

**A MISSING LINK?:  
AN EXPLORATORY STUDY OF THE  
CONNECTIONS BETWEEN NON-CONSENSUAL  
SEX AND TEENAGE PREGNANCY**

**Final Report**

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Centre for independent research, evaluation,  
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## **Executive Summary**

### **Introduction**

Teenage pregnancy has been a policy priority traversing health, education and crime agendas at national and local levels for a decade. In 1999 a twin track strategy for England and Wales was introduced that aimed to halve teenage conception rates among under 18s by 2010, whilst simultaneously reducing social exclusion among teenage parents (SEU, 1999).

Although the 1999 strategy identifies sexual abuse as a risk factor for teenage conception, this link is not evident in annual reports and evaluations of the strategy. Moreover, whether or not teenage pregnancies are a result of non-consensual sex has yet to be specifically addressed in the substantial UK evidence base on risk factors, conducive contexts, interventions and outcomes. That said, international research findings demonstrate connections between sexual abuse, coercion and intimate partner violence and teenage conception rates. The potential links are reiterated in the public consultation on the Teenage Pregnancy Strategy (DCSF, 2010) '2010 and Beyond' and the NHS Taskforce on Violence against Women and Children refers to teenage pregnancy as one of many impacts of abuse. This report presents findings from the first contemporary UK study to focus on this association.

### **Methodology**

The study was commissioned by Government Office for London, and had three broad aims:

- to identify the extent and impact of non-consensual sex on teenagers in London;
- to estimate the effect of non-consensual sex on teenage conception; abortion and pregnancy rates in the under 18 London population;
- to identify underlying risk factors associated with non-consensual sex and suggest prevention strategies that can be employed with young men and women who are particularly at risk.

A multi-methodological approach was taken comprising:

- an extensive literature review;
- a 'week count' in sexual health agencies;
- an online survey with Teenage Pregnancy Co-ordinators (TPCs) in London boroughs (n=23);
- an online survey with Rape Crisis Centres (n=17);
- surveys with young people watching a play in youth settings and contacted via social networking sites (n=172);

Whilst five sites were recruited for the day count – which was extended to a week – only two young women had attended and fitted the inclusion criteria. While this data is not used in the report the screening tool that was developed (see Appendix 1) has the potential to be implemented in health settings.

### **Research Evidence on Non-consensual Sex and Teenage Pregnancy**

- Although the national aim was to halve teenage conception rates, by 2008 the rate for under 18s had decreased by only 13.3 per cent in England and Wales over a decade. In London this decline is even smaller, at 12.7 per cent (ONS, 2009). There are three factors identified in the TP strategy

to reduce conception: poverty; lack of knowledge about contraception and media representations of sex (SEU, 1999). Connections between the first two factors and teenage conception are complex, while with the third are clearer in terms of messages about masculinity and prioritisation of male sexual pleasure. Recent studies show that young women are subject to emotional pressure/manipulation to consent to sex, and experience high levels of sexual violence (Barter et al, 2009; Hird, 2000; Hoggart, 2006a; 2006b; Hoggart & Phillips, 2009; Maxwell & Aggleton, 2009). A key concept informing this study is the 'continuum of sexual violence' developed by Kelly (1987) to reflect the complexity of women's experiences, and understanding of, unwanted sex.

- Global epidemiological data and the British Crime Survey both find that four per cent of rapes result in conception, a figure that will undoubtedly be greater where sexual abuse is ongoing or there is repeat victimisation.
- The international evidence base on links between teenage conception and non-consensual sex has focussed on two key areas: historical sexual abuse as a precipitating factor and current intimate partner violence.
- A number of themes emerge from studies exploring teenage motherhood as a consequence or legacy of childhood sexual abuse: disruption to young women's lives and enhanced vulnerability to revictimisation, substance misuse, mental health issues, and poor school attendance (Erdmans & Black, 2008); more active and positive endeavours to become pregnant; a decreased likelihood of using contraception (Saewyc et al, 2004).
- Thus addressing childhood sexual abuse and its legacies explicitly becomes an important policy focus, and may reduce teenage conceptions (Noll et al, 2008).
- With respect to intimate partner violence, the overarching theme here is coercive control (Stark, 2007) that limits women's ability to retain autonomy over sexual intimacy, including use of contraception. This manifests in: the need to hide contraception from abusive partners; lack of decision making power about contraception and reproduction (Williams et al, 2008) and limitations on young women's ability to negotiate condom use (McFarlane, 2007).
- The key conclusions here by a number of researchers centre on gendered power within intimate relationships including young men's sense of entitlement to sex from partners (Jewkes et al, 2001; Rosen, 2004; McFarlane, 2007; Firmin, 2010).

### **Teenage Pregnancy Co-ordinators: Knowledge, Services and Gaps**

- Teenage Pregnancy Co-ordinators (TPCs) in each local authority area have a remit to develop and implement a local strategy that reflects the national approach. As there is currently no national steer to address how violence, abuse and coercion intersect with teenage conception, the study sought to explore if, and to what degree, non-consensual sex as a precursor to teenage pregnancy is recognised by TPCs in London, if any data is routinely collected on possible links, and if any initiatives have been developed and/or delivered locally that address this connection.
- The majority lack data on possible links between non-consensual sex and teenage conception, thus limiting the development of policy and practice.
- While two thirds perceive that non-consensual sex is very or quite common amongst young people, there is a significant lack of knowledge and resources with which to address it (see also Firman, 2010): thus, not only is sexual violence in young women's lives not addressed, nor are the links with teenage pregnancy.
- TPCs reported that sexual coercion was an under-developed, but nonetheless important theme in their work.

- There is a danger of a vicious circle here – with the absence of data preventing practice initiatives, and the absence of initiatives ensuring continued limited evidence.
- The lack of strategic steer at a national and local level (including from LSCBs and Children's Trusts) on sexual violence and links to teenage pregnancy means that TPCs have been inadequately supported to develop work on non-consensual sex.

### **Young People's Perspectives**

- The surveys of young people sought to explore their attitudes and perceptions of sexual relationships, particularly with respect to contraception use and pregnancy.
- Analysis focused on findings relating to non-consensual sex, and the landscapes of consent, coercion, and codes of gendered sexual behaviours.
- Young people have good knowledge about biological and technical aspects of conception but are grappling with pressure, coercion and expectation.
- Young women showed awareness of the 'male in the head' (Holland et al, 1998) discourse, privileging male pleasure and desires on the basis that this is what boys expect and demand.
- At the same time, young women are perceived to factor pregnancy into decision making about sex more than young men and hold more responsibility for pregnancy even if it is a result of non-consensual sex.
- Young people report that the most common reason for boys not to use contraception is a loss of pleasure/sensation, indicating a need for campaigns and interventions to address notions of 'proper sex' and meanings of masculinity that are associated with ejaculation inside the vagina.
- Finally, more young women than young men report that abuse is common, that rape is more often committed by known men and young women are pressured into sex. Between a third and two thirds of young women know girls who have become pregnant as a result of non-consensual sex.

### **Survey of Rape Crisis Surveys**

- RCCs were asked about their own knowledge of links between teenage pregnancy and non-consensual sex, how often young women disclosed abusive experiences, and any local initiatives addressing the intersections.
- Nearly all reported that non-consensual sex is 'quite' or 'very' common among young people, and made clear links here with the gendered dynamics of young people's relationships and sexualised popular culture.
- RCCs provided evidence of supporting young women who have conceived as a result of non-consensual sex.
- Many referred to young women's lack of sense of ownership and control over their bodies, and dynamics of guilt, fear and shame.
- RCCs also identify, as essential, training on sexual violence for all relevant professionals, and development of prevention and intervention work on non-consensual sex, embedded in a gendered analysis of the continuum of sexual violence.

### **Conclusions and Recommendations**

All data collected for this study point in the same direction: that there are links between teenage pregnancy and non-consensual sex. Drawing on these findings we make recommendations across five key areas: addressing risk and prevention; SRE programmes; routine enquiry; building the evidence base; integration in teenage pregnancy work.



### Reducing risk and prevention

- Locating non-consensual sex within the recent Violence Against Women strategy means that prevention should be prioritised.
- This must engage explicitly with how constructs of masculinity shape how sex is negotiated, including notions of male entitlement.
- In addition professionals and young people need to explore the continuum of non-consensual sex in young women's lives, moving away from the presumption that the rape/consent binary reflects experiences.

### Recommendations

- **Children's Trusts should view supporting local initiatives on teenage pregnancy and non-consensual sex as contributing to better outcomes for children and young people.**
- *Local Safeguarding Children's Boards should explore the continuum of non-consensual sex for young women as a safeguarding issue.*
- *Sex/sexual health education should address the continuum of non-consensual sex, both unpicking common sense notions of 'uncontrollable male sexual urges' and 'reputations' for young women, thus enabling exploration of what consent looks and feels like.*
  - *Within this how being drunk or incapacitated becomes a conducive context for sexual coercion needs to be addressed. Rather than promoting the message that young women should not get drunk an alternative promoting sexual ethics for young men in such situations should be developed.*
- **There is an urgent need for innovative and engaging approaches which enable young men to reflect on how they understand and 'do' masculinity. The goal is to de-couple masculinity from sexual conquest and the privileging of male sexual pleasure.**
- **Since appropriate and sensitive support following sexual abuse in childhood reduces teenage pregnancy addressing the legacies of child sexual abuse should be urgently integrated into national and local work on teenage pregnancy, and specialised sexual violence services, especially Rape Crisis Centres, should be valued partners in this.**

### Routine enquiry

This study confirms that sexual health and contraception services are not routinely asking young pregnant women about non-consensual sex, especially if they are over 16. There is a strong argument for routine screening protocols to be implemented for all young women attending sexual health services. There is broad consensus on the need for training.

### Recommendations

- **All sexual health and genito-urinary medicine clinics, and other relevant agencies, should introduce routine enquiry with all young women under the age of 18, particularly those who are pregnant, regardless of whether or not they wish to continue with a pregnancy.**
- **Training on the extent and consequences of non-consensual sex should be developed for all professionals, in order that that they can provide sensitive and non-judgemental support to young women who may be grappling with complex layers of decision making where a pregnancy is a result of non-consensual sex.**
- *Practitioners should develop referral routes to specialised sexual violence services.*

### **Extending the evidence base**

The lack of weight given to non-consensual sex in the national teenage pregnancy strategy means there is no central steer to develop research nor is there a mandate for services to record and monitor data. The evidence base needs to become more robust.

### **Recommendations**

- **Data on non-consensual sex and circumstances of conception should be collated in line with other monitoring requirements and included in all reports on service use and needs.**
- *Children's Trusts and LSCBs should collate and analyse this data, and it should be used to guide policy development and interventions.*
- *Further national and local research should be funded, especially with pregnant young women and young mothers addressing their experiences of the continuum of non-consensual sex, including legacies of childhood sexual abuse, circumstances of conception and decision making processes. Consideration should also be given to similar studies with young men, as some research findings suggest experiences of sexual abuse increase the likelihood that they will be young fathers.*

### **Sex and Relationships Education (SRE) programmes**

SRE programmes should as a matter of urgency integrate work on consent, the continuum of non-consensual sex, sexual ethics and media literacy to address sexualisation into the core curriculum, drawing on the recent VAWG strategy. This, alongside the responsibility of schools to promote gender equality, should be included in OFSTED inspection standards.

### **Recommendations**

- **In line with the recently published VAW strategy, the continuum of sexual violence and its gendered dimensions should be a core aspect of SRE lessons, with young people and teachers encouraged to work towards a whole school approach.**
- *Consent, coercion and pressure must be explored explicitly, including how notions of sexual reputation influence expectations and reinforce notions of masculinity that normalise sexually coercive behaviours.*
- *Young women's control of their bodies and sexual autonomy should also be foregrounded: both their right to refuse sex they do not want, and to exercise control over reproduction.*
- *SRE should explicitly address myths about infertility that some young people appear to ascribe to, and take into account recent research findings that suggest how the issue of abortion is dealt with affects the choices young women make.*
- *Data on non-consensual sex and conception that is collated at a local level should inform the development of local SRE programmes. Teachers with responsibility for co-ordinating SRE in schools and PSHE advisors in local authorities are ideally placed to take the lead on this.*
- **Media literacy should be introduced into SRE to enable young people to critically analyse media messages that sexualise girls and young women and present narrow and exploitative models of masculinity.**

### **Developing initiatives on non-consensual sex in teenage pregnancy work**

The need for sexual violence to be mainstreamed into teenage pregnancy policy and practices is evident from this study. Currently small pockets of ad hoc work are taking place, but they lack a coherent direction or framework, and are dependent on committed/aware individuals.

### **Recommendations**

- *Training on the continuum of sexual violence should be integrated into multi-agency programmes on teenage pregnancy.*
- ***In line with the recommendations of the NHS Taskforce on Violence Against Women and Children, PCTs should commission local specialised sexual violence services to deliver support and services to young women.***
- *Initiatives on non-consensual sex should be integrated into local teenage pregnancy interventions.*
- *Specialised sexual violence services should be consulted about, and participate in, local multi-agency forums. The severe under-resourcing of such services means that they may need to be recompensed in order to undertake this role.*

## Introduction

Teenage pregnancy has been a priority issue across a number of different policy strands at national and local levels for a decade, stemming from research released in 1998 highlighting teenage pregnancy rates in the UK as the highest in Western Europe (Kmietowicz, 2002; Lawlor & Shaw, 2004). A twin track Teenage Pregnancy Strategy for England and Wales provides a framework for local and regional implementation, with dual aims of halving teenage conception rates among under 18s by 2010 and reducing the social exclusion experienced by teenage parents (SEU, 1999). In 1999 the cross governmental Teenage Pregnancy Unit (TPU) was established with the aim of halving under-18 conceptions by 2010, driven by concern over comparatively lower teenage pregnancy rates in other countries (Arai, 2009) and funded with £60million for implementation (Hoggart, 2006a). The development of a policy framework to reduce teenage pregnancy rests explicitly on a framing of early motherhood as a negative experience for young women, their children and society, a worrying social problem, yet some research on teenage pregnancy reveals young women's positive experiences (Duncan, 2007).

The national strategy identifies three main factors behind early motherhood: low expectations as result of poverty and limited opportunities for employment and education; ignorance about contraception; mixed messages about sexual behaviour, influenced by the increasing sexualisation of popular culture (SEU, 1999). A substantial evidence base has developed about risk factors and conducive contexts, with interventions aimed at prevention, outcomes for young mothers and effective support provision (Arai, 2003, 2007; Bell et al, 2004; Cater & Coleman, 2006; Department of Health, 2006; Hoggart, 2006b; Letherby et al, 2007; Wiggins et al 2005). Despite extensive international studies (see Chapter Three) that provide evidence linking sexual abuse, coercion and intimate partner violence to teenage conception rates, there is a notable gap in British research addressing these connections.

The *Teenage Pregnancy Strategy* identifies sexual abuse as a risk factor for teenage conception, citing U.S research on the links and data from Childline revealing that 5 per cent of calls received in 1996-1997 in the UK about teenage pregnancy also referred to sexual abuse (SEU, 1999). The document also acknowledges that some abortions and births to girls under 14 will be a result of sexual abuse, and sexually exploited children are named as a group at specific risk of teenage parenthood (SEU, 1999). However, the issue disappears in annual reports and evaluations of the strategy (see, for instance Dennison, 2004; Wellings et al, 2005; Allen et al, 2007). The 2006 Autumn Strategy document claims 'seven years into the strategy, we now know far more than we did in 1999 about the characteristics of young women who become pregnant early, what factors increase the risk of early pregnancy' (DfES, 2006: 5). The risk factors noted include substance abuse, early sex, mental health, involvement in crime, markers of disadvantage such as socio-economic context, and educational and family factors (DfES, 2006), but abuse, violence or coercion are absent. An implicit assumption here is that all teenage pregnancies arise from consensual sexual encounters. A review of research evidence released in 2004 that aims to 'be of use to those engaged in implementing the TP strategy... to support and inform their activities' (Dennison, 2004: 1) does not refer to the substantial international literature on non-consensual sex. Equally the 2005 evaluation of the strategy does not refer to coercion or abuse, with the only discussion of sexual behaviours focussed on age at first intercourse and contraception (see Wellings et al, 2005). Only in the new strategy consultation document are child sexual abuse and sexual violence in intimate relationships recognised as connections with poor sexual health and possible pregnancy (DCSF, 2010), and the recent report of the NHS Taskforce on Violence against Women and Children refers to teenage pregnancy as one of many impacts of abuse (Department of Health, 2010). In short, despite the acknowledgment in the 1999 strategy that sexual

violence has a known association with teenage pregnancy, strategic and policy work since has neglected this issue, and no UK research has been carried out exploring this association.

