proportion of single girls who were formally engaged (17%) compared with the abortion patients (8%) and the young mothers (10%). "Common law" wives are not included in these proportions of single girls, although the very small figure for the clinic group (one girl) is interesting when compared with the high figure of 19 (9%) for the young mothers and 7 (3%) of the abortion patients.

Arranged Marriages

A number of our teenagers, particularly among the young mothers, were themselves born, or their parents had been born, in Muslim societies in the developing world. Although, inevitably, their attitudes and the strength of their adherence to traditionally held values would be diluted and changed by their experiences of living in this society, practices such as arranged marriages were still followed here, and largely supported by these teenagers.

In a study designed for our urban-reared population, it was not possible to analyse too deeply the strength of all those customs which were being maintained by such groups as the Muslim Pakistanis or the Greek or Turkish Cypriots. However, the custom of arranged marriages was relevant to our research and, although their numbers were small, it was of interest to observe changing attitudes, particularly of the Turkish Cypriot girls.
In developing societies, one of the most serious losses experienced by rural women in their transition to urbanisation and modernisation is the loss of the traditional customs and knowledge which enabled them to space their families, or to cease child-bearing once they have had the number of children they want.

Movement to the towns and cities, an inadequate knowledge of "family planning" - the breakdown of traditional beliefs and their replacement by modern drugs which are seldom understood - have created serious problems for these women. In Muslim societies, for example, pollution beliefs and religious rituals demand sexual abstinence at certain times. These, together with prolonged breast-feeding, help to restrict the proportion of women's lives in which they may conceive. Also, in some of these societies men have traditionally migrated long distances to find work, sometimes for periods of years at a time.

A report from Kenya has indicated that "modernisation" has been a major factor in Kenya's record population growth rate (World Fertility Survey (1982)), shorter duration of breast-feeding and fewer polygamous unions leading to an increase in childbearing among younger women.

Historically, abstinence from sexual intercourse during breast-feeding probably played a significant role in prolonging child-spacing in Kenya. This has now changed, with the average duration of post-partum abstinence now being only three months. Women in polygamous unions tend to have fewer children; this is especially true where older wives are neglected when new wives enter the household. The practice of husbands and wives sleeping together under the same roof was also uncommon in many East African traditions; Westernization has changed that. The same factors which break down the fertility-inhibiting traditions are also leading to an increase
in modern contraceptive use. However, only in women over
35 is there evidence that levels of contraceptive use
offset the decline in traditional methods. The contrast
is greatest between women in rural and urban areas. Shorter
duration of breast-feeding in urban areas means that child­
bearing is higher in city-dwelling under 25s than in their rural counterparts (reported in People (IPPF (1983))).
This tendency for childbearing to increase with the early
stages of modernization has been observed elsewhere in
Africa - in the Sudan, Western Nigeria and in Zaire.

A Muslim Pakistani mother who was interviewed with
the help of an interpreter (an Urdu speaking social
worker previously working in the hospital) was a village
girl who had helped her family on the land and had never
been to school.

She surprised the sophisticated Indian interpreter
with her no-nonsense approach to family planning and her
good, basic knowledge of the way in which to avoid, or
to ensure, conception. She knew when the "safe period"
was and laughed at the suggestion of a young hospital
doctor (who, after our interview, used the opportunity to
discuss contraception with her through the interpreter)
that she might need some method before her postnatal
check-up. "It is not our custom", she informed him with
dignity, (to have intercourse) "before 40 days after the
baby is born." This girl's husband was 55. He had been
married to a woman who had had five stillbirths. His
former wife had even made a pilgrimage to Mecca in her
efforts to improve her chances of bearing him a son. All
had failed; he had divorced her and his family had
arranged his marriage with this young Punjabi girl. Two
weeks after her first missed period, our young mother
had a positive pregnancy test, but she was five months' pregnant when she first attended the antenatal clinic.
There did seem to be evidence of changing attitudes towards the use of contraception among some of the young Turkish and Cypriot teenagers we interviewed. Although their marriages were still arranged and they were marrying at young ages, they appeared to be delaying the commencement of child-bearing for a few years. The pattern of contraceptive use by these young women was most commonly not to use it for the first week or so of marriage but to take the pill "when the honeymoon was over" for a year or so until a baby was planned.

A Turkish Cypriot mother was a typical example of this pattern of behaviour. She had been married for almost 3 years and had taken the pill for the first 1½ years, except for the first week of marriage. It had taken her 6 months to become pregnant.

She told us that when her baby daughter was put onto her stomach by the midwife, she wouldn't take the baby. "I don't want a girl, take it away, take it away!" she cried. Her husband too was disappointed. All their relatives and friends here and in Cyprus had predicted that the baby would be a boy. Now, she said (at the time of the interview) they are happy enough with a daughter. She said that having a baby will make their marriage better.

Occupation/Socio-economic Status

Social class is a notoriously difficult concept. It is particularly difficult to apply in respect of a young female population since it is a concept used to differentiate people according to lifestyle, determined in part by income and in part by type of occupation. Kingsley and McEwan (1977) have described the particular difficulties encountered in family planning research.
Problems arise in comparing groups of young women by their socio-economic status because of the high proportions of school-age girls and young married women describing themselves as "housewives". In addition, because high proportions of girls work in offices, as clerks or typists, or in shops, they appear to belong to a non-manual class, yet they are the daughters or wives of manual workers.

In order to circumvent these problems, the socio-economic group of fathers or husbands is often used instead of a woman's own occupation. This is not a satisfactory alternative mainly because it ignores the real change in status which may have been achieved by some young women with working class backgrounds. It also fails to take into account single parent families or those where fathers are absent (and mothers are the heads and principal earners of the family – in fact, in the two groups of pregnant teenagers, over 10% of the girls did not know what their father's job was; this proportion was much lower for the clinic attenders (3%)).

Not surprisingly, in view of their age distributions, the abortion patients and clinic attenders had the highest proportions of girls still at school, 18% and 17% respectively, compared with 8% of the young mothers. These two groups also had the highest proportions of girls at college full-time.

Teenagers describing themselves as "housewives" predominated among the young mothers, 24% compared with only 7% of the abortion patients and 1% of the clinic attenders.

The most substantial difference in the social class composition of the three groups was between the mothers and the other two groups. While 68% of the working mothers
were to be found in the non-manual groups, 78% of the abortion patients and 80% of the clinic attenders were in non-manual work. The mothers also featured most prominently in the least skilled manual group.

Using occupation of respondent as a measure of social class, we found very little difference between the abortion patients and the clinic attenders, largely because of the high proportions in both groups of girls working in non-manual occupations. However, when the social class of respondent's father is used as a measure (where working and where occupation is known), there are immediate differences, clinic attenders having a far higher proportion of non-manual class fathers, 43%, compared with the abortion patients, 28%, or the mothers, 19%.

There were few pregnant teenagers in the non-manual classes, particularly young mothers, compared with the national figures, and the proportions in the manual classes were correspondingly greater.

Social class of respondent's father - %

<table>
<thead>
<tr>
<th></th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
<th>Farrell's Study</th>
<th>1971 Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-manual</td>
<td>28</td>
<td>19</td>
<td>43</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>Manual</td>
<td>70</td>
<td>76</td>
<td>52</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>Other/Unclassifiable</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>13</td>
</tr>
</tbody>
</table>

100% 100% 100% 100% 100%

NB These figures exclude those who did not know their fathers' occupations and those whose fathers were dead.
It was not possible to compare our figures with those quoted for the King's preliminary study (McEwan et al (1974)) as in that study three different sources are used in combination (that of respondents' husbands, if married, their fathers if they were single and still living at home, or their own if they were living independently). Nevertheless, differences between the abortion patients and the antenatal group in that study showed a trend similar to our figures, with a particularly small proportion in the non-manual class for the antenatal group, though numbers are small.

Social class - King's preliminary study  

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Antenatal Group</th>
<th>Abortion Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-manual</td>
<td>13.8*</td>
<td>24*</td>
</tr>
<tr>
<td>Manual</td>
<td>86.2</td>
<td>72</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* These figures are derived from information in the text of McEwan et al (1974).

Education

The clinic attenders were well ahead of the other teenagers in proportions having O levels, CSEs or A levels, in all age groups. A similar distribution could be seen amongst girls still in education and working towards exams: 68% of the clinic attenders were sitting for O or A levels, compared with 35% of the abortion patients and 20% of the young mothers (although numbers in this latter group are very small). In our entire sample of 550 girls, only three were attending university, two
abortion patients and a clinic attender. Another clinic attender was working for a degree, but not at a university.

Respondents' Educational Qualifications and Years of Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O/CSE A Other</td>
<td>O/CSE A Other</td>
<td>O/CSE A Other</td>
</tr>
<tr>
<td>16</td>
<td>14</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>17</td>
<td>26 1 1</td>
<td>12 1 1</td>
<td>21 3 2</td>
</tr>
<tr>
<td>18</td>
<td>22 2 2</td>
<td>23 1</td>
<td>19 2 1</td>
</tr>
<tr>
<td>19</td>
<td>22 6 3</td>
<td>45 2 2</td>
<td></td>
</tr>
<tr>
<td>N=</td>
<td>84 9 6</td>
<td>33 4 3</td>
<td>67 5 4</td>
</tr>
</tbody>
</table>

The clinic attenders received slightly more encouragement from their parents to stay on at school or college. Nevertheless, almost half of the girls said they were given no encouragement at all, 48% compared with 51% of the abortion patients and 57% of the young mothers.

The parents, but particularly the mothers, of UK Black girls were much more likely to have encouraged their daughters to stay on at school than the UK White girls' mothers, and apparently with some success, for fewer UK Black girls than UK White girls had no educational qualifications at all. Also, UK Black girls, with a higher proportion still at school, were likely still to be working for exams and not to have received their qualifications yet.

It would appear that the parents, particularly the mothers, of the UK Black girls, interpret their parenting or mothering role differently from the mothers and
fathers of UK White girls. In West Indian families greater emphasis is placed on discipline and educational achievement than is usual in similar indigenous families.*** For the children of black immigrants to succeed in our race-conscious society, they must have as good if not better qualifications than their white contemporaries. It may be that the way to achieve these qualifications works to the detriment of close mothering. Unfortunately, the unplanned and unwanted pregnancies which UK Black girls in the study appeared to be experiencing so disproportionately, may make the struggle to succeed even more difficult for these girls and their mothers.

Ambitions

Dunnell (1979), looking at planning and social class, has observed that "women in the lower social groups may hold marriage and childbearing as their principal objectives; they are certainly goals that are reached earlier in life than by women in the higher social groups. But before the first major stage of the adult life cycle, marriage, is reached, women in the lower social classes reduce their expectations for other important aspects of their lives such as their home, education, work and travel or holidays, to a greater extent than women in the higher social groups. By the time they are married, women in higher social groups have also been much more successful than other women in achieving their aims" (p.24).

**Encouragement to stay on at school: UK Black and UK White teenagers**

<table>
<thead>
<tr>
<th></th>
<th>Young Mothers</th>
<th>Abortion Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK Black</td>
<td>UK White</td>
</tr>
<tr>
<td>Mother only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>encouraged</td>
<td>13 (21%)</td>
<td>7 (11%)</td>
</tr>
<tr>
<td>Both parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>encouraged</td>
<td>29 (47%)</td>
<td>10 (11%)</td>
</tr>
<tr>
<td>Other person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>encouraged</td>
<td>1 (2%)</td>
<td>6 (7%)</td>
</tr>
<tr>
<td>Not encouraged</td>
<td>19 (31%)</td>
<td>69 (75%)</td>
</tr>
<tr>
<td>Total:</td>
<td>62 (101%)*</td>
<td>92 (101%)*</td>
</tr>
</tbody>
</table>

*Figures rounded
Dunnell found that "within each social class those who received more or further education and had jobs classed higher on the SEG scale were less likely to have been teenage brides or pregnant at marriage. However, differences between women in different social classes with similar educational experiences persisted".

Dunnell has implied that all women set out in life with similarly "high" expectations and ambitions and that those of the lower social classes fail to achieve their aims. However, it seems more likely that there is a considerable variation in aims and expectations between groups of young women. Many of our indigenous teenage mothers had opted out of education well before the official school leaving age. We heard from respondents of mothers who were pleased to pay the fines imposed on them for not enforcing their daughters' attendance at school. For people such as these, the education they were offered did not provide the key to achieving their ambitions.

Comparatively few white parents encouraged their daughters to continue at school (and by continue, most girls appeared to think we meant that they remain until the age of 16). An abortion patient told how she had decided not to have the baby and had "finished up" with her boyfriend because her career was more important to her — she worked in a supermarket.

We have noted that the working young mothers had the highest proportion in the least skilled manual group. These girls were found to be just as satisfied with their most recent job as the other teenagers and, in fact, were less likely to say they were not satisfied.

For some young women it may be that a greater turnover of the more menial and less demanding jobs compensates for any lack of prospects or low remuneration.
For certain types of women, meeting other like-minded women at their workplace is probably more important than the work itself; or simply the financial rewards of any work may well make it acceptable and "satisfactory", especially if it is seen as being merely of a temporary nature, filling in time before having a family. These may also be the only jobs available which are part-time and so expectations may not be so great. Many of our teenagers' mothers worked as part-time office or school cleaners and the very early or very late hours seemed to make such jobs attractive, as husbands or other older family members were usually at home at these times to keep an eye on the younger children.

Foner (1976) has reported West Indian women receiving great intrinsic satisfaction from their jobs. "Many nurses' auxiliaries and ward orderlies talked with enthusiasm and pride about their dealings with hospital patients ... those in catering often described the new dishes they had learned to prepare and many women boasted of the sewing skills they had acquired in England. This enthusiasm for their jobs ... relates at least partially to their pattern of interrupted work histories and in part to the comparison between occupational opportunities in Jamaica and England."

We asked our teenagers what they thought was most important for a girl - her job or career; her baby and family; or perhaps they were equally important?

Making a choice between career and family:

<table>
<thead>
<tr>
<th>(%)</th>
<th>Young mothers</th>
<th>Abortion patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job or career</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Baby and family</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Equally important</td>
<td>67</td>
<td>55</td>
</tr>
<tr>
<td>Other/dont know</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>* Figures rounded</td>
<td>99%*</td>
<td>99%*</td>
</tr>
</tbody>
</table>
While there was comparatively little difference between these two groups, the same replies looked at by ethnic origin - here UK White and UK Black girls only - revealed a considerable difference between the expectations and ambitions of these two groups of teenagers.

Making a choice between career and family - UK Black and UK White teenagers

<table>
<thead>
<tr>
<th>(%)</th>
<th>Young Mothers</th>
<th>Abortion patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
</tr>
<tr>
<td>Job or career</td>
<td>5 (5)</td>
<td>4 (7)</td>
</tr>
<tr>
<td>Baby and family</td>
<td>34 (37)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Equally important</td>
<td>51 (55)</td>
<td>57 (92)</td>
</tr>
<tr>
<td>Other/dont know</td>
<td>2 (2)</td>
<td>-</td>
</tr>
</tbody>
</table>

Almost the entire group of UK Black young mothers placed equal emphasis on career and family, compared with about half of the UK White girls. And while just over a third of the UK White girls in the two pregnant groups seemed to view child-bearing (not necessarily marriage) as a principal objective, very few of the UK Black girls shared their view. In our multi-cultural sample of teenage girls, it did not appear that early child-bearing necessarily indicated a lowering of expectations, but rather different expectations and a re-ordering of priorities, precipitated by their earlier sexual experience and pregnancy.
Geographical dispersal and residence

In the late 1960s, Moody interviewed 100 West Indian mothers in the antenatal clinic at King's College Hospital (Moody and Stroud (1967)). On the basis of these findings, it was recommended that West Indian women in the area be given financial assistance in the form of loans to help them buy their own homes. A few years later, Pollak (1972) in her study of three year old children in Brixton, noted the comparatively high rents for poorer amenities being paid by West Indians.

Benson (1981) and Patterson (1963) have described the historical changes in the Borough of Lambeth. "Between 1961 and 1971, the percentage of Lambeth households in rented accommodation fell by 7.4% to 50.1%; but the percentage of the housing stock, defined in terms of rooms occupied by these households fell even faster, by 10.2% to 40.2%. Overcrowding was especially bad in the furnished sector, where 11.2% of the population occupied 8.5% of the housing stock" (Benson (1981) p.25).

In the last decade enormous changes have taken place in this district. Today council estates proliferate in the heart of Brixton, the area bounded by Brixton Hill, Denmark Hill and Tulse Hill (encompassing the so-called "frontline", the Railton Road area where rioting was most severe in 1981). For this study, three months at the end of 1979 were spent moving about the district interviewing teenagers in family planning clinics. All community clinics were either located on or close to council estates.

Sixty-three percent of the pregnant teenagers and 45% of the clinic attenders said that they lived in council accommodation. Clinic attenders had the highest proportion living in privately owned accommodation, 38% compared with 21% of the abortion patients and 13% of the mothers.
Part of the reason for the very small proportion of young mothers living in privately owned accommodation may be that more of these girls were married and living independently of their parents. In fact, more of the clinic attenders lived with their mothers than did the pregnant girls, 74% compared with 64% of the abortion patients and only a third of the mothers.

More of the young mothers had lived in their present area of residence (for example, Peckham or Brixton) for only a year or less, 49% compared with 24% and 22% of the abortion patients and clinic attenders. Not surprisingly, there were fewer young mothers who had lived in their present area of residence for ten years or longer, 19%. However, the group of mothers is the oldest group, with fewer still living in their parental home. Almost half of the clinic attenders (48%) had lived in the same area for 10 years or more, compared with 31% of the abortion patients.

The areas of residence themselves are, of course, related to the types of accommodation available in those areas, so that higher proportions of the pregnant teenagers came from high density council housing areas.

Non-residents of the district were usually from bordering areas, although a small number of non-resident young mothers who were from further afield had been referred to the main study hospital because they were at high medical risk. In fact, a quarter (26%) of the mothers came from outside the district, mainly from neighbouring areas, a few because they had had their first babies at the hospital and wanted to return - a practice encouraged, or in any case, not discouraged.

Non-resident clinic attenders (20%) were a similar group, girls who had moved out of the district but wanted to
return to the same clinic and girls whose nearest clinic was in the district, although they lived just over the border.

Non-resident abortion patients were an even smaller proportion, but of the three groups these women attracted the greatest controversy in the hospitals. Women who lived outside the district were very firmly turned away when they requested abortions at district hospitals. It may be that even non-residents having babies or requesting family planning, because of financial stringencies, will eventually be similarly discriminated against, although of course hospitals and clinics in areas bordering this district did see non-residents of their districts in the same way as our district's hospitals saw their residents. Nevertheless, at the time of the study, only the exclusion of non-residents requesting National Health Service abortions was strictly applied.

It is, therefore, surprising that our abortion patients included as many non-residents as they did. A small number were "friends of friends" ("my mother's friend is secretary to a consultant and she fixed it up for me"). Some were personal referrals made by doctors outside the district to doctors they knew in the hospitals ("the old boy network"). Some girls were shrewd enough to give false addresses inside the district, sometimes even at their GP's suggestion, when he knew the hospitals' strict rules. Some actually moved into the district, staying with a relative or boyfriend, and registered with a local GP; and some just slipped through the net, their addresses unchecked or perhaps on the district's boundaries.

Young and Willmott (1957), looking at families in the East End of London in the 1950s, commented on the way in which working class mothers and daughters remained in physical contact after the daughters' marriages, continuing to reside as near each other as possible, the mothers
making extensive enquiries in their search for suitable accommodation and even bribing officials if necessary in order to maintain their proximity (pp.39-40).

Twenty-nine percent of our young mothers who were not living with their own mothers saw them daily and almost half at least once a week. This is much more frequent contact than that reported by the abortion patients and clinic attenders, of whom only 20% and 18% respectively of those who were not living at home saw their mothers daily, and 31% and 21% respectively weekly.

Over half, 56%, of the mothers of the young mothers who lived independently, themselves lived in the district, which made frequent contact much easier for them. In fact, only a few of the pregnant teenagers had mothers living at any distance away, compared with the clinic attenders, 22% of whose mothers lived in the U.K. but outside London, and 22% of whose mothers actually lived outside the U.K. This compared with 14% and 9% respectively for the abortion patients and 16% and 10% respectively for the mothers.

This raises two interesting questions: the importance of close geographical proximity for some groups of family members, particularly mothers and daughters, and the limited geographical mobility of some groups of people. Some immigrant groups, notably the West Indians in South London (Lee (1977)), show only a limited degree of mobility beyond a particular locality, but social class differences in groups of indigenous people are usually regarded as having the greatest influence on mobility.

Partners

Age: Girls were asked the present age of their partner (or the putative father); his work, how old he was when he left school and whether he had any
qualifications; where he was born and his ethnic origin. Where a girl's current partner or boyfriend was not the putative father, details of both men were recorded, but it is the characteristics of the putative fathers which appear here.

Two interviews with abortion patients were incomplete and so their subjects have been excluded; three girls refused to speak at all about the putative fathers and these have also been noted in comment or excluded. There nevertheless seems to be an excess of abortion patients who were not able to give us basic information about their partners.

For all the girls, their partners were considerably older, the young mothers quite outstanding with 8% of their partners over 30 years old. This group also had the oldest partner (55 years, a Pakistani husband). Only 1% of the abortion patients' partners were over 30 and none of the clinic group's were. Altogether 6 partners were under 16; 5 of these were 15 and one 14 years old.

**Education:** A quarter of the young mothers did not know how old their partner was when he left school, compared with 20% of the abortion patients and only 3% of the clinic attenders. This is probably not surprising, since the young mothers' partners had in the main left school or other education at least several years before. Only 3% of the young mothers' partners were at present at school, compared with 10% of the abortion patients' and 12% of the clinic attenders'. None of the four young Asian mothers could answer this question. It is possible that their husbands had never been to school.

Twenty-five partners had left school at the age of 14 or even younger, 5% of the abortion patients', 6% of the young mothers' and 2% of the clinic attenders' partners.
The clinic attenders had by far the highest proportion of partners with A levels (13% compared with 5% and 4% of the abortion patients' and young mothers' respectively). Thirty-five percent of the abortion patients did not know what qualifications their partners had, compared with 28% of the young mothers and 12% of the clinic attenders.

Mothers of our teenagers

About two-thirds (68%) of the clinic attenders' mothers had been married once only and were still living with their husbands, compared with about half of the pregnant girls' mothers (49% of the abortion patients' and 55% of the young mothers'). Almost a fifth (19%) of the abortion patients' mothers were, in fact, divorced, compared with 13% of the mothers of the other two groups of girls. Cultural differences probably provide part of the explanation for these differences and the apparent greater stability in the clinic attenders' parents' relationships.

Eight (4%) of the young mothers' mothers had had 10 or more children (one had had 20), compared with 7 (3%) of the abortion patients' mothers. Only 2 (2%) of the clinic attenders' mothers had had such large numbers of children (each with 11).

<table>
<thead>
<tr>
<th>No. of Children of Respondents' Mothers (%)</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 children</td>
<td>96 (44)</td>
<td>70 (32)</td>
<td>68 (60)</td>
</tr>
<tr>
<td>4 - 6</td>
<td>91 (41)</td>
<td>100 (46)</td>
<td>38 (34)</td>
</tr>
<tr>
<td>7 - 9</td>
<td>21 (10)</td>
<td>38 (18)</td>
<td>4 (3)</td>
</tr>
<tr>
<td>10 or more</td>
<td>7 (3)</td>
<td>8 (4)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Dont know</td>
<td>5 (2)</td>
<td>1 (1)</td>
<td></td>
</tr>
</tbody>
</table>

Figures rounded
Estimates of family size of our teenagers could not be based on the numbers of siblings of these girls. Numbers of true siblings (including respondent) and numbers of children of the girls' own mothers make an interesting comparison. While 9 (4%) of the abortion patients were the only children of their mothers (as far as they knew), 17 (8%) were the only children of a particular mother and father, although their mothers had had other partners' children. Similarly, 8 (4%) of the young mothers were their mothers' only children, while an additional 11 (5%) were the only children of their mothers and a particular partner. Only for the clinic attenders was there a close correspondence between numbers of true siblings and numbers of mothers' children, 63% being one of up to three siblings (respondent alone or with one or two siblings), compared with 54% of the abortion patients and 42% of the young mothers. Again, the large numbers of West Indian girls in these latter groups and their mothers' different family patterns largely account for the differences.

Two (2%) of the clinic attenders' mothers had been 15 years or under when they had their first children, compared with 8 (4%) of the abortion patients' (one of whose mothers was believed to be 10 years old at the time) and 16 (7%) of the young mothers' mothers (the youngest said to be 11 years). Proportions of girls' mothers who were under 20 years at the time of their own first births were a fifth (23) of the clinic attenders' and 32% (70) of the abortion patients' and 40% (87) of the young mothers' own mothers.

As anticipated, it was the mothers of our young mothers who had commenced child-bearing at the earliest ages and who had had the largest numbers of children.

Some of the difficulties we experienced with classification were commented on in the discussion of the methodological issues raised by survey procedures. In addition, the reliability of certain data on partners (p.70-1) and the girls' own mothers (p.60-6) was called into question. The possible effects of these factors on the above findings should be borne in mind.
B. Sexual and Reproductive Histories

Menarche

Three girls said that they first learned about periods when they were 5, and one young mother said she had been 17. (She meant, probably, that this was the age at which she had learned about periods at first hand - or perhaps she really did mean that it had been a surprise. Unfortunately we do not know.)

Age at which first learned about periods (%)

<table>
<thead>
<tr>
<th>Years</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10</td>
<td>42 (19)</td>
<td>24 (11)</td>
<td>27 (24)</td>
</tr>
<tr>
<td>10</td>
<td>49 (22)</td>
<td>39 (18)</td>
<td>24 (21)</td>
</tr>
<tr>
<td>11</td>
<td>44 (20)</td>
<td>60 (28)</td>
<td>28 (25)</td>
</tr>
<tr>
<td>12</td>
<td>37 (17)</td>
<td>37 (17)</td>
<td>16 (14)</td>
</tr>
<tr>
<td>13</td>
<td>24 (11)</td>
<td>34 (16)</td>
<td>6 (5)</td>
</tr>
<tr>
<td>14 and over</td>
<td>18 (8)</td>
<td>18 (8)</td>
<td>12 (11)</td>
</tr>
<tr>
<td>Don't know/ not asked</td>
<td>6 (3)</td>
<td>5 (2)</td>
<td>-</td>
</tr>
</tbody>
</table>

Figures rounded

The abortion patients and clinic attenders appeared to have much more in common here than they did with the young mothers, 45% of the clinic attenders learning about periods by the time they were 11 years old, compared with 41% of the abortion patients. Only 29% of the young mothers had learned by this age. Since the clinic attenders' ages at menarche were also later, it was less likely that they would start menstruating unprepared. By the time they were 13 years old, more than half of all the teenagers had had their first period. In fact, adolescent girls (and boys) have been shown to reach maturity over a wide range of ages (Tanner (1962)).
Respondent's Age at Menarche (%)

<table>
<thead>
<tr>
<th>Years</th>
<th>Abortion Patients</th>
<th>Mothers</th>
<th>Clinic Attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10</td>
<td>3 (1)</td>
<td>4 (2)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>10</td>
<td>16 (7)</td>
<td>14 (7)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>11</td>
<td>56 (26)</td>
<td>56 (26)</td>
<td>24 (21)</td>
</tr>
<tr>
<td>12</td>
<td>51 (23)</td>
<td>50 (23)</td>
<td>28 (25)</td>
</tr>
<tr>
<td>13</td>
<td>52 (24)</td>
<td>46 (21)</td>
<td>31 (27)</td>
</tr>
<tr>
<td>14 and over</td>
<td>39 (18)</td>
<td>46 (21)</td>
<td>24 (21)</td>
</tr>
<tr>
<td>Don't know/ not asked</td>
<td>3 (1)</td>
<td>1 (1)</td>
<td>-</td>
</tr>
</tbody>
</table>

Figures rounded

Over forty percent of the UK Black young mothers menstruated before 12 years, compared with about a third (32%) of the UK White mothers. Numbers of UK Black and Jamaican girls in the clinic group and Jamaican young mothers were too few to compare.

Abortion patients' and young mothers' age at menarche (%)
UK Black and UK White teenagers only

<table>
<thead>
<tr>
<th>Years</th>
<th>Abortion patients</th>
<th>Young mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
</tr>
<tr>
<td>Under 10</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>10</td>
<td>4 (5)</td>
<td>6 (9)</td>
</tr>
<tr>
<td>11</td>
<td>20 (24)</td>
<td>23 (33)</td>
</tr>
<tr>
<td>12</td>
<td>17 (21)</td>
<td>23 (33)</td>
</tr>
<tr>
<td>13</td>
<td>22 (27)</td>
<td>10 (15)</td>
</tr>
<tr>
<td>14 and over</td>
<td>19 (23)</td>
<td>6 (9)</td>
</tr>
<tr>
<td>Don't know/ not asked</td>
<td>1 (1)</td>
<td></td>
</tr>
</tbody>
</table>

Figures rounded

In Farrell's study, the average age at which girls started to menstruate was 12.5 years, almost two years after they had been told about periods. This is very close to the average ages in our three groups, although the abortion patients were slightly younger, 12.2 years, compared to 12.4 years in the other two groups.
First and most recent sexual experiences

National statistical information on the first sexual experience of young people and their later sexual activity is rare. For the U.K., we have only Schofield's and Farrell's dissimilar studies, and Dunnell's rather different findings. A decade separates Schofield's and Farrell's studies and this period, from the mid-60s to the mid-70s, saw substantial changes in teenage experience and attitudes. Our study is of a local and special group of teenage girls which is not representative of the young people in the district as a whole and it is not realistic to judge its findings by those of other studies.

Age at first sexual experience:

Farrell found that "nearly half of those who said they were sexually experienced said that they had had their first experience before they were 16. This means that a fifth (21%) of the whole sample had had at least one sexual experience by the time they were 16; three-quarters of them were boys. Twelve per cent of all the girls in the sample said they had had intercourse by that age and 31% of all the boys" (p.21).

If we look just at those teenage girls who admitted being sexually active in Farrell's sample, 17.6% had had their first sexual experience before 16 years. Schofield's 1965 study showed 6% of the 15 year old boys and 2% of the girls aged 15 saying they were sexually experienced.

Fewer of our clinic attenders (31%) had their first sexual experience before they turned 16 years than comparable proportions of the other groups, 46% of the abortion patients and 42% of the young mothers.

Differences related to ethnic origin account for part of the difference between the girls who had been pregnant and those who had not. Of all the pregnant girls, 42% of the UK White girls and 56% of the UK Black girls were sexually experienced before turning 16. The abortion
patients were the more extreme group, with 62% of the UK Black girls having intercourse before 16 years compared with 43% of the UK White girls. In the group of young mothers, these two proportions were half of the UK Black girls and 41% of the UK White girls.

Social class differences in age at first sexual experience, young working class people becoming experienced earlier, have been found in several studies (see especially Kantner and Zelnik (1972) and Venner (1972)) although Farrell found that working class girls showed a greater similarity to middle class boys and girls than to working class boys. Certainly our finding has been that the clinic attenders who composed the better educated group of girls, whose fathers were proportionately more in the non-manual class, had had their first sexual experience later than the pregnant teenagers. In fact, 16% had had their first experience at 18 years or older, compared with 7% of the abortion patients and 10% of the young mothers, and this is not taking into account the much higher proportion of young mothers in the older age groups.

Over two thirds (68%) of the young mothers were aged 18 or 19 years at the time of the interview, compared with 43% of the abortion patients. Comparison of their experiences showed great similarity, with 12% (17 girls) of the young mothers and 11% (11 girls) of the abortion patients having had their first sexual experience by the time they were 15 years old. By the time they turned 17, 62% (91) of the 18 and 19 year old young mothers and 58% (56) of similar abortion patients had had their first sexual experience. However, proportions of UK White and UK Black girls among the 18 and 19 year old pregnant girls showed opposite trends, with half of the UK Black young mothers in that age group, compared with almost three-quarters (73%) of the UK Black abortion patients; while 77% of the UK White young mothers and 40% of the UK White abortion patients were in this older age group.

Ford, Zelnik and Kantner (1981) reported socio-economic status of young women related to age at first intercourse, contraceptive use at first intercourse,
regularity of use and use of medical methods. They noted an earlier initiation of sexual activity and less regular use of contraceptives as in all probability leading to a concentration of pregnancies in the lower socio-economic groups. Their findings were that black women and women whose parents or guardians had a relatively low level of education were more likely to be sexually active.

Our UK Black teenagers in the two pregnant groups certainly were more likely to have had their first sexual experience by the age of 15 years than were similar UK White girls - in fact, 62% of the UK Black abortion patients were sexually experienced by that age.

<table>
<thead>
<tr>
<th>Years</th>
<th>Abortion patients</th>
<th>Young mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
<td>UK White</td>
</tr>
<tr>
<td>11</td>
<td>-</td>
<td>2 (3)</td>
<td>-</td>
</tr>
<tr>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>2 (2)</td>
<td>5 (7)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>14</td>
<td>11 (13)</td>
<td>20 (29)</td>
<td>8 (9)</td>
</tr>
<tr>
<td>15</td>
<td>23 (28)</td>
<td>16 (23)</td>
<td>24 (26)</td>
</tr>
<tr>
<td>16</td>
<td>25 (31)</td>
<td>14 (20)</td>
<td>30 (33)</td>
</tr>
<tr>
<td>17</td>
<td>12 (22)</td>
<td>9 (13)</td>
<td>16 (17)</td>
</tr>
<tr>
<td>18</td>
<td>-</td>
<td>3 (4)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>19</td>
<td>3 (4)</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (1)</td>
<td>-</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

83 (101%) 69 (99%) 92 (101%) 62 (102%) 75 (100%) 10 (100%)

(Figures rounded)

* Numbers in this group very small.
Number of sexual partners and nature of first sexual experience:

There was very little difference between groups in the number of girls' sexual partners. In all, over half had only ever had one partner and over three-quarters of all the teenagers had only ever had one or two sexual partners.

Altogether, 33 girls had had sexual partners too numerous to remember, equally high proportions for the clinic attenders and abortion patients (8%), while the young mothers were 3%.

There were four abortion patients who reported being raped on the first occasion, one young mother and one clinic attender. Although in the most recent relationship we have recorded only one abortion patient as a rape victim, several other girls were described in their hospital notes (by social workers, nurses or doctors) as rape victims. One girl was educationally sub-normal and the boy was a neighbour and friend of her brother who visited her home frequently and who certainly did not use force with her. She had realised what was happening and had not opposed it. Cases like this posed considerable problems for us. It is quite likely that among the rape experiences reported by some girls as their first sexual experiences, there were similar cases.

The majority of the UK Black girls in the pregnant groups had had only one or two sexual partners, similar proportions to the UK White girls in these groups. In fact, over half of the UK Black and the UK White abortion patients had only ever had one sexual partner, while 61% of the UK White young mothers and 65% of the UK Black young mothers had only ever had one sexual partner.
Slightly more of the UK Black abortion patients' first sexual relationships were categorised as casual, but as already discussed in Part I, satisfactory definitions of steady and casual were difficult to apply.

<table>
<thead>
<tr>
<th>Nature of First Sexual Experience</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
<td>UK White</td>
</tr>
<tr>
<td>Casual</td>
<td>10 (12)</td>
<td>12 (17)</td>
<td>12 (13)</td>
</tr>
<tr>
<td>Steady at time</td>
<td>39 (47)</td>
<td>26 (38)</td>
<td>29 (32)</td>
</tr>
<tr>
<td>Steady and continuing</td>
<td>31 (37)</td>
<td>29 (42)</td>
<td>51 (55)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raped</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td></td>
</tr>
<tr>
<td>Dont know</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td></td>
</tr>
<tr>
<td>Not yet sexually active</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>83 (99%)</td>
<td>69 (99%)</td>
<td>92 (100%)</td>
</tr>
</tbody>
</table>

Figures rounded

* Numbers in this group very small.
Previous pregnancies

A fifth of the abortion patients and the young mothers had been pregnant before (in fact, for 4% of the abortion patients this was their third pregnancy, as it was for 2% of the mothers).

Most of the previous pregnancies had resulted in live births - 28% of the previous pregnancies of the abortion patients and 40% of the young mothers' had been terminated.

In the group of abortion patients, only 7% of the UK White girls had been pregnant before, compared to 31% of the UK Black girls and 50% of the Jamaican girls (although there were only 14 girls in this last group).

Of the young mothers, 18% of the UK White girls had been pregnant before (and accounted for 3 of the 4 girls who had been pregnant twice before) compared to 21% of the UK Black girls. The outcome of the previous pregnancies of UK Black and UK White abortion patients and young mothers is shown on p.139.

The proportion of previous pregnancies of the abortion patients was similar to that found in the King's preliminary study, 20% of that termination group (McEwan et al (1974)). In that study, 41 girls (19% of the abortion group) said that they had been pregnant before: 26 had had babies, 2 had had two babies, 8 had had abortions and 5 had had a baby and an abortion previously.
Previous pregnancies of UK Black and UK White girls (%)

<table>
<thead>
<tr>
<th>No. of previous pregnancies</th>
<th>Abortion patients</th>
<th>Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
</tr>
<tr>
<td>0</td>
<td>77 (93)</td>
<td>48 (70)</td>
</tr>
<tr>
<td>1</td>
<td>6 (7)</td>
<td>17 (25)</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>4 (6)</td>
</tr>
<tr>
<td></td>
<td>83 (100%)</td>
<td>69 (101%)</td>
</tr>
</tbody>
</table>

(Figures rounded)

Later pregnancies

We referred to the hospital notes of all teenagers a year after we interviewed them. There were considerable difficulties in locating all the notes and after numerous attempts only 207 sets could be found for the abortion patients (94%) and 180 for our young mothers (83%). A number of our teenagers could have become pregnant again and either had babies or abortions at other hospitals or centres.

From the notes, we learned that more of our young mothers than our abortion patients had returned to have babies in the 12 months following our interview: 15 (8%) compared with 10 (5%). Seven mothers (4%) and 6 of the abortion patients (3%) had had abortions. One girl in each group had had a miscarriage. In total, 13% of the young mothers and 8% of the abortion patients returned to our hospitals with pregnancies within a year of their earlier pregnancy.
C. Contraceptive Use

Method used at time of first sexual experience:

It became evident during interviews with the girls attending family planning clinics that a number were already taking the pill at the time of their first sexual experience. In fact, 22% of the sexually experienced girls (27% if the not yet active girls are included) had been taking the pill on the first occasion, while a third of the clinic attenders had used the sheath (making 60% of these teenagers reasonably safe from becoming pregnant the very first time they had intercourse).*

Contraceptive method (if any) used at first sexual experience (%)

<table>
<thead>
<tr>
<th>Method</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>11 (5)</td>
<td>24 (11)</td>
<td>25 (22)</td>
</tr>
<tr>
<td>Sheath</td>
<td>56 (26)</td>
<td>35 (16)</td>
<td>37 (33)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>12 (6)</td>
<td>8 (4)</td>
<td>12 (11)</td>
</tr>
<tr>
<td>Chemicals</td>
<td>-</td>
<td>1 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Safe period</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>-</td>
</tr>
<tr>
<td>Nothing</td>
<td>138 (63)</td>
<td>148 (68)</td>
<td>32 (28)</td>
</tr>
<tr>
<td>Not yet sexually active (to be pill users)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dont know/ not asked</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>220 (102%)</td>
<td>217 (101%)</td>
<td>113 (100%)</td>
</tr>
</tbody>
</table>

(Figures rounded)

* 17 of the girls who were pregnant had become so the first (and for some, the only) time they had had intercourse: 6% of the abortion patients and 1% of the young mothers.
Only 5% of the abortion patients were on the pill at the time of their first sexual experience; 26% had used the sheath, giving almost a third (31%) using some reasonable contraception on that occasion.

Eleven percent of the young mothers had been taking the pill the first time they had intercourse, and 16% had used the sheath, meaning that only 27% of the group had used reasonably reliable contraception on the first occasion. In the sample as a whole, other attempts, apart from withdrawal, to prevent conception on the first occasion were very limited: two girls had used chemicals (one mother and one clinic attender) and two had used the safe period (one abortion patient and one mother). Very few even attempted to use withdrawal - 11% of the clinic attenders; 6% of the abortion patients and 4% of the mothers. The great risk takers were those who did not attempt to do anything at all to prevent conception - 28% of the clinic attenders, 63% of the abortion patients and 68% of the young mothers.

Very few of the UK Black girls among the pregnant girls had used the pill to cover their first sexual experience, only 1 (2%) of the UK Black abortion patients fell into this category and only 20% had used the sheath, compared with 8% of the UK White girls who were on the pill and 35% who were using sheaths. Among the young mothers, the proportions were slightly higher (accounted for partly by the inclusion in this group of older girls having planned pregnancies), 19% of the UK White girls had used the pill and 23% the sheath, while 5% of the UK Black girls were taking the pill and 11% had used sheaths on the first occasion.
Method of Contraception (if any) used at time of First Sexual Experience - UK Black and UK White Teenagers (%)

<table>
<thead>
<tr>
<th>Method of Contraception</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK White</td>
<td>UK Black</td>
<td>UK White</td>
</tr>
<tr>
<td>Pill</td>
<td>7 (8)</td>
<td>1 (1)</td>
<td>17 (19)</td>
</tr>
<tr>
<td>Sheath</td>
<td>29 (35)</td>
<td>14 (20)</td>
<td>21 (23)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>7 (8)</td>
<td>1 (1)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Chemicals/Safe period</td>
<td>1 (1)</td>
<td></td>
<td>2 (3)</td>
</tr>
<tr>
<td>Nothing</td>
<td>39 (47)</td>
<td>52 (75)</td>
<td>52 (57)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong>:</td>
<td>83 (99%)</td>
<td>69 (98%)</td>
<td>92 (101%)</td>
</tr>
</tbody>
</table>

Figures rounded

* Includes 5 girls (7%) not yet sexually active

** Numbers in this group very small

When the experiences of our girls are compared with those of the teenagers in Farrell's study, it is almost impossible to discern any similarity.
Method of contraception used at first sexual experience (%)

<table>
<thead>
<tr>
<th>Method</th>
<th>Farrell's Study</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>8</td>
<td>5</td>
<td>11</td>
<td>27*</td>
</tr>
<tr>
<td>Sheath</td>
<td>36</td>
<td>26</td>
<td>16</td>
<td>33</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Chemicals</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Safe period</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Nothing</td>
<td>43</td>
<td>63</td>
<td>68</td>
<td>28</td>
</tr>
</tbody>
</table>

Figures rounded
* Including 5% not yet sexually active

However, if we look at the same proportions for our groups by ethnic origin (previous page), the UK White girls in the abortion group show a striking similarity with Farrell's teenagers, not even closely shared by any of our other groups - in pill, sheath and proportions using no contraception at all. Our clinic attenders as a group and all of our West Indian girls, show very distinct opposite leanings. Over three-quarters of the West Indian girls in the two groups of pregnant girls used no contraception at all the first time they had intercourse, only the UK White young mothers approaching them with over half (57%) using nothing at all. There is no doubt that in our total sample we have two very unusual groups behaving very differently from the "average".

Method used at time of conception:

None of the young mothers was taking the pill when she became pregnant, but 8 of the abortion patients (4%) claimed to be taking it correctly when they became pregnant. Those girls who were taking the pill but had forgotten it for a few days were classed as using nothing (and they were aware that they were taking chances).
However, contraceptive pill failure would not have been expected to be as high as this (that is, higher than the proportion of IUCD failures we found) and it is impossible to say whether or not some of these cases were user failure rather than method failure.*

IUCD failure was much easier to validate as these devices were usually removed at the time of the abortion (2%). Three of the young mothers (1%) said that their IUCDs had failed, but we do not know at what stage of the pregnancies the IUCDs were removed or expelled.

Sheath failures were said to have accounted for 9% of the abortion patients' pregnancies and 2% of the mothers'.

