

Youth Support - Professional Training
Reprints - Series One No 1

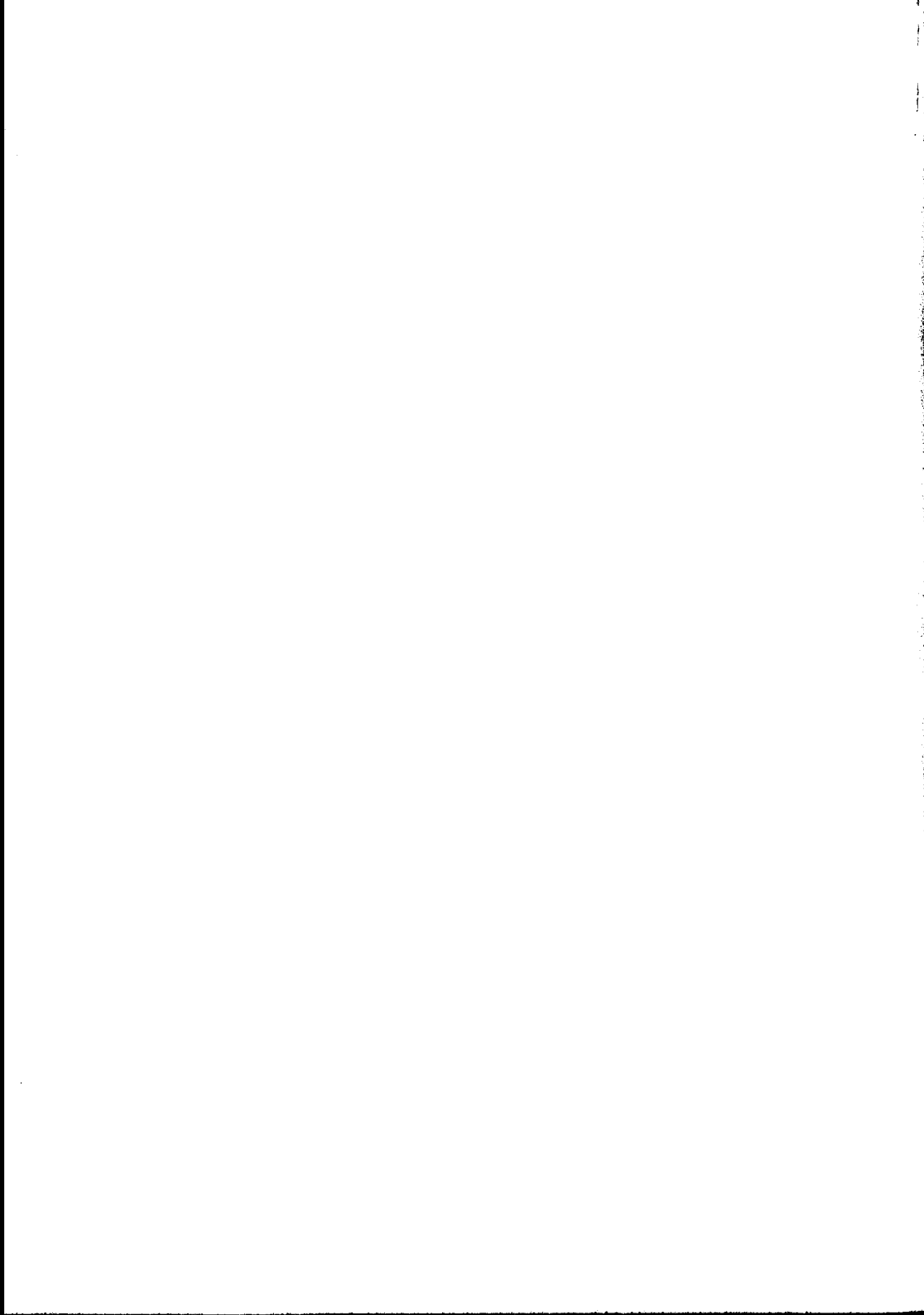
"Schoolgirl Pregnancy".

Chapter 5 - "Progress in Obstetrics
and Gynaecology - vol 7" Jan 1989
(Series editor John Studd).

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Schoolgirl pregnancies

'I didn't really know what was wrong with me and I was feeling sort of funny. Then I got scared 'cos I could feel my stomach sort of moving about. I told my dad I didn't feel well and he took me to the doctor. First he said it was probably wind and "come back next week" but I thought I had something really serious, like maybe cancer or something, so I went back and then he checked me over and he said I was pregnant.' (Susie, 13)

Each year in England and Wales 10 000 schoolgirls make this same discovery.

The media would have us believe that there has been a 'tragic rise in schoolgirl pregnancies'! Is this truly the case? The actual number of pregnancies to schoolgirls has shown fluctuations from year to year but has not substantially altered since 1972. There are, however, proportionately more births in the younger age ranges. In 1973, under-14s accounted for 4% of schoolgirl pregnancies, rising to 6% in 1983 (OPCS 1983) (Table 5.1).