In London, there are variations in rates by borough including with respect to the 2010 target of halving the under 18 conception rates, and the Government Office for London has developed a range of evidence based resources and toolkits to inform local authority approaches. In terms of violence against women, London has the highest rate of female victimisation of any area of the UK and women are more likely to report fear of rape than those in other regions.<sup>1</sup> Although the British Crime Survey does not include the experience of under-16s, it does reveal that young women aged 16-19 are the age-group at most risk of sexual violence and over a third (36%) of rapes and serious sexual assaults reported to police are of under 16s, the vast majority of whom are female.

Thus while the rates for both teenage conceptions and abortions and reported rapes and sexual assaults on teenagers for London are known, the connections between them are not. Government Office for London commissioned this research to explore links between teenage pregnancy and non-consensual sex, in order to inform policy approaches and add to the current knowledge base. This report presents the findings from the study, which includes a detailed discussion of international research evidence, exploration of young people's attitudes to sex, consent, contraception and pregnancy, findings from a survey of Teenage Pregnancy Co-ordinators and Rape Crisis Centres about their perceptions and knowledge of non-consensual sex and intersections with teenage pregnancy.

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<sup>1</sup> Analysis of British Crime survey data by CWASU

## Chapter 2: Aims and Methodology

The study had three broad aims:

- To identify the extent and impact of non-consensual sex on teenagers in London;
- To estimate the effect of non-consensual sex on teenage conception; abortion and pregnancy rates in the under 18 London population;
- To identify whether there are any underlying risk factors associated with non-consensual sex and suggest prevention strategies that can be employed with young men and women who are particularly at risk.

A multi-methodological approach was used, gathering qualitative and quantitative data to address the research questions. Each is described below. The original research design had to be adapted, as several elements proved difficult to implement. We report on these and the processes as they raise interesting themes about the issue and why the evidence base continues to be so weak.

### A 'week count' of sexual health agencies

The intention of this strand of data collection was to recruit six agencies coming into contact with sexually active young people in London in order to undertake a 'week count'<sup>2</sup> in relation to a) non-consensual sex and b) subsequent pregnancy. We also intended to explore if circumstances of conception affect decision-making processes about continuation with the pregnancy. This process was to simultaneously act as a pilot for a screening tool and could be implemented across all relevant agencies. This screening tool could supplement the Working Towards 2010 Data Collection and Information Sharing toolkit developed by Young London Matters. Routine screening for non-consensual sex with pregnant young women has been strongly recommended by US research (Saewyc et al, 2004; McFarlane, 2007).

Six organisations were approached to participate in the week count, including Marie Stopes, borough based sexual health clinics, the Margaret Pyke Trust and Brook London. Some organisations did not respond to requests for participation; and the final sample of five sites comprised: an NHS Walk-In Centre providing a specialised sexual health service for young people on a sessional basis (Croydon); two community contraception and sexual health clinics (Enfield and Lewisham); two Brook sites, one full time and one offering sessional clinics (Camden and Barking/Ilford).

The procedure for the week count was for two questions to be incorporated into general assessments and screening by direct health care professionals. These were:

- Have you ever been pressured do something sexually that you did not want to do?
- Was this pregnancy conceived through sex in which you were pressured/forced?

The screening tool also included a text box for qualitative data details that was optional (see Appendix 1).

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<sup>2</sup> This is an adaptation of the much cited 'day count' on domestic violence (Stanko, 2000)

All young women presenting as pregnant, aged 19 years and under, were to be asked if they would agree to answer the questions, and if they consented for their answers to be used in research. Basic demographic data was gathered (age, ethnicity), as well as whether they were planning to continue with the pregnancy. Assurance was given that all information was anonymous and the research team would have no way of linking information to personal identifying details.

All sites were supplied with copies of participant information sheets, consent proformas, and SAEs for the forms to be returned. The research team also offered to visit sites to brief staff on the purpose of the project and the procedure for the week count; three sites requested this while for reasons of practicality, Brook held briefings internally following extensive consultation with the research team.

At the end of the specified week, three sites reported that no young women who met the inclusion criteria for the project had attended. At one site, five young women attended and two consented to participate in the research (aged 17 and 18 years). Neither reported any experiences of non-consensual sex. Another young woman from the final site (aged 18 years) also agreed to participate and she too reported no experiences of non-consensual sex. This data is not sufficient to generate any conclusions about the extent of non-consensual sex amongst young women presenting as pregnant. On reflection, it is clear that a week was too short a timescale, given the small numbers at each agency. The ethics procedures required for the process, however, precluded both recruiting larger numbers of agencies and extending the time frame, once low responses were known about.

#### *Ethical considerations*

In order to undertake the week count, ethical approval had to be obtained from the NHS National Ethics Committee. This process proved to be lengthy, involving multiple stages, and delayed data collection by six months. The NHS REC committee meeting (April 2009) approved the application subject to minor amendments to the consent form for participants - requesting inclusion of a line explicitly stating that certain disclosures may obligate a report to safeguarding professionals. This was a complicated stipulation and evoked debate at the REC meeting. The sites concerned offer a specialised service to young people and all have well-established Safeguarding protocols. Some members of the REC felt additional statements were unnecessary given that the two screening questions were to be incorporated into existing history taking assessments by direct health care teams. Despite this, initial approval required the amendment, and final approval was granted in June 2009.

The second stage of obtaining ethical approval was local, involving processes at all participating agencies. As three sites are NHS agencies, they required research governance authorisation, which involved resending all the project documentation, often in different formats. This process typically took several weeks, although one site was able to grant agreement on the basis of the national REC approval.

For the two Brook sites, the study was subject to an internal ethics committee hearing. At this stage Brook raised concerns about the wording of the sentence about disclosure. They feared that it implied the research team would make Child Protection reports and thus compromise their confidentiality policy, whilst also acting as a deterrent to young women to answer the questions. After negotiations to amend the wording, Brook agreed to proceed without changes, as their staff would contextualise the clause by reminding young people of Centre confidentiality procedures.

### **Survey of Regional and London borough Teenage Pregnancy Co-ordinators**

A short online survey was developed for London borough based Teenage Pregnancy Co-ordinators, as the most efficient way of reaching busy professionals, in order to explore: their knowledge of the links between abusive sexual behaviour and teenage pregnancy; whether there were the screening procedures in relation to non-consensual sex; and any initiatives to address the connections. The link to the survey was distributed via email. As the initial completion rate was low, several reminder follow up emails were sent, and the final response rate was 23 out of a possible 32. Information from the survey was analysed using an SPSS database.

### **Survey of Young People**

This survey aimed to capture information about: young people's knowledge bases with respect to pregnancy and contraception and decision making processes; the landscape in which young people are negotiating sexual relationships, including attitudes to sexual norms; the context in which non-consensual sex may occur and if, and how, they factor possible pregnancy into their decision-making about sex and contraception.

This survey was developed in two stages: the research team attended an educational forum (interactive) play on healthy relationships<sup>3</sup> and devised pre and post performance questionnaires based on the content of the play. This workshop, TRUST, explores issues of violence in young people's relationships and has been subsequently featured in a BBC documentary, *Dangerous Love*. However the four youth centres hosting the play experienced difficulties in organising distribution/completion of the questionnaires and not enough were completed for both pre and post attendance. Instead, the completed pre and post questionnaires were combined and analysed as one dataset. Results are presented in Chapter Five.

The questionnaire was then adapted as an online survey, and additional content was incorporated from another, simultaneous CWASU research project with young people. It was not possible here to limit the sample to young people living in London.

A link to the survey was hosted on a page on Facebook that was created for the project. The initial aim was for a link to the survey to be placed on several social networking websites, but negotiating permission proved difficult. Facebook is a fruitful route to reach young people, with data suggesting that 72 per cent of all 11-15 year olds in the UK use the site (compared with 28% for its nearest rival Bebo and 25% for MySpace), and 80 per cent of 17-25 year olds using it (nfpsynergy, 2009).

A page entitled 'teenage pregnancy' was created for the project, and the researchers joined young people's groups from all over the UK, although particular attention was paid to identifying groups in London. A snowballing technique was also used to invite young people as 'friends' to the project and thus participate in the study. This resulted in 116 young people completing the survey; results are presented in Chapter Five.

### **Survey of Rape Crisis Centres**

Rape Crisis Centres (RCCs) are specialised support services for women and girls who have experienced sexual violence. For over three decades they have provided vital support for both those recently assaulted,

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<sup>3</sup> The play was delivered byTender, an organisation that promotes healthy relationships based on equality and respect. Launched in 2003, Tender uses drama workshops to deliver educational prevention programmes about violence against women.



but also for adult survivors of childhood sexual abuse (Sen et al, 2004)<sup>4</sup>. There are currently 37 RCCs fully affiliated to the Rape Crisis Network in England and Wales. While there is only one in London, the Mayoral administration has committed to expanding provision in the capital. However, as surveying only one rape crisis centre would add little to our knowledge, all member groups were approached.

Questions asked about: the knowledge base on teenage pregnancy and non-consensual sex; numbers of teenage girls who approach the services with recent experiences of non-consensual sex; local initiatives and available data. The survey was constructed to parallel that for the London Teenage Pregnancy Co-ordinators, in order that responses could be compared. Results are presented in Chapter Six.

### **Literature Review and Secondary Analysis**

A thorough literature review was conducted using social science databases and internet searches for research on teenage pregnancy risk factors, and any studies exploring the relationship between sexual violence/abuse/coercion and teenage pregnancy. The electronic databases were; Pubmed; psychINFO; medline; JSTOR; intute.ac.uk; and ERIC. The searches were based on keyword searches using the combinations of the terms: *teenage pregnancy*; *risk of teenage pregnancy*; *adolescent pregnancy*; *abuse and pregnancy*; *coercion and pregnancy*; *sexual violence and teen pregnancy*; *conception rates*; *sexual abuse* and *teenage parents*. Findings from this review are detailed in Chapter Three.

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<sup>4</sup> The services provided are combinations of a helpline, telephone counselling/support, face-to-face sessions, advocacy, accompaniment to court and self-help groups.

### **Chapter 3: Research Evidence on Non-consensual Sex and Teenage Pregnancy**

This chapter does not reproduce the wealth of evidence on teenage pregnancy in the UK, but instead focuses on what is known about links with non-consensual sex, with a particular focus on those factors most relevant to young people in London. As Judith McFarlane (2007) points out, pregnancies conceived through non-consensual sex are unintended; therefore understanding the links between teenage conception and sexual coercion will inform approaches to reduce unplanned pregnancies.

Here we explore the progress of the strategy; and research evidence on teenage pregnancy and non-consensual sex.

#### **Teenage Pregnancy: Progress of the Strategy**

Although the national aim is to halve teenage conception rates, by 2008 the rate for under 18s had decreased by only 13.3 per cent in England since 1998. In London this decline is slightly smaller, at 12.7 per cent (ONS, 2009). English authorities with the highest and the lowest rates of under 18 conceptions can be found in London. Similarly, percentage change since 1998 is widely varied across London boroughs with some achieving reductions at over twice the national average. The 2008 provisional data also shows that rates have decreased in nearly three quarters of London's boroughs (71.9%, n=23), with an increase in nine boroughs all of which are in outer London (ONS, 2009).

Socio-economic contexts, highlighted as a 'risk' factor in the TP strategy, are consistently found to be associated with teenage pregnancy (Arai, 2007; Bradshaw & Finch, 2001; McLeod, 2001; Imamura et al, 2007). Higher early conception rates are identified in local authority wards where markers of social exclusion are greatest (McLeod, 2003; Paton, 2002; Bradshaw et al, 2005). For instance, living in a deprived ward with low educational attainment doubles the under-18 conception rate from 40 per 1000 to 80 per thousand (Young London Matters, 2007). Disenfranchisement from education and backgrounds of local authority care appear to be particularly significant experiences in the lives of teenage mothers (Hosie, 2007; Cater & Coleman, 2006; Wiggins et al, 2005; Arai, 2003; Barn et al, 2005). However, what is also known about both of these contexts is that they increase young women's vulnerability to sexually exploitative individuals and networks (O'Neill et al, 1995; Pearce et al, 2003; Coy, 2008), and may therefore influence teenage conception in as yet unexplored ways. For some young women, early pregnancy is actually a route to social inclusion, offering a means to connect to the social respectability of motherhood and achieve a valued social role (Graham & McDermott, 2005, Hoggart 2006a). While the UNICEF report 'A League Table of Teenage Birth in Rich Nations' suggests that teenage pregnancy increases future social disadvantage, it is equally possible that it is instead 'part of social disadvantage, rather than it's cause', with poor socio-economic outcomes pre-dating conception/motherhood (Duncan, 2007: 314; see also Cater & Coleman, 2006). New research highlights that although teenage mothers face considerable barriers to returning to education or employment, most had negative experiences of school before becoming pregnant (Evans & Slowley, 2010). Health inequalities associated with children born to teenage parents may also reflect existing backgrounds of poverty and disadvantage (Cater & Coleman, 2006). In short the connection between socio-economic context and teenage pregnancy may be more complex than currently understood, and as Lisa Arai (2009) notes, tackling this has received far less attention than enhancing knowledge and access to sexual health services.

The dominance of the 'technical/educational' explanation has shaped efforts to reduce teenage pregnancy in the UK (Arai, 2003; 2007; 2009), with high rates of teenage pregnancy attributed to poor contraceptive

use (McLeod, 2001; SEU, 1999). One study suggested that compared to other countries contraception use by teenagers in the UK is relatively low (King, 2000), with another reporting that in the UK only around 50% of teenagers under 16 report using contraception at first intercourse, increasing to 66% for 16-19 year olds (Tripp & Viner, 2005). In comparison, in the Netherlands and Denmark around 80% of young people report using contraception (King, 2000). These findings have led to postulation that increasing knowledge about contraception and consistent sex education and 'openness' will reduce teenage conception rates (Arai, 2003; 2009). For the former, again evidence is mixed; while a recent meta-analysis suggests that curriculum based sex education can delay sexual activity and increase contraceptive use (Kirby, 2007) and that targeted sexual health services aiming to reduce teenage pregnancy can be effective (Ingham et al, 2001), other studies have found that a lack of knowledge among young people about contraception is not a significant factor in teenage pregnancy (Allen et al, 2007), and young women who had not accessed a sexual health service were more likely to use contraception (Stone & Ingham, 2002). One study revealed that pregnant teenagers were actually more likely to have been in contact with a sexual health clinic (Hippisley-Cox et al 2000). Imamura et al (2007) considered the role of sexual health/family planning service accessibility across Europe and concluded that evidence for it serving as a protective factor against adolescent pregnancy was weak. In short, improving information/knowledge about contraception does not appear to have had the preventative impact that the UK strategy presumed it would (Arai, 2009; Hoggart, 2006b). There are, however, few studies that explore young people's knowledge before and after sex education, and the impact of their learning is hard to measure.

This noted, systematic reviews of sex education conclude they enhance knowledge but do not significantly transform behaviour in the long term (DiCenso et al, 2002), particularly contraceptive use (Wight et al, 2002). It has long been a concern of experts on violence against women that sex education does not adequately address the landscapes of consent and coercion that young people are negotiating (Holland et al, 1998; Coy et al, 2008). A study in Haringey, where young women reported experiences of sexual violence and coercion to researchers, recommended that SRE education in schools facilitate more discussion on 'sexual pressure' (Hoggart, 2006b). Part of the work of Government Office for London has been the development of a Sex and Relationships pack for London schools (Power & Proctor, 2009). We discuss the implications of our research for sex education programmes in the conclusion.

The third factor, mixed messages about sexual behaviour, is particularly pertinent to unpicking links between teenage pregnancy and non-consensual sex. The sexualisation of popular culture, has been described by Rosalind Gill (2007: 151) as: 'the extraordinary proliferation of discourses about sex and sexuality across all media forms... as well the increasingly frequent erotic presentation of girls', women's and (to a lesser extent) men's bodies in public spaces'. How this affects young people's sexual behaviour and attitudes has been a topic for research. One study established a connection between listening to sexualised music lyrics and early sexual activity (Martino et al, 2006). Given that early sexual activity is associated with teenage pregnancy (Wellings et al, 2001), media sources that influence young people to engage in early sexual relationships are at odds with the policy aims to reduce teenage conception (Coy, 2009a). A recent report by the Independent Advisory Group on Sexual Health and HIV identified the sexualisation of toys and product advertising as direct influences on young people's sexual behaviour and values (DoH, 2007). A UNICEF report also highlights young people's ability to negotiate changes in sexual norms as a key context influencing teenage pregnancy rates.

*countries with low teenage birth rates tend to be **either** countries that have travelled less far from traditional values [for example, Italy or Greece] **or** countries which have*

*embraced the socio-sexual transformation but have also taken steps to equip their young people to cope with it* (Adamson et al, 2001: 13, original emphasis).