In fact, if we look at all attempts to prevent conception, ranging from use of the pill to withdrawal, 22% of the abortion patients and only 7% of the young mothers were making some effort not to conceive when they became pregnant. In spite of the fact that only just over half (57%) of the mothers described this pregnancy as "planned", for some of these girls the concept of planning a pregnancy seemed a little elusive, as a number of these girls also confessed to being shocked or upset when they first learned they were pregnant.

Simms and Smith (1980) in their study of schoolgirl mothers noted "an air of fatalism" which seemed to pervade the whole subject of birth control. "Whether 'intended' or not, pregnancy in these cases just seemed to happen and the girls went ahead with it, possibly because none of the educational or work alternatives seemed to be very attractive. Having a baby, even so young, constituted an acceptable lifestyle in their circle, and one that conferred

* One girl had not been told to take additional precautions in the first fortnight of taking the (low dose) pill which she was prescribed in one of our community family planning clinics and she became pregnant. Vomiting, diarrhoea, the use of broad spectrum antibiotics and certain other longterm drugs are also likely to affect the efficacy of the low dose contraceptive pills.
more status and perhaps more genuine satisfaction than did anything else open to them."

Use of the most effective methods - pill and IUCD

In view of our emphasis on the use by young women of a reliable method of contraception in the context of a serious boy-girl relationship, it is important to note the experiences of the pregnant girls in their previous efforts to use an effective method.

Abortion patients:

Pill use was much more common than IUCD use - 44% of the girls using a less effective method (for example, the sheath) initially had at some time taken the pill, and 35% of those who had used no contraception initially had at some time taken the pill. Just as many UK Black as UK White girls had used the pill at some time (about 40%).

All girls who had ever used the pill were asked how diligently they had taken it (that is, did they always remember to take it?); how long (in months of use) they had taken it; why they had ever stopped taking the pill; and the source from which they had first obtained it.

The initial pill users were much more likely never to have forgotten (49%) than those girls who had initially used nothing (13%). The diligence of UK Black and UK White girls was very similar, both groups with only about 18% who had always remembered. It may be that the initial pill users (in integrated relationships) found it easier to remember because they were encouraged to by their partners. Conversely, there were partners who actually sabotaged their women's efforts not to become pregnant ("he threw my pills away" or "he wouldn't let me take them").
Initial pill users far exceeded the other girls in the length of time they had taken the pill - 4 of the 7 girls who had taken it for longer than one year had taken the pill for between 2½ and 3 years. Only one initial pill user had taken the pill for 3 months or less, whereas over a quarter (28%) of those who had used no contraception initially had given up in 3 months or less, and UK Black girls were also more likely than UK White girls to take the pill for only a very short time.

It became very quickly apparent that the reasons given by girls for stopping the pill gave an incomplete, even misleading view of the situation. Those who said they stopped because they "ran out" or "just forgot to take them" were probably in similar situations to those who stopped because there seemed no longer to be any reason for taking them, since they had stopped seeing that boyfriend. Girls who said they "couldn't be bothered to take them" were also indirectly telling us that their relationships with their boyfriends were deteriorating or had finished. Some girls, but only a small number, gave medical reasons.

Almost a third of the UK Black abortion patients who had used the pill at some time had first been given the pill by a hospital doctor. None of the UK White abortion patients had. Also, about a quarter (23%) of the girls who had used no contraception at the time of their first sexual experience had first been given the pill by a hospital doctor - this was not the experience of any of the girls who had initially used some form of contraception, however unreliable.
In fact, 21 UK Black abortion patients (31%) had already been pregnant once (17 girls) or twice (4 girls), compared with only 6 of the UK White abortion patients (7%). Their contact with hospitals on those occasions would explain the high proportion having at some time used the IUCD or having obtained the pill from a hospital doctor as the first source.

Ford, Zelnik and Kantner (1981), looking at the sexual behaviour of young women in the United States, noted that "black teenagers were more likely than white teenagers to use medical methods.* For white teenagers, those with more highly educated parents were more likely to have used medical methods. In contrast to this, there was little difference in the percentage of blacks who used medical methods regardless of parents' education".

However, Ford, Zelnik and Kantner do not give any details of the sources of these methods nor of the proportions of these girls who had been pregnant. It seems likely that, as in our group, their sources were hospitals at the time of a pregnancy. The implication that these girls obtained medical methods on their own initiative may well be misleading.

Over half of the initial pill users had first obtained the pill from their GPs. (Similarly, since the majority of the initial pill users were UK White girls, almost half of the UK White girls who had used the pill had first been given the pill by their GPs.)

Family planning clinics were an important source of the pill for those who might be thought to be in greatest need of advice and encouragement, those girls who had

* "Medical methods" here include the pill, IUCD and the cap.
initially used no contraception and UK Black girls. The service and attitudes of the hospital and community family planning clinics' staff in the district are dealt with separately (see pp. 327 - 338).

A fifth of the abortion patients (43 girls) had at some time attended a clinic - 22% (18 girls) of the UK White girls and 23% (16) of the UK Black girls. Sixteen percent (34 girls) had first obtained the pill there, while for others it was their second or third source of the pill.

Young mothers:

In addition to the 3 girls who became pregnant with the IUCD in situ (and one of these is doubtful, since the girl said she knew that it had "fallen out" but she did not know when), 8 of the young mothers (5%) had at some time used the IUCD (compared with 6% of the abortion patients). Six of these eight other IUCD users had previously been pregnant and had been given the IUCDs after having abortions.

We recorded the periods of use of these IUCDs, ranging from a fortnight to just over two years:

<table>
<thead>
<tr>
<th>Name</th>
<th>IUCD Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Black girl</td>
<td>IUCD in situ 2 months</td>
</tr>
<tr>
<td>UK Black girl</td>
<td>25 months</td>
</tr>
<tr>
<td>UK Black girl</td>
<td>6 months*</td>
</tr>
<tr>
<td>UK White girl</td>
<td>12 months</td>
</tr>
<tr>
<td>Mixed race (West Indian)</td>
<td>1 month**</td>
</tr>
<tr>
<td>UK born girl with Irish parents</td>
<td>6 months***</td>
</tr>
</tbody>
</table>

As with the abortion patients, the pill had been used at some time by half of the girls who had used a less effective method initially, and 34% of those who

* "Fell out".
** Bad pains so removed. Later replaced by another IUCD which was expelled after 2 weeks.
*** "Fell out".
had used nothing initially (that is, 45% of the young mothers had at some time taken the pill). Fifty-five percent of the UK White and 39% of the UK Black mothers had used it - that is, more of the UK White young mothers than the UK White abortion patients (who were generally younger), but the same proportion of the UK Black girls as was found in both groups of pregnant girls.

There was no difference in the group of young mothers between the initial pill users and those who had used nothing initially in their diligence in taking the pill, over half of both groups either never forgetting or having forgotten once or twice only.

However, the initial pill users were much more likely to have taken the pill for over 6 months - only 21% having taken it for 6 months or less, compared with almost half (46%) of the girls who had used no contraception initially. Three initial pill users (13%) had given up after 3 months or less, compared with a third of those who used nothing initially.

Of those who had at some time taken the pill, 33 young mothers (34%) said they had stopped because they wanted to have a baby; 20 (21%) had been taking the pill in a rather lackadaisical manner and at the time of conception had either "run out" or "forgotten" to take them. Twenty-five (26%) gave reasons such as "felt sick", "put on weight", "had headaches", while 9 girls (9%) stopped because their relationships had ended and 10 girls (10%) "couldn't be bothered taking them". As with the abortion patients, these are probably superficial explanations which do not adequately reflect the girls' reasons for "forgetting" or "not being bothered".
The young mothers had a much smaller proportion receiving the pill from a hospital as a first source - only 7 girls (7%) of all those who had at some time used the pill. However, previous pregnancies present a very different picture for the young mothers than was seen among the abortion patients. Eight percent (2) of the UK White girls and 2% (1) UK Black girl quoted hospital as their first source of the pill.

Outcome of previous pregnancies*

<table>
<thead>
<tr>
<th>Abortion patients:</th>
<th>Abortion</th>
<th>Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 UK White girls (7%)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>21 UK Black girls (31%)</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young mothers:</th>
<th>Abortion</th>
<th>Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 UK White girls (18%)</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>13 UK Black girls (21%)</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

* Excluding miscarriages;
  some girls pregnant more than once;
  some girls had previously had miscarriages only (e.g. 3 UK Black young mothers).

GPs were the first source of the pill for about half of the young mothers (51%) who had ever used it - 47% of the UK White and 67% of the UK Black users. Fifty-eight percent of the initial pill users and 42% of the girls who had used no contraception initially had first obtained the pill from their GPs. Some girls were very young at the time; 14 and 15 year olds said they had first been given the pill by their GPs. A 19 year old was given the pill for "bad periods" when she was 15 and had used it for almost four years.
Forty-three young mothers (20%) had at some time attended a family planning clinic, 26% of the UK White girls but only 10% of the UK Black girls. Thirty-eight girls (18%) had first obtained the pill there and for 5 others (2%) it had been their second source. These proportions were similar to those found among the abortion patients.

Future contraception

We asked all the girls in the two groups of pregnant teenagers who, if anyone, had talked to them about contraception since they had become pregnant. Two-thirds of the young mothers, compared with about a third of the abortion patients, replied that no-one had talked to them.

A fifth of our young mothers said that a hospital doctor or nurse had talked to them about contraception since they had become pregnant; 2% named family planning clinic doctors or GPs and 10% said their mothers or their partners had talked to them.

It is suggested that there are many places more appropriate than on the ward immediately after the baby's birth at which contraception can be discussed - for instance, by district nurses and midwives, health visitors, GPs, perhaps at the six week postnatal check-up visit. Because of the belief that there will be other occasions which will provide opportunities to discuss contraception, with some women opportunities are sometimes lost forever - appointments are missed, other problems (such as illness or housing) are more pressing and the subject is never discussed in the detail it deserves.

Virtually every abortion patient had, in fact, been asked what method of contraception she intended using in the future (even though, in many cases, there was in reality little choice). However, to many girls this did not
constitute "someone talking to them about contraception". It was part of the bargain, in exchange for an abortion.

The young mothers were not at this disadvantage, evidenced by the much lower proportion saying they had spoken to someone about contraception. The young mothers, when asked what method they planned to use in the future were just as likely as the abortion patients to say the pill (55% compared with 59%), but far less likely to say they intended using the IUCD (18% compared with 35% of the abortion patients).

More UK Black girls than UK White girls were given the IUCD in hospital after an abortion (72% of the UK White girls left with the pill, compared with 48% of the UK Black girls, while 24% of the UK White girls and 44% of the UK Black girls said they would be using the IUCD). Of the young mothers, 63% of the UK White girls opted for the pill and 13% for the IUCD, while these two proportions for the UK Black mothers were 55% and 16%.
D. Knowledge and attitudes

Sources of information about periods, "where babies come from" and contraception

Periods and "where babies come from":

Parents, particularly mothers, played the leading role in telling their daughters about periods and about "where babies come from". However, the clinic attenders were much more likely to learn from their parents about periods and "where babies come from" than were the pregnant teenagers, many of whose parents seemed to be particularly reluctant about providing information on "where babies come from".

For each group, teachers had been more important as a source of information about "where babies come from" than they were about periods, perhaps because this is where most parents showed reluctance. However, on both questions fewer clinic attenders named a teacher as the first source of information.

Person who first told respondent about periods (%)

<table>
<thead>
<tr>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>66 (30)</td>
<td>42 (19)</td>
</tr>
<tr>
<td>Mother</td>
<td>104 (47)</td>
<td>104 (48)</td>
</tr>
<tr>
<td>Father</td>
<td>1 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Parents</td>
<td>3 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Older sister</td>
<td>15 (7)</td>
<td>16 (7)</td>
</tr>
<tr>
<td>Girlfriend</td>
<td>13 (6)</td>
<td>25 (12)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (1)</td>
<td>8 (4)</td>
</tr>
<tr>
<td>No-one</td>
<td>10 (5)</td>
<td>16 (7)</td>
</tr>
<tr>
<td>Dont know/not asked</td>
<td>5 (2)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

Figures rounded
Person who first told respondent "where babies come from" (%)  

<table>
<thead>
<tr>
<th></th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>74 (34)</td>
<td>68 (31)</td>
<td>24 (21)</td>
</tr>
<tr>
<td>Mother</td>
<td>76 (35)</td>
<td>78 (36)</td>
<td>69 (61)</td>
</tr>
<tr>
<td>Father</td>
<td>-</td>
<td>5 (2)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Parents</td>
<td>9 (4)</td>
<td>4 (2)</td>
<td>8 (7)</td>
</tr>
<tr>
<td>Older sister</td>
<td>13 (6)</td>
<td>11 (5)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Girlfriend</td>
<td>19 (9)</td>
<td>31 (14)</td>
<td>5 (5)</td>
</tr>
<tr>
<td>No-one</td>
<td>5 (2)</td>
<td>5 (2)</td>
<td>-</td>
</tr>
<tr>
<td>Other person</td>
<td>7 (3)</td>
<td>6 (3)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Not asked/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dont know</td>
<td>17 (8)</td>
<td>9 (4)</td>
<td>1 (1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>220 (101%)</strong></td>
<td><strong>217 (99%)</strong></td>
<td><strong>113 (101%)</strong></td>
</tr>
</tbody>
</table>

Figures rounded

The ages at which our teenagers learned "where babies come from" ranged from 2 to 18 years, which seems an extraordinarily wide range. Most girls learned this fact of life earlier than they did about periods, 70% of the clinic attenders, 57% of the abortion patients and 51% of the young mothers by the age of 10. The two extremes in ages when girls said they first learned "where babies come from" may partly be accounted for by their different cultural backgrounds - being present at a home birth, either to their mother or a near relative, or brought up in an environment where this type of knowledge is only passed on to a girl after her marriage.

Although the UK Black abortion patients learned about periods only slightly later than the UK White abortion patients, the most important person from whom they learned was reversed, UK White girls being more likely to learn from their mothers and the West Indian girls from their teachers about both periods and "where babies come from".
Teachers and parents as sources of knowledge about periods and "where babies come from"  
UK Black, Jamaican and UK White girls only 

<table>
<thead>
<tr>
<th></th>
<th>Periods</th>
<th>&quot;Babies&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teacher</td>
<td>Parents</td>
</tr>
<tr>
<td>Abortion patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK Black</td>
<td>32</td>
<td>45</td>
</tr>
<tr>
<td>Jamaican*</td>
<td>57</td>
<td>36</td>
</tr>
<tr>
<td>UK White</td>
<td>27</td>
<td>58</td>
</tr>
<tr>
<td>Young Mothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK Black</td>
<td>27</td>
<td>48</td>
</tr>
<tr>
<td>Jamaican*</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td>UK White</td>
<td>12</td>
<td>54</td>
</tr>
<tr>
<td>Clinic attenders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK Black*</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>UK White</td>
<td>16</td>
<td>71</td>
</tr>
</tbody>
</table>

* Small numbers in these groups

We can compare our findings on first sources of information about reproduction with those of Schofield and Farrell (replies from girls only):
First sources of information about reproduction %

<table>
<thead>
<tr>
<th>Source</th>
<th>Schofield (1965)</th>
<th>Farrell Abortion Clinic (1978)*</th>
<th>Patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>44</td>
<td>33</td>
<td>9</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Girlfriends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>28</td>
<td>32</td>
<td>35</td>
<td>36</td>
<td>61</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Teacher</td>
<td>18</td>
<td>24</td>
<td>34</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Siblings</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Books etc.</td>
<td>3</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>No-one</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Don't know/ can't remember</td>
<td>-</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

99% 117% 101% 96% 101%

* Some girls mentioned more than one first source
Figures rounded

It seems odd that so few of our girls learned from friends about "where babies come from" compared with Schofield's and Farrell's girls. One explanation may be that as boys were included in those two studies, there was a greater implication and expectation somehow reflected in the phrasing of the question(s) to make them appropriate to both sexes which encouraged this reply. Or it may have been the pervading flavour of their interviews in comparison to our obviously all female oriented interview. We have only quoted the figures for girls' replies above. In fact, the figures for boys' replies show even higher proportions giving "friends" as first source (Schofield 62%; Farrell 45%).
Farrell asserts that her results, compared with Schofield's, "reflect a developing awareness and preparedness on the part of parents and teachers to tell young people about the process of reproduction". Our figures would certainly support this, with much higher proportions in all groups learning from these sources than did Farrell's subjects, EXCEPT for the girls who had never been pregnant, who had an even lower proportion than Farrell found learning "where babies come from" from teachers as a first source.

First source of information about periods %

<table>
<thead>
<tr>
<th>Source</th>
<th>Farrell (1978)</th>
<th>Abortion patients</th>
<th>Mothers</th>
<th>Clinic attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers</td>
<td>47</td>
<td>48</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Fathers</td>
<td>66</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parents</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Teachers</td>
<td>30</td>
<td>19</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Other people</td>
<td>32</td>
<td>14</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>Don't know/</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not asked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No-one</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>101%</strong></td>
</tr>
</tbody>
</table>

Figures rounded

Teachers are not quoted specifically as a source of information about periods/menstruation by Farrell. They have probably been included with "other people". They are quite an important source for our groups, particularly the abortion patients.

We asked girls if their lessons had included learning about the menstrual cycle, periods and contraception. "Periods" was included shortly after interviewing began. It concerned us that in our first few interviews, some girls seemed not to understand what was meant by the menstrual
cycle. Apparently because of this failure to understand the meaning of "menstrual cycle", we found 69% of the mothers replying that they had learned about periods, while only 48% said that they had learned about the menstrual cycle. (The differences were not so extreme in the other two groups: 81% and 71% respectively for the clinic attenders and 74% and 72% for the abortion patients, although 11% of this group was not asked about periods at all.)

We did not attempt to explore the opinions and feelings of girls concerning the best source of information for them about periods and "where babies come from". Farrell did, and concluded "from the findings, it is clear that many young people and their parents see lessons at school as the best way to learn about sex" (p.226). "What this study has done is to point out that those young people who had first learned about sex at school were more likely to be satisfied with the way they had learned than those who had first learned from friends; that over half of them thought that school was the best way to learn about sex and birth control" (p.227).

From our findings, it appears likely that teachers are educating many girls in matters related to sex in default of their parents. It is the girls from those cultures and classes where parents do not easily accept this role themselves, who appear to have a greater likelihood of experiencing an early, unplanned pregnancy.

Some of the UK Black and Jamaican girls were likely already to have begun menstruating by the time they were given information about periods and the menstrual cycle at school, for as we have seen, a third of the abortion patients and the young mothers had had their first period by age 11. The clinic attenders were more fortunate. Not only were they far more likely to have learned about
periods from their parents, but they were also more likely to have heard about periods at school, before they began to menstruate.

Although they took a close interest in their daughters' education (see p. 108), the mothers of UK Black girls were less likely to have told their daughters themselves about periods or about "where babies come from". They were also much less likely to be named as the person girls had talked to most often about sex or who had been most helpful to talk to about sex, than the UK White girls' mothers.

Contraception:

Three-quarters of the abortion patients said they had learned about contraception at school compared with 65% of the clinic attenders. Just over half of the mothers (54%) could say this, but (as with their replies about the menstrual cycle), this may have been because some girls did not know what the word contraception meant. This group was the only one in which we had girls making such comments as "I don't like people using big words with me - I don't know what contra-whatever means". In fact, when it came to listing ways people could make sure they don't become pregnant, the mothers had the highest proportion listing five or more ways (35% compared with 25% of the abortion patients and 30% of the clinic attenders).

We also asked girls how old they were when they first found out, from any source, what contraception was. Of the clinic attenders, 24% knew before they were 12, although 16% of the abortion patients and only 11% of the young mothers knew by that age. But there must be some doubt about how this question was interpreted, for it seems extraordinary that 13% of the clinic attenders, 8% of the abortion patients and as high a proportion as 18% of the mothers could be 16 years or older before they found out what contraception is. It may be, again, that the word "contraception" was a stumbling block for some, particularly the young mothers, although it was asked in an obvious context. When it became apparent that a girl
did not understand, the meaning was explained to her. We are concerned about those who did not appear to us to be having difficulty understanding the meaning of the word "contraception" or who interpreted it to mean a sophisticated, or taught, knowledge, beyond the very general understanding we intended.

The abortion patients and the clinic attenders had similar age distributions - about 70% of both groups were aged 17 or over, and just over a quarter of both groups were aged 15 or 16 years (see p.98). They had similarly lived and been educated in the district - almost all these girls had had sex education lessons and over a quarter had started these lessons before they had turned 12. Three-quarters of the abortion patients said that lessons had included information about contraception, compared with 65% of the clinic attenders. Slightly more (89%) of the clinic attenders said that they thought they had "a pretty good idea" of contraception compared with the abortion patients (83%).

The opportunities the abortion patients had to learn about sex and contraception were equal to, if not better than those experienced by the clinic attenders. So how did their knowledge compare?

When asked simply to list as many ways they could think of to avoid getting pregnant (the words "family planning" or "contraception" were not used), 56% of the abortion patients could think of 4 or more ways, compared with 65% of the clinic attenders. The girls invariably listed methods of contraception here, although it was hoped that they would suggest other possibilities. (One unusual answer from an abortion patient was: "Couples talking to each other." She added: "The pill is not very good because you have to hide it!")

The girls were then asked if they had heard of a particular method, and what they thought were its advantages and disadvantages. Their replies were recorded as correct or incorrect. For every method tested in this
way, the clinic attenders had higher proportions knowing the correct answer. In some cases, the differences were slight (for pill, IUCD, withdrawal and the injectable contraceptive), but in others the clinic attenders were well ahead of the abortion patients (for the cap 47% - 28%; sheath 91% - 76%; pessaries 47% - 31%; and rhythm method 52% - 36%).

Occasionally it was difficult to gauge the extent of a girl's knowledge from the descriptions of advantages and disadvantages which were given:

The pill was believed to cause "brain damage"; "it affects your body - it makes your hormones cause you bronchitis and it also depends on your age"; "it's more proof" and "it's 98% proof"; or simply "you can put on weight and later in life you can have trouble with your inside".

The IUCD (which we called the coil and some girls, appropriately, called the "curl") was said to "rot inside you and ruin your womb"; and "a few friends have said they have messed up their insides".

The cap "gets in the way" or "it's for oldish women who don't have sex all the time"; "you don't know it's there - the skin might grow over it"; and "you have to touch yourself too much".

The sheath was almost universally known, but had various names, ranging from "bags" and "jolly bags" to "the rubber band thing that goes round 'them'".

Girls were then asked questions with a choice of replies:

About the pill: How long after you stop taking the pill are you in danger of becoming pregnant? Similar proportions, 63% of the abortion patients and 62% of the clinic attenders said 24 hours or less.
Sheath: More clinic attenders than abortion patients were correct, 83% compared with 73%.

Safe period: Many more clinic attenders than abortion patients could answer this correctly, 51% compared with 37%.

Abortion: Slightly more of the clinic attenders than the abortion patients said that abortion is less dangerous at under 16 weeks gestation, 51% compared with 47%.

Pessaries: More clinic attenders than abortion patients knew how to use these - 88% compared with 71%.

A comparison of knowledge and attitudes between our UK Black and UK White abortion patients

The UK Black and UK White abortion patients, making up about two-thirds of that group (31% and 38% of the abortion group respectively), similarly youthful, and to a similar extent brought up and educated in our district, were compared in their knowledge and attitudes towards contraception.

We have already discussed the differing sources of information about periods and "where babies come from" - the UK Black girls learning from teachers more often as a first source than from their mothers, the reverse of the UK White girls' experience - but what about the knowledge acquired by these two groups of girls?

Exactly the same proportions of UK Black and UK White abortion patients could list 4 or more ways of preventing pregnancy - 57%. Similar proportions had had school lessons on the menstrual cycle, periods or contraception, three-quarters of each group agreeing that they had had lessons on all three topics.

In testing their knowledge of the different methods of contraception, the two groups of girls also fared similarly, the following proportions giving correct replies:
The UK Black girls were slightly more familiar with pessaries and the rhythm method and slightly less so with the cap.

In the questions where they were asked to give methods according to their reliability, for very reliable and quite reliable methods, the UK White girls seemed to favour the pill and the UK Black girls gave more importance to the IUCD.
The slight preponderance of UK Black girls over UK White girls believing that the IUCD was a very or quite reliable method may be attributable to a cultural preference, but it is more likely to be a reflection of their differential experience with doctors and councillors. By the time we interviewed these girls, after the abortion operation, almost all who would be leaving with an IUCD would have already had it inserted. These were 44% of the UK Black girls, but only a quarter (24%) of the UK White girls.

Fewer UK Black girls knew about the cap. Although many girls had apparently been taught that it is an unpleasant and messy method (since its disadvantages were commonly described in this way), another reason for its low popularity is that many people do not think teenagers, particularly West Indian girls, would use it regularly and efficiently, in spite of the fact that there are those who work with West Indian women who recommend its use. West Indian women, they believe, are less likely to be inhibited by contact with their own genitalia, and their frequently unstable and unpredictable sex lives make this a convenient method (Christopher (1980)).

It is interesting that our UK Black girls were more knowledgeable than the UK White girls about pessaries (which may be obtained anonymously from chemists, unlike the cap which requires attendance at a clinic), but they fared less well in all the other practical knowledge tests.

In some respects the UK Black teenagers tried even harder than the UK White girls to keep themselves well-informed. We asked all the teenagers if they remembered any books or pamphlets, TV programmes or films connected with sex education which they had been given or shown at school, and also any books or pamphlets, TV programmes or films they had seen at home or elsewhere, from which they could say they had learned something useful. Except
for reading matter at school, which 46% of the UK Black girls and 48% of the UK White girls could remember, the UK Black girls had consistently higher proportions (from 7% to 10% higher) remembering films and TV programmes at school and at home; and more than twice as many UK Black girls said that they had read literature on this subject at home (38%).

Topics covered under the broad heading of sex education are frequently published in booklet form, funded by such organisations as the Family Planning Association or Brook Advisory Centres* or the Health Education Council, especially for distribution in schools, clinics and hospitals. This type of literature, the leaflets on display in doctors' or hospital waiting rooms and the informative articles which are frequently published in women's magazines, provide the bulk of the reading matter available to teenagers. Occasionally girls said that they had been given books by their parents or that they had bought paperbacks or borrowed books from the library. We asked girls to name the books and films they had read or seen, but it was exceptional for a girl to remember the names of booklets, although many girls mentioned seeing a film of a baby's birth and remembered its name.

More of the UK Black girls said that they would like to know more about contraception (68%) than the UK White girls (54%), even though similar proportions of the girls had said that they thought they had "a pretty good idea" about contraception (84% of UK Black girls and 88% of UK White girls).

The UK Black teenagers had had similar opportunities to learn about contraception; their knowledge was almost, though not quite as good; and they were eager to know

* Such an example is a pamphlet entitled 'Abortion' which contains the note: "This booklet is an introduction to the facts about abortion produced in response to requests from students and teachers to help with projects." Brook Advisory Centres, printed by the Spastics Society (May 1980).
more - in fact, more of them had tried independently to obtain information on the subject. There seem to be other barriers, which in spite of interest and effort make it more difficult for these girls to avoid pregnancy. Over twice as many (15-6%) of these black teenagers felt that it was the boy's responsibility to make sure that a girl doesn't become pregnant. Two-thirds of them thought it was either the girl's or a couple's joint responsibility - compared with a high 87% of the UK White girls. The UK Black teenagers also admitted to having taken chances at a time when they knew they could have become pregnant more often than the UK White girls - only a tenth could say they never had (compared with 22% of the UK White girls). For many of these young black girls there seemed to be an ingredient missing in their relationships. Their expectations of their partners were apparently not fulfilled. Young white girls also shared this experience, but not to quite the same degree.
Summary:

Just over a third of the pregnant teenagers we interviewed were girls of West Indian origin - 44% of the abortion patients and 34% of the young mothers. The young mothers were best represented in the older age groups, with 68% aged 18 or 19 years, compared with 43% of the abortion patients and 52% of the clinic attenders. Fourteen percent of the abortion patients were under 16 years old, compared with 4% of the young mothers and 6% of the clinic attenders - all of these very young mothers (9 girls) were of West Indian origin, as were 70% (21) of the 30 abortion patients under 16 years. The young mothers were much more likely to be or have been married, 40% compared with only 3% of the abortion patients and 4% of the clinic attenders.

Of the three groups, the young mothers' own mothers had commenced child-bearing at the earliest ages and had had the largest numbers of children.

Using occupation of the teenagers' fathers, where working and where known, we found that our clinic attenders had a higher proportion of non-manual class fathers, 43%, than either the abortion patients, 28%, or the young mothers, 19%. The clinic attenders were also more likely than the pregnant teenagers to have or to be working towards, some educational qualification.

The clinic attenders' ages at menarche were later than those of the pregnant teenagers and they were also more likely to have been prepared beforehand for this by their parents or schoolteachers. They were also less likely to have had their first sexual experience before turning 16 - 31% were sexually experienced when they turned 16 compared with 46% of the abortion patients and 42% of the young mothers.

Not only were they more likely to begin to menstruate later and to have their first sexual experience later, the
Clinic attenders were more likely, when they did become sexually experienced, to be using an effective method of contraception - 27% were using the pill, compared with 5% of the abortion patients and 11% of the young mothers.

The general trend of our findings, as anticipated, reflected the findings reported by other similar studies. Where we have been able to make a unique contribution in this field of research is in respect of our findings for teenagers of West Indian origin. The characteristics which distinguished UK White teenage mothers and those having abortions did not divide the two groups of pregnant black girls in the same marked manner. Some of the factors influencing a young West Indian girl's decision to continue with the unplanned and initially unwanted pregnancy in preference to having an abortion are discussed in the section on the young mothers (see p. 243 - 258).

In the next Part, the experiences elicited uniquely from each of the three groups of teenagers are considered - for the abortion patients, their experience of pregnancy and the abortion operation; and for the young mothers, their experience of pregnancy and of having their babies. The clinic attenders, their histories not complicated by the experience of pregnancy, provided us with a comparison group. Our own observations made during the study's programme of visits to the district's hospital and community family planning clinics, together with the comments and reactions of their teenage clientele to the services provided by these clinics, are referred to in the final Part of this thesis, when we return to a general discussion of the implications of our findings for policy in the hospitals and the clinics.
Introduction

Most women (and certainly most men) are ill informed about abortion, partly probably because it is felt to be such a distasteful, unhappy subject; like cancer and car accidents, it only happens somewhere else, to someone else; partly also, perhaps, because the information we do receive is conflicting and tends to confuse.

For the lay person, knowledge of abortion is likely to be a mixture of incidents remembered from novels, gossip and reports of various kinds in the media, ranging from emotive stories in the popular press about premature babies left to die in hospitals, "babies for burning" and the "scandal" of "schoolgirl" pregnancies, to the more serious but no more balanced reports of pro- and anti-abortion campaigns and debates. In fact, society is extremely ambivalent in its attitude to abortion. Potts and his colleagues (1977, p.2) comment that "observation suggests that abortion is an acceptable form of fertility control for the individual, although it is frequently condemned by the community".

Between May 1979 and March 1980, 220 teenage girls were interviewed in the hospitals after having had abortions. The study began by looking at the problem of unwanted teenage pregnancies, its aim to make recommendations, if possible, for ways in which the services might be changed to help reduce these. In our particular inner city area, the high proportion of women experiencing repeat abortions (that is, unwanted pregnancies) is viewed as a matter of considerable concern.
In addition to learning as much as possible about each teenager (in the belief that there is some predictability possible once those most at risk of an unwanted pregnancy are identified), we endeavoured to learn as much as possible about the experience of abortion - important if we are to pinpoint opportunities to help young women at risk of repeated unwanted pregnancies.

In this chapter, we deal, first of all, with the teenager's realisation that she might be pregnant and with the opportunities each girl had had to discuss her dilemma, before tracing her route, via GP or clinic doctor, to the hospital for the operation.

We found that merely to observe the services at a fixed point in time gave little insight into some of the problem areas we were noting, such as the pursuance of the active family planning policy at the hospitals (Newton et al (1973)). In order to understand the way in which this policy had evolved, it was necessary to look back at two research projects into abortion which took place in the district's hospitals in 1971-73. This gave an indication of how the role of the abortion counsellor, as counsellor, had gradually been undermined and dwindled in importance and how an authoritarian family planning policy may produce certain unforeseen results.

The different experiences of those girls having "early" abortions and those having "late" abortions are also compared and reference is made, in connection with the latter group, to those teenagers who were also recruited to a research project involving fetoscopy which was taking place at the hospital during the time of our study.
"Getting rid of it" - the experience of having an abortion

"I think I might be pregnant..."

Gestation (or "menstrual age" or number of weeks' pregnant) is calculated in this study in the conventional way: the number of completed weeks between the date of the first day of a woman's last menstrual period (LMP) and the date of the operation. In the cases where the date of the LMP could not be remembered, or when a false period occurred, it was often possible to make a very close estimate by fixing on the most likely (even the precise) date on which conception occurred and subtracting two weeks from the number of completed weeks between that date and the date of the operation, in order to make this estimated gestation comparable with the figures for the remainder of the group.

Well over three-quarters of the girls having abortions first realised that they might be pregnant by eight weeks after their last period, that is by the time they had missed 2 periods. There was virtually no difference between the initial pill users and those who used no contraception initially. Eighty-eight percent of the UK White girls and 81% of the UK Black girls thought they might be pregnant by 8 weeks after their last period. The UK Black girls, however, had had an early advantage with 38% realising as soon as their first period was missed, compared with 28% of the UK White girls. UK Black girls may have been slightly more likely to think they might be pregnant after missing only one period because they were also more likely not to have been using contraception at the time of conception; they also had a higher proportion of respondents who had been pregnant previously, and who might therefore recognize their pregnancies earlier.

About 10% of both groups of pregnant girls did not know exactly when they first realised that they were
probably pregnant, for a number of reasons, the most common being that they had in any case very irregular periods or had had false periods; or they were using a reliable method of contraception - the girls with IUCDs in situ found it hard to believe they could be pregnant.

We were interested to learn about the people the pregnant girls had approached for support and advice once they realised they might be pregnant. Three of the abortion patients had not told anyone at all (2 of the 4 African girls and one of the 14 Jamaican girls in the group). Half of the UK White girls (51%) had told as many as 3 or more people. These were likely to include mother, boyfriend and at least one girlfriend. For several girls, it seemed that everyone knew.

"A lot of people know I'm pregnant, but I'll tell them I fell down the stairs or something."

"Mum, the person she works for and her daughter; my (girl)friend; another friend who works in the pub - she sort of guessed it; his (boyfriend's) mum; his dad; him; and his brother found out somehow."

While for another, it was more of a (big) family secret: "Mother, a few relations, aunt, grandmother, boyfriend."

But only 29% of the UK Black girls were likely to have told as many as 3 or more people. Twice as many UK Black girls had only told one person compared with the UK White girls - 23% and 11%. Sisters were equally likely to be included for almost a third of both these groups, and fewer girlfriends were the confidantes of UK Black girls, 39% having told a girlfriend compared with half of the UK White girls. Thirty-five percent of the UK White girls and 23% of the UK Black girls also named a variety of other people who included cousins, aunts and other relatives, people at work, neighbours, ex-boyfriends and
In fact, we found that the UK Black girls were less likely to discuss their problems with others than the UK White girls, and this included their mothers. This could be interpreted in a number of ways: as a reluctance to discuss a very emotional and personal problem; as an inability to articulate their problems; or it may reflect the type of relationship they shared with a particular person.

Half of the UK White abortion patients reported a positive and sympathetic reaction to the news of their pregnancies from their mothers, compared with 19% of the UK Black girls, who were also more likely to have had negative or neutral (no apparent interest or sympathy) reactions from their mothers - 10% compared with 4%.

Twice as many UK Black girls as UK White girls kept the pregnancy a secret from their mothers - 44% compared with 22%, while 46% of the UK White girls had told their mothers themselves, compared with 23% of the UK Black girls, with similar proportions of their mothers guessing what was happening, 15-16%.
The route to the hospital – GPs and clinic doctors:

Confirming the suspected pregnancy was the next step for most girls. Some bought pregnancy testing kits from the chemist and secretly made the tests themselves. These were usually very young girls who were too frightened to go immediately to their doctors – the girls who must have found it hardest to afford the £4 or so which the kits cost.

Eventually all girls must approach a doctor, whether their GP, a family planning clinic doctor or a doctor at one of the other clinics (usually called the "charity clinics"), such as Brook Advisory's centre in Walworth, which referred about 12% of our abortion patients to the hospitals.

About 70% of the girls saw their own GP (or a locum) first; and about 10% were referred by doctors (or nurses) in family planning clinics.

On the occasions when a girl approached a doctor other than her own GP, she was usually encouraged to give permission to that doctor (often a Brook Advisory clinic doctor or a doctor at a family planning clinic) to inform her GP. These doctors usually phoned the GP and gained his or her agreement with their proposal to refer the girl for an abortion.

Letters of referral from doctors were required from all young women approaching the hospital for an appointment. These varied considerably in length and formality, ranging from the typewritten letter and accompanying social worker's report provided by the Brook Advisory clinics to the single handwritten sentence on a doctor's "With Compliments" slip.
Some GPs did provide detailed letters, but more often than not a GP would simply write a few lines by hand. One memorable note read: "This girl's mother want (sic) abortion. Please advise."

Letters which failed to state the precise purpose of the girl's referral occasionally caused serious problems in that the girl was presumed either to want to keep the baby or to have some other gynaecological problem (amenorrhoea, for example) and so would be given a much later appointment than if she were requesting an abortion. One such experience is worth reporting in detail.

Lynne was a 16 year old UK White girl. She visited her GP soon after she missed her first period - at the time of the abortion she was at least 22 weeks' pregnant. When she first saw her GP, he gave her some pills "to bring on my period", she said, but this didn't happen and she returned to him and he gave her a letter for the hospital. The letter said simply that she had amenorrhoea and he requested advice.

Lynne, accompanied by her mother, brought the letter to the hospital and was told that she would receive an appointment by post. This arrived almost exactly 2 months after the date of the doctor's letter.

Lynne had only ever had intercourse once, in late July. She had gone to the off-licence with a black acquaintance, in his car, but instead of driving to the off-licence, she said, he drove somewhere else and he "raped" her. In any case, she found herself in a situation which she could not control. When she did not "see" her period in August, Lynne said she went to her GP. She was very confused about dates and the exact sequence of events and it is not clear whether she returned to him more than once before she was given his letter to the hospital which was dated early November.

Lynne did not appear ever to have been examined or to have had a pregnancy test until she was seen at the Gynaecology Clinic in early January when she was told that she was about 22 weeks' pregnant.

The female hospital doctor she saw believed that Lynne did not want to have the baby. In our interview, Lynne insisted that she hadn't had an abortion - that was something only other girls had - but that she couldn't have the baby because it wasn't "her kind" and her father would never allow it as "he can't stand black people". Numerous times during our interview, she justified the abortion by saying that "it" wasn't "her kind".
On that first visit to the Gynaecology Clinic, Lynne had been told that she had to have her parents' consent if she wanted an abortion. In fact, since she was 16, this was not the case. She was told to return the following day with her mother, but in the meantime was directed to the Social Work Department within the hospital. Lynne did not arrive at this department. She instead returned home and told her sister about an "operation" she was to have. The following day her father came to the hospital, alone, in an effort to find out what was wrong with his daughter. In the meantime, Lynne had disappeared. Her social worker in the district was informed, as were the police, and she was found staying with a friend and his family. She returned to the hospital where she was admitted for a "late" abortion. In this way, Lynne bypassed the abortion counsellor and the abortion clinic.

Lynne's story is one of a typical "casualty". She had not been to school regularly since she was about 14. She liked old ladies, she said, and had been friendly with a particular woman from childhood. Instead of going to school, she would go and help her, running errands and cleaning the house. Whenever she returned to school, she would get into so much trouble for truanting that, in the end, she said, she got fed up with it all and stopped going to school altogether.

She had been working in a factory for six months and was very happy there. She had a close platonic friendship with a young man who also worked there and it was he and his family who had taken care of her when she ran away from home.

Occasionally, a series of "phoney red-tape"* delays seemed to build up for a particular girl. One, who was still able to have the "early" type of abortion, was referred by a family planning clinic doctor to the hospital, but because she lived in another district's catchment area, she was sent to one of its hospitals, only to be referred by the staff there back to her GP. As the GP was on holiday, she had to wait for 2 weeks before seeing him and when she did, he refused to sign the "green form"**. This was precisely the reason why

* "Phoney red-tape" because these rules were not rigidly applied, or even applied at all in some cases. We noted one girl who had come directly to the hospital, simply saying that her GP would not be sympathetic, and her request was accepted.

** The Certificate to be completed before an abortion is performed under Section 1(1) of the Abortion Act 1967.
she had not approached him initially - she had felt that he would be unsympathetic and he was known not to agree with abortion. However, he did write a letter to the hospital and 4 weeks after seeing the family planning clinic doctor, she had an abortion. Where doctors preferred not to sign the "green form" themselves, the hospital would, nevertheless, accept their letters of referral and, in these circumstances, signatures were obtained from two hospital doctors instead of from the GP and a hospital doctor.

GPs frequently missed opportunities to discuss the girl's situation, her feelings about the pregnancy or to give family planning advice. Often girls visited their GPs and requested a pregnancy test and were told to leave a urine sample and to ring in a day or two for the results. The results might even be given on the phone by someone other than the GP who had seen the girl, with no attempt being made to follow up.

For the majority of girls there seemed to be very little delay between first seeing a doctor and the abortion operation. For over three-quarters (77%) there was 5 weeks or less between the two events, and for over half of the girls (55%), there was three weeks or less.

What must be of concern is the number of girls who were first seen by a doctor between 10 and 20 weeks before the abortion. Eleven of 12 girls in the group were seen between 10 and 13 weeks before the abortion; the twelfth was Lynne, mentioned above, who was first seen by her GP about 18 weeks before the abortion.

Of course, what is crucial here is the number of weeks' pregnant the girl is at the time of the first visit, but even GPs did not always appear to know the maximum
number of weeks' pregnant a woman may be still to qualify for an abortion.

Several girls were told by their GPs that they were "too late", although they were more often than not still in time even for the "early" method of abortion. One girl was actually told by a hospital doctor that she was too late for an abortion there and that she would have to have the operation privately and pay £200 for the abortion. This girl was referred by the nursing staff to another doctor in the hospital who agreed to her request.

Other GPs did not appear to have alerted girls sufficiently to the danger of delaying action if they wanted an abortion. One girl went on holiday with her mother to Spain and another had been to her GP twice before she went to France with her school for a fortnight.

A 17 year old UK Black girl with a 2 year old son, was probably about 12 weeks' pregnant already when she first went to her GP. She was seen by his locum who advised her "not to rush into it" (abortion). She continued to think about whether or not she wanted an abortion for another month before returning to ask for a letter of referral to the hospital. She had an abortion 2 weeks later, when she was about 18 weeks' pregnant. "The pain is worse than having a baby", she said. "I wouldn't go through it again. You think that you'll have anaesthetic and you won't feel anything ... There should be people to talk to." The girl was re-admitted 3 days after her discharge, via casualty, and remained in hospital for another fortnight. Her notes read: "?Perforated uterus" and "?PID" (pelvic inflammatory disease). She was given the injectable contraceptive while in hospital.
Her next pregnancy was planned. When we referred to her notes one year later, she was already 6 months' pregnant and had been booked into the antenatal clinic for three months.

One abortion patient talked about a girlfriend who had had quite a different experience. A young woman doctor from a well-known local practice had "dropped-in" casually on her girlfriend just to enquire how she was, after the girlfriend had discussed the possibility of having an abortion when her pregnancy was confirmed at the practice. The doctor was concerned that she might leave her decision too late to have an "early" abortion.

All the girls were asked how many times they saw the first doctor. Over half of the UK White girls saw this doctor once only (53%), but only 29% of the UK Black girls were referred to the hospital after only one visit to the first doctor. In fact, 88% of the UK White girls only saw the first doctor once or twice before being seen by a hospital doctor. Only one UK White girl saw her doctor more than 3 times, but 10 UK Black girls (14% of the UK Black abortion patients) saw the first doctor more than 3 times before being referred. From the UK Black girls' descriptions of these visits to their GPs, they did not provide the opportunities to discuss problems which had been missed elsewhere. Instead they seem to accentuate the extent to which the young black women and their GPs failed in their attempts to communicate with each other.
Two 16 year old UK Black girls, interviewed some time apart, were asked the reason for each of their many visits to, what turned out to be the same, GP.

