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# Journal of Adolescent Health and Welfare

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*Incorporating the Newsletter of the International Regional Chapter of the Society for Adolescent Medicine*

*Dear Colleagues,* - **Letter from the editor** -

*This is a jam-packed edition - lots of comments about the Conference in Israel last year and the first part of the International Institute write up from San Francisco.*

*We have had some problems with the mailing of the last issue (summer 1997) with some going astray so if you missed out and now would like a copy - please write and let us know. Also we would VERY MUCH appreciate any help people can give us with postage - the 'foreign' post outs are very expensive and as a charity the costs are beginning to hurt - whereas on an individual basis you can probably all afford to donate something towards postage .. please …*

*The conference bookings are coming in for 1998 - so send in your forms soon please to guarantee a place. The new rooms at Youth Support house are ready and occupied and the half way house / semi independance unit is almost ready … after building delays - so referrals can now be accepted.*

*Hope to see you all at the evening meeting in October '97 and at the International meeting October 1998.*

*Diana Birch*
*Director Youth Support*

## *Contents*

## * CONFERENCE ROUND UP *

### - Personal views of those attending recent conferences -

**FIRST INTERNATIONAL CONFERENCE ON HEALTH AND CULTURE IN ADOLESCENCE - 24-27th November 1996 Paradise Hotel - Jerusalem - Israel**

Impressions from Youth Support Staff who travelled to the conference We were due to be a large contingent-Sheila Atherley; Vivene Gordon; Esther Mensah; Ann Slater;John Ryan and myself-Diana Birch sadly a dose of flu' put paid to my travel plans and the following reports only served to make me more jealous that I missed the conference!

**Ann Slater** - Senior Nursery Nurse - Youth Support House.

A new and expanding state. A country of contrasts - you can go from crowded cities to the open desert. Then in the middle of the desert you come across lush green settlements. Life in the midst of dry sand and rock. A guide said it was the politicians who caused conflict once all the politicians go peace will come. The majority of the people in Israel just want to get on and live together, working for the future. Young boys and girls are conscripted into the army - boys for three years and girls for two. They are in a constant state of war; even off duty the young men carry their guns with them. We didn't feel comfortable but it must make the people feel safe. To be under the constant threat of bombings must be a strain but life goes on and daily routines carried out. A bag was left on the bus we travelled in, the conductor just took the bag and opened it. We were a little concerned - it could have been a bomb! On another occasion we were in MacDonalds (yes,they even have one in Israel) when a young soldier and his daughter were eating and laughing together - across his lap was his gun; unnerving for us,normal for them.

Israel is truly cosmopolitan people from all four corners of the world arrive to help a new land grow, to be free to practise their religion. Many come from war torn countries or repression, they give up everything, even their families. Many adolescents come to Israel to be educated, and their families later join them. They not only have to learn a new culture and way of life but also a new and difficult language People we met were friendly,happy and welcoming.

***"It was a place I had never thought I would see. To be able to visit places I had only heard about in the bible was magical. I will never forget it."***

This was the first international conference on health and culture in adolescence. Over 35 countries took part, with one thing in common - the education and understanding of their young. Each country had its own problems and ways of dealing them - some government funded, some run as part of the church, and some charities. AIDS, drugs, sexual and alcohol abuse,eating disorder teenage violence and problems facing young immigrants to Israel were discussed. A full programme, lots to take in. Many facts and figures, too many to absorb, but the overall outcome was a world wide consensus that youth are finding it hard coping with

growing up,need to be listened to and need help to find their way.

The part of the conference I am going to write about has its beginnings 50 years ago in Nazi Germany. Nir was a 9 year old Jewish boy living with a widowed mother and a sister in Poland. For 6 years they lived in fear of capture and death evading capture through deception cleverness, endurance and luck, not allowed outside their home as he looked Jewish he spent six years hidden away, losing his childhood and becoming a man before his time. Yehuda Nir is, to give him his full title, MD,Clinical Professor Division of Child and Adolescent Psychiatry at University Medical College, New York. In 1989 he published his memoirs, The Lost Childhood, which open with a quote from Samuel Beckett:"Let me say before I go any further that I forgive nobody. I wish them all an atrocious life and then the fires and ice of hell, in the execrable generations to come.."

But in 1995 he journeyed for the first time since the war to Dessau, Germany, to hear a production of Lohengrin directed by Gottfried Wagner Gottfried Wagner, the great-grandson of the composer Richard Wagner was born in 1947 and grew up in Germany. At the age of nine he began to discover the role his family played in Nazi Germany and the part they played in the Holocaust Since then he had dedicated his life to both German and Jewish survivors. Disinherited by his wealthy and influential family,he now lives in Italy with his wife and young adopted son. He has sent photos and letters to his father but all were sent back unanswered. He is treated like this because he dared question the Holocaust and feel guilt. These two men who have lived their very different lives talked many times together and became friends, united in the quest that what happened in the second World war never happens again.

**Sheila Atherley** - Senior Nurse - Youth Support House.

Israel is an historic country with many exciting and beautiful sights. It was wonderful to visit places I had heard about in the bible as a child, especially to wade in the Dead Sea. The visit to Masada was breathtaking,a good start to the trip. It was particularly interesting to learn something about Jewish culture and customs.Orthodox Jews adhere strictlyto the religious practice of the Sabbath. No work is done, no hot meals served and they use special lifts in the hotel during this period. On public transport they never sit next to women.

The conference was interesting and covered varied topics. I was particularly interested in the Bedouin tribe. We saw the tents and people on the way to Masada. The Bedouins are a tribe living mainly in the hills, and keep very much to themselves. According to Dr Aref Abu-Rabia the Bedouin are a society in transition in terms of their social and cultural situation. Some conduct their daily lives according to tradition, whilst others follow modern lifestyles.

The Bedouin have taken on aspects of western culture and experience sicknesses previously unknown to them such as heart disease, ulcers, high blood pressure, diabetes and social stress. The changing patterns of behaviour of the modern Bedouin is an example

of internalisation of western culture evidenced by changes in traditional diet and medicine. There is a dichotomy between traditional remedies and western medicine - to quote Dr Abu Rabia "There are ambivalent attitudes to the causes of illness and appropriate modes of cure". i.e., the older generation still practise the old traditional medicine whilst the younger generation are inclined to resort to modern methods. As the Bedouin become more influenced by western culture and experience more western ailments and diseases they will need to adopt more western remedies. There is also a danger that the Bedouin culture will be submerged in western culture and tradition. During the meeting I presented "The adolescent parent-A fifteen year longitudinal study of school age mothers and their children" on behalf of Dr Diana Birch.