An emerging body of research reveals that sexualised popular culture has a range of negative impacts on girls and young women, including diminished self esteem, body image and educational achievement (American Psychological Association, 2007; Coy, 2009a; Home Office, 2010): less attention has been paid to the influence of young men's understandings of masculinity and their sexual practices. In terms of non-consensual sex, evidence shows that young people, particularly boys, who are exposed to sexualised media are more likely to perceive women to be sex objects (Peter & Valkenburg, 2007). For instance, 'lads mags', lifestyle magazines aimed at young men, feature depictions of women as sexual objects (Krassas et al, 2003). Taylor (2005) explored articles about sex in lads mags and concluded that they endorse notions of aggressive masculinity and male sexual pleasure as more important than women's, with accompanying images that 'activate stereotypes about women as sex objects; these stereotypes would then be expected to influence how readers understand what they read' (p162). While one study suggests a statistically significant association between exposure to sexual content in the media and pregnancy before the age of 20 (Chandra et al, 2008), sexualised media also influences young people's perceptions of acceptable sexual boundaries. Recent research with young people in London found that they identified the media as normalising sexual activity to the point where young people feel inadequate if they are not having sex (Hoggart & Phillips, 2009). The emphasis in the TP strategy has been the media glamourisation of sex with minimal reference to contraception; but there are unacknowledged linkages between messages that reinforce a form of masculinity that endorses sexual pressure and prioritises male sexual pleasure<sup>5</sup>.

The following section discusses research on non-consensual sex and teenage pregnancy.

### **Non-consensual sex**

The concept of the continuum of sexual violence, developed by Kelly (1987) emerged out of women's accounts of unwanted sex. Using dictionary definitions of the word continuum it was defined as:

- 'a basic common character that underlies many different events' – the many forms of coercion, abuse and assault that women experience;
- 'a continuous series of elements or events that pass into one another and cannot be readily distinguished' – that the categories of sexual violence are not discrete: sexual harassment/assault/rape.

There was no intention that the concept be understood as linear or implying anything about seriousness – the 'more or less' referred to prevalence: that most women recall at least one incident of intimate intrusion in their lifetime and many report multiple experiences.

Methodologically the continuum permitted analysis of how women described experiences. With respect to sexual violence women's experiential knowledge did not fit the legal binary of sex being either consensual or rape; to reflect this complexity – and the definitions used by women themselves – two additional categories of 'coercive sex'<sup>6</sup> and 'pressurised sex'<sup>7</sup> were introduced'. Whilst some of the behaviours

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<sup>5</sup> The new TP strategy does acknowledge the relevance of sexualised popular culture, and references the Home Office review on sexualisation as a valuable source (DCSF, 2010).

<sup>6</sup> 'Coercive sex' was defined here 'to cover experiences women described as 'like rape' (Kelly, 1988: 109).

<sup>7</sup> 'Pressurised sex' was defined as 'experiences in which women decided not to say no to sex but where they felt pressured to consent' (Kelly, 1988: 82).

recorded under these categories would have met the then legal definition of rape, the majority would not. The continuum concept, therefore, was intended to draw attention to this gap and to generate debate about the concept of consent itself. The argument being that current constructions of heterosexuality – now often termed heteronormativity – was a conducive context for non-consensual sex, with men encouraged to ‘take’ sex with women, and women allocated responsibility for setting limits on sexual activity, but in situations where they do not perceive themselves as having the power to do so.

The research in the 1990s by the WRAP group on HIV/AIDs prevention among young women further evidenced the limited agency young women felt they had in negotiating sex and sexual practice (Holland et al, 1998). The most recent developments with respect to the continuum concept has been its adoption – in the context of defining violence against women – by the UN (Secretary General, 2006), Nicola Gavey’s (2005) adaptation and the recent identification of ‘incapacitated sex’ to refer to situations in which someone is so affected by alcohol or drugs that meaningful consent is not possible. The latter has been adopted as an element in rape law in Sweden, and German sexual offences law includes a category of ‘sexual coercion’ (Lovett & Kelly, 2009).

Kelly (1987) also explored overlaps between sexual harassment and sexual assault, which whilst also designated distinct categories in law were not so distinguishable in everyday lives. Research in the UK and Australia has subsequently documented that girls are sexually victimised by boys in schools on a daily basis, with behaviours ranging from verbal harassment to assault (Duncan, 1999; Shute et al, 2008), but that these are seldom addressed as criminal violations.

Further data illustrating the continuum can be seen in an online survey of 19,250 16 to 24 year olds conducted in 2006, which showed around a third of young people first have sex before the age of 16. Here a quarter (24%) also said they felt under pressure when having sex for the first time, a third (37%) had drunk alcohol beforehand and a quarter (24%) used no form of contraception (BBC, 2006). A study of 2081 young people in Rochdale found a ‘blurring of lines’ between persuasion and coercion, with young people aware at an intellectual level of risks of both assault and pregnancy, but not translating this knowledge into behaviour/actions (Redgrave & Limmer, 2004). This disjunction between awareness and action is what Holland et al (1998) refer to as ‘intellectual’ empowerment (knowledge of risks and responses/behaviours that are considered appropriate) and ‘experiential’ empowerment (ability to act on this knowledge); we would add that awareness of young women’s limited ‘space for action’ (Lundgren, 1998) in sexual matters needs to be better understood.

Recent studies on young people’s sexual health also show that young women are subject to emotional pressure/manipulation to consent to sex, whilst also reporting instances of rape and assault (Hoggart, 2006a; 2006b; Hoggart & Phillips, 2009; Maxwell & Aggleton, 2009). A recent survey found that almost a quarter of 14 year old girls have been coerced into sexual acts (WAFE/Bliss, 2008). While there is limited data on sexual violence in young people’s relationships, one study of 489 young people found that almost one in five girls (17.9%) reported that their boyfriends had either attempted to force, or had forced, sexual intercourse within the past year (Hird, 2000: 72). An NSPCC study reveals that one in three teenage girls have experienced sexual violence from a partner, and that 70 per cent reported this having a negative impact on their welfare. For a minority the sexual violence was ongoing in their relationship (Barter et al, 2009). Research on the prevalence of sexual abuse more broadly is relevant here, with the most current prevalence study confirming that girls and young women are more likely to be sexually victimised than boys and young men: around 21 per cent of girls and 11 per cent of boys had experienced some form of sexual abuse (May-Chahal & Cawson, 2005).

New research on youth violence in London found high levels of sexual violence and exploitation among young people, with rape (and threats of rape) used against girls involved in gangs and their female family members (Firmin, 2010). Significant issues emerged about: pressure on young women to engage in sexual activity; holding young women responsible for their own victimisation; lack of clarity around meaningful consent; and examples of young women being considered 'fair game' – surrendering their right to consent - for all gang members where they had already had sex with more than one (ibid).

Unpicking these experiences in terms of the continuum of unwanted sex, and the various trajectories that can lead to a teenage pregnancy is the research agenda that emerges from this exploratory study.

### **Teenage Pregnancy and Non-Consensual Sex: Evidence of the Links**

Global epidemiological data and the British Crime Survey both find that four per cent of rapes result in conception, a figure that will undoubtedly be greater where sexual abuse is ongoing or there is repeat victimisation. For instance, the guidance for education professionals on forced marriage specifically suggests that young women may be raped repeatedly until they become pregnant (FCO, 2005). However, in the course of this project, no UK research exploring the association between sexual coercion and violence with teenage pregnancy was identified. In contrast, international literature has placed considerable emphasis on sexual abuse and violence as a factor influencing likelihood of teenage pregnancy. This evidence base has focussed on two key areas: historical sexual abuse as a precipitating factor and current intimate partner violence. Both are discussed in depth below.

#### ***Historic sexual abuse***

Research from the US indicates that young women who have experienced sexual abuse are more likely to become pregnant during adolescence (Rainey et al 1995; Saewyc et al, 2004; Erdmans & Black, 2008). Prevalence findings range from 15-66 per cent of pregnant teenage girls reporting experiences of sexual abuse (Stock et al., 1997; Boyer & Fine, 1992; Bayatpour et al 1992). One longitudinal study found that just over a quarter (26%) of teenagers who experienced childhood sexual abuse became pregnant during adolescence (Roberts et al, 2004), and another found that a quarter of teenage mothers had experienced sexual abuse, almost half by multiple perpetrators (Erdmans & Black, 2008). A meta-analysis of 21 studies on childhood sexual abuse and adolescent pregnancy (Noll et al, 2008), and US national data, suggest that girls who have been sexually abused are twice as likely to become pregnant than non-abused peers (National Vital Statistics Report, 2003, cited in Erdmans & Black, 2008). Establishing a causal link here is problematic, as studies use different definitions of sexual abuse (Blinn-Pike et al, 2002), but the knowledge base shows a clear association.

A number of themes emerge from studies exploring teenage motherhood as a consequence or legacy of childhood sexual abuse. First is the wide ranging disruption to young women's lives and enhanced vulnerability to revictimisation, substance misuse, mental health issues, and poor school attendance. These circumstances are in themselves indicators of increased likelihood of teenage motherhood (Erdmans & Black, 2008), meaning that delineating the route from sexual abuse to adolescent pregnancy is complex, but it is logically possible that the recognised markers are consequences of childhood sexual abuse, including how it is coped with. Thus addressing childhood sexual abuse and its legacies explicitly becomes an important policy focus, and may reduce teenage conceptions (Noll et al, 2008).

The psychological and emotional legacies of violence are clearly significant. A strong theme from research evidence is the impact on sense of self in the world. Sexual violence can lead to development of a self-

identity based on sexualisation (Finkelhor 1984), making young women more likely to engage in early sexual activity (linked by research to teenage pregnancy) and/or become vulnerable to targeting by older men. The latter may, in turn, affect likelihood of conception in two ways; older men may encourage younger women to start a family with them (Rainey et al, 1995); and age gaps between young women and their partners are a known risk for domestic violence that in turn affects contraception use (see later in this section). Associations between sexual abuse and 'risky' sexual behaviour, defined in the literature as multiple partners, not using contraception or protection against STIs, and early sexual initiation, also all intensify the possibility of pregnancy (Stock et al, 1997). Roosa et al (1997) suggest from research with over 2000 young people that sexual abuse itself did not result in teenage pregnancy, but rather this was connected to subsequent sexual activities linked to the abuse (such as multiple sexual partners).

A second link highlighted by research is the more active and positive endeavours to become pregnant reported by young women with histories of sexual abuse. Rainey et al (2005), through a self-administered questionnaire, discovered that those who reported previous sexual abuse in comparison to non-abused peers were more likely to be actively seeking pregnancy. One motivation here was the concern among victim-survivors of sexual violence that they would be unable to conceive as a result of the abuse (ibid). While this is framed by researchers as a self-destructive legacy of abuse, it is often regarded by young women as a positive step – a means to social inclusion (Graham & McDermott, 2005) and to forge healthy connections with others that may otherwise be lacking in victim-survivors' lives (Hillis et al, 2004), as well as alleviate depression and anxiety linked to abusive experiences (Rainey et al, 1995).

A final connection is the finding that young women and young men with histories of sexual abuse are less likely to use any form of contraception (Saewyc et al, 2004). The reasons behind this are unexplored, and may be related to the active desire for motherhood outlined above. Material consequences of sexual violence, such as running away, homelessness, substance misuse and sexual exploitation also make it less likely that young women will have access to contraception or be in a position to use it regularly (Saewyc et al, 2004). There are considerable overlaps here between these activities and vulnerability to further sexual violence that may have an additional impact on whether young women are able to negotiate the use of condoms as a contraceptive. However this finding may also reflect a more complex lack of sense of ownership over the body. Sexual violence often disrupts victim-survivors' relationships with their bodies, with women reporting feelings that their body does not belong to them, of invasion and shame and guilt (Kelly, 1988; Jordan, 2008; Coy, 2009b). This may be significant where using contraception represents a degree of self-care and control over their body that young women who have experienced sexual violence do not believe they have.

One interesting finding is that young men who have experienced abuse are disproportionately likely to be involved in teenage parenthood than those without a history of abuse (Pierre et al, 1998; Saewyc et al, 2004). One possible reason for this is the equation of masculine virility with ability to father a child; studies suggest that teenage boys who father children often perceive that getting a young woman pregnant proves they are 'manly' and repairs a sense of damaged masculinity inculcated by victimisation (Resnick et al 1993; Saewyc et al, 2004). We return to how young men 'do' masculinity (Renold, 2005) and the implications for non-consensual sex in later chapters. In summary, international research establishes a clear link between childhood sexual abuse and teenage pregnancy. The next section discusses research on intimate partner violence and teenage conception.

## **Sexual violence in intimate relationships**

*The role of partner violence in the lives of sexually active, pregnant, and mothering adolescents has been a seriously neglected issue (Rosen, 2004: 27).*

Similarly to prevalence of sexual abuse, intimate partner violence<sup>8</sup> features disproportionately in the lives of pregnant young women, with estimates ranging from 26 per cent to 80 per cent (Centre for Impact Research, 2000; Canadian Mental Health Association, 1999 cited in Liederman & Almo, 2001). Research from the north west of England found high levels of violence among (adult) women experiencing unintended pregnancy and those seeking abortion, including sexual assault by partners that resulted in conception (Keeling et al, 2004)<sup>9</sup>. With respect to teenagers, Silverman et al (2004) found that adolescent girls experiencing violence from partners were approximately four to six times more likely to become pregnant than teenage girls not subject to abuse. It is well documented that intimate partner violence often begins or escalates during pregnancy (Lewis & Drife, 2005), and reducing levels of violence that teenage mothers experience from partners was one of the aims of the national Sure Start Plus pilot schemes (Include, n.d.)<sup>10</sup>. However, the aim of this section is to draw together research that explores non-consensual sex by intimate partners as a contributory factor for teenage conception.

In an overview of research on contraception and intimate partner violence, Williams et al (2008) identified several relevant themes that inhibit effective birth control: the need to hide contraception from abusive partners; sexual violence that prevents women from being able to use certain methods; lack of decision making power about contraception and reproduction. The overarching theme here is coercive control (Stark, 2007)<sup>11</sup> that limits women's space for action and ability to retain autonomy over sexual intimacy, including use of contraception. This is further complicated where sexual violence is perpetrated by boyfriends/friends, with women less likely to name it as abusive (Koss, 1985; Walby & Allen, 2004; McMullin & White, 2006). One study found this held true for including pregnant/mothering young women (Gilson & Lancaster, 2008). However women are more likely to name experiences as sexual violence where there is physical injury (Walby & Allen, 2004), demonstrating the enduring power of rape myths. A ground-breaking London study on women and gang violence found that relationships with sexual partners are an important factor with respect to pregnancy and outcomes for another reason: if young women defined as 'wifey's' (steady girlfriends) conceived, continuing with the pregnancy was more likely to be supported by the male sexual partner, women regarded as 'links' (casual partners) were often pressured to have abortions or subjected to physical violence that induced miscarriage (Firmin, 2010). Thus pregnancy

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<sup>8</sup> We use the term intimate partner violence (IPV) here to reflect the focus on sexual violence in relationships, rather than domestic violence, which in UK policy definitions refers to a wider range of violence including that perpetrated by family members.

<sup>9</sup> McFarlane (2007) found that women who conceived as a result of rape were more likely to report opting for abortions, and show poor sexual health and emotional well being. She also cites research from China and the US showing that rates of requests for abortions were higher among women who became pregnant as a result of rape.

<sup>10</sup> Research in Leeds with pregnant teenagers/young mothers found high levels of intimate partner violence, and that young women feared disclosing this to professionals for fear that they would be deemed bad mothers and their children removed (Include, n.d.).

<sup>11</sup> Stark (2007) provides a detailed breakdown of the behaviours that comprise 'coercive control': violence (including sexual coercion and jealousy); intimidation (including threats, surveillance, stalking, degradation and shaming); isolation (including from family, friends and the world outside the home) and control (including control of family resources and 'micromanagement' of everyday life).



for some young women increased the likelihood of intimate partner violence and the circumstances of conception were mired in coercion and exploitation.

Intimate partner violence is associated with inconsistent condom use by a number of studies with both adult women and adolescent girls (Silverman et al., 2004; Winwood et al, 2001, Teitelman et al, 2008). Winwood & DiClemente (1997) found that abusive men were significantly less likely to use a condom during sex, and women's fear of repercussions prevented them from asking for condoms to be used. As Rosen (2004) points out, successful condom use depends on co-operation from male partners, and violence and abuse severely limit women's capacity to negotiate using condoms. Judith McFarlane notes:

*To focus on condom negotiation skills as if knowledge results in action is to ignore the realities of gender power dynamics, social context and sanctions, and the fear and potential harm that can result when a woman decides to control her sexuality' (2007, p131).*

In Williams et al's (2008) study, younger women were more likely to struggle to use their preferred method of contraception. Similarly, young women in Rosen's (2004) research reported using contraceptive pills that they were able to hide from partners who were forcing them into sex and refusing to use condoms. Some young women who conceived while in abusive relationships viewed the pregnancy as an opportunity for change. However, there are constraints here; some young women were able to escape the relationship with impending birth as a spur, but others found that their partner's behaviour did not change, contrary to their expectations, and a few did not have control over decisions about the outcome of the pregnancy (ibid). He concludes that non-consensual sex was a direct cause of pregnancy in only a minority of young women's relationships, but the violence led to 'a pattern... in which ultimately some teenage girls lost autonomy and control over the decisions that shaped their lives' (p 25).