Both had been told that, before they would be given a letter of referral to the hospital, they would need to give a £5 "donation" to the doctor. One girl said "it was something to do with old people at Christmas", and the other thought he had said something about children. Neither questioned the doctor's request and both returned later with the money and were given their letters. Since it was not our intention to question every visit girls made to their doctors, but simply to discuss their reception and treatment in general terms, these were the only two occasions when payments to a doctor were, by chance, brought to light. We could not, of course, verify the girls' statements, but we do not think they were contrived. They certainly did not think they were reporting an illegal or iniquitous action.

In spite of the difference in number of visits between the UK Black and UK White girls, UK Black girls did not have a higher proportion of girls attending for "late" abortions, although it may be that once the procedure of the "late" abortion is explained to them, UK Black girls might be more likely to decide to have the baby instead.
Two abortion patients came directly to the hospital. One said: "I told them I didn't want to go to my own doctor as he wouldn't agree, so they did a test and sent me to Dulwich Hospital where I saw a doctor and came in the next day" (for the abortion).

The other girl was a non-resident of the district: "Mum knows someone who works for the surgeon" (as a secretary), she explained. In fact, this girl by-passed all the usual channels and the first doctor she saw was actually on the ward.

All girls were asked how sympathetic and helpful all the doctors they saw were. Their replies to this question were coloured by their expectations. One of the girls who visited her GP four times before being referred said: "He was very nice. At first he was a bit rough with me - he said it's part of his job to be a bit rough with me. He told me about taking the pill and taking precautions."

A 14 year old girl said of her GP: "She had a go at me ... gave me a green form and a letter. She said: "People don't like to do things like this."" These girls felt that their GPs were entitled to have such attitudes.

Some girls thought their doctors were using delaying tactics deliberately. A 16 year old girl who visited her GP three times said: "I think he was trying to put me off, so my mum rang him up and had a go at him. He was very nice but he was trying to talk me out of it when I changed my mind - he said you might not be able to have children afterwards."

A girl who visited her GP first when she was about 8 weeks' pregnant was examined and told she wasn't pregnant. She was told to come back again in a month's time. When she returned a month later, the pregnancy
was confirmed and she asked for and was given a letter to the hospital. Another who visited her GP three times said she told him "I think I'm pregnant"... "he didn't examine me. He told me to come back and he would send me to the hospital for a urine test. He wasn't there (when I returned) but he left me a letter for the hospital. He didn't waste any time. He wasn't rude ...".

One girl didn't even have to say to her GP that she wanted an abortion: "He expected me to say I wanted an abortion, because he took the words out of my mouth!"

Earlier experiences with their GPs had made some girls bitter about the situations in which they now found themselves. Having in the past summoned the courage to request contraception, their requests had been refused.

A girl described how, when she started going out with her boyfriend at 15, she went to her GP and he refused to give her any contraception because he said he thought she was too young. Another girl who also visited her GP when she was 15, was refused the pill and so her sister gave her some of her own for 3 months. After she had finished those, she used nothing. A girl who had originally gone to her GP in Leicester, accompanied by her mother, was refused a second supply of the pill by the same doctor when he learned that her boyfriend had come to London. One girl who didn't have the courage to ask said: "I was scared to get the pill - my doctor's not someone I can talk to. He just says "yes", "no"."

A non-resident said of her GP: "At first he was terrible, but then he arranged for me to come to King's." He had originally incorrectly assessed her pregnancy and had rudely, she felt, told her she would not be able to get an abortion in their area (which was outside London).
She had left his surgery with no expectation of any further help from him, but to her surprise he telephoned her at home the following day to say that he had arranged for her to attend King's, apparently through his friendship with a doctor at the hospital.

It may be that a girl's manner and appearance influence the way in which she is treated. One pale, waifish English girl was overwhelmed by the kindness of her treatment at every stage. Others, from the outset, seem to have been treated harshly. The first approach to a doctor may set the tone for later contacts. This seemed to have been the case for one girl who said of her GP: "He was so abrupt, so I was abrupt back. "I'm not ready to have a child!" "What do you mean, you're not ready?" he said!"

In all, 37% of the abortion patients described their GPs as having been "very sympathetic and helpful". A typical comment of this group was: "He gave me a letter to come straight up here - he said I'd been stupid and that - he was very understanding and he said to my mum 'I want to have a word with you' and I've got to go back a fortnight today."

Also included in this group, however, are those whose doctors appear, to an observer, to have been rather less than "very sympathetic and helpful", such as the GP who was described as "very nice", but who said: "You do know I'm making it easy for you, don't you?"

For almost another third (29%), there was a little less help and sympathy, and for 17% of the girls, GPs had been neither helpful nor unhelpful, just neutral. In general, there was very little difference between the way UK Black and UK White girls perceived their GPs' reactions, with 68% and 65% respectively saying they had been treated very or quite sympathetically and helpfully. More UK Black girls described their GPs as neutral, but fewer
described a negative attitude.

It may be that UK White girls' expectations were for more sympathetic treatment than they in fact received, with fewer describing GPs as "very sympathetic and helpful" and more as "unsympathetic and unhelpful" than the UK Black girls. Since many girls commented during the interviews that, on the wards, they were treated better than they had expected, it may be that, in retrospect, they viewed their GPs' attitudes as less helpful.

The hospital interview to request an abortion

The following describes the clinic practice at the time of our study.

On most weekday mornings at King's, the antenatal clinics would spill out into the general booking area as dozens of evidently pregnant women were weighed and checked by nurses in the open waiting room, before being examined by doctors in the nearby cubicles.

At about midday, as the antenatal clinic gradually became quieter, about half a dozen women who were requesting abortions joined the other pregnant women on the banks of hard-backed chairs, each one called in turn by the clinic clerk to complete various forms. On her desk, headed boldly "ABORTION ACT 1967 - Certificate to be completed before an abortion is performed under Section 1(1) of the Act", each woman's "green form" - was just another form for just another routine appointment for the clerk, but it could be, as a number of teenagers mentioned to us, a source of extreme embarrassment for the woman being interviewed, its words seeming to spring out to shout her guilt to all the prospective mothers round about. (One girl described how she tried, with a pretence at nonchalance, to drop her hand across the form to cover the offending words, but the form was immediately pulled away by the clerk.)
Some time after returning to her seat, her name was called by a nurse who led her to an office where she sat at a desk on which there were more forms. These particular forms had been devised especially for the use of the nurses who interviewed women requesting abortions, incorporating information outlining the "patient's reason for termination", "social factors", "previous obstetric history", "use of contraception" and "putative father of this pregnancy" (making up Section A); and information concerning the medical examination (Section B); together with an "administrative section" (Section C).

Women requesting abortions were seen between midday and about 3 p.m. at this particular clinic. After seeing the nurse and completing the forms, the woman would return to the waiting area until being called again - this time to see the doctor who would decide whether or not she would be accepted for an abortion. The abortion counsellor/nurse specialist accompanied her. If she were to be booked for admission for an abortion, she would later be sent to the Pathology Department for a blood test, although some doctors' decisions were a foregone conclusion and blood tests were completed before his examination. She may have been told that she would be receiving a letter giving details of her admission, or she could telephone the hospital herself if she did not want any correspondence sent to her, or she might, there and then, be given the date and time and ward to which she would come.

Not all women attended the antenatal clinic at King's; some attended a similar clinic at Dulwich Hospital, while others were asked to attend the gynaecology out-patients clinic there. Others went directly to the main abortion ward. This ward incorporated its own operating theatre for minor gynaecological operations, of which abortions were a high proportion. Sterilizations and, ironically, investigations for infertility, were also performed here.
Women requesting abortions would go to an office on this ward to be interviewed, usually in the early afternoon when the operating list had been completed and all was quiet on the ward. These women saw, beforehand, the ward to which they would be admitted and patients in the beds who had had the same experience that they would have.

Poor preparation for the operation and the events surrounding it creates additional problems for nursing staff on the wards, as well as for the patient. Even though the abortion counsellors during the initial interview usually explained the procedure (that the woman should not eat or drink after midnight if she is having the abortion the following morning, just what the operation involves, that she will probably bleed as if she is having a period, and so on), the surroundings and the circumstances of that initial interview, in most cases, did not appear to be conducive to absorbing much information. In our experience, those girls who were seen on the abortion ward and those girls referred by Brook Advisory's clinic, were somewhat more relaxed and had been better prepared. At the time of this study, a young male doctor and two nurses, all (including the doctor) of whom preferred not to wear uniform, were working in the clinic on the abortion ward. They believed that a relaxed, informal approach was necessary in order to put women at ease and to encourage them to discuss their reasons for coming to their decision to request an abortion. Because of their attitudes, it is difficult to say whether the better preparation of patients coming from their interviews was due to the surroundings or to their particular approach.

Family planning nurses (nurse specialists) as abortion counsellors:

In 1977, the DHSS, in its Circular on Counselling advised that "the purpose of counselling is to ensure that the decisions by the two medical practitioners and particularly by the woman herself are taken in the light of all relevant facts about her situation and about the
alternatives to termination which are available to her" (DHSS (1977)).

Many excellent books have described the practice of abortion counselling and its aims. Simms (1977) has listed six tasks of abortion counsellors: to provide psychological support during a critical period in a woman's life; to help a patient through the actual operation with the minimum of trauma; to persuade women of the importance of medical follow-up and instruct them in effective contraception; to screen out those with more serious problems and refer them on; to try to derive some general benefit from an otherwise negative human experience; and to avoid unnecessary regrets and guilt.

Good counselling cannot take place in a "battlefield" when one of the participants is working out how to get round the doctor and the other participant is feeling resentful of being manipulated by a demanding woman (Allen (1981)).

The King's Termination Study, carried out by Lewis and her colleagues in the early 1970s, is frequently quoted as giving support to the third of Simms' points: "Counselling at the point of crisis also seems to make it more likely that people will return more readily for other help they may need ... Women who have been sympathetically treated and who understand the nature of the operation and its implications are more likely to return for post-operative check-ups and contraceptive help (Lewis et al 1971)", quoted by Cheetham (1977), and: "The good rapport achieved with the patient proved valuable for the satisfactory attendance at the subsequent follow-up clinics. An 87% follow-up* at six weeks ensured

* 10% of this 87% required strenuous attempts to ensure their eventual attendance, and only returned after being "chased up" very tenaciously by one of the research team, the social worker Shirley Lal (personal communication).
that these women, who are a high-risk group so far as future unplanned pregnancies are concerned, all received contraceptive advice (Lewis et al, 1971), quoted by Simms (1977).

Lewis and her colleagues personally followed 360 women from their first attendance before termination, through the operation itself to follow-up appointment. The continuity of care and attention by the same people must have been influential on the high proportion returning for follow-up appointments. (Incidentally, but possibly significantly, both social worker and doctor were women.) This continuity of care, although successfully reported for that study, is no longer practised in these hospitals.

Since a considerable proportion of our teenagers who were referred for abortions had already been given appointments for follow-up by Brook Advisory's clinic, the family planning clinic doctors or their own GPs, and so would not necessarily have been given appointments to return to the hospital family planning clinics for follow-up, the poor follow-up rate for our girls observed after informal checking at the hospital clinics, gives no indication of the actual rate of return to all doctors for further contraception and advice.

It might have been anticipated that the 220 teenagers who were interviewed on the wards for this study would have felt, following our interview, that a personal interest had been taken in their problems and needs and that this might, therefore, have encouraged a higher proportion than usual to return to the clinics. This did not appear to be the case. If an abortion counselling service (such as that we observed) were to be judged on follow-up attendance alone, it could not be deemed "successful". It is misleading for the experience of the King's Termination Study, with its exceptional conditions and extra financial resources to be set up as a standard.
The most frequently quoted object of an abortion counselling service appears to be to reduce the numbers of women returning for abortions. In fact, this is probably its raison d'être in most centres.

In 1973, when abortion counselling was already being practised at King's, Newton et al (1973) attempted to show in a study of the numbers of terminations and repeat terminations for the period 1970-72 that a decrease in repeat abortions was brought about, not by the counselling service, but by the use of "intensive family planning". The main constituent of this type of family planning was "active family planning", so described as the decision on future method of contraception was taken at the time of the abortion counselling visit.

In their study, Newton and his colleagues reported that "despite initiation of contraception in hospital after the termination patients still fail to attend for follow-up. Over 70% of those referred to their local family planning clinic and 40% of those referred to the hospital family planning clinic failed to attend for follow-up visits." (This information highlights the unusual nature of Lewis's team's experience, since we are here describing events in the same hospital in the same two or three years.)

Newton and his colleagues' conclusion was that "this (poor follow-up rate) emphasises the need for a method of contraception that does not require regular medical care". They recommended the IUCD as "those (mainly from social classes IIIb, IV and V) started on a method of family

* Coles (1971) in a retrospective study of patients seeking pregnancy advice at the Brook Advisory Centre in Bristol also noted that an increasing number of patients were being fitted with an IUCD at the time of their abortion - 0 in 1971, increasing to 11 in 1972, 40 in 1973 and 26 in the first 6 months of 1974.
planning other than intrauterine devices tend to revert to the sheath or no method at all by the time of their second unwanted conception. This emphasises their failure to persist in effective contraceptive methods." Their findings, after initiating this "active family planning policy", were that "repeat terminations have shown a dramatic drop over the past two years in our area due to the intensive family planning policy after termination." The article notes the drop in repeat terminations at King's after a peak in 1970 of 3.1% to 0.5% in 1972.

However, not all women who have once had an abortion at King's necessarily return if they become pregnant again and wish to request another abortion. Changing policies of neighbouring hospitals (perhaps refusing to accept women for abortions if they have already had one abortion in their hospitals) and the increase in the number of charitable clinics in London at the time of that study might well have made substantial changes at King's. There may have been changes in members of staff and their individual policies - fewer "late" abortions accepted, more women requesting "repeat abortions" refused. Events such as these in the early 1970s would need to be investigated to see if there is likely to be any other reason for the drop from 24 "repeat abortions" in 1971 to only 4 in 1972. "Repeat abortions", in any case, do not give a complete picture of unwanted pregnancies.

An "active family planning policy" was at the time of the study still being followed at the hospitals, in spite of the fact that previous abortions were considerably higher than they were in 1973, almost 7 years earlier. In our (admittedly unusual) group of teenagers, one year later we found that 16 of 207 girls (8%) had returned to our hospitals, having become pregnant again, 6 to have abortions and 10 to have babies. We have no way of knowing how many others became pregnant
who had moved out of the district, or who had had private abortions or had been accepted for abortions or had had their babies at neighbouring hospitals.

In spite of the emphasis on the significance of non-attendance at follow-up appointments, there will be many non-attenders for whom the crisis of abortion has helped clarify their feelings, or has enabled them to overcome what seemed to be an insuperable barrier to using contraception, and whose boyfriends have been supportive. Most of these girls will have gained from the abortion experience. Not attending a clinic immediately for contraception should not lead one to conclude that they will not when the need arises.

Those girls who have just ended relationships with their boyfriends will be unable to see the need for contraception immediately after the abortion. Those whose relationships have ended acrimoniously, whose so-called boyfriends have denied paternity, would be unlikely to be using contraception in the expectation that their relationships will be reinstated. A teenager not in a serious and steady relationship may well profess to feeling "a bit cheapish" if she is on the pill. Those girls who leave the hospital with IUCDs will not see the necessity for attending a family planning clinic (after all, it was the expectation that they would not return which led to the introduction of the "active family planning policy") - unless they have problems, and those with serious problems are more likely, as we found, to be re-admitted to the hospital via casualty.

The position of the abortion counsellors must be viewed in the context of the climate of opinion about the abortion service at the time of the study. Although to outsiders the hospital presented the appearance of having a generally "liberal" policy, in fact views on abortion and methods differed widely between the consultants' firms. At this time, in the guidelines for the abortion counsellors, the preferences of the
different consultants were set out in such terms as "you (the counsellor) need to do all counselling, he (the consultant) just quickly examines them. Will do Asp TOP (aspiration termination of pregnancy) up to 16 weeks under GA (general anaesthesia)"; and another was "not keen on social workers, so discuss with him first"; one consultant would not perform second trimester abortions at all, and another, who coincidentally was carrying out research requiring second trimester size foetuses, would see in his clinic "mostly second trimester TOPs".

When centres such as these, at the two study hospitals, pursue a policy of active family planning, using the services of an experienced family planning trained nurse specialist, the abortion counsellor aspect of her role may well be invisible under the trim white uniform and the nurses' badges.

In such circumstances, it was not unexpected to find that almost a fifth (19%) of our abortion patients, when asked "did you talk the abortion over with a "nurse counsellor" when you first came to the hospital?", replied "no". Those who recognized having seen a "nurse counsellor" or someone they thought might have fitted that role, were then asked "was that helpful for you?". We deliberately described the role as "nurse counsellor" so that girls would not be misled into thinking we meant a lay counsellor.

Of those teenagers who agreed that they did speak to an abortion counsellor or someone similar (such as a "nursing consultant"), 58% said that they found her very, or quite helpful. A higher proportion of UK White girls (72%) than UK Black girls (59%) described her this way. Just what was deemed to have been helpful may have been construed differently by different individuals - taking the girl to the pathology laboratory, or simply agreeing that she should be granted the abortion, were thought to be "helpful". Many girls expected to be treated harshly by the clinic staff and so were sometimes pleasantly surprised.
Eleven percent of the girls who said they had seen the nurse counsellor (10% of the UK White and 15% of the UK Black girls) actually found the counsellor unhelpful, sarcastic, rude or hurtful.

The comments patients made when asked whether they had talked over the abortion with a nurse counsellor divide into two main groups, reflecting the difficulty the abortion counsellors appeared to have in performing adequately either of their two main functions - counsellor and family planning nurse. Doctors on the hospital wards frequently over-ruled the method of contraception decided at this initial interview, as the abortion counsellors were well aware, usually advocating the IUCD where girls had given the pill as their preference.

The following are some of the comments of teenagers relating to the function of counsellor:

I saw "a nurse - I think she was a nurse anyway - she just told me that I would have to argue with someone because they might not do it. But I didn't have to, since he was talking (to the nurse) about tennis!"

"Sister in the Outpatients? Yes, we were not really talking - she was asking questions."

"She fires questions at you like in the army!"

"Yes - she agreed straight away (to the abortion request), but that was when she thought I was 3 months. She walked around, helping me with my blood tests and that." (14 year old UK Black girl who was, in fact, 6 months' pregnant. She was accepted for a "late" abortion.)

"One of the nurses told me she was the "Sister". (She was) not really helpful. I'm a very reluctant person to talk freely to people I don't know. She was rushing too much and so I didn't have the chance."

"I saw the woman once and around a week or so later they sent a letter to come, but I thought it was too soon and I needed time to think about it, so I had to come again because they said they have lost my records! The man gave me a funny look!" Then, on her second visit: "The woman, she was sarcastic about it. Why did I get pregnant and why did I leave a spare hospital bed and not turn up and why wasn't I using something!"
Another girl who had also talked to abortion counsellors on two occasions said: "She was sort of stating things to me about being pregnant and the chances I was taking. They had a white overall on both times - she was different the second time. She sort of seemed to spend more time and told me what was actually happening. She should have told me all that in the first place."

A third girl who had the same experience, but in reverse, said: (The first was) "very helpful, told me to go away and think about it and be admitted in two weeks". The second one was different, she "was out to put me off - she was awful - she said at first that they wouldn't admit me."

"I don't know if it was the nurse counsellor. I saw this woman who was writing down all these bits and pieces on my files - the same things the doctor asked me."

"No (I didn't talk it over). I didn't really feel that I had to do anything like that to get it off my chest."

"No (I didn't speak to a nurse counsellor). One doctor - but I didn't talk much to her - like "what's your name" and that sort of thing." (She believed that the counsellor was a doctor.)

"I don't know if the nurse was the counsellor. She wasn't very nice. She said that they have to be strict because many girls turn up again after a few months saying they've made another mistake."

"She was very helpful, but I think she tries to frighten you."

"She was very nice - it was the district nurse I saw first and then the doctor - but I didn't really speak to him... She was annoyed at first, but I just smiled and she was OK after that. She was telling me about the risks and about the abortion and have I talked it over with my boyfriend and told my parents and things like that."

"I never really talked it over. She was very nice - she just asked me questions."

"She was really horrible. She said to me: "Do you realise that if you lived in another country and you got in this position they would send you away and you would have to have the baby? Your boyfriend thinks he can just send you up here as soon as he's got you pregnant", and she kept saying, "Well, what would you do if we don't give you the abortion?" and I was crying and I said: "I would bloody well have to have it, wouldn't I?"
"She told us what was going to happen and the way she put it as well was enough to make you sick. It was dreadful. She shouldn't have that job at all." (Some girls found the descriptions used, such as "mini-labour", disturbing, but in this case, the girl was to have the vacuum aspiration operation. Sometimes perhaps, both types of operation are described to a girl.)

A girl who came with her mother said: "She was all right. She seemed much older. I didn't get into conversation. She was more interested in talking to my mum than me."

Some girls described the interview as a "test":

"I had a counsellor to see whether or not I would have the abortion."

"Yes, I saw the counsellor - had to tell her a pack of lies to get it done! I told her that my boyfriend had gone off!"

Some girls' comments emphasised the function of family planning nurse:

"She was like a doctor but she weren't - she said I should have the coil."

"The consultant I came to see? I don't know her name, but even then she didn't really go too deep into it. She just named the methods and showed me some coils. She didn't really tell me about the pill and side effects - most of my information came out of magazines and things."

"The first lady doctor I had, she was a bit horrible and asked me why should we give you this abortion when you don't believe in contraception and when I started to cry, she was a bit nice then."

"The lady last Thursday asked what I was going to use afterwards and I told her I would take the pill." (This girl left the ward with an IUCD.)

"When I went to the hospital they said my tubes could be blocked - I may not be able to have another kid, and that turned me off - nursing consultant I think she was - "You might have to go through labour", she said ... I am supposed to go to the family planning clinic next week but I want to go to the GP instead."

"She said I had to have the coil fitted or go on the pill, so I said go on the pill."
"The woman at the hospital told me about the coil - she gave me a choice, pill or coil."

Another girl was told she was "too irresponsible to have the pill, you must have the coil."

"I don't know who she is - she asked me and I told her the coil. I had already decided" (after talking to the social worker at school).

"They asked me what I want in - the coil and the pill - but I found out a lot about the coil in the last few days and I said I don't want the coil." (It had been intended that she use both - double contraception.)

One girl who said she had been severely reprimanded for her behaviour in getting herself into "this position", said that the abortion counsellor could see how upset she was after seeing the doctor and told her that his treatment was "to give her a conscience".

The same doctor examined a UK Black girl next and was much more explicit in his remarks. "He said my boyfriend should have his thing cut off!" This girl called the abortion counsellor "Dr.____". This doctor, she said, didn't say much to her and didn't smile at all, so she thought that "she didn't like me much".

During the study, when members of staff at the hospital became aware that the teenagers we were interviewing were having difficulty in recognizing the nurse specialists' counselling role, the Consultant in Family Planning at the hospital, at the abortion counsellors' monthly meeting, suggested that although recruitment to the study was only half complete, it would be worthwhile to experiment. The abortion counsellors were asked not to wear their white uniforms, but everyday clothes. It was thought that this would create a different atmosphere in which the young women requesting abortions would recognize the previously disguised counsellor aspect of their role. It was also thought that the counsellors themselves would benefit from the experience and that, being treated differently by patients, they would react differently.
The "experiment" lasted barely a few weeks, by the end of which time all of the abortion counsellors (with the exception of the two who had never, in any case, worn uniform) had drifted back into wearing uniform. Several nurses "forgot" that they should be wearing ordinary clothes, others quite openly said they had "stopped the experiment", while another requested permission to change back into uniform, since "some of the girls who come in are not very clean and they have various other things wrong with them; we have to examine them and I really don't like wearing my own clothes then". Some counsellors acknowledged their awareness of a different type of relationship with patients when they were in ordinary dress. None of these nurses liked the feeling.

Also in the latter part of the study, badges reading "nurse counsellor" were provided for all the abortion counsellors to help patients identify them. This may have been useful to some patients, but it is difficult to say how many.

Inevitably, in the circumstances of these particular nurses, re-defining their counselling function caused them distress because there was so little flexibility permitted as the outcome (mainly because of the requirements of the active family planning policy).

In addition, the characteristics for which these particular abortion counsellors had been selected emphasized their skills as family planning trained nurses (although these skills were not exploited, at least at the level at which they were all capable) and not their ability to empathize with women, especially black and white teenagers, with unwanted pregnancies.

There is no way of knowing how influential on the attitudes of the abortion counsellors towards their patients was their awareness of the progress and particular findings of this study. A cynical view would be that had they been
ignorant of the fact that their patients' views were being sought, the proportion of negative comments concerning their treatment of our teenagers might have been even higher.

Because of their monthly meeting, the abortion counsellors as a group were also more accessible than others concerned with the abortion service. Although doctors concerned with the service had on occasion been invited to attend, in their busy schedules such a meeting probably had low priority and they did not come. In some ways then, the abortion counsellors were sitting targets for any criticism of the abortion service and throughout the time of the study they indeed felt this.

**Hospital doctors:**

At the time of the study, all relevant firms of consultants in the hospitals accepted a proportion of the abortion patients for their operating lists. Their individual policies have already been referred to - some refusing all abortion requests from women over 12 weeks' pregnant, others preferring to accept second trimester abortions. Consultants did not always see abortion patients themselves. The young hospital doctors on their firms were expected to see the majority of the women on these lists of minor operations.

There appeared to be little or no preparation given to young doctors before they were initiated into the hospital abortion service. Some complained that their introduction to abortion techniques was, to say the least, unceremonious: a young doctor beginning a new rota might find that vacuum aspiration abortions were included on his operating list only when he arrived at theatre. Not surprisingly, the experience could be traumatic. Doctors did not appear to be encouraged to discuss their personal feelings on issues about which they might never have
thought seriously before. The effect this could have on their attitudes towards and treatment of patients (especially, perhaps, teenagers) could be particularly severe.

It could do little to instil confidence in a patient having a "late" abortion if the young hospital doctor seemed to be unfamiliar with the abortion procedure. One girl told us that the doctor "didn't seem to know what he was doing as he asked the Sister and the nurses if he was doing the right thing". She said she was given saline for 15 hours without any effect. "The nurses stuck up leaks in the tube with plaster and then, within two hours", she said, "it was all over, and the doctor pulled the baby's head out." (In fact, such leakage during this type of abortion is not uncommon.)

For 83% of our abortion patients, the second doctor they saw (after their GP or clinic doctor) in the chain to request an abortion, was a hospital doctor. When asked how sympathetic and helpful this doctor had been, a quarter replied that he (or she) had been very helpful, 31% said quite helpful (a total of 56%), 20% said his behaviour was quite neutral and 21% said that he had been rude and unpleasant (or even worse).

These proportions compared rather unfavourably with the perception girls had of the treatment they received from their GPs.

Most hospital doctors simply examined the young women requesting abortions and asked them one or two questions. These girls had already been seen by the abortion counsellors and there no doubt appeared to be no additional information which was required. "All right" was the obvious comment on their attitude in the view of many of the girls.
Some doctors did not actually speak at all.

"I've only seen the side of his face and the back of his head", said one girl.

"I saw a nurse and then I was examined by a doctor who didn't say a word to me."

"I never really spoke to him."

"He was very tired - he didn't seem to care."

A girl who had felt uncomfortable when the doctor brought in 7 students (without asking her, she added) and one of the students had examined her internally, said: "He was all right."

"He was blunt in a nice way."

"He was kind but frightening."

"He sort of ... he was rough, and he said: "You don't want this baby then?" and I said "No!"
"You were on the pill last time, will you remember to take it this time?" and that was it."

"He kept saying to me "Why are you doing this? Why don't you have it and send the baby out to your parents?" (in West Africa)."

"They are a bit cold - they were how I expected the family doctor to be - cold. I didn't take to him."

"It's just their daily routine - I only saw him for about two minutes."

"He said he wouldn't give me an abortion. He was nice ... He went to talk with the Professor and the Professor said that since my mother is in that state (in a wheelchair) and no-one would be able to look after the baby, he would go through with it." (14 year old UK Black girl, 20+ weeks' pregnant).

Another girl thought the hospital doctor was "horrible", but added: "I suppose he has his job to do."

The doctor was "bloody horrible - why didn't I use this! He was shouting at me and everything. He was horrible faced and there were four other doctors there when he was putting his finger up me."

"I didn't think much of him. He was another one that was saying it's not nice to do and you should think about it and there could be a lot of hang up and lot of complications later on when you try to have children - are you still sure about it? And I said yes." (This girl was only 8 weeks' pregnant at the time of the operation.)
A 15 year old UK White girl said: "My mum walked into the room with me. "What's she doing in here - tell her to get out!" he said. So the nurse took her out. He said to me: "Is it your mum making you have it? Do you want to have it yourself? Does your boyfriend know?""

"He was OK - he gave me an internal and he must have thought he was dipping his hand into a paper bag.* It did hurt me - because like I said, I've never had a Tampax or anything up there. The only thing I'm grateful to him is for doing it and doing it so quickly - because I didn't like his manner at all and there were six students there!"

Fewer girls than expected mentioned the physical discomfort of being examined, considering the concern some nurses expressed privately about what they described as deliberately rough examinations. Nurses told of one doctor who frequently made women bleed when he examined them internally.
"Early" and "late" abortions

Although the study district had what is loosely described as a "liberal" abortion policy, the reality of the situation was much more complicated and confused at the time of the study.

Many doctors, GPs and hospital doctors, and nurses accept the need for and support the practice of legally inducing abortions up to 12 weeks' gestation. However, after 12 weeks, foetuses are, of course, larger, and they are crushed in the evacuation process. It is one thing to approve of, and perform, abortions which are little more than menstrual extraction - quite another when the extract contains an identifiable foetus. It is here that the pro-abortion group begins to divide into those who accept the need for and will perform abortions on women to the upper legal limit, and those who refuse to go beyond approximately 12 weeks.

Numerous women were refused abortions in the hospitals - either because their pregnancies were too far advanced for legal abortion or because they were over 12 weeks' gestation and by chance had been given appointments to see those hospital doctors who did not perform "late" abortions, or the doctor they saw, having discussed with them their reasons for requesting the abortion, did not feel that there were sufficient grounds for terminating the pregnancies.

Some of the hospitals in neighbouring districts applied quotas; some refused to perform "late" abortions at all. One refused to accept any woman who had already had one abortion there. A woman who became pregnant with an IUCD in situ was sent by that hospital to one of the study hospitals because she had already had the one abortion permitted.
Only a small proportion of all the abortions which are performed is by the method and at the time of gestation which could produce a live foetus - a baby so premature that it could not survive independently for more than a few minutes. It is the realization that this can happen at all which makes abortion generally seem so abhorrent. In fact, in 1980, 92% of the 160,903 abortions performed in England and Wales were either by vacuum aspiration, vacuum aspiration with D and C, or dilatation and evacuation only; 6.2% (7.6% if "other medical inductions" are included) (2,261) of all abortions were the type where labour is induced by the use of prostaglandins, saline or paste (these are usually called "late"* abortions, mid-trimester or second trimester abortions, as they are most frequently performed at gestations between 13 and 26 weeks) (OPCS (1980)).

Teenage girls, for a variety of reasons, have a higher proportion having "late" abortions where labour is induced in this way. In England and Wales, in 1980, 10.4% of all abortions to teenage girls were performed using prostaglandins, saline or paste, that is almost double the proportion overall (12.6% if "other medical inductions" are included) (OPCS (1980)). The proportion of our abortion patients experiencing "late" procedures, 17%, was high. Part of the reason is that hospitals performing "late" abortions to some extent "compensate" for those which refuse to accept any at all. However, there are other reasons for viewing our high proportion with concern and these are discussed in the following pages.

While the dividing line between the need for these two very different procedures (different in method as well as emotional or psychological impact), is usually

* We have used the descriptions "early" and "late" abortions for our respondents on the basis of the procedures used to terminate their pregnancies. In the majority of cases use of the "early" procedure coincided with "early" or first trimester pregnancies, while "late" procedures were usually experienced by those teenagers whose pregnancies were further advanced, into the second trimester.
drawn at 12 weeks' gestation, in some centres abortions are regularly, safely and successfully performed by dilatation and evacuation on pregnancies up to 16 weeks' gestation. It is argued that at the later gestations this procedure is not as safe as abortion induced by prostaglandins, but this is disputed.

At the time of the study, in the study hospitals the main method of abortion used for first trimester pregnancies and for a small number of pregnancies between 12 and 16 weeks was vacuum aspiration (also called "suction termination of pregnancy"). Pregnancies under 10 weeks might be terminated using this method with local anaesthesia (only 2 girls in our group of 220 were offered this type, and one was in fact 12 weeks' pregnant), while those from 10 to 12 weeks were usually performed under general anaesthesia.

The more dangerous procedures which women with pregnancies over 12 weeks usually face, at the time of the study involved inducing labour by several different methods:

Extraovular prostaglandins - requiring a catheter to be passed through the cervix and prostaglandin solution instilled at intervals (usually every 2 hours);

Intra-amniotic injection - performed under local anaesthesia, hypertonic saline or saline and prostaglandins is instilled into the amniotic cavity with a needle;

Prostaglandin pessaries - vaginal pessaries inserted every 3 hours.

These methods are expected to induce abortions between 12 to 18 hours later. About a third of these "late" abortions then require evacuation of the retained products of conception (ERPC), performed under general anaesthesia.
The "late" method using intra-amniotic injection appeared to induce abortion in a considerably shorter time than the other methods and also expelled a dead foetus, unlike the other methods, which, being less toxic, could produce abortions where the foetus still showed some signs of life. (The 22 week foetus of one of our teenagers took 40 minutes to die.)

Research in the United States has shown that it is possible to use dilatation and extraction (D and E) under general anaesthesia to produce abortions on women with pregnancies from 12 to as high as 20 weeks with fewer physical complications than when using intra-amniotic methods with hypertonic saline solution or prostaglandins (Kaltreider, Goldsmith and Margolis (1979)).*

Patients who had abortions by the latter method experienced more pain and reacted with more anger and depression. But, while D and E may be "safer, less painful, quicker, more convenient and less expensive" than these intra-amniotic methods, the two procedures have markedly different effects on patients and medical personnel. Since the D and E requires the dismemberment of the foetus, medical personnel appear to avoid this method - although as those who carried out the research insist, "D and E procedures in the operating room are quick and allow for a spirit of co-operation in the care of the patient by all involved. This can occur when the surgical team is thoroughly oriented and participation is voluntary for

* Potts et al (1977) have noted that "neither urea nor prostaglandins have found much favour in America, where the induction of late abortion by hypertonic saline is still preferred, despite the greater dangers. The reason is probably that the less toxic alternatives are more likely to produce an abortion where the foetus may still show some signs of life. One is then dealing with late abortions that are not only aesthetically offensive, but also raise the ethical problem as to whether or not resuscitative measures should be attempted, even though the possibility of survival is remote" (p.203).
all members." Abortion procedures using the intra-amniotic method on the other hand, require "protracted and intense nursing care with physician involvement only in emergencies. The floor nurse must deal with the expelled foetus; even nurses in favour of abortion find this a lonely and difficult task" (Kaltreider, Goldsmith and Margolis (1979)).

Savage (1979) has argued strongly that while suction abortion alone is unsatisfactory as a method of terminating pregnancy after 14 weeks "unfortunately, even today some gynaecologists who see a woman at 14 weeks gestation send her away to allow the uterus to grow sufficiently to use an intra- or extra-amniotic injection technique at 16 or 17 weeks gestation. There is no justification for this in the light of experience gained in the U.S.A. and the U.K. showing that dilatation and evacuation of the uterus is the safest method to use between 13 and 16 weeks gestation. From 17 weeks onwards one of the intrauterine methods has to be used. The factors which influence the choice of method include the morbidity and mortality of the procedure, which is related to gestation, the skill and experience of the operator and the personality, age and emotional state of the woman. It is quite wrong that doctors have been forced to choose a more dangerous method because of the attitudes of paramedical staff or the inadequacy of facilities provided by the NHS or even the political climate of that particular area, but all these factors may influence the doctor's judgement, consciously or not".

We referred to the hospital notes of our abortion patients* a year after we had completed their interviews and recorded details of the method of abortion ("early" or "late" procedures) and the size of the patient's uterus at the time of the termination. "Size of uterus" is usually recorded for each patient at several different

* 207 cases only, as 13 were impossible to locate in spite of repeated attempts.
stages - the first time at the visit to her GP, then at her first hospital examination, and finally at the time of the abortion operation. It is not always recorded on all three occasions. In three cases, no reference whatsoever appeared in the hospital notes regarding size of uterus, number of weeks' pregnant, or weeks gestation etc. (these were one girl having the "early" method and two girls having "late" abortions). In 17 other cases (9 "early" and 8 "late" abortions) size of uterus was not recorded at the time of the abortion and so we have had to rely on the size recorded beforehand in the following calculations.

Eighty-two percent of the "early" abortions (140) were recorded as having been performed on patients whose uterus size was 12 weeks or less, while 18% (30) were 13 - 15 weeks; 17% of the "late" abortions (6) were recorded as having been performed on girls with a uterus size of 12 weeks or less. One of these cases was recorded beforehand as being 21 weeks, and another as 19 weeks (the latter assessed by ultrasonic scan). A further 19% (7) were recorded as 13 - 15 weeks (two of these figures had queries after them in the notes).

The pain, fear and misery of a "late" abortion brought about by inducing labour, make it an experience in no way comparable with an "early" abortion. Nursing staff, more than any other medical personnel, share with the patient the burden of the experience. Our teenagers frequently told of encountering difficulties with night staff - nurses who were often agency staff who had no sympathy or understanding for abortion patients, and probably little or no experience of abortion.

On one occasion during the study, after interviews with two girls having "late" abortions revealed a considerable degree of ambivalence in their decisions for abortion,
a ruling was made within the hospitals that all those women who were to have "late" abortions and all girls under 16 should be routinely referred to the hospital social work departments. However, because of the differing views of the consultants whose firms performed the abortions, this ruling was ignored and existing practices continued.* Some consultants never referred to social workers; some held the view that, if a woman requested an abortion, as far as they were concerned, she could have an abortion and so there was no necessity for her to discuss it further with a social worker.

In spite of the fact that girls would have been given some idea of what a "late" abortion entailed before they arrived on the ward, many girls appeared to be completely unprepared for what actually happened.

One girl told us she would advise "people to be careful if they went past the limit where they could have it sucked out. I really didn't think it would go on that long ... Having the abortion has really put me off (having children)."

Another said she "wouldn't want to go through it again. You think you'll have anaesthetic and you won't feel anything. I felt low in hell ... I couldn't get out of bed.... The tube squirted every 2 hours," she said, and "I had to wait for the last squirt until the Sister was ready." In pain all day, she felt very sad after the last injection. She felt that the Sister took the point of view that the girls brought it on themselves and therefore they deserved to suffer. She overheard a nurse

* One abortion counsellor, defending the non-referring doctors' point of view that such referrals were a waste of time, commented: "Suppose after seeing the social worker the woman changed her mind? Then she would come back and say she didn't want an abortion after all. How would the doctor feel about having his time wasted like that?"
say: "All these young girls who come in here for abortions should be whipped!"

The abortion counsellors, endeavouring to understand their own reactions, at one of their meetings discussed the case of a girl whose foetus had had to be decapitated while she was under general anaesthesia in theatre and having an ERPC, after aborting. The Sister had left the theatre in tears and the nursing staff had felt unable even to speak to the girl after the operation, although beforehand they had been wholeheartedly sympathetic towards her case.

One of our teenagers induced in the most commonly used "late" method in the hospitals at the time of the study, extra-amniotically with saline, aborted her 22 week foetus into the bed early one night after a long and painful labour. She called for help from the nurse on night duty. The nurse came, but on seeing the reason for the cry for help, burst into tears and rushed away, leaving the patient (with her mother who was visiting at the time) until another nurse could be found.

In the circumstances of "late" abortions, the regular nursing staff were for the most part understanding. It was rare during the study to hear stories from patients reflecting these nurses' anger. More often than not, the nurses, when distressed, withdrew as far as possible from the patient and kept communication with her to an absolute minimum.

It is generally recognized with all methods of abortion that "if the professional personnel caring for the woman adopt a punitive attitude, she is likely to feel some degree of guilt afterwards. If they adopt a sympathetic attitude, she is likely to come through
the experience with no long-term emotional scars" (IPPF (1974) p.32).

We asked all the girls in the study a question about abortion: "To have an abortion may be harmful to a girl's health if it is done after a certain point in pregnancy. Is this: after she is 12/16/20/28 weeks' pregnant?"

We had hoped to find a substantial number of girls knowing that abortion after 12-16 weeks is very different from abortion before then. Thirty-five percent of the girls (over 30% in each of the three groups) actually said it could be harmful to a girl's health to have an abortion only after 28 weeks. In the three groups, the girls who said it could be harmful after 12 or 16 weeks were: 47% of the abortion patients, 34% of the young mothers and 51% of the clinic attenders.

The majority of even the girls who had just had abortions did not appreciate the difference. Of course, since most of them had undergone vacuum aspiration operations, there would have been no reason to explain other techniques to them. However, in view of this widespread ignorance (which appeared even to extend in some cases to GPs), it is all the more surprising to find most teenagers managing to arrive at the hospital in time to have the earlier type of abortion.
Fetoscopies:

On some occasions it is necessary for women to be scanned ultrasonically in order to determine more accurately the number of weeks' gestation. This is done when it is thought that the pregnancy might be too far advanced for legal termination, or when it is uncertain whether a pregnancy can safely be terminated by the vacuum aspiration method or whether it will have to become a "late" abortion.

At the time of our study, scanning was also carried out on all those women whose pregnancies were already known to be well into the second trimester who were to be included in the fetoscopy research project which was being carried out at the hospital. In these cases, scanning took place on two occasions. On the second occasion, blood was taken from the foetus for the research, after which hypertonic saline was administered intra-amniotically by injection in order to abort the foetus. The abortion usually occurred within the next few hours. This procedure was quicker than the extra-amniotic method usually used for those women having "late" abortions who were not taking part in the fetoscopy research project. Particular skill is required to perform the former type of termination and it was rarely carried out at the hospitals.

In our semi-structured interview conversations with teenagers about having an abortion, we sometimes learned about experiences which were associated by our subjects with the abortion which were not foreseen by us and so data were not systematically collected from the outset. The fetoscopy research was such an experience. We learned about the inclusion of some of the abortion patients we interviewed only when they described their feelings about the scan procedure.

Nineteen of the 198 teenagers we asked (the first 22 were not asked) had been scanned - that is 10%. We asked them how they had felt about it. Six of the girls,
about a third, had been embarrassed, upset or extremely
distressed by the experience - the remainder said that
they had not minded.

During the study, we did not know how many girls
had been recruited to the fetoscopy research, since
they did not or could not tell us themselves, but
several descriptions make it clear that some of them
were. One girl initially only mentioned the fetoscopy
in connection with her feelings about her boyfriend:
"I was going to run away from him," she said, "because
I thought it was wicked killing it, and I have seen it
on the machine - I have seen its heart and its brain."
This girl was one of those who had been inconsolable when
she returned to the ward after the scan. The girl
described what had happened: "They put a telescope in
me. They just asked me if I would and I said I didn't
mind." This vulnerable girl was not quick witted or
intelligent, in fact she may well have even been subnormal.
From her story, one has the impression that her presence
was ignored while the heart and brain of the foetus moving
on the screen were pointed out to others, probably students
who were present, since these features certainly could
not have been pointed out to her.

