Diverse Communities: Identity and Teenage Pregnancy
A resource for practitioners
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Produced by the Teenage Pregnancy Unit
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Introduction

Why tackling teenage pregnancy needs to include diverse communities

As has been widely recorded, Britain’s teenage birth rates are the highest in Western Europe – in 1998 there were around 41,000 conceptions to under-18s in England, resulting in 23,600 live births. While teenage pregnancy rates have fallen dramatically in other countries, the UK has not matched this success in reducing rates during the 1980s and 1990s.

To address this, the Government’s report, *Teenage Pregnancy*, from the Social Exclusion Unit (SEU, 1999), set two goals:

• to halve the rate of conceptions among under-18s in England by 2010 and to set a firmly established downward trend in conceptions among under-16s;

• to reduce the risk of long-term social exclusion for teenage parents and their children by supporting teenage parents in education, training and employment.

The under-18s conception rate fell by 6 per cent between 1998 and 2000 (the latest year for which data are available), but the rate must continue to fall if the Government’s goal is to be met.

In meeting the two goals, professionals working in the field of teenage pregnancy need to engage with a wide range of communities, including those from minority ethnic and faith groups. It has been estimated that 1 in 11 young people aged 15 to 19 is from a minority ethnic community (Low, 2001). Children and young people within these communities are more likely to experience poverty, deprivation and social exclusion, which can increase the likelihood of teenage pregnancy.

Evidence suggests that, for young people from African Caribbean, Bangladeshi, Pakistani Muslim and Traveller communities, there is a high incidence of early pregnancy, which may be within marriage. Anecdotally, other minority groups, such as Jewish and British Chinese communities do not report a high incidence of teenage pregnancy, probably due to cultural factors including high educational expectations and family cohesion (see Chapter 3, pages 27 and 32).

The Diverse Communities Project

This practitioner resource is part of a project commissioned by the Teenage Pregnancy Unit (TPU). The project’s aim was to gather views through consultation with a variety of groups and individuals. These could then be used to develop a practical resource for making teenage pregnancy work more relevant and accessible to ‘diverse communities’. When consulted, teenage pregnancy co-ordinators and other associated professionals identified the particular communities they wanted included in the project. (Chapter 1 describes the groups but does not attempt to be comprehensive.)
The term ‘diverse communities’ is intended to encompass those from the main religions and philosophies (including denominations or branches of Christianity, Islam, Judaism, Sikhism, Hinduism, Buddhism and Humanism), other faiths, and all the different black and minority ethnic (BME) communities living within the UK. The term acknowledges the differences between religious practices and cultural traditions.

The work was carried out over a period of four months using a number of strategies:

- reviewing literature on sexual health and diverse communities;
- a questionnaire to teenage pregnancy co-ordinators;
- a questionnaire on teenage pregnancy to members of diverse communities using the Interfaith network, Bradford Interfaith Education Centre, the TPU and Sex Education Forum networks;
- reviewing existing surveys of young people from diverse communities and devising a questionnaire for young people using National Children's Bureau contacts;
- interviews with a range of faith and BME workers;
- reviewing literature on the law, guidance, ethnicity and faith identities;
- a community participation literature review.

**About this resource**

This resource has been produced as a consequence of the findings of the Diverse Communities Project. It focuses on strategies that teenage pregnancy co-ordinators and others can use to develop an inclusive approach to their work. Its aims are:

- to place teenage pregnancy in the wider context of identity, self-esteem, and the need to foster a sense of belonging in young people;
- to raise awareness about the importance of addressing cultural and religious diversity in relation to sexual health services;
- to provide background information on the beliefs and perspectives held by members of spiritual and philosophical traditions on issues including marriage, sex and contraception, pregnancy, young people, sexuality and relationships;
- to provide practical ideas and support for engaging with people from different faiths and minority communities in order that appropriate and accessible services can be developed.

**Format of this resource**

This resource is divided into four main chapters and three appendices:

*Chapter 1: Young people, cultural influences and sexual health* – considers some of the cultural and religious influences that young people may have grown up with, and features young people’s views on a range of topics.

