Research paper

'I didn't do it cause I wanted a baby': sexual decision making, roles and choices in relation to early parenthood amongst black and minority ethnic young parents in England

Gina Marie Awoko Higginbottom
Canada Research Chair in Ethnicity and Health and Associate Professor, Faculty of Nursing, University of Alberta, Edmonton, Canada

Laura Serrant-Green
Principal Research and Development Fellow, University of Wolverhampton, UK

Nigel Mathers
Institute of General Practice, ScHARR

Peter Marsh
Department of Sociological Studies, University of Sheffield, UK

Mavis Kirkham
Sheffield Hallam University, UK

Jenny Owen
ScHARR, University of Sheffield, UK

What is known on this subject
- The phenomena of sexual decision making and early parenthood in black and minority ethnic (BME) communities are complex.
- For some BME women, the age at which they first became parents has little or no impact on the level of poverty experienced in later life.
- BME young people have higher rates of sexually transmitted disease.

What this paper adds
- Insights into the complex phenomena of sexual decision making in BME communities in England.
- Young BME people in this study did not attach a fatalistic or inexorably negative view to the notion of becoming a parent early.
- A renewed and strengthened relationship between the young women and their mothers was a recurrent theme within this research.

ABSTRACT

This paper explores sexual decision making in relation to early parenthood amongst black and minority ethnic (BME) young parents in England. It is based on research funded by the Teenage Pregnancy Unit (formerly in the Department of Health) at the Department for Education and Skills in England. Data were collected using focus groups and semi-structured interviews, and analysed using the 'framework' method. Eighty-eight young people, 10 mothers of the young people and 41 service providers participated in the study. The findings presented here relate to patterns of sexual decision making that precede early pregnancy, and to young parents' immediate responses to pregnancy. The findings organised into four domains: contraception, precursors to pregnancy, reactions to pregnancy, family and service support to young parents. The findings indicate that BME young people in this study shared some commonality of experience with the general population of young white British people who become parents early, such as aspects of sexual decision making, decisions around contraception, timing of sexual intercourse and choice of partner. One of the key findings was the level of acceptance and adjustment to becoming parents, which contradicted the negative assumptions usually attributed to teenage pregnancy and early parenthood.

Keywords: black and minority ethnic, early parenthood, sexual decision making, young parents

Introduction

This paper explores sexual decision making, roles and choices in relation to early parenthood amongst black and minority ethnic (BME) young parents in England. The paper draws upon the findings of a research project funded by the Teenage Pregnancy Unit (formerly part of the Department of Health) now located in the Department for Education and Skills (DfES) in England. This paper presents findings from the study in relation to patterns of sexual decision making that precede early pregnancy, and to young parents' immediate responses to pregnancy

The phenomenon of sexual decision making and risk of early pregnancy among BME young people is complex. Low (2001) demonstrated that BME young people have higher rates of sexually transmitted diseases, and the ethnic profile of teenage pregnancies in England reveals that Bangladeshi, African-Caribbean and Pakistani young women are disproportionately at risk of early parenthood (Social Exclusion Unit, 1999; Berthoud, 2003). For BME young people, the chances of becoming parents have been said to be further enhanced by higher rates of associated indices for early pregnancy, such as social and economic disadvantage, e.g. school exclusions and numbers of 'looked after' children (CAPSE Research, 2000). However, it must also be noted that, for BME women, the age at which they first became parents had little or no impact on the level of poverty experienced in later life (Robson and Berthoud, 2003). In their study of BME young people, Jayakody *et al* (2005) concluded that other risk-taking behaviour such as smoking, drinking and experimenting with illegal substances also increased the risk of early sexual intercourse.

Studying the sexual decision-making and early parenthood experiences of BME young people must take into account that, while some shared experiences exist between them, for example in their experience of poverty, disadvantage, personal and institutional racism, the heterogeneity of British BME groups means they present a diverse profile. Cultural variations such as early marriage, the need to evidence fertility in marriage, religious affiliations, and gender roles may be more powerful influences on some BME young people than others. Affiliation to traditional birth cultures may have a role in delaying the onset of sexual activity (Jayakody *et al*, 2005). It is, therefore, axiomatic that ethnicity and ethnic identity are underpinning aspects of this paper and the study that preceded it.

Ethnic identity

Ethnicity, as a concept that is different from the concept of *race*, has risen to prominence in health-related research and social care provision in England (Bradby, 2003). The concept of ethnicity goes beyond perceptions of phenotype into a complex sharing of culture, values, traditions and perceptions of belonging that interfaces with every aspect of the human experience. As such, ethnicity in this study is distinctly explored within a British context and is not necessarily related to geographical location or national state boundaries. Nazroo (2006) asserts that the formation of ethnicity is complex, and contributes to self-identity and self-concept. Ethnic identity is therefore not static, but may change according to context, place and time. Ideally ethnicities-based approaches to research recommend that participants should self-assign ethnicity to account for the personal and subjective nature of the self-assignation of ethnic identity.