In most centres where scanning is used to estimate,
where necessary, the size of the pregnancies of women
requesting abortions, an effort is made to conceal the
screen from their view. This was rarely, if ever, the
case at our hospital during the study. During the same
period, research into the use of scanning in "bonding"
between mothers and their unborn babies was being carried
out, so there was an obvious awareness of the implications
for a young pregnant woman of seeing her moving foetus
on a screen. In fact, at the entrance to the clinic where
scanning took place, there was a large poster on the wall,
picturing an ethereal, exquisite baby curled up inside a bubble-womb.

The majority of those girls who "didn't mind" the scan do not appear to have taken part in the fetoscopy research. "It looked like a big blob - I saw the screen, but it didn't bother me," said one. And another who didn't mind, said: "I was watching it." They also do not appear to have heard features of the foetus being pointed out to groups of students, probably because they were not yet large enough. These two girls' pregnancies were not very advanced and they both, in fact, had "early" abortions.

A non-resident of the district who came to the hospital for an abortion had first visited her GP five weeks before the operation. She was at that time about 14 weeks' pregnant. She said: "He said it was too late - I should talk it over with my parents and if you want an adoption I'll give you the names." So she went to another GP, who said it was not too late and referred her to a gynaecologist at a nearby hospital. "Late" abortions were not performed there and the gynaecologist made her an appointment at King's.

After her initial interview at King's*, this girl recalled: "I had to come back on the Tuesday to have a scan. (At the time of the scan) Mr. _____ was very rough and off-hand. I think they should be nicer to the patients. I know it's a teaching hospital and so there

* This teenager, when asked if she had talked the abortion over with a nurse counsellor when she first went to the hospital, had said: "Sister _____ was so hard with me. I was crying and I went out to my mother and she said: "I suppose they're trying to test you to see if you'll really go through with it.""
are always students, but really, it's so embarrassing. The first Irish doctor* was very nice and careful and she turned the screen so I couldn't see it. But Mr. didn't, and I tried not to look, but he was pointing it out and I could see this shape ... I really didn't like it at all. Everything was open so anyone could see you. Oh, it was awful. I was really upset that day. It was lucky my mother was with me or I don't know what I would have done ... He just poured all this oil over me and it was running everywhere and the students were just watching while he went to take a phone call and he said I could get up and I couldn't find something to wipe it up with."

Possibly the only advantage that inclusion in the fetoscopy research project had for these young women having abortions was that the abortion was over much quicker than in the case of the other methods of inducing "late" abortions.

One of the rare occasions when we missed an interview with a prospective respondent was because she had had a fetoscopy and an abortion and was discharged from the ward much more quickly than had been anticipated. A day before, the nurse on the ward had told me how excited she was because she was to observe a fetoscopy. Having missed the patient I had come to interview, I stopped to talk to the nurse and asked her if she had seen the fetoscopy. By chance the patient involved was the young woman I had just missed. "It was a real laugh!" said the nurse. "What a shambles! There was Mr. on his knees - he had gone in quite low down, so he had his head down on her leg and there was I with the ---- (I didn't catch the word) and I couldn't see anything, and we both had our heads down and he said: "There's a toe, can you see it?" and "There's a heartbeat, can you see it"

* She was actually a nurse.
on the scan?" She laughed because she hadn't been able to see. When it had finished, the nurse said, the girl had said: "The lump's still there, hasn't it gone yet?" She seemed to think that what had been happening around her was the abortion.

Sandra's story was particularly poignant. She was a 17 year old UK White girl who had been raped less than a year before. She had been staying with a girlfriend in a flat which was burgled by three West Indian boys. In their defence, the boys later said that they had only intended to burgle the flat and that they hadn't known that the girls were there. In any event, the experience had been quite traumatic for Sandra who had been raped three times while her terrified friend ran to call the police. The boys were arrested, but Sandra had been humiliated in court by their Defence, called a liar and "all sorts of terrible things". Sandra had been a virgin before the rape. After the boys had been sentenced to 3½ years imprisonment, Sandra never went out alone at night, always carried a knife in her handbag and usually had a friend drive her home from work.

Five months before we met her, she was leaving work, unusually alone, when a West Indian boy stopped her and asked her if she knew who he was. Sandra said no and he told her that he was a friend of the three boys and that he wanted her to change her statement about them so they could be released. Again she said no. So Sandra was raped again. "He said just because he felt like it" and she "just lay down and took it". Sandra took no-one about the rape because she couldn't bear to go through the same experience again.

At about this time, Sandra began going out with a boy she worked with. He was Turkish, like the boyfriend of the divorcee friend Sandra lived with (the mother of the girlfriend Sandra had been with when she was first raped).

This woman friend had cared for Sandra for some time, as Sandra's family was scattered. When Sandra's
older sister was 12, she was always tearful and upset and her mother discovered that the reason was that her father was having intercourse with her. The parents divorced. The older sister was mentally retarded and had two children and was unmarried. The mother was in the care of the Maudsley Hospital (a mental hospital) and in fact lived with the father of the woman Sandra lived with, who took care of her.

Coming from this complex and unhappy background, Sandra was very happy with her new boyfriend and when she found she was pregnant they planned to become engaged and to marry. She told her mother that she was pregnant and, Sandra said, "she was over the moon". Her boyfriend was thrilled and bought a pram.

When Sandra came to the antenatal clinic to book in, she was told that the pregnancy was much further advanced than she had realised, so that it could not have been her boyfriend's baby. She had, in fact, become pregnant when she was raped. Sandra was desperately upset and the only person she could tell was the woman she lived with; even her boyfriend and mother were then told that she had to be admitted to hospital because she was miscarrying.

At the time of our interview, Sandra was dreaming about a white wedding. She said she was trying only to think of the future and not the past.

It was, of course, a "late" abortion. Sandra had been very upset about seeing the "baby" when she aborted. She said she had gone to the toilet and it had suddenly started to come out and "its head was sort of purple and it was like jelly". She said she felt terrible about having the abortion and "killing the baby" and asked me what had happened to it. I remembered that when I had come to see Sandra the previous day, I had been told that she
was off the ward, having a fetoscopy. I thought it might help her to talk about the good that having the fetoscopy would do for other babies in the future. I did not use the word "fetoscopy" but reminded her of where she had gone for the special operation and used the simplest language I could. Sandra said she knew "nothing of that" and it became clear that no-one had told her anything about the fetoscopy, at least in language that she understood.

A year later we saw from her notes that Sandra had had a baby, but it may not have been the happy affair she had been dreaming about. She had first come with that pregnancy to the abortion clinic, but had "changed her mind". She had not married, although the same boyfriend was named as her next of kin.

When referring to the hospital notes of all the abortion patients 12 months after the interviews, we were able to see precisely how many of our teenagers had taken part in the fetoscopy research.

Nine girls were recorded as having had fetoscopies. The length of time 8 of the 9 girls had taken to abort ranged from 2 to 11 hours, considerably shorter than the other girls experiencing the "late" procedures. However, one girl was recorded as having taken 34½ hours, which seems exceptionally long for the intra-amniotic method used for the fetoscopy cases.

Procedures for the remaining patients having "late" abortions took between $7\frac{1}{4}$ and 60 hours. The average duration was 23 hours. The two girls experiencing the most prolonged abortions, about 60 hours, had uterus
sizes recorded at the time of the abortion as 10 weeks for one (although 21 weeks was recorded before the operation), and 14 weeks for the other, only recorded before the operation. It may well be extremely difficult accurately to assess size of pregnancy, but the discrepancy between 10 and 21 weeks seems very substantial. The girl estimated at 14 weeks beforehand would probably have been accepted for an "early" abortion had she been given an appointment with the surgeon who was prepared to include pregnancies up to 16 weeks on his list of "early" abortions.

A considerable difference between the UK White girls having abortions and those having babies had been anticipated. Early motherhood is known to attract particular girls - those from large families, whose mothers also began child-bearing early, from the lower social classes and with a lower level of education (Connell (1979), Wilson (1980) and Kernes (1979)).

These distinguishing characteristics were not immediately evident in comparison between the UK Black girls having abortions and those having babies.

Although the UK White abortion patients were more likely to say they had been undecided at some stage about having an abortion compared with the UK Black girls (18%) - (8%), the reasons for this indecision were not strong enough to deter them (emotional pressure from boyfriends and distress at the thought of "killing a baby" perhaps outweighing social pressures).
Introduction

Between December 1979 and July 1980, 217 young mothers were interviewed on the two hospitals' five maternity wards after they had given birth to their babies. During their recruitment, interviews with the UK White girls were distinctly different in "feel" to those with the UK White girls who had had abortions. The UK White young mothers seemed generally less articulate, less interested in the study and were less interesting to talk to. The liveliness generally of the interviews with the UK Black mothers, on the other hand, resembled the experience of interviewing we had had with the UK Black abortion patients.

A considerable difference between the UK White girls having abortions and those having babies had been anticipated. Early motherhood is known to attract particular girls - those from large families, whose mothers also began child-bearing early, from the lower social classes and with a lower level of education (Dunnell (1979), Wilson (1980) and Kiernan (1980)). These distinguishing characteristics were not immediately evident in comparisons between the UK Black girls having abortions and those having babies.

Although the UK White abortion patients were more likely to say they had been undecided at some stage about having an abortion compared with the UK Black girls (58% - 42%), the reasons for this indecision were not strong enough to deter them (emotional pressure from boyfriends and distress at the thought of "killing a baby" perhaps outweighing social pressures).
Among the young mothers, only 13% of the UK White girls had entertained the idea of having an abortion, compared with a third (34%) of the UK Black girls. Part of the explanation for this may lie in the much higher proportion of UK Black young mothers describing their pregnancy as (initially) unplanned and unwelcome (39% - 19%).

With their apparent firmness in deciding to have an abortion, and their ambivalence when they did have the babies, the UK Black teenagers generally presented a picture of young women who were not greatly attracted by the prospect of teenage motherhood, at least compared with the UK White girls who did not approach abortion with such single-mindedness and who were less likely to consider terminating the pregnancies which eventually resulted in their becoming teenage mothers.

In this chapter, devoted to the group of young mothers, the description "planned" when applied to a pregnancy, is discussed and the experiences of those young mothers who described their pregnancies as such are compared with those who described their pregnancies as unplanned.

The teenagers' experiences of having a baby, from the time the pregnancy was first suspected, are described, as are the attitudes of health service staff as perceived by these teenage girls who had decided to continue with their pregnancies. A small number of the mothers had arranged for their babies to be fostered or adopted and their experiences are recounted.

West Indian mothers, and those mothers who were under 16 years, all of whom were of West Indian origin, and some of the popular misconceptions that are held concerning West Indian attitudes towards pregnancy and motherhood, form a substantial part of this chapter on young mothers, which is equally applicable to the majority of the teenagers of West Indian origin recruited into our group of abortion patients.
A. Planning a pregnancy

What is a "planned" pregnancy? Frequently, illegitimate births and those to teenage mothers are presumed to be "unplanned" and believed to be (at least initially) unwanted. However, births to teenage mothers cover a wide variety of types and degrees of "plannedness" which may make the generalised use of the division between "planned" or "unplanned" pregnancies as recorded, for example, in patients' notes at their first visit to the antenatal clinic, somewhat misleading.

Chamberlain (1976) has reported finding semantic problems revealed in the meanings her respondents (women who had had 6 or more children) attached to "planning" and "not planning", some mothers interpreting "planned" to mean "wanted" if the pregnancy was just wrongly timed. If one is pleased about one's pregnancy, then it is seen as "wanted" so that even the philosophy of "just letting them come along" may also be seen as a planning approach.

There is some difficulty in attempting to interpret the significance of intentions from survey data such as ours. Nevertheless, even those teenage mothers who had quite patently not planned their pregnancies, but who still described them as such, were indirectly giving us an insight into their relationships and their hopes (even their plans) for the future.

The individual or the couple? Is a girl having a baby to satisfy her own personal needs and desires, or is it viewed as the couple's baby, brought into the world for their joint satisfaction and happiness, its rearing their joint responsibility?

A baby may be seen as the necessary ingredient in creating a family. The Asian girls and others from
the great traditions (Muslim and Hindu cultures in our study) do not anticipate using contraception when they marry. Contraception is seen as useful only for spacing and once the desired family size has been achieved. A young Asian mother whose marriage had been arranged said that having a baby would now make them a family and was her reason for marrying.

The gift of love? One of the West Indian girls we interviewed in the family planning clinics who had never been pregnant, said that she was waiting for "Mr. Right". It was her ambition, not to marry him and live happily ever after, but to bear him his first child. The UK born daughter of an English mother and a Maltese father whose boyfriend was West Indian, had been pregnant twice (first a miscarriage and then a stillbirth at the time of our interview) and was anxious to become pregnant again as soon as possible in order to stake her claim on her man as the mother of his first child.

Half of the UK White girls in the group of single mothers with "planned" pregnancies had West Indian partners, for whom marriage is seen more as an economic responsibility (which young men, therefore, cannot entertain). In the West Indies, while monogamy is the ideal for all classes, formal marriage is usually deferred until a man can afford a house and an elaborate wedding and can support a wife who then need not go out to work. Because most young men do not command such resources, a legal ceremony often marks the culmination rather than the commencement of a relationship (Lowenthal (1972) p.105). However, working class Christian marriage is sometimes singled out as a West Indian family pattern in its own right (see pp. 247 - 248).
Blackmail or "friendly persuasion"? A number of the girls who had conceived pre-maritally were self-confessed blackmailers. They were, however, taking a risk expecting their partners to marry them, without demur, in order to assure the baby's legitimacy. Our numbers of pre-marital conceptions and the (white) single mothers masquerading as married women give an indication of the continuing, although perhaps diminishing, importance of legitimacy and marriage to working class South London girls.

Nevertheless, the unromantic reality of a "shotgun wedding", marriage precipitated by the girl's pregnancy, may have been unpalatable to some of our indigenous teenagers, who were unwilling to jeopardise their chances of one day experiencing their true love idyll, like the engaged girl who said she would be marrying, "but I'll wait till I'm thin again - I want a church wedding".

However, all our indigenous teenagers did not view marriage through rose-coloured glasses.

A mother who said she had thought of marriage (in fact they were waiting for his divorce) added rather sadly that he had hit her last Friday when he'd been drinking and so she thought she would wait and see ...

One girl said "we were considering marriage", but she "didn't feel too happy about it". They were presently waiting for a council flat and "we will probably get married then".

Another couple who were living together: "We were going to marry a year ago, but we couldn't get a flat and couldn't really afford it."

A UK White girl living with her fiance said: "I'm frightened that if I got married it might change the way he is."

And a 19 year old when asked if she'd considered getting married said: "Yes, but I'm a bit too young."

A 17 year old with an Irish mother said that she wasn't keen on marriage, she preferred "going steady" because "I'm young and like being by myself or with my own family - I didn't like living with him" (she had lived briefly with her boyfriend).
A girl who had thought about marriage said that she had intended marrying on 21 June (it was then 12 March), but since she was pregnant she had decided to cancel these plans; anyway, "he gets on my nerves". She didn't think a girl should marry just because she was pregnant.

An advocate of marriage said: "You know you've got them then ... they can't back out when the going's tough."

And a girl who said she had had mixed feelings when she found she was pregnant and had not thought they would marry, in fact did.

One of the few black girls who had white boyfriends had married. At first, she said, her boyfriend had suggested she have an abortion and she had agreed. She said she had been pleased that the suggestion had come from him "because I'm a coward, but sad because I wanted his child... We talked seriously about it. It was the worst time in our lives. I thought it best to settle down. He wanders around the country with a rucksack". His parents wanted the young couple to marry although she "didn't like the idea of marrying - it didn't seem necessary". Her own father was against the marriage and she had not seen him since her sister had told him she was pregnant.

Eighty-seven (40%) of the young mothers were married, three of them already separated from their husbands. Half of these girls (43) had conceived pre-maritally. Similar proportions of both the pre- and post-marital conceptions were described by these mothers as "planned", 65% of the post-marital conceptions and 56% of the pre-marital conceptions.

In fact, very few of our teenage girls were prepared to marry "for the sake of the baby". We asked all the girls who had conceived pre-maritally: "Would you have got married at that time if you hadn't been pregnant?" "Oh yes," replied just over half (55%). Of those girls answering "no", we asked: "Do you think you would have married at all?" Every one of them replied "yes".
Describing her pregnancy as "planned" did seem to indicate that a young woman wanted the pregnancy - either because she wanted a baby, or, more frequently, because she wanted to create a bond with her partner, or to strengthen her relationship with her partner which having a baby would bring about.

Over half (57%) of the pregnancies to our young mothers were described as "planned". Of these, 66% were those of married mothers and 34% were those of single women. Of the 43% describing their pregnancies as unplanned, 18% were to married women and 82% were to single women.

In fact, few teenagers could be said to have "planned" babies because they wanted a child of their own. Unsupported girls, frequently the very young girls among our mothers, whose relationships with their partners, if continuing, could be described as segregated, more frequently described their pregnancies as unplanned than "planned". Only one (4%) of the 26 mothers under 17 years described her pregnancy as "planned". It was only among the 19 year olds that we found a higher proportion of girls describing their pregnancies as "planned" (52%) than either unplanned and welcome or unplanned and unwelcome. This proportion was 37% of the 18 year olds and 26% of the 17 year olds.

The majority of the young women describing their pregnancies to us as "planned" seemed also to be making a statement about the types of relationships they had with their partners. Two-thirds of the teenagers with "planned" pregnancies were married, while only 18% of those describing their pregnancies as unplanned were married and only 21% of these latter girls also described their pregnancies as unwelcome. The majority of the unplanned pregnancies (43% of all the pregnancies) were to single teenagers (82%) and these girls were much more evenly divided between those describing their unplanned pregnancies as welcome and those as unwelcome (as is shown in the following pages).
So although a teenager might describe her pregnancy as "planned" when in fact the event was unintentional and unpremeditated, she was likely to be indicating to us, by using this description, something of the level of commitment and support in her relationship. Those single girls describing their pregnancies as unplanned appeared to experience a far lower level of commitment and support in their relationships with their partners than the single girls who described their pregnancies as "planned" experienced in their relationships.

In the absence of the commitment to a partner which marriage may reflect, in the case of the single young mothers, in the following pages three separate factors are looked at in an attempt to assess the commitment the couples felt jointly to rearing a "planned" baby. These three criteria were: (1) whether or not the couple lived together; (2) what the girl's partner's reaction had been to the news of her pregnancy; and (3) whether or not her partner had been present (or "nearby") when the baby was born. (If she had been taken to theatre for a Caesarian section, he might not have been permitted or have wished to be present.)

(1) Forty-one percent of the young mothers were living separately from their partners. These girls were asked if their partners were voluntarily financially supporting them (and their babies) or, with very young couples, at least making a regular contribution to the girls' upkeep and/or that of their babies. However, it may be that this "criterion for commitment" has less significance in West Indian society, where it is the expectation that very young girls and their babies should remain in the care and be the responsibility of their own families.
Over three-quarters (79%) of the UK White girls were living with their partners. Of the remaining 19 girls:

10 (53%)* were receiving no help
2 (11%) had received money for the baby
6 (32%) had received money for themselves and the babies
1 (5%) did not know if she would be helped or not

Almost a quarter (23%) of the UK Black girls were living with their partners. Of the remaining 48 girls:

14 (29%)* were receiving no help
5 (10%) had received money for the baby
2 (4%) had received money for themselves
25 (52%) had received money for themselves and the babies
2 (4%) could not say what would happen at that time

Although we did find fewer UK Black couples cohabiting, over half of those girls who were living alone, and their babies, said that they were being helped financially by their partners, compared with about a third of the UK White girls who were not living with their partners. Since many of the West Indian partners had other children with other women, it is understandable that they found it difficult to make a complete commitment to any one family unit.

(2) About 90% of all the young mothers had themselves told the fathers that they were expecting babies - 88% of the UK White girls and 92% of the UK Black girls.

Their partners' reactions to the news showed variation between the groups, with 83% of the UK White girls' partners reacting immediately positively, compared with 65% of the UK Black girls' partners. Of course, a positive reaction can mean as little as smiling and saying "that's nice", buying a round in the pub, and having virtually no more to do with the prospective mother. It can also mean visiting the doctor together, living together and sharing the day-to-day experiences of pregnancy, giving financial support.

* Figures rounded
and emotional support and being present at the birth of their baby.

(3) The presence of the father at the birth of their baby is encouraged in most hospitals. In a teenage sample, the proportion of fathers present is likely to be much smaller than it is in the older age groups, since it must, at least partially reflect the degree of anticipation and preparation of a couple for the event, and with the very young single girls their own mothers may well replace the young fathers in this supportive role. However, in the group as a whole, half of the girls shared the experience of the birth with the fathers: 60% of the UK White girls' partners were present compared to about a quarter (26%) of the UK Black girls'.

### Marital Status and Planning a Pregnancy

**UK White and UK Black Young Mothers**

<table>
<thead>
<tr>
<th></th>
<th>Married Unplanned</th>
<th>Married Planned</th>
<th>Single Unplanned</th>
<th>Single Planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Black</td>
<td>1</td>
<td>2</td>
<td>45 + 2*</td>
<td>12</td>
</tr>
<tr>
<td>(62)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK White</td>
<td>25 + 1*</td>
<td>28</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>(92)</td>
<td></td>
<td></td>
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</tbody>
</table>

* Includes "Other"
Young mothers with "planned" pregnancies

(a) Married teenagers with post-marital conceptions

Over half of our young mothers (57%) described their pregnancies as "planned"; two-thirds of them (66%) were married - 52 girls. Only 29 of these young married women had conceived post-maritally; 7 of these had, in fact, been pregnant before.

Married teenagers with "planned" pregnancies

<table>
<thead>
<tr>
<th></th>
<th>Never previously pregnant</th>
<th>Previously pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post-marital conception</td>
<td>Pre-marital conception</td>
</tr>
<tr>
<td>2 UK White</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>2 UK Black</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>22 Others</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>N = 52</td>
<td>22</td>
<td>17</td>
</tr>
</tbody>
</table>

The three UK White girls who had previously been pregnant had been unmarried at the time of the earlier pregnancy - all of them had then had different partners, two had had miscarriages and one an abortion. Of the four other girls who had conceived post-maritally on this occasion who had been pregnant before, all had had the same partner at the time of the earlier pregnancy - two having had babies and two miscarriages.

Among the young mothers, 24 girls (11% of the group) had first conceived after marriage and described their pregnancies as "planned" (7 were UK White girls). Most of the other girls had been born abroad (one UK born girl with Irish parents; 5 Cypriot girls; 1 Turkish girl;
6 Asian girls; 1 UK born Asian girl; 1 UK born daughter of European parents; 1 Sudanese girl and 1 Nigerian girl - 17 girls).

(b) Married teenagers with pre-marital conceptions

Seventeen girls who had never been pregnant before had conceived pre-maritally (14 UK White and 3 UK born girls with Irish parents); 6 girls who had previously been pregnant had conceived pre-maritally - they were: 4 UK White girls (2 had previously had abortions - one then had the same and one a different partner; and 2 had previously had babies - one to the same partner and one to a different partner) and 2 UK Black girls (1 had previously had an abortion and one a baby - both had had the same partners).

(c) Unmarried teenagers

Twenty-seven girls who were not married described their pregnancies as "planned".

Single girls with "planned" pregnancies

<table>
<thead>
<tr>
<th></th>
<th>Never previously pregnant</th>
<th>Previously pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Black girls</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>UK White girls</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Jamaican girls</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Other girls</td>
<td>2*</td>
<td>2**</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>8</td>
</tr>
</tbody>
</table>

* Both UK born (1 with an Irish mother; 1 a German father)
** Both UK born of mixed race (West Indian)
Criteria for commitment:

Single girls with "planned" pregnancies

<table>
<thead>
<tr>
<th>Ethnic origin</th>
<th>Cohabiting</th>
<th>Positive reaction</th>
<th>Present at birth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ UK White</td>
<td>8</td>
<td>10**</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>2/ UK Black</td>
<td>8**</td>
<td>11***</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>3/ Jamaican</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4/ &quot;Other&quot;</td>
<td>3**</td>
<td>4</td>
<td>2***</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>26</td>
<td>13</td>
<td>27</td>
</tr>
</tbody>
</table>

1/ 5 of these girls had West Indian partners
   ** 2 West Indian partners' reactions were positive initially, but had since deteriorated
      ("I'm going to pack him in anyway")

2/ All partners West Indian
   ** One girl going to a mother and baby home; one to a hostel (and receiving no financial help from her partner)
   *** 2 partners' reactions were "quite" pleased
      One partner said "nothing much"; she "planned" the baby and he "didn't mind".

3/ Only 1 of the 8 Jamaican respondents in the group of young mothers who had previously been pregnant.
   She had had an abortion and had conceived again 3 months later - same partner and "planned".

4/ One partner English, one Algerian and 2 West Indian.
   ** The 18 year Old UK born daughter of English and Maltese parents had never lived independently with her West Indian boyfriend but had spent several months before her stillbirth living with his family and he was to spend some weeks with her and her family on her discharge from hospital.
   *** Although she knew beforehand that her baby would be stillborn, her boyfriend stayed with her for its delivery.

θ Twenty of the 27 partners were West Indian:
   8 were present at the birth of their babies (40%).
Young mothers with unplanned pregnancies
(a) Married teenagers

There were 35 young married mothers in the group who described their pregnancies as unplanned - 7 (20%) said they had also been unwelcome and the remainder described their pregnancies as welcome.

Married teenagers with unplanned pregnancies

<table>
<thead>
<tr>
<th></th>
<th>Never previously pregnant</th>
<th>Previously pregnant</th>
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<tbody>
<tr>
<td></td>
<td>Post-marital</td>
<td>Pre-marital</td>
</tr>
<tr>
<td></td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>UK White (2g)</td>
<td>4</td>
<td>1*</td>
</tr>
<tr>
<td>UK Black (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (6)</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

N = 35
* Extra-marital conception
+ Welcome
- Unwelcome

Thirteen (37%) of these married young mothers had conceived post-maritally, another had had an extra-marital conception. Two girls said that the pregnancy had been initially unwelcome - the UK White girl with the extra-marital conception (she was awaiting a divorce and planned to marry the baby's father) and the UK born daughter of Greek Cypriot parents who actually described her reaction as "pleased and shocked".*

* This 18 year old seemed ambivalent about having a baby. Although she had been an initial pill user, she had stopped taking it because, she said, she wanted a baby. Nevertheless, once pregnant, she considered having an
Only three UK Black young mothers were married. All had conceived pre-maritally. One described her pregnancy as unplanned and initially unwelcome; she had not been pregnant before. The other two had previously been pregnant and now described their pregnancies as "planned".

(b) Unmarried teenagers

Single girls with unplanned pregnancies

<table>
<thead>
<tr>
<th></th>
<th>Never previously pregnant</th>
<th>Previously pregnant</th>
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<tbody>
<tr>
<td></td>
<td>Welcome</td>
<td>Unwelcome</td>
</tr>
<tr>
<td>UK White (20)</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>UK Black (45)</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Jamaican (7)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Other Black (3)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other White (13)</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Mixed race (West Indian) (5)</td>
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<td>2</td>
</tr>
</tbody>
</table>

One hundred and one single mothers described their pregnancies as unplanned - 54% were also initially unwelcome. West Indian girls accounted for just over half of this group (45% UK Black and 7% Jamaican girls) of whom 62% (32) describing their pregnancies as unwelcome.

Not unexpectedly, when we looked at the single young mothers with unplanned pregnancies, using the same criteria as we did for the single girls describing their pregnancies as "planned", we found that the level of support and commitment in most of these girls' relationships was very low indeed.

abortion but did not because "I was frightened in case I couldn't have another child". She envisaged herself at 25 as "more grown up, with one more child - and happy". Her attitude towards the pregnancy was very similar to another Cypriot girl we interviewed who although conceiving post-maritally, had an abortion.
Criteria for commitment
Single girls with unplanned pregnancies

As with those having "planned" pregnancies, the UK Black young mothers having unplanned pregnancies were less likely than the UK White girls to be living with the putative fathers who were also less likely to have been present at their babies' births and these are differences which prevail whether the pregnancy was initially welcome or not, although more extremely so where it was unwelcome. However, those UK Black girls for whom the pregnancy was welcome were more likely to describe their partners' initial reaction as positive than were similar UK White girls, although this difference was not maintained for the unwelcome pregnancies.
B. The experience of having a baby

Confirming the pregnancy and deciding what to do

Three-quarters of the young mothers thought they were probably pregnant by the time they had missed their second period. By 12 weeks after their last period, 86% thought so and by 16 weeks, 91%.

The majority of the young mothers realised that they were probably pregnant in time to request an abortion if they had wanted one. Only 14 girls (7%) did not realise until over 20 weeks after their last period. As with the group of abortion patients, UK Black girls were slightly quicker than UK White girls to suspect they might be pregnant.

All the young mothers who described their pregnancies as unplanned were asked: "When you first found you were pregnant, did you think of having a termination?" And, "Did anyone else suggest to you that you might consider a termination?"

A fifth of the young mothers (44) said that they had thought about having an abortion, 13% (12) of the UK White girls and about a third, (34%) (21) of the UK Black girls. For many of these girls, this first thought was no more than an idea which they entertained briefly and then discarded. Some who had not thought about it, and certainly did not want an abortion, nevertheless had partners, mothers, other family members, friends, doctors and social workers making the suggestion to them.

A West Indian girl who changed her mind about having an abortion after she had been admitted to the ward for
one, said that everyone, her boyfriend, family and friends, wanted her to "get rid of it". Another West Indian girl said she had burst into tears when a young woman hospital doctor tried to "talk me into an abortion" when she booked into the hospital for antenatal care.

In fact, UK Black girls were not only more likely themselves to consider having an abortion, they were also more likely to find others suggesting the possibility to them. Of the 27 UK White girls (29%) who had had this suggested, 16 said it had first come from their parents or other family members, and 2 from their partners, with only 5 saying that a doctor had made the suggestion. On the other hand, of the 26 (42%) UK Black girls who had had the suggestion made to them, 10 quoted their families, 4 their partners and 8 quoted doctors.

When asked why they had not had abortions, most of the girls who had considered the possibility, could not give any reason beyond saying they had just changed their minds. Obviously, either the thought had only been a passing one or there had been numerous influences on their decision to continue and have the babies. Six girls only (3 UK White and 2 UK Black girls among them) said that they had been told by their GPs or the hospital doctors that they were "too late".

It seems that even though obtaining an abortion may require some perseverance, the majority of the young mothers had made conscious decisions against abortion or were ambivalent enough not to pursue the possibility of abortion.
Attitudes towards young mothers

Macintyre (1977) has reported a difference in the treatment at antenatal clinic of single women in that, apart from the fact that they were called "Mrs." and that the atmosphere of the clinic was geared to "happy events" within the framework of marriage, single women were routinely asked whether they wanted to see a social worker and encouraged to do so; and they spent longer with the obstetricians, who tended to ask them more about social and emotional problems (p.152).

If our younger teenage mothers were similarly singled out, it was not immediately evident to them. It may be that in an area with high illegitimacy and a substantial population from a different cultural background, doctors and nurses (many nurses themselves West Indian) accepted the inevitability of single motherhood and were less perturbed by it. Our observations and the informal comments of respondents which we recorded, left us with the impression that in a large inner city teaching hospital, there were often medically defined problem groups, such as women at risk of having babies with thalassemia, with a higher priority than those merely defined as young and single.

The focus of interest and orientation of care provided in a teaching hospital often results from the individual interests and preoccupations or research of the doctors currently working in a particular clinic or department. For a short period near the end of our recruitment of young mothers, a woman doctor in the antenatal clinic was taking a particular interest in schoolgirl mothers, attempting to provide a continuity of care from antenatal to postnatal. Referral of pregnant school-age girls to her clinic was incomplete as some doctors preferred not to differentiate by age between women attending their (separate) antenatal clinics. When the young woman doctor left the hospital, part of
her work was taken over by another interested woman doctor. This doctor too, left and later returned to the hospital, but any real continuity of care would have been difficult. As we have already noted (p. 200) one of the consultants accepting girls for "late" abortions was recruiting these young women to research involving fetoscopy. It was not clear whether such advanced pregnancies would continue to be accepted for abortion by his team once this research was completed.

Evidence in general seems to indicate a greater risk of complications for girls under 17 years than for women 20–29, but less than for women over 30 (Pregnant at School (1979)). A number of inter-related social and medical factors are likely to account for this. Physical immaturity, the fact that these are usually first pregnancies, inadequate diet during pregnancy and anaemia are all likely to contribute to the health risks for the young mother and her baby. Immigrant women generally are also known to experience a higher infant mortality rate and other complications related to childbirth than indigenous women (Bamford (1971)).

The lower socio-economic groups are over represented among very young women having babies and such women are more likely to have received minimal antenatal care. This, in turn, is the result of a lack of information and low estimation by women for the care they do receive, together with difficulties in the women's backgrounds which mitigate against their efficient use of the services available (for example, those in unstable relationships, young working women or schoolgirls and women with children already).

Very few of our teenage mothers seemed to have "copybook" pregnancies, even those describing their pregnancies as "planned". The reasons why they should attend the antenatal clinic were believed, by most, to be to book a bed, and to assess the gestation of their pregnancy (presumably so that the hospital knew when to book the bed).
Like the 16 year old who had told no-one she was pregnant and who said she hadn't been frightened, "I did biology at school", all the girls educated locally had seen films such as "Having a Baby" either at school or on television. It seemed not to have occurred to them that it was advisable in pregnancy to check for any problems; they could hardly be blamed for their naivety. As many of them had said, no-one explained the reasons for doing what they did, or for asking certain questions. Sickle cell anaemia is commonplace among West Indians and every pregnant black woman is given an appropriate blood test - before abortion or before childbirth. Such a debilitating, hereditary problem should be well understood by the community which suffers from it almost exclusively. Yet even at this hospital, when blood tests were made the opportunity was not taken to explain to the women the purpose of the test; no written or verbal explanation of the problem was given to any of our black teenagers.

Similarly, no explanations were given to young women for the need to attend antenatal clinics regularly. Communication between the medical profession and working class women, and immigrant groups, is known to be poor - evidenced in this study by such comments as "well, they have to be a bit rough with you, don't they? - to make you think!" from the patient's side, and "you have to humiliate them - it's the only way to make them understand" from the doctor's side.

We did not attempt to collect detailed data on the content of the health education our respondents received at school. Nevertheless, from the information we did record, it appeared that while their knowledge (for example, of contraceptive methods) was generally quite good, and the biological and medical aspects of reproduction and childbirth were dealt with in their lessons, the role of the nurse and the doctor and the function of the clinic in providing antenatal and
postnatal care did not seem to feature in them.

Our young mothers did not think doctors and clinic staff any more sympathetic or helpful than the abortion patients had done. However, staff, while conscious of the special problems and risks involved for some girls in early child-bearing, seemed nonetheless more sympathetically disposed towards young mothers who described their pregnancies as unplanned and initially unwanted than they were to those girls having abortions. Prospective abortion patients who had changed their minds, even at the last minute, on the ward, were commended by smiling nurses: "She's changed her mind, isn't that wonderful!" was the greeting when we went to interview one such teenager.

Doctors

GPs

Of the 217 young mothers we interviewed, 27 (12%) had not been to a GP in connection with this pregnancy. In addition, a small number had been to their GP for a pregnancy test only and not returned.

Many girls simply said that they had been to their GPs "to get a letter for the hospital". Once having decided that they would have their babies, when they went to their GPs, either immediately they thought they were pregnant, or just before the baby was due, did not seem

* Also perhaps an indication of the greater self-confidence and self-importance of the young mothers was the higher proportion of refusals we experienced with this group, ranging from an aggressive "I don't have to answer questions from no-one!" to "no, I'd rather not, no no..." - a stubborn reply which could not be won over in spite of perseverance.
to many girls to matter - as long as it was before they were due to be admitted into hospital for the birth. One young mother who first saw her GP three weeks before her baby was born, said he was very nice, but she was surprised when he said: "What do you think you're playing at? You might as well have waited and just phoned for the ambulance!"

A small proportion of young mothers attended their GPs early in their pregnancies and felt that they had benefited from doing so. Only one of our teenagers was delivered in the hospital by her own GP. He visited her during our interview. A girl who said her GP had been the family doctor for a long time said that he had encouraged her to think over having an abortion and she had returned several times to see him.

However, on numerous occasions girls told stories of misunderstandings by GPs and hospital antenatal clinic doctors which simply confirmed to them that, for pregnant women, except as referees, essential in the bureaucracy of the National Health Service, doctors are really irrelevant.

A 16 year old UK Black young mother said of her GP: "He didn't look at me - he looked past me. He was really funny and I won't go back to him - I don't know ... he was a bit shaky - he was quite nervous. It was a group practice. He must have been at least 40. He said: "It would be dangerous to have an abortion anyway", which I wasn't going to ask for anyway. He gave me a letter for the clinic here."

A girl who was to go to a local health centre for her antenatal care said that the doctors there were "very nice - very welcoming even if you haven't been for a long time." Nevertheless, she failed to attend the antenatal clinic "because it clashed with work".

A young black mother who had already had one child went first to her GP when she was 3 months' pregnant. The thought of all the travelling to the hospital antenatal clinic put her off, she said. "The longer
you leave it the quicker you get over it." So she wrote a letter instead to book into the hospital. "I'd already had one baby so I knew all about it."

Over half of the young mothers who saw their GPs described them as very, or quite sympathetic and helpful - UK White girls (68%) being more likely to feel this than UK Black girls (56%). In fact, a quarter of the UK Black girls (26%) described their GPs as not sympathetic or helpful, compared with only 11% of the UK White girls. Almost a fifth of the UK Black girls had not even seen their GPs about the pregnancy (12 girls, 19%), compared with 7% of the UK White girls (6 girls).

It is difficult to say whether what young black women feel is unsympathetic treatment apparently meted out by their GPs deters them from attending or whether the girls' late attendance during pregnancy and the difficulty they appear to have in communicating their needs results in what the girls feel is unsympathetic treatment.

"All he said was "do you want it?"" said one girl, while others felt that they were being pushed to have abortions they did not want. Two young mothers who had previously had abortions were quite distressed by this. One said that her GP had just written her a letter for the abortion before she had had time to think about what she really wanted to do.

Another girl felt she was being pushed in the opposite direction. "You couldn't call him a doctor really. If I'd wanted a termination I wouldn't have had any help from him."

"He was rough", said another, "and wanted to know why I wasn't on the pill."
A 16 year old UK Black mother told how on her first visit to see her GP, he had asked her: "Have you had sex-yoo-al intercourse?" (Her unintentionally exaggerated pronunciation of an unfamiliar and embarrassing word.) "Oh no!" she replied, horrified at the thought. Part of the problem for young black girls in talking about a suspected pregnancy may be their fear of the dire consequences for having "misbehaved", frequently threatened by their strict mothers. However, to describe the incident which had led to her becoming pregnant as "sexual intercourse" seemed more shocking to the girl than some more euphemistic expression or the simple question: "Do you think you could be pregnant?".

Hospital doctors

The differences between UK Black and UK White girls in perception of their treatment by hospital doctors did not show the variation that was reported for GPs. Generally, more girls found hospital doctors very, or quite sympathetic and helpful (65%) and UK Black and UK White girls' experiences were similar.

However, descriptions of treatment as generally sympathetic and helpful were frequently qualified by comments about waiting times, lack of information or the confusion caused by frequent changes of doctors.

We do not know precisely what form the examination of our young respondents took or whether it varied from that of older pregnant women. What is evident from many of our respondents' comments is that they frequently felt out of place and unwelcome.

Those girls who failed ever to attend a clinic, often did so for a number of related reasons: they did not wish to acknowledge their pregnancy or they wanted it to remain a secret for as long as possible; they did not see any (medical) need to attend (having a baby being seen as a perfectly natural and healthy activity); or they professed an aversion to the medical profession generally
"doctors and hospitals and the like") and so avoided any but essential contact with them.

The comments of those girls who did attend a clinic at least once, fell into two related areas:

(i) Those indicating a lack of understanding and so an undervaluing of the functions of the antenatal clinic — confirmed, as far as the teenagers were concerned, by the lack of information and explanation received and the long waiting times to see a different doctor on every visit, so that there was no feeling of being treated as an individual, someone whose failure to keep her next appointment would even be noticed;

(ii) And those comments from girls who felt that they were treated rudely or abruptly; and those who felt that for a number of reasons the doctors knew even less than they did about their pregnancies.

From some of the comments recorded which fall into the former category, there was evidently widespread ignorance of the importance of attending for antenatal care, not only among those who failed to attend, or only attended once, but even among those teenagers who regularly visited the clinics.

One girl who said she didn't see a doctor, said she only came to book a bed, although she did add that she had come for a scan at 3 months to see if she was having twins.

A GP described by one 16 year old as "nice", referred her to the hospital antenatal clinic. She was turned away by the receptionist because she lived outside the hospital catchment area. She didn't go to another hospital. Her boyfriend brought her into hospital in labour. Again she said, the doctors were "nice" on the labour ward!

Some girls became so irritated by the long wait they were invariably faced with in the antenatal clinics that
they simply stopped attending.

One young mother said: "It was nice to begin with but I got fed up with all the trundling around ... I didn't enjoy antenatal at all." "It was awful if you had to wait for hours", complained another. "With a 10 o'clock appointment you could be in there until 12, 12.30 - so I felt like not going sometimes."

A West Indian mother with another child took her booking letter to the hospital, but she "got bored first time with all the waiting - I couldn't be bothered. I'd already had a baby. The doctors just said what they had to say."

A frequent comment was: "They don't tell you a lot." It is difficult to value a service without understanding its purpose. "Quite helpful, but you have to ask about everything" was another comment, and this is only possible if you know what to ask. "They hide things from you", another thought. "They didn't explain what's happening"; and a doctor told one girl to come to the hospital if she lost blood, "but he didn't explain the reasons why" and this worried her.

A 16 year old said she felt lost in the antenatal clinic. "I spent a couple of hours sitting there - they didn't tell me anything. They were treating me like the rest, as though I'd had a child before and knew the routine." Another said: "They gave funny answers when you asked them anything."

Those girls who attended the antenatal clinic regularly said they had seen so many different doctors that it was impossible to generalise about their treatment. "Some were all right, some miserable."

Being allocated to a consultant at the time of booking confused some girls who then thought that this
was the name of the (usually young) doctor they then saw. Others who did not make this mistake complained that they had never once seen the consultant. One young mother was very unhappy about seeing so many different doctors, but never the consultant. "They argued in front of me, about which way round the baby was." A 15 year old said: "It was all different doctors - nothing special - no classes or nothing - just leaflets and iron tablets."

"Rush in, rush out, couldn't care less"; "calm and cool, just another patient" - conjured up very different images, but expressed the same indifference these two girls felt was shown towards them.

A student nurse said that she had been taught that it was important for her to develop a relationship with her doctor, and she had consciously tried to do this, but, she said: "It was impossible because I never saw the same doctor twice."

There were several spontaneous comments about women hospital doctors. They were "more pleasant and friendlier than the men"; "first of all I had a woman, then I had all different ones, I never seen her again ... they were OK". The hospital doctors were "not very helpful, but the women were better than the men".

A number of teenagers remarked on what they interpreted as ignorance of the doctors, and the rudeness of some. A 17 year old Irish girl felt hurt when the clinic doctor told her to "go back to Ireland". Another girl said hospital doctors were "all right - but some were horrible and didn't treat you like a human being".

Patients were invariably quick to point out their doctors' mistakes, especially if they thought they knew better themselves, and with pregnancy in particular, women who may not be able to communicate their feelings coherently, or to appreciate the type of information which
it is valuable to give to a doctor to enable him to assess her condition more accurately, may well find themselves "knowing better".

A not unusual case was that of a young mother whose baby was born in mid-February. She had visited her GP once and the antenatal clinic once. She first visited her GP, for a letter in January. He gave her the letter and some iron tablets. "He didn't say nothing. I never went before because I was working and I didn't have time." On 21 January she first attended the antenatal clinic at the hospital. The doctors didn't know how many weeks pregnant she was, and, she said, she was told to return to the clinic on 18 February, nearly a month later. She was admitted to hospital on 15 February and the baby was born the following day.