Table 5.1 Number of schoolgirl pregnancies* in England and Wales

	All schoolgirls	Under-16s	Under-14s
1973	10 650	9700	400
1974	10 100	9300	400
1975	10 050	9200	400
1976	9900	9100	400
1977	9800	9000	400
1978	10 000	9100	400
1979	10 000	9100	400
1980	9350	8500	400
1981	9400	8500	400
1982	10 400	9100	500
1983	10 500	9100	600

* These were estimated values (including under-16 conception figures plus figures for a proportion of 16-year-olds).

Nationally, the general fertility rate has fallen. Taking the three decades 1951-1981, numbers of births per 1000 women aged 15-44 years rose by 19% from 1951 to 1961, while births per 1000 girls aged 15-19 years rose alarmingly by 76%. During the next 10 years, rates slowed, showing a fall of 6.7% in the general fertility rate with a smaller rise of 38% in the 15-19-year age group; this trend continued in the period 1971-1981, with a fall of -26%

for all women and a fall of -45% in teenagers (OPCS 1981). The lowest birth rate among teenagers for 20 years occurred in 1981 (Bury 1984).

In considering fertility rates and statistical data on schoolgirls, it is important to differentiate data on under-16s from information on 'teenagers' (the 15-19-year age group). The presence of this younger group of high-risk girls needs to be emphasised since their figures are often masked by analysing data on teenagers as a whole (Stanley & Straton 1981).

The dramatic fall in teenage fertility has been attributed to better contraceptive services. However, while older teenagers (over 16 years) have, to an increasing extent, been protected from unwanted pregnancy by better availability and use of contraception, this has not been the case for the under-16-year age group.

The conception rate for under-16s peaked in the early 1970s, the peak fertility rate for 15- and 16-year-olds being for girls born in 1955. Rates then fell until 1979, but from then on abortion rates have increased and the birth rate has also shown an upward trend since 1982 (Hansard 1983) (Fig. 5.1).

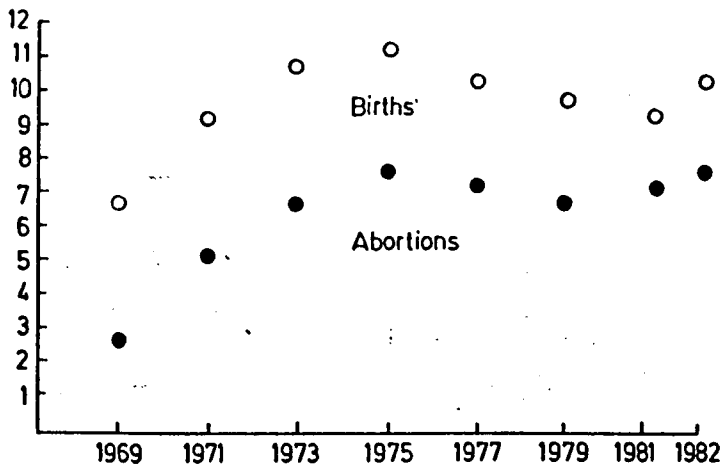


Fig. 5.1 Total pregnancies (○) and abortions (●) per thousand in 15-year-old girls in England and Wales (from Hansard 1983)

SOCIETY AND THE FAMILY

In Britain, schoolgirl pregnancy is part of a culture of poverty and deprivation. Pregnant schoolgirls live in areas of poor housing, overcrowding and unemployment (Fig. 5.2). A 6-year longitudinal study of pregnant schoolgirls

in an inner city area, Camberwell (Birch 1986), revealed that 40% of such families are already known to social service agencies before their daughter's pregnancy, and that 20% of the girls had been in care. 13% of girls have been on the social services 'child abuse' register. The family background is often a violent one (in 29% of cases), with frequent brushes with the law.

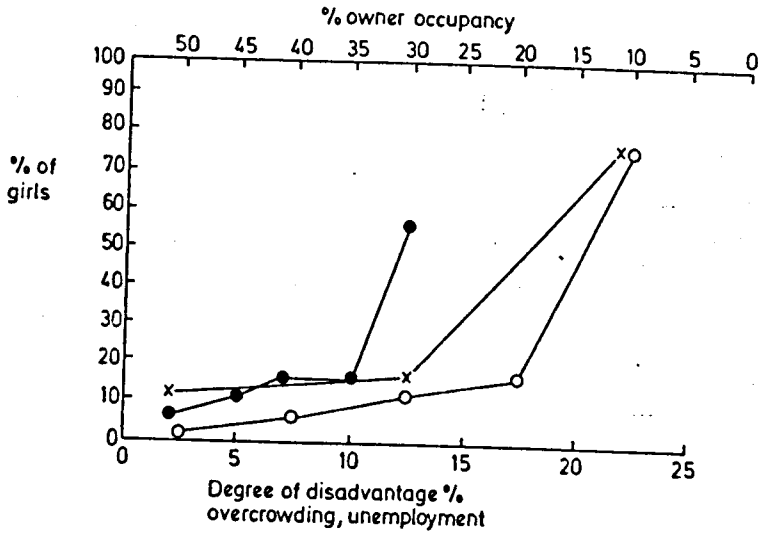


Fig. 5.2 Percentage of pregnant schoolgirls living in ACORN (a classification of residential neighbourhoods) districts with varying degrees of deprivation. ○ = male unemployment; ● = overcrowding; x = housing