The issue of defining ethnic identity is further compounded by longstanding evidence to indicate that the relative positions of individuals and groups in society influence all aspects of their lives including their health. The research of Karlsen and Nazroo (2002a,b), for example, indicates that socio-economic status and racism outweigh cultural and ethnic influences on health inequalities. Gender, ethnicity and socio-economic status are identified in this and many studies as influencing power positions within and between social groups (Karsen and Nazroo , 2002a,b). These, in turn, impact on individual and group prospects of preventing disease and maintaining health. This suggests that health and life chances are influenced by more than individual choice and that any research focusing on ethnic aspects of experience must also take into account these broader influences on health and life chances.

The diversity of perspectives on how to account for ethnicity in research means that early on in their studies, researchers must indicate the approach they have taken to conceptualising ethnicity, so that findings may be appraised in this context. In this study the authors have embraced the multifaceted view of ethnicity recommended by Nazroo (2006) and others (Balsa and McGuire, 2002; Serrant-Green, 2002; Higginbottom, 2006; Testa *et al*, 2006). This incorporates the right of each individual to self-assign ethnicity and recognition of the associated external structural, political and communal influences on their health and life chances.

However, the authors recognise that in order to locate ethnic identity in this study and report the findings, a pragmatic label must be applied. The possible variations in experiences arising out of the interplay between gender, racisms and ethnicities in society mean it is important that research set within these contexts makes explicit the ways in which researchers identify their research in relation to these concepts (Serrant-Green, 2004). The authors have therefore chosen to use the term black and minority ethnic (BME) in this paper to reflect the fact that:

> There exists within Britain as in other parts of the world, a host of communities who by virtue of a difference in language, customs, and country of origin, religion, norms and values are different from the majority ethnic populations. Many of these communities are made up of 'black communities' but also include other minority ethnic identities who do not define themselves as black. The term BME is used as it is increasingly accepted by the members of the groups themselves as representing a unity of experience of racism, discrimination. It makes no claim to a homogeneous black identity and acknowledges the modifying effects of other socially determined factors such as gender, education and class on experiences. In doing so it embraces the diversity of BME experience within and between individuals and communities. In relation to health needs assessment, service planning and social provision, however, BME people also experience a degree of discrimination that is often hidden. (Serrant-Green, 2004, p.14)

These are the BME communities referred to in this paper.

Background to the study: teenage sexual health in the British context

The effects of individual sexual choices in British society are reflected at a community level by the relatively high rates of unplanned and teenage pregnancy compared with other countries in Europe.

> The latest figures show that Britain's teenage birth rate is five times that in Holland, three times higher than in France and double the rate in Germany. (DfES, 2007)

However, the profile is complex with regional and geographical variations so that some areas demonstrate a declining trajectory of teenage parenthood. Overall, there is an increased rate of sexually transmitted infections (STIs) and continued rise in HIV infection (Department of Health, 2001). Primary and community-based health and social care provision have been identified as key components in the drive to reduce the levels of sexual ill health in Britain and optimise the experience of positive sexual health. As far back as 1992, the British government document *The Health of the Nation* identified HIV/AIDS and sexual health as one of five key areas for improvement of the public's health by the millennium (Department of Health, 1992). This early response by the government to the challenge posed by rising levels of sexual ill health was advanced in subsequent years through the introduction of a range of strategies designed to improve the physical sexual health of the general public. Reports by researchers in sexual health in the years that followed these initiatives highlighted the fact that the sexual infection risk was not equally distributed across the population in the Britain (Lacey *et al*, 1997; Low *et al*, 1997). These studies reported, for example, that infection rates for the STIs gonorrhoea and chlamydia were higher in young people, homosexual men, and people from BME communities.

The definition of sexual health utilised in the British National Strategy for Sexual Health and HIV (NSSHH) emphasises a holistic model reflecting the broader contexts in which individual understanding and experience of sexual health take place:

> [Sexual health is] an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness and disease. (Department of Health, 2001, p.5)

This encourages greater consideration of the social, psychological, educational and economic impact of

poor sexual health on members of particular communities. Sexual health behaviour and the choices people make are influenced by a range of factors including social grouping, education, peer pressure and access to services/information (Serrant-Green, 2001b; Di Clemente *et al*, 2002; Fortenberry *et al*, 2002). Sexual health decisions are no longer to be viewed as simply physical acts concerning only the individual, but are identified as an area of health need requiring planning, assessment and services to support it (Adler, 1997; Green and Tones, 2000; Department of Health, 2003).