Another young mother said: "He was quite nice, a young fair-haired fellow - Dr. _____" (she looked at her plastic wrist-band and read the consultant's name). "But I wasn't sure that he knew what he was doing. I went to the hospital on my usual Tuesday - Nan had said because I had pains that I'd better get to the hospital and she told the doctor, but he said it's OK, take it easy, your blood pressure is a bit high and you've a slight infection (I had blood in my urine). She (Nan) insisted that the pains were really quite bad, so he said "hop up on the couch and I'll have a look". Then he said "my goodness, we'll have to send you straight in!"."
Adoption and fostering

At the time of our interviews, only six girls told us that their babies were for adoption: 2 of these were Irish girls, one of whom later changed her mind.

We asked all the young mothers with unplanned pregnancies and all the abortion patients if anyone had suggested the possibility of adoption to them. Thirty-seven (17%) of the young mothers said that this suggestion had been made to them, but less frequently to the UK White girls (only 8 girls, 9%) than to the UK Black girls (15 girls, 24%).

In reply to our questions about adoption, many girls added such comments as: "I would never have a baby that would call my mother "mum"!" (adoption here, in working class families, being understood as the girl's own family taking the baby to bring up); and "oh no, I think that's more wicked than killing it - giving it away!" A number of the girls who had considered adoption said they did so because they had been adopted themselves.

Our society's concept of adoption is probably unfamiliar to many West Indian women whose large families often must be flexible enough to include one more child, adapting to cope with early child-bearing by their young single women. In such a society there is probably little necessity for the formalities of adoption. Those who suggested adoption to our UK Black young mothers were for the most part social workers (5), schoolteachers (1) or members of the medical profession (5), and not members of their own families. Although we were told that the mothers of two and the partner of one suggested the possibility of adoption, it is likely that they meant that they would "adopt" the babies. One young African girl used the word "adopt" throughout our
interview; only afterwards did we learn, from her social worker, that she had meant "foster" (we also returned to see the girl and confirmed that this was what she had meant). As far as the small number of UK White girls was concerned, the parents of three, the doctors of three, one social worker and one other person were quoted as suggesting adoption.

The only mother who intended to have her baby fostered was the young West African girl mentioned above who used the word "adopt". She had been sent to England to take her O levels and was living with an older sister and the sister's 4 year old child. The social worker at the hospital gave her clothes for her baby "to tide her over Easter", as she was to be discharged with the baby just before the holiday and foster parents couldn't be arranged until after Easter. A month later I met her in the street, smiling as she rushed to collect her baby from its minder - no foster parents having been found.

This young West African had conceived before coming to London. Almost as soon as she had arrived here, she realised she might be pregnant and bought a pregnancy testing kit from a chemist. She told no-one she was pregnant and never saw a doctor. Her sister helped deliver the baby when she gave birth "in the kitchen". Her mother wrote to her sister that she was "annoyed".
Our teenager said she had not thought of having an abortion, but had she been at home, she thought her parents "would probably have had it removed". Her older brother was providing financial support for the young mother and baby, and she had not told her "boyfriend".

Fostering is notoriously difficult for the social workers to arrange. In the hospital during the time of the study there were posters in waiting areas advertising for foster homes for needy children. Our West African teenager, in fact, probably never found foster parents for her baby. Like her sister who left her child at a nursery while she worked, she would just have to manage somehow.

In spite of the fact that adoption as an alternative to abortion is included in every pregnancy-abortion counsellors' training course, it seems that in a district such as ours where abortions are not difficult to obtain, the possibility that the young woman herself might benefit from having the baby, and having it adopted, rather than, for example, having a "late" abortion, had been neglected. Harsh practicalities probably made the omission of any serious discussion of adoption more understandable. How easy is it to find adoptive parents for black babies? And, as is frequently argued by hospital staff, is it not a waste of time even discussing adoption in a society where many single teenagers have babies, and once the young mothers see their babies, they in any case change their minds about adoption?

However, except where the young mother is ambivalent from the outset, the reasons for such a change of heart may not lie solely with the young woman, but may also lie with the adoption agencies.
One of our UK White young mothers talked over her wish initially to have her baby adopted with her GP. He gave her the address of the local office she had to contact, which she visited, accompanied by her mother. The officials there took her details, she said, and told her they would contact her again. She never heard from them again and as the months passed, she gradually adjusted to the idea of single motherhood and kept her baby when it was born.

We interviewed a young UK White mother who had become pregnant by a former boyfriend during what she described as a very possessive and unhappy relationship which she had had difficulty in ending.

She was engaged at the time of our interview, to a new boyfriend. He knew about her baby and they both felt it would be best to have the baby adopted. She had never considered an abortion because she was already 6 months' pregnant when she came to the hospital and had a scan. The hospital doctor referred her to the hospital social workers who arranged the adoption through the Red Cross. The baby was several weeks' premature and our teenager's mother informed the adoption officials by telephone the day the baby was born. The baby was transferred to a different ward from its mother. It was two days' later before the hospital social worker visited her and there had been no word from the Red Cross by the time she was due to be discharged. The young mother did not want to see her baby at all, although her own mother had (against the advice of her father). The girl and her family gradually became quite concerned about leaving the baby in the hospital without knowing with certainty what was to become of it.

The adoption of a young Irish mother's baby was the happiest and apparently least traumatic of all we heard about. The daughter of a farmer's family, Bridie had three brothers and got along well with her mother and
family. She had not told her "boyfriend" that she was pregnant and her mother had arranged for her to come to England not long before the baby was due to stay with a friend who ran a private nursing home. Bridie said that only her family knew about the baby; everyone else had been told that she was "trying out working in England for a bit". She planned to return as soon as the (privately arranged) adoption was completed.

Bridie kept her baby with her on the ward for the week she was in hospital but, much to everyone's amazement (both nurses and patients) showed not the least inclination to change her mind and keep the baby. She breastfed him and was visited frequently by her mother's friend and the friend's daughter. Her mother's friend had introduced Bridie to a married couple not long after she had arrived in London and they had shown interest in adopting Bridie's baby. Bridie liked them and felt certain that her baby was going to a home where it would be loved and well cared for. She didn't talk very much about the adoption and its formalities, carefully avoiding answering questions which were too specific.

Much of the indecision and trauma attached to "giving your baby away" is absent from the experience of girls coming from societies where there is never any possibility of a single woman openly keeping her illegitimate child. This partly explained Bridie's well-adjusted and happy outlook, and made her experience very different from that of the local girls. However, there seemed to be other lessons to be learned from Bridie's experience. She was obviously much happier about relinquishing her rights to her baby, having met the adoptive parents and approving of them beforehand. There was never any doubt about what would become of the baby and her baby was not faced with the prospect of a longer than usual stay in hospital separated from both natural and adoptive mothers, then being placed with foster parents before the adoption could be arranged.
C. West Indian young mothers

Young West Indians' attitudes towards pregnancy: Some popular misconceptions

There is a frequently expressed view among those professionals who work with West Indians that pregnancies, even those which are unplanned, are usually welcome, for several reasons: they are "proof of fertility"; West Indian men and women like and want children; and having a baby is seen as a means of escaping the restrictions of the family and "jumping the queue" for a council flat.

We are dealing in this study in the main with the UK born daughters of West Indian immigrants. The cultural heritage of these girls will undoubtedly have a considerable impact on their attitudes and behaviour. Nevertheless, life in the UK is very different from the life their parents knew in the West Indies (more specifically, Jamaica, where the majority of our teenagers' parents' origins were), so that this new generation will exhibit an amalgam of values and attitudes, some reminiscent of those of the West Indies, some of the working class South London culture with which they rub shoulders and some those of the dominant culture of this country.

In the West Indies, there is a widely held belief that a woman is only really a woman after she has borne a child (Clarke (1957) p.96). This is not to say that in the West Indies a pregnant teenager's mother will not punish the girl severely, possibly turning her out of the home, only relenting and allowing her to return on the intercession of friends, relatives or neighbours (p.99). (Clarke also reported some "bad" mothers obtaining abortions for their daughters (p.96).)

While in the past in the West Indies, an angry mother would, after relenting, take charge of the upbringing
of her teenage daughter's child, the type of work West Indian women do here, that is, outside the home, and the possibility of obtaining recourse to other means to help with such problems (contraception, abortion perhaps, or social security for the young single mother) have probably made West Indian mothers in the U.K. today less willing to accept responsibility for another child in the home.

Jamaican women both at home and abroad have a tremendous ambition and desire to work and to be financially independent (Foner (1979) p.57), but the absence of relatives in London, while adding to the wife's power in the home (husbands becoming more dependent on them and even helping about the house), means that child-rearing responsibilities are a heavier burden for them here (p.84).

Not only are the girls' mothers' attitudes changing. The girls themselves, born and educated here, are much less likely to accept the explanation that early pregnancy is an event they seek to mark their transition from childhood to womanhood. They are less likely to believe that only by experiencing this do they really become women (although, in reality, becoming a mother may well see a change in her treatment and the attitude of others to a girl formerly regarded as little more than a child herself).

Explanations such as the "proof of fertility" argument tend, by their over-simplification, to mask the more important reasons underlying a society's behaviour and attitudes. It would be misleading to describe early pregnancies in the UK Black teenagers as being attempts to prove fertility on the grounds that similar behaviour observed in teenagers in the West Indies has, in the past, been interpreted in this way.
While the social structure of rural West Indian society (to which the "proof of fertility" argument has been most frequently applied) differs in many ways from that of West Indian immigrant communities in the U.K. (not least as a result of rural/urban differences, and the contrast of being a member of a disadvantaged black minority group), it seems more likely that the behaviour and attitudes common to these two societies which result in a high proportion of very early teenage pregnancies, are related, not to young women attempting to "prove their fertility", but to the types of sexual relationships young couples have in both societies.

In fact, the similarities between the sexual behaviour of young people in the West Indies (described in some detail by Clarke (1957)) and the experiences described by numbers of our young UK Black respondents are striking.

Clarke relates that "it is usual for the girl's first pregnancy to occur while she is still a dependant in her mother's home ... the result of a first and exclusive sexual relationship with one boy. Such an incident may even sometimes be said to be an isolated episode in a girl's life." The boy's early sex-play is regarded with amused indifference, if not admiration, by the older men and he early learns the general attitude of his seniors that children are primarily, if not solely, "woman's business". It is not part of the social ethic that he should provide for his girl and their children. In any case, if it is a boy and girl affair he is unlikely to be in any position to support her or provide a home for her and his parents do not concern themselves with the affair (pp. 98-9).

Relationships between young West Indian men and women

We have commented elsewhere (see p. 215) on the relevance for young West Indian couples of certain criteria for commitment, such as co-habiting or financial
assistance. It may be that assessing commitment by these standards is completely meaningless in West Indian society, where it is the expectation that very young girls and their babies should remain in the care and be the responsibility of their own families.

Even older single girls with babies or young children may see their role not as recipients of financial support from the babies' fathers, but as the (economic) providers for these partners who are frequently unemployed and frequently without a permanent home. From the "hustlers" who work prostitutes (who may also be their girlfriends), to the aunts, sisters and mothers who keep, feed and wash for their (single) menfolk - the movement of money is frequently from women to men.

The greater mobility of young black men, teenagers and those in their twenties, is evident in the U.K. and United States censuses, where this sub-group is known to be substantially under-enumerated. Young men habitually circulate around their girlfriends', relatives' and parents' homes, staying for a few nights at each place.

Pryce (1979) in his study of young West Indians in Bristol, pondered on whether the under-representation of young West Indian women working as prostitutes was not beginning to change as black female prostitutes were being recruited from among delinquent West Indian girls whose parents had rejected them (p.78).

Rutter et al (1974) have noted that West Indian girls showed rates of behavioural deviance much nearer to that in the boys, compared to indigenous girls whose rates of deviance were much lower than that in the boys, and when disorder or deviance was present in West Indian girls, it was likely to involve conduct disturbance rather than emotional disturbance (p.259).
A number of the girls we met had prison records, others spoke quite openly about their involvement in physically violent arguments.

It may be that the rootless existence of many young West Indian men is now also to be found amongst young West Indian women.

Two UK Black young mothers interviewed on the same day had been close friends since childhood and school days. One of them had been particularly mobile, with numerous jobs and addresses over the past year. She was being discharged to a mother and baby home in Streatham. She said she hated her father and told how he would beat her mother and sister and herself. She had stayed with her boyfriend's parents at some point during her pregnancy and her boyfriend's father had wanted her to go there with the baby, but she said, she didn't get on with her boyfriend's mother and she had left there after an argument when she had broken down their front door. She then went to stay with her girlfriend (the other girl interviewed) although she had not been living there when she went into labour, having already moved on.

It seems, therefore, that young couples not co-habiting and young women unsupported financially by the babies' fathers are not necessarily indicators of a lack of commitment. Even the young man's presence at the baby's birth may be vetoed by the girl's own mother who may wish to "supervise" that herself.*

West Indian family patterns in Jamaica and the U.K.

Wood (1974) has summarised the four main types of family pattern noted by Fitzherbert (1967) as follows:

Middle-class marriage - with father the breadwinner and disciplinarian;

* The presence of someone close, such as a partner, mother or aunt, at the baby's birth, was encouraged at the hospitals. A single white girl's own girlfriend was with her, which she said had made a great difference to her. Sometimes, however, these observers could become a problem, particularly the very possessive and supervisory partners and mothers (as in the case of the partner of a UK White girl whose baby was stillborn).
Working-class Christian marriage - father the head of the house but mother works because of the economic necessity; children are disciplined strictly and brought up along religious lines;

Faithful concubinage - an egalitarian relationship lacking formal ties which can also make it transitory; and

Affairs - father's behaviour ranging between support, interest and affection and complete abdication of responsibility.

The experiences of three of our UK Black young mothers, from a variety of family types, illustrate the similarities between Jamaica and West Indian society in the U.K. which we observed.

Sally was a beautiful, very mature looking Jamaican girl of 16, of large build, possibly explaining why no-one at all, including her parents, suspected that she might be pregnant until she actually had the baby at home. She asked her brother to call an ambulance at lunchtime on Sunday and the baby had been born by the time it arrived.

Sally said that her boyfriend was black, about 20. She knew no more about him than that and she had not seen him since becoming pregnant. It was her first and only sexual experience. Sally was born in Jamaica and had stayed there with her father's mother, together with her brother, from the age of two until she was nine, when both joined their parents in the U.K.

Sally said that she didn't feel close to her parents because she had spent most of her childhood with her grandmother who she thought of as "mother". She had gone to her GP for a pregnancy test, but had told no-one else she was pregnant. She was told to ring for the result of the test which she was simply given over the phone. She said that she had not been afraid of having a baby: "I did biology at school." Her parents were understandably shocked, but they had been OK, she said, and her mother had told her that she would care for the baby for her. Sally had not decided whether to go back to school or not. She was waiting for the results of her CSEs.
Ida was a pleasant West Indian girl, although very aggressive when first approached. She said she did not get along with her mother - they had not even spoken for a year. Their relationship had deteriorated after her sister had been born (7 years earlier). Her father turned his attention from Ida to the baby. Later he left her mother.

During the previous summer Ida and her mother had not even cooked in the same pans, although Ida continued to live at home. She had been very depressed then, she said, having been for interviews for jobs for which she had either been turned down or told that the vacancies had been filled. Asked if that was why she had become pregnant, Ida said that she was, in fact, more depressed because she was pregnant. She had not seen a GP until 3 weeks before the baby was born because, she said, she didn't like doctors or hospitals. She had had no antenatal care whatsoever.

Ida planned to continue to live with her mother. She said they just went their own ways. She had never told her mother she was pregnant and her mother had never commented on it, but recently she had offered to put some money towards buying things for the baby.

Sonia was a 15 year old UK Black young mother, the type of smiling, good-natured but shy girl that people usually like immediately. She was obviously a great favourite with staff and patients on the ward.

Sonia had come with her mother to King's to request an abortion in January (her baby was born in June). Her mother wanted her to have an abortion but since Sonia did not, it was perhaps fortuitous that she was told she was too late (presumably for the "early" type of abortion only) and she was booked into the antenatal clinic.

Sonia's mother, a housewife, intended to care for the baby, bottle-fed*, while Sonia was at school. Sonia had left school in May, only a month before the baby's birth and was returning almost immediately. She said she had not seen her father for many years and her parents had never married. She spoke to him

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* Breastfeeding by all mothers was strenuously encouraged in the clinics and on the wards. Young, single mothers who are pressurised in this way may feel particularly guilty if they do not agree to breastfeed their babies, even though it may make their immediate return to school or work impossible. Cases need to be judged individually, but as in Sonia's, the advantages of her early return to school would seem far to outweigh the advantages to her baby of breastfeeding.
sometimes on the phone, but had not told him she was pregnant. She had an older sister of 23 with a 5 month old baby and she had helped Sonia break the news to her mother, who was very angry and upset at first, but who had taken over completely since, accompanying her to their GP, to the hospital and the clinic.

Sonia had not thought she was taking chances because she didn't think she and her (ex) boyfriend had been having "proper" sex. When she told him she was pregnant, "he just didn't say anything" and she had not seen him since. He had been asked for nothing and had given nothing.

Sue Sharpe (1976) in her study of young London girls, recorded one of her young black respondents as saying: "My mum said, don't let boys touch you or nuffink, don't let boys kiss you or nuffink - and when I was about twelve years old a boy kissed me on my cheek. I ran home, into the bathroom and washed it off - scrubbed my face. My sister found me in the bathroom and said "What's wrong?" "O don't tell Mummy don't tell her please, a boy kissed me on my cheek." And my sister started to laugh - she go "Poor you"." (p.241)

Mothers' stern warnings about the consequences of friendships with boys are just one aspect of their strong views on discipline generally. However, alienation between the young sexes must only be increased in such circumstances, so that as a girl grows up, her mother's words will seem to gain confirmation. Real friendship between the sexes will seem unusual; their common ground will seem to be mainly in the negotiation of sexual favours.

The attitudes of the young men described to us had much in common with working class boys' attitudes described elsewhere (including Allcorn (1954) in Bott (1957) p.xxviii; Rainwater (1970) p.304; Farrell (1978) p.219).

In his study of black families in an American slum, Rainwater (1970) noted that by her late teens, a girl's
"experience is liable to leave her feeling that the only thing a man can be counted on to provide is an expressive relationship centered on sex and good times, and that she will have to depend on herself to accomplish the instrumental tasks of acquiring income to support herself and her children" (pp.304-5). He commented that "few girls in the ghetto are strongly motivated to begin sexual relations in early or middle adolescence, but their commitment to peer group activities and to the pursuit of maturity inevitably involves most of them in sexual activity despite their own feelings about the costs involved" (p.307). "The pressure from boys for sexual privileges is a result of their commitment to the values of the street culture and of the fact that the costs of engaging in sexual relations with girls do not seem great" (p.308).

A number of our UK Black teenagers described their pregnancies as either having resulted from an isolated act or from one of just a small number of sexual incidents (perhaps two or three) with the same boy, a young man whom they did not know particularly well or with whom they did not share the type of intimate relationship in which such personal matters as contraception or the possibility of pregnancy could be discussed.*

* See the accounts of Sylvie who became pregnant and had abortions twice, on neither occasion mentioning this to her boyfriend (p.67) and Julie, also pregnant twice and having experienced abortions twice by the age of 16 (pp. 79 - 82).

In the pilot of the study, we met a 15 year old UK Black schoolgirl with her mother at her first hospital interview and again on the ward before and after the abortion operation. The girl's mother became quite friendly with the researcher and told of her own first pregnancy in very similar circumstances to those described to us earlier by her daughter - becoming pregnant on the first isolated occasion of intercourse to a boyfriend who very quickly disappeared from the scene (p. 64).
Coping with early motherhood

Many of the young black mothers we met were returning to their own families where their own mothers would be helping to bring up the baby. Of the 15 single UK Black girls who had never been pregnant before and who, although describing them as unplanned, had welcomed their pregnancies, 11 were returning home to their own mothers and families, two were living with their boyfriends (one couple lived in a council flat and one girl lived with her boyfriend’s family, although she, and they, rarely saw him); one was living with her own brother; and one girl was being sent to a mother and baby home.

Of the 21 single UK Black girls who had never been pregnant before and who described their pregnancies as unwelcome, 18 were returning to their own families, one intended to live with a girlfriend, while one was being sent to bed and breakfast accommodation and one to a hostel. The 9 previously pregnant UK Black girls with unplanned pregnancies were an older group – nevertheless, only two were living independently with their other children in council flats; 5 lived with their own families; one with her partner and one with her partner and his family. We could find no evidence that young West Indians are seeking an independent life in their own council flat as a motive for becoming pregnant.

We are not in a position to judge how much the UK Black young mothers and their partners actually liked children, or to assess the attitude generally of the UK Black teenagers towards children. It did seem likely though, from our observations of a number of incidents (including the UK Black abortion respondent first observed chastising her son in a very hostile manner in a district family planning clinic), and from our records made during a number of interviews that, as with most new mothers, while caring for a young baby
had initially been a novel and rewarding experience and the change to the role of mother and adult, which having a baby had often endowed on the girl, had been welcomed, bringing up older babies and children single-handedly had proved rather less enjoyable.

Rainwater (1970), referring to black American teenage mothers who left their babies in the care of their own mothers, commented that this type of arrangement is functional for a time. The young mother has many reasons for hostility toward her baby, and the distance she can achieve from it makes it easier to reduce her ambivalence toward the child (p.314).

It may be that the teenagers' own mothers' decreasing acceptance of the responsibility for caring for their daughters' babies, forcing these girls into the role of full-time mother, will lead to even greater problems for these young black mothers than their own single mothers experienced - with a corresponding increase in the problems of the children reared in such circumstances. It would seem important to look closely at these young mothers' needs in order to establish the most appropriate means of compensating for the loss of the safety-valve previously provided by children's grandmothers.

The decision to continue with a pregnancy

The pronounced differences between the UK White abortion patients and the UK White young mothers were not features distinguishing these two groups of UK Black girls. There were a number of factors which seemed important in aiding a pregnant UK Black girl's decision on whether or not to continue with a pregnancy. These were:
First pregnancy: UK Black abortion patients had had more previous pregnancies and more babies than the UK Black young mothers. Occasionally West Indian girls, when asked whether any of their close girlfriends had been pregnant and, if so, what they had done, commented that girls usually had the babies the first time they were pregnant and abortions for later pregnancies. We observed such a tendency in our study. Six UK Black girls and one Jamaican girl having babies had previously had abortions. We were interested to see if there was any particular reason for their not having had the babies the first time. In fact, five of these seven girls had become pregnant again almost immediately after having the abortion, between 3 and 11 months later. Nevertheless, two again described these later pregnancies as unwelcome. The remaining two girls had had abortions when they were only 14 years old (4 and 4½ years earlier). It may be that in these cases strong parental influence and discipline following the first pregnancy had lessened the possibility of any "compensatory" pregnancy.

In comparison, of the six UK White young mothers who had previously had abortions, two had conceived again within a year - one 4 months and the other 10 months after the abortion. Both girls had the same partners for both pregnancies and both welcomed becoming pregnant again. In fact, one girl planned the later pregnancy. The other four girls became pregnant again between 15 months and 4 years after having had abortions.

For most of the West Indian girls there was no expectation of marriage (only three UK Black mothers were married, 5% of that group). Pregnancy did not almost automatically lead to marriage, as it did for a considerable proportion of the UK White girls (see those who conceived pre-maritally). For many of the West Indian girls, having a child appears to be simply an experience every girl has.
For the indigenous teenagers, marriage and motherhood may be regarded as marking a girl's transition into adulthood; for the West Indian teenager, motherhood alone marks this transition.

Particular circumstances at the time of becoming pregnant - whether the girl herself wants to have a baby and feels she can cope, as well as the strength of other pressures placed on her (particularly by her mother) either to have the baby or an abortion - must also influence the outcome. The reasons given by West Indian girls for deciding to have abortions were of a different type from those given by the indigenous girls. A 16 year old UK Black young mother, living with her family and preparing for exams at school, told us she had thought about having an abortion but didn't think she had any reason for requesting one.

In fact, West Indian girls' decisions on whether or not to continue with a pregnancy are probably much more closely related to the number of unwanted pregnancies they experience (and these they do experience in higher proportion than similar UK White girls), resorting to abortion only when they feel they cannot cope.
Mothers under 16 years

Of particular interest, and perhaps concern, in the group of mothers, were the girls who were under 16 years of age. All were UK Black or of mixed race (West Indian).

These very young girls found it much more difficult to talk about their boyfriends than did the older girls. Part of the reason must have been their fear of the repercussions (including legal) for the boyfriends, but it must partly be due to the nature of their relationships, whether it was an escapade or an assault, or even an incestuous relationship.

The difficulties we encountered in assessing "steadiness" mean that the translation of these very young girls' relationships with their partners into statistical terms had little real meaning. One of the 14 year old girls could probably be described as promiscuous, her first and most recent relationships were both described as casual and she had earlier had an abortion. Only one other girl's relationship (her first and only) was described as casual; another, the 13 year old and youngest of our mothers, would not, or could not give us sufficient information about the young man; all other partners were "more-or-less steady" relationships. For various reasons, nursing staff, doctors and social workers feel that they ought to know about the putative fathers of young girls' babies. (In part, they seem to find eliciting this information a challenge.) However, the 13 year old refused to say anything or in any way admit that there was a father of the baby. She had been responsible for taking care of her 16 year old mentally handicapped brother, taking him to his special school and collecting him every day. It seemed possible that he was the baby's father and that her family was protecting both the children and the family's reputation.
A 17 year old UK Black girl who was interviewed as a young mother, had had a baby when she was 12. This was learned by the nursing staff from her hospital notes. Nevertheless, no mention was ever made by her of her 5 year old son in our interview and she did not include a 5 year old among her own siblings.

Lena was the promiscuous 14 year old. Her mother was white, her father West Indian. A very beautiful, tall girl, she looked more sophisticated than her years, but during the interview she became very restless and said, "I'm going to suck my thumb!" and did so. She had been in care for some time and in the "lock up" for not attending school, she said. She talked about her previous abortion but excused that because, she said, she was raped that time. There were three boys and one of them asked her out, and she said she didn't want to go out with him. ("Well, I don't have to go out with someone if I don't want to, do I?") and so he raped her, she said, and she had an abortion. She wasn't using any contraception then. (The doctor on the ward told us that she had also had VD.)

Her boyfriend was black, she said - he models clothes ("you know, the sort of clothes the coloured people wear"). She had not seen him for 5 months. He gave her some money for the baby once and she spent it on cigarettes.

The baby was in intensive care and it seemed likely that Lena would be discharged before the baby, although she didn't want the baby moved to a hospital closer to the mother and baby home where she had been staying and to which she was due to return.

Her mother lived not far from the hospital, about 15 minutes by bus, but had only been to visit her once since the baby was born because, Lena explained in her defence, "it's too far for her to come". She didn't seem to want to admit to herself, or others, that her mother didn't care much for her. "We're close", she kept insisting, of both mother and father. She said her mother used to visit her more often when she was in the "lock up".
The sheath and withdrawal were the only contraceptive methods ever used by nine of the girls under 16. None of the girls was using any contraception when she conceived. When asked what they thought they would use in the future, three did not know and four said they would be given the pill before they left the hospital; one was to be given the injectable contraceptive and one an IUCD before leaving the hospital.

Only one of the girls had told her mother herself that she was pregnant; four mothers had eventually guessed and the remainder had been told by other people.

A 15 year old UK Black girl, when asked what her initial reaction was to the pregnancy, replied: "I didn't feel anything." Her mother and her boyfriend had wanted her either to have an abortion or to have the baby adopted. How did she feel about that? "I didn't say anything - didn't think anything." Under the barrage of commands, advice and threats, this type of armour is the only defence some young girls had when their own feelings were being over-ruled or disregarded.
Summary

Because the abortion patients' treatment by hospital staff and the experiences they had were so inextricably interwoven with hospital policy on abortion and attempts to reduce the numbers of women returning for "repeat abortions", it was appropriate in the section dealing specifically with the abortion patients, for us to discuss the implications of the girls' perceptions of their treatment.

Where the young mothers were concerned, no separate hospital policy existed. At the time of the study, the only attempt to concentrate attention on the problems specific to very young mothers was made through a small project aimed at "schoolgirl" mothers, run sporadically through the antenatal clinic. Since attendance at antenatal clinic is, of course, voluntary, in order to maintain the type of relationship with these "schoolgirl" mothers which would encourage their continued attendance, some inducement needs to be offered by staff. The most effective inducement appeared to be the "schoolgirl's" individualised treatment - being seen always by the same doctor, recognized and welcomed and allocated more time on her visits. The majority of our teenage mothers were not channelled into any special group and did not appear to have received preferential treatment or treatment which in any way differed from that of other pregnant women attending the antenatal clinics.

In the case of the young mothers, the medical aspects of the experience of giving birth to a baby concerned us less than the events leading up to and immediately following the event - the teenagers' perceptions of the role of the antenatal clinic and the information and support they received both before and after the event.

There was a higher proportion of married teenagers among the young mothers (40%) than among the abortion
patients (3%) or the clinic attenders (4%). Half of these girls had conceived pre-maritally, but the married mothers were nevertheless more likely to describe their pregnancies as "planned" than unplanned than the single mothers.

West Indian mothers were less likely to be married, to describe their pregnancies as "planned" and appeared to receive a lower level of support from their partners than did the indigenous mothers. They were also less likely to attend for antenatal care than the indigenous girls. In fact, a third of the West Indian girls had considered having an abortion.

Very few of the young mothers were giving their babies for adoption or having their babies fostered. These alternatives to either a "late" abortion or to struggling to raise an unplanned and unwanted baby, were not viewed as realistic propositions by those who were in a position to advise the pregnant teenagers. In the case of adoption, this was believed to be impractical since many young women, having seen their babies, change their minds. However, among the girls we met who were proposing to have their babies adopted, there was a marked lack of support and encouragement to proceed with this course of action from either social workers or the adoption agencies. In the case of fostering, the main difficulty seemed to be in finding foster parents for the babies.

The high proportion among our respondents of unsupported, single, young mothers and those who already had one or two children who were managing single-handedly, as well as teenagers who were still involved in education, at school or college - would indicate that there is a need for antenatal clinics to react to the particular circumstances of such young women. The implications for the services of this substantial minority of young women with special needs are discussed in the concluding Part.
8. CLINIC ATTENDERS

Introduction

The group of clinic attenders was, by definition, a special group of teenagers. They were not a random sample recruited in the district from teenage girls who were sexually active and who had never been pregnant, but a small proportion of those teenagers who have chosen not only to attend family planning clinics in preference to any other source for contraception (in fact, more young women in this age group attend their GPs for family planning (Bone (1973) (1978)) but they were also a group of teenage girls using or about to use an effective method of contraception.

First attendance at a family planning clinic is a formidable hurdle for a young woman seeking contraception to overcome - not knowing what to expect, how to behave, what their reaction will be. In fact, most women are introduced to family planning clinics by friends who accompany them. Even in the hospital family planning clinics we visited, over half of whose clients are referred from hospital wards, the next highest proportion by source of referral was the 14% whose friends had referred them - 17% of the indigenous women attending. (The proportion referred by friends is much higher in the community clinics where there are fewer referrals from the hospitals.)

The majority of the 113 girls we interviewed in the family planning clinics between September and November 1979, were either attending for the first time (33%) or had attended for the first time within the same year (43%), a total of 76%. A quarter had been attending since the year before (15%), two years before (8%) or even longer (2%).

The girls who had attended first in 1977 or earlier (two years before) were all UK White (11 girls), 8 of whom were initial pill users. Over a third of the initial pill users among the clinic attenders (36%) had first
attended in 1978 or earlier, compared with only 16% of those who used no contraception initially.* So although a third of our teenagers were approaching the clinics for the first time when we interviewed them, a quarter were well established users of the service provided by these clinics.

Bone (1978) has shown that in 1975, 19% of unmarried 16 and 17 year olds had used the services at least once (she did not interview girls under 16) - the services being GPs, family planning clinics, "other doctor" users and "other" (presumably other clinic) users. This proportion rose to almost a third (32%) of unmarried girls aged 18 - 19 years. While similar proportions among the 16-17 year olds, 6-7%, were current GP users and current family planning clinic users, a much higher proportion of the slightly older girls were current GP users (16%) compared with current family planning clinic users (only 7%).

Girls of 17 and under were much less likely to attend either our hospital clinics or our community clinics than they were to go to Brook Advisory's Centre. Since we knew that the hospitals referred many of their young abortion patients and young mothers to the clinics in the hospitals for follow-up, their proportion of teenage clients seemed very low at 13%, compared with that of either the community clinics, 17%, or Brook Advisory at Walworth, 41%. Brook Advisory's services, however, are youth orientated and its catchment area at the time of the study was wider, so their particular success with this group is perhaps to be expected.

Brook Advisory Centres have a number of walk-in clinics for young people in South London. At the time of the study the nearest one was at Walworth. At this

* We have already seen that in the groups of pregnant girls, those girls who had been initial pill users had taken the pill for much longer periods than other girls who had taken the pill at some time.
clinic, in 1979, 56% of all teenage clients were 17 years or under; 15% were 15 years or under.

### Family planning clinics: Teenage clients by age (1979) %

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<th>Hospital</th>
<th>Community</th>
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<tr>
<td></td>
<td>Walworth</td>
<td>FP clinics</td>
<td>FP clinics (new patients only)**</td>
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<tr>
<td>Under 16</td>
<td>14.5</td>
<td>8.5</td>
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<td>16 years</td>
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* Brook Advisory Centres, 1979 Annual Report

** Although these are proportions of new patients only, the distribution probably reflects quite closely the proportions of all clients.

These figures include girls who have been pregnant, but it is interesting to see how proportions vary between the three centres. Our interviews took place only in the district's hospital and community family planning clinics.

There were ten centres where clinics were held at the time of our study, covering a wide geographical area and largely located in or near council estates. Although family planning clinic users usually include a higher proportion of women from the non-manual classes, whereas GP users contain more balanced proportions of manual and non-manual social classes (Bone (1973), (1978)), it is probable that in this district the proportion of working class clinic attenders is above average (partly due to the clinics in the two teaching hospitals and referrals of hospital patients to the community clinics).

Nevertheless, the findings for our particular group of teenagers, while of interest on their own, cannot be considered as a control for our pregnant teenagers. This must be borne in mind whenever any comparisons between the three groups are made.
Of the 113 teenagers who had never been pregnant who were recruited in the family planning clinics, 40 were interviewed in the two hospital clinics and 73 in eight of the nine community clinics (we failed to recruit anyone suitable in one small clinic).

Sexually inexperienced clinic attenders

Six of the teenagers were not yet sexually active but intended to become so in the near future. Three of these girls were 18 years old, 2 were 17 and one was 15. Dr. E. Wilson (1980), writing about the 31 girls under 16 who attended a family planning centre in Glasgow in the first 8 months of 1979, noted that two of these girls, aged 15, "were deferring coitus until they were "safe""; and, she commented, they "have both continued to attend regularly since they started the Pill".

The first clinic attender we interviewed was not yet sexually active. She was the UK born daughter of Irish parents and came to the clinic in the company of an older woman friend.

The youngest of the six girls not yet sexually active was a 15 year old schoolgirl who arrived at the clinic wearing her school mac. She had only just turned 15.

One of the 17 year olds not yet sexually active was interviewed in a hospital family planning clinic. She had a particularly close relationship with her mother but her first visit to the clinic she had kept secret.

Clinic attenders under 16

In the two groups of pregnant girls, special note was made of the girls who were having abortions or babies who were under 16 years old - 30 abortion patients (14%) and 9 young mothers (4%).
Seven clinic attenders (6%) were only 15 when we interviewed them and six of them were still at school. Four were UK White, one girl was Irish and two had fathers born abroad. Five of the girls had white partners, one a West Indian partner. Specific characteristics of one girl's partner, regrettably were not obtained.

Their partners' ages ranged from 15 to 21. Three of the 6 sexually active girls under 16 had used no contraception at the time of their first sexual experience, two had used the sheath and one withdrawal. All but two were first attenders when we interviewed them and those two had become pill users. All were to be pill users in future.

One of the six sexually active 15 year olds had had her first sexual experience at the age of 12½, one at 14 and 9 months and the other three at 15, within the past few months. The first sexual relationship of two of these girls was casual, one was now over (but had been "steady") and three were "steady" and still continuing with that same partner.

Already 5 of all 6 girls had thought they might be pregnant (two once and three more than once). When asked if they had ever thought they would like to have a baby, 5 of these 6 said "yes" - 4 of them had thought so within the past month and the other within the past year. Five of the 6 sexually active girls said that they had "taken chances more than twice". They had apparently come to the family planning clinic as a consequence of thinking that they might be pregnant.

Five of all seven 15 year olds had first been told about periods by their parents (mothers, except for one girl whose mother was dead and who was told by her father), one girl was told by an older sister and only one learned first from school. Similarly, 5 learned first "where babies come from" from these mothers and father,
one again from her older sister and one from a girlfriend - none learned first at school.

Except for the still sexually inexperienced 15 year old, these very young clinic attenders seemed to be a high risk group. They were unusual in the clinic group, having become sexually active so early, without using effective contraception (or even a less effective method) in most cases, with a high proportion of casual relationships and having frequently taken chances. Nevertheless, these particular girls did not appear to have been treated any differently from older girls by the clinic staff. They were not allocated more time than other girls and were not asked to return any sooner than other first attenders.

**Clinic attenders who were initial pill users**

As a group, the clinic attenders were at least risk of experiencing an unplanned teenage pregnancy, their comparatively high proportion of initial pill users (27% if the girls not yet sexually active are included) having characteristics distinguishing them from the majority of the girls who had been pregnant.

It was the realisation that the initial pill users, first met in this group in considerable numbers and then again in very small numbers in the groups of pregnant girls, were outstanding in our sample, that led to the development of our hypotheses concerning relationship types. The next Part discusses those findings which would seem to give most support to our hypotheses.
Summary

Our impressions of the clinics and the services being offered by their staff to teenage clients are recorded in the concluding section where recommendations are also put forward for changes aimed at making clinics more approachable and their services more appropriate to the needs of their teenage clientele.

The main function for the study of the group of clinic attenders was to provide a comparison group in order to contrast the socio-demographic characteristics of pregnant and never pregnant teenagers, as well as to act as a stimulus in the formulation of hypotheses to explain the high proportion of girls of West Indian origin requesting abortions.

The, to a considerable extent anticipated, differences in the characteristics of the three groups of teenagers have been reported in Part III, while the most significant ideas which grew out of our interviews with the clinic attenders and observations made in the clinic environment are outlined in the study's recommendations.

In view of our findings and observations, it is suggested that a radical move away from the present emphasis by clinics on providing contraception towards providing support and information on a wide variety of subjects related to teenage sexuality and relationships, would benefit a much broader section of our teenage population.
PART V

SUPPORTING THE HYPOTHESES

9 Towards Explanation

There are obvious difficulties in attempting to validate hypotheses developed after the completion of a study. The limited assumptions on which this study could be based made development of any but the most general of hypotheses beforehand virtually impossible.

Nevertheless, the hypotheses which evolved, outlined in Part II, are substantiated to quite a considerable extent by our survey data and observations. In fact, the importance of the nature of mother-daughter and boy-girl relationships, the connections between the two and their ultimate influence on the use by a young couple of a reliable method of contraception, do seem entirely logical, particularly when our findings are supported by material from other sources (among them Rutter (1979); Pollak (1972), (1979); and Farrell (1978)).

In an attempt to discern some pattern of behaviour, we examined separately the experiences of two small groups of our teenagers, those young mothers who had described themselves as initial pill users, and those abortion patients who had previously been pregnant and who had had more than one partner.

In the former group, our aim is to show that those young women who, of their own volition, commenced taking the pill before their first sexual experience, in the context of a serious relationship, were those girls who also had good relationships with their mothers. Such girls who fulfilled our criterion for initial pill users would, we believe, be likely to follow the same pattern of behaviour
in later sexual relationships - always taking the pill at the time of the first sexual experience with a boyfriend.

In the latter group of girls, the previously pregnant abortion patients, our aim is to show that, at least during their teens, most girls, because of the types of sexual relationships they have, follow a similar pattern of contraceptive use in consecutive relationships, so that, for example, a girl (in a segregated relationship) who uses no contraception when sexual activity is first initiated (although she may progress to using an effective method during that relationship), is likely to follow a similar pattern of behaviour within her next relationship, that is, using no contraception in its initial stages.
Patterns of behaviour

Young mothers who were initial pill users

Twenty-four of the young mothers (11%) said that they were taking the pill at the time of their first sexual experience. (There were only ten such girls (5%) among the abortion patients.)

When unplanned pregnancies did occur among initial pill users, the main criterion for our definition of an initial pill user (that pill use should have been initiated by the girl herself in the context of a steady relationship) had usually not been fulfilled.

The majority of the girls with post-maritally conceived babies were from the more traditional cultures, born outside the U.K. - Asian, Turkish and Cypriot girls. However, two UK born daughters of Cypriot parents were initial pill users, both conceiving post-maritally, and three of the 8 UK White girls described as conceiving post-maritally, were initial pill users and had planned babies. In all, 7 of the 24 initial pill users conceived after marriage.

Of the 24 young mothers who initially used the pill, 17 were UK White and 3 were UK Black girls. Their particular experiences are compared in the following.

UK Black initial pill users: These three girls were exceptional in the group of UK Black girls in that
all three had supportive partners. All three partners had been present at the births, all had reacted positively to the news of the pregnancy and in two cases they were living with and supporting their girlfriends. In the third case, the girl still lived with her family, her boyfriend was financially supporting her and the baby, and he had taken responsibility for first telling her mother that she was pregnant.

All three girls' mothers had reacted positively to the news of the pregnancy (only one being upset initially) and all these girls had been told first about periods by their mothers. Compared with many of the West Indian girls we interviewed, these three initial pill users seemed to have particularly good relationships with their partners and reasonably good relationships with their mothers. Even though unplanned, their pregnancies had been happy and generally welcome.

UK White initial pill users: 19% of the UK White young mothers described themselves as initial pill users. However, use of the pill by over half of these 17 girls (53% - 9 girls) actually seemed to be only tenuously linked with the relationship they had had with their first sexual partner. Evidently the girls had in mind preparing themselves for sexual activity, but in all of these cases, some factor other than that particular first boyfriend's friendship was given as the reason for commencing pill use. These grouped into three different types of reasons:

Some excuse was made for using the pill ("to help with my periods" - this girl's first sexual experience was not until 9 months later; for "irregular periods" - 5 months before this girl's first sexual experience; "I had to because of bad periods" - this girl's first sexual experience followed immediately).
The timing of initial pill use did not coincide with a girl's first sexual experience - pill taking commenced months before the first sexual experience, and so does not appear to have been initiated by a decision made with a particular partner to become sexually active. The first two examples under the previous point also apply here; other examples are: a girl who was given the pill at 14½ years by her GP (perhaps because she had been sexually assaulted at 10 years and had become engaged at 14 years!), but did not have her first sexual experience until she was 16; a girl who obtained the pill from a family planning clinic when she was exactly 15 and had her first sexual experience 4 months later.

Obtaining the pill was initially suggested and encouraged by someone other than the girl or her partner (a typical example was the girl who said "my mother told me to go to the family planning for the pill"). There is considerable overlapping in these three groups of reasons.

It could be argued that such excuses are commonplace and do not give any indication that girls had not discussed contraception with their partners, with whom they anticipated soon becoming sexually active. If this had been the case, we might have expected that, in an interview in most cases taking place years after the event, the pretext of separating their sexual partner from "going on the pill" would have been forgotten or at least dropped by such girls. This was not the case.

Only one of the 9 UK White young mothers for whom pill taking was positively related to their first sexual experience described her pregnancy as initially unwelcome. In fact, for 7 of these 9 girls, this was a planned pregnancy. There were no other girls with planned pregnancies in this group of 17 young mothers.
UK White young mothers – initial pill users

Relationship of pill taking to first sexual experience and girl's reaction to pregnancy

<table>
<thead>
<tr>
<th></th>
<th>Pregnancy welcome</th>
<th>Pregnancy initially unwelcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill taking positively related to first sexual experience</td>
<td>8*</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(= 9)</td>
</tr>
<tr>
<td>Pill taking not directly related to first sexual experience</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(= 8)</td>
</tr>
<tr>
<td>(N = 17)</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(=17)</td>
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</tbody>
</table>

* 7 of these 8 were planned pregnancies

In an effort to identify those girls with a close mother-daughter relationship, we "rated" mothers on a scale from 1 to 3 according to whether they had been first to tell their daughters about periods and "where babies come from" and whether they were named as those to whom the girls had talked most often and had been most helpful to talk to about sex generally.