Similarly, a survey by the US Centre for Impact Research (2000) of girls aged between 11-21 (average age 18) found that for two thirds (66%) of those in abusive relationships, perpetrators had tampered with birth control either verbally or behaviourally. Verbal sabotage refers to emotional manipulation and pressure to bear children as proof of love for the perpetrator, and behavioural sabotage to either being banned from using contraception or forced to have sex. Both escalated where the violence increased in severity, and the researchers suggest 'inability or unwillingness to squarely confront the issue of domestic violence would appear to doom teen pregnancy prevention programmes to failure' (p27). Research from South Africa echoes both these findings: exploration of the relationship dynamics of 544 young women revealed a strong association between forced sexual intercourse, physical violence and teenage pregnancy (Jewkes et al, 2001). Here early sex itself was not the risk factor, but rather the context in which it occurred. The researchers emphasise the need to address male dominance and entitlement to sex within young people's relationships: 'the dynamics of sexual relationships are of considerable importance in teenage pregnancy... More equal power relations seemed to be protective against pregnancy' (ibid: 742/741). As UK research demonstrates that many adolescent girls experience physical, sexual and emotional violence from partners (Barter et al, 2009; Firmin, 2010), there is a pressing need for teenage pregnancy work to address issues of violence and abuse.

## **Summary**

International research has considered a wider number of factors associated with teenage pregnancy than the UK, and empirical studies demonstrate that historic and current abuse increase the likelihood of teenage pregnancy. The neglect of non-consensual sex in strategic and policy frameworks on teenage

pregnancy has led not only to a significant gap in knowledge, but also that policy frameworks and practice interventions are incomplete.

The material consequences of violence also need to be addressed by service providers. Young women experiencing intimate partner violence are less likely to be in education (Rosen, 2004), which may affect their access to information about sexual health and to supportive adults. Sexual abuse also renders young mothers more likely to experience post-natal depression (Gilson & Lancaster, 2008). Of great importance is that young women who have experienced childhood sexual abuse are less likely to become pregnant during adolescence if they receive counselling and support (Erdmans & Black, 2008). Yet specialised support services for victim-survivors of sexual violence are scarce and poorly funded, particularly in London (Coy et al, 2009), albeit that the current Mayoral administration has recently announced expansion of Rape Crisis Centres. Yet young women remain unaware of the existence and remit of specialised services (Firmin, 2010), suggesting that such information needs to be included in sex/sexual health education and publicised at youth centres.

## Chapter 4: Teenage Pregnancy Co-ordinators Survey: Knowledge, Services and Gaps

The national policy framework is led by Teenage Pregnancy Co-ordinators (TPCs) in each local authority area, whose remit is to develop and implement a local strategy that reflects the national approach along four key lines: multi-agency partnerships; media and communications work; prevention of teenage conceptions and enhanced support for teenage parents (Webster & McCormick, 2005; Wellings et al, 2005). Central to this is unifying relevant agencies to meet national and local targets set by the Government. TPCs have been described as 'representatives of the [Teenage Pregnancy Unit] in English localities, [who] can offer insights into the normative environments of such places' (Arai, 2007:90).

There is currently no national steer to address how violence, abuse and coercion intersect with teenage conception. Hence this study sought to explore if, and to what degree, non-consensual sex as a precursor to teenage pregnancy is recognised by TPCs in London, if any data is routinely collected on possible links, and if any initiatives have been developed and/or delivered locally that address this connection.

### Survey Results

A link to the online survey was distributed to all 32 TPCs in London boroughs. Almost three quarters (71.9%, n=23)<sup>12</sup> responded to the survey, but not all completed all the questions. The 23 who responded had been employed as TPCs for between 1-6 years, with an average of 2.7 years in their current role. Professional backgrounds varied, with just under half in health (n=6) or sexual health (n=5), and similar proportions in youth work (n=6) and education (n=4). A further five were previously employed in social work/psychology/therapy.

The following sections report on TPCs awareness of non-consensual sex and risk factors related to teenage pregnancy. While not intended to present a comprehensive picture of knowledge and provision in London, we explore their localised insights in relation to the TPCs and the international knowledge base.

### Frequency of non-consensual sex

18 of the 23 TPCs responded to the question 'How common do you think non-consensual sex is amongst young people?'. Table 4.1 shows the range of responses:

**Table 4.1: Teenage Pregnancy Co-ordinators estimates of frequency of non-consensual sex**

Frequency	N	N %
Very common	4	17.4
Quite common	8	34.8
Happens sometimes	4	17.4
Rare	0	0
Don't know	2	8.6
No response	5	21.7
Total	23	100

Just over half (52.2%, n=12) perceive non-consensual sex to be quite or very common amongst young people, with none believing it to be rare. This highlights that the absence of sexual violence, coercion and

<sup>12</sup> 23 is therefore the baseline figure for percentages throughout this section, unless otherwise stated.

pressure in national policy on teenage pregnancy does not reflect the perceptions of many of those working at a local strategic level.

### **Gender differences in frequency of non-consensual sex**

Research consistently demonstrates that sexual violence and coercion disproportionately affect women and girls (Kelly, 1988; Barter et al, 2009; May-Chahal & Cawson, 2005; Walby & Allen, 2004). Thus the survey sought to explore TPCs perceptions of gender differences in young people's experiences of non-consensual sex.

Just over two thirds of TPCs (69.6%, n=16) describe non-consensual sex as more likely to be experienced by young women, with none perceiving it as more likely to be experienced by young men and only two reporting frequency as the same for both.

Reasons offered for these perceptions centred on two themes: the first draws on evidence from research and experience (n=7), often based on local knowledge.

*Evidence from young women who access services locally indicates a level of pressure/force which is not reported by young men. There are reports regarding rape and sexual assault by young women as an ongoing theme within services.*

*Views of young people we have accessed locally show young women feel more pressure and experience non-consensual sex from male partners than vice versa.*

The second theme is the social context, with references made to gendered constructions of behaviour that render young women less able to withdraw consent, while simultaneously more vulnerable to compulsion and manipulation by young men (n=7).

*My sense is that young women - especially in groups with less social capital, where teenage pregnancy is more likely - are less confident in their sense of equality with young men, at least, in private... People don't know they have the 'right to say no' in the same way that people with greater self confidence/social capital might.*

*Often this [non-consensual sex] is seen as acceptable and if you can 'get' a young woman to have sex with you (either with pressure, promises of love, coercion, alcohol and other substances, etc) it's fair game.*

Interestingly, one TPC reported that the pressure on young men to lose their virginity from male peers made it more likely that they would force young women into sex. This route to 'doing masculinity' through sexual prowess and conquest (Renold, 2005) is here described as having a direct impact on young women's ability to resist advances and negotiate sex on their terms. One TPC named 'young men's biological imperative' as a risk factor for young women, reflecting the enduring hold of the notion of a male sexual drive discourse (Hollway, 1984) that offers a justification for young men not controlling their sexual desire, or concerning themselves with female desire.

*Biological/physiological issues [are significant] and perhaps the perception that bad sex is still quite good sex for a young man, as it will most likely involve an orgasm/ejaculation, but this would most likely not be the case for the young woman.*

This has implications for the development of work with young men around healthy and respectful relationships that do not privilege male sexual gratification, but recognise the landscapes of consent and bodily autonomy for young women.

The two respondents that perceived the frequency of non-consensual sex to be the same for boys and girls also focused on pressure to become sexually active, and one suggested that young men’s experiences of coercion are unexplored.

*There is so much pressure on young people to have sex and it is really difficult to know whether this is non-consensual or consensual for both parties as what might have seemed right in one instance may not have felt right on reflection for either party... There is perhaps more reporting for young women re non-consensual sex, but we have much further to go in understanding the picture for young men.*

TPCs were also asked to name key risk factors that increased the likelihood of young people experiencing non-consensual sex. Just over half (n=12, 52.2%) offered risk factors for young women, and slightly fewer (10, n=31.3%) for young men. Table 4.2 presents these.

**Table 4.2: Teenage Pregnancy Co-ordinators perceptions of risk factors for non-consensual sex**

Risk Factor*	For young women	For young men
	N	N
Low self esteem	9	8
Peer or other social pressure including media	5	7
Gender inequality	3	0
Young men’s attitudes to young women	3	0
Lack of educational achievement and social capital	3	2
Alcohol/drug use	2	1
Relationships with older men	2	0
History of abuse (within and outside family)	2	1
Inadequate emotional support/self-care skills	0	2
Depression	1	1
Lack of adult supervision	1	0
Young men’s biological imperatives	1	0
Inappropriate friendships	0	1
Unaware of risks of non-consensual sex	1	0
Unable to discuss sexual issues	1	0
Risky behaviours	0	1

\* Multiple responses possible

What emerges here are two constellations, one which recognises the established factors for teenage pregnancy, which are perceived as affecting young women and young men similarly (low self-esteem, peer pressure) and others which are understood as gendered in their impact and meaning. Here gender roles and codes of appropriate sexual behaviour for boys and girls are prominent. Three TPCs specifically named gender inequality and young men’s attitudes to women as increasing young women’s vulnerability to coercive sex. Personal and social factors such as low self-esteem, alcohol/drug use, history of abuse,

and lack of material resources such as educational attainment/social capital are all perceived to be more acute for young women. The substantial evidence base on sexual violence also identifies these issues as diminishing young women's space for action when negotiating sexual encounters (Holland et al, 1998; Hoggart & Phillips, 2009). A recent study by the NSPCC found that young women in relationships with older men were significantly more at risk of sexual, emotional and physical violence (Barter et al, 2009). Some risk factors were suggested only for young men, based on a lack of self-protection (inadequate self-care skills, risky behaviours and inappropriate friendships). Overall, the range of risk factors suggested demonstrates that TPCs in London have an awareness of the dynamics of sexual violence and coercion.

The next set of questions of the survey sought to explore how TPCs understand connections between non-consensual sex, contraception use and teenage conception rates.

### **Contraception and non-consensual sex**

Almost half (47.8%, n=11) suggested that contraception was less likely to be used when sex is non-consensual<sup>13</sup>, with three being unsure. The majority attributed this to the absence of negotiation (n=8), but this was often perceived as connected to inadequate planning rather than inequalities of power and the coercion inherent in non-consensual sex.

*I think that if a young person has been coerced into a sexual act then they will not have prepared for this situation, as they were not necessarily planning to take part in a sexual act at that time.*

*It won't even be on the agenda – if the sex isn't chosen then there's unlikely to be much communication or negotiation or time or planning or any of the things needed for successful contraceptive use.*

A further two respondents suggested that the use of drugs and/or alcohol and young people's 'altered states of mind' meant that contraception was less likely to be used. This suggests an implicit link between non-consensual sex and alcohol or drug use, but neither participants expanded on whether they viewed this as connected to behaviours of young women or young men. Surveys of young people indicate that the majority perceive a strong link between drinking alcohol and unprotected sexual activity, and that intoxication leads to 'going further' sexually than they would if sober (Redgrave & Limmer, 2004; Bellis et al 2008; British Youth Council, 2009). Research also demonstrates that alcohol can be used to facilitate sexual assault in certain contexts and environments (Lovett & Horvath, 2009); we return to this in the concluding chapter.

### **Links with Teenage Pregnancy**

Respondents were asked what proportion of teenage pregnancies they thought were associated with non-consensual sex. Eleven completed this question: table 4.3 shows the range of responses:

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<sup>13</sup> Only 14 TPCs responded to this question

**Table 4.3: Teenage Pregnancy Co-ordinators estimates of proportion of teenage pregnancy associated with non-consensual sex**

Proportion	N
8-10%	1
20%	1
40%	2
80% or higher	1
Not sure	6

What this reveals is a lack of knowledge and awareness about non-consensual sex as a precursor to teenage pregnancy, but a belief among a few that the link is significant.

#### **Collecting data on non-consensual sex and teenage pregnancy**

One respondent reported that agencies in their borough routinely collect data on non-consensual sex. Eight reported that this data is not collected, with four not knowing. Ten reported that there was no data on links between teenage pregnancy and non-consensual sex for their borough, with one reporting that it was available in Child Protection data and two being unsure. Here we have an explanation for the lack of confidence in data, as it is not routinely collected.

When asked if agencies screened pregnant young women about the issue of non-consensual sex, TPCs were largely unsure, as table 4.4 shows:

**Table 4.4: Whether agencies routinely screen young pregnant women about non-consensual sex**

If agencies screen	N
Not sure	6
None	3
Yes, several	3
Yes, one*	1
Total	13

\* Specified as a young parents support project

Again these responses illustrate that there is a dearth of knowledge on whether teenage pregnancy is connected to non-consensual sex in London boroughs; this data suggests that agencies are not routinely asking pregnant young women about the circumstances of conception, and that data on links is thus unavailable. The absence of an evidence base as to whether non-consensual sex is a contributory factor in teenage conception rates reflects the lack of recognition of possible links in national policy. This in turn means at a local level, non-consensual sex in relation to teenage pregnancy is not integrated into the work of Local Safeguarding Children's Boards and Children's Trusts or TPCs. For the latter, charged with responsibility for developing and implementing strategic approaches to teenage pregnancy based on local need, a national and local policy steer is essential.

#### **Training on sexual violence and coercion**

Of those TPCs who completed this question (n=13), over half (n=8) had not received any training on sexual violence/non-consensual sex. Five reported that they had received 'a little' training, ranging from one day

(n=2), half a day (n=1) and a quarter of a day (n=1). Subjects included sexual exploitation (n=3) and domestic violence (n=1), provided by voluntary sector specialised organisations and local sexual health teams.

Even allowing for missing data from those that did not complete the survey, over a third (34.8%, n=8) of TPCs in London who responded had not received any training on non-consensual sex, and for the five (21.7%) that had, none was directly focused on sexual violence. There is considerable scope here to equip TPCs with the knowledge and skills to understand the dynamics of non-consensual sex and the implications for service provision. Table 4.5 shows the need for training for TPCs and all professionals coming into contact with young people.

**Table 4.5: Knowledge and resources in London boroughs on non-consensual sex**

Local knowledge and resources	N*
Not enough knowledge on links with teenage pregnancy	9
Not enough knowledge on non-consensual sex	8
Not enough resources to address non-consensual sex	7
Don't know	2

\* Multiple responses possible

The majority answering this question report that there is inadequate knowledge on non-consensual sex in their borough and the links with teenage pregnancy, suggesting a pressing need for targeted training on sexual violence and coercion. However, one did note the emergence of relevant work in their borough.

*There is a lot of talk building on this issue, and we are all becoming more aware of the problem than before. There are courses, conferences and projects burgeoning. I think people take this very seriously, and in my new role as TP co-ordinator, it is certainly an issue I will be holding foremost in my mind.*

The following sections explore the implications for TPCs work, given the associations between teenage pregnancy and non-consensual sex.

### **Implications for Policy and Practice**

The survey asked TPCs if links between non-consensual sex and teenage pregnancy would make a difference to their work. Of the 12 that responded, almost all (83.3%, n=10) reported that it categorically would, with two not sure. The following consequences for TPC work were identified.

- Implementing and enhancing prevention work (n=5)

*I have been pushing for years to get better preventative work going in a whole range of setting, including schools, around the issue of consent. I would like to see everyone exploring with young people the point at which something you want turns into something you don't want, how to recognise this, avoid it or do something about it.*

*If high instances of rape are recorded/found in teenage pregnancies then the work we need to do must centre around young men in combating current societal views on women, rape, on sex, and on acceptable/honourable behaviour.*



- Development of specialised initiatives (n=3)

*It would mean that the kinds of services and messages that were being offered would shift to some extent. A strategic rethink would be a priority.*

*A strong connection between non-consensual sex and teenage pregnancy would support requests for funding around self-esteem and other supportive workshops for young women.*

One TPC suggested that an underdeveloped strand of work was: 'issues related to cultural, faith and urban communities and ongoing difficulties that young people experience in negotiating adolescence, risks and peer pressure'. These responses suggest that initiatives on non-consensual sex should be embedded in local contexts, and attentive to the influences on young peoples' attitudes to sex and relationships as well as access to advice and support.

- Standardised routine screening and data collection (n=2)

*It would be important to ensure that adequate data was collected*

While one respondent stated that knowledge of links between teenage pregnancy and non-consensual sex would raise Child Protection issues in relation to strategic work, another reported that non-consensual sex is an issue for the local safeguarding team/police and that TPC input should be limited to data sharing, reduction and prevention.

### ***Non-consensual sex and decision making with respect to pregnancy***

Eleven of the 12 TPCs who responded to this question reported that conception as a result of non-consensual sex raised different issues for young women's decision-making processes as to whether or not to continue with the pregnancy, specifically:

- Young women are more likely to terminate a pregnancy (N=4) (see also McFarlane, 2007)
- Young women will require more support in order to reach a decision (n=3).