These issues suggest that sexual health decisions are not simply based on awareness of scientific, official and hence trustworthy *facts*. Jayakody *et al* (2005) call for any approach to influence the sexual decision making of young people, and BME young people in particular, to take into account the contextual situation in which sexual decisions are made. In relation to this study, this means accounting for the dual challenges faced by participants of being both a teenager and a member of a BME community.

In relation to sexual health behaviour, birth rates provide a demonstrable reference point for sexual health behaviour in young people. In relation to ethnicity, however, it is less useful as birth data in England currently include details identifying the mother by country of birth, but fail to identify BME mothers born in Britain. In addition, the ethnicity of children born with dual heritage, where the mother is white British, is rendered invisible by this strategy. Attempts to appraise the sexual health needs of specific BME communities in Britain, such as young people, are further compromised in that much of the qualitative research in this area has been conducted outside Britain. This raises questions of transferability and relevance to a British context (Kempadoo, 2001; DiClemente *et al*, 2002; Ford *et al*, 2002).

The teenage years are also characterised by massive changes in psychological, physical and social capacities. This is far removed from any rational and objective weighing up of choices and consequences underpinning information-based strategies for improving health. Instead, adolescence is more likely to involve personal challenge, periods of uncertainty and insecurity. Stanton *et al* (2002) suggest that peer pressure to engage in risky activities may exert a powerful influence on the decision to become sexually active. For example, recent research has established that for many young people in Britain, drinking and experimentation with drugs are associated with increased risk of early sexual activity (Jayakody *et al*, 2005). For BME young people, this process may be compounded by the additional challenges of racism, poverty and lower educational achievement or expectations. Consideration therefore needs to be given to whether sexual risk taking may be increased in BME teenagers as a result of the other stresses related to disadvantaged life circumstances.

Understanding the complexities of the issues relating to sexual decision making and early parenthood among BME young people is key to informing health policy and practice development. More research is therefore required to understand the life courses of teenagers from BME groups in Britain, which relate to their higher risk of early pregnancy and the impact this experience has on their wider health and life chances. This paper presents findings aimed at contributing to such an evidence base.

Study aims

The qualitative study on which this paper is based set out to explore the teenage parenting experiences of BME young parents in England. This paper presents findings relating to patterns of sexual decision making preceding early pregnancy among young BME parents, and their immediate responses to pregnancy.

Methodology

The research drew upon on ethnographic traditions in focusing on a naturally occurring subculture or group (Fetterman, 1989; Hammersley and Atkinson, 1995). The research was conducted in three cities in England, each with particular social, economic, political and ethnic profiles. Information gathering through collaborative working with local stakeholders, and review of these study locations prior to data collection, elicited valuable information to help contextualise the parenting experience of the young parents who participated in the study. This information was essential for understanding the lived experience of teenage parenting within the context of their culture or community, and is key to the ethnographic approach adopted in this research.

Ethical approval for the study was secured from the three British National Health Service local research ethics committees (LREC) and research governance bodies linked to each location. All young parents taking part were provided with a thank-you gesture in the form of a £10 gift voucher.

A purposive sample was generated initially via health and social care professionals such as midwives, health visitors, and teenage pregnancy co-ordinators. Prior to the commencement of the study, key stakeholders, including young people, were invited to preparatory networking events in each study location. Attendees were briefed on the study and consulted as to the best and most effective ways of recruitment. As suggested by the attendees, further briefing events were held with key health and social care professionals who were already in contact with the young people and who passed the information to young parents

with an invitation to take part in the study. As the study progressed, a snowball technique (Grbich, 1999) was adopted to gain further participants, where each young person interviewed was asked to pass on information about our study to other young parents. We provided freepost (no cost) envelopes for the young people to return a reply slip and express their interest.

The heterogeneity of our study populations is an important factor, including recognition that dual-ethnic young people do not form a single ethnic group. All participants were afforded the opportunity to self-assign ethnicity (Nazroo, 2006). Eighty-eight young people (82 young mothers and six young fathers) took part in the study. They included young people of African-Caribbean, Bangladeshi, Pakistani, Somali, Yemeni, Turkish, and dual-ethnic origin (see Table 1 and Box 1). Ten mothers of teenage parents were recruited to provide an intergenerational perspective, and 41 service providers, e.g. health visitors, midwives, Sure-Start-Plus advisors, provided a professional perspective.

In relation to the self-assignation of ethnicity, the dual-ethnic origin young parents used the following terms: mixed race (most common term), mixed white/Caribbean, bi-racial, mixed black white, half-caste.