It was anticipated that those mothers who were rated highest would probably also have been supportive and sympathetic towards their daughters when they learned of their pregnancies, if these were not welcome.
UK White young mothers - initial pill users

"Ratings" of girls' own mothers and relationship of pill taking to first sexual experience

<table>
<thead>
<tr>
<th>Mother's &quot;rating&quot; (2 or 3)</th>
<th>Mother's &quot;rating&quot; (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill taking positively related to first sexual experience</td>
<td>8* 1 (= 9)</td>
</tr>
<tr>
<td>Pill taking not directly related to first sexual experience</td>
<td>4** 4 (= 8)</td>
</tr>
</tbody>
</table>

(N = 17) 12 5 (=17)

* 6 rated at 2 and 2 at 3
** 2 rated at 2 and 2 at 3

In comparing the "ratings" of the 17 girls' mothers with the reasons for initial pill use positively related to the girls' relationships with their first sexual partners, we found that those girls with unwelcome pregnancies either had mothers with low scores, reasons negatively related to their first pill use, or both. Of the four girls who described their pregnancies as unwelcome, three had mothers with the lowest ratings and only one commenced use of the pill at the same time as her first sexual experience without attempting to dissociate her use of the pill from becoming sexually active.

The girls' own mothers with the lowest scores are clustered in the group describing their pregnancies as unwelcome - there are only two in the "welcome" group.
and neither of these girls gave positively related reasons for commencing pill use.

Initial pill use, it would appear, has value as an indication of a pattern of behaviour only if it occurs within the context of a young couple's relationship. From this small group of UK White girls' experiences, we can see how an unplanned and unwelcome pregnancy is more likely to result if initial pill use is not positively related to the first sexual experience and the type of relationship a young couple has. The numbers in the group of young mothers who initially used the pill, only 24, were too small to show any statistical differences within their group, but a closer look at the different experiences of the individual young mothers would seem to support these hypotheses.

Abortion patients who had previously been pregnant

What had gone wrong for the 41 abortion patients who had been pregnant before? This seemed an appropriate group to observe more closely in order to test the hypothesis that patterns of contraceptive use are dependent on the types of sexual relationships young couples have, and these same patterns are likely to be repeated in consecutive relationships, so that a girl (in an integrated relationship) who ensures that she is using, for instance, the pill, when sexual activity is first initiated, is likely to cease using the pill when the relationship ends, and to follow a similar pattern of behaviour within her next relationship.

The method of contraception used at the time of first sexual experience for the 41 previously pregnant abortion patients was:

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>2 girls (5.0%)</td>
</tr>
<tr>
<td>Sheath</td>
<td>4 girls (10.0%)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>2 girls (5.0%)</td>
</tr>
<tr>
<td>No method</td>
<td>32 girls (78.0%)</td>
</tr>
<tr>
<td>Dont know</td>
<td>1 girl (2.0%)</td>
</tr>
</tbody>
</table>
However, 18 of these 41 girls had only ever had one partner and are, therefore, excluded from the following description since it would not be possible, in their cases, to show that a pattern was likely to be repeated in consecutive relationships. Of the remaining 23 girls: 18 had had 2 partners, 2 had had 3 partners, and 3 had had "numerous" partners.

Girls who had had two or more partners

A comparison of the sexual and reproductive histories of each of these 23 girls showed that in 19 cases the same pattern of contraceptive use as had occurred with the first partner was repeated with a later partner or partners. In two other cases, there was insufficient data to show that the same pattern had definitely been followed, although this seemed likely. In only 2 of the 23 cases was there no apparent pattern. The most striking support is given in the cases where girls had had three or more partners and in all recorded relationships the same pattern was seen to be followed.

Initial pill users: In the group of previously pregnant girls, there were only two girls who had been using the pill when they first became sexually active. One had had only one partner and so is excluded from this comparison; the other had had two partners. She was married to the second partner and actually attributed this pregnancy to failure of the pill.
Debbie was a 19 year old UK White girl who had started taking the pill as soon as she turned 15 and had taken it in total for almost 32 months. Her mother (she described them as "the best of friends") had accompanied her to see their family doctor to request the pill. Theirs was one of the few close mother-daughter relationships in this small group (previously pregnant) which had included discussion and help about sex generally.

Debbie said she had twice become pregnant while taking the pill, but in conversation with her it soon became evident that her pill taking routine was rather haphazard. She said she hated taking pills. ("My husband put them in my mouth every night!") In retrospect she laughed about it, but within three months of having her baby, Debbie was pregnant again.

Debbie was a lively working class South London girl. Conversations with her were always animated and frank. We met several times in the hospital and on every occasion she was smiling and chatted about her latest plans.

Debbie had been admitted for the abortion as a day case. It was a day which seemed almost as though it had been reserved for teenagers' abortions. Between the two hospitals there had been five girls to interview post-operatively, all in the afternoon, all of the girls to be discharged that evening. Debbie was the last to be seen. She was very eager to leave as she had left the baby, then aged 7 months, with her mother for the day and was anxious to collect him. Unusually, she was returning to the hospital family planning clinic in a fortnight to have an IUCD inserted (IUCDs were more commonly inserted at the time of the operation). She asked if she could talk to me then instead. She also gave me her address and said I was welcome to come and see her there if I preferred. I felt confident that I would not lose contact with her. Debbie was the only abortion patient interviewed in this way.

She came looking for me on her return to the hospital clinic, bringing her baby son with her. The interview took place in the hospital. On subsequent visits (she experienced some problems with the IUCD) she always came to say hullo and the last time I saw her she had come to have the IUCD removed as she planned to have another baby.

Debbie, probably not unusually for our South London teenagers, became sexually active when she was 15½ years old. Her first boyfriend was 10 years older than she was. At 17 she met her second "steady", later became pregnant and had her first baby while she was still single. She married the baby's father when the baby was two months old.
Debbie's mother was a divorcee with seven children who worked as a cook. Looking at their family tree, one could see some of the problems which must have influenced her mother's action in accompanying Debbie to their doctor for the pill when Debbie had just turned 15.

The eldest sister, who at 24 had already been widowed, had three children and a new boyfriend; the second eldest and only brother had two illegitimate children; the sister 2 years older than Debbie had had an illegitimate son when she was only 15.

In spite of the many features in her background which would normally be expected to result in non-use of contraception initially and an even earlier first pregnancy, Debbie's example seems to have some of the features of an integrated relationship. Her use of contraception preceded sexual activity with both sexual partners and there was some evidence of her husband's concern and sharing of responsibility. However, her pill taking did commence several months before her first sexual experience, probably because of her mother's concern. Her mother had been highly influential in obtaining the pill for her 15 year old daughter and certainly, Debbie's pill taking had been erratic enough for her to experience two unplanned pregnancies.
Initial sheath users: Four of the girls in the group of 41 had used sheaths at the time of their first sexual experience. Two are excluded as they had had only one partner and the remaining two were found to have followed a similar pattern of contraceptive use with later partners as they had with their first partners.

The histories of the two girls, both UK Black, bear many similarities. For both girls this was their third pregnancy: the 19 year old had two children and the 18 year old had an abortion and had a baby.

Jean: She looked much older than her 19 years and was one of only two teenagers in the study who had had a "wide-awake" abortion under local anaesthesia as an out-patient.

Although she said that there had been "other boys", these relationships had all been when she was between the ages of 15 (when she had her first sexual experience) and 16 and 9 months when her relationship with the man who was to be the father of all three pregnancies, first began.

He was her second "steady" boyfriend, and until the birth of her first baby when she was 17 and 9 months, she said she had used "the sheath and nothing" with all her boyfriends. Once she had made contact with the hospital, however, her experience broadened to include the IUCD, the pill and sheaths with pessaries.

The father of Jean's children was Nigerian. Understandably, Jean knew little about his family in Nigeria, except that his father had three wives and he was one of the four children of one of these wives. Their relationship was typical of the unstable "steady" type which many of our UK Black teenagers seemed to experience.

Jean recalled how at 16, when she was only 2 months pregnant, "he didn't want to know" and she didn't see him again till the baby, a boy, was several months old. "Of course, he was pleased - because it was a boy!" She was given an IUCD in hospital before she was discharged with the baby. It fell out 3 months later and she was prescribed the pill at one of the hospital family planning clinics, but after 4 months she stopped taking it. She blamed it for the headaches she was getting and was given instead sheaths and pessaries by the same clinic.
Jean became pregnant again almost immediately and this time she went to a hospital in a neighbouring district (St. Thomas's) to request an abortion. She was refused and the second baby was born in the month she turned 19. Jean was given the pill on her discharge from hospital and took it for almost three months (the supply she was probably given by the hospital). She said the reason she got pregnant was that she missed taking it for 2 days.

Jean lived with the two children in a council flat. Although she said at the time of the interview that her boyfriend "hadn't shown up at home" more than once a week "since I got pregnant" (she had been 12 weeks pregnant), she did not include him as an occupant of her flat when she was asked about her accommodation. Jean said that she never knew his whereabouts, or when he was returning and never knew when he was going to come back to her with VD. She said that they had talked about marriage a few times but never very seriously. They argued and he complained about the untidy flat and the children's toys scattered everywhere.

Jean described her relationship with her mother as "great". It wasn't so "great" though when she was 16 and pregnant. In fact, she had not told her mother she was pregnant this time, even though she lived nearby and they met several times a week. "She would kill me. She said if I ever fell pregnant again, forget that I had a mother or a father!" What about her father? "I couldn't tell him - he'd go bananas. All hell broke loose when I got pregnant for Johnny" (her son).

Jean had been given the injectable contraceptive after the abortion. She did not know its name and did not recognize the two names suggested to her.

Beth was just 18 and like Jean had become pregnant three times by the same boyfriend.

She was 16 the first time and had had an abortion. Before that she had had two "steady" boyfriends and had used the sheath or "took chances". After the abortion she was given the pill but only took it for 3 months because "I kept bringing it up". (It may have been unsuitable for her, but this can also happen if, after forgetting pills for a few days, a girl takes several pills at once.) She became pregnant immediately she stopped the pill and after she had had the baby, took the pill (the same one, she said) for another 3 months after discharge from the hospital (3 months being the usual supply given on such occasions). But, she said, "I kept bringing it up and I was getting tummy pains". The third pregnancy she called "the will of God". She had had an IUCD at the time of the interview abortion.
Beth and her baby lived with her parents and a brother. She said she got along "all right" with her mother. She had not told her about this pregnancy: "She's not really having an easy time. She has to go into hospital next week." Her father "doesn't talk a lot - he's got a lot of pressure. He doesn't like my boyfriend very much - after the first termination he keeps calling him "murderer"."

Girls who used no contraception initially: Nineteen girls who had used no contraception initially had had two or more partners. The pattern of contraceptive behaviour of only one of these girls was not repeated with both partners. This girl was, in any case, exceptional in that her most recent pregnancy was due to failure of the IUCD. She is excluded from the following description. Two other girls could not be adequately categorized. Both girls were UK Black with 2 year old babies - one had previously had an abortion as well. Both started taking "left-over" pills they had been given on their discharge from hospital at about the time their second sexual relationships began. Unfortunately, it is not clear from our notes whether they started taking the pill before becoming sexually active or after taking chances a few times, and these two cases have also had to be excluded.

The 16 girls remaining who had initially used no contraception and who had had two or more partners, had in every case, followed the same pattern of contraceptive behaviour with every relationship, that is, using no contraception in each relationship's initial stages.

Half of the girls in this small group had, up until the present abortion, never used an effective method of contraception (included in this number is the Jamaican girl who had taken the pill for one week only). This, in spite of the fact that some of these girls had had two earlier contacts with hospitals. A mixed race (West Indian) girl with 2 children had never used any method at all. "I was frightened of going for the coil ... I didn't like the idea of being prodded about with", she said.
A UK White girl with a 5 months old baby said the "thought of internals and being touched by doctors" had put her off, and a UK Black abortion patient who already had a 19 month old baby said her boyfriend "didn't believe in it". Neither of these girls had ever used contraception.

Two Jamaican girls had been given the pill on discharge after the birth of their babies. One said: "It didn't agree with me and my boyfriend didn't want me to take it." (So she had stopped after a week.) The other never took any because once she got home she "couldn't find them to take". Another UK Black girl with a one year old child had never used contraception because "I don't believe in it".

In fact, 11 of the 41 previously pregnant teenagers in the abortion group (if the girl who had taken the pill for one week only is included), had never used any effective method. Two of the girls had at some time used sheaths, one had used sheaths and withdrawal and three had at some time used withdrawal. These 11 girls described their relationships with their mothers in terms ranging from "terrific", "me and her don't get on that well" to "terrible". Only one of the 11 girls had been told by her mother about periods and only one had been told by her mother "where babies come from". None of the 11 girls named their mothers as the person they talked to most often about sex, or who had been most helpful to talk to about sex. Over half of these girls had not told their mothers that they were pregnant and having an abortion.

The characteristics and experiences of this small group of 16 previously pregnant abortion patients who had had two or more partners and who had used no contraception initially, places them close to the negative extreme of our hypothetical continuum - teenagers in segregated relationships and with distant mothers. Three of these girls were UK White; the remainder were UK Black (8), Jamaican (3) and mixed
race (West Indian) (2), making girls of West Indian origin disproportionately represented in this disadvantaged group.

In this study, one of our major concerns has been to learn why more black teenage girls become pregnant without planning or wanting a baby. With such a high proportion in our abortion group, and such a high proportion of young mothers who said the pregnancy was unplanned and initially unwanted, it cannot be argued that these black teenage girls wanted to have babies. We found that they were comparatively well educated, as well informed as their indigenous counterparts, even more interested in knowing how to control their fertility, and generally ambitious and optimistic for their futures.

Their problem appears to lie partly in their upbringing. This, in turn, seems to be an adaptation (the mother-centred household, with mother as breadwinner) to cope with the failure of the male to provide for his household, his joblessness the result of discrimination on grounds of colour and class, discrimination which he suffered in the West Indies and continues to suffer here.

West Indian society's adaptive mechanisms have created a wide variety of lifestyles for the man who is unable to fulfil the role of husband and provider, so that he does not completely lose his self-esteem. The problems for the black girls we have studied appear to be twofold - they have gained an education to help them to succeed, often prodded mercilessly by their mothers, who have in the process, lost their acceptability as confidantes; and the West Indian boys who become their partners, having little chance in the near future of becoming respectable husbands and providers, show all the dilettante traits justifiable in their subculture.

An attempt has been made to take the study of teenage pregnancy beyond simply the discussion of sex
education and knowledge and the availability of contraception to teenagers. The hypotheses and the development of a typology of relationships suggested here will need to be followed up by a more intensive study designed specifically to test these ideas. The West Indian aspect of the study provides us with clues to unravelling the problems of pregnancy in our indigenous teenagers by highlighting differences more extremely and pin-pointing the vital links.
PART VI

CONCLUSIONS AND RECOMMENDATIONS

10 Introduction

The capacity to distance ourselves while recording the intense experiences of 550 teenage girls, the majority of whom had just been pregnant, enabled us to disentangle the common themes underlying many of the young women's experiences. While explanations for the type of social phenomena we were observing during the study are extremely difficult to derive from social survey research, our strong suspicions and gradually mounting evidence, encouraged the belief that it is the quality of (sexual) relationships young couples have which provide an explanation for the increased likelihood of some of these teenagers experiencing an unplanned and unwanted pregnancy.

The method of contraception (if any) used by a teenager at the time of her first sexual experience provided a useful indicator of the type of relationship. Once having identified what seemed to be a key to the problem (exemplified in the classifications of relationship types which we then devised for our young subjects) the question of how best to utilise this knowledge arises.

If, as is generally accepted, the fertility behaviour of a generation of young women arises largely out of their own family and social backgrounds, it is impossible to be optimistic for health or medical programmes which aim to reduce "repeat abortions" without taking the powerful influence of such antecedent factors into consideration.

As young women enter their child-bearing years and a pattern of sexual behaviour commences, it may be that the most appropriate strategy for the health and education services would be one which focuses on the children of
these young women, and particularly on parent-child relationships. To this end, the more humanitarian the approach to young pregnant women, the more likely the health services are to have a far-reaching impact by encouraging use of the services (GPs, antenatal, child health and family planning clinics) by those who would reap most benefit from them. If the significance of the antipathy we observed (particularly between young black women and the services) is ignored, access to these services by many of the present generation of child-bearing women and so of the next, is likely to be severely restricted.

The most appropriate recommendations we felt could be made and which are outlined in the following pages, centred upon changing the attitudes of service workers towards young people in the hope of improving their image in the community and making them more approachable. A campaign for "hearts and minds" would, on its own, be unlikely to reduce noticeably the present generation's rate of unplanned pregnancy. Nevertheless, the goodwill and opportunities it would create might well be advantageously tapped by the services in the future.

It is hoped that our study, based on data collected from a comparatively sophisticated urban population of teenagers, residing in a district well served by the family planning services, which nevertheless continues to experience a higher than expected number of unwanted pregnancies, will contribute to research on fertility behaviour as well as having practical implications for the health services, particularly those aimed at or utilised by young people.
Laying the blame - society or the individual?

The impact of deprivation and disadvantage reverberates to the very heart of society, affecting every institution and grinding unremittingly at morale. These pervasive ills take their substance in, and are to some extent legitimated by, social class distinctions and racial discrimination - although this latter is more often perpetrated clandestinely.

Social classes (and racial divisions) are maintained and reinforced not only by their widespread general acceptance, but also their constant affirmation by those in positions of power in society, thus emphasising differences (between classes or ethnic groups) and ensuring that the negative aspects of differences are stacked higher on the side of the less privileged.

Socio-economic characteristics are commonly used to pinpoint antecedent factors in unwelcome and unplanned pregnancy. This practice encourages the belief, not only within the health services but in society generally, that it is the sub-group itself which bears the foremost responsibility for the "problem" to be attacked, rather than the inequalities and disadvantages with which this sub-group is unfairly burdened.

An individual's self-image is a reflection of the values and judgements of society at large. We observed in our study the low self-esteem of the young mothers who never told the putative fathers they had had their babies, sometimes disguised in a defensive or aggressive manner, which only too evidently indicated feelings of inferiority (typically expressed in such words as "I cared more for him than he did for me" and "I didn't mean anything to him - I'm not important enough, why should he care?"). Self-esteem and the concept of identity, particularly of the West Indian
girls, were subjects we were not in a position to evaluate in the context of this study. Some valuable comments and references, particularly in relation to Jamaican children and Londoners of different ethnic origins are collected in Young and Bagley (1979).

Some teenage girls had not liked to refuse their partners or to make any demands they thought might not be acceptable to them. They were vulnerable, the antithesis of the clinic attenders we described who had placed a higher value on themselves, believing that their relationships would endure and were worthy of care and preparation. These latter girls had delayed having intercourse until their relationships were suitably serious.

In our non-systematic observations, one of the elusive features we noted of many of the abortion patients, setting them apart from the majority of young mothers, was a combination of rebelliousness and optimism. Although many of these girls were subject also to those influences mitigating against their efficient use of a reliable method of contraception, they often appeared, from their attempts during our interview conversations to analyse the events leading up to the abortion, to be utilising the pregnancy experience, turning it into an opportunity for learning and growth, for increasing their self-awareness.

It would, of course, be ingenuous to expect that deep-rooted inequalities such as those we have described between the clinic attenders and the young mothers, might be removed at a stroke, simply by promoting youth advisory clinics and advocating more comprehensive sex education in schools. Nevertheless, the cycle must be entered at some point, and these means might also be utilised to inculcate in young women a feeling of pride in their feminity.

The successful management of sexual relationships by young couples of all ethnic groups and social classes depends on mutual respect and shared responsibility.
These attitudes result from behaviour learned within the family, observed in one's own social and peer groups and reinforced at school and in other learning situations.

Focus of other studies of unwanted pregnancy

The identification of those young women most at risk of experiencing an unplanned and unwanted pregnancy has engrossed the attention of many researchers.

Research methods and viewpoints have varied. Those which have been service-orientated have ranged, at the practical level, over recommendations covering training of professionals both in family planning methods and the communication of this knowledge to patients and the setting up of more comprehensive family planning services integrated with the other medical services (see McEwan (1974) in the study district and Allen (1981a) in two other health authorities).

Recommendations have included those for increased sex education, an integrated family planning service and for increased availability of male methods, in conjunction with social changes such as greater equality for women in the hope of reducing the pressures on them of the double standard on sexual morality (Francome and Francome (1979)). Other recommendations have been for the education and involvement of parents, since the family and sub-cultural attitudes are such powerful agents (Black (1979)(i)) and for the systematic collection of reliable information and advice for school and youth counsellors, GPs and family planning clinics (Ashken and Soddy (1980)). More generally, emphasis has been placed on the need to encourage girls to equip themselves with the qualifications and skills needed for satisfactory work, whether inside or outside the home (Kiernan (1980)).
Ideologies and belief systems influencing fertility behaviour have been another focus of interest, ranging, for example, from proposals for a modernity scale (Gough (1976)), an index used to distinguish on an 8-item scale those who value rationality (among other ideals); to the analysis of the social construction of teenage pregnancy (Murcott (1980)).

Research into family intentions and the factors related to these intentions and their achievement (Cartwright (1976)); the attitudes generally of women towards planning their future, in relation to their demographic background (Chamberlain (1976)); and the social context of high fertility (the construction of an abstract framework of factors strongly associated with the development of motivation to use birth control) (Chamberlain (1980)), have similarly been attempts to analyse the fertility behaviour of groups of women in an effort to identify the reasons for their failure to use contraception.

Studies of antecedent factors in adolescent pregnancy indicate that those girls who continue with the pregnancy tend to be older and have poorer educational achievement, while those requesting abortions are more intelligent, outgoing and ambitious (Black (1979)(i)). They also indicate that those girls becoming pregnant during adolescence are more likely than those who do not to have been academic under-achievers, to have made a court appearance, to have been referred to a child guidance or psychiatric clinic at an early age, to have come from large families, to be illegitimate and to have had mothers who were themselves teenage mothers (Wilson (1980)). For young American women, indicators such as earlier commencement of sexual activity and less regular use of contraception have been described as in all probability leading to a concentration of pregnancies in the lower socio-economic groups (Ford, Zelnik and Kantner (1981)).
This study: Patterns of behaviour as exemplified in relationship types

Our socio-demographic data largely agreed with the findings of other similar research in the U.K. (for example, Wilson (1980) and Kiernan (1980)); but while the differences between our UK White abortion patients and the UK White young mothers were largely anticipated (for example, the young mothers having poorer educational achievement, larger families of origin and higher illegitimacy), these features did not distinguish between the UK Black abortion patients and the UK Black young mothers. For these girls, the outcome of an unwanted pregnancy seemed to depend more on the girl's situation and feelings at the time of becoming pregnant than on indicators such as social class, family size or level of education achieved. Such factors as pressures from parents (particularly mothers) and the order of the pregnancy - first pregnancies tending less frequently to be aborted (see p.254) - appeared to be influential in determining the outcome of the pregnancy.

While the UK Black teenagers' experiences drew our attention more sharply to specific areas - for example, their apparently increased likelihood of experiencing an unwanted pregnancy over that of the UK White girls, and their greater difficulty or reluctance in communicating their feelings and needs, not only within their own families, but also to their doctors - it seemed that the patterns of behaviour in relationships which we observed were common to indigenous and West Indian teenagers.

Using a combination of data - statistical findings supporting systematic and non-systematic observations made at the time of the study - a means of identifying teenagers at risk was devised, based on types of boy-girl relationships. Relationship types appeared to be correlated with the method, if any, of contraception used at the time of a girl's first sexual experience.
While early identification of a teenager at risk may indeed be made by a teacher, social worker, doctor or even a girl's mother, as we found in a number of cases observed during the study, contraceptive use initiated by a person other than the teenager herself appeared to be much less likely to be efficient or consistent enough to prevent the occurrence of an unplanned pregnancy than if it had been initiated by the girl herself.

Attempting to reduce the risk of a teenager becoming pregnant by influencing her use of contraception outside the context of a steady relationship would not, therefore, appear to be the most appropriate type of intervention. In addition, a pattern of behaviour, once begun, appeared to be maintained in succeeding relationships. Although a substantial proportion of our teenagers had only ever had one sexual partner, we found on closer inspection of the histories of a group of 23 teenagers who had previously been pregnant and who had had more than one sexual partner, that this was indeed the case - the initial pattern of behaviour was maintained. Only two girls in this small group failed to follow the same pattern in succeeding relationships that they had established in their first sexual relationship (see p. 276).

If patterns of behaviour in the use (or non-use) of contraception are related to the types of relationships young couples have, and if these evolve from earlier intra-familial experiences and relationships, then it seems important that the area of origin of the "problem" should receive most attention. Once a girl becomes sexually active, however, and a pattern of behaviour commences, the temptation for professionals is to concentrate attention on the symptoms rather than the cause. The result is that the girl with the least stable relationship (that is, the girl who does not view herself as being in a serious relationship and therefore "entitled" to use effective contraception)
may find herself an IUCD user. To use the pill or IUCD outside the context of a serious relationship is felt to be immoral. A 16 year old said to us to explain why she took chances: "You feel sort of cheapish if you're on the pill and you don't have a steady boyfriend." This view is reinforced by those in authority, for example by the doctor who was said to have refused to prescribe the pill to one teenager because her boyfriend had moved away from the locality.

There is, obviously, a dilemma here. How can young people be encouraged to find casual sexual encounters where reliable contraception is least likely to be used undesirable, when sexual conquest is so much a part of a young (particularly working class) man's self-esteem when this is often at a low ebb, more prone as he is to be unskilled and unemployed. Our so-called permissive society condones, even glamorizes, sex without strings. Do we, therefore, gear our educational and health services towards ensuring first and foremost that all young (especially working class) women are constantly using reliable contraception? Or do we put greater emphasis on the importance of the emotional content of a sexual relationship?

The active family planning policy promoted by the hospitals (see pp. 178 - 180) in respect of the young women we interviewed, would appear to be a reaction by the services consistent with the former approach, treating the symptoms and largely ignoring the cause. It might perhaps also be said that the predominantly middle-class staffed health services are, by this practice, reinforcing inequalities between themselves and the, for the most part, working class teenagers who attend their antenatal or abortion clinics. They are imposing the solutions (IUCDs or the pill) on such teenagers which they themselves seek as a free choice. In addition, little is known of the effects that coercing young women into the use of a particular contraceptive method may have on their attitudes in the future - attitudes towards sexual relationships and towards medical methods of contraception.
Man-woman relationships as observed in other studies and from our viewpoint

The importance of the relationships of couples as an indicator of their fertility behaviour has been noted briefly in many studies. However, few have viewed types of relationships as a feature of their findings or have attempted to develop classificatory systems using these as prime indicators. Nevertheless, certain deficiencies in interpersonal relationships have been implicated as important correlates of irregular or non-use of contraception.

While it is possible that the strong demand for policy-relevant findings has drawn attention away from those areas which seem to be less accessible to direct action or control, there is among professionals in all the services a general awareness that the quality of an individual's relationships (intra- and extra-familial) is a critical factor, impinging on all aspects of a person's life.

There are three interrelated themes recurrent in the numerous studies of unwanted pregnancy which are of particular relevance to our findings: the "commitment to sex" theory; the observation of patterns of contraceptive use, especially the progression to more effective methods; and the search for an explanation for repeat abortion behaviour. It may be that if their findings were to be viewed by these researchers from the standpoint of the hypotheses we have suggested, more satisfactory insights would be revealed into what they have tended to treat as mysterious and unrelated events.

Directly related to the first theme concerning "commitment to sex" and leading into the second, concerning patterns of contraceptive use, are those studies which have referred to the significance of the use or non-use of contraception by a young woman at the time of her first sexual experience (among them Farrell (1978) p.39; Zelnik and Kantner (1977); and Francome and Francome (1979)). The third theme, concerning repeat abortion behaviour, is often treated independently. However, in the following we aim to show that explanations for such behaviour are, in fact, closely related to the first two themes.
Farrell (1978) noted that "there are differences in the methods used by those who had used contraception on the first occasion and continued to use birth control regularly, those who had used a method on the first occasion but then subsequently took a chance, and those who had not used a method on the first occasion ... those who used contraception on the first occasion and continued to do so also used a more reliable method to help them avoid pregnancy" (p.39).

Bone (1978) extended her observations of behaviour similar to this, speculating on those areas she believed might be interrelated. She suggested that there was a "need to obtain histories of sexual attachment and contraceptive use from single women and to find out from the relationship between patterns of attachments and contraception, the situation in which inadequately protected intercourse most commonly occurs. Is it, for example, when sexual experience begins, does the risk increase at the beginning of any new involvement or towards the end of faltering attachments; in steady or casual relationships? And do such patterns vary with age and social characteristics?".

Unwanted pregnancy in young women is much higher in the United States than it is in Britain. It is, therefore, a matter of considerable interest to researchers to compare the attitudes and behaviour of the two populations. The Francomes were attempting to isolate the main reasons for the much lower abortion rate experienced by British women than by American women (Francome and Francome (1979)). They supported Lambert (1971) in suggesting that the reason why single British women have far more unwanted pregnancies in comparison with married British women (when years at risk are considered) is, among other reasons, because of the frequent omission of use of contraceptives at the start of a relationship.
Explanations for the behaviour observed have varied. The Francomes argue that American women face an even stronger double standard than British women, with males regarding the problems of birth control and pregnancy as a woman's responsibility to a much greater degree and being less likely to encourage their partners to obtain protection (as well as having a greater prejudice against condoms than men in Britain). They also believe that there is less sex education in the United States and that chastity is held up as an ideal in the United States to a much greater degree. It is virtually impossible to support or disprove comparisons such as these.

The Francomes believe that the explanation for non-use is that it is an indication that a young woman has not come to terms with her sexuality. However, it may be that in the young woman's view, it is the relationship which is not yet "mature" enough to be treated as a serious or steady relationship (requiring the use of effective contraception), not that she is not ready to "commit herself to sex" or to "come to terms with her sexuality". In fact, the Francomes go on to describe situations which were common among our respondents. "It is particularly difficult for a young woman with no regular relationship to accept the fact that she may have intercourse in the near future for, while the culture may accept sexual activity with a regular partner, it is nevertheless very censorious of casual female liaisons. So, once a relationship is over, a young woman may well stop using her method of contraception. This is especially the case if she is on the pill, for she may well not wish to have the trouble of taking it regularly if there is no apparent reason." (The reasons given by the Francomes' respondents for stopping the pill were particularly familiar to us - such as, "I couldn't be bothered, I wasn't seeing anyone anymore").
Zelnik and Kantner (1977) refer to Lindemann (1975) "who sees more frequent sex as indicative of commitment with a self-concept to match, leading not only to more contraception but, ultimately, to the use of medical methods of birth control which require the user to bear witness to her behaviour before various authority figures". They argue that "the proportion of those who had intercourse only once and who used contraception is about the same as the proportion of users at first intercourse among those who had subsequent episodes of intercourse. If, as some theorize, the use of contraception is a function of the "commitment" to sex, i.e. to the incorporation of sex into the "self-image", it would seem from the evidence here regarding the early use of contraception that the commitment develops subsequent to sexual initiation".

For Lindemann (1975) "sexual activity is the background to a commitment to sex, but it does not mean commitment, just the possibility of commitment. It is the decision to get a birth control method that really means commitment to sex". This means that "there is a delay in getting a birth control method until after intercourse has taken place. Basic to the natural stage is this seeming paradox of not using contraceptives when pregnancy is unwanted. The lack of commitment to sex explains this paradox" (pp. 24-5).

Although Lindemann tends to neglect the emotional aspect of the relationship between the young woman and her partner, she records one of her respondent's words: "I won't have sex now unless I like somebody a lot. I would wait three months before having sex. I would use withdrawal again. I won't use the pill or coil until I get married. I would like to wait till I'm married to have a lot of sex. If I do have it once or twice before, I would use withdrawal again. If I find somebody I love a lot, I would use the coil." (p.45) (my emphasis).
For us, the last statement is the most revealing. Another girl is described as saying, after breaking off a relationship "I'm not going with anyone in particular so I don't have a need for pills." (p.48). Lindemann views marriage as a situation in which there is likely to be more sexual activity, rather than as indicative of a strong emotional commitment between two people. "A change in sex patterns due to marriage has the same effect as a change in sex patterns in nonmarital situations. A girl who is married perceives an increase in the frequency of coitus as one cause for obtaining an expert prescription just as does the girl who is not married. ... the effects of a decrease in the frequency of coitus are not unique to unmarried women. The girl whose sexual patterns change due to separation or divorce from her husband retrogresses like the one who breaks up with a boyfriend: Due to separation from my husband, I was not having relations with anyone. Then my husband and I unexpectedly got together and that was it!" (pp. 48-9).

Lindemann was observing behaviour very similar to that observed among our respondents, but her greatest emphasis was on sexual activity, rather than the relationships in which sexual activity occurs.

Our findings were that young women in what we have described as intermediate or segregated relationships, who used no contraception or a less effective method at the time of their first sexual experience, could, in the context of the same relationship, progress to using more effective methods, but that, on the cessation of that relationship and the commencement of a new relationship, the former pattern of behaviour would be likely to be re-established. This would explain how young women who have at some time in the past used effective methods, who may have had earlier pregnancies, remain vulnerable to experiencing a further unwanted pregnancy.
Zelnik and Kantner (1977) comment that "... it appears that proportionately more unmarried female teenagers are having intercourse; they are initiating sex earlier; and, on the average, they have had more partners, but without any increase in frequency of sexual activity. Perhaps the reason that coital frequency has not increased is that more partners mean that relations are somewhat less established". This would result, in our observations, in a greater risk of experiencing unplanned pregnancies.

By using an argument based on "commitment to sex" rather than "commitment to a sexual relationship with a particular partner", Zelnik and Kantner have difficulty in reconciling some of their observations. They note that "the least sexually committed teens, at least at the time of adoption of a contraceptive method, are those who used contraception at first intercourse. By definition, those who did not begin to use contraception right away were sexually experienced by the time they did; those who began contraception at their first intercourse were sexually inexperienced at that time...". Yet, they go on to say: "Seemingly, the more committed to sex a young woman is, the more sophisticated is her initial use of contraception. There are striking differences in the first-use profiles of those who have sex only once, those who continue to have sex but use contraception from the start and those who delay the use of contraception. For these three groups, pill use as the first method goes from less than 10% to over 20% to over 50% respectively; while condom use declines from 62% to 41% to 18%. Experience with pregnancy and age at first use of contraception cannot explain these differences."
Where repeat abortion behaviour is concerned, many researchers (and, as we have observed, many doctors) have found it perplexing that, having once experienced an abortion, a woman may find herself in the same position again. If the patterns of behaviour in the use of contraception that we observed are, in fact, closely related to the types of relationship young women find themselves in, it is surprising that there are so few women experiencing repeat abortions.

The Francomees seemed surprised at their finding that "... over four out of five of those who had had an abortion were still not using contraception regularly when they became pregnant again ... (Some girls) very often took the view that their first abortion was due to their mistake in having premarital intercourse and that they would have no more intercourse until they were married. This was particularly true of those who had ended the relationship that had led to their pregnancy. As they had no plans to have intercourse in the immediate future they often took the view that their next romance would be different."

Lindemann recorded similar observations among her respondents.

Shepard and Bracken (1979) are absorbed by the same problem: "The intriguing question, therefore, is why and under what circumstances do so many women who have terminated one pregnancy expose themselves to unprotected coitus and the risk of repeated unwanted pregnancy which requires another abortion?" They note that "previous findings have suggested that an unstable relationship with the partner may be associated with elevated risk of unprotected coitus and repeat abortion".

Brewer (1977) concurs in his study of women who have had three or more abortions, and notes that "all
studies agree that "instability" seems to be associated with erratic contraception. "Erratic" contraceptive use appears to mean, for many researchers, the failure always to use an effective method, once use of such a method has been initiated. In fact, Brewer notes that "a past history of consultation for psychiatric reasons or - in the case of the unmarried - of having changed sexual partners between the second and third abortion, may both be manifestations of a more general disorganization of which disorganized contraception is only one facet". Brewer goes on to differentiate one group of women as "the erratic group". It may be that if the contraceptive use of these women were viewed over succeeding relationships that the patterns of behaviour of the women might be shown not to be "erratic" at all, but to follow a distinctive pattern, for example, with non-use at the beginning of a relationship and later, as the relationship becomes more committed, use of a more effective method of contraception. However, the influence should be borne in mind of the intervention of pregnancy, its effect on the relationship and the significance of the method of contraception which termination might initiate, such as the IUCD. It is interesting that Brewer observed a change in sexual partner for some of these women between their second and third abortions.

It is noteworthy also that Brewer refers to "general disorganization" and suggests that "in the case of erratic contraception, especially if there are indications of instability and disorganization, more consideration should perhaps be given to the insertion of an IUD". He concludes with the comment that "the incidence of second-time abortion indicates that the human capacity for wishful thinking is considerable".

This view is apparently shared by the Francomes (as was noted, above, when they referred to young women
thinking they will have no further intercourse until after marriage) and by Shepard and Bracken who found themselves perplexed by the observation that women on welfare (welfare, in the U.S., often being equated with generalised instability) having repeat abortions appear to have become less likely to use any form of contraception at conception. All these researchers refer to unstable and broken relationships and yet are puzzled by the failure of the women involved to use contraception even after the experience of an abortion.

Hamill and Ingram (1974) were also concerned about the failure of women to use contraception effectively even after having had abortions and concluded from their study that it confirmed "the sad state of contraceptive practice among married and single women and older and young women, both before and after abortion or unwanted pregnancy. Evidence from other sources (they quote Schofield) suggests that this is unlikely to be remedied, and the number of unwanted pregnancies and hence of abortions is unlikely to decrease in future".

Aguirre (1980) commented that the results of his study demonstrated "the centrality of man-woman relations for an understanding of repeat abortion behaviour, and the need to orient future work on repeat abortion away from a predominant concern with contraception. Abortion can be understood only in terms of the cultural values and social practices which regulate different couple relations".

If our hypotheses that contraceptive use is related to the type of relationship a young couple has (the most effective method being used when the relationship is steady) and that patterns of behaviour are repeated for each different relationship are correct, then this would explain what has seemed to many researchers, including the Francomes, the apparently illogical behaviour of
young women in not using contraception for a casual encounter or at the start of a relationship.

We would suggest that patterns of behaviour - as reflected in the use of contraception and types of relationships - are in fact, logical and observable. The question to be asked is how can changes be effected in patterns of behaviour based on certain types of relationships?

11 Attitudes of health service workers

Pregnancy in teenagers when unplanned, unwanted or both, provokes a variety of reactions from staff in those sections of the health services with which these teenagers come into contact. Differential treatment has been said to result from social class differences; for example, women of lower social class being thought by some doctors to experience fewer ill-effects psychologically with an illegitimate birth than women of the higher social classes, are said to be more likely to have their requests for abortions refused. Baird (1967) expresses such a view: "In the lower social classes there is much less emotional upset and less disruption of the way of life, and the family is more inclined to accept the situation."

There may be blocks to communications between medical staff and teenage girls, resulting from age, class and cultural differences and attitudes. "'Class warfare' is played by both patients and doctors", Ingram (1971) has pointed out. "There is evidence that those of higher social class are more likely to be terminated than those of lower social class, especially among single girls pregnant for the first time. Doctors sympathise more readily with the situation of those girls who might easily be their own daughters ..... The middle-class are usually more knowledgeable about the law, better able to put their case convincingly, and are more skilled in doctor/patient games" (Ingram (1971)), thus the professional woman is
commended, for she "has determined not to accept the situation as irretrievable without a struggle. She will argue her case with clarity and courage" (Baird (1967)).

Sometimes the harsh treatment (as the girls themselves perceived it) meted out to both black and white girls requesting abortions, distracted them from the central issue of their feelings and the reasons for having come to the decision. A white girl who said she had had a particularly unhappy experience with one of the two GPs she saw and with the hospital doctor, felt that the humiliation and distress she had been caused completely over-ruled all other feelings about being pregnant, such as her attempts to make a careful, well-judged decision about her relationship with her partner, and her thoughts about her own future - essential if there is to be a beneficial aspect to an otherwise negative experience.

Abortion counselling:

For the young woman requesting an abortion, possibly the most important person she would meet would be the abortion counsellor/nurse specialist on her first visit to the hospital. Yet, in the experience of many of the teenagers in our study, this professional was either unrecognizable in her role of counsellor, or thought to be unsympathetic, dealing as she was required to within the short interview, with a considerable number of administrative formalities.

Counselling, to be beneficial, involves the free and honest discussion of all aspects of a woman's unwanted pregnancy. In this respect, counselling may be within the scope of numerous professionals with whom the young woman is likely to come into contact before reaching the hospital. Most of these people will not be in a position to
grant outright the young woman's request for an abortion, although they might impede her. They might, therefore, be viewed by the young woman as being able to counsel more objectively than those, particularly hospital doctors and nurses, directly involved in granting her request.

In addition, counselling by these latter professionals may not be recognised as counselling by the young woman who is more familiar with the functions performed by such people as schools counsellors, pregnancy counsellors (at the charity clinics or youth advisory clinics) and, from her general knowledge, marriage guidance counsellors. That social workers, teachers and doctors might also see themselves in some situations as acting as counsellors might not be as well understood. Counselling will also be defined differently by these various people, according to their personal views and their professional interests.

For a combination of reasons, therefore, a woman dressed as a nurse, believed to be in a position to influence or perhaps even grant a teenager's request for an abortion, will not be immediately recognised by the teenager as a potential counsellor.

From the view of the abortion counsellor, it may be that her definition of counselling has an additional limitation. She may feel that the scope of the assistance she is in a position to offer is so restricted that any attempts at counselling would be misleading and inadequate and, on a more personal level, that simple inflexible solutions will be harder to content herself with after having been close to an individual, seeing her problems, her strengths and weaknesses in all their complexity (Cheetham (1977) p.10).
When abortion counselling has become subservient to an active family planning policy (see pp. 178 - 187) the relevance of counselling diminishes. The power implicit in the authoritarian approach of an active family planning policy, when combined with an abortion service, is in grave danger of being misused. To seek the agreement of a young woman to use a certain method of contraception in future, before she is even told that her request for an abortion has been granted (often with emphasis placed on the appropriateness for her of the IUCD, inserted at the time of the operation) may perhaps be construed by the young woman as being her part of the bargain, to be accepted if she is to have the abortion.

Abortion counselling has a number of aims, one of which may be seen as attempting to reduce numbers of repeat abortions. Its main aim, in the words of the DHSS Circular (1977), is to ensure that the decisions "particularly by the woman herself are taken in the light of all relevant facts about her situation and about the alternatives to termination which are available to her". If, however, abortion counselling is regarded merely as a vehicle, justifying (indeed, enabling) the pursuance of an active family planning policy in the belief that such coercion is the only means of minimising the number of repeat abortions, then such counselling is a sham.

* The DHSS Health Circular HC(77)26 issued in July 1977 is quoted by Simms (1977): "In informing women about the local arrangements for these (family planning) services there must be no suggestion that a decision about abortion is conditional on the woman agreeing ... to use a method of contraception." (p.27)
"Late" abortions:

In view of the difference between "early" and "late" abortions, it would seem to be of particular importance that all those young women who qualify for the "early" procedure should actually have their abortions performed by methods such as the vacuum aspiration method. It was, therefore, of some consequence that when collecting data from hospital notes a year after the interview abortions, we found on later examination of hospital records, that a number of those young women who had had "late" abortions appeared to be 12 weeks' pregnant or less. If accurate, this would imply that over a third of the "late" types of abortion were performed on patients whose pregnancies would be regarded by many surgeons as being more safely terminated by the "early" method.