One respondent speculated that young women might prolong decisions about progress of the pregnancy if conception is the result of sexual assault by someone who is not their intimate partner, as they may wish to ascertain paternity. Three TPCs suggest that young women's fears about bonding with a child conceived as a result of non-consensual sex might also affect their decision-making processes.

One TPC provided an example of a young woman 'who had been raped and still continued with the pregnancy' because 'abortion is becoming a less acceptable option (regardless of consent issues)'. A recent study of 103 young women found that half held a 'foetus centred' attitude towards pregnancy rather than a 'woman centred' one, and that young women identified only 'a narrow range of instances when [abortion] might be acceptable' (Lee et al, 2004: 16). Although sexual violence was one of these 'justifiable' instances, the researchers conclude that 'the case for the right to choose abortion exists in a relatively weak form as part of the cultural context in which young women's opinions about the abortion issues are

generated' (ibid: 16)<sup>14</sup>. A recent study in London also found that many young women regard abortion as 'immoral', adding layers of confusion and distress to their decision making processes (Hoggart & Phillips, 2009). Young people who responded to surveys in this study also expressed ambivalence about the acceptability of abortion (see Chapter Five). The way that information about abortion is presented in schools, particularly where messages (even if only by implication) have a moral tinge, affect the choices that young women feel able to make (Hoggart & Phillips, 2009).

Ten respondents reported that if conception was the result of non-consensual sex, then different issues are raised for workers/advisors. These included:

- enhanced support for young women that takes into account the need for heightened sensitivity (n=3);
- reassurance around confidentiality and awareness of the impact of sexual violence (n=3);
- consideration of child protection issues (n=4).

Two added that the involvement of safeguarding professionals could lead to tensions with respecting young women's choices, as intervention could lead to young women being overwhelmed by professional opinions about the right course of action.

*Seeing the pregnancy as a child protection issue can determine how the whole thing proceeds. [It] might make workers assume what will/should happen.*

*How the pregnancy is discussed, options available, social services involvement, police involvement, specialist agencies informed, all can put tremendous pressure on a client. As a worker it would be important to let the young person lead and not to take charge.*

Similarly three respondents perceived that advising young women in these circumstances is more challenging for practitioners, as they might 'tend to' recommend an abortion, yet seek to remain careful not to influence young women's decisions.

One TPC disagreed on the grounds that the main task for practitioners is unaffected by the circumstances of conception:

*The question remains what a young woman wants, and ensuring that the support that is provided is appropriate to that. This is the same in any situation.*

### **Initiatives and Services in London Boroughs**

Almost half of TPCS who responded (43.5%, n=10) had not delivered any targeted projects or interventions on non-consensual sex in their borough. Two replied that such work had been undertaken: in one borough, unspecified work through the Community Safety Partnership on gender, violence, gangs and non-consensual sex; and in the other, the TPC had delivered presentations on the issues in Teens and Toddlers programmes.

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<sup>14</sup> However they also note that young women's socio-economic context is significant, with options for future employment and education affecting how the timing of motherhood is perceived. Similarly, research about attitudes to abortion highlights that young people from areas of social deprivation reporting higher levels of disapproval (SEU, 1999).

Support services for victim-survivors of sexual violence are scarce and poorly funded - three quarters of all local authorities in Britain do not have any specialised services. In London, while the Mayoral administration has committed to increasing rape crisis provision in the capital, the situation is particularly acute, with just one rape crisis centre located in Croydon and eight specialised voluntary sector services located in seven different boroughs, and three Sexual Assault Referral Centres providing a pan-London service (Coy et al, 2009). Four TPCs (17.4%) identified specialised sexual violence services in their borough, five (21.7%) youth support services and two (8.7%), no available services. Whilst all seek to support young women, there are no services dedicated solely to meeting their needs.

Seven TPCs made suggestions for improving services for young people, (four did not have any suggestions and 12 did not answer this question) including:

- making existing services more visible to young people (n=3);
- more funding for intervention projects addressing issues of non-consensual sex (n=2).

*Drama workshop activities are very useful to look deeper into the issues with young people in a safe way, but funding is scarce to do this<sup>15</sup>*

- mainstreaming issues of sexual violence and coercion into youth work (n=2);
- educating young men about attitudes to women (n=1);
- defining non-consensual sex as part of range of abusive behaviours, not limited to rape/sexual exploitation (n=1).

These recommendations cluster around the need for more specialised education and awareness raising initiatives with young people, and deeper exploration of how young people negotiate consent and coercion. A twin track strategy is suggested here; mainstreaming gender and violence work in education and youth settings alongside developing targeted interventions on non-consensual sex, especially with young men.

## Summary

Responses from London TPCs show that the majority lack data on possible links between non-consensual sex and teenage conception, thus limiting the development of policy and practice. While two thirds perceive that non-consensual sex is very or quite common amongst young people, there is a significant lack of knowledge and resources with which to address it (see also Firman, 2010): thus, not only is sexual violence in young women's lives not addressed, nor are the links with teenage pregnancy. There is a danger of a vicious circle being reinforced here – with the absence of data preventing practice initiatives, and the absence of initiatives ensuring continued limited evidence. Local strategic bodies – LSCBs and Children's Trusts – need to take responsibility for supporting TPCs to develop work on non-consensual sex, as we explore in more detail in the concluding chapter.

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<sup>15</sup> Drama workshops were also specifically highlighted by young people from BME communities in London as an effective way to deliver information about sexual health (see Testa & Coleman, 2006).

## Chapter 5: Young People's Perspectives

This chapter presents findings from two surveys of young people that sought to explore their attitudes and perceptions of sexual relationships, particularly with respect to contraception use and pregnancy. The first dataset is drawn from questionnaires distributed to young people, before and after an interactive drama performance about teenage parenting in the context of an abusive relationship. The second dataset is from an online survey for young people on the same themes, accessed via Facebook. Where questions were the same across both surveys, responses are presented comparatively. Analysis focuses on findings relating to non-consensual sex, and the landscapes of consent, coercion, and codes of gendered sexual behaviours.

### Profile of young people

A total of 178 young people completed the surveys, 62 from four youth centres across London and 116 young people via Facebook. As six young people across both samples did not specify their gender, proportional analysis in this section is based on the 172 responses where gender was known.

### Gender

In contrast to the youth centres sample, significantly more girls than boys responded to the online survey, suggesting that they were more likely to view a project about teenage pregnancy and non-consensual sex as relevant to their own experiences. In total, therefore, three quarters of this sample were female (see Table 5.1). In the youth centre sample however, nearly twice as many boys as girls completed the questionnaire, which may reflect the populations at the youth centres. All responses are analysed by gender, but readers should bear in mind that the sample of young men across both samples is small.

**Table 5.1: Sex of young people who completed the surveys**

Sex	Online		Youth centres		Total	
	N	%	N	%	N	%
Female	87	75	20	32.3	107	60.1
Male	26	22.4	39	62.9	65	36.5
Missing	3	2.6	3	4.8	6	3.4
Total	116	100	62	100	178	100

### Age

The average age of young people completing the online survey was 15.6, slightly older than the youth centre sample (13.5), although the age range across both ran from 11-21 (see table 5.2). Over half (57.8%) of the online sample and nearly two fifths (38.7%) of those from youth centres were aged 14-16. No significant correlations were found when responses were analysed by age.

**Table 5.2: Age of young people who responded to the survey**

Age	Online		Youth centres	
	N	%	N	%
11	1	0.9	4	6.5
12	2	1.7	10	16.1
13	9	7.8	6	9.6
14	28	24.1	8	12.9
15	25	21.6	8	12.9
16	14	12.1	8	12.9
17	12	10.3	5	8.1

18	10	8.6	5	8.1
19	6	5.2	1	1.6
20	2	1.7	1	1.6
21	3	2.6	1	1.6
Missing	4	3.4	5	8.1
Total	116	100	62	100

### **Ethnicity**

In the youth centres sample, a third of young people did not specify their ethnicity and thus the data is not presented comparatively here. However a diverse range of ethnic backgrounds were represented, with a quarter (24.2%, n=15) defining themselves as White British/European, almost a fifth (17.8%, n=11) as Black British or Black Caribbean, with smaller proportions of Mixed, African, Asian, Chinese and Portuguese backgrounds. In the online survey, young people were asked to specify their ethnicity in accordance with the Census categories. Three quarters (74.1%) defined as 'white British', as Table 5.3 shows, fewer than the 2001 UK Census data of 92.1 per cent (ONS, 2003) and slightly more than the population of London, where almost a third (30.2%) are from non-white backgrounds (ONS, 2004). No significant correlations were found when responses were analysed by ethnicity.

**Table 5.3: Ethnicity of young people who responded to the survey**

Ethnicity	Online	
	N	%
White British	96	74.1
Mixed Race	9	7.8
Black Caribbean	7	6.0
White Other	4	3.4
White Irish	2	1.7
Black British	2	1.7
White European	1	0.9
Black African	1	0.9
Asian Pakistani	1	0.9
Missing	3	2.6
Total	116	100

### **Knowledge and Attitudes**

The survey asked young people to indicate whether or not they agreed with a series of statements about the contexts in which sex occurs, gendered behaviour and their assessment of frequency of sexual violence. Table 5.4 presents their responses.

**Table 5.4: Online survey attitudes**

Statement	Young women		Young men	
	N	%	N	%
<b>You should only have sex with someone if you care about them a lot</b>				
Strongly Agree/Agree	62	71.3	12	46.2
Undecided/unsure	11	12.6	6	23.1
Strongly Disagree/ Disagree	14	16.1	8	30.8

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<b>It's OK for a girl to make the first move</b>				
Strongly Agree/Agree	66	75.9	20	76.9
Undecided/unsure	18	20.7	5	19.2
Strongly Disagree/ Disagree	3	3.4	1	3.8
<b>Having sex means you have something to tell your mates</b>				
Strongly Agree/Agree	6	6.9	6	23.1
Undecided/unsure	5	5.7	4	15.4
Strongly Disagree/ Disagree	76	87.4	16	61.5
<b>It's difficult to say no when someone is pressuring you to have sex</b>				
Strongly Agree/Agree	39	45.3	10	38.5
Undecided/unsure	13	15.1	3	11.5
Strongly Disagree/ Disagree	34	39.5	13	50
<b>It is bad for boys to have sex with lots of girls</b>				
Strongly Agree/Agree	58	66.7	9	34.6
Undecided/unsure	15	17.2	4	15.4
Strongly Disagree/ Disagree	14	16.1	13	50
<b>It is common for boys to pressure girls into sex</b>				
Strongly Agree/Agree	66	75.9	16	61.5
Undecided/unsure	18	20.7	6	23.1
Strongly Disagree/ Disagree	3	3.4	4	15.4
<b>Girls often go all the way when they don't want to</b>				
Strongly Agree/Agree	57	65.5	17	65.4
Undecided/unsure	17	19.5	4	15.4
Strongly Disagree/ Disagree	13	14.9	5	19.2
<b>Girls who have sex with lots of boys are easy</b>				
Strongly Agree/Agree	14	54.0	19	73.1
Undecided/unsure	14	16.1	4	15.4
Strongly Disagree/ Disagree	26	29.9	3	11.5
<b>If a boyfriend hits a girlfriend it shows that he cares</b>				
Strongly Agree/Agree	2	2.4	1	3.8
Undecided/unsure	2	2.4	2	7.7
Strongly Disagree/ Disagree	81	95.3	23	88.5
<b>The first time a girl has sex it's normally because a boy wants her to</b>				
Strongly Agree/Agree	30	34.9	12	46.2
Undecided/unsure	31	36.0	8	30.8
Strongly Disagree/ Disagree	25	29.1	6	23.1

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<b>Girls will have sex with a boy to please him even if she doesn't want to do it</b>				
Strongly Agree/Agree	51	59.3	15	57.7
Undecided/unsure	21	24.4	6	23.1
Strongly Disagree/ Disagree	14	16.3	5	19.2
<b>Girls will have sex with their boyfriend to keep him</b>				
Strongly Agree/Agree	54	62.1	18	69.2
Undecided/unsure	20	23.0	5	19.2
Strongly Disagree/ Disagree	13	14.9	3	11.5
<b>Boys have sex with girls to increase their ratings with friends</b>				
Strongly Agree/Agree	61	70.1	15	57.7
Undecided/unsure	18	20.7	4	15.4
Strongly Disagree/ Disagree	8	9.2	7	26.9
<b>Unwanted sex is common in young peoples' relationships</b>				
Strongly Agree/Agree	53	62.4	13	50.0
Undecided/unsure	20	23.5	8	30.8
Strongly Disagree/ Disagree	12	14.1	5	19.2
<b>Physical violence is common in young peoples' relationships</b>				
Strongly Agree/Agree	20	23.0	4	15.4
Undecided/unsure	40	46.0	10	38.5
Strongly Disagree/ Disagree	27	31.0	12	46.2

There is here consensus between young people about the extent of sexual pressure, but disagreement about the contexts in which sex is acceptable. The strongest agreement is evident with respect to the statement 'girls often go all the way when they don't want to', where two thirds of boys and girls concur. Across the responses there is clear evidence of the 'male in the head'<sup>16</sup> construction of sexual norms, where codes of behaviour associated with masculinity are normalised among both young women and young men (Holland et al, 1998). More young women than young men perceive that sex is related to emotional intimacy, and over half of all young people (60.9% of girls and 57.7% of boys) perceive that sex means different things for boys and girls. All the reasons girls offered for this perception (n=46) centred on the emotional context of sexual activity being more important to them (see also Firmin, 2010).

*For a girl sex is done because they love the person or because they like them and want to take things further, but for boys sex is done just for the pleasure they don't care who you are or how they feel about you.*

*Most girls have sex because they are in love whereas some boys see every hole as a goal.*

<sup>16</sup> The term 'male in the head' emerged from research by Janet Holland and colleagues (1998) with young people about sexual relationships and practices in the context of developing safer sex. It refers to the powerful construction of ideas about sex that privilege male pleasure, specifically associations of 'proper sex' with male orgasm following penetration, and the goal of heterosexual intercourse being to meet men's needs and desires. That both young men and young women ascribed to these views led the researchers to conceptualise this as the 'male in the head', to indicate how these notions are internalised.

*Boys generally don't really care, they just do it because they feel like they 'NEED' it whilst most of the times with girls it means something special.*

*Lads do it for attention and something to show off to their mates, sex for a girl is something special in the relationship.*

Responses from boys (n=9) reflected the same ideas.

*Boys treat it more casually and meaningless while girls treat it as a great passionate special time in life - not applying to all boys and girls just the majority there are exceptions.*

*Lads do it for fun and girls do it 4 "love".*

While three quarters of both young women and young men state that it is acceptable for young women to initiate sex, gender differences emerge in perceptions of sexual reputations. Two thirds of girls but only a third of boys agree that it is 'bad for boys to have sex with a lot of girls'. Half of girls but almost three quarters of boys report that girls who have sex with lots of boys are 'easy'. These gendered standards about appropriate sexual codes were also documented by Sue Lees (1993), Janet Holland and colleagues (1998), and Katy Redgrave and Mark Limmer (2004), and demonstrate that gender equality has yet to reach the landscapes of intimate relationships. Only a very small number of girls (6.9%) believe that having sex is something to tell friends, whereas almost a quarter of boys (23.1%) agree with this statement. Almost three quarters of girls and just over half of boys report that boys have sex to increase ratings with friends. Together these responses indicate that young people associate masculinity with sexual prowess and conquest (see also Holland et al, 1998; Renold, 2005). Qualitative responses from young people confirm this.

*Young men feel sex is just sex and a game to get their ratings up with friends.*

*Boys see sex as a thing to tell their friends about but girls think that it is a big step in a relationship.*

*For boys it is to big up their ego, and to tell their friends. For girls it's done for the boys so they can keep them, also some girls think the boy loves her because he wants sexual intercourse with them.*

Similar findings were reported in a large survey of young people in Scotland, where young women reported being humiliated, threatened and physically abused by boyfriends. One in ten had experienced attempted sexual assault and three per cent had been forced to have sex from partners (Burman & Cartmel, 2006). One in 14 young men considered 'forcing a partner to have sex' as '*something that just happens*' (p32, original emphasis). Recent research in London identified an imbalance in power between young men and young women as a consistent theme, diminishing young women's capacity to negotiate safer sex and build a sense of sexual autonomy (Hoggart & Phillips, 2009).

## **Non-consensual sex**



In terms of non-consensual sex, responses are extremely revealing. Three quarters (75.9%) of girls and almost two thirds (61.5%) of boys who responded to the online survey report that it is common for boys to pressure girls into sex, and only a tiny minority (3.4%) of girls disagree with this statement. Two thirds of young people believe that young women 'go all the way' when they don't want to, and that girls will have sex with their boyfriends to keep him. A slightly smaller proportion agrees that girls will have sex to please boys even when they do not want to (see also Firmin, 2010). Almost two thirds of girls (62.4%) and half of boys (50%) report that unwanted sex is common in young people's relationships. Slightly more girls (45.3%) than boys (38.5%) report that it is difficult to say no when being pressured to have sex.