A variety of qualitative data collection methods including focus groups, telephone, and face-to-face interviews were used to increase the reliability of the information elicited from the participants and to allow exploration of the issues from a range of perspectives (see Figure 1). Forty-one service providers participated in a telephone survey to obtain a broad overview of the issues related to the phenomena. These data to some extent formed the development of the semi-structured interview schedule. Semi-structured interviews were conducted with young parents (male and female) who were currently teenage parents, and mothers of teenage parents. In order to establish if the perspectives of young parents changed over time, five focus group interviews were conducted with other

> **Box 1** Ethnicity of dual ethnic origin young people
>
> - Jamaican/English (largest group 16)
> - Yemeni/English
> - Barbadian/American
> - Irish/Somalian
> - St Lucian/English
> - English/Indian
> - Dual ethnic origin/English
> - Grenadian/Portuguese
> - Kititian/English
> - Iranian/ English
> - English/Seychelles

young parents aged over 18 years who had past experience of early parenthood, enabling us to gain a retrospective view of the issues. The interviewers in this study had a diverse ethnic profile including African-Caribbean, dual-ethnic origin, white British and South Asian. All interviews were conducted in English as no participants required translation support. Interviews and focus groups were tape-recorded with the permission of the participants, and transcribed verbatim. In this paper we present findings from the young people of African-Caribbean and multiple ethnic origins.

Transcripts generated from the recorded data were analysed to elicit the key issues relating to young people's experience of early parenthood. The framework method for data analysis, developed by the National Centre for Social Research (NCSR), was used to structure the analyses (see www.natcen.ac.uk/natlearning/nl_cis_qual_data_analysis.htm). The specific steps in analysis are mapped out in Figure 2. This method generates domains based on themes elicited from repeated review of the data transcripts.

Table 1 Breakdown of participants

Service providers	Grandmothers	Young mothers		Young women with children older than 1 year with experience of early parenthood		Young fathers
41	10[a]	45 (individual interviews)[b]	3 (audio-diaries)	19 (focus group participants)	15 (individual interviews)	6

[a] Eleven grandmothers were interviewed, but interview 76 was disregarded because of the poor quality of the data and recording.
[b] Sixteen young mothers of African-Caribbean origin, 19 of multiple or dual-ethnic origin (Box 1 demonstrates the ethnic origin of these young people) and 10 young mothers of Muslim faith were the individual interview participants. Challenges in the recruitment determined the need to use the term Muslim, rather than the names of individual ethnic groups. (The young people of Muslim faith interviewed were of Pakistani, Bangladeshi, Yemeni, Somali, and Turkish origin.)
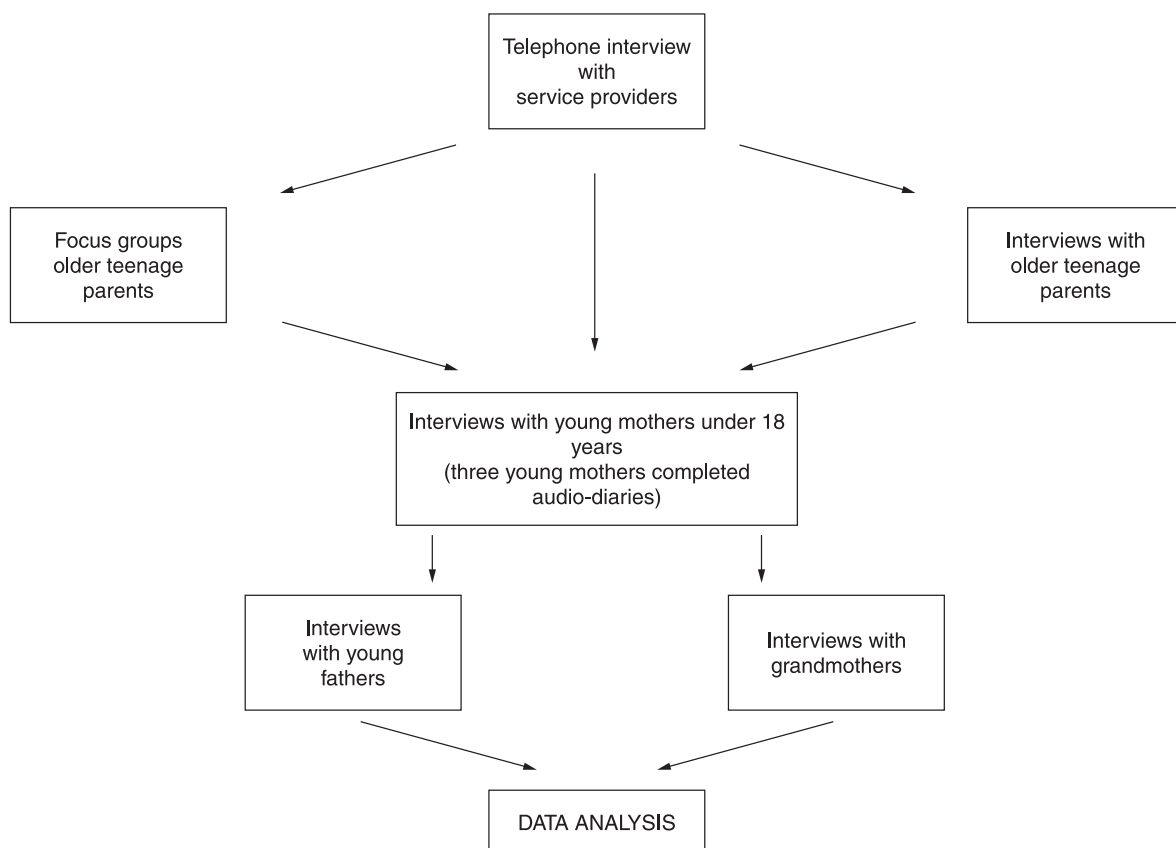
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                    ┌─────────────────────┐
                    │  Telephone interview │
                    │        with          │
                    │   service providers  │
                    └─────────────────────┘
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Figure 1 Research design and recruitment