*Chapter 2: Involving communities in teenage pregnancy work: practical approaches* – gives step-by-step guidance on setting up and running community-based projects and looks at ways of overcoming some of the potential difficulties. Drawing on practical expertise, advice is also provided on developing active partnerships with whole communities and on increasing shared ownership of the work undertaken.
Chapter 3: Working with young people from specific minority communities – gives the perspectives of professionals working with young people. It explores some of the specific issues that have arisen and highlights implications for work carried out by others in the field.

Chapter 4: Faith and cultural perspectives from community members – provides ‘snapshot’ perspectives on teenage sex, pregnancy and parenthood from individual members of faith and philosophical communities.

Appendix 1: Sexual health of young people from black and minority ethnic groups – a briefing paper written by Nicola Low of Bristol University (2001). It provides comprehensive information on the sexual health of young people from BME groups.

Appendix 2: Ethnic diversity and religious discrimination – a factsheet extract from the Commission for Racial Equality (CRE), giving a breakdown of the size of ethnic communities within Britain. (The 2001 Census data will update this information and is expected in late 2002.) Also included are findings from a Home Office research study on religious discrimination.

Appendix 3: References and useful resources – provides references for research and reports highlighted in the text, and gives a list of useful resources.
1 Young people, cultural influences and sexual health

This chapter considers some of the cultural and religious influences that young people may have grown up with, and explores how these contribute to their sense of identity and feelings about sexual relationships. The views of young people from a cross-section of communities on a range of topics are also described.

Ethnic and religious influences

Ethnicity, culture and religious beliefs can have a major influence on young people’s attitudes to sexual behaviour, pregnancy and teenage parenthood. For example, in her research briefing on the sexual health of young people from BME groups (2001), Nicola Low of Bristol University compiled data demonstrating that cultural trends may also influence sexual activity levels. In one survey, black African women and South Asian women were seen to have much lower levels of sexual experience than either African Caribbean or white women. Among predominantly Muslim South Asian women, only about 1 in 10 unmarried women had sex. South Asian men and white men were less sexually experienced than men from black communities. African Caribbean men had the most concurrent partnerships.

Low also found that many African Caribbean communities may traditionally hold pro-fertility beliefs: that is, they act on the principle that large families are necessary as economic assets, and a source of strength. Family Planning is therefore contrary to these beliefs. Within some South Asian communities (that is, those of Indian, Pakistani and Bangladeshi descent), a teenage marriage followed by pregnancy is often perceived as the norm. This may pose difficulties for some young people who do not want to conform to these norms:

‘Gujarati and Bangladeshi women who wanted to delay conception and have small families faced conflicts with cultural and religious traditions. Unmarried mothers also faced strong community disapproval. Attitudes towards abortion were less tolerant amongst Asian than other ethnic groups.’ (Low, 2001)

Statistics also showed that, within the UK, teenagers from African Caribbean backgrounds are at highest risk of gonorrhoea and chlamydia.

Teenage motherhood was more common among African Caribbean, Pakistani and Bangladeshi groups than among white ethnic groups, according to national surveys. However, recent figures from the Labour Force Survey suggest that patterns may be changing:

‘Fertility rates in all South Asian groups have fallen substantially over the past 25 years but have remained stable in white and black Caribbean women. By the 1990s teenage birth rates amongst Pakistani women had fallen by more than half to 30 per 1000, the same as for white women, and the rate amongst Indian teenagers was only 7 per 1000.’ (Low, 2001)

The full version of this briefing paper by Nicola Low (2001) is presented in Appendix 1.
A sense of belonging

Many young people from minority communities may belong to extended families with strong community or faith alliances. These young people will often grow up with a sense of belonging.