**The first International Conference on Health and Culture in Adolescence - An Impression.**

**Vivene Gordon - Principal Nurse - Youth Support**

In November1996 we were fortunate enough to be part of a delegation to the First International Conference on Health & Culture in Adolescence. The conference stretched over a week and the timetable was extremely intense. On days it would begin at 8am and end at 6pm. This is a brief overview of the issues and events which struck me and our gains from the experience.

The conference was comprised of experts and workers from all over the world presenting talks on differing aspects of adolescent behaviour and different world solutions for youth problems. This aspect of the visit was interesting and informative although at times it was difficult for the laymen to understand the complexities of the talks. We submitted a paper by Dr Diana Birch who sadly could not attend the conference. Her presentation was a longitudinal study of young mothers and their children questioning the myths surrounding the schoolage mother in the west.

Speakers presented papers on a wide range of issues. For example Francis Wing-Lin spoke of 'night-drifting' in HongKong where an isolated subculture of young people gather in groups all through the night causing disruption and drawing public attention. This study employed the use of in depth interviews and exploratory studies. We heard talks about teenage violence, sexual education depression and sexual abuse. One of particular interest was a South African study which dealt with suicidal behaviour and prevention of suicide in contemporary society. We gained a wide perspective from international studies and experiments. However the sum of our experience encompassed more than what we heard within the conference wall. We were also lucky enough to travel around the country and the spiritual experience was awesome.

One of my first impressions was not surprisingly religious. The orthodox presence in Israel is very strong. For example at the conference and in the hotel there were separate lifts for religious groups. We arrived at the hotel during the period of Shabbat. Everything is closed down during this period.This was of great interest and the people of Israel were extremely warm, welcoming and friendly. Nevertheless the culture difference could cause problems. At one stage a woman in the group sat next to a man in

the bus. The gentleman became extremely angry as we had not realised that a woman may not sit next to a man in their culture.

Despite the intense schedule of the conference we visited many areas of interest and witness much of the culture of the country. We saw the Bedouins, travelling nomads who live off the land. We visited castles including the historical castle of Herod the great. These were extremely high above sea level and were reached by cable ca. We also visited Nativity church which claims the exact spot where Christ was born attracting crowds of people lining to kiss the spot. We visited the Garden of Gethsemane and from there we could see the road Jesus took the Golden Gates and Mount of Olives. We witnessed a scheme by the Israeli government dealing with Ethiopian adolescent immigrants without their parents called the Goldstein Youth Village. Youth villages deal with adolescents in distress who have experienced a discontinuation of their culture and must adapt to a new one. In order for children to integrate into the culture, they are placed in an adolescent village where they can learn the Israeli language and culture.At seventeen they are automatically conscripted The hope is that they will eventually be able to join their parents. While there we were treated by a musical performance by one of the young visitors. They gave us more direct evidence of tactics used in other countries to solve problems experienced by young people. The scheme seemed very effective and well done although reasons may be purely political.

The experience gained was invaluable educational and enlightening. It is impressive that groups from all over the world were able to come together and share knowledge and experience of dealing with young people in different societies.

**"THE ADOLESCENT PARENT - A FIFTEEN YEAR LONGITUDINAL STUDY OF SCHOOL AGE MOTHERS AND THEIR CHILDREN."**

**DR DIANA M.L. BIRCH**

Most behaviour, including early childbearing is measured as problematic in terms of how it measures up to the norms and values of a particular society or group. In many developed nations school age pregnancy is regarded as a 'deviant' pattern arising from lack of contraceptive availability, poverty and ignorance and resulting in poor parenting standards, and family disturbance. For a great many young mothers however pregnancy is desirable and very much the norm of their family culture. Continuing this argument, there are also many cultures where early marriage and pregnancy is very much desired and one should separate the 'problems' raised by cultural expectations and lack of societal support from the personal and individual conflicts and stresses which might be caused by early pregnancy.

Findings of a fifteen year longitudinal study of nearly 200 young families in which the mother gave birth under the age of 16 years has provided information which refutes many of the stereotypic views regarding young parents. It illustrates how the presence of a supportive family leads to an improved prognosis for young mothers and their children and gives insights into positive and negative

predictive factors. Some unexpected outcomes and their possible aetiology are discussed.

Consideration is given to approaches which may enable professionals to confront the 'cultural trap' in which many young people are caught - in that those suffering the worst deprivation in early childhood, those raised in the 'care' system and children's homes are those young parents most likely to perpetuate the cycle of deprivation for their offspring.

**Introduction -**

***"The Doll that Grew Up"*** **-**

Lorna's bedroom was like that of any fourteen year old - walls papered with posters and cut outs from teen magazines and bits of record covers - a football scarf draped round the light switch and a scatter of old cinema tickets and memorabilia blue-tacked to the mirror. The floor obscured by discarded school books and dirty underwear with the odd sweet wrapper, cotton wool balls and mother's 'borrowed' best shoes. Mixed in among the tea shirt collection on the bed lay the required row of furry animals and mascots - teddy, pink pig, Emu puppet, cabbage patch kid doll which she had pleaded for on her tenth birthday, grotesque stuffed 'something' which Mum won for her at the Easter fair ..... and a baby.

She had never gone out much; was certainly not promiscuous and had no boyfriend then, now or ever. The baby was conceived on an ill-fated outing with friends when the little 'stay at home' was persuaded to have one taste of the bright life. On return from hospital with little David she sat shell shocked in her room - not knowing whether to play with baby or toys and alternating between them with mother anxiously hovering. She slept with David beside her in his carry cot and Teddy snuggled up to her inside the covers.

Fifteen years later she still has no boyfriend, she hardly ever goes out except to visit Mum. David is a fine boy, quiet and well mannered and his mother's only companion.

* * * * *

Sonia also got pregnant at fourteen but was delighted to have her baby. Her one and only boyfriend stuck by her and they are now married with a delightful family of four children ranging in age from 14 to 6. Sonia is working and has taken up professional training. She would like to become a therapist.

* * * * *

The lives of young mothers have taken many turns along differing paths in the fifteen years that we have followed them. For some it has been a success story, for others the road has been paved with disaster - some are lonely and sad - others have come through pain and hardship with immense fortitude.

Whatever the outcome - the one message that we need to learn from these stories is not to prejudge young parents - there are many stereotypes and many false impressions and whatever concept we may have of teenage parenthood we are likely to be wrong - we need to keep a completely open mind and remember that all parents - young or old,

are individuals and deserve unique attention.

* * * * *

**The study - "Are you my sister, Mummy?" - Early studies on teenage pregnancy** - This first part of the survey provided an important database regarding pregnant schoolgirls and their circumstances. It was a vital piece of work since previously available information had dealt with American groups whose population was not comparable in any demographic or social sense. We needed information on our own population to examine the factors, risks and social stresses of the environment pertinent to British teenagers. (Birch 1987)[1] An information base was important in terms of understanding factors which led to early pregnancy and childbearing - what motivated young people, what the family's influence might be and how we might intervene to help at any stage.