The 'typical' pregnant schoolgirl is a member of a large single-parent family (McEwan et al 1974, Birch 1986). In South London, 70% of girls do not live with both of their natural parents, 16% have no mother and 65% have no father. Of those who have a father, one-third have a poor relationship with him and 12% of fathers suffer from mental illness, including severe alcoholism (Birch 1986).

The absence of a father is a critical feature. Fatherless teenage girls may become sexually involved in an attempt to find a kind of paternal caring which is absent in their homes (Zongker 1977, Gispert et al 1984). A poor relationship between pregnant girls and their fathers, who are often ineffectual or absent, may result in girls lacking affirmation of their femininity and thus initiating relationships with immature men who are drug abusers, alcoholics or in jail and with whom they cannot establish a stable relationship (Landy et al 1983).

Pregnant schoolgirls' families fall into three groups as regards the relation-

ship between the girl and her mother (Birch 1986): those where the relationship is a good one (25% of cases), those where the relationship is very poor or the mother is absent (54% of cases), and a third group where there is an 'over-close', suffocating relationship between mother and daughter (21%). This relationship largely results in the exclusion of peers and the father and in the mother assuming control and care of her daughter's baby. Characteristically, the mother is always present at interview and answers questions on her daughter's behalf. 'She also contradicted her daughter's response to questions about the baby' (Parks & Jenkins 1983). The pattern of weak father/dominant mother has been described as a family syndrome which can identify an 'at risk' group (Landy et al 1983).

Despite their single-parent status, families are large with an average of five children, a consequence of a repeating pattern of having a man coming and going and fathering children without living permanently in the household.

Two-thirds of schoolgirl mothers in South London have a family history of teenage pregnancy, and in 35% their mothers have had the same experience. 43% of girls have sisters who are also teenage mothers (Birch 1986) and, interestingly, the same percentage of 'baby fathers' (teenage fathers) also have brothers who are teenage parents (Hendricks & Montgomery 1983).

SEXUALITY AND SEX EDUCATION

As one might expect, in view of the difficult family circumstances, very few pregnant girls have had any sex education at home. 87% of Camberwell girls have learned nothing from their parents about the facts of life, and a further 8% have picked up a very small amount of information from home. This ignorance is further compounded by the fact that 64% of girls have also had no sex education at school. Many become pregnant before the sex education course begins, but most miss out because of truancy. In fact, 62% of pregnant schoolgirls are persistent truants, of whom 20% have been out of school for more than 1 year (Birch 1986), the result being that the most common source of sex education is information picked up from friends, which is often unreliable and inaccurate (Reichelt & Werley 1975, Ashken & Soddy 1980, Birch 1986) (Fig. 5.3, SD 2). These findings clearly refute the often-quoted opinion that sex education in schools encourages promiscuity, while supporting the premise that it is 'those young people most in ignorance who tend to experiment early and to suffer the consequences of unwanted pregnancies and sexually transmitted diseases' (Christopher 1978).

Contrary to popular belief, pregnant schoolgirls are not a promiscuous group. They tend to have long-standing relationships or to follow a pattern of 'serial monogamy', having a series of fairly long relationships in which they are 'faithful' to that one person (Farrell 1978, Ashken & Soddy 1980, Bury 1984, Tobin 1985). Most pregnancies are unplanned (98% of cases) but arise out of a regular sexual relationship (59%). For two-thirds of girls

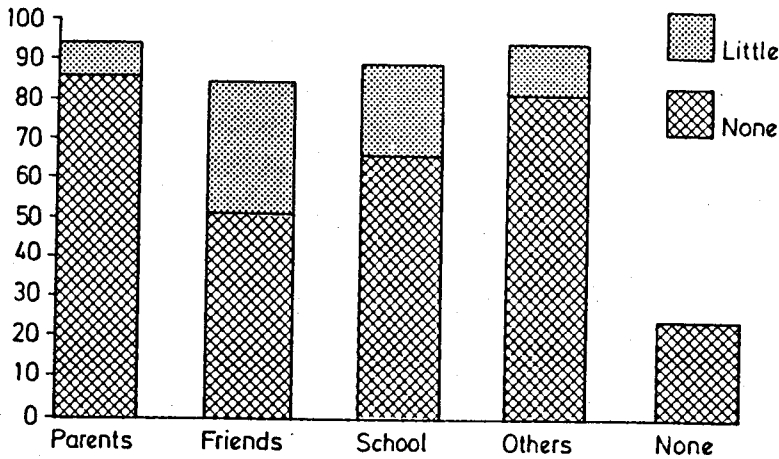


Fig. 5.3 Sex education sources

this is their first sexual relationship, and 5% conceive the first time they sleep with a boy. In South London, this first sexual encounter occurs at an average age of 13.5 years, 1 year later than the mean menarche of 12.5 years (Birch 1986).