Young people are less ambivalent about physical violence, but even here there are gender differences. Nearly a quarter of girls (23.0%) and one in six boys (15.4%) agree that physical violence is common in young people's relationships but only small numbers (2.4% of girls and 3.8% of boys) agree that 'if a boyfriend hits a girl it shows he cares'. It is worth reflecting here on the difference between attitudes to intimate partner violence and sexual violence; with more awareness of the former. This echoes findings from over a decade ago for the Zero Tolerance Trust (Burton et al, 1998). The message of campaigns on IPV has got through but there remains a need for similar investment and delivery of campaigns and programmes around sexual violence and coercion. Specifically, these should focus on enabling young people to refuse sex when under pressure and encouraging new meanings of masculinity. As one young woman said: 'most girls wish for boys to change the way they think'.

In the youth centres questionnaire, almost two thirds of young people believe that abuse in relationships affects a minority of people, but more than twice as many boys than girls agree with this. A statement that 'rapists are most often a stranger/someone you don't know well' reveals the starkest gender differences: nearly four times as many boys as girls agree, a statistically significant correlation ( $p=0.009$ ). As research shows that women are more often raped by an acquaintance, partner or ex partner (Kelly et al, 2005; Lovett & Kelly, 2009), girls' perceptions here more accurately reflect reality. Boys are more likely to endorse myths about rape based on 'stranger danger' (Kelly et al, 2005; Krahe et al, 2007) and thus perhaps hold a narrow perception of what constitutes rape. This has implications for how consensual sex is negotiated between young people, particularly how boys might perceive coercive sex between young people who know each other as 'not rape'. The need for comprehensive education that challenge stereotypes of rape and rapists in order that young people are able to name and define abusive experiences is clear. This was also noted in consultations for the new government violence against women strategy (Home Office, 2009).

The majority of young people from the youth centres thought that young women are pressured into having sex at least 'sometimes'. However more young men than young women believe that this happens rarely/never, and proportionately more girls think that this happens often. If this is based on experiential knowledge, then it suggests that young women are subject to sexual coercion, a finding also supported by empirical research (Burman & Cartmel, 2006; Barter et al, 2009; Firmin, 2010).

The youth centres questionnaire also asked young people if they agreed with a series of statements beginning 'is it OK for young men to pressure a woman for sex' if: a) he thinks she wants it; b) she has got him really aroused; c) he knows she is easy; d) she is drunk; e) she is his girlfriend.

Responses are extremely revealing. Girls are entirely unequivocal (100%) that pressuring a young woman for sex is unacceptable if she is drunk, or perceived by him as 'easy'. For the girls who responded, a young woman's behaviour, whether this refers to alcohol consumption or sexual reputation does not entitle young men to attempt to coerce her into sex. There is a little uncertainty where 'she has got him really aroused'

and a little more still if the young woman is his girlfriend (1 in 6 thinking maybe this is ok) or he thinks she wants it, but even here the vast majority do not think it is acceptable. The only situation in which a minority of girls report that it is acceptable is if he thinks she 'wants it'. Nearly half of boys, however, think it is or might be acceptable to pressure a young woman into sex if he thinks she 'wants it', is drunk or is his girlfriend. Here context and vulnerability appear to justify coercion; where there is a relationship, boundaries of consent are blurred; where it is possible to take advantage of intoxicated young women, nearly half of boys think it is acceptable to do so. In addition, two thirds report that it is acceptable if she 'has got him really aroused', reflecting a masculine sexual need discourse (Holloway, 1984) that privileges men's sexual gratification and release through a justificatory recourse to 'uncontrollable biological urges'. The ideas that both men 'need' sex and that past a certain point they are unable to control themselves are as old as the hills, but retain a 'common sense' currency. A New York police officer made the wry, but accurate, comment at a conference in the 1980s that 'no man has ever died due to an erection, but too many women and children have'. It is these kind of ideas which need to be addressed in sex/sexual health education, in order that their influence on the perceptions and behaviours of young women and young men can be defused.

Similarly, with just over a third of young people completing the questionnaires believing that if a young man thinks a girl is 'easy' it is or might be acceptable to pressure her into sex, we see the issue of reputation asserting its influence. To the extent that young women are unfortunate enough to have such ideas attached to them, and this is public knowledge, they are likely to encounter young men in their peer group who feel entitled to have sex with them. The intersection of female sexual reputation, unwanted sex and teenage pregnancy is as yet unexplored territory.

### **Non-consensual sex and pregnancy**

The online survey asked if young people had ever sex when they did not want to. A third of girls (33.3%, n=29) and a quarter of boys (26.9%, n=7) said they had. For five young women (5.7% of total number of girls who responded), this resulted in pregnancy. Further questions probed the extent of young people's knowledge about pregnancy related to non-consensual sex, both for sex they did not want and experiences of coercion. Table 5.5 presents this data.

**Table 5.5: Young People's sense of the links between non-consensual sex and pregnancy**

Statement	Girls		Boys	
	N	%	N	%
<b>Do you think young women get pregnant after having sex they did not want?</b>				
Yes	62	75.6	22	84.6
No	20	24.4	4	15.4
Total	82	100	26	100
<b>Do you think young women get pregnant after being forced to have sex?</b>				
Yes	65	75.6	20	76.9
No	21	24.4	6	23.1
Total	86	100	26	100
<b>Do you know anyone who has become pregnant after having sex they did not want?</b>				
Yes	32	37.2	7	26.9
No	54	62.8	19	73.1
Total	86	100	26	100

The majority of young people who responded to the online survey think that young women do become pregnant after non-consensual sex. Not only this, but over a third of girls (37.2%) and a quarter of boys (26.9%) know someone that this happened to, with 14 girls and four boys reporting that they know one young woman, eight girls and three boys two young women and nine girls knowing three young women. In the youth centres sample, more girls than boys believe that it is quite common for young women to become pregnant as a result on non-consensual sex, and two thirds of young women knew at least one girl that this had happened to, whereas the majority of boys did not. This is extremely strong evidence of the intersection of non-consensual sex and teenage pregnancy, and it alone should provide a spur to implementing routine screening and policy development.

### **Knowledge about and use of contraception**

Young people were asked about their knowledge and experiences of different forms of contraception, and their responses are presented in table 5.6.

**Table 5.6: Methods of contraception young people have heard of**

Method	Girls		Boys	
	N	%	N	%
Condom	86	98.9	24	92.3
Oral contraceptive (the pill)	87	100	24	92.3
Diaphragm	46	52.9	17	65.4
Injectable contraceptive	67	77	16	61.5
Intrauterine contraceptive device (the coil)	53	60.9	14	53.8
Rhythm method (withdrawal method)	49	56.3	19	73.1
The morning after pill	83	95.4	24	92.3

All young women have heard of the oral contraceptive and the vast majority are aware of condoms and Emergency Hormonal Contraception (the ‘morning after’ pill). Slightly fewer boys have heard of these methods, but again this is a small sample. Methods young people were least familiar with are the diaphragm and withdrawal. However, as table 5.7 shows, nearly a quarter of girls (23%) and one in six boys (15.4%) report using the withdrawal method. The most commonly used type of contraception is a condom, followed by oral contraceptives and the ‘morning after’ pill, and the least used a diaphragm and intrauterine device (coil). While a tiny number of boys report using a diaphragm, intrauterine contraceptive and post-coital contraception, this may refer to having a partner who has used these methods. Findings here confirm a recent study which found oral contraceptives and condoms to be the methods that young people are most familiar with (Hoggart & Phillips, 2009).

**Table 5.7: Methods of contraception young people have used**

Method	Young women		Young men	
	N	%	N	%
Condom	65	74.7	17	65.4
Oral contraceptive (the pill)	36	41.4	5	19.2
Diaphragm	0	0	2	7.7
Injectable contraceptive	4	4.6	2	7.7
Intrauterine contraceptive device (the coil)	2	2.3	1	3.8
Rhythm method (withdrawal method)	20	23	4	15.4
The morning after pill	29	33.3	6	23.1

We also asked about young people's views on responsibility for contraception, as these may also reveal gendered assumptions, of which interventions need to be mindful if they are to be effective.

Exploring young people's attitudes towards responsibility for contraception is useful as they are closely linked with notions of appropriate gendered behaviour, and enable interventions to be targeted at the issues that young people struggle with.

**Table 5.8: Young people's views on contraception**

Statement	Girls		Boys	
	N	%	N	%
<b>Only girls should be responsible for contraception</b>				
Strongly Agree/Agree	2	2.3	0	0
Undecided/unsure	8	9.2	4	15.4
Strongly Disagree/ Disagree	77	88.5	22	84.6
<b>Girls who carry condoms are looking for sex</b>				
Strongly Agree/Agree	13	14.9	11	42.3
Undecided/unsure	12	13.8	6	23.1
Strongly Disagree/ Disagree	62	71.3	9	34.6
<b>Using condoms is a good way to avoid sexually transmitted infections</b>				
Strongly Agree/Agree	83	95.4	22	88.0
Undecided/unsure	3	3.4	3	12.0
Strongly Disagree/ Disagree	1	1.1	0	0
<b>Having sex with a condom on doesn't feel as good as sex without a condom</b>				
Strongly Agree/Agree	34	39.1	17	65.4
Undecided/unsure	38	43.7	5	19.2
Strongly Disagree/ Disagree	15	17.2	4	15.4
<b>Boys don't like wearing condoms</b>				
Strongly Agree/Agree	49	56.3	17	65.4
Undecided/unsure	32	36.8	5	19.2
Strongly Disagree/ Disagree	6	6.9	4	15.4

Whilst the majority disagree that contraception is the responsibility of young women, qualitative responses explored throughout this chapter reveal contradictions between this and perceptions that young women are to blame if they become pregnant. Almost half of boys (42.3%) agree that girls who carry condoms are 'looking for sex', compared to just one in six girls (14.9%).

A majority of young people, although not all, are aware that condoms prevent sexually transmitted infections. Over half of girls (56.3%) and two thirds of boys (65.4%) agree that boys do not like wearing condoms, and linked to this, nearly two fifths of girls (39.1%) and two thirds of boys (65.4%) perceive that using condoms reduces sexual pleasure. This is explored in more detail below.

Young people in both samples were also asked to give two reasons why girls and boys might not use contraception. Tables 5.8 and 5.9 present these findings.

**Table 5.9: Why might a girl not use contraception?\***

Responses	Online				Youth centres			
	Girls		Boys		Girls		Boys	
	N	%	N	%	N	%	N	%
Wants a pregnancy	40	46.0	10	38.5	7	35	18	46.2
Embarrassment	20	23.0	1	3.8	1	5	1	2.6
Feels better without	15	17.2	6	23.1	5	25	5	12.8
Doesn't have any	13	14.9	2	7.7	0	0	0	0
Drunk	11	12.6	3	11.5	6	30	4	10.3
Scared to ask him to use one/he refuses	9	10.3	3	11.5	2	10	0	0
Pressure	9	10.3	1	3.8	1	5	3	7.7
Carried away in heat of moment	6	6.9	1	3.8	0	0	0	0
Doesn't want to	6	6.9	3	11.5	0	0	1	2.6
Forgets	5	5.7	0	0	0	0	0	0
Laziness	3	3.4	1	3.8	2	10	2	5.1
To show she's not frigid/not cool to use them	3	3.4	0	0	1	5	0	0
To please her boyfriend	3	3.4	0	0	0	0	0	0
His responsibility	3	3.4	1	3.8	0	0	0	0

\* Multiple responses possible

Other responses offered by a minority of young people included: allergies; infertility<sup>17</sup>; a belief that pregnancy would not occur; not knowing how to use contraception; fear that parents would discover that they were sexually active; using another form of contraception; and prohibitions on using contraception due to faith/personal beliefs. Two young men suggested that girls might not use contraception because they were 'easy' or 'a slut'. As almost half of boys also perceived that girls who carry condoms are looking for sex, it seems young women are subject to judgements about their intentions and moral worth either way.

The most common reason given by boys and girls is a desire to conceive, attributing an active sense of agency and rationale to this decision. It may, however, be a reflection that it seems obvious to young people that lack of contraception will result in pregnancy - if asked directly if they wanted to conceive responses here may be different.

Girls' responses contain more references to coercion, with one in ten from the online survey (10.3%) suggesting pressure and the same proportion a fear of asking boys to use condoms or his refusal and some citing wanting to please boyfriends or reluctance to appear 'frigid' or 'uncool'. One young woman suggested that a girl would not use contraception because 'she might want to get pregnant to keep her boyfriend'. Young women are also more likely to identify the influence of alcohol/drugs and embarrassment as a possible factor, suggesting more influences here of external contexts and coercion, and less an active desire for motherhood. Where young people are relying on barrier forms of contraception, these are much less likely to be used, and young women even less able to insist on it where they are 'incapacitated' through drugs or alcohol.

<sup>17</sup> Hoggart & Phillips (2009) found that young people ascribe to a number of myths about infertility, including that having abortions renders young women unable to have subsequent children.

**Table 5.10: Why might a boy not use contraception?\***

Responses	Online				Youth centres			
	Girls		Boys		Girls		Boys	
	N	%	N	%	N	%	N	%
Feels better without	46	52.9	11	42.3	5	25	10	25.6
Wants a pregnancy	14	16.1	4	15.4	5	25	9	23.1
Laziness	13	14.9	3	11.5	2	10	6	15.4
Doesn't have any	11	12.6	3	11.5	1	5	5	12.8
Doesn't want to	9	10.3	1	3.8	0	0	0	0
Her responsibility not his	7	8.0	3	11.5	0	0	0	0
Embarrassment	6	6.9	1	3.8	1	5	1	2.6
Drunk	5	5.7	1	3.8	3	15	2	5.1
Carried away in heat of moment	5	5.7	0	0	0	0	0	0
Look 'big'/tell his friends/feels manly not to	4	4.6	1	3.8	0	0	0	0
Will pull out at the last minute	4	4.6	0	0	0	0	0	0
Doesn't care	4	4.6	0	0	0	0	0	0

\* Multiple responses possible

Again a minority of young people suggested that young men might not use contraception because of allergies; infertility; a belief that pregnancy would not occur; not knowing how to use contraception; fear that parents would discover that they were sexually active; using another form of contraception; and prohibitions on using contraception due to faith/personal beliefs. Additional reasons included a perception that using contraception is 'not cool'; forgetting and no fear of contracting infections.

Across both samples, there is consensus about the loss of pleasure/sensation as a reason why young men do not use contraception. As Jennifer Oriel (2005) points out, the 'male right to sexual pleasure' has serious potential consequences for sexual health – a study across 14 countries found that the most common reason men refused to use condoms was reduced sexual pleasure (UNAIDS, 2000). Here masculinity was equated with ejaculation directly inside a vagina that condoms prevent, a perception that is also apparent in some young people who responded to these surveys: one young man suggested that boys might not use contraception 'because [they] want to have proper sex'.

Many also refer to a lack of effort, constructed as laziness ('can't be bothered'). Girls are also perceived by young men to be more knowledgeable about the risks of pregnancy and responsible for managing these risks (in contrast to agreements about joint responsibility for contraception). Here is evidence of 'an expectation that men initiate sexual activity which women are then supposed to regulate' (Hird, 2000: 74, see also Holland et al 1998). For instance, young people at the youth centres were asked if both boys and girls think about the possibility of pregnancy before having sex. The majority of respondents perceive that young women think about this more frequently than young men at least some of the time, and believe that young men do not think about it all. Again there is an acceptance here that responsibility for preventing pregnancy lies with young women. Although this appears to contradict instances where young people disagreed that contraception is girls' responsibility, we suggest instead it reflects the disjunction between intellectual and experiential empowerment, between expectations and experience (Holland et al, 1998), as discussed earlier.

### Knowledge and attitudes towards conception and pregnancy

Here young people who responded to the online survey were asked whether or not they endorsed common myths about conception. Table 5.10 shows the range of responses.

**Table 5.11: Online survey responses - myths about pregnancy**

	Girls		Boys	
	N	%	N	%
<b>A girl can't get pregnant the first time she has sex</b>				
True	8	9.3	1	3.8
False	78	90.7	25	96.2
<b>If a boy masturbates before having sex a girl won't get pregnant</b>				
True	3	3.5	2	7.7
False	82	96.5	24	92.3
<b>If you have sex standing up a girl won't get pregnant</b>				
True	5	5.7	2	7.7
False	82	94.3	24	92.3
<b>A girl won't get pregnant if a boy doesn't come inside her</b>				
True	44	51.2	13	50.0
False	42	48.8	13	50.0
<b>A girl won't get pregnant if she jumps up and down straight after sex</b>				
True	3	3.5	1	3.8
False	83	96.5	25	96.2
<b>A girl won't get pregnant if she has sex on her period</b>				
True	15	17.6	11	42.3
False	70	82.4	15	57.7
<b>If a boy doesn't put his penis all the way in a girl won't get pregnant</b>				
True	7	8.2	1	4.0
False	78	91.8	24	96.0

The young people who were surveyed on the whole rejected these common myths and appear to be well informed about the possibilities of conception. One exception however is that almost a fifth of girls (17.5=6%) and nearly half of boys (42.3) believe that it is not possible for young women to become pregnant while menstruating, and half believe that the withdrawal method prevents pregnancy.