Contact was made with every school girl who became pregnant in a specific geographical area - covered by a London Health District. All school girls falling pregnant and who by intent or by default continued their pregnancies within a time limit were included - addition to the group began in 1980 and ceased in 1987. The first 126 cases were analysed for baseline data and formed part of an MD thesis (Birch 1986) [2]; 150 cases were reported in the book "Are you my sister, Mummy?" ; 174 entered long term study which is fully described in "The child that rocks the cradle" (Birch 1996)[3].

The initial piece of research involved a number of stages :-

- base line information gathering during the pregnancy
- data regarding the birth
- six week follow up
- six month follow up
- one year follow up
- two year follow up

**The fifteen year survey.**
Further survey points have been:-

- five years follow up
- ten years follow up
- fifteen years follow up

**Findings and comments** - It is hard to do justice in a paper to the findings of a fifteen year survey which has generated volumes of data on this population - both in terms of statistical facts and , perhaps even more importantly, in terms of qualitative information. The following is thus a brief summary of some of the more pertinent features of the study.

**A. Fertility and Repeat pregnancy**
Those who have been pregnant as schoolgirls are a highly fertile population. They begin their childbearing career at an early age and are likely to remain fertile during a large segment of their life span. The rate of repeat pregnancies continued to be high throughout the years. Each follow up showed a high number of girls had become pregnant again since the last interview.

Childbearing patterns- Three sub-populations were identifiable :-
1) **Single pregnancies** - girls who have one pregnancy only.(12%)
2) **Constant repeaters** - who maintain a high level of repeat pregnancy throughout (68%)
3) **Late repeaters** - girls who have one pregnancy as a school girl then do not have repeat pregnancy until they enter a

second later stage of child bearing (adult childbearing stage) (20%)

This group of young women have a higher fertility rate than other girls of the same age. The risk of pregnancy is particularly high during the first year after the birth of the first child when teenage mums are eight times more likely to get pregnant (250 live births per thousand) than the general teenage (< 20) population (30 per thousand) [4].

Girls who had been in care tended to have more pregnancies over the years than those who had not been in care. Girls from more difficult circumstances may have a greater need to repeat their pregnancies. They form a greater percentage (90%) of the 'constant repeater' group.

**B. Patterns of Relationships.**
**Staying Together-Single Partners.** The myth of the promiscuous schoolgirl mother was exploded when it was noted that at the time of conception, over two thirds of the couples had been together for more than six months and for over two thirds of the girls this was their first sexual relationship. Fifteen years later over a third of the girls (39%) have only ever had one boyfriend. For another 12% the 'rescuing' boy who entered their lives at an early stage during pregnancy or in the first months of the baby's life and became an 'early replacement father' was the only other man on the scene. So 51% of the girls only had one significant relationship.
**Multiple Partners.** Nearly half the sample (49%) follow a serial monogamy of more than two partners. Girls who 'bounce' from one man to another without breaking down have a high level of flexibility which allows them to adapt to these differing domestic arrangements - but a low ability to learn from their experiences - they thus continue to 'repeat' their pattern. The parade of parenting partners takes a toll - both on the children - in terms of instability, inconstant boundaries and on the mothers experiencing recurrent loss and being left 'holding the baby' quite literally over and over again. A need to fill a 'father shaped' gap in her life coupled with low self esteem means that she is likely to form a relationship with an inadequate man or a boy with problems of his own. He is placed under enormous pressure to cope with a needy 'instant family'. He too does not enter the arena in a pristine state - nor does he leave the scene unscathed.

**Asexual lives.Girls without Boyfriends.** 10% of the girls did not ever have a real relationship with a boy after the birth of their first and only child. They feel let down by society and by the father of their child and do not seek sexual relationships in the future. Some never actually had a boyfriend EVER.

**The Late Relationship - the 'Adult' Relationship.** Many mothers who had been through painful periods in their lives made a deliberate change of life-style and passed through a threshold in identifying with their new 'adult' selves.They had 'teen' and later 'adult' lives

**C. Families**
There are many different family structures. Our society in general has moved away from the

single idea of the nuclear family - mother, father and two children - as being the only acceptable pattern. Single parent families are much more the 'norm' than when this study commenced in the early eighties. It has also become more acceptable for couples to live together outside marriage.

**The family of origin of the teenage mothers.** They generally came from large single parent families with an average of five children. Two thirds of their natural fathers were absent from the household and the 'father figure' was usually a man who moved in and out of the 'family' fathering more children and then going on his way. Neither fathers nor stepfathers figured significantly in most girls lives.

Just under half the girls (45%) got on with their mothers but in half the of these cases - a fifth of the whole (21%) - the relationship was described as 'over close' and suffocating. The families fell into the main groups of - good relationships with both parents ; absent or weak father and dominant or poor relationship with mother; both parents absent or ineffectual. To a large extent this family pattern was recreated in the next generation.

**Baby Fathers** - It was noted in the early part of the study that the boyfriends of schoolgirl mothers tended to be of similar background and characteristics - dropping out of school, not often in employment, having similar family histories of school age pregnancies with regard to their mothers and sisters and had similar needs to become parents. Despite all the negative connotations and difficulties a reasonably high number of the natural fathers of the first born children were still in contact with their offspring at the age of two years. (45%). Past this stage a number of 'baby-fathers' dropped out of the children's lives with the result that by the time the children were in their teens themselves only 20% of fathers were still in touch with their children. This figure was significantly different for the partners of young mothers who had been in care - they were ten times less likely to maintain contact with their children (2%).

**Grandmothers** often have a very hard time coping with their children and grandchildren. It is also extremely difficult for a child brought up by grandparents who may be too old to do some of the 'parental' task or have fun. Children are also immensely bereaved when grandparents who have been their prime carers eventually die. Children who had been brought up by grandparents were markedly deprived in comparison to those brought up by their parents.

**D. The Children**

**Child Care -Placement of Children**

The majority of children were brought up by their natural mothers and lived with them throughout the time of the survey. 80% of the children were with their natural mothers at 5 years and this dropped very slightly to 78% at 10 years and 75% at 15 years. Splitting the groups into subgroups of girls who have been in care and those who had not, once more the care group had a worse prognosis with only 62% continuing to care for their children at 15 years as

opposed to 82% of the non care group.

**Children's Views and Lifestyles** The children of school age mothers are like other children of the same age. As teenagers they have similar likes and dislikes and indulge in all the usual teenage activities. In the main they came across as a confident and healthy group.