Although most pregnant girls have stable relationships with boys and 77% have known their 'baby fathers' for more than 6 months, a subgroup of girls can be identified who have been sexually abused (11%), involved in an incestuous relationship (6%) or introduced to prostitution (9%). This subgroup of sexually exploited young girls has a very poor prognosis. A review of their circumstances 2 years after the birth of their babies revealed that half had become involved in prostitution and an equal number were drug abusers; moreover, their babies constituted 60% of the cases of child abuse occurring within the sample (Birch 1986).

REALISATIONS AND DECISIONS

Being largely ignorant of the facts of life, it is hardly surprising to find that girls do not immediately realise that they are pregnant. One-third of Camberwell girls did not realise the significance of missed periods or did not realise that they were late, and 90% were unsure of the date of their last period; those that did miss periods generally missed three before suspecting pregnancy. Younger girls took longer to realise that they were pregnant; only 33% of those aged 12-13 years eventually realised the significance of amenorrhoea, as opposed to 68% at 14 years and 78% at 15 years. 4% of girls were alerted to pregnancy by fetal movements and 1% by actual labour, and 20% were informed of their pregnancies by a sister or mother who realised that

she was putting on weight or had not used sanitary towels for some time (Birch 1986).

Realisation of pregnancy can be a crisis point. Many girls cannot cope with this realisation and deny it to themselves, or they may try to hide their pregnancies, fearing discovery by their parents or teachers or to prevent their boyfriends from getting into trouble.

'I kept convincing myself I wasn't—I kept missing periods but I kept putting it off, saying nay, it's just ... I was saying to myself, I've had sex so it's most probably changing my body or something. Just giving myself any old excuse.' (Janet, 15, 'Schoolgirl Mum' 1985)

Faced with the monumental decision of what to do, who to tell and who to trust, the reaction of many girls is to do nothing and tell nobody. The 'average' pregnant schoolgirl takes no action until 15 weeks' gestation; her boyfriend is usually the first to be told, followed by her parents or family doctor. Most girls find it very difficult to tell their parents about their pregnancies. They avoid the problem by asking a sister to tell them or using ploys such as semi-deliberately leaving their antenatal appointment cards where their parents will find it. One-third of girls never tell their parents, but in half of these cases the parents notice themselves (Birch 1986).

Nationally 2 out of 3 pregnant schoolgirls decide to terminate their pregnancies; however, in areas of socioeconomic deprivation a higher proportion of girls go to term (Simkins 1984, Straton & Stanley 1983). In Camberwell, only 1 in 4 girls choose abortion (Birch 1986, Dean 1984).

Younger teenagers present late for abortion due to failure to realise that they are pregnant, concealment of pregnancy, and conflicts with parents. They thus have a higher rate of late, more dangerous abortions. 81% of Newcastle girls aged under 16 years presented for termination after 10 weeks' gestation as opposed to 75% of 17–19-year-old teenagers (Russell 1983). This later presentation produced a 4% increase in lacerated cervix, a 5% increase in retained products, a 4% increase in uterine infection and a higher mortality. In the United States, where schoolgirl pregnancies show the highest rate of a 'developed' country, mortality from legal abortions rose from 0.5 in 100 000 at 8 weeks' gestation to 1.4 at 10 weeks, 2.3 at 12 weeks and 6.7 at 15 weeks (National Center for Health Statistics 1976). However, 'the later a girl applies for an abortion—the more she needs it' (Ketting 1982, Savage 1985).

Three-quarters of girls who eventually keep their babies make this decision as soon as they realise that they are pregnant (Birch 1986). Others decide to terminate and later change their minds, often under family pressure, and 10% present too late for abortion. In 62% of cases the decision of girl, boyfriend and parents concur, but when disagreement occurs a great deal of stress and unhappiness results. 13% of Camberwell schoolgirls were forced either to abort their pregnancies or to keep their babies against their wills, often with the result that they became pregnant again or rejected their chil-

dren. Adoption is not a popular option. In America, only 7% of girls chose adoption (Block et al 1981), while in Camberwell the 2% who did so were strongly pressured by their families who sent them to London to have their babies in secret (Birch 1986).

ANTENATAL CARE

In the 1950s and 1960s the social stigma attached to a teenage pregnancy discouraged young girls from attending hospital, resulting in poor antenatal care and thus higher obstetric risks (Marchetti & Menaker 1950, Morrison 1953, Hassan & Falls 1964, Mussio 1962).