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┌──────────────────────────┐   ┌──────────────────────────┐
│ Indexing                 │   │ Pilot charting           │
│ Apply numerical series   │   │ Preliminary charting of  │
│ to working framework     │   │ transcripts using working│
│ Label or code transcripts│   │ framework – adopt new    │
│ numerically              │   │ framework in light of    │
│ Adapt framework in light │   │ gaps or overlap          │
│ of gaps                  │   │                          │
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Telephone interview with service providers

Focus groups older teenage parents

Interviews with older teenage parents

Interviews with young mothers under 18 years (three young mothers completed audio-diaries)

Interviews with young fathers

Interviews with grandmothers

DATA ANALYSIS

Indexing
Apply numerical series to working framework
Label or code transcripts numerically
Adapt framework in light of gaps

Pilot charting
Preliminary charting of transcripts using working framework – adopt new framework in light of gaps or overlap

Charting
Summarise/synthesise verbatim data within finalised thematic matrix
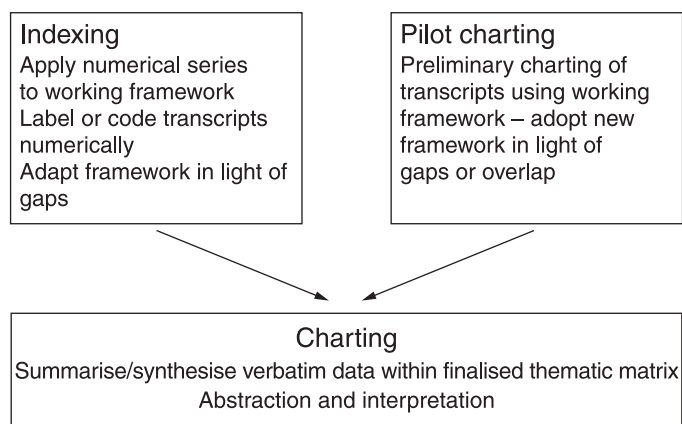Abstraction and interpretation

Figure 2 Process of data analysis using framework (National Centre for Social Research, 2001)

Findings

Overall, the findings demonstrate commonality of experience with the wider white community of young people who become parents early, particularly with young people of African-Caribbean and dual-ethnic origin. The main exceptions to this were young parents of Muslim faith, all of whom were married prior to becoming parents. The findings related to this group are reported elsewhere (Higginbottom *et al*, 2006a,b).

Analysis identified four important domains which informed the process of sexual decision making for participants. These were contraception, precursors to pregnancy, reactions and responses to pregnancy, and family and service support to young parents. The detailed findings are discussed below under these domains.

Contraception

Ethical, political and moral controversies over the impact of prescribing contraceptives and giving family planning advice to young people have been a long-standing focus of debate in England. At first glance it may appear that this is less of an issue for pregnant teenagers or new parents, as they have already engaged in sexual relationships below the age of consent or at an early stage in their development to adulthood. However, the findings indicate that contraceptive advice for young people who are or have recently been pregnant was inadequately managed, accessed and administered in many cases. Participant 74 gives an indication as to how she acquired her knowledge of contraception:

> 'I've heard like people talk you know, they use this and they use that, but that's just, and only once in a science lesson I learnt in year 9 or 10 I think it was.'