**School** - Forty percent of the boys reported being bullied at school, but often this was part of a two way process of disruptive behaviour since 70% had behavioural problems relating to violence in school, fighting and disregarding teachers. A quarter of the boys had been involved in something illegal.

The rates for girls were lower. 20% had behavioural problems at school and were disruptive in class. 35% were bullied at school. 6% had been involved in minor crime.

**Relationships with Parents** - 80% of boys and 95% of girls said they get on with their parents. Half the boys (50%) and rather more of the girls (70%) said they could talk to Mum about most things and 50% of boys and two thirds of the girls said they would confide in their mothers if they had problems.

Pregnant schoolgirls often lack a father figure in their lives. Their sons seem greatly affected by lack of a father within the household. It is the boys who appear to be reaching out to a paternal figure, miss their fathers and get involved in early sexual liaisons possibly in an attempt to identify with the father figure. This axis of father / teenage son has often previously been ignored in the study of causes of early pregnancies. A significant factor in prevention of early pregnancy is the psychological and emotional status of the boy.

**Sex Education.** 50% of boys and 75% of girls had knowledge of sex education, 10% of boys and 50% of girls learned this from their mothers which was a significant improvement on the previous generation.

**Sexual Activity.** Boys are more sexually active than the girls some started as early as 11 Most used condoms but 15% boys had unprotected sex.

**Conclusions.**
The influence of the care system is pernicious and young mothers who have been in care do worse than those who have not over a number of different dimensions. They have more children, they have more relationships, their relationships are less stable and more of their children end up in care themselves ... But is this an influence of the care system alone - does being a young Mum who has been in care differ from being an older Mum who happens to have been in care? If you are a family on low income, you are more likely to have a daughter who is pregnant young ... if you are in an area of social deprivation ... you are more likely to have a schoolgirl who is pregnant .... Schoolgirl pregnancy is very much a 'culture of poverty' ("Schoolgirl Pregnancy - a Culture of Poverty")[5] and traps deprived girls in a cycle of derivation.

"The repercussions of teenage childbearing are long lasting: the young parents acquire less education than their

contemporaries ; they are more often limited to less prestigious jobs and the women, to more dead end ones. .." (Card and Wise 78)[6]. "The adolescent mothers consistently experienced great difficulty in realising their life plans when compared to their classmates who did not become pregnant premaritally in their early teens .." (Furstenberg 76)[7]. If you are in care you are more likely to get pregnant early - in our sample 22% of the pregnant girls had been in care at a time when less than 2% of the child population of the area was in care. The important message is that if families are supported and the effect of social deprivation and poverty is minimised. then not only will the rate of 'premature' motherhood diminish - but those mothers who do start their families early will be able to raise their families happily and well.

There is a group of girls who wish to become pregnant at an early age, are ready for it, are mature emotionally and physically and if it were not for the stigmatising of our society and the lack of support - they would have every chance of success. Others are immature, they neither desire motherhood nor feel able to cope with the birth of their children, they may pass the child over to the care of others. Between these two extremes we have a whole spectrum of girls who though not actively and consciously seeking pregnancy, nevertheless are happy to be mothers and make some emotional or existential gain by virtue of their 'mothering' status. Most important in this context is the gain in self esteem and a sense of 'purpose'in life. Even from the other side of the Atlantic, where the general view is perhaps more pessimistic than ours, there are encouraging comments - "Some adolescent parents do overcome the handicaps imposed by adolescent childbearing; they complete their education, get decent jobs, avoid welfare dependency ..." (Furstenberg and Crawford 1978)[8]

Most studies from the USA show that children of teenage mothers do badly in comparison to their peers. (East and Felice 90)[9] " .... The children of teenage mothers are distinctly worse off throughout childhood than the offspring of older childbearers." (Furstenberg, Brooks-Gunn and Chase-Lansdale 89)[10]. In Britain the same factors operate to an extent but are highly dependant on social status of young mothers rather than her age per se. Children can bear a heavy burden when they are expected to fulfil the role of 'little parent' to their child mothers. These children fill a need in their parents, provide love, fulfilment and self worth. Perhaps in some ways this is a valid role? These children are valued, wanted and loved in return. What more could a child want?

The male first born children seem to fare worse. Daughters take the role of sisters and at least have a mother as role model and confidante - something the young mothers wish they had themselves. Sons have no role model,do not know quite how to relate to their mothers who they often end up 'fathering'. Single mothers can lack the knowledge and resources to appreciate and provide for their developing sons needs. These very first born sons are more prone to early sexual acting out and their numbers swell the ranks of the less supportive and

less stable teenage fathers for the next generation.

Families certainly play an important role. Girls tend to recreate their family of origin. Those with good supportive families fare better. Those with no families do worse. But there are casualties and surprise successes in all life styles.

Being a young parent is not the end of your life and dreams - it need not be a life of toil and hardship - sadly for some unfortunate families it can be - but given adequate support young parents can do remarkably well. Perhaps it is time to stop condemning young families and instead try to help them. To look for the positive attributes of young parents and work on them rather than spell doom and gloom with negative statistics. Young mothers have the potential to succeed in all walks of life - if we give them the chance to do so.

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## - International Chapter News -

News of the **International Regional Chapter (IRC)** of SAM
(Society for Adolescent Medicine)

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| Co Chairs - | Diana Birch | Gustavo Girard | Treasurer Aric Schichor |
| | London | Buenos Aires | Connecticut |
| | England | Argentina | USA |

In this issue we are including several 'International' contributions and some of the Proceedings of our 1997 'Institute' San Francisco March 5th Unfortunately we do not have space to print all the contributions - since it was rather a long Institute - but the others will be printed in subsequent journals - *patience!*

The plan for the 1998 'Institute' is as follows -

*- SAM meeting 1998 - Atlanta - International Regional Chapter Institute -*

***The Exploitation of Youth - an International Perspective.***

*Wednesday March 4th 1998 1pm - 5pm*

*Outline - Our youth are our resource for the future - but are we exploiting that resource? Across the world employers know that youth are a source of low waged labour, from teens working in fast food outlets to primary school children whose tiny hands can knot high quality carpets. They often work in dangerous and abusive conditions. Adolescent sexuality provides another rich area for exploitation - sexual tourism is on the increase and young prostitutes of both sexes are a prime attraction. Presentations will look at types of exploitation in differing cultures from the USA to the far east and raise the question of 'where lie our responsibilities and our role in prevention?*

*Aim - To increase awareness of how our societies exploit young people and to discuss ways in which we might be able to intervene to prevent some of this abuse.*

Suggestions and contributions welcome.