At the time of the study, it was also a practice to delay any patients who were regarded by the doctors performing their abortions as too late for the vacuum aspiration operation, as they were 12 to 14 weeks' pregnant, for 2 or so weeks before booking them into the hospitals for the abortion, since "late" abortions performed by inducing labour are more easily and safely carried out at the later gestations. On this subject, Savage (1979) has commented that "mortality rises steadily with increasing gestation, but it is more difficult to obtain figures about risks of individual methods in the second trimester as in many reported series the numbers have been too small for statistical significance, and the skill of the individual operators is more important late in pregnancy. However, it is clear that the risks of vaginal termination are lower than those of intrauterine methods".

In the study hospitals, the delaying of patients who were 12 to 14 weeks' pregnant for a further fortnight was practised in spite of the fact that there was at
least one surgeon at the time of the study who was willing to perform and skilled at performing "early" procedures on pregnancies of up to 16 weeks. A quarter of the "late" abortions (9) were recorded as being about 16 weeks (size of uterus). If all those girls in our study whose pregnancies were under 16 weeks at the time of the operation, but who experienced "late" abortions, had been channelled into the vacuum aspiration group, the very high number of our teenagers falling into the "late" abortion group would have been reduced dramatically — from 36 to 23. Moreover, we do not know how many of those recorded as just over 16 weeks at the time of the operation had in fact been deliberately delayed before having the "late" method of abortion.

Disseminating family planning information:

Where young women did not have appointments to return about a fortnight after the abortion operation to their GPs or clinic doctors, the abortion counsellors, if they worked in the district, gave them appointments to return to see them at the family planning clinics where they worked at other times of the week. In fact, many of the counsellors did not work at clinics in the district, or when they did, their clinics were held at inconvenient times, for example in the morning, which would be difficult for young working women or schoolgirls to attend. Those counsellors who did not work in clinics themselves, referred girls who had no other follow-up appointments to one of the hospital family planning clinics. Attendance at follow-up appointments was poor. In practice, therefore, opportunities to speak to young women about contraception were usually restricted to the first hospital visit and the ward. However, the application of an active family planning policy made any in-depth
discussion of contraception somewhat superfluous.

Not only the family planning clinics and GPs, but also the hospital staff, frequently missed opportunities to impart practical information to the young women they themselves deemed at risk. "You've got to humiliate them - that's the only way!" was the belief of one hospital doctor, advocating a register of girls at risk who had failed to keep their follow-up appointments. Even those young women who were given the pill, for example, on their discharge, would have benefited from a detailed discussion of its use with a doctor or nurse, instead of verbal instructions (no written instructions were given) simply to start taking it that night and to make sure they kept their follow-up appointments.*

An indication of what might be done was noted by an interviewer on one occasion when a UK Black teenager who had already had a young child and had previously had an abortion was being interviewed. The young hospital doctor making his ward rounds stopped to talk to her about the pill, which she was to be given on her discharge. He told her simply how the pill worked, then explained how it should be taken, asking her questions to check that she understood. He asked her what she would do if she forgot one or two pills, then he explained how risky this could be and what back-up action could be taken: the "morning after pill" or having an IUCD inserted if it was too late to take the extra precaution of using sheaths or a cap or abstaining. His voice was low and his language simple. The girl contributed to their discussion, not the least intimidated or defensive because of her ignorance. He spent 10 or 15 minutes with her and when he left, the

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* A request on the special abortion ward for any literature they might have to give to a young woman who had requested some, was met with the reply that they did not keep any there, "it would give girls the wrong ideas".
girl sat there with a look of both shock and delight. "Never, in all the times I've been pregnant, has anyone talked to me like that!"

The most appropriate method - an area of conflict:

We noted frequent occasions when hospital doctors' judgements of the most appropriate method of contraception for use by a teenager in future differed from those of the doctors (clinic and GPs) and abortion counsellors who had previously discussed methods with the girls.

It seemed that doctors directly involved in the abortion procedure were likely to have firmer views about the appropriateness for teenagers of the IUCD, than did the girls' own GPs or the clinic doctors. In fact, hospital doctors were paid a fee for the insertion of an IUCD at the time of the abortion, or later, on the ward. During the time of the study, young doctors on one busy ward could earn more in a month from these fees than their normal salary. Some doctors frankly admitted that the financial remuneration influenced their action in "urging" women to agree to have IUCDs instead of the pill.

A Nigerian student of business studies, described by hospital staff as "completely thick", already had an IUCD, inserted at the time of the operation, when she was interviewed. She was very worried about what her GP would say. He had earlier given her a supply of the pill and she said she didn't know what she would tell him when she went back to see him.

One reason for concern about this situation is that hospital doctors had over-ruled the GP's advice and agreement with his patient, and this at a time when the girl was particularly vulnerable, just before the abortion operation. The other concern was that at the time of the study a new type of contraceptive pill was being researched in the district, by GPs and family
planning clinic doctors, and the reason why the girl was particularly concerned about breaking her promise to her GP to take the pill might well have been because she had been recruited into this study and felt a responsibility to him. In this particular case, this possibility was not explored.

The arguments sometimes used to convince particularly reluctant girls that they should have an IUCD at the time of the operation were usually vague ("it's the best contraception for a young girl" was one overheard), always practical ("you won't even feel it being put in - this is the best opportunity for you, under the anaesthetic"), but also sometimes self-defeating ("she (the doctor) was all right - she told me about the coil, that it would be advisable, and that if I don't like it I can always take it out"). It seemed likely that those girls who felt that they had been coerced into having an IUCD would return to their doctor or clinic to have it removed.

It is sometimes argued that the greater use of the IUCD by black women is evidence of their preference for this method. Among our abortion patients, we saw that over a third left the hospitals with an IUCD - 44% of the UK Black girls and 24% of the UK White girls; and that while 59% of all the abortion patients left with the pill, this was in fact 72% of the UK White girls but only 48% of the UK Black girls.

If there were a genuine preference for IUCDs shown by young black women, we would expect to find evidence of this in the future methods named by our young mothers. In fact, we found very little difference between the future methods named by UK Black and UK White young mothers. In this group as a whole, 55% named the pill and 18% the IUCD as their future method. These proportions were 63% and 13% for the UK White girls and 55% and 16% for the UK Black girls, indicating no strong preference for IUCDs among these UK Black girls.
There was far less interest in young mothers' family planning needs taken in the hospitals, for several reasons: many doctors believed that for some teenage girls the most appropriate method of contraception was the IUCD, the girls having shown themselves to be unreliable and irresponsible in their use of contraception, as evidenced by their unplanned pregnancies. At the time of our study, the practice of inserting IUCDs into young women on the maternity wards had just been discontinued (although some cases, such as one of our young mothers under 16 years, were regarded as being exceptional and exempted from this general recommendation).

The practice of inserting IUCDs before discharge from the maternity wards had been controversial for two main reasons: it was thought unnecessary to pressurise young women so soon after their babies had been born; they would, it was believed, in most cases not need any contraceptive cover for at least 6 weeks, by which time they would have been for their postnatal check-up and in the course of this discussed their future contraceptive needs. The generally higher regard for child-bearers than abortion patients, together with recognition that one does not have the same bargaining power with the mothers, would seem to explain the difference in treatment of the two groups. The other main reason was that the advisability of insertion of IUCDs immediately after childbirth had been questioned in view of reports of increased risks of expulsion and perforation.

Recent research into IUCDs has concentrated on two main areas: improving the rates of acceptance of IUCDs and learning more about the risks it has for certain
groups of women. Studies have shown that those women in whom a close, sympathetic and personal interest has been taken at the time of insertion of the IUCD and who understand the possible side-effects, are much more likely to continue with the method and accept some discomfort with it than those women who have been given the IUCD without explanation and support (Reading and Newton (1977). Other studies have shown that the risks of acute pelvic inflammatory disease are greater in IUCD users than non-users, particularly in young women who have "multiple partners" and who are nulliparous. In addition, there are minor problems, such as pain, discomfort and heavier menstrual flow (Booth, Beral and Guillebaud (1980)).

Even more recently, the International Planned Parenthood Federation in a policy statement on meeting the needs of young people (1984) advised that "there is a need for caution in offering an IUD to an adolescent who has never had a child, or who is likely to have more than one partner and is therefore more likely to be exposed to pelvic inflammatory disease. Age is in any case a significant factor in the incidence of PID, and younger adolescents are at greater risk".

The expectation of hospital staff that young mothers' family planning needs would be cared for in the community clinics, may not always be realised. Young mothers once discharged from hospital can be just as elusive as any other young women in the community. For Black (1979)(i) "the difficulty in following up the group of girls who had babies, 34% only returning for personal interview ... was mirrored by the experience of all the other statutory agencies involved with them. I would suggest that this is a reflection not only of their greater social problems if they kept the baby, but is related to the pre-existing social and attitudinal risks in their environment".
Coping with "the system"

Graham and Oakley (1981), looking at medical and maternal perspectives on pregnancy, devised a frame of reference incorporating notions of ideological perspectives and reference group (obstetricians' and mothers') to show differing perspectives on: the nature of childbearing (appropriately a medical subject versus a natural biological process); the context of childbearing (a medical event, a defined episode versus a change in social role); the criterion of success (a medically successful pregnancy versus successfully raising a child); and the control of childbearing (the medical experts with their abstract knowledge versus the mothers' individualised and intuitive knowledge).

While making passing references to the contrasting treatment of women who are perceived as middle class and working class, Graham and Oakley presented what were largely accepted views of the conflicting medical and maternal perspectives, each side recognising what the others' view was and how it differed from their own. Since our study concentrated on the experiences of a subgroup, a special group of young women whose sexual behaviour and attitudes towards pregnancy were frequently regarded by the medical side as aberrant or deviant (these girls were mostly single, very young, frequently black, and with a high proportion of unplanned and initially unwanted pregnancies), the differing perspectives were much more starkly contrasted. The frame of reference used by Graham and Oakley gave an impression of greater compliance of mothers with obstetricians' views, most paying at least lip service to the medical perspective in default of any serious alternative, than we found to be the case with our young women.

Our black teenagers, in particular, appeared to have had great difficulty in presenting appropriately to their GPs when requesting abortions; on average it took them
more visits before securing the necessary letter to the hospital than it did white teenagers. Young black mothers were much more likely than young white mothers not to see their GP at all, to present late for booking, or not to book at all. Not understood by and failing to appreciate the indigenous frame of reference, these young black women seemed simply to have opted out of the system.

Some doctors may have difficulty in interpreting the problems of girls when expressed more in non-verbal terms than in the familiar pattern of a patient presenting with symptoms. To some professionals, this inability to communicate in a conventional manner may indicate stupidity. The word most commonly used was "thick". A local GP said that he believed the West Indian girls in his practice were "a bit thick". In the hospitals, African girls even more than West Indian girls, were likely to be described by the nursing staff as "really thick". Hospital notes sometimes bore the note "IQ ��".

Undoubtedly, interviewing the African girls was more difficult for us. The 19 year old Nigerian student of business studies provoked the comment from one of the interviewers: "She was really hard work ... didn't really seem to understand anything I asked". The nursing staff had described her as "completely thick". This girl had visited her GP three times before being referred to the hospital and she was also one of the two African girls who had told no-one at all (apart from doctors) about the abortion.

There are cultural differences in the manner used to describe comparatively minor ailments, just as there are in the ways in which different societies cope with major upheavals in their lives, such as death. Our own society denigrates the voluble expression of pain and grief.

Pregnancy is an area of particular interest. In many
societies a pregnancy is acknowledged only when it is considerably advanced. High rates of miscarriage, stillbirth and infant mortality and the precariousness of the first few days of life in these societies, all make the happy outcome of a pregnancy uncertain. Poor nutrition, stomach disorders, diarrhoea, dysentery or infection can also make periods irregular. There are many explanations and pitfalls before a healthy pregnancy can be confirmed. When a pregnancy is unwanted, how much more difficult, for women from certain backgrounds, must its conscious acknowledgement (although not necessarily its recognition) be.

Even in clinics and hospitals where a high proportion of pregnant women is young and single, they seemed constantly to be reminded of their non-conformity, by being addressed as "Mrs.", being reproved for failing to book early (or for failing to book at all), or for failing to attend clinics regularly. An education which seemed irrelevant and the apparent inability of officials and professionals with whom they came into contact to understand their particular needs and difficulties, encouraged young single black women to withdraw from those areas where they experienced conflict or condemnation.
Proposed modifications in the behaviour and structure of the hospital services

Although only a longitudinal study could attempt to explore the subject adequately, our observations of teenagers' experiences lend support to the view that the emphasis placed by professionals on ensuring that all abortion patients leave the hospitals with either an IUCD in situ or pills which they have agreed to commence using immediately, if done in the belief that this will minimise the likelihood of another unplanned pregnancy (Newton et al (1973)), will only increase their feelings of frustration as they become aware that their solution is inadequate.

Poor attendance at the family planning follow-up appointments given to young women having abortions, ostensibly to check their IUCDs or to make sure they are not having any problems with the pill, is another source of concern for these professionals, as they realise that the high priority they place on (the constant use of) effective contraception is not shared by these young women.

The experience of Julie, (see pp. 78 - 82) illustrates the futility of a policy of active family planning which does not take account of an individual's particular background and needs. A 15 year old UK Black schoolgirl, Julie had only ever had intercourse three times when she became pregnant. When asked by the abortion counsellor what she planned to use in future, Julie requested the pill, but her choice was over-ruled on the ward, where the consultant told the group of medical students surrounding her bed that she must have an IUCD, it was "the price she had to pay". It was a high price because Julie was anaemic. She was given iron tablets when she was discharged, but in the following
months bled so profusely that the IUCD was expelled and she was then prescribed the pill. She was also admitted after taking an overdose of the iron tablets - she was having "boyfriend trouble", and her 14 year old sister was about to have a baby. Within a year of the first abortion, Julie was back in hospital having another.

**Lay visiting on the wards:**

The term "lay visitor" is merely used descriptively in the following to emphasize two important aspects of this, perhaps professionally well qualified individual, (for example, a sociologist or a social worker): she would not be medically qualified or a nurse (therefore "lay") and she would initially approach young women informally, on the wards (therefore a "visitor"). Her qualifications would be similar to those of the counsellors employed by the charity clinics, emphasis being placed on experience in working with young people. Social work qualifications might well be an asset, but it would be the personality of the individual, her energy and resourcefulness which would identify the right person, together with her ability to utilise contacts with all those organizations (and individuals) in the community already existing and anxious to support the type of work she would be doing. For their counsellors, Brook Advisory Centres believe in the value of trained social workers. The Pregnancy Advisory Service, London, in 1973 appointed a sociologist as its director of counselling, while their actual counsellors are mostly unqualified in the formal sense, although they all have in-service training. Grapevine, the Family Planning Association's community birth control project, has some senior members of staff with social work qualifications, but its fieldworkers have not. The British Pregnancy Advisory Service does not insist on this qualification, although it does employ some social workers (Simms (1977) p.18).
There are a number of different ways in which the experiences of teenagers like Julie could be utilised to their longer term benefit. Having an abortion is an event which obliges all women to re-assess the direction in which their lives are heading. For some, this opportunity to stop and survey their situations is only fleeting - either they are forced into a defensive position by families, partners or professionals and there is no opportunity for them to see their experience in perspective; or the experience is made so unpleasant for them (even physically painful) that feelings of self-pity obliterate all other thoughts. Those teenagers who keep the abortion a secret, or who tell very few people, do not have the opportunity to explore their feelings with a sympathetic and impartial outsider.

We also saw from numerous contraceptive histories that for many young women opportunities to discuss their contraceptive needs in detail were very rare. At the (now closed) South London Hospital for Women, at the time of our study, a nurse was employed to visit every maternity and abortion patient to discuss her needs before she was discharged. This family planning adviser could give sheaths and pessaries and could arrange for prescriptions of the pill to be issued; she could make family planning clinic appointments and knew the locality well enough to advise women of the place (and times) of their most convenient clinic. She carried a bag of leaflets, pamphlets and maps and examples of every contraceptive method to show her patients. She encouraged them to take the information leaflets and to discuss the different
methods with their partners. She would return to see them if they wanted to ask more questions or needed more help. This type of information service, particularly if performed by a young lay worker, would be invaluable in all hospitals.

The one or two packets of pills given, without written instructions to patients in the hospitals, the insertion of an IUCD or the giving of the injectable contraceptive (which must be repeated in about 2 months) are no substitute for information which can be utilised by women when the need arises. The young women in our sample who had previously had abortions or babies, who only took the pills they were given and then stopped, who could not find them when they wanted to take them or who could not remember how to take them (and had no instructions to refer to) would possibly have been better off if they had also had caps or sheaths and pessaries, if they had been told about methods of post-coital contraception and if they had known precisely where to find their nearest clinic.

In addition to showing or actually providing some methods of contraception, information about methods (including post-coital contraception), answering questions about reproduction and common medical problems and giving practical advice (about young people's centres and their locations), a lay visitor on the wards could provide the sympathetic ear and objective interest which many young women do not find in their everyday lives. Some girls would gain more from a private discussion, while others would probably benefit from sharing their feelings with others who have had the same experience, perhaps in a guided discussion group. Lay visitors would be able to assess the different needs of young women admitted to wards on the same days and arrange the most appropriate opportunities for them to talk, undisturbed, together.
In Julie's case, a lay visitor would probably have talked to her alone. Julie's relationship with her "boyfriend" could have been brought into the conversation. In the absence of either mother or mother-figure, she had had little opportunity to learn about or discuss relationships with boys. Julie's self-esteem was low and she appeared to be particularly vulnerable. It was, after all, "boyfriend trouble" which was to bring her back to the hospital twice in the year following the interview abortion. Yet apart from the consultant's fatherly admonition ("boys are only interested in one thing and you shouldn't be having sex at all at your age"), the crux of Julie's problem was never dealt with. Her greatest need was not for someone to tell her what method of contraception to use, but for someone to help her with her relationships, and to give her guidance in building self-confidence. The lay visitor would need to be armed with the training, information and contacts which would enable her to help Julie.

The type of help which might have benefited Julie by its nature is long-term and could have taken a number of different forms:

On a one-to-one basis: There were probably a number of people who saw Julie frequently as she was growing up who would have recognised her very early as being at risk of experiencing an unplanned and unwanted pregnancy: her teacher(s), doctor and (later on) social worker. All of these people would have been in a position to foster a special relationship with Julie or to lead her to someone better suited or qualified. In the event, no-one appears to have taken on this role.

As a member of a group: Once having been identified as someone in need of help, perhaps only at the time of
her first abortion, Julie might have profited from the encouragement and sympathy of a group, either of teenagers who had had similar experiences, or as a member of a more diverse group. She might even have been "paired" with one particular person. However, since an abortion is an experience which most women would prefer to forget as quickly as possible, the raison d'être of any self-help group would need to be oriented towards the achievement of some socially acceptable goal.

The role of the main hospital youth advisory clinic held every week, in the early evening, could be broadened to include counselling young people with personal problems, by inviting the lay visitor to participate in that clinic. In this way, the lay visitor would be in a position to provide follow-up support to the girls she had already seen on the wards, by welcoming them to drop in informally to see her at the weekly clinic.

Some years before our study, volunteers regularly visited women on the maternity wards to discuss family planning and to make clinic appointments. These visits were regarded within the hospital as particularly useful, although they were discontinued for a number of reasons, among them a heavier workload for the volunteers (staff members who visited in their own time) and criticisms from local GPs who felt that the offering of family planning services to their patients by the hospital competed with the services they were providing (and for which they received a fee). If a lay visitor with a special interest in teenagers were to be employed in the hospitals, the possibility of obstacles such as these arising would need to be discussed with local doctors before her appointment.

Where young people are concerned, there is a need to dispel the mystique surrounding medical methods of
contraception, to move away from experts prescribing towards lay workers explaining and showing. The power and pull of the peer group plays a large part in socialisation and character formation (Rainwater (1970) and Allcorn (1954)). Greater emphasis could be placed on the involvement of young people in helping other young people as well as on the use of lay workers.

The possibility of identifying early those young women at greatest risk of experiencing an unplanned and unwanted pregnancy and therefore of developing a realistic strategy or plan of action would also help to counteract the frustration and impotence many professionals feel on recognising that sex education and access to contraception have not solved the problem of unwanted pregnancy.

Pregnancy termination procedures in the hospitals:

There is a need to rationalise the hospital policy for "late" abortions, concentrating on those methods requiring particular skill at the same time as benefiting the patient. Those women who are 12-16 weeks' pregnant at the time of the operation should be channelled into the operating lists of those surgeons skilled at and willing to perform vaginal methods at these higher gestations. Experience in Newcastle (Lawson et al (1976)) has shown that after setting up a separate appointment system the percentage of early abortions rose from 66.7% to 81.4% in the first year of operation (Savage (1979)).

An increase in the hospitals in the number of "early" procedures for pregnancies up to 16 weeks would not only benefit the women involved. There would probably be financial savings (due to shorter hospitalization) as well as benefits to staff - with fewer "late" procedures
being performed and these, ideally, being cared for by a highly skilled and committed team of doctors and nurses.

The time in hospital for all women undergoing early abortions should be kept to a minimum - if possible no more than a matter of hours (Dunlop (1978)). The possibility should be investigated of making administrative changes to reduce two day hospitalization for some women having early abortions to a maximum of one day or one day and one night where patients have not recovered sufficiently to be discharged on the same day; and of increasing the proportion of outpatient ("wide-awake") operations, both changes requiring re-organisation of staff, but almost certainly resulting in considerable financial savings.

We noted that only two of our subjects were referred for "wide-awake" abortions as outpatients. Prospective patients for this procedure had to be judged "stoical" by doctors and nurses at their first hospital appointment, and it was suggested that previously pregnant women would be most suitable. At the time of the study, it appeared that little effort was made to channel patients onto this particular weekly operating list. Young doctors performing this method of abortion were on a number of occasions heard to plea for more referrals as that particular theatre session was under-utilised. If these doctors and those abortion counsellors who also worked in the theatre could be teamed for the interviews of women on their first hospital visit to request an abortion, in order to assess their suitability for the "wide-awake" method, they would at the same time be able to provide the continuity of care and the assurance which are necessary for the success of a method such as this. In the study hospitals, Lewis et al (1971) noted the importance of using the same team to see women through the abortion experience from first interview to operation to follow-up appointment (see pp. 176 - 177).
Many of our subjects were admitted to the special abortion ward on the day preceding their operations and were discharged either in the evening after the operation or the following morning. Their admission during the preceding day instead of on the morning of the operation was to permit the administrative work of booking them into the hospital to be completed in good time. An additional nurse employed to assist with bookings on the morning of the operation instead would, therefore, achieve considerable savings. Nurses frequently commented on the unruliness of groups of bored, restless young women on the ward during the day preceding the operating day, as they came and went from the ward (buying cigarettes, papers, making phone calls), formed noisy gatherings and argued with the staff.

It hardly seems necessary to mention also that "the attitude of everyone the patient comes into contact with should be as pleasant and helpful as possible. There is no place for staff who have not come to terms with their own childlessness. Likewise, it is tactless to put the patient beside a woman being investigated for infertility or with a pregnant patient hospitalized because of a history of repeated miscarriages" (Dunlop (1978)). Nevertheless, all of these difficulties were observed being experienced by patients at the time of our study.

Fees to doctors providing IUCDs on hospital wards could be paid into a central fund (possibly to finance the employment of a lay visitor). At the time of the study, in other hospitals, doctors were putting these fees into a central fund to be used for some specified purpose. Some doctors might be reluctant to relinquish this source of income, but in our experience many seemed aware of the potential for criticism they faced in advocating to women the insertion of IUCDs for which they were paid.

* However, changes may be required in present Inland Revenue regulations to make this feasible.
Antenatal clinics:

Obviously, the child-rearing practices of single, working or student mothers must be viewed very differently from those of young married women who have given up work in order to devote their energies to raising a family. Yet although these are two lifestyles recognised as being well established in our multi-cultural urban society, the young single mother is treated as aberrant; she is pressured to conform to a culturally inappropriate norm through shaming and by the services failing to make provision for any alternative way.

In a population with a high proportion of young single mothers, alternatives to attending daytime antenatal clinics need to be available. A choice, including evening or weekend clinics, would enable single girls to attend without having to inform employers and workmates or schoolteachers and schoolfriends that they are having babies and without missing classes or being absent from work.

A number of schoolgirls who were having their babies were encouraged by schoolteachers to stay on at school almost until the baby was due and to return as soon as possible after the birth. We were also told of others who had been asked by their teachers to leave school, or were expelled, as soon as the pregnancy became visible. Those given encouragement and support and working towards exams would probably be reluctant to spend whole mornings (at least half a day if travelling by public transport to a clinic and a waiting time of one to two hours are included) in the antenatal clinic and would either fail to attend or would find themselves under the additional strain of catching up with missed classes if they did. Many single working girls are employed in hourly paid work and the loss of time and, therefore, income may not be thought worth the effort, particularly if one then meets with rudeness, no explanations, "a few leaflets and iron tablets".
The district's family planning clinics: A service for teenagers?

The district's family planning clinics, located in the hospitals and in premises scattered throughout the area, provided the recruiting grounds for a comparison group of teenage girls who had never been pregnant.

In addition to our interest in the characteristics of teenagers who attended family planning clinics, the service itself was a focus of interest. The motivations behind the setting up of a special service for young people seemed to have a considerable influence on the type and popularity of the service provided. From observations of clientele made during our study, the teenagers' comments, and our observations of the clinics themselves while they were in session, the "ideal" features of a youth advisory clinic emerged. Using these as our main criteria for a successful service, those changes which might most advantageously be made have been put forward.

Although in a cosmopolitan, inner city area it is not possible to evaluate the effectiveness of a family planning service, services are often forced to justify their policies and to answer those critics who, frequently unrealistically, link high abortion rates among young women with the "failure" of the family planning services to attract and cater for their teenagers. The reasons for labelling a particular session a youth advisory clinic may vary between and within centres. These may be any combination of administrative convenience, altruism and window-dressing.

For many centres, it is administratively convenient to concentrate similar "problems" (in this case, those of teenagers) into one clinic and to allocate the most suitable staff to those sessions.
The setting up of some youth advisory clinics may have been initiated through the efforts of those doctors who believe in the right of all teenagers who approach the services responsibly and request contraception to receive their help and support. Many doctors are aware that young women, especially those still at school, frequently have their requests for contraception refused by both GPs and clinic doctors.

Placating the critics and showing that the services are acting positively to deal with a "problem" area means that some visible evidence of a reaction to observed needs may be deemed necessary. "Schoolgirl" pregnancies are an emotive issue both in the community and the health services. The family planning services are expected to be in the forefront of any community's endeavours to prevent unplanned and unwanted teenage pregnancies. Family planning services, just as all other departments of the health services, are faced with challenges to justify their expenditure and to show that they are providing a useful (even essential) community service.

At the time of our study, there were three clinic sessions in the district designated as youth advisory clinics. We anticipated recruiting a higher proportion of suitable teenagers in these clinics than in the general family planning sessions and were interested to observe the different format of these clinics regarded as appropriate for teenagers.

Two of the clinics were held in the hospitals. These two clinics provided us with over half of our recruits from all the hospital sessions (24 of 40). At the time of our recruitment, financial stringencies were forcing a reduction in the number of clinics being held in the hospitals, so that new patients were being refused unless they were referred by a doctor or they were under
20 years old. New teenage clients and the already established teenage clients, when requesting appointments, were as a matter of course booked into the youth advisory clinic at one hospital, while at the other, where there was less pressure on all clinics (due partly to the clinic layout which facilitated the more efficient turnover of patients), the distinction "youth advisory clinic" was not rigidly maintained and teenagers were booked into other clinics and older women were booked into the youth advisory clinic.

There was only one youth advisory clinic in the community which, because of poor attendance over quite a long period prior to the time of the study, was transferred to another centre in the district in the last weeks of our recruitment. Clinic workers were extremely concerned about the dropping of this clinic from their centre which had been very popular when doctors and nurses were visiting a nearby school regularly and when a well-liked female doctor was in attendance. We heard of no-one visiting schools to talk to students in the area while we were recruiting and the male doctor who attended this youth advisory clinic at that time was reputed to send away very young girls requesting the pill with sheaths and pessaries and the instruction to bring a letter from their parents to say they agreed that he should prescribe the pill for their daughter. The doctor's different cultural background may well have influenced his beliefs and made it more difficult for him to accept the attitudes to pre-marital sex which prevailed among his teenage clients.

The session held at the same centre on the following evening, however (half an hour later, at 5 p.m.), was evidently particularly popular with young women, providing us with a third of our teenagers from that particular centre. Another session at a different community centre was then designated a youth advisory clinic, although at the time we were interviewing there were very few teenage girls in evidence.
We encountered some very popular family planning clinic sessions during the study. Their popularity stemmed for the most part from the personalities of clinic staff - most frequently receptionists and doctors. The importance of the almost charismatic personalities of a few people for the success of a number of clinics was well-known among the district's family planning clinic staff and evident to us as interested observers. The converse was also apparent.

The role of clinic staff, both clerical and medical, is extremely important in the image of a clinic and highly influential in ensuring its continued patronage by young women. Crabbe (1977) has referred to the important role nurses have to play in building a trusting relationship with a teenager. This relationship can "tip the balance between her continuing on or giving up the pill". The personality and temperament of clinic staff and the ability to establish a swift rapport with clients require special new skills which appear to have been largely neglected by the family planning services. Many of the staff we met in the shop window of family planning, the clerical workers - clinic secretaries and receptionists - appeared for the most part unaware of their poor image and oblivious of the necessity to move with the changing needs of a population very different from that using the clinics a generation ago. These staff were given no training or guidance on the desired image of the clinic, neither were they selected for having the desired capabilities, or re-educated or replaced if they were unable to identify with the clinic's new aims.

There is an increasing interest among doctors in family planning, mainly because work on a sessional basis in family planning clinics is (or has been until now) readily available to those doctors who have completed
the required training. The hours are fixed and usually undemanding and so one or two sessions a week may be a welcome source of extra income and interest in addition to a doctor's full-time work. Several of the family planning clinics' doctors were GPs in the community as well. At the time of the study, about a quarter of all family planning sessions in community clinics were being attended by doctors of Asian origin, the majority of them men.*

There is no doubt that today the heavier burden of responsibility for contraception falls on young women. Young men have apparently been happy to see this role taken over by women. This is partly because the efficacy of the sheath is consistently devalued in comparison with that of the pill and partly because pre-marital sex is now openly acknowledged as occurring in our society and oral contraception has become more easily available to young unmarried women.

Nevertheless, it is still much more difficult for a teenage girl to obtain the pill than it was in the past for a teenage boy to buy sheaths. There are numerous obstacles and fears which must first be overcome - fear of rejection or humiliation when she makes the request, fear of being discovered by her parents, fear of the vaginal examination and, perhaps, the fear of the medical consequences of taking the pill.

Pill use has become widespread throughout all the social classes, which means that among those young girls now requesting the pill are the least articulate and those least able to cope with the setback of a doctor's refusal and ensuring that she, or her partner, uses an alternative method, such as sheaths.

* The unit, based at King's College Hospital, which organised training for doctors in family planning for the area, at the time of the study anticipated receiving about a third of the applications for every course from Asian doctors.
However, in spite of an evident change in the clientele of family planning clinics, little effort appears to have been made to recruit the type of doctors who are sympathetic towards the young women now faced with the responsibility of using contraception and who will ensure that young sexually active couples are "safe". For example, it might be expected that many doctors from cultural backgrounds which strictly prohibit premarital sex would find it difficult to empathise with sometimes very young, single, sexually active girls.

Not only does the clinical expertise of doctors need to be shown before their appointment to family planning sessions in an area such as the King's Health District, but the attitudes of family planning doctors towards their teenage clients must also be seen to be in harmony with the needs of the community they serve.

Criteria for a youth advisory clinic

The type of clinic which is appropriate for teenagers is also, of course, appropriate for all women, the only difference being its designation so that young people know in advance that they will be made welcome there and its restriction to the younger age group so that embarrassing encounters are avoided.

There are six features which seem to be of particular importance:

1) Pregnancy diagnosis and abortion counselling and referral (as well as cervical cytology and STD referral). These are aspects of the clinic services of particular importance to young sexually active women which were not, however, uniformly available either to first attenders or established clients at the time of our study. The
main problem seemed to be one of central policy, pregnancy diagnosis not being regarded by the family planning clinics (unlike the charity clinics) as one of their primary functions. Nevertheless, some clinics did react sympathetically to these needs: about 10% of our abortion patients were, in fact, referred to the hospitals by clinic doctors or nurses. It is essential that a youth advisory clinic should offer these services to their clients.

The fact that if a woman was not registered as a client at a family planning clinic, she might be turned away if she were to request a pregnancy test there, may partly account for the numbers of girls in our study who had been to a clinic (obviously with the possibility that they might be pregnant on their minds), who had been given a method, usually the pill, and then returned a short time later saying that they thought they might be pregnant. Of course, it might also be the fear of pregnancy while having unprotected intercourse which prompted these girls to attend and we do not know how often visits to clinics are precipitated in this way for girls who are not, in fact, pregnant. In any case, it was evident that some young women were turned away from family planning clinics and referred to their GPs or even to chemists for pregnancy tests. Far from being viewed as an opportunity to give help and advice to young women at risk, this type of visit was viewed by some clinic staff as a nuisance.

2) Sex of medical staff: If a choice cannot be offered, it seems preferable to employ female staff, although we did encounter some male doctors who were well-liked. Many young women who do not feel comfortable about having a vaginal examination manage to overcome their fears, only to find that on their first visit to a clinic they are expected to see a man.

3) Staff: From clinic receptionist to nurse to doctor - a client makes contact with each of these people on a visit to a family planning clinic (in contrast to her experience when visiting a chemist where she will approach one cashier or shop assistant to whom she may not even be required to speak). Teenagers approach
clinics with a variety of problems, frequently needing the encouragement of a friendly and sympathetic reception from staff before feeling confident enough to discuss personal feelings. Staff need to be well-informed and able to make appropriate referrals, to give advice, to be friendly and efficient; they need not necessarily be young themselves, but should encourage attendance by young people and their friends.

4) Atmosphere: This needs to allow for privacy and anonymity and yet not be too clinical. For older clients, the cameraderie of many clinics is not a deterrent (perhaps it is even an attraction), but for teenagers such an atmosphere may well be overwhelming. However, at the other extreme, it is not an essential for a family planning service which is suitable for use by teenagers, that it should provide a coffee shop atmosphere. Many young people would much prefer to talk over their contraceptive needs in a quiet, sympathetic atmosphere.

5) Information: The clinic setting provides an ideal "grapevine". Leaflets, posters and noticeboards need to be used liberally, as well as talks given to local schools and visits arranged by clinic workers to schools and vice versa.

6) Location and times: A clinic needs to be well located - sign-boarded, with adequate street numbers, bus or train routes nearby, and its phone numbers publicised. In the absence of a full-time, walk-in clinic for young people, a full-time telephone service is extremely important. The timing of sessions needs to take the target population into consideration: late afternoon if there are schools or colleges nearby; evenings where most clients are working; and lunchtimes if located in busy shopping or office areas. When there is only one session in a week, its timing is extremely important.
Many people do not know even when there is a clinic in their own street or on their own estate. MacDevitt and Goldman (1976) noted that two-thirds of the patients at a busy London clinic were surprisingly ignorant about the contraceptive facilities available in the area in which they lived. Particular sessions could be publicised in conjunction with the youth advisory clinics run by the charity clinics. Such publicity could emphasize that the service is for young men as well as young women and is free. There appeared to be no men at all registered at clinics in our district.

Do family planning clinics matter anyway?

Allen (1981) emphasised the changing attitudes of clients in her study of family planning services: "Women know a lot more today, demand a lot more and are prepared to use their knowledge of what is available in a very functional way. Professionals, on the other hand, are not always prepared for this functional attitude. They still control access to things that the consumers want - like the pill and IUD, sterilisation and abortion - and they were certainly not usually prepared to hand them over without their advice being sought and taken."

In fact, in an editorial entitled "Contraception and the under 16s" in the magazine of the National Association of Family Planning Doctors (1980), the belief of many family planning doctors in their right to control the provision of contraception was expressed directly (together with the threat of the dire consequences should they be disregarded): "The question of whether they (young people) actually need birth control can only be decided in consultation with a doctor, but if they never get to see one, the numbers of abortions and births will rise."
Many more liberal and realistic family planners have seen that the answer to unwanted pregnancy (if there is one) does not lie in the control by doctors of contraception, but precisely the reverse. McEwan et al (1974) in their study of pregnancy in girls under 17 (carried out at the study hospital) commented that "in many ways it is a pity that the medical nature of contraceptive methods requires a doctor's intervention..... As far as contraception is concerned, it might be nearer the ideal to have an acceptable effective method, not involving medical advice or prescription, which could be made easily available to young people." A decade has elapsed since this statement was made and, although the day may be a little nearer, as yet this ideal has not been realized.

From the experience of our study, we would question the assumption that family planning clinics which welcome teenage girls are essential if abortions and unplanned pregnancies generally are not to continue or even to increase. They are probably not, at least for the majority of the girls who had never been pregnant, if the evidence of our interviews in the clinics can be generalised.

Our clinic attenders were exceptional when compared with the girls in our two groups of pregnant teenagers. The majority were pill users (and the pill is obtained by a higher proportion of young women from their GPs.) Those girls who were initial pill users who were found in such a high proportion in the clinic group and who were noteworthy by their absence from the other groups, have the characteristics of girls who are in any case least at risk of an unplanned teenage pregnancy. The majority of these young women probably need only minimal help in order not to become unintentionally pregnant. Nevertheless, there was still a considerable number of teenage girls attending the clinics who could be regarded as being at
risk (those who used no contraception initially, we would argue). They needed more than minimal help and yet they were being treated no differently from any other clinic attenders.

In the preceding pages, we have suggested that the ideal youth advisory clinic is the family planning clinic which welcomes young people and provides them with contraception. This is to deal with the subject on its own terms, within the framework of the philosophy of family planning provision as it currently stands.

Family planning clinics obviously have considerable potential which remains unexploited. As pill dispensers, they duplicate services which are widely available elsewhere, although older women experiencing problems with methods of contraception are particularly well served by them. However, the main problem for teenage users is least of all contraception itself. It is their relationships with their partners and their attitude towards being sexually active. In fact, if our argument that the real problem lies in the successful management of relationships is to be followed logically, we would recommend that, instead of family planning clinics, there should be "relationship clinics", where family planning would have an important, though subsidiary, role.

Even as they are structured now, family planning clinics could be in the vanguard of changing young people's attitudes towards contraception - by advocating methods appropriate to the needs of their relationships, methods which do not require daily use or medical intervention, of particular relevance to young women who may only have intercourse once or twice a month*; by encouraging young men

* At present, the only widely available methods are the diaphragm, sheaths and pessaries. The new vaginal barrier may prove to be more acceptable to young women than the diaphragm presently appears to be. Post-coital contraception - the "morning after" pill and the IUCD inserted within 72 hours of unprotected intercourse, are unlikely ever to be used as other than emergency measures.
to share the responsibility for contraception by providing sheaths, by encouraging their attendance with or without their girlfriends, and by welcoming their questions and problems; and by cultivating the functions of "grapevine" and referee - identifying needs and referring young people to more appropriate sources for help.

Educating for "safe sex"

We found, from informal discussions about sex education with our subjects, that in many of our district's classrooms, opportunities were utilised by teachers, in the context of the subjects being taught, to discuss young people's own values and experiences. Lessons in social studies, literature and health and hygiene subjects were all providing opportunities for exploring ideas.

A young UK Black subject even told us that her best white friend was one of her teachers. We could not study within the limitations of this research the social networks of our teenagers or evaluate their most important sources of advice and for learning values. However, comments recorded about individual teachers indicated that those who have a good rapport with pupils will probably wield considerable influence and their views will carry weight.

We have also seen that the opportunities the abortion patients had to learn about sex and contraception at school were equal to, if not better than, those experienced by the clinic attenders. In spite of this, the girls having abortions showed a poorer knowledge of contraception than the clinic attenders.
Farrell (1978) concluded from her study that "there is no obvious link between birth control lessons and use of birth control" (p.217). Her finding was that knowledge was linked instead to experience. We would not agree that knowledge gained from sexual experience necessarily results in the practice of "safe sex". Instead, for teenagers, experience may only have this effect within the framework of a particular relationship - with the pattern of behaviour found with the first partner probably being repeated with later partners. If this is the case, it is not experience in the form of using progressively more effective methods of contraception (as Farrell implies) which is what makes sex progressively safer, but experience within a long term relationship which is more likely to be the explanation for knowledge resulting from experience.

We have seen with the West Indian girls in our two groups of pregnant teenagers in particular how use of the most effective methods of contraception is in all probability related to their (comparatively high) proportion of previous pregnancies. Nevertheless, we interviewed these girls when they were experiencing another (in the majority of cases unplanned) pregnancy, conceived most often when no contraception at all was being used.

It was not possible for us to assess just how influential the exposure of young women to family planning advice and the acquisition of methods at the time of a pregnancy was on their later use of contraception. However, from our observations of the patterns of contraceptive use of the previously pregnant abortion patients described in Part V, if the young women's relationships remain unstable (or segregated), it seems that their patterns of use of contraception are unlikely to change.
The techniques required for the practice of "safe sex" could possibly be taught, but they would need to focus on the management of relationships rather than on the mechanics of contraception. They would also need to be taught in an environment conducive to their practice. It is doubtful, therefore, in view of the complex factors operating to increase the risks of unwanted pregnancy for some young women, that an improvement simply in their knowledge of the sociology of relationships would have the desired impact.

The predictive value of relationship types

The crude risk score technique devised by Wilson (1980) in Aberdeen is complex and depends on a considerable knowledge of the background of a young woman which is not available under normal circumstances, information which would possibly be withheld by the girl herself (such as court appearances and illegitimacy).

Types of relationships exemplified at the positive extreme in what we have called the integrated relationship (an initial pill user with a steady partner, the product of a close mother-daughter relationship) could allow for the identification of a teenage girl at low risk of experiencing an unplanned pregnancy as part of normal clinic or surgery routine.

A routine interview could elicit sufficient information about a young woman's relationship with her partner and her previous use of contraception, particularly the method (if any) used at the time of her first sexual experience, to permit the allocation of a degree of priority - low priority to the girl in the integrated relationship (less frequent attendance at clinics), high priority to the girl in what we have described as the segregated relationship (more time to be allocated to discussing problems and giving support generally).
It would appear from our findings that in spite of their eventual introduction to the more effective methods of contraception, those girls who initially used no form of contraception (and a high proportion of these were UK Black teenagers) continued to be at greater risk of having an unplanned pregnancy than the teenagers we described as initial pill users. It may be that the circumstances surrounding their introduction to the more reliable methods are not conducive to learning or motivating, or it may be that the manner in which contraception was given and the hospital environment were inappropriate or inadequate. It seems likely, however, that the mechanisms operating to influence efficient and regular contraceptive use are all-important and that if these are lacking, the absence of a positive attitude towards contraceptive use remains, even after an unplanned and unwanted pregnancy. If the relationship between a girl and her partner is segregated and the sharing of the responsibility for, or at least common interest in, contraceptive use is not part of it, then the girl's problems will continue, unless she is exceptionally enterprising and self-assured.

The patterns of contraceptive use of the teenagers we described who were having abortions, pointed to the likelihood that it was their relationships which determined use, not the packet of pills thrust into a hand or the insertion of an IUCD at the time of the abortion operation.

It has not been possible in view of the design of our study and the development after completion of the survey of hypotheses appropriate to a practical approach to teenage sexuality and pregnancy, to produce neatly boxed and validated theories. However, intuition and observation, supported where possible by our statistical results, have provided clear indications for future research. In the meantime, it may be that the use by professionals of our relationship types as a frame of reference will provide them with new insights into an elusive problem.
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**APPENDIX 2**

**Study of Teenage Pregnancy**

A. IN THE FIRST PART OF OUR INTERVIEW, WE ASK YOU QUESTIONS ABOUT SUCH THINGS AS YOUR AGE, WHETHER OR NOT YOU'RE MARRIED, ABOUT SCHOOL, WHERE YOU WERE BORN, AND SO ON.