The general standard of care has improved over the last 20 years, but many girls book late and attend hospital irregularly with the result that 'the antenatal care of pregnant teenagers is often grossly deficient' (Block et al 1981). One-fifth of teenagers under 20 years of age do not consult their general practitioners until they are more than 20 weeks pregnant (Simms & Smith 1983).

The situation for younger, school-age teenagers is even worse: over half (52%) of South London schoolgirls book for antenatal care after 20 weeks gestation (Birch 1986). Girls do not realise that they are pregnant and conceal their pregnancies. Some girls wait until they are 16 years old before coming to the clinic, 'risking their health and that of their future child because of the state of the law' (McEwan et al 1974). Problems of diagnosis also occur; there is a tendency for some professionals not to want to believe that a very young girl could be pregnant.

'My mum sent me to the doctor's when I was about four months, because I hadn't been on the periods. So the doctor said it was just puppy fat. So then she sent me back when I was seven and a half months and he said it was wind... (Kirsty, 14, 'Schoolgirl Mum')

'He said I definitely was not pregnant but my mother said I was because I was too fat so she made him write a letter for the hospital.' Julie was an emergency admission from the termination counselling clinic at 38 weeks' gestation with severe pre-eclampsia. Her baby died at 10 months of age—a 'cot death'.

If antenatal care is adequate, the risks of childbearing do not appear to be greater for the teenager than for older women, but the risks to the baby are increased, particularly for very young mothers (Straton & Stanley 1983). Multiparous mothers are more likely to have small-for-dates babies if they are younger and have little prenatal care, but in the case of primiparous mothers poor care exerts a more powerful influence than young age (Elster 1984).

Many studies have reported higher rates of anaemia in teenage patients than in older pregnant women and the rates of anaemia (defined as less than 10 g of haemoglobin per 100 ml) have been shown to be inversely proportional to the age of the sample group (Jovanovitch 1972, Elliott & Beazley 1980,

Osbourne & Howat 1981, Scholl et al 1984, Miller & Field 1984). The rates of anaemia in these studies were in the region of 14% (mainly in the 16-year and under age group).

The increased frequency of anaemia in teenagers is related to socioeconomic circumstances (Russell 1983, Miller & Field 1984). In Liverpool, young girls attending hospital in a deprived area of the city were more likely to be anaemic (18%) than in the more affluent areas (6%) (Elliott & Beazley 1980). The incidence of anaemia in pregnant Camberwell schoolgirls is high at 19% (Birch 1986).

Camberwell has a deprived population where 57% of pregnant schoolgirls have no employed parent and 33% have a grossly inadequate diet. If one excludes girls with an associated haemoglobinopathy—HbS or HbC—which are present in 10% of the overall sample, the rate of antenatal anaemia is still 16%. White anaemic girls are more likely to come from homes with no employed parent (100%), have a poor diet (86%) and book late for antenatal care (65%). The mean time of booking for anaemic girls is at 24 weeks' gestation as opposed to 20 weeks for all schoolgirls. Hence it would appear that those girls most in need of antenatal care are less likely to receive it.

Studies have varied in their findings regarding hypertension in pregnant teenagers. In Australia a higher incidence of pre-eclampsia was found in the under 16s (16.6%) than in older mothers aged 20–25 years (14.7%), although hypertension alone was shown not to be significant (O'Brien et al 1982). Other workers have found hypertension to be more common (Duenhoeelter et al 1975). In Camberwell, the overall incidence of hypertension (defined as a diastolic measurement of 90+ mmHg) was found to be 18%, with an increased incidence in the upper range of schoolgirls (16 years and over) which was associated with an increase in smoking and drinking alcohol during pregnancy (Birch 1986) (Fig. 5.4).

THE BIRTH

'Obstetric complications are bedevilled with conflicting reports using different control groups' (Block et al 1981). 'With the exception of preeclampsia and a small bony pelvis the majority of complications are due to lack of prenatal care rather than maternal age' (McKenry et al 1979).

Maternal mortality rates can give a false picture if age groups are not considered separately. The maternal mortality for girls aged 16–19 years at 9.6 in 100 000 (OPCS 1981) is actually considerably better than the national mean of 13 in 100 000, whereas the mortality for mothers aged less than 16 years is very high at 49 in 100 000. These parameters can equal out if all teenage births are taken together, thus giving a false impression that there is little difference in maternal mortality rates for all teenagers and older mothers.