For young people from BME communities, lack of awareness of cultural norms by staff may create an additional barrier which is not conducive to supporting informed choice in family planning. Evaluation of contraceptive services for BME clients reveals varying levels of knowledge about the cultural, religious and social impact of contraceptive use in this section of the community. This knowledge is often based on a menus or checklist approach to fulfilling the needs of BME people, and has been widely criticised in the general health literature (Kai, 2003; Nazroo, 2006). The issue of sexual advice giving is difficult in itself, and has been recognised as one of the few areas that health professionals find difficult to discuss (Royal College of Nursing, 2000, 2001). When combined with the already difficult area of ethnicity, sexual issues such as contraception are likely to be perceived as tricky even for those practitioners specialising in sexual health. Evidence of this may be found in research reporting the reluctance of healthcare staff to address or discuss sexual health issues with clients from BME communities (Kai, 2003; Serrant-Green, 2003).

Precursors to pregnancy

Most young women in this study stated that their pregnancy was unplanned, with a small number stating that they felt that they had planned to become pregnant. One young woman stated that she wished to become pregnant, as she felt unloved by her own mother:

> 'I did it for one reason, I didn't do it cause I wanted a baby, I did it because my mum didn't love me, you know what I mean. I went without love, so I did it because I wanted to love someone, so I did it, I don't know, I don't know what to say.' (interview 104: young mother of dual-ethnic origin – self-assigned ethnicity)

> 'It was just basically … well just I'm having a baby. None of us used anything, it was stupid, it wasn't planned at all.' (interview 57: young mother of 'mixed race' origin – self-assigned ethnicity)

A small number of participants stated that they had planned to become pregnant. Three young women had a friend or relative who had had a termination or a miscarriage; their own choice to continue with their pregnancies had partly been influenced by not wanting to have what was perceived as a very difficult experience (sense of loss, doubts about the decision):

> 'My aunt, because she was in the same situation as I was when she was younger, and she said ''don't make the mistake that you give away your child or you have an abortion, bring it, because at the end of the day you might never get the chance to have the next child'' … I discussed it with the midwife and she said it was up to me and from there and then I knew I wanted it and my friend was advising me to have it anyway. But in my heart I wanted my child.' (interview 39: young mother of 'black Caribbean' origin – self-assigned ethnicity)

Reactions and responses to pregnancy

When young women found themselves to be pregnant, a range of emotions were experienced, including happiness, shock, anger, disappointment and despondency:

> 'I were happy, but … I were happy in a way but I was gutted. Like just … it's life. And I always wanted a baby anyway, but not at that age. That's my life ended. Not in way … in an horrible way, but that's something I've got to have responsibility now, because I've got responsibility and I've got to grow up.' (interview 57: young mother of 'mixed race origin'– self-assigned ethnicity)

> 'I was happy. I was over the moon. I was so excited to be a mum.' (interview 8: young mother of 'mixed' origin – self-assigned ethnicity)

> 'Angry, upset um, a bit disappointed.' (interview 33: young mother of 'mixed race origin' – self-assigned ethnicity)

Interviewee 24 exemplified the complexities of the situation in the following comment; having become a parent early she described how at 18 she became pregnant again, without having explicitly planned this:

> 'It was, it was hard really … it was hard because I was struggling with her [first child], and then this one was coming, so it was really, really hard … I was going to have an abortion, but I sit down and think … maybe having this child would make it better, and I just don't know. I made the appointment for the abortion and everything, and the day I just ring them and tell them I am not coming, and that's it. And I am really happy I didn't do it.' (interview 24: young mother of 'black Caribbean' origin – self-assigned ethnicity)

Most of the young people expressed fear and anxiety when they had initially shared news of their pregnancy with parents and family members. Often this resulted in tension and, in some cases, fracture of their relationships:

'I was frightened ... to think what am I going to tell my dad ... I was just scared ... like I don't know what to do. The first person I phoned was my boyfriend ... He was happy, I was unhappy. He was more happy than me. Normally it's the other way round.' (interview 11: young mother of 'black Caribbean' origin – self-assigned ethnicity)

Interviewee 12 (young mother of black British origin – self-assigned ethnicity) provided a good example of the range of feelings and reactions described by many in the sample who had not planned their pregnancies, but had not taken active steps to prevent pregnancy either:

Q: 'Was your pregnancy planned?'

Interviewee 12: 'No ... we used to talk about it all the time, but I had been with my boyfriend for 5 years anyway. I was shocked and scared at first, but happy at the same time. Even though I was a bit young I was still happy.'

Q: 'Were you at all worried about how you would cope?'