Young people were also asked if they agreed with statements about responsibility for pregnancy and acceptability of abortion. Table 5.11 shows that overall the young people surveyed perceive that pregnancy is a joint responsibility. Interestingly more boys report that pregnancy is young women's 'fault', yet also believe that young men should 'stand by' young women if they become pregnant, again demonstrating contradictory positions. Attitudes to abortion are less equivocal with over half disagreeing with the statement that abortion is not acceptable, and slightly more boys being unsure or agreeing with the statement (see also Hoggart & Phillips, 2009).

**Table 5.12: Attitudes to pregnancy and abortion**

	Girls		Boys	
	N	%	N	%
<b>If a girl gets pregnant it's her fault</b>				
Strongly Agree/Agree	10	11.8	6	23.1
Undecided/unsure	15	17.6	7	26.9
Strongly Disagree/ Disagree	60	70.6	13	50.0
Total	85	100	26	100
<b>It is not acceptable for a girl to have an abortion/termination</b>				
Strongly Agree/Agree	10	11.8	4	15.4
Undecided/unsure	26	30.6	7	26.9
Strongly Disagree/ Disagree	49	57.6	15	57.7
Total	85	100	26	100
<b>A boy should stay with a girl if she gets pregnant</b>				
Strongly Agree/Agree	51	60.0	20	76.9
Undecided/unsure	25	29.4	3	11.5
Strongly Disagree/ Disagree	9	10.6	3	11.5
Total	85	100	26	100

In the youth centres sample, a stark difference emerged where young women are pressured to have sex; while no young people think pregnancy in this case is her responsibility, nearly three quarters of young men perceive boys to be responsible. In contrast two thirds of girls report that it is a joint responsibility; a surprising finding which suggests that even where pregnancy is a result of non-consensual sex, girls still hold themselves at least partly responsible. This may reflect two linked notions; first, that young women have an embodied sense of ownership of pregnancy, and also that, despite some contradictions, traditional ideas about contraception being an issue for girls and women persist.

### Summary

Responses from young people demonstrate that they are grappling with complex landscapes of pressure, coercion and expectation, although they have good knowledge about biological and technical aspects of conception. Young women show awareness of the 'male in the head' (Holland et al, 1998) discourse, privileging male pleasure and desires on the basis that this is what boys expect and demand. At the same time, young women are perceived to factor pregnancy into decision making about sex more than young men and hold more responsibility for pregnancy even if it is a result of non-consensual sex. As young people report that the most common reason for boys not to use contraception is a loss of pleasure/sensation, there is a need for campaigns and interventions to address notions of 'proper sex' and meanings of masculinity that are associated with ejaculation inside the vagina. Finally, more young women than young men report that abuse is common, that rape is more often committed by known men and young women are pressured into sex. Between a third and two thirds of young women know girls who have become pregnant as a result of non-consensual sex. These findings reinforce the call for interventions to address young women's experiences of non-consensual sex, starting with routine screening of pregnant young women. The next section turns to analysis of a survey of specialised sexual violence services for women and girls, to contextualise these findings with the experiences of support providers.



## Chapter 6: What Specialised Agencies Know: Rape Crisis Centres

Rape Crisis Centres emerged in the 1970s from grassroots feminist activism on sexual violence, and provide support to women and girls regardless of when abuse occurred (Jones & Cook, 2008). There are currently 38 Rape Crisis Centres affiliated to the Network in England and Wales, so the 17 responses here represent almost half of provision and 13.6% of the 125 non-statutory specialised sexual violence services in Britain (Coy et al, 2009).

The latest annual report from the Rape Crisis Network in Ireland reveals that in 2008, 2.9 per cent of all service users became pregnant through sexual violence (RCNI, 2009)<sup>18</sup>. For young women who had experienced childhood sexual abuse, 1.9 per cent conceived as a result, and were more likely to continue with the pregnancy than adult victim-survivors, although this may have been due to the limited options with respect to abortion in the republic of Ireland (ibid).

The RCC survey sought to probe knowledge and evidence of links between teenage pregnancy and non-consensual sex, how often young women disclosed abusive experiences, and any local initiatives addressing the intersections. In their responses, many RCCs referred to outreach work and liaison with other agencies that added depth to their knowledge of young people. Where appropriate comparisons are drawn with responses from Teenage Pregnancy Co-ordinators (see Chapter Four).

### Frequency of non-consensual sex

RCCs were asked how common they thought non-consensual sex was amongst young people. Nearly all (88.2%, n=15) report that it is 'quite' or 'very' common (see Table 6.1). Teenage Pregnancy Co-ordinators were more cautious with just over half (52.2%, n=12) opting for the quite or very common categories (see Chapter four). There was consensus in so far as no TPC or RCC believed that non-consensual sex among young people was rare.

**Table 6.1: How common RCCs think non-consensual sex is among young people**

How common	N
Very common	8
Quite common	7
Happens sometimes	1
Rare	0
Don't know	1
Total	17

When asked why they thought this, the majority of responses focused on the gendered dynamics of young people's relationships and the impact of the sexualisation of popular culture, that they were aware of through experiences of their service users:

*Many young girls do not feel confident enough to say no to their first / second and continuing sexual experience. As well as there being a 'currency' element for sexual acts with young people i.e. a mainstreaming of this. Many young boys (and girls) too are often educated by pornography in terms of their values and 'how to' knowledge*

<sup>18</sup> These are noted to be minimum levels given that information was not available for all service users (RCNI, 2009).

*around sex - unfortunately pornography does not involve conversations around consent and what relationships are really about.*

*Young women are ill informed with regard to sex and consent and do not realise that they are not giving their full consent - often having sex to ensure that they can be in with certain gangs for example. We have had cases where a girl has agreed to meet a boy to have sex and then finding that he has brought his friends along - although she may say yes to then engage in sexual activity with his friends it is not genuine consent as this is her only option to keep herself safe - girls are being abused by boys and young men who are quite simply taking advantage.*

The RCCs were asked how many teenage girls their service saw per year that had recent experiences of non-consensual sex. 11 respondents gave an approximate number, and two exact figures based on organisation records. The smallest number offered was 10, and the highest 70, with the average 34.5 young women per year. One centre suggested that it is 'difficult to estimate. Approximately 50 helpline contacts per year aged 14 – 17. Generally all teenage contacts are calling with recent or present experiences of sexual abuse'.

### **Contraception and non-consensual sex**

When asked if contraception is less likely to be used when sex is non-consensual, nearly two thirds of RCCs (64.7%, n=11) perceive that it is, often drawing on practice experiences to illustrate their position:

*In the cases when non-consensual sex has been disclosed contraception has not been used.*

*We have recently come into contact with young girls who were forced to give oral sex to boyfriends - the acts have been filmed on mobiles and circulated, no contraception was used.*

*The young woman probably had no intention of needing contraception so she was unprepared.*

*Many of the young women who are coerced are in a situation where discussion about contraception just does not happen and the male youths do not care about possible outcomes of non use.*

Here RCCs draw on similar themes as the TPCs, lack of planning and negotiation between young people, but crucially they also identified the gendered power inequalities that TPCs largely did not. By highlighting that young women are forced into sexual acts – a context in which the space for negotiation is considerably removed RCCs demonstrate knowledge of dynamics in non-consensual sex – an arena in which they have considerable expertise. The continued significance of gender inequalities and power relations is echoed by recent research into abortion among teenagers in London (Hoggart & Phillips, 2009).

### **Links with Teenage Pregnancy**

Responses to whether or not there are links between teenage pregnancy and non-consensual sex were mixed, with only one 'yes', based on experience of support provision:

*Youth service workers see young women who are pregnant who have been coerced into sex.*

Seven thought that there were no links, although one qualified this answer with 'it is difficult to say as we have unwanted pregnancies as a result of non-consensual sex in all age ranges not just teenage'. Over half (n=9) indicated that they did not know if there are any links. These responses sit at odds with certainty expressed with respect to limited contraception use. The need for national and local data collection is again underscored and the necessity of an evidence base for all agencies working around non-consensual sex, teenage pregnancy and sexual health.

### **Collecting data on non-consensual sex and teenage pregnancy**

Respondents were asked if any teenage girls/young women (aged 19 or under) had used their service who had become pregnant as a result of non-consensual sex, and if so, how many in the last 12 months. Ten RCCs responded 'yes' to this question - two gave no figures, but eight had seen at least one young women who conceived as a result of sexual coercion and one centre has seen five. Specialised sexual violence support services are seeing young women who have become pregnant as a result of coerced and/or pressured sex.

Respondents were also asked if they knew whether young women disclose experiences of non-consensual sex to other agencies. Responses were mixed; with as many services indicating that they do not disclose as that they do (see table 6.2). Garnering a sense of how many young women do disclose offered one route to assessing how hidden this knowledge is from services. One respondent referred to the weight of responsibility and blame that young women carry; another suggested here that disclosure 'depends on... the response the young woman thinks she will get'. The shame and stigma that still suffuse sexual violence, linked to processes of normalisation that encourage young women to not name experiences as abusive, create a pincer movement which result in a minority of young women telling anyone. Their own ambivalence is reflected in that of responses to this question.

**Table 6.2: RCCs views on young women's disclosure to other agencies**

<b>Do young women disclose to other agencies?</b>	<b>N</b>
Yes	7
No	7
Don't know	3
Total	17

One respondent highlighted that the ways in which young women describe their experiences to other agencies, which may hinder whether or not they are recognised as abusive.

*They don't necessarily name it as non consensual but describe relationships characterised by pressure and bullying and are told they will be "chucked" if they don't agree to sex.*

*In the cases I've worked with the young people have not disclosed to other agencies at first, however with support they have disclosed to others later.*

*Young girls tend to think if they keep it hidden it will just 'go away'. They live in a blame culture and still do take on the weight of responsibility for everything that happens to them.*

RCCs were asked if they knew of any information relating to teenage pregnancy and non-consensual sex, including their own records, research and reports. Five RCCs record this information in their own organisation statistics, two in sexual health reports, and one in child protection data.

As with the responses from the Teenage Pregnancy Co-ordinators, collecting data on links between teenage pregnancy and non-consensual sex is not undertaken consistently or systematically.

### **Training on sexual violence and coercion**

Nearly all RCCs (n=14, 82.3%) who responded believe that training on sexual violence for professionals working in the teenage pregnancy field is relevant. Yet over half (n=10, 58.9%) also report that in their area, there is not enough knowledge on non-consensual sex and almost three quarters (n=12, 70.6%) not enough resources. Five report that non-consensual sex is addressed in local initiatives on teenage pregnancy, details revealed that this was often down to individuals and the input of RCCs themselves. Given their scarcity this is unlikely to be repeated in most areas, and definitely not in London.

*I have a good relationship with teenage pregnancy and can and do consult with them on matters.*

*We go into schools and colleges and talk about 'staying safe' in relation to sexual matters as well as drugs and alcohol safety.*

*The girls group that I co-facilitate [addresses this]. By the Sexual health advisor and at GUM clinics. I am not sure the extent to which they push this perspective in other initiatives.*

*Our Youth Outreach worker runs an education programme in schools which covers non consensual sex, but I don't know of any other initiatives.*

Whilst delivery by Rape Crisis Centres is a promising model, since they have considerable experience and expertise, it could be another burden on already under-resourced organisations<sup>19</sup>. If initiatives are being carried out on issues of non-consensual sex, specialised services should be involved in the development of content and where possible, delivery. As almost half were not aware of any targeted programmes in their localities, it is reasonable to suppose that none are being delivered.

*I think that we need to start educating both boys and girls about sex - what is consent; why is consent important; consequences for not gaining full consent for both parties...*

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<sup>19</sup> Recent research indicates that the average annual income for each RCC was £81,598, only marginally more than the cost to the state of investigating a single rape (£76,000) (WRC & Rape Crisis, 2008), and that sustainable funding is the biggest challenge for continuing service provision (Coy et al, 2009). Twenty-nine of the 38 affiliated centres completed a survey for Map of Gaps 2, and results indicated that almost a quarter (24.1%) faced closure during 2008/9, and almost two-fifths (39.3%) fear closure in 2009/10 because of a lack of funding. One RCC in England and Wales indicated, as an example of unmet need, that they have 71 women on their waiting list, who will have to wait an average of six months to access support.

*young men and women need to be fully informed of not only what safe sex is but also the consequences of having unsafe/non consensual sex to ensure that they are aware of the difference between rape and consensual sex. For example - rape is not about violence and physically restraining someone so they have no choice to have sex it can be through manipulation and fear.*

This mirrors the recommendations from TPCs that targeted education programmes be developed and delivered that focus on the meanings and contexts of consensual sex, particularly drawing out the range of ways in which sex can be pressured and coerced: the continuum of sexual violence as it was termed (Kelly, 1987).

### ***Non-consensual sex and decision making with respect to pregnancy***

Almost all (n=16, 94.1%) of RCCs report that young women who conceive as a result of pressured/forced sex grapple with complex decision making over the future of the pregnancy.

*There is... the fact that the baby is a reminder of a violation against them. Will they be able to care for and love this child? The emotional and physical elements of such a pregnancy and birth prove to be too much for some, sadly.*

*There are varying issues for the young woman. 1) When pregnancy has occurred not through her choice, her own agency has been taken away from her body and as such making the decision to have a child as a result of rape is a huge decision for anybody, let alone a young person to make. 2) If she decided to have that child, she has to make the decision around whether she should disclose the nature and context of the pregnancy to family, friends, and professional alike. 3) If the child is carried to full term the implications on the mother about that child's heritage and parentage are huge.*

*She has to make decisions around whether she could love the baby and whether there would be too much of a reminder of the incident in having the "result" of it around. She has to decide whether the examinations, ante and post natal care, and the birth process will be too traumatic for her. She has to consider, if she is or was in a relationship with the perpetrator, or if the perpetrator was a family member or close associate, what the implications might be both if she continues with the pregnancy or if she has a termination.*

Responses from TPCs also raised the same issues about emotional legacies and potential for reminders of the perpetrator, but respondents from RCCs also highlight a lack of ownership of the body that research also reveals is often a legacy of sexual violence (Kelly, 1988; Jordan, 2008; Coy, 2009b). This reinforces the need for pregnant young women to be asked about non-consensual sex and appropriate specialised support made available regardless of whether they choose to continue with the pregnancy. They need to find ways to regain a sense of pride and ownership in their own bodies: sexual autonomy and sexual agency are key to young women's physical and sexual safety.

### **Summary**

Specialised sexual violence services have considerable experience and expertise on conception, pregnancy and decision-making following non-consensual sex. Many respondents referred to young

women's lack of sense of ownership and control over their bodies, and dynamics of guilt, fear and shame. Rape Crisis Centres are also seeing young women who have conceived as a result of non-consensual sex and cases where young women are forced into sex and unable to negotiate use of contraception. It is clear from their practice experience and examples that understanding the continuum of sexual violence (Kelly, 1987) is key to supporting young women. They also identify, as essential, training for all relevant professionals and development of prevention and intervention work on non-consensual sex, embedded in a gendered analysis of the continuum of sexual violence.

## Chapter 7: Reflections and Conclusions

This study aimed to: document the extent and impact of non-consensual sex on teenagers in London; explore links with conception and pregnancy; identify risk factors; and make suggestions for prevention strategies. Responses from young people who participated reveal that sexual violence, coercion and pressure are common experiences. Whilst drawn from a small sample size, the findings echo those in several recent studies (Burman & Cartmel, 2006; Barter et al, 2009; Firmin, 2010). All data sources that contributed to this report confirm links between teenage pregnancy and non-consensual sex. International research suggests a range of connections, including childhood sexual abuse and sexual violence within relationships. While no similar British research has been carried out, it is likely, given the prevalence of non-consensual sex in the lives of young women, that some are becoming pregnant through sex that they have been forced, coerced or pressured into. TPCs reported that sexual coercion was an under-developed, but nonetheless important theme in their work. Young people who participated in the online and youth centre questionnaires reveal knowing of young women who became pregnant in these circumstances, and Rape Crisis Centres are providing support to girls who have conceived after coerced sex.

Based on the already reported findings, we make recommendations with respect to five key issues: addressing risk and prevention with respect to non-consensual sex; SRE programmes; routine screening of pregnant young women; building the evidence base on teenage pregnancy and non-consensual sex; integrating initiatives on non-consensual sex in teenage pregnancy work.