South Asian communities have historically operated within the context of the extended family rather than the culture of the individual. This brings social and economic support based on tradition and shared belief:

‘Such extended family systems can be a liberating experience in terms of the social conditions of individual members. To rely on the family for such support – emotional, physical and financial, relieves much of the burden for sustaining self…’ (Khan, 1994)

Growing up in this extended family context gives a different meaning to personal privacy, with personal information and professional confidentiality being viewed as unnecessary or sometimes with suspicion. Also, families may worry that public behaviour which breaches accepted codes of conduct will bring shame and the family honour (or ‘izzat’) will be lost. Both these factors have implications for how young people conduct sexual relationships and how they access services.

Many young African Caribbean people belong to communities where black-led churches are thriving. One example is the Centre for Black and White Christian Partnership in Birmingham, which works to challenge inequalities, promote racial justice, and empower African Caribbean people through education. Young people growing up in this type of climate have the opportunity to develop a strong sense of belonging.

However, young people in both African Caribbean and South Asian communities are often influenced by mainstream ‘youth culture’ and wider institutional influences such as legislation or education, as well as their own community’s culture. All these aspects of their identity require consideration when supporting their needs.

The experience of discrimination

Historically, both black and some white minority ethnic communities have experienced racial discrimination. In recognition of this, race relations legislation identified the Jewish, Romany and, more recently, Irish communities as groups for protection alongside black communities. Despite legislative change and more widespread acceptance of diverse communities, discrimination towards people from minority ethnic communities has continued. This has sometimes fuelled mistrust of institutions and professionals from statutory organisations.

Religious discrimination is also widespread. In a Home Office report (see Appendix 2), respondents from all faiths said that they had experienced discrimination on the grounds of faith. Some reported being made to feel awkward if they practised their religion and, where ethnicity and religion intersected (for example, with Muslims, Sikhs or Hindus), some felt that they experienced double discrimination. Many faith communities felt that institutional discrimination, for instance in schools, was significant and that this could have a negative influence on young people’s sense of self.
Young people’s views

During the Diverse Communities Project, research into young people’s views on sexual health and sex and relationships education (SRE) was gathered. This included views from young people from South Asian communities with Muslim, Sikh and Hindu faiths, young people of African, African Caribbean, Jewish and Chinese heritage, and young Christians from a variety of denominations. The project also looked at youth surveys and peer-led magazine articles. The following themes emerged:

- Some young people value their faith or cultural identity much more than a wider youth identity.
- Some have a strong sense of their identity within a minority group from a faith, ethnic or cultural perspective.
- Some feel that their different values are ignored or derided and should be included in SRE.
- Some feel that they are not given access to information about sexual health.
- Some want to talk to their parents about sexual matters; others feel that they could not.
- Some are not always certain that confidentiality by a health professional would be maintained.
- Some highlight other issues of concern to all young people, including embarrassment from teachers, lack of information about sex and sexual health, and needing an arena to discuss relationship issues.

The following sections describe the views of young people from diverse backgrounds on a range of topics. Their views often parallel those expressed by young people generally. However, for many from a particular faith community, there is also a desire to follow the guidance of their religion and to be given information and support from professionals that acknowledges their cultural and religious upbringing.
Sexual activity

Young people who identify strongly with a particular cultural or religious group have a range of responses to the idea of sexual activity before marriage. The following quotes, taken from a survey of young Jewish people (1997), demonstrate how diverse beliefs can be within the same faith.

‘Virginity is the most precious thing that someone can have and should be saved until one is mature and ready for sex.’

‘Sex in a loving relationship, in my opinion, is a natural and good activity. However, people younger than 16 are not mature enough to have sex and are not ready for it.’

‘I want to wait.’

‘I don’t want the obvious social and emotional problems.’

‘Why not? I wouldn’t dive in though; I wouldn’t want to go against the law.’

‘Question should not even need to be asked; see Bible for further guidance.’