**Society for Adolescent Medicine - San Francisco March 5-9 1997**

## *'Poverty and Neglect - Deprived Youth in varied societies'*

**Description** - *Deprivation comes in all shapes and sizes* - Those of us working in so called 'developed' countries can sometimes be oblivious of the degree of deprivation experienced by our Youth. Class differences still exist in terms of perinatal mortality, birth weights and growth in schoolchildren. Adolescents from differing subcultures within the same city may experience enormous variations in their socio-economic circumstances . Presentations will highlight the presence of deprivation in all aspects of youth culture - from street children to poverty in inner city Europe and north America and including the 'poverty traps' such as early childbearing and the 'danger areas' of child and youth labour and 'survival sex'.

**Objectives** - To heighten awareness of the areas of deprivation and youth poverty, to exchange information on a wide experience of cross cultural issues and to discuss possible interventions available to the adolescent health practitioner.

### ■ Programme - ■

**Poverty and Neglect - An Overview**
Welcome and introductions (Diana Birch and Gustavo Girard).
"Global trends in Adolescent Health - From where have we come - where are we going?" Robert Blum, Minnesota.

**Deprivation in the midst of plenty?** -
"Teenage Pregnancy - A culture of poverty?" Diana Birch, England.

*.... To be continued ..... The following will appear in the next issue of the Journal -*

"Deprivation among immigrant Youth" - Manny Chigier Israel.
"Marginalized Youth in British Columbia" Roger Tonkin, Canada.
Greetings from the President of SAM - Gail Slap.
"Nutritional issues affecting Youth" Semi Sznajderman, Israel

**Growing up in Poverty - Youth in deprived societies.**
"Deprivation in Latin America - how are youth affected? " Gustavo Girard - Argentina.
"Living on the Streets - Health concerns of street youth in Brazil" Irene Adams - Brazil
"Attitudes and Practices of Physicians in Israel regarding adolescent Medicine" - Daniel Hardoff

## *'Poverty and Neglect - Deprived Youth in Varied Societies'*

### "Global Trends in Adolescent Health - From Where have we come - where are we going?"

**Robert Blum - Minnesota**

In my presentation I'd like to talk a little bit about the trends that we see globally, what do those trends mean and then what is it that we know about programming for young people that makes a difference and how do we organise programmes that support young people in a time of tremendous change.

I would like at first to focus on some of the social and demographic changes. Changes that we see across the world today are nothing short of dramatic. We see for example that 30% of the worlds population are young people between the ages of 10 and 24; 83.5% of that population of young people live in developing countries. The number in many countries, for example in sub-Saharan Africa, the number of young people under the age of 24 are five times greater and even under the age of fifteen - in some of sub-Saharan Africa half the population is under the age of fifteen - that applies to Kenya, in Mali in Mozambique .

In many developing countries young people represent 25% of the population, compare that to France or Japan where it is 13 % or China 16%. Clearly young people today represent a major force and a major part of the population throughout the world.

Well some of these trends seem to tie in with what we see in life expectancy. As life expectancy has increased dramatically in industrialised countries at the upper age range - we have not seen comparable rises in developing countries as yet. In Latin America and in Africa where we have seen such changes, they have been in the youngest age groups. Their child survival has increased dramatically. The consequence of child survival, the work that was done in the 1970s and 1980s is that we now have a bolus of young people moving into adolescence and into adulthood.

It is because of those demographic changes as well as because of those social and economic changes that are happening in those countries that today adolescence is on an International agenda in a way that it never has been before. Some of the social changes that we are seeing includes migration, and migration is not just between countries but it is within countries as well.

Its rural to urban migration and while there as always been rural to urban migration, it has been the men, males who have travelled to the urban areas to work for the week ad to the return home to the rural areas back to the village at the weekend. But what we are now seeing is a greater migration of young women, more than young men who are travelling from the country to the city, so you have in a city like Bogota for example a three five to four ratio of females to males under the age of twenty four.

Another change that is occurring is the rising value of education. That change is being seen around

the world again where the pressure is increasing and the desire is increasing among young people for attending school and to stay in school, so there is a hope that with education will come social development and social progress. These changes in many ways are akin to changes that we saw in North America and in Europe in 1910 and in 1920. Prior to 1910 there was virtually no universal education mandated, these changes were all within this century for industrialised countries and are beginning now I developing countries as well, additionally as well what we are seeing which goes along with education is a rise in the age of marriage, well if you live in a world village and you are 12 or 13 years of age and education is not in your career path anyway then age of marriage doesn't pose any problems, child bearing doesn't pose problems large families, high infant mortality in fact had a certain protective value, but today, with these changes in urbanisation and education there is likewise a push, in may countries there is a very deliberate strategy, of family planning to delay the age of marriage.

We have seen marriage delayed for example in Tunisia and in Indonesia with very significantly positive effects in reducing childbirth. What we also see however that with the postponement of marriage a whole new set of problems which heretofore never occurred because you have for the first time an extended time from puberty to marriage with added risk - of out of wedlock births become of more of a concern. Certainly if you marry at the age of 12 you don't have a high out of wedlock birth risk.

What have probably not changed dramatically are sexual behaviours. What has changed is the context in which those behaviours occur.

What we have seen , and this is of relevance throughout the world, that ethnic minorities are disadvantaged. If you are in Brazil and black you are disadvantaged if you are American Indian in the united States you are disadvantaged, if you are an ethnic minority anywhere in the world you have a tendency to be disadvantaged
What we are seeing today is a rising voice in ethnic minorities throughout the world who are strongly speaking out and in many settings are striking out to claim their rightful portion of the resources of a country, so we have these significant changes.

As we have said we are also seeing this vast shift to urbanisation, in France Japan, Brazil Columbia, United States, in many countries almost the entire population live in urban settings , you have cities such as San Palo where twenty million people live in them, Cairo with an estimated 18 million people so we are seeing the spawning of not just urban centres but of mega urban centres whose size and scope is almost incomprehensible.

With the changes in urbanisation there are a number of very major social changes, one is the disintegration of the traditional family. And traditional structures. For example in many communities in Africa, marriage does not exist as it exists for example in the USA or Europe where March 3rd you walk down the aisle and someone says you are married, it is much more of a

process, it's a process where sometime around the age of puberty perhaps your parents build you a hut right behind their hut , that makes a lot of sense to me, and you live in the hut and maybe at some point you meet somebody and then at some point maybe depending on the society you are going to move into her hut or she is going to move into your hut. And at some point maybe with childbirth or maybe after a certain length of time or depending on a pronouncement depending on the society they say you guys are together now for good, for real and there is some sense of connectedness. Take that kind of process and put it in an urban setting and it does not work, it falls apart .. and so it is with many many other issues.
I said there was a push towards education with the hope that with it would come social and economic benefits that certainly was the promise of many of our grandparents, great grandparents and even parents, but in many countries of the world and particularly in Africa, education is by no means a guaranteed pathway to social and economic benefits because there is not the economic substrate to sustain it, so what we have is people moving from the countryside to the city in hope of better life ad jobs but what they are left with is rising unemployment and with rising unemployment comes rising violence, you also get suicide and youth suicide is a relatively new phenomenon in developing countries and certainly reflects the changes in developing countries throughout the world.