In Glasgow, obstetric risks were not significantly different in all teenagers (under 20 years) than in older women (20–24 years), but an 'at risk' group of younger teenagers who remained single was defined. They were more

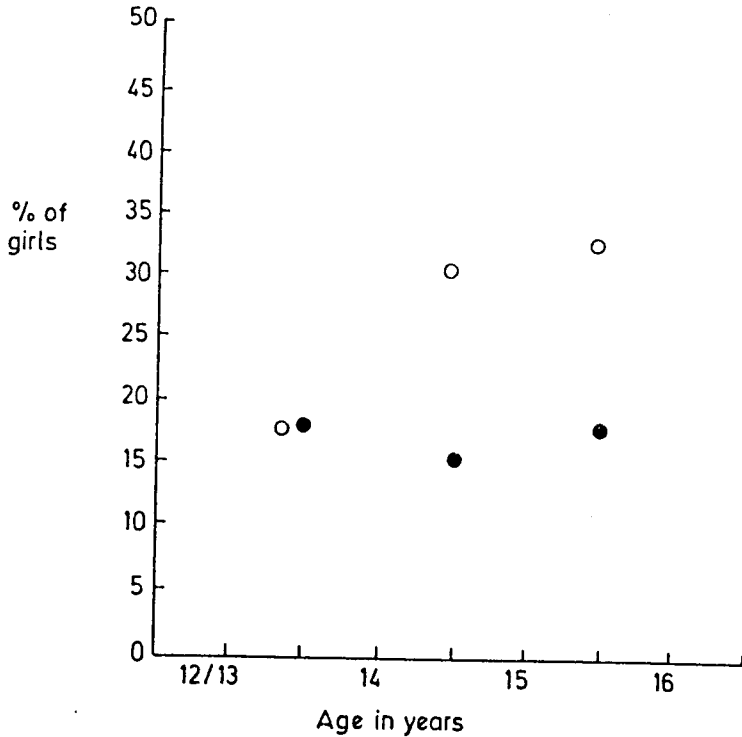


Fig. 5.4 Percentage of cases of high blood pressure (●) by age group (○ = smoking/alcohol)

likely to go into premature labour and had a higher perinatal mortality than those who married.

It might be expected that the teenager's pelvis may not be fully grown by the time she delivers her baby, thus giving high rates of cephalo-pelvic disproportion and caesarean section. Russell (1983) did not find a high caesarean section rate in Newcastle girls, while Glaswegian teenagers actually had a lower rate (9.2%) than women 20–24 years (14.7%) (Osbourne et al 1981), nor was the incidence of operative delivery increased in Liverpool in the under-16s (Elliott & Beazley 1980).

In the United States, Duenhoelter et al (1975) found that, while the rates of contracted pelvis were high, the caesarean section rate was not raised significantly. Dwyer (1974) found very low rates of all delivery complications and particularly a low caesarean rate—2.6% overall (6% current hospital average). He concluded that the female pelvis is not contracted because it is fully grown before a girl is physiologically old enough to reproduce.

Possibly there are not more operative deliveries because although the teenager's pelvis is smaller, the babies are of lower birthweights. In Camberwell,

77% of schoolgirls experienced a normal delivery, the caesarean section rate was 10% (Birch 1986). Some of the 'problem deliveries' presented difficulties not normally recorded in obstetric textbooks—such as Sabrina, who delivered at home by candle-light when the electricity was cut off; or Kim, who was so afraid that she tried to get up and go home when her baby's head appeared; or sexually abused Marie, whose waters broke prematurely in my car on our way from seeing a psychiatrist.

BIRTHWEIGHT AND PERINATAL MORTALITY

Figures from the National Birthday Trust and Royal College of Obstetricians and Gynaecologists survey (1970) showed perinatal mortality for babies of mothers under 20 years to be one of the highest.

Illegitimacy, independent of age, is a predictor of low birth weight and high perinatal mortality. The important factors which have been shown to be more important than age for teenage mothers are marital status at conception [Gill et al (Aberdeen) 1970, Osbourne & Howat (Glasgow) 1981, Ventura & Hendershot (USA) 1984], timing of antenatal care (Ventura & Hendershot 1984) and socioeconomic status (Phipps-Yonas 1980).

Whereas in general second babies have a lower risk of perinatal mortality, the highest mortality rates are among children of teenage mothers who have already borne a child (Lambert 1976). This higher perinatal mortality in multipara is unfortunate since 25% of girls are pregnant again within 12 months (Block et al 1981, Birch 1986).

The precise effect of nutrition on pregnancy outcome is not entirely clear, although studies would suggest that attention to adequate food intake and quality of diet can only be beneficial to the pregnant schoolgirl and her developing baby (Block et al 1981). Alton, in 1979, studied dietary habits in pregnant schoolgirls enrolled in an American school-based pregnancy programme and found that, even in this relatively well cared for group, 75% of girls had diets that were deficient in protein content.

In the Camberwell study, one-third of girls were regarded as having a poor diet. These girls had a diet that was grossly deficient in both quantity and quality. Two were clinically anaemic due to dietary causes and two were generally debilitated, very thin and weak because they had too little to eat. All families were on low incomes so that they were unable to spend much money on food, and two-thirds were surviving on supplementary benefit only. The younger girls had poorer diets than the older girls. This was associated with the birth of smaller babies (Birch 1986) (Fig. 5.5).

In Liverpool, 10% of under-16s gave birth to babies weighing less than 2500 g (Elliott & Beazley 1980) and this same figure was recorded in Camberwell primiparous schoolgirls (Birch 1986), where the number of small babies was inversely proportional to the girl's age and increased with repeat pregnancies (16%).