(from a 1997 survey conducted by Chris Jennings, a youth worker for the Birmingham Jewish Youth Trust)

Many young people see the benefits of education, friendships and interests beyond the need to become sexually active, and recognise the role of peer pressure in early sexual activity:

‘If dating is early or excessive, I believe it can have a negative effect. When dating is the teenager’s life, other interests like academics, sports, hobbies and friendships suffer. In some cases affection leads naturally to sex. But, in others, curiosity and peer pressure is the main factor especially among the youth.’ (young African Caribbean man)

‘The thing is that they (non-Asian) don’t understand if you say you don’t want to have sex before marriage. They say ‘how can you do that? How can you go without?’ They start going silly and saying ‘are you a virgin?’ (young South Asian woman)

The dual standards that operate for young men and young women is highlighted by both genders across different faiths and ethnic groups:

‘What I really hate, it is okay for a guy to have sex with loads of girls, but if the girls have sex with just a guy, they are automatically called a slag. Why? Attitudes should change.’ (young Pakistani woman, aged 19)

‘I only sleep with clean girls ... you can tell.’ (young man from HertShapes Project (2001), which focused on BME groups)

Sometimes, young people’s perceptions of another faith may be based on misunderstandings, which may lead to negative perceptions:

‘In our holy book sex before marriage is a sin, but in the other religious holy books it does not say anything. They do not have strict rules, which I think they should because that’s how all these teenage pregnancy and diseases would not be caused. It is their own fault; they should be able to control themselves.’ (young Bangladeshi woman, aged 19)
Sex and relationships education (SRE)

When young people from minority communities are asked about SRE, their views often mirror those of young people everywhere, with concerns focusing on teacher embarrassment, an inaccurate expectation that ‘young people know it already’, and a lack of information:

‘Our education on sexual health is so boring and very brief. Our teacher who takes the lesson always looks embarrassed and not confident speaking about the issue. So we think, if they are not bothered, why should we?’ (young Pakistani man, aged 14)

‘In schools, college, they don’t publicise the support agencies that are around for young people. For example, I remember I wanted to get condoms for myself in an emergency, I wanted to go to a clinic, not my local one, but anyway. I looked for leaflets around the college but there was nothing at all. How do we know what is around when there is nothing there to tell us?’ (young Sikh man, aged 18)

‘We had a nurse speak to the 11- to 12-year-old girls about periods in my secondary school. That was it. We asked our biology teacher why we hadn’t been given a sexual health session. He replied, “You know it all already”. Three of my friends left school pregnant. Parents and teachers often assume that young people know about these things when, in reality, they don’t. Many learn the hard way.’ (young woman from HertShapes Project, 2001)

Although these comments reflect the views of young people generally, some are also of the opinion that young people’s cultural and religious backgrounds are often ignored, with teachers assuming that mainstream youth culture identity is the most important factor for all young people:

‘We’ve been brought up differently, we should be taught differently about sex, in a different way that’s appropriate to the way we’ve been brought up.’ (young South Asian man)

‘We are not taught from a religious point of view, school should try to provide this, as we can’t talk to our parents.’ (young South Asian man)
Termination of pregnancy (abortion)

Termination of pregnancy is debated from many standpoints in both the majority and minority communities. Some young people noted the importance of religious interpretation in deciding on whether a termination was necessary, while others felt that a woman’s right to choose was crucial. The shame for a young woman of having an abortion was also highlighted, as was the lack of information provided by professionals:

‘It’s always the girls that get the worst side of it in the end, the guys just get a slap on the wrist, it’s always worst for the girls, and there’s more shame.’ (young South Asian woman)

‘We weren’t told if we were in that situation where we could have an abortion or what it would involve or anything like that.’ (young South Asian woman)

‘If a girl was raped and she wanted an abortion, some scholars would allow that.’ (young South Asian man)

Confidentiality

While most professionals strictly adhere to professional codes of confidentiality, a minority of young people noted that confidentiality had been breached:

‘My GP is Asian. I went to him asking for information on contraception but, before I did, I asked if he would tell my parents. He said no, as everything is confidential. We had a family party, which he attended, as he got to the drink, it slipped out of his mouth that I went to see him. Since then I have had no trust with Asian doctors.’ (young Asian Sikh woman, aged 17)

Parents

Some young people noted that they could not tell their parents about being in a relationship because of their parents’ disapproval:

‘It is difficult for me to speak to my parents about such things. I am 18 years old and going out with this girl for two and a half years. I asked my parents about love, going out with girls and if there is anything I should know. The reply I got. “Don’t you dare put shame on this family, what if someone from the community sees you going around, what face will we show?” I thought they would understand as parents, but boy was I wrong.’ (young Bangladeshi man, aged 18)

‘I’m 18 and I never told my parents about my boyfriend even after we had been together for three months. I knew that they would dislike it a lot as they think that I should be concentrating on my studies and not be distracted.’ (young British Chinese woman)
However, some young people felt that they could confide in their parents about sexual matters:

‘I have to say I am lucky to have parents who are very open. They told me about sexual health, contraception, the different type of diseases there are, way before I was taught at school. It was explained at the age of 13 by my parents and taught at school at the age of 15. Parents should be more open to their kids, why share problems with friends if you have parents but, then again, I suppose it is the parents’ upbringing and education they had in their time.’ (young Hindu man, aged 24)

‘Whenever I get leaflets around safe sex and STIs I leave them lying around the house for my sons to read. They need to know about these things in this day and age. We as parents have to be realistic.’ (South Asian mother, aged 38 from the HertShapes Project, 2001)
2 Involving communities in teenage pregnancy work: practical approaches

This chapter gives practical guidance on developing active partnerships with local communities in setting up and running teenage pregnancy projects. After a brief checklist of the various stages, a planning grid provides a useful means of working through the process and can be used to pose questions to all partners involved. Karamjeet Ballagan, South Asian Communities Cultural Consultant and Sexual Health Worker at the Heart of Birmingham Teaching Primary Care Trust, describes her work on tackling areas of potential difficulty and involving all sections of the community to ensure joint ownership.

Underlying principles

Research for the Diverse Communities Project has identified some key principles that should be taken into account when working with minority communities.

- While most of these communities regularly deal with discrimination and exclusion, in many cases, this leads to a strong and positive community identity which can provide a sense of place and self-esteem to individual members.
- If young people feel that they belong and have a sense of who they are, they are more likely to accept and put into practice positive sexual health messages.
- The negative effects of discrimination can erode some young people's sense of self and affect their risk-taking behaviour.
Planning a project: the key stages

The key stages in planning a project are:
1. Needs or situational assessment
2. Consideration of resources
3. Funding
4. Support and monitoring
5. Setting up the project.

1. Needs or situational assessment

The first important step is to identify the needs of the community, and to develop an idea for a project together with aims and objectives for how these can be met. It is essential to establish the potential effects of teenage pregnancy within the community rather than just focusing on the causes. In addition, make contact with local agencies and individuals. (For further guidance on carrying out an assessment, see The Health Needs Assessment Workbook, which can be downloaded from www.hda-online.org.uk/downloads/pdfs/HNA.pdf.

2. Consideration of resources

The next stage is to think about practical considerations such as a base and resources needed. This includes not just finances but also human resources, such as numbers, roles, skills and time availability of staff, volunteer costs and materials. Also take into account what resources are already available, for example existing policies used in other health-related or community work.

3. Funding

Decide how to obtain and maintain funding, and establish who is responsible for the financial viability of the project and for reporting the process to the funders.

4. Support and monitoring

Consider record keeping, monitoring and evaluation of the project and determine who has responsibility for this and how it will be carried out.

5. Setting up the project

Ensure that roles and responsibilities of workers and managers are clarified, that relationships have been set up with other relevant agencies and groups, and that clear communication pathways are in place.
Planning grid

This grid is adapted from the work of Smithies and Webster, from their useful book *Community Involvement in Health – From Passive Recipients to Active Participants* (1998).

The grid provides a way of systematically considering the planning process and project design. It is intended that all the agencies or individuals involved in the proposed project are encouraged to work through the grid.

The first column asks a question. The next two columns ask additional, focused questions and make suggestions depending on whether the answer to the question is ‘Yes’ or ‘No’. Note that it might be necessary to add extra questions depending on local circumstances.