There are some other consequences of education as well. Clearly there are positive consequences, but one of the things we see is a delay in the age of marriage because as I said before, marriage certainly gets in the way of schooling and what we also see is a rise in out of wedlock birth, because of the delay in marriage and the lack of change of sexual behaviours.

And therefore there is a rise in clandestine abortions. It has been estimated in six countries in Latin America that there are approximately 2 million clandestine abortions per year. In Africa in six East and South African countries 66% of kids 15-19 years old that we surveyed - that is about 7,000 kids in six countries said that they knew someone who had an abortion.

There is a wide range of abortions that are clandestine abortions that range from absolutely illegal, insanitary to where in some countries even though illegal there is a high tolerance of abortion it is estimated that abortions account for 40 to 50 percent of all maternal deaths in countries where they are illegal because of haemorrhage and sepsis and the other thing which holds good for abortions as for HIV and Aids is that it is a phenomenon of those who are in school and have high hopes, hence it is wiping out the intelligentsia. It is wiping out those who have completed their schooling, who have completed their university because it is those who are in the cities who are delaying their marriage and are at greatest risk for these conditions.

Let us touch on trends for mortality and morbidity. For both industrialised countries, and for developing countries what we are seeing clearly is a convergence

of issues around mortality unintentional injuries, suicide, homicide and maternal mortality are really the major causes of death in nearly every country of the world but when we look at mortality trends there are a number of countries where we have data that calls for some level of optimism. In the decade 1980/1990 we saw a 13% decline in mortality in the second decade of life in the United States, I should also say that it was not evenly distributed For American white males we saw a decline of 17%. Among African American black males we saw an increase in mortality of 11 % so while we see this overall trend - it is not even.

There is a decline in Latin America of 3.5% and 7.5% in France so there seem to be some general trends that are pointing in a positive direction. Some of the things that we see as the causes of these trends is the declining mortality in vehicular deaths. Between 1986 and 1992 in the USA we saw a 38% decline in vehicular deaths. Another is that the primary causes of mortality remain unintentional injury, homicide, suicide war and males are 2 to 4 times more likely to die than females during adolescence and this is true in every single country where we have been able to look at it.

Mortality declines from birth to 14 years of age and then begins to rise at 15 years of age and beyond when there is a disproportionate increase in deaths in males and this all suggests behavioural factors are responsible.

When we look at suicide what we see during the decade of the eighties is that most countries there has been a dramatic increase. In some countries and particularly those where there has been a dramatic social change the rates are particularly high - and where there has been political upheaval we continue to see this through the nineties, the previous Soviet Union, the changes with the fall of communism , dramatic increases in suicide and homicide, interestingly countries that had a decline in the 80s such as Czechoslovakia and Hungary and for some reason Venezuela, in the last ten years have had a dramatic rise in suicide. Particularly in eastern European countries.

Traditionally countries that have had a lower rate have been the Mediterranean, Latin America and the Muslim countries and Saharan Africa. There is certainly a religious bias that becomes a reporting bias but even so the rates are lower.

Industrialised countries of Europe, the pacific basin and the far east have the highest rates. I think that these data underscore a very important perspective for us - we tend to think of ourselves as developed and of poor countries as undeveloped but a measure of social stress and community angst is suicide and certainly many in poorer countries look at what is going on in the industrialised world and ask is this really what we want - is this the end product that we are aiming for. In the industrialised world we have paid a very high price for the social changes and the economic benefits that we sustain.

Some of the factors which influence suicide rates include the sort of social changes we

have been looking at. Main influences include - unemployment, dual parent employment, divorce rate which has gone up many fold to over 50% in the USA, high homicide rates, alcohol use rising, this whole set of patterns and secularisation of society. This is a issue which is hotly debated in the USA and very much politicised but the reality is that belief is protective - it is protective on an individual level and it is protective on a society level. We also should note social disruption, overcrowding, urban stress societal norms that sanction it - such as some countries in the east.

As I indicated maternal mortality is one of the major causes of early death and 50% of maternal deaths are due to abortion complications another set of problems that are more prevalent in young women are cephalo-pelvic disproportion and ritual mutilation causing disproportion, haemorrhage, toxaemia and sepsis. Finally what we are seeing in eastern Europe is that at least 25% of maternal deaths are due to abortion. This is surprising given the tradition that in eastern Europe there was not ready availability of contraception and abortion was an accepted method of limitation of birth rate and the prime contraceptive method in many countries, in Russia for example.

When we look at issues relating to violence and homicide it used to be said that in the United States had a disproportionately high rate of homicide. The USA has a higher rate of juvenile deaths from violence than the other 25 industrialised countries put together. Other areas are also seeing rises in violence - Columbia 28% - Jamaica street gangs etc.

In the new Independent Eastern European states homicide violence accounts for 80o% of the excess mortality. Increase in violence is a major global issue, access o weapons is increasing around the world and access to drugs also. Drugs that used to be export drugs in poor countries are increasingly being used locally also and this is associated with increasing violence.

When we look at morbidity we must also consider HIV infection. Seropositivity is increasing significantly. Age of sexual debut is falling in El Salvador 40% report having had sex by age 15. In Spain 45%, in Nigeria about half the population, in North America and Europe 40-60% the trends of sexual debut do not vary vastly from one region to another. What we have is some variability within regions and certainly there are areas that are significant exceptions - for example the Muslim countries, Japan have much different ages of sexual debut although even there it is declining.

What does vary significantly though is birth rate from 2/1000 in Japan to 59/1000 in the USA. However although one can say that Japan varies because of the late age of sexual debut, the same cannot be said for Denmark, the Netherlands or UK which have a lower rate than the USA so what must be different is contraceptive behaviour.

One of the consequences which we are likewise seeing in countries around the world that are willing to look at it - is the rise in out of wedlock births - in the USA we saw a rise from 10% to 76%

from 1960 to the present and interestingly in a paper that is just about to be published out of Chile it was identical and so these trends that we are seeing are not unique to a single population - one of the things that is occurring which I think is very significant - those who are from Europe in North America - your grandmother or great grandmother had how many children? I hear in the back of the room 10 - 9 five was a small family - 10, 9, 14 was common in the United States at the turn of the century - we have gone from that size family - think about it - is there a person here in the United States - anyone who knows a family with 12 children today? It is not in our frame of reference - but it was in grandma's frame of reference. In two generations we have shrunk our family sizes. The first significant change is not a change of behaviour but a change of desire - and what we have seen is a change of desire of what is the normal family size. People, women want smaller families and I would suggest men want smaller family sizes as well. The reasons are economic families 1975 - 1985 the ideal family size shrunk by as much as a third. - based on family fertility data. Contraception continues to rise and there is a growing awareness of contraceptive alternatives. People want smaller families, contraceptive awareness in Kenya Thailand Brazil - in small rural villages - where there are 90-95% of young people aware of contraception - I am amazed there is that level of awareness. Clearly behaviour and use of contraception lags behind.