Dietary supplements have been provided for women considered to be 'nutri-

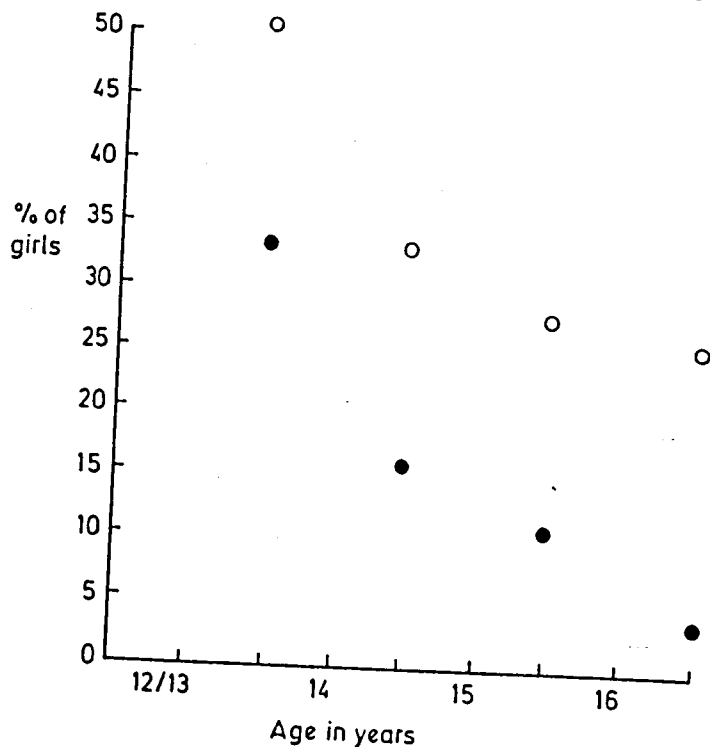


Fig. 5.5 Percentage of premature babies—relationship between age and diet (○ = poor diet; ● = premature delivery)

tionally at risk', with the result of an improved obstetric outcome [Blackwell et al (Taiwan) 1973, Lechtig et al (Guatemala) 1975, Scholl et al (USA) 1984]. Teenagers on relatively good diets have been shown to have similar pregnancy weight gains to older women, while still giving birth to smaller babies. Girls on poor diets have poor weight gains and even smaller babies [Frisancho et al (Peru) 1983].

'Health and social factors are more important to fetal outcome among primiparous mothers than adolescent status' (Zuckerman 1983). 'The prevalence of low birthweight is not due to their age but to sociodemographic features of women of this age who carry their pregnancies to term' (Horon et al 1985). Thus it would appear that factors other than maternal age per se influence the obstetric outcome and numbers of small babies borne by young mothers. The diet and social habits of young people are important. Young people start smoking because they perceive it to be an adult behaviour (Bewley 1984). These same teenagers are likely to be those experimenting in other 'adult behaviours' such as sexual activity, drinking alcohol or using drugs.

It has been estimated that smoking less than 20 cigarettes per day during pregnancy results in a 150–200 mg reduction in birth weight and a 20% increase in neonatal death rate (Martin 1982), while heavy smoking more than doubles the chances of a girl losing her baby at or near birth (Surgeon General 1980).

Few estimates have been made of the drinking and smoking habits of pregnant schoolgirls. In Camberwell, 33% smoked and 30% had more than the occasional drink. These figures are likely to be underestimates due to the common problem of under-reporting and denial of alcoholism. Alcohol abuse and drug-taking are well known to affect fetal growth (Ghishan & Greene 1983, Meadows et al 1981). Less well known are the effects of solvent abuse or 'glue sniffing' which is becoming more prevalent among young people. It is to some extent a substitute for alcohol in the young since it is cheaper and often more readily available to under-age, under-privileged teenagers.

WHY DO SCHOOLGIRLS BECOME PREGANT?

Why do so many girls become pregnant at an early age? A multitude of factors are involved which are equally applicable to the often-forgotten teenage 'baby father'. Social and family problems deprive boys and girls of love and self-worth. These emotionally immature young people are brought together by their loneliness and, by virtue of their lack of knowledge and motivation to control their reproductive ability, have unprotected sex, resulting in school-age pregnancy.

The majority of schoolgirls become pregnant as the 'inadvertent consequence of a normal erotic relationship in itself desired and rewarding, abnormal only in that the usual social taboos had not been effective ...' (Anderson et al 1960). Social taboos may be broken down by social deprivation; absent or working mothers unable to talk to their daughters and set examples of behaviour; overcrowding causing lack of privacy; boredom and frustration encouraging early sexual experimentation; and the model of peers and siblings who may also be sexually active.