Interviewee 12: 'Not really, 'cos I used to look after all my little cousins when they were younger and my little brother when he was a baby as well. I really knew what I was coming in for, going into that. I knew 'cos when my brother was young I used to sleep in the same bed as my mum and brother. So all the crying and everything, I knew what I was putting myself in for, but I was just willing to take the risk.'

A renewed and strengthened relationship between the young women and their mothers was a recurrent theme within this research. The participant below described how the birth of infant had impacted positively on her relationships with her mother:

'I already had it in my head but I was still scared. My mum was really upset when she found out I was pregnant. She asked me what I was going to do about it, and I kept saying I don't know, even though I already knew. For about a week she stopped talking to me, but when me and my boyfriend were just in the house together, she came in and she said it feels like nothing is happening here and she said she needed some answers, so we told her and she was ok. She still wasn't talking to me really, but after that she got over it and she was happy. I mean she couldn't wait for it to be born. I think it is just the initial shock, knowing that your little girl is having a baby, but after that she was fine. She loves him now, even when I was pregnant, she enjoyed my pregnancy, cause she had all my cravings, 'cause we got closer. Me and my mum are closer. Normally it's the other way round.' (interview 11: young mother of 'black Caribbean' origin – self-assigned ethnicity)

Interviewee 11 continued with reference to the decision to continue with pregnancy, in the context of a continuing relationship with her partner, including the comment that 'we don't really argue over stupid things no more':

'He wanted me to keep it. 'Cause I was kind of thinking about like my life, I was like "I don't think we should, because we have got our whole lives ahead of us", and the he was like "oh we should, because we could have not more kids" ... so I was just sitting there thinking about it, so I just thought "yeah".' (interview 11: young mother of 'black Caribbean' origin – self-assigned ethnicity)

For young parents, while there may still be a level of joy associated with the pregnancy and impending parenthood it could also be a time of role conflict and personal challenge arising out of the conflicting responsibilities of being a teenager and becoming a parent. It is important, therefore, that young people are given adequate advice; often the young person's judgements about the reality of parenting may be tempered by a degree of naivety:

'Um, I knew in my mind that I was going to do it. Like, you see other people with their children and you just think, "I want one, I want one, I want one", you think you can just go to the shop and buy a baby [laughs]. And when you actually have your own, you don't really realise um, what the labour is going to be like, and during the pregnancy is going to be like ... you just think about when it's here ... what you want to do, and all the things you want to, like, give the baby, the stuff that you hadn't had when you was little and stuff like that. You just get carried away with the future moments, you don't really think about.' (interview 10: young mother of 'black British' origin – self-assigned ethnicity)

The participant went on to contrast her own experience with that of her partner:

'It depends on if he wants to be a part of it, because he can easily get up and go ... men can do what they like, but women, now they are just stuck.' (interview 10: young mother of 'black British' origin – self-assigned ethnicity)

For the majority of couples the realisation that they were about to become parents was seen as a positive experience and welcomed by friends, parents and the wider family. Parenting is a very specific social role which has far-reaching effects on an individual's perception of self, and identity as part of a social group. Parenting is not wholly instinctive but comprises a range of socially determined and ethnically specific skills, roles and responsibilities. Many of these skills are developed over time and change according to the developmental stage of the child, the expertise of the parents, and the expectations or norms of the communities to which they belong.

Family and service support to young parents

Some young women described doing the pregnancy test with a female cousin or an older woman friend of the family and only telling the rest of the family a lot later (6–7 months). The influence of extended family networks was important in a number of examples; for instance, interviewee 37 also referred to two of her cousins: both had been pregnant, one had a termination and the other continued the pregnancy:

'My cousin had a um, her son when she was 16 and she dropped out of school, so for me, it's a lot easier, cause she understands, but my other little cousin she's like, she wants to have a baby now ... She's 17, she is going to be 18, but it's still not, she is still not ready, and she had to have an abortion earlier ... at 16. And then cause she has seen my son ... like, she cries, cause she says "look what I did", that's what I'm saying, I could never have an abortion, cause my cousin looks at my son and cries and she says "oh, I shouldn't have done that", but she never had a choice. My auntie told me what she would have done to her ...' (young mother of 'black Caribbean' origin – self-assigned ethnicity)

In general, most young mothers felt that family support was most reliable and consistent. Many teenagers relied on their own mothers, even if there had been an initially negative or anxious reaction to the pregnancy:

'I thought my mum would be a lot more understanding ... because of what I went through, leaving home so early ... I thought she would have understood, she did understand but, she was just like, "your career", and I would have never thought she would say something like that to me, cause she knows, I'm focused and my head's there ... but she's my mum. Nah, the best support ever, regardless, she is a distance away from me, but she gives me all the support I need. Like if there is any problem, can I talk to my mum, like yeah, that's my mum.' (interview 37: young mother of 'black Caribbean' origin – self-assigned ethnicity)

A limitation of the study was the low recruitment of young fathers. This was rather disappointing, but reflects the fact that teenage relationships are not enduring and many of the young mothers in our study did not wish us to contact the fathers of their infants.