<table>
<thead>
<tr>
<th>Needs or situational assessment</th>
<th>Next steps if the answer is:</th>
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<tr>
<td>Has the idea to explore setting up a teenage pregnancy project come from a single agency?</td>
<td>Are there other agencies and groups who would want to work in partnership on this initiative? How might they be involved?</td>
<td>Has a multi-agency ‘steering group’ been established? Have roles, responsibilities, relationships, boundaries and expectations been explored?</td>
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<tr>
<td>Has the idea come from local people or out of existing local community participation work?</td>
<td>Can local people maintain control of the initiative? Can a local community/voluntary committee manage the project? Do local people also need to consider the involvement of local professionals and agencies?</td>
<td>What approaches will be used to involve local people in the next steps to get their views and ideas? (situational audit and needs assessment)</td>
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<tr>
<td>Has an audit of the current situation re: teenage pregnancy issues and services in the locality already been carried out? Has there been an assessment of what a teenage pregnancy project would change or add to the area, and its impact on the community?</td>
<td>Does the proposed teenage pregnancy project enhance and/or complement existing work? Give concrete examples.</td>
<td>Who will undertake this situational audit and needs assessment, and how? How will the findings be disseminated to appropriate, potential stakeholders?</td>
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<td>Are the aims and objectives for the project clearly and understandably defined? What will the project achieve and how?</td>
<td>Are the aims and objectives based on the situational audit and needs assessment? How do they need to be changed in the light of any findings?</td>
<td>Do the findings of the situational audit and needs assessment allow for the creation of workable aims and objectives? If so, who needs to be involved in setting these?</td>
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2. Consideration of resources

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<tr>
<th>Question</th>
<th>Yes</th>
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<tr>
<td>If the project needs to have a base, is there somewhere in mind?</td>
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<td>Has the assessment carefully considered the resources that will be</td>
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<td>needed to meet the aims and objectives (e.g. numbers and roles of staff,</td>
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<td>type of base needed, non-pay essentials, volunteer costs etc.)?</td>
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<td>Have training and other team and staff development needs been included</td>
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<td>in the budget?</td>
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<td>Have you assessed how much funding is needed for team and staff</td>
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<td>development?</td>
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<td>Has there been an assessment of possible sources of funds? Have the</td>
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<td>pros and cons of these sources been considered?</td>
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Next steps if the answer is:

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Is the location of the base suitable? Has this been checked out and with</td>
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<td>Does a further ‘venue audit’ need to be</td>
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<td>whom? From when will it be available and for how long?</td>
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<td>carried out? Will it be possible to use or</td>
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<td>adapt an existing building or premises? Will</td>
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<td>a new build be necessary?</td>
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<td>Will resources be allocated to realistically allow the achievements</td>
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<td>aimed for? If not, is it necessary to reconsider the aims and objectives?</td>
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<td>It is better to pare these down at this stage to avoid ‘built-in failure’.</td>
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<td>What will be the process for determining team and staff development</td>
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<td>needs? Has any initial assessment been carried out on this? How will</td>
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<td>money be apportioned for this?</td>
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<td>Will this cover all the needs generated by the resources that have been</td>
<td></td>
<td></td>
</tr>
<tr>
<td>identified and will be used? (see answer to above question)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What, if any, are the limits or conditions attached to certain types of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>funding? Do these cause any conflict with the aims and objectives of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>teenage pregnancy project? Will you have to compromise and will this</td>
<td></td>
<td></td>
</tr>
<tr>
<td>require a rethink of the aims and objectives? Do funding sources promote</td>
<td></td>
<td></td>
</tr>
<tr>
<td>commercial products? Are there ethical considerations to be taken into</td>
<td></td>
<td></td>
</tr>
<tr>
<td>account? If multiple sources are going to be used, how and who will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>manage the potential relationship issues between them?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Who can you ask to be involved in determining what development needs are  |                                |                                              |
| generated from the resources you will be using?                          |                                |                                              |