Some pregnant girls seem to have an unconscious desire to get pregnant, are trapped in a culture of poverty (McKenry et al 1979) and use pregnancy as a supposed avenue of escape from an unhappy life and to resolve their own sense of dependency and deprivation (Phipps-Yonas 1980). Others are seen to be re-enacting unhappy circumstances rather than escaping from them. 'They need to do so largely to understand and excuse their mothers' behaviour towards themselves' (Gough 1966).

Pregnant schoolgirls have difficulty in developing and sustaining interpersonal relationships (Cohen 1983); both peer and family relationships are poor (Elster 1983, Landy et al 1983). These young people are lonely, feel unloved and may become involved in a sexual relationship to cope with their loneliness. A sexual relationship is merely part of the spectrum of possible

relationships, and some girls may inadvertently become pregnant while exploring the possibilities of such a relationship and attempting to define their own boundaries.

An experience of failure, for instance in poor school performance and in failing to be lovable, is common in young pregnant girls (Elster 1983, Ulvedal & Feeg 1983), resulting in a feeling that 'the only thing I can do right is have a baby' (Rosenstock 1980).

Physical maturity may be coupled with psychological immaturity. Lacking the adolescent change from concrete to abstract reasoning (Blum & Resnick 1982), a young girl has no clear sense of a personal future (Babikian & Goldman 1971); she is thus unable to plan ahead. Such a girl is unable to visualise how having a baby might change her life. She is unable to appreciate the consequences of her actions in that having sex might result in a baby and is therefore unable to take steps to protect herself by using contraception.

Older teenagers (16-19 years) have been using contraception more effectively (Bury 1984), but this has not been the case for sexually active, under-16s who continue to have a very low rate of contraceptive use (Zelnik et al 1979, Miller 1984, Schinke 1984).

Contraceptive use among the British under-16s is difficult to quantify. The extensive studies of Schofield in the 1960s and by Farrell and Dunnell in the 1970s relate mainly to older teenagers (15-19 years). There is a vast difference in contraceptive use between under- and over-16s, both in motivation to use, knowledge of and availability of contraception. Contraceptive use prior to pregnancy in an American sample was only 9% for girls aged 12-15 years and 25% for older teenagers (Miller 1984).

Knowledge of contraception among pregnant teenagers in Camberwell in 1974 was poor and frequently inappropriate. 17% of under-17s used spermicides or withdrawal only and 49% had never used anything (McEwan et al 1974). Only 7% of a younger sample of pregnant Camberwell schoolgirls had ever used any contraception prior to their first pregnancy (Birch 1986). Girls gave varied reasons for non-use of contraception, the most common being that they did not think that they could get pregnant and they had not expected to have sex.

'I never thought I could get pregnant, I thought I was too young. I mean you hear about girls at school getting pregnant and you think, "She's having sex", you don't think you are, you don't think it'll happen to you, do you?' (Annette, 15)

Young girls do not want to use contraceptives because this implies that they are planning to have sex, which indicates promiscuity. If they use contraceptives they are acknowledging that they are sexually active, something which they are denying to themselves.

'If my mum knew I was on the pill she would think I was sleeping around.' (Janet, 15)

'Let's face it—good girls don't—so they don't need the pill; bad girls go out and do it anyway!' (Dianne, 16)

The low rate of contraceptive use results in it being a rarity for young people seeking contraceptive advice not to have been involved in unprotected sex. Half of pregnancies occur in the first 6 months after a girl starts to have intercourse, and 20% occur in the first month (Zabin et al 1979). We must therefore reach teenagers before they begin sexual activity in order to be effective with family planning programmes. The median delay for contraceptive clinic attendance is 12 months, but the median delay for pregnancy is 6 months (Zabin et al 1979).

After giving birth to unplanned babies, and in many cases unwanted babies, schoolgirl mothers still demonstrate low levels of contraceptive use and high failure rates. In Camberwell, one-third never used any contraception during a 2-year follow-up period. There was poor compliance with methods and girls did not follow instructions adequately. Some appeared not to actually want contraception: they were given pills and did not take them; coils fell out and girls did not bother to go back to the clinic—one girl certainly pulled it out herself. Girls did not like barrier methods and they proved ineffective. Depot injections were more the choice of the doctor than their own (Birch 1986).

Why is contraceptive use so poor even after an unwanted pregnancy? Do these girls need to take risks? Are they so used to being unable to control their environment and bodies that the idea of controlling their reproductive capacities is totally alien to them? Unwanted pregnancy is the ultimate form of loss of control over one's body. Is this their subconscious aim? Is there a tendency for professionals to push these girls into using contraception against their true wishes because the concept of young mothers having another child is considered undesirable?

Seen from the young girl's viewpoint, pregnancy may not be so undesirable. Certainly it brings heartache and hardship, the extent of which should not be underestimated, but for underprivileged girls with little education and non-existent job prospects, motherhood is a fulfilment. With the birth of her baby a 'failed' school drop-out, an unemployable misfit, becomes an acceptable member of society with a valued role—that of a mother. She is successful, and out of her loveless world she has created her own baby who will love her.

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