There are many reasons for this the barriers to contraception - clearly one is cost and in many countries the cost of a months supply is $22 - in Brazil $3; Israel $6; $3/4 Mexico Argentina $11 very expensive - and even if you take $3/4 per month kids whose income may be selling the odd cigarette on the street - that may be al they make and so the possibility of using these kinds of methods may be extraordinarily prohibitive. Barrier methods too - in Russia - local made condoms break whereas western condoms cost a lot more.

There are many legal barriers also for adolescents or unmarried women to obtain contraceptives. Medically we should be looking at safeguarding women over the age of 35 from the side effects but over the counter use of oral contraceptives for young women makes very good sense.

Cultural issues also involve the stress between cultural groups when one uses contraception more than the other and may be worried about dwindling population - example was given from the audience by Indian delegate regarding Hindu / Moslem issues. The focus is on population reduction and whether it is race or culture within countries or contraceptive 'imperialism' these are major issues there are many examples of programmes that are very culturally sensitive and are grounded in the local community that are very sensitive and respond to local issues rather than a political agenda.

Alcohol and drug use - 47% of fourth graders in Australia (about 16 years old) use alcohol. In the USA we have seen a decline in heavy drinking and this decline has continued through 1996 data .

Let us pull some of these threads together - there are some common issues. How do we ground our programmes in the community to serve local need and be effective?

There have been a generation of projects and programmes that look at what works and what does not - almost every problem focused intervention fails - the data in all focused interventions is terrible. Look at a few in the USA that have had high levels of publicity - DARE - on drug abuse prevention - repeatedly shown to be an ineffective agency. Scared Straight - in the late 80 as a wonderful violence prevention strategy - ineffective . Christian Moore came out last year with a two volume analysis of teen pregnancy prevention programmes and she concludes that maybe , maybe six programmes work - that is not many given the number of programmes and the hundreds of millions of dollars invested. We know we must formulate more effective programmes, we know that if we take any risk factor, we can improve the outcomes for kids, we know that there is no discrete risk factor for discrete problems and the most effective programmes are those that strengthen families, improve education and provide economic opportunities and there are some terrific examples, terrific examples from the poorest communities across the world. One in Argentina where a guy started to work with homeless kids and getting them to paint buildings and he started tying their work into school - they had to go to school and then work - they got money and education. In Chile a baker did the same thing. In New York a guy went to his elementary school and said he would support every kid who would stay in school. \they say if we support you in this way - then the other problems will diminish. These programmes have something in common - they know how to provide a connectedness. We know from a decade of research that establishing social bonding - the 'connectedness' that links people to each other is the number one most important thing that protects young people from harm. Kids that feel connected to adults are protected from harm. Sure every drug dealer in the world knows the principles of social bonding. A guy is standing on the street corner and a ten year old comes by and he says - .. 'I want you to go across the street and deliver this package and come back to em and I'll give you money'. … he makes a successful trip - using his skills and the man says - you did a great job , come round again and do some more things for me. This dealer provides opportunity for participation and active involvement , teaches skills for participation - this dealer did not give the kid a task which was beyond him, he gave him something which was appropriate to his level - he did not give him 15 packages and a list - he gave one package at a time, just perfect for a ten year old, and there was recognition and there was reward for a job well done - that is how we create a sense of connectedness of kids with each other and kids with the community.

Optimally interventions need to be multi system, involving family, school , community, they need to be based on a set of principles which focus on known risk factors, interventions based on what is known to work and frequently there is a political compulsion to invest in things

which we know don't work. We are about to embark in this country , perhaps because we have far too much money, on a two hundred million dollar investment in teen pregnancy prevention under the name of abstinence only education which we know does not work, it has been demonstrated not to work, and yet we will do it anyway. We institute DARE programmes in school after school all over the country even though we know it does not reduce drug use and we still propagate school clinics knowing that they do not reduce school pregnancy.

We must base our interventions on what we know will work, we must focus on risk factors but also on protective factors and we must intervene early before behaviours stabilise. I would proposed a model for thinking through an approach. Young people's service need four factors in order to be successful - 1 - you need an adult , one they can trust, who cares and with whom they can feel connected. 2 - They need the opportunity to make a contribution - we talk about youth involvement and participation - but it is important because the opportunity to give to your community provides a source of connectedness. 3 - Kids need activities, community, school opportunities again for connection - 4 - a place to hang out, a safe place where there is an adult - a village playing field where adults on a volunteer basis perhaps make sure it is safe e t c these four elements are needed for young people - they are not costly and would make sure that a decade from now we would not still be looking at worsening trends.

## "School age pregnancy - A Continuing Culture of Poverty"

**Diana Birch Youth Support**

In 1996 Youth Support celebrated it's tenth anniversary - but it also marked over fifteen years work on our longditudinal survey of pregnant schoolgirls and school age parents. In 1987 I presented a paper at the International Medical Women's Federation meeting in Sorrento, Italy entitled ' Teenage Pregnancy - a culture of poverty' [1] and it is with some dismay that I find myself writing about the same subject ten years later.

In fact poingnantly on the internet today I found a discussion note from Martin Wolfish , Past president of SAM (Society for Adolescent Medicine) which almost uses my words [2]. to quote :-

*'I read with dismay Jonathan Klein's reporting of the US Secretary of HHS "National Strategy to prevent teenage pregnancy" I am reminded of the futility of King Canute to hold back the tide. The problem of teenage pregnancy will not be solved by governmental pronouncements but by improving the life of urban and rural poor. Better educational opportunity, adequate housing, proper nutrition, better health maintenace and prevention of individual and social abuse will improve self esteem of teenagers where girls do not have to feel that their reproductive ability is their only raison d'etre and*

*teenage boys do not have to flaunt their potency to prove that they are persons of worth. Teenage pregnancy cannot be treated as an isolated problem - it is part of the culture of poverty.'*

Yes, we too have our government white papers which tell us how to stem the tide of teenage pregnancy - ****! I am not sure how strong an expletive would be allowed in ethical debate but you can guess! The trouble is that sometimes those of us who are working at the frontline with young parents see such profound levels of deprivation that we become numbed and immune to the full horror of how some people live and maybe we are then to blame for not carrying the message to the politicians and policy makers who feel deprived when the pile in their carpets falls below a certain thickness. Many of my girls don't have carpets, or curtains, or comfortable beds of their own, or gardens to look out on, or enough food or warmth. I could show hundreds of slides of deprived homes, broken windows, graffitied halls ... but that could demean our families who generally speaking are making the best of a bad job.