**Time interview began:**

1. First of all, how old are you and what is your date of birth?

<table>
<thead>
<tr>
<th>DAY</th>
<th>MONTH</th>
<th>YEAR</th>
</tr>
</thead>
</table>

2. Are you married or single?

   | 1   | Married - living with husband |
   | 2   | separated                     |
   | 3   | divorced                      |
   | 4   | widowed                       |
   | 5   | Single                        |
   | 6   | Common law                    |
   | 7   | Engaged                       |
   | 8   | Don't know                    |

3. Are you working or studying?

   | 01  | At school                     |
   | 02  | Under 16 but not at school    |
   | 03  | College full-time             |
   | 04  | College part-time             |
   | 05  | Working full-time             |
   | 06  | Working part-time             |
   | 07  | Unemployed over 6 months      |
   | 08  | Housewife                     |
   | 09  | Given up work to have baby    |
   | 10  | Given up school to have baby  |
   | 11  | Apprenticed (specify)         |
   | 12  | Other (specify)               |
   | 99  | Don't know                    |

4. ASK THOSE WHO HAVE LEFT SCHOOL OR FULL-TIME STUDY

How many full-time jobs have you had since you began work?

   | Not applicable 88 |
   | Don't know 99     |

5. ASK THOSE WHO ARE HAVING BABIES

Are you returning to work/school after you've had the baby?

   | No |
   | Yes |

IF YES (returning to work), When do you expect to return?

   | 1   | Within the next 3 months     |
   | 2   | Within the next year         |
   | 3   | After a year or longer       |
   | 4   | No plans to return to work at all |
   | 8   | Not applicable               |
   | 9   | Don't know                   |

6. ASK ALL THOSE WHO ARE OR HAVE BEEN WORKING

What is your present/last occupation?

   | Position: |
   | Business or industry: |
   | Are you in charge of other people? Yes |

   | 01  | SEG 01                         |
   | 02  | SEG 02                         |
   | 03  | 3N                             |
   | 04  | 3M                             |
   | 05  | 04                             |
   | 06  | 05                             |
   | 10  | Other (specify)                |
   | 08  | 08                             |
   | 09  | 09 Unemployed                  |
   | 88  | Not applicable                 |
   | 99  | Don't know                     |

7. Are/were you satisfied with your job?

   | 1   | Very satisfied                |
   | 2   | Satisfied                     |
   | 3   | Not very satisfied            |
   | 4   | Dissatisfied                  |
   | 8   | Not applicable                |
   | 9   | Don't know                    |

8. What area are/were you working in?

   | 1   | King's Health District        |
   | 2   | Other (specify)               |
   | 8   | Not applicable                |
   | 9   | Don't know                    |
9. Ask all students and those who have left school/study to have babies:

Are/were you working for any exams?

1  No
2  O levels
3  CSEs
4  A levels
5  Diploma
6  Degree
7  Other (specify)
8  Not applicable
9  Don't know

10. Ask all students and those who have left school/study to have babies:

Where were/are you studying?

1  School
2  Sixth Form College
3  College of Further Education
4  Teacher Training College
5  Polytechnic
6  University
7  Other (specify)
8  Not applicable
9  Don't know

11. Ask those still at school

When do you plan to leave school?

1  At 16
2  After O levels/CSEs
3  After A levels
4  Other (specify)
8  Not applicable
9  Don't know

12. Ask all no longer at school or other full-time education

How old were you when you left school or other full-time education?

Code: 14 = 1  13 = 7  15 = 2  11, 12 = 0  16 = 3  17 = 4  18 = 5  19 = 6  Don't know = 9

13. Do you have any certificates or diplomas?

1  None
2  O levels
3  CSEs
4  A levels
5  Other (specify)
8  Not applicable
9  Don't know

14. Did/do your parents want you to stay on at school or college?

1  No, neither
2  Mother only
3  Father only
4  Both parents
5  Other (specify)
8  Not applicable
9  Don't know

15. Now, can you tell me something about your father - what is his occupation?

Position:

Business or industry:

Is he in charge of any people?  No/Yes

Unemployed over 6 months
Retired (put former occupation)
Dead

01 SEG 01  09 Disabled, mentally ill, etc.
02 SEG 02
03 3N  11 Armed forces
04 3M
05 04
06 05
07 09 Unemployed
08 Other (specify)
88 Not applicable
99 Don't know

16. If you have a stepfather, can you tell me about him too?

Position:

Business or industry:

Is he in charge of any people?  No/Yes

Unemployed over 6 months
Retired
Dead

Don't know
Not applicable

/Use same code as for father/
17. Now, what about your mother? Does she work?

No
Unemployed over 6 months
Dead

If mother works:
Position:
Business or industry:
Is she in charge of other people? No/Yes

12 = 06 Student
11 Armed forces
10 Disabled etc.
77 Dead

01 SEG 01
02 SEG 02
03 3N
04 3M
05 04
06 05
07 08
08 09 Unemployed
09 Other (specify)
88 Not applicable
99 Don't know

Is she working full-time or part-time?
1 Full-time
2 Part-time
8 Not applicable
9 Don't know

18. If you have a stepmother, can you tell me about her too? Does she work?

No
Unemployed for over 6 months
Dead

If stepmother works:
Position:
Business or industry:
Is she in charge of any people? No/Yes

(Code same as for mother, above?)

88 Not applicable
99 Don't know

19. Next, we ask you about your household arrangements. Is your accommodation -

1 Council
2 Privately owned
3 Privately rented unfurnished
4 Privately rented furnished
5 Hostel, Mother and baby home
6 Other (specify) Housing Trust etc.
8 Not applicable
9 Don't know

20. Who do you live with?

Relationship to Respondent Male Female Under

1 Respondent 15
2 15+
3
4
5
6

7 (Include newborn baby if applicable)

DON'T CHECK You have —— people in your household then?

88 Not applicable
99 Don't know

How many rooms do you have, excluding bathroom and kitchen?

88 Not applicable
99 Don't know

Has your household got its own inside toilet which no-one else uses?

Yes
No
21. Where are you living? (Write in postal district also)
   01 Brixton
   02 Camberwell
   03 East Dulwich
   04 North Dulwich
   05 West Dulwich
   06 Herne Hill
   07 Kennington
   08 Peckham
   09 Toxteth
   10 West Norwood
   12 Other (specify)
   88 Not applicable
   99 Don't know

22. How long have you lived in this area?
   [ ] years

   88 = Not applicable
   99 = Don't know

23. Where were you living before this?
   1 London (inside King's Health District)
   2 London (outside King's Health District)
   3 Elsewhere in UK (specify)
   4 Outside the UK (specify)
   8 Not applicable
   9 Don't know

24. ASK ALL NOT LIVING WITH THEIR MOTHERS
   Where does your mother live?
   1 King's Health District
   2 London (outside KHD)
   3 Elsewhere in UK (specify)
   4 Outside the UK (specify)
   5 Mother dead
   8 Not applicable
   9 Don't know

25. How often do you see her?
   1 Daily
   2 Once to six times a week
   3 Once a fortnight
   4 Once a month
   5 Once - 5 times every six months
   6 Once a year or less
   7 Never
   8 Not applicable
   9 Don't know

26. Where were you born?
   Where were your mother and father born?
   If applicable: Where were your stepfather/stepmother born?

   Husband/
   Resp. Mo S'Mo Fa S'Fa Boyfriend
   England, Scotland or Wales
   1 1 1 1 1 1
   N. Ireland or Eire
   2 2 2 2 2 2
   Europe (specify)
   3 3 3 3 3 3
   Africa (specify)
   4 4 4 4 4 4
   West Indies (specify)
   5 5 5 5 5 5
   India, Pakistan or Bangladesh (specify)
   6 6 6 6 6 6
   Asian
   Other (specify)
   7 7 7 7 7 7
   Other (specify)
   0 0 0 0 0 0
   Not applicable
   8 8 8 8 8 8
   Don't know
   9 9 9 9 9 9

Is your husband English? No/Yes
   If not, what is he?
   1 Caucasian
   2 Negro West Indian
   3 Negro African
   4 Asian - Indian subcontinent
   5 Asian - other (specify)
   6 Other (specify)
   8 Not applicable
   9 Don't know
27. Was most of your childhood spent in a country area or in a town or city?

1 Rural area
2 Urban area
3 Not applicable
4 Both areas
5 Don't know

28. ASK THOSE BORN OUTSIDE UK
How old were you when you first came to England?

88 = Not applicable
99 = Don't know

Who did you come with?

1 Alone
2 With parents
3 Other (specify)

29. ASK ONLY THOSE WHO JOINED THEIR PARENTS HERE LATER
Who were you staying with in your country of birth before you joined your parents in this country?

1 Mother
2 Father
3 Grandmother
4 Aunt
5 Other (specify)
6 Not applicable
7 Don't know

30. Next we ask about your religion. What is your religion, if you have one?

1 Church of England
2 Roman Catholic
3 Baptist
4 Presbyterian
5 Methodist
6 'Christian'
7 Other (specify)
8 None
9 Not applicable
10 Don't know

31. Were you brought up in a (different) religion?

No / Yes
If yes, what was that? [Code as above]

32. Ask if presently have a religion
Would you say you practised your religion?

1 No
2 Yes (formally)
3 Yes (informally)
4 Not applicable
5 Don't know

33. ASK CHRISTIANS ONLY
Have you been baptised or christened?
If yes, how old were you?

1 Not baptised
2 Baptised as a baby
3 Baptised at some other age (specify)
4 Not applicable
5 Don't know
6 Not asked

34. ASK CHRISTIANS ONLY
Have you been confirmed?
If yes, how old were you?

1 Not confirmed
2 Confirmed at 10 years
3 Confirmed at 11 years
4 Confirmed at 12 years
5 Confirmed at 13 years
6 Confirmed at 14 years
7 Other age (specify)
8 Not applicable
9 Don't know
0 Not asked

35. ASK THOSE WHO HAVE BEEN MARRIED
Where were you married?

1 Church
2 Chapel
3 Registry Office
4 Other (specify)
5 Not applicable
6 Don't know
7 Not asked
36. ASK IF MARRIED
Now the last part of this section is about your husband. What is his occupation?
Position:
Business or industry:
Is he in charge of other people? No/Yes
Unemployed for over 6 months
Dead
Don't know
01 = SEG 01
02 SEG 02
03 3N
04 3M
11 Armed forces
05 04
06 05
07 06
08 09 Unemployed
09 Other (specify)
88 Not applicable
99 Don't know

37. ASK IF UNMARRIED
Do you have a particular boyfriend I can ask you about?
Yes
No
If NO, ask (EXCEPT FOR THOSE NEVER PREGNANT)
Then what about the man concerned with your getting pregnant - can we talk about him?
No
Yes
(If NO, go to next page)
(If YES, ask: What is his occupation?
and complete Question 36 above....
ask: Where was your boyfriend born?
and complete Question 26 on page 4...
ask: Is he English?
and complete Question 26 on page 4)

38. ASK IF HE IS NOT WORKING
What is he doing if he's not working?
and complete Question 36 above.

39. ASK IF HUSBAND/BOYFRIEND IS NO LONGER AT SCHOOL OR OTHER FULL-TIME STUDY
How old was he when he left school/college
88 Not applicable
99 Don't know

40. What exams did he do?
1 None
2 O levels
3 CSEs
4 A levels
5 Other (specify)
8 Not applicable
9 Don't know
B. The second section is about your family. Instead of asking you lots of questions and writing down the answers, we want you to describe your family and we will draw your family tree. Let me show you. To start with, how many brothers and sisters do you have?

ASK if any are adopted or fostered, record ages of everyone, ask when parents were married and when they came to the UK if not born here, ask if brothers and sisters are married, how many children and their ages etc.

- Non resident boyfriend, but steady relationship
- Partner gone away
- Married
- Living together unmarried, or any other unmarried/divorced relationship
- Divorced
- Dead

ASK about any children who have died; and update all ages of those who have died to present.

GIRL'S FAMILY TREE

PARTNER'S FAMILY TREE
<table>
<thead>
<tr>
<th>Question</th>
<th>Girl</th>
<th>Man</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of siblings + girl/man</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of half sibs. only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>00 None (although have Step-parents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88 Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 Don't know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of girl's/man's mother when her first child was born (years):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88 Not applicable (adopted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 Don't know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girl's/man's mother's marital status when her first child was born:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>/Code:</td>
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</tr>
<tr>
<td>1  Married</td>
<td>0 Remarried</td>
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</tr>
<tr>
<td>2  Separated</td>
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<td></td>
</tr>
<tr>
<td>3  Widowed</td>
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<tr>
<td>4  Divorced</td>
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<td></td>
</tr>
<tr>
<td>5  Single</td>
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<td></td>
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<tr>
<td>6  Common law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7  Other (specify) Dead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8  Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9  Don't know/not asked</td>
<td></td>
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<tr>
<td>Present marital status of girl's/man's mother:</td>
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<tr>
<td>No. of years between 1st and 2nd real siblings in girl's/man's family:</td>
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<tr>
<td>/Code: Use real numbers +</td>
<td></td>
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<td>88 Not applicable</td>
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<tr>
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<td>3rd and 4th</td>
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<td>4th and 5th</td>
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<td>5th and 6th</td>
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<td>6th and 7th</td>
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<td>7th and 8th</td>
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<td>8th and 9th</td>
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<td>(birth order)</td>
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<td>0  None</td>
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<tr>
<td>7  7 and over</td>
<td></td>
<td></td>
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<td>Relationships</td>
<td>Contraceptive method</td>
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<td>Apr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. So the method of contraception you used the very first time you had sex was: [ ]

2. And the most recent method (for NEVER PREGNANT, the method used the LAST time you had sex; for MOTHERS and TOPS, the method used when you conceived): [ ]

3. And all the other methods you have ever used are:

4. Do you agree with that, or would you like to add something? (If yes, add above.)

[Code:
01 Pill
02 Coil, IUD, loop
03 Sheath, Durex
04 Jellies, pessaries, chemicals etc.
05 Withdrawal
06 Safe period, rhythm
07 Washing afterwards
08 Injectable
09 Breastfeeding
10 Nothing
88 Not applicable
99 Don't know
77 Abstinence (within a relationship)
11 Oral sex
12 Cap
13 Other (specify)]

First source of pill:
1 GP
2 Hospital doctor
3 FP clinic
4 Other doctor (specify)
6 Other clinic
7 Other person
8 Not applicable
9 Don't know

Second source (if different):
As above

ASK ALL MOTHERS AND TOPS:
5. ASK IF USING SOME METHOD (INCLUDING WITHDRAWAL, SAFE PERIOD ETC.) WHEN SHE BECAME PREGNANT

Why do you think you became pregnant then?

6. ASK IF NOT USING ANY METHOD WHEN SHE BECAME PREGNANT

Was there some reason why you weren't using contraception at that time?

7. ASK ALL EXCEPT NEVER PREGNANT

What contraception do you plan to use in the future?

8. ASK ALL EXCEPT NEVER PREGNANT

Has anyone talked to you about contraception since you became pregnant?

If yes, who was that?
[01 Nurse in hospital
02 Doctor in hospital
03 FP clinic
04 Brook Advisory
05 Other clinic (specify)
06 GP
07 Abortion counsellor
08 Mother
09 Boyfriend/husband
10 Other person (specify)
11 No-one has talked to me
12 Everyone!
13 Social worker
88 Not applicable
99 Don't know]

ASK ONLY GIRLS WHO HAVE TAKEN THE PILL AT SOME TIME

9. How long have you taken the pill altogether?
01 1 month or less [ ] [ ] months
88 Not applicable 99 Don't know

10. Did you ever stop taking it for a while or forget to take it within that time?
1 No, never
2 Yes, once or twice
3 Yes, many times
8 Not applicable
9 Don't know
4 Not asked
ASK ONLY GIRLS WHO HAVE TAKEN THE PILL AT SOME TIME

11. What was your reason for stopping taking the pill?

1 Planned so stopped
2 Made me sick
3 Made me put on weight
4 Gave me headaches
5 Other medical problem (specify)
6 Stopped seeing my boyfriend
7 Couldn’t be bothered taking it
8 Not applicable
9 Don’t know
0 Other (specify) Ran out/forgot

/TO BE COMPLETED BY INTERVIEWER:

<table>
<thead>
<tr>
<th>No. of previous TOPS:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of previous pregnancies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

/TO BE COMPLETED BY INTERVIEWER:

<table>
<thead>
<tr>
<th>Age at menarche:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age at first intercourse:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

888 Not applicable
999 Don’t know

Nature of first sexual relationship:

1 Casual
2 Steady at that time
3 Steady and presently continuing
4 Other (specify)
5 Not applicable
6 Don’t know
7 Raped
8 Incestuous

<table>
<thead>
<tr>
<th>Nature of most recent sexual relationship (if different):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of sexual partners ever:</th>
</tr>
</thead>
<tbody>
<tr>
<td>77 Unspecified</td>
</tr>
<tr>
<td>88 Not applicable</td>
</tr>
<tr>
<td>99 Don’t know</td>
</tr>
</tbody>
</table>

Sources of contraception ever used:
(First, second, third and fourth)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>GP</th>
<th>FP clinic</th>
<th>Other clinic</th>
<th>Chemist</th>
<th>Pub</th>
</tr>
</thead>
</table>

88 Not applicable
99 Don’t know/not asked

<table>
<thead>
<tr>
<th>Age of first partner (at that time):</th>
</tr>
</thead>
<tbody>
<tr>
<td>88 Not applicable</td>
</tr>
<tr>
<td>99 Don’t know</td>
</tr>
</tbody>
</table>

07 Dispenser in public lavatory
08 Other commercial source
09 Partner obtained - don’t know from where
10 Other
88 Not applicable
99 Don’t know
1. IN THE NEXT SECTION WE ASK ABOUT PREGNANCY:

(a) NEVER PREGNANT

1. What would your reaction be if you found yourself pregnant?

(Code:
- Very pleased
- Wouldn't mind
- Not too happy
- Horrified
- Not applicable
- Don't know /

2. What do you think you would do?

(Code:
- Have the baby
- Have an abortion
- Not applicable
- Don't know /

3. Have you ever thought you might be pregnant?

(Code:
- No
- Yes, thought so once
- Yes, thought so more than once
- Other (specify)
- Not applicable
- Don't know /

If yes, what did you do?

4. Have you ever thought about having a baby? No / Yes

If yes, when was that?

(Code:
- Within the last 3 months
- 3-12 months ago
- Over a year ago
- Never thought of having a baby
- Other (specify)
- Not applicable
- Don't know /

5. Do you want to have children one day? No / Yes

If yes, when would you like to?

(Code:
- Within 2 years
- After 2 years
- Other (specify)
- Not applicable
- Don't know /

6. How many children would you like to have together - boys and girls?

- None (don't want any)
- Not applicable
- Don't know

7. Tell me about your parents:

How do you normally get along with your mother? (And your stepmother?)

(Not applicable)

What about your father? (And your stepfather)

(Not applicable)

8. ASK IF UNMARRIED

Do you have a particular boyfriend?

No (go to (ii))

Yes

(i) IF YES, How often do you see him?

1. Daily
2. One to six times a week.
3. Once a fortnight
4. Once a month
5. Other (specify)
6. Not applicable
7. Don't know

Do you go out with other boys as well?

No / Yes

IF YES, Do you have sex with more than one boy at the moment? No / Yes

IF NO, DO NOT HAVE A PARTICULAR BOYFRIEND:

Are you going out with any boys then at the moment? No / Yes

IF YES, Do you ever have sex with any of them? No / Yes

(Code:
- Steady boyfriend, no sex with others
- Steady boyfriend, sex with other(s)
- No steady boyfriend, no sex with anyone at present
- No steady boyfriend, sex with other boy(s)
- Other (specify) (eg steady boyfriend but sexually inexperienced)
- Not applicable
- Don't know)
1. Were you undecided about having a termination at any stage?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Don't know</td>
<td></td>
<td></td>
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</tbody>
</table>

If yes, when was that

Why was that?

2. Did anyone suggest to you that you have the baby adopted?

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</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Don't know</td>
<td></td>
<td></td>
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</tbody>
</table>

If yes, who was that?

What was your reaction?

3. Who knows about the termination?

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</thead>
<tbody>
<tr>
<td>01</td>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Stepmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Stepmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Husband</td>
<td></td>
<td></td>
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<tr>
<td>06</td>
<td>Boyfriend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Sister</td>
<td></td>
<td></td>
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<tr>
<td>08</td>
<td>Brother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Girlfriend(s)</td>
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<td></td>
</tr>
<tr>
<td>10</td>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>No-one at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Don't know</td>
<td></td>
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</tr>
</tbody>
</table>

4. First of all, your mother -

ASK IF MOTHER was not told:

Why didn't you let her know?

/Code mother's reaction:

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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive; sympathetic; helpful</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Neutral; uninvolved; passive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Negative; scathing; hurtful; unhelpful</td>
<td></td>
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<tr>
<td>4</td>
<td>Upset, disapproving at first - sympathetic, accepting finally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Not applicable</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Don't know</td>
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</table>

How do you normally get along with your mother?

/Code:

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</thead>
<tbody>
<tr>
<td>1</td>
<td>Very well</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>All right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not so well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Very badly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Never see her</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other (specify)</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Don't know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Now, what about your STEPMOTHER?
ASK IF STEPMOTHER was not told:
Why didn’t you let her know?

ASK IF STEPMOTHER was told:
Who told her?

/Code:
1 Respondent
2 Boyfriend/Husband
3 Doctor
4 Father
5 Stepmother guessed
6 Stepmother does not know at all
7 Other (specify)
8 Not applicable
9 Don’t know
What did she say?

What did she do?

/Code stepmother’s reaction:
1 Positive; sympathetic; helpful
2 Neutral; uninvolved; passive
3 Negative; scathing; hurtful
4 Unhelpful
5 Upset, disapproving at first - sympathetic, accepting finally
6 Other (specify)
7 Not applicable
8 Don’t know

How do you normally get along with your stepmother?

/Code:
1 Very well
2 All right
3 Not so well
4 Very badly
5 Never see her
6 Other (specify)
7 Not applicable
8 Don’t know

6. Now, what about your father?
ASK IF FATHER was not told:
Why didn’t you let him know?

ASK IF FATHER was told:
Who told him?

/Code:
1 Mother
2 Husband/Boyfriend
3 Respondent
4 Sister
5 Brother
6 Doctor
7 Father does not know
8 Not applicable
9 Don’t know
10 Other

What did he say?

What did he do?

/Code father’s reaction:

(See as for stepmother, at left:

How do you normally get along with your father?

/Code as for stepmother at left:

7. Now, what about your STEPFATHER?
ASK IF STEPFATHER was not told:
Why didn’t you let him know?

ASK IF STEPFATHER was told:
Who told him?

/Code as for stepmother, top left:

1 Respondent
2 Boyfriend
3 Doctor
4 Mother
5 Guessed
6 Does not know
7 Other
8 NA
9 Don’t know
10 Other
What did he say?

What did he do?

[Code stepfather's reaction:

How do you normally get along with your stepfather?

[Code stepfather:

8. What about your boyfriend/husband?

ASK IF HE WAS NOT TOLD

Why didn't you let him know?

ASK IF HE WAS TOLD Who told him?

[Code:

1 Respondent
2 Girl's mother
3 Girl's father
4 Doctor
5 Boyfriend/husband doesn't know
6 No steady boyfriend/husband - man not told
8 Not applicable
9 Don't know
7 Other (raped)
0 Some other person told

What did he say?

What did he do?

[Code boyfriend's reaction:

9. Is he a steady boyfriend? No / Yes

If no, do you go out with other boys as well? No / Yes

If yes, do you have sex with other boys? No / Yes

What did he want you to do?

[Code:

1 Abortion
2 Have the baby
3 Nothing to do with him/denial of paternity etc.
4 It's up to you!
7 Joint decision on what was best
8 Not applicable
9 Don't know

10. Has being pregnant affected your relationship? (Has it made you think again about the two of you?)

[1 No
2 Yes - positively
3 Yes - negatively
4 Other (specify)
6 No steady boyfriend/husband
8 Not applicable (raped)
9 Don't know

If yes, in what way?

11. Do you think having the termination will affect your relationship?

[1 No
2 Yes - brought us closer together
3 Yes - caused us to split up
4 Other (specify)
6 No steady boyfriend/husband
8 Not applicable (raped)
9 Don't know

12. When was the last time you saw him?

[1 Within last 2 days
2 Within last week but over 2 days ago
3 More than a week, less than a month ago
4 Over a month ago
5 Other (specify)
6 No steady boyfriend/husband
8 Not applicable
9 Don't know

13. How often do/did you see him?

[1 Daily
2 One to six times a week
3 Once a fortnight
4 Once a month
5 Other (specify)
6 No steady boyfriend/husband
8 Not applicable
9 Don't know

[Code:

1 Steady boyfriend, no sex with others
2 Steady boyfriend, sex with other(s)
3 No steady boyfriend, no sex with anyone at present
4 No steady boyfriend, sex with boy(s)
5 Other (specify) - including rape
6 Former steady relationship now ended
8 Not applicable
9 Don't know
14. How long after the first day of your last proper period did you think you were probably pregnant?

[ ] weeks

88 Not applicable
99 Don't know

15. Now, can we work out how many weeks pregnant you were when you had the termination?

What was the date your last period started?

Day ______  Month ______

And you had your termination when?

Day ______  Month ______

So you were how many weeks?

Respondent's estimate: [ ]

Hospital estimate: [ ]

Interviewer's estimate: [ ]

66 Other (specify)
77 Hospital did not say
88 Not applicable
99 Don't know

If there is a discrepancy, ask:

[Code: Reason for discrepancy -
1 Interviewer's estimate from conception
2 Irregular periods
3 Period during pregnancy
4 Doctor's estimate (could be supported by scan)
5 Miscalculation
6 IMP not known
7 Other (specify)
8 Not applicable
9 Don't know

Any obvious complications:

Were there any complications that the girl has mentioned to you?

1 No
2 Yes - minor (felt sick)
3 " drip
4 " severe (long painful "labour")
5 " (perforated uterus etc.)
6 Other
7 Retained product
8 Not applicable
9 Don't know
0 Not asked/noticed

[wide-awake]
16. Now we'd like to ask you about all the doctors you've seen since you became pregnant, and how many weeks pregnant you were when you saw each one.

Who did you see first?

<table>
<thead>
<tr>
<th>Doctor seen</th>
<th>No. of Visits</th>
<th>No. of weeks ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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<td>3</td>
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<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

/Codes:
1. Own GP, locum or partner
2. Other GP
3. FP doctor
4. Other clinic doctor (specify)
5. Hospital doctor
6. Other doctor (specify)
7. Not applicable
8. Don't know

17. Can I ask you about each of those doctors - how sympathetic and helpful were they?

/Code:
1. Very sympathetic and helpful
2. Quite sympathetic and helpful
3. Neutral
4. Not sympathetic or helpful *
5. Unhelpful, rude or obstructive
6. Other (specify)
7. Not applicable
8. Don't know

18. What about the nurses you have come into contact with - how sympathetic and helpful were they?

/Code as above:

19. Did you talk the abortion over with a counsellor when you first went to the hospital? If yes, was that helpful for you?

/Code:
1. Very sympathetic and helpful
2. Quite sympathetic and helpful
3. Neutral
4. Not sympathetic or helpful
5. Unhelpful, rude or obstructive
6. Other (specify)
7. Respondent says she did not speak to a counsellor
8. Not applicable
9. Don't know
0. Not asked
20. How do you feel about this experience you've had?

Felt ill all the time
Terrible, painful (physical)
Terrible, traumatic (emotional)
Not too bad, but wouldn't like it again
OK, no feelings about it at all
Other (specify)
Not applicable
Don't know
Very depressed, miserable, nervous

21. What were your feelings about abortion before this?

Against abortion
Had no particular feelings about it
In favour of abortion
Other (specify)
Not applicable
Don't know

22. Are your feelings different now?

No
Yes
Other (specify)
Not applicable
Don't know

23. Do you think your feelings about having an abortion will change in the future?

No
Yes
Other (specify)
Not applicable
Don't know
Not asked

24. Have you ever thought about having a baby? No/Yes

If yes, when was that?

Within the last three months
3-12 months ago
Over a year ago
Never thought of having a baby
Other (specify)
Not asked
Not applicable
Don't know

25. Do you want to have children one day?

No/Yes

If yes, when?

Within 2 years
After 2 years
Other (specify)
Don't want children/anymore children
Not applicable
Don't know

26. How many children would you like to have altogether - boys and girls?

Boys
Girls

8 Not applicable
9 Don't know
7 7 and over
**MOTHERS ONLY**

1. How long after the first day of your last proper period did you think you were probably pregnant?
   - [ ] weeks
   - 88 Not applicable
   - 99 Don't know

2. Tell me about your feelings when you FIRST found you were pregnant. How would you have described your pregnancy then? Was it:
   - 1 Planned
   - 2 unplanned but welcome
   - 3 unplanned and at that time unwelcome
   - 4 Other (specify)
   - 8 Not applicable
   - 9 Don't know

3. When you first found you were pregnant, did you think of having a termination? 
   - 1 No
   - 2 Yes
   - 8 Not applicable
   - 9 Don't know

4. Did anyone else suggest to you that you might consider a termination? 
   - 0 No
   - 1 Yes
   - 8 Not applicable
   - 9 Don't know

5. **ASK IF UNPLANNED**
   Did anyone suggest to you that you could have the baby adopted?  
   - No / Yes
   - IF YES, Who was that?
   - [Code as for Q.4: ]

6. **ASK THOSE WHO CONSIDERED AN ABORTION**
   Why didn't you have a termination then?
   - [Code: ]

7. **ASK ALL**
   What was your mother's reaction when she found that you were pregnant?
   - Who told her?
   - [Code: ]

   What did she say?
   - What did she do?

   - [Code mother's reaction: ]
How do you normally get along with your mother?

\[\text{Code:}\]
1. Very well
2. All right
3. Not so well
4. Very badly
5. Never see her
6. Other (specify)
8. Not applicable
9. Don't know

8. Now, what about your stepmother?
What was your stepmother's reaction when she found that you were pregnant?

Who told her?

\[\text{Code as for mother on preceding page: } \underline{\phantom{00}}\]

What did she say?

What did she do?

\[\text{Stepmother's reaction: } \underline{\phantom{00}}\]

How do you normally get along with your stepmother?

\[\text{Code as for mother above: } \underline{\phantom{00}}\]

9. Now what about your father?
What was your father's reaction when he heard that you were pregnant?

Who told him?

\[\text{Code:}\]
1. Respondent
2. Husband/boyfriend
3. Doctor
4. Mother
5. Father guessed
6. Father does not know at all
7. Other (specify)
8. Not applicable
9. Don't know

What did he say?

What did he do?

\[\text{Code father's reaction: As for mother - } \underline{\phantom{00}}\]

How do you normally get along with your father?

\[\text{Code as for mother: } \underline{\phantom{00}}\]

10. Now, what about your stepfather?
What was his reaction when he found that you were pregnant?

Who told him?

\[\text{Code as for father, above: } \underline{\phantom{00}}\]
What did your stepfather say?

12. Do you think having a baby will change your relationship?

[ ] No
[ ] Yes - positively
[ ] Yes - negatively
[ ] Other (specify)
[ ] Not applicable
[ ] Don't know

IF YES, In what way?

What did he do?

/Code stepfather's reaction - as for mother:

How do you normally get along with your stepfather?

[ ]

/Code as for mother:

13. When was the last time you saw your boyfriend/husband?

/Within the last 2 days
[ ] Within the last week but over 2 days ago
[ ] More than a week, but less than a month ago
[ ] Over a month ago
[ ] Other (specify)
[ ] No boyfriend/husband
[ ] Not applicable
[ ] Don't know


Who told him?

(NB initial reaction)

/Code:

[ ] Respondent / he guessed
[ ] Girl's mother
[ ] Girl's father
[ ] Doctor
[ ] Boyfriend/husband does not know
[ ] Respondent has no boyfriend/husband
[ ] Other (specify)
[ ] Not applicable
[ ] Don't know

What did he say?

What did he do?

/Code boyfriend's/husband's reaction - as above:

15. Do you want to have another child? No/Yes

IF YES, when?

/Within 2 years
[ ] After 2 years
[ ] Other (specify)
[ ] Don't want any more children
[ ] Not applicable
[ ] Don't know

16. How many children would you like to have altogether - boys and girls?

Boys

Girls

[ ] Not applicable
[ ] Don't know
17. Is your baby going to live with you?  
If NO, where will the baby be living?

1 Fostered  
2 Adopted  
3 Going to other person (spec.)  
4 Yes, living with mother  
5 Other place (mother and baby home)  
6 Baby died (spina bifida)  
7 Stillbirth (reason unknown)  
8 Other death  
9 Don't know

18. ASK IF NOT LIVING WITH BABY'S FATHER  
Do you receive any financial help from him?  
Have you so far?

| 1 | No help at all |
| 2 | Yes, for baby only |
| 3 | Yes, for respondent only |
| 4 | Yes, for both mother and baby |
| 5 | Yes, but not voluntarily |
| 6 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

IF NO, Why doesn't he help you?

19. ASK UNMARRIED  
Did you consider marrying the baby's father?  

| 1 | No |
| 2 | Yes |
| 3 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

IF YES, Why didn't you then?

20. ASK MARRIED  
Did you fall pregnant before you married?  

| 1 | No |
| 2 | Yes |
| 3 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

IF YES, Would you have got married at that time if you hadn't been pregnant?

| 1 | No |
| 2 | Yes |
| 3 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

IF NO, Do you think you would have married at all?

21. Tell me about having the baby -  
Was your husband/boyfriend present at the birth?

| 1 | No |
| 2 | Yes |
| 3 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

22. Was your delivery normal?

| 1 | Yes |
| 2 | No, forceps |
| 3 | Caesarian |
| 4 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |

23. Was the baby on time or was it premature or late?

| 1 | On time |
| 2 | Premature (specify) |
| 3 | Late (specify) |
| 4 | Other (specify) |
| 8 | Not applicable |
| 9 | Don't know |
24. How much did the baby weigh?

888 Not applicable
999 10 lbs. and over

25. Were you admitted to hospital at any other time(s) during your pregnancy?

[1 No
2 Yes, once
3 Yes, twice
4 Other (specify)
8 Not applicable
9 Don't know

26. Can you tell me something about the first doctors you saw when you became pregnant? What about your GP and the hospital doctor - would you say that they were sympathetic and helpful when they saw you?

GP

HOSPITAL DR.

OTHER DOCTOR (Specify)

[1 Very sympathetic and helpful
2 Quite sympathetic and helpful
3 Neutral
4 Not sympathetic or helpful
5 Unhelpful, rude or obstructive
6 Other (specify)
8 Not applicable
9 Don't know
ASK ALL

Here's a question we've asked you before. You answered it before we asked you all about your own experiences. Do you think your answer might be different now?

Have you ever taken chances at a time you knew it was possible you could become pregnant?

1. No
2. Yes, once or twice
3. Yes, many times
4. Other (specify)
8. Not applicable
9. Don't know
F. THE LAST SECTION IS ABOUT YOUR ATTITUDES TO MEN AND TO MARRIAGE

1. Do you think it is best to have your first baby
   1. When you're a teenager, or
   2. When you're over 20?
   3. Depends on the particular circumstances
   4. Other
   5. Not applicable
   6. Don't know

   Why is that?

2. What about the expense of bringing up a child? Has this had any influence on you?
   1. No
   2. Yes
   3. Other (specify)
   4. Not applicable
   5. Don't know

   In what way?

3. Do you think having the first baby is more important to the
   1. Boy
   2. Girl
   3. Equally important to both
   4. Other (specify)
   5. Not applicable
   6. Don't know

   In what way is it important?

4. Who do you think usually makes the decision to have a baby?
   1. Girl
   2. Boy
   3. Both together
   4. Neither.
   5. Other (specify)
   6. Not applicable
   7. Don't know

5. What do you think is the best way to have a family?
   1. 1 baby when you're a teenager, then more in your twenties
   2. All the babies you want while you're still a teenager
   3. No babies when you're a teenager and all when you're in your twenties
   4. Spread evenly over the years from teenage to 30s
   5. Depends on the particular circumstances
   6. Other
   7. Not applicable
   8. Don't know

6. If you could only have ONE baby in your life, at what age would you choose to have it:
   □ □ □ years
   8. Not applicable
   9. Don't know

7. Do you think most girls look forward to being mothers?
   1. No
   2. Yes, generally
   3. Yes, when they're young
   4. Yes, when they're older/married
   5. Other (specify)
   6. Not applicable
   7. Don't know

8. Do you think most boys look forward to being fathers?
   [Code as above]

9. Which do you think is most important for a girl?
   1. A job or career
   2. A baby and family
   3. Both equally important
   4. Other (specify)
   5. Not applicable
   6. Don't know
10. Some girls decide never to have children. What do you think about that?

And which of the three would be second best?

Why is that?

And the other way? What about that?

11. Some people would say it is better to be married when you have a baby. Do you agree with that?

If no, why not?

12. What about those who say that nowadays it doesn't matter if a girl is single when she has a baby? Do you think it matters?

If yes, why do you think it matters?

13. There are three main types of relationships men and women have — being married, living together but unmarried, and going steady and not living together.

Which of these three ways would you say is the best for you?

What is that?

14. Do you think the same man would make a good partner in all three of these relationships?

If yes, why do you think it matters?

What would you think if the argument came to blows?

15. Some people would say that if a couple has a good argument every now and then it clears the air. Do you agree with that?

If yes, in what way?
27 376

Has this ever happened at your place?

[Code:

To the girl herself:
1. No
2. Yes
3. Other (specify)
8. Not applicable
9. Don't know
4. Not asked

To others in the family:
1. No
7. Yes
3. Other (specify)
8. Not applicable
9. Don't know
4. Not asked

16. Do you think a good husband would also make a good father?
[1. No
2. Yes
3. Other (specify)
8. Not applicable
9. Don't know
4. Not asked

17. Now a final question - How do you see yourself when you're 25?

[TO BE COMPLETED BY INTERVIEWER:

What sort of rapport did you have with this respondent?
1. Very good
2. All right
3. Indifferent
4. Poor
8. Not applicable
9. Don't know

Did you get the impression that you were told the truth throughout the interview?
1. No
2. Yes
3. Other (specify)
9. Don't know

Any other comments?

THESE ARE A FEW EXTRA QUESTIONS WHICH WE WANT TO ASK ALL GIRLS WHO WERE NOT BORN IN THE U.K. OR WHOSE PARENTS WERE NOT BORN HERE.

1. How often do you eat the sort of food eaten in your country of origin?
1. Daily
2. At least once every week
3. About once a month
4. Rarely
5. Never
8. Not applicable
9. Don't know
6. Not asked

2. How often do you read magazines or newspapers which are written especially for people from your country of origin?
1. Daily
2. Once a week
3. Once a month
4. Rarely
5. Never
8. Not applicable
9. Don't know
6. Not asked

3. How many close white English friends do you have?
1. None
2. One or two
3. Three or four
4. Five+
5. Other (specify)
8. Not applicable
9. Don't know
6. Not asked

4. Do you have close ties with friends or relatives in your country of origin?
1. No
2. Yes
3. Other (specify)
8. Not applicable
9. Don't know
6. Not asked

Date:
Time interview ended:
Total time interview took:
Hospital No.
1. Please could you list some of the ways people can make sure that they don't get pregnant:

__________________________________________________________________________

__________________________________________________________________________

2. How old were you when you first learned about periods? __________

3. Who first told you about periods? ____________________________

__________________________________________________________________________

4. How old were you when you first learned where babies come from? _____

5. Who first told you where babies come from? ____________________________

__________________________________________________________________________

6. Have you ever had sex education lessons at school? __________

If yes, what were they called? ____________________________

__________________________________________________________________________

How old were you when you first had them? ____________________________

7. What was the name of your primary school? ____________________________

8. What is/was the name of your secondary school? ____________________________

9. Did the lessons you had include teaching you about: (Circle your answers)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The menstrual cycle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Who gave these lessons? Say whether it was a male or female teacher, a class teacher, or biology teacher or some other subject teacher, or whether the lessons were given by outside speakers, such as nurses, doctors or speakers from Brook Advisory – whatever you can remember.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
11. Who have you talked to most often about sex? ____________________________

12. Who have you found most helpful, talking to about sex? ___________________

13. Apart from talking to people, how else have you learned about sex?

______________________________________________________________________

Tick any of the following which have been sources of information about sex for you, and write in the names of any films, books etc. which you may remember.

Radio/TV programmes
   At school ____________________________
   Elsewhere ____________________________

Films
   At school ____________________________
   Elsewhere ____________________________

Books
   At school ____________________________
   Elsewhere ____________________________

Magazines
   At school ____________________________
   Elsewhere ____________________________

What magazines or comics do you normally read? (Like Woman, or Mate etc.)

______________________________________________________________________

14. Where, or from whom, would you say you have learnt most about contraception?

______________________________________________________________________

15. How old were you when you were first given any sort of information about contraception?

______________________________________________________________________

16. Who do you think should take the main responsibility for making sure that a girl doesn't become pregnant?

______________________________________________________________________

17. Do you think you've got a pretty good idea about contraception?

______________________________________________________________________

18. Would you like to know more about contraception?

______________________________________________________________________
19. Have you ever taken chances at a time when you knew it was possible you could become pregnant?
   (Tick one answer only)  No
   Yes – once or twice
   Yes – many times

20. Do you think avoiding pregnancy is:
   (Tick only one answer)  Luck
   Good Planning

   Do you think it is:
   (Tick only one answer)  Easy
   Difficult

21. How many times did you have sex in the last four weeks? ________

22. Now, imagine you're somewhere far away on holiday, with the man of your dreams and you haven't got any of the contraceptives we can get here. It's a dangerous time of the month for you, you could easily get pregnant and you certainly don't want to. Using your imagination, what could you do to try to make sure you don't get pregnant?


23. Back in London – your best girlfriend asks you where she can get some method of contraception. Where would you advise her to go?


24. But she finds out too late. She's pregnant, but she doesn't want to have a baby right now. Where would you advise her to go?


25. Have any of your close girlfriends ever been pregnant?


26. If they have, what did they do?
27. In this question, we ask you to tell us if you've ever heard of some different methods of contraception, and also to tell us what you think is the main advantage and the main disadvantage of each one.

<table>
<thead>
<tr>
<th>Tick here if you've heard about these</th>
<th>Write below what you think the main ADVANTAGE of each group is</th>
<th>Write below what you think the main DISADVANTAGE of each group is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td></td>
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<tr>
<td>Cap</td>
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<td>Diaphragm</td>
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<td>Chemicals</td>
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<td>Withdrawal</td>
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<td>&quot;Taking care&quot;</td>
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<td>Rhythm</td>
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<td>Safe Period</td>
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<tr>
<td>Washing afterwards</td>
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<tr>
<td>Douching</td>
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<tr>
<td>Injection</td>
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</tbody>
</table>

28. Now, look at the different methods listed above -

List all the methods which you think are VERY RELIABLE:

Now list those which you think are QUITE RELIABLE:

Which ones do you think are NOT VERY RELIABLE:

Now list here the ones you think are definitely UNRELIABLE:
29. Next we want to ask you a few questions about some of the main methods of birth control. Choose ONE answer which you think is right.

About the pill – how long after she forgets to take a pill is a girl in danger of getting pregnant? (Tick one answer only)

6 hours
12 hours
24 hours
2 days

30. About the sheath – when should the man put on the sheath? (Tick one answer only)

One hour before intercourse
Just before he enters the girl's vagina
Straight after reaching a climax

31. About the safe period – at what time in a girl's monthly cycle is she most likely to get pregnant (that is the time which is definitely UNSAFE)?

Just before a period
Just after a period
In the middle between two periods
Any time

32. Now, about abortion – to have an abortion may be harmful to a girl's health if it is done after a certain point in pregnancy. Is this:

After she is 12 weeks pregnant
16 weeks pregnant
20 weeks pregnant
28 weeks pregnant

33. About such things as pessaries, jellies, foams and creams – what is the right way to use these?

On their own
With something else (like Durex or the cap)