Discussion

This paper has provided an overview of many of the factors that impinge on the holistic sexual decision-making experience of young people from BME communities in England who become teenage parents. Many of the issues are not exclusive to the situation of BME young people, but are related to their developmental stage as teenagers and the experiences of poverty or socio-economic status. However, their contextual experiences as members of BME communities underpin some particular aspects of their experience as young people and impact profoundly on sexual decision making.

In exploring the sexual decision-making experiences of young people, many of the issues raised in research reports and the media have a direct or indirect association with the notion of early pregnancy as a negative consequence of sexual activity (Jayakody *et al*, 2005). In considering the issues pertinent to young people who become parents early, this negatively laden assumption arises from an implicit belief that the pregnancy is unplanned, not welcomed, and will have a destructive impact on the life chances of the young people involved. The presumed negative association between early pregnancy and reduced life chances is a key contextualising factor in producing a negative view of young parents. As discussed earlier in the background to this paper, negativity historically underlies discussions of sexual health, and remains one of the predominant concepts uniting the perception of young people's health decisions in general and sexual health decision making in particular.

Increasing knowledge about the consequences of particular behaviour is commonly used in preventative strategies for raising awareness and improving sexual health (Teenage Pregnancy Unit, 2006). It assumes that if individuals are made aware of the facts concerning the impact of particular activities on health, they will make the rational choice to change their behaviour and thereby reduce the health risks to themselves and others. The implications of this approach are that an expectation is set up that the ability to increase health chances by reducing health-limiting activities and increasing health-enhancing ones is solely dependent on the individuals themselves.

What is clear from the findings of this study is that the young people operated with a model of sexual decision making that was largely underpinned by a philosophy of acceptance rather than a desire to minimise the negative impact of early parenthood. Theoretical models of health-related behaviour often emphasise the negative consequences of particular choices and need for rational assessment of benefits to improve health. What is clear from the findings of this study is that the perspectives of young parents, academics and practitioners vary widely in relation to early pregnancy as a wholly negative experience. The situation is complex. The findings of this study seem to indicate that the young people did not attach a fatalistic or inexorably negative view to the notion of becoming a parent early, and in some instances viewed the prospect of early parenthood more positively than current UK government strategy would suggest (Teenage Pregnancy Unit, 2006). It is this point that potentially may have the greatest potential impact in relation to policy

and practice development in the area of teenage parenting, sexual decision making and BME young people.

Conclusion

If the credibility of messages espousing the negative impact on future life chances of early pregnancy as a driver for encouraging abstinence or safer sex messages is considered in the context of the experiences of BME young people, the impact may be lost. BME young people are more likely than some of their peers to be living with racism, social exclusion and lowered expectations of them by educational institutions or wider society (Bhopal, 1998; Balsa and McGuire, 2002). In addition, their personal experiences may include witnessing positive messages concerning parenthood and drive to succeed through their own mothers' lives (Higginbottom *et al*, 2006a,b). It is, therefore, reasonable to suggest that the use of shocking messages espousing the negative long-term consequences of teenage pregnancy or parenting on life chances may assume a lower priority or have less real impact on the lives of many BME young people who may already experience severe disadvantage and may live with the associated low self-esteem (Teenage Pregnancy Unit, 2000).

This paper set out to provide some insight into the experiences of some young parents from BME communities and the contexts in which their pregnancies began. The findings are particular to the experiences of the young people but provide some useful messages as a starting point for further reflection in a wider context. They suggest that what may be required is new and additional ways of engaging with young people from BME communities, ones that acknowledge the diversity and complexity of their relationships and experiences of parenthood. This calls for inter-disciplinary and interprofessional working in health promotion and service provision for teenage sexual health that engages with individuals and communities and that understands and takes into account the local contexts. Mechanisms to reduce teenage pregnancy may be better served by engaging with BME communities to both build health and life expectations through which young people may be enabled to better manage the challenge of early parenthood as well as optimise the opportunities for them to realise, prior to engaging in sexual activity, the alternatives available to them.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Gina Higginbottom, Canada Research Chair in Ethnicity and Health and Associate Professor, Room 6/30B, University Terrace, Faculty of Nursing, University of Alberta, 8303 – 112th Street, Edmonton, Alberta, Canada T6G 2T4. Tel: (001) 780-492-6761; fax: (001) 780-492-1926.