The effects of poverty are complex and far reaching and no less so in the field of young parenthood. The complexity renders research difficult; statistics are vulnerable to challenge by those with opposing politics and qualitative results are often pushed to one side by the less knowledgeable.

Some facts are discernible however. In Britain, schoolgirl pregnancy is part of a culture of poverty and deprivation where pregnant schoolgirls live in areas of poor housing, overcrowding and unemployment. Results from the first six years of the longitudinal study [3] revealed that 40% of families of pregnant teens were already known to social service agencies before their daughter's pregnancy and 20% of girls had been in care. The typical pregnant schoolgirl is a member of a large single parent family, 70% of girls do not live with both their natural parents; 16% have no mother and 65% have no father.[3] [4]

Demographic variables associated with schoolgirl pregnancy were studied by comparing rates of teen pregnancies in the very small government census zones covered by what are called ACORN (A classification of residential neighbourhoods) groups. Analysis of ACORN groups in the study area of London revealed that 75% of pregnant schoolgirls lived in areas with a male unemployment rate of over 20%. Poor housing also constituted a significant factor over half the young mothers lived in ACORN groups with more than 10% overcrowding and 61% in groups with less than 10% owner occupied accommodation. In fact, housing conditions were unsatisfactory for 44% of pregnant schoolgirls. Families are cramped, pregnant girls share bedrooms with other family members in some cases beds are also shared, few have enough room for the expected baby.

The study area (Camberwell) is a deprived inner city area. The disadvantaged circumstances of its young people can be seen to influence rates of antenatal anaemia, perinatal mortality and birthweight. One third of girls had a diet which was grossly deficient in both quantity and

quality. All of their families were on low income so that they were unable to spend much money on food - two thirds were surviving on state benefits alone. The younger girls had poorer diets than the older girls and this was associated with their giving birth to smaller babies. Here we are dealing with a life long legacy since 'there is a cycle of maternal nutritional deprivation which leads to low birth weight ... the important stage of deprivation for a mother originates not at the time of giving birth , but at the time of her own birth' [5].

The perinatal mortality for babies of mothers under 20 is one of the highest [6] but our sample babies had a perinatal mortality of 16.95% per thousand, higher than that seen in social class V mothers and one and a half times the district average [7]. The class difference in low birth weight and perinatal mortality is highly significant [8] [9] it is estimated that each year more than 6,000 perinatal deaths occur in the 'lower classes' in excess of the rates for social class I babies and the children of teenage mothers are those most at risk. Katy had her tiny premature babies at roughly 6 month intervals after her first incestuous pregnancy at age 12 years - of the first five, three survived, all sickly.

Looking at long term deprivation - the criteria of disadvantage used in the Newcastle 'Thousand family study' (10) were applied to the sample. (Score of 1-6 for 1-family disruption; 2-parental illness; 3-defective care; 4-social dependence; 5- housing overcrowding; 6-poor mothering.) On this basis 82% of girls and 96% of their babies score as very deprived. In addition babies scored higher numbers of criteria of deprivation the mean being three criteria for schoolgirl mothers and four for their babies.

Multiply deprived children have been shown to be shorter, poorer school attenders, less likely to take exams, and more likely to attend court (28% as opposed to 6% non deprived) (10). These very factors have been ascribed to schoolgirl mothers (11) [3] and it would indeed seem that such young mothers are locked in a cycle of deprivation with the degree of deprivation increasing in the next generation. Early pregnancy can thus result in a spiral of social deprivation. Pregnancy results in loss of education, which reduces the chance of finding employment. This leads to poverty and the tendency for the girl to find another man, in the hope that he will support her. She then becomes pregnant again and the spiral takes one more turn towards poverty, illiteracy and poor health.

Predictions and reality - So having made such comments after the initial years of the survey - how did the situation change over the years? (12).

Sandra at the stage of her second pregnancy was living in misery in a damp flat with no furniture, no heating and with a small son who could only communicate by burping He was so emotionally traumatised by his experiences of poverty and abuse at the hands of mum's last boyfriend. We helped her and the next few years were a little easier with Paul learning to speak, going to school and settling down - but at fifteen he truants, goes missing, is angry and upset at his situation - mum

has had several pregnancies by different men - has lost twins at birth and is now finding support in a marriage to an older man who is 'fathering' them all.

Della has had one knock after another - living at first in squalour ,sharing a two mattresses on the floor with her mother and sister and two small children. A victim of life, her children have followed in her footsteps - they are perhaps the most deprived family I have ever known.

So why does the situation persist and the problems repeat from generation to generation ?

Because even after 15 years - 10% still have no housing. After giving birth, housing conditions are characterised by more severe overcrowding, due to the presence of the baby and sometimes the boyfriend and lack of privacy. Girls frequently change address in the hope of finding better accomodation, moving from parents house to boyfriends family and friends flats. It took Julie 12 years and the lost opportunity of growing up with her young family before she was able to move into her own home.

Because training and work opportunities are so poor.

Because baby fathers fade out of the picture and most of all - Because there is a heavy loading in all the parameters against girls who have been brought up in the care system or without a supportive family. They have higher pregnancy rates and more of their children end up in care.

We talk of family structures and traditions as if the childbearing experience of our mothers is inevitably copied. A third of pregnant schoolgirls are following in the pattern of their mothers - that means that *two thirds do not*. Hence it is not so much teenage pregnancy that forms the cycle of transgenerational repetition - but the deprivation that fosters early childbirth.

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# *Semi-Independence Unit Halfway House*

**Youth Support House, residential unit in Beckenham is a therapeutic resource providing a highly structured and intensive programme for 'high risk' families, parents and children as well as individuals who have either been grossly deprived or abused.**

**Patients who move on from the residential unit are helped by means of 'out-reach' and follow up work - but there is a very big gap in the resources available in the community. Some of the more needy families and parents are unable to move straight from residential care to the community and there is a danger that much of the hard work done to help them achieve a measure of independence and self confidence, will be lost by being exposed to the stresses of the community at large. The same applies to young girls who perhaps have not yet acquired the maturity to live alone and indeed fend entirely for themselves.**

**There is thus a dire need for an aftercare unit or halfway house, where patients, whether single or parents with children, can be offered a semi-independent lifestyle. They will be able to move on to their 'own flat' although this will be in a shared house setting with a member of staff available for support. The ethos will be of an extended family set up - like having a live in 'aunt'. At the same time clients will have access to the services of therapy, counselling and occupational opportunities run by the charity both in Beckenham and Penge.**

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