### Reducing risk and prevention

There are a number of policy frameworks which require prevention of violence against women (VAW), of which non-consensual sex forms a large part. These include international human rights obligations and the new government VAW strategy (Kelly & Lovett, 2005; Coy et al, 2008; Home Office, 2009). Moreover, the Gender Equality Duty (GED) requires all public bodies to actively promote equality of opportunity and eliminate unlawful discrimination and harassment. Given that VAW is internationally recognised as ‘a major impediment to achieving gender equality’ (United Nations, 2006:9), addressing sexual violence and coercion is a key obligation under the GED. Necessary measures here include the collection of local data and the development of policies that explicitly incorporate links between VAW and health, substance misuse, housing needs and teenage pregnancy (EVAW, 2007).

Here we draw together the main findings with respect to risk and prevention and make recommendations accordingly.

Responses from young people support wider research literature that notions of masculinity shape how sex is negotiated with respect to male entitlement, consent and young women’s capacity to resist pressure (Cowburn et al, 1992; Holland et al, 1998; Crooks et al, 2007; Firmin, 2010). For instance, young people referred to ‘boys doing it for the ratings’ and for two thirds of the sample, being driven by uncontrollable biological urges justified using coercion to obtain sex. Young people, Teenage Pregnancy Co-ordinators and Rape Crisis Centres all perceive that young men prioritise their own pleasure in sexual encounters. This, combined with the wealth of evidence that the vast majority of perpetrators of sexual violence are men, illustrates that work on prevention needs to begin with initiatives aimed at transforming how young men ‘do masculinity’ (Berkowitz, 2002; Flood, 2005/6; Jensen, 2007). Alan Berkowitz suggests:

*... sexual assault prevention should help men explore how they are taught to be men, the conflicts and discomfort associated with trying to live up to the male role, and how*

*they may intentionally or unintentionally enable the coercive sexual behaviour of other men* (Berkowitz, 2002: 164).

Berkowitz offers practical suggestions for addressing and involving young men in sexual violence prevention work, including: a gendered analysis of sexual victimisation; focussing on the emotional and communicative aspects of consent as well as legal dimensions; recognition of the range of coercive behaviours, from verbal pressure to physical force that constitute non-consensual sex; and enabling men to actively challenge others' coercive behaviours. We also recommend these as basic principles for the development of work with young men that seeks to establish positive meanings of masculinity (see also Coalition of Men and Boys, 2009) and make 'consensuality' a positive standard for all sexual activity. Placing prevention at the core of work with young people will encourage professionals and agencies to think beyond responding to individuals, to imagine how to create deeper and longer term change (Coy et al, 2008)<sup>20</sup>.

Unpicking and raising awareness of the continuum of non-consensual sex in young women's lives also emerges as a key issue. Research indicates that young women experience sexual coercion in a range of contexts, including: intimate relationships (Barter et al, 2009); peer groups and friendship networks (Firmin, 2010) and through commercial sexual exploitation (Pearce et al, 2003; Coy, 2008). Here work is needed on enabling young women to name their experiences of non-consensual sex, to have accurate information about the most likely contexts for rape and sexual assault (by known men in situations of social contact) and to unpick stereotypes of sexual violence, victims and perpetrators. The positive side to this, and recommended by TPCs, is to build knowledge about what consensual sex is – the contexts that promote it and the feelings it evokes.

The relationship between alcohol and sexual activity also require attention, as surveys indicate that young people's intentions and expectations are altered by alcohol (Limmer & Redgrave, 2004; Bellis et al, 2008; British Youth Council, 2009). Responses from young people in our surveys reveal that being drunk is a possible reason not to use contraception, and that nearly half of boys report that it might be acceptable to pressure a young woman into sex if she is drunk. That alcohol is used to facilitate sexual assault, particularly where victims and perpetrators do not know each other well, has been well-documented in research (Lovett & Horvath, 2009). There is, therefore, a clear need for work on the continuum of non-consensual sex to address alcohol as a potentially conducive context.

### **Recommendations**

- Children's Trusts should take responsibility for supporting the development of local initiatives on teenage pregnancy and non-consensual sex under their remit of improving children's wellbeing and contributing better outcomes for children and young people.

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<sup>20</sup> Examples of programmes working with young men include the White Ribbon Campaign ([www.whiteribbon.ca](http://www.whiteribbon.ca), [www.whiteribboncampaign.co.uk](http://www.whiteribboncampaign.co.uk)) and Men Can Stop Rape ([www.mencanstoprape.org](http://www.mencanstoprape.org)). Both provide a range of educational and awareness raising materials. The United Nations has also formed a global network of Men Leaders as part of the Framework for Ending VAW (United Nations, 2008) and the UK based Coalition of Men and Boys produced a report which explores men's violence to women ([www.comab.org.uk](http://www.comab.org.uk)).



- Local Safeguarding Children's Boards should integrate the continuum of non-consensual sex, including that within young people's intimate relationships, as a safeguarding issue.
- Sex/sexual health education should integrate raising awareness of the continuum of non-consensual sex, both unpicking common sense notions of 'uncontrollable male sexual urges' and 'reputations' for young women and enabling exploration of what consent looks and feels like.
  - Within this exploration of how being drunk or incapacitated becomes a conducive context for sexual coercion needs to be addressed. Rather than promoting the message that young women should, therefore, not get drunk an alternative of addressing what sexual ethics for young men are in such situations should be developed.
- Developing innovative and engaging ways that enable young men to reflect on how they understand and 'do' masculinity should be developed in all relevant settings, including educational contexts and youth centres. The goal here should be to de-couple masculinity from sexual conquest and the privileging of male sexual pleasure.
- As international research indicates that appropriate and sensitive support reduces the likelihood of young women who have been abused in childhood becoming pregnant in adolescence (Erdmans & Black, 2008), addressing the legacies of child sexual abuse should be urgently integrated into national and local work on teenage pregnancy. As part of this, specialised sexual violence services should be supported by health trusts under the umbrella of teenage pregnancy.

### **Routine screening of pregnant young women**

Many sexual health and contraception services are not asking young women about experiences of non-consensual sex and the circumstances of conception. Some routinely screen girls under the age of 16 as this is the threshold for legal consent to sexual activity, but do not ask the same questions of 17 and 18 year olds, relying instead on young women to spontaneously disclose abuse. There is an assumption here that where young women are over the threshold of legal consent for sexual intercourse, they have always consented to sexual activity. Given that Rape Crisis Centres report that young women often do not tell sexual health agencies, GPs and midwives about sexual violence, there is an argument for routine screening protocols to be implemented. Careful thought must be given to the phrasing of questions, avoiding the use of 'rape' and 'force' as young women often do not identify these terms with their experiences. Suggestions for possible phrasing in routine screening tools can be found in Appendix 1. Routine enquiry with respect to domestic violence sends out a message to women that violence is unacceptable, aims to reduce the stigma associated with disclosure and offers an opportunity for women to be given details of support services (Taket, 2004). The same principles should apply in this case, with additional thought given to the Safeguarding issues that may arise.

As both TPCs and Rape Crisis Centres identify additional issues for professionals supporting abused young women over the future of their pregnancy (see Chapters Four and Six), specifically with respect to abortion and emotional attachments, training for health professionals and practitioners is essential. The report of the NHS Taskforce on Violence Against Women and Children recommends education and training on violence and abuse for all NHS staff, with advanced programmes for 'first contact' staff who are more likely to encounter women and girls who have experienced abuse (Department of Health, 2010). We suggest that sexual health professionals are regarded as 'first contact' staff and thus receive advanced

training that enables them to identify signs of abuse, provide a safe space for victim-survivors to disclose and make referrals to appropriate specialised support services.

### **Recommendations**

- All sexual health and genito-urinary medicine clinics (and other relevant agencies) should ask all pregnant young women, as a matter of routine, about experiences of non-consensual sex, regardless of whether or not they wish to continue with a pregnancy. A template screening tool that can be incorporated into assessments and history taking processes can be found in Appendix 1.
- Practitioners and health professionals should receive training on the dynamics of sexual violence, in order that they can provide sensitive and non-judgemental support to young women who may be grappling with complex layers of decision making where a pregnancy is a result of non-consensual sex.
- Practitioners should develop referral routes to specialised sexual violence services.

### **Extending the evidence base**

The process of collating evidence on intersections between teenage pregnancy and non-consensual sex for this project highlighted gaps in data collection across a range of relevant agencies. The lack of weight given to non-consensual sex in the national teenage pregnancy strategy means there is no central steer to develop research nor is there a mandate for services coming into contact with pregnant young women to record and monitor data on abusive experiences. There is, therefore, currently a weak evidence base and we make a number of recommendations to address this.

### **Recommendations**

- Data on non-consensual sex and circumstances of conception should be collated in line with other monitoring requirements and included in all reports on service use and needs.
- Children's Trusts and LSCBs should collate and analyse this data, considering it an essential aspect of local information about teenage conceptions and sexual activity which will be used to guide policy development and interventions.
- Further national and local research projects should be funded and undertaken with pregnant young women and young mothers about sexual violence. This should explore their lifetime experience of the continuum of non-consensual sex and connections, if any, to their pregnancies, including legacies of childhood sexual abuse, circumstances of conception and decision making processes. Consideration should also be given to similar studies with young men, as research highlights that boys' experiences of sexual abuse increase the likelihood that they will be young fathers.

### **Sex and Relationships Education (SRE) programmes**

In October 2008 the government announced that Personal, Social and Health Education (PSHE) would be made statutory in schools in England in 2011, following a review of SRE programmes (DCSF, 2008), although the bill fell when the election was announced in April 2010. Several themes emerged from the review that are relevant here, including that effective interventions deal with pressure, negotiation and

relationships as well as attitudes (rather than simply information), but teachers report a lack of confidence about addressing these issues. The new draft SRE guidance emphasises the importance of respectful attitudes, enabling young people to negotiate sexualised media and resist sexist and sexual bullying (DCSF, 2010). Coercion, consent and signs of abusive/exploitative behaviour are identified as themes to be addressed in SRE, using PSHE as the context for exploring sexual and emotional relationships. However, there is no gendered analysis and minimal reference to power inequalities or the continuum of non-consensual sex. Moreover, the aspects most likely to be mainstreamed as statutory are biological and technical, what has been termed the 'plumbing and prevention of pregnancy' approach to sex education. We have two decades of research showing that this is not what young people want or need.

Concern about the content of SRE programmes has long been expressed by young people and researchers/practitioners on sexual violence. For instance, a survey of over 20,000 young people by the UK Youth Parliament (UKYP) reported that 40 per cent rated SRE education as poor, and almost half received no sessions about relationships (UKYP, 2007). Another study of 4,353 young people in schools in England found that over half requested more information and advice on how to resist sexual pressure and coercion, with girls expressing concerns about boys 'expecting' sex, and how to negotiate refusing to have sex (Forrest et al, 2004). A smaller number specifically raised the issue of sexual violence. Other themes where information was considered lacking included: sexual health; emotions and feelings; bodily development and same sex relationships. The researchers conclude that SRE is failing to address the contexts in which young people are having sex, particularly constructions of gender and 'values which in part militate against young people using ... information in their sexual behaviours and relationships' (Forrest et al, 2004: 349). Young people from BME communities in London highlight SRE as a particularly crucial source of information, ideally delivered by sexual health professionals and focussing on emotions and relationships (Testa & Coleman, 2006). Similarly, research in New Zealand showed that young people also wanted more information about emotions and pleasure (Allen, 2008). Focus groups in this study revealed that when young people did not receive information that they require they seek it from other sources (ibid). This has worrying implications, given that we know young people turn to the media as a 'super peer' (Levin & Kilbourne, 2008), and are thus building a sense of norms and expectations from highly sexualised sources such as advertising, music videos, and crucially for boys, lads mags and pornography: all contexts in which neither contraception nor consent feature strongly. Sexualised media sources influence young people's perceptions and attitudes in harmful ways: promoting notions of women as sex objects; equating masculinity with predatory sexual prowess; and damaging young women's relationships with their bodies (APA, 2007; Peter & Valkenberg, 2007; Coy, 2009a). As the Teenage Pregnancy Strategy aims to address the impact of the media, introducing media literacy classes that enable young people to decode these notions would be an important step, recommended in the recent sexualisation review (Home Office, 2010).

SRE programmes should therefore integrate work on the issues of consent and negotiation that young people report struggling with, as the new guidance proposes. This should be firmly grounded in a gendered analysis of the continuum sexual violence. As part of the new government violence against women (VAW) strategy, gender equality and VAW will be included in the school curriculum and PSHE lessons and introduced into teaching and OFSTED inspection standards (Home Office, 2009). An evaluation of a school based programme on violence against women delivered in UK schools demonstrates that it successfully challenged tolerance of violence against women when embedded in a gendered analysis and was most effective when part of a 'whole school approach' (Mahony & Shaughnessy, 2007). The SRE Core Curriculum for London and the national SRE draft guidance have a number of areas at both primary and secondary level where issues around non-consensual sex could and should be addressed, including

sessions on emotions and feelings, managing risk, social pressures and healthy lifestyles (see Power & Proctor, 2009; DCSF, 2010).

### **Recommendations**

- In line with the recently published VAW strategy, the continuum of sexual violence and its gendered dimensions should be a core aspect of SRE lessons, with young people and teachers encouraged to work towards a whole school approach.
- Issues of consent, coercion and pressure should be prioritised, with particular attention paid to how notions of sexual reputation influence expectations and operate to reinforce notions of masculinity that, as previously noted, are linked to sexually coercive behaviours.
- Young women's control of their bodies and sexual autonomy should also be key issues, in terms of their rights to both refuse sex they do not want, and to exercise control over reproduction.
- SRE should explicitly address myths about infertility that some young people appear to ascribe to, and take into account recent research findings (Hoggart & Phillips, 2009) that indicate how the issue of abortion is dealt with affects the choices young women make.
- Data on non-consensual sex and conception that is collated at a local level should inform the development of local SRE programmes, as recommended by the new draft guidance (DCSF, 2010). Teachers with responsibility for co-ordinating SRE in schools and PSHE advisors in local authorities are ideally placed to take the lead on this.
- Media literacy should be introduced into SRE lessons to enable young people to critically analyse media messages that sexualise girls and young women and present narrow and exploitative models of masculinity.

### **Developing initiatives on non-consensual sex in teenage pregnancy work**

London Teenage Pregnancy Co-ordinators and Rape Crisis Centres consistently report that initiatives on non-consensual sex are currently lacking in programmes addressing teenage pregnancy, although some work on sexual bullying is taking place. Overall, the small pockets of work that are being delivered appear to be ad hoc and without a coherent direction or framework, dependent on committed individuals. TPCs suggested that 'a strategic rethink would be a priority' if a strong connection between teenage pregnancy and non-consensual sex was revealed. This exploratory study has identified that young people and sexual violence services know of young women who have conceived as a result of non-consensual sex. This combined with the international knowledge base and British studies highlighting sexual violence and coercion in young people's relationships (Burton et al, 1998; Burman & Cartmel, 2006; WAFE/Bliss, 2008; Barter et al, 2009; Firmin, 2010), underscores the continuing need for sexual violence to be mainstreamed into programmes of work on teenage pregnancy. Lack of confidence in responding to issues of sexual violence, based on insufficient knowledge, was also highlighted as pointing to the need for training in the NHS taskforce report (Department of Health, 2010).

### **Recommendations**

- Training on the continuum of sexual violence should be integrated into programmes on teenage pregnancy for all agencies and individuals working in the field, including Teenage Pregnancy Co-ordinators, youth workers and sexual health professionals.
- In line with the recommendations of the NHS Taskforce on Violence Against Women and Children, PCTs should commission local specialised sexual violence services to deliver support, and ensure that they are funded to provide services to young women.
- Initiatives on non-consensual sex should be integrated into teenage pregnancy programmes of work. Drama workshops were suggested as a creative and effective way to engage young people.
- Specialised sexual violence services should be consulted about, and participate in, local multi-agency forums about teenage pregnancy. The severe under-resourcing of such services means that they may need to be recompensed in order to undertake this role.

### **Last words**

This project has found that the intersections between non-consensual sex and teenage pregnancy is both hidden and subjugated knowledge. Subjugated in that young women are not being encouraged or enabled to name their experiences; hidden in the sense that data is not routinely collected which would establish the direct and indirect connections. Ten years after being identified as a potential factor in teenage pregnancy, it is time for the issue of sexual coercion to move from margin to centre.

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## Appendix 1



### Routine Screening Protocol

- Have you ever been pressured do something sexually that you did not want to do?

Yes once

Yes, several times

No, never

Details (optional)

- Was this pregnancy conceived through sex in which you were pressured/forced?

Yes

No

Details (optional)

- Have you received any support/talked to anyone about your experiences? (if no, offer contact numbers for specialised organisations)

Yes

No

Details (optional)