What will be the process for determining team and staff development needs?  |                                |                                              |
| Has any initial assessment been carried out on this? How will money be    |                                |                                              |
| apportioned for this?                                                    |                                |                                              |

Can you go back and include this? Are there other ways that this training  |                                |                                              |
| and development can be provided (e.g. free places on courses run by other|                                |                                              |
| local agencies)? Are there other sources of funding e.g. grant-making     |                                |                                              |
| bodies, Regeneration and Renewal funds, Lottery, etc?                     |                                |                                              |

Who is best placed to carry out this assessment and report the findings?  |                                |                                              |
| Do they understand the issues (e.g. as raised in the ‘Yes’ column). The   |                                |                                              |
| assessors must be able to think critically about this in order to prevent |                                |                                              |
| as many potential problems as possible.                                  |                                |                                              |
### 3. Getting and maintaining funding

<table>
<thead>
<tr>
<th>Question</th>
<th>Next steps if the answer is:</th>
<th>Next steps if the answer is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you confident that the amount and length of funding will allow the</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>teenage pregnancy project’s aims and objectives to be met?</td>
<td>Have you outlined a system</td>
<td>Do you need to alter your aims</td>
</tr>
<tr>
<td></td>
<td>for monitoring and reviewing</td>
<td>and objectives to fit in with</td>
</tr>
<tr>
<td></td>
<td>this?</td>
<td>available funding?</td>
</tr>
<tr>
<td></td>
<td><strong>No</strong></td>
<td></td>
</tr>
<tr>
<td>Have you outlined a plan for sustaining funding if the initial monies</td>
<td>Consider the next question</td>
<td>You will need to put a re-funding</td>
</tr>
<tr>
<td>are short-term?</td>
<td>below.</td>
<td>plan together as soon as possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after the start of the project.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funders, both statutory and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>non-statutory, do their</td>
</tr>
<tr>
<td></td>
<td></td>
<td>resource allocation plans a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>long time in advance (up to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a year or more in many cases),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>so you will need to be ready</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for this.</td>
</tr>
<tr>
<td>Is somebody already responsible for ensuring the ongoing financial</td>
<td>Do they have the resources</td>
<td>Will the workers be left to</td>
</tr>
<tr>
<td>viability of the teenage pregnancy project?</td>
<td>to do this job (e.g. time,</td>
<td>pick up this task? If this is</td>
</tr>
<tr>
<td></td>
<td>knowledge, skills, contacts)?</td>
<td>is not expected then time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>will be lost delivering on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>objectives as they scout</td>
</tr>
<tr>
<td></td>
<td></td>
<td>around for pots of money.</td>
</tr>
<tr>
<td>Will the worker(s) be expected to take on re-funding? If so, has this</td>
<td>This must be carefully</td>
<td>The project manager or</td>
</tr>
<tr>
<td>been formalised in light of their other commitments?</td>
<td>monitored.</td>
<td>management group need to lead</td>
</tr>
<tr>
<td></td>
<td>Often staff are on short-term</td>
<td>on funding issues and have</td>
</tr>
<tr>
<td></td>
<td>contracts and unplanned time</td>
<td>it as a regular agenda item</td>
</tr>
<tr>
<td></td>
<td>spent on fundraising can lead to</td>
<td>in both committee and staff</td>
</tr>
<tr>
<td></td>
<td>the non-delivery of the</td>
<td>meetings.</td>
</tr>
<tr>
<td></td>
<td>project’s services.</td>
<td></td>
</tr>
<tr>
<td>Is it clear what the relationship between the funders and the</td>
<td>You and your funders will</td>
<td>If there is a lack of clarity</td>
</tr>
<tr>
<td>evaluation processes will be?</td>
<td>have a clear agreement.</td>
<td>between what funders and</td>
</tr>
<tr>
<td>Do you know what funders expect from your reporting process?</td>
<td>Regular reporting systems</td>
<td>providers expect from the</td>
</tr>
<tr>
<td></td>
<td>and review sessions will be</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td></td>
<td>organised.</td>
<td>processes then time and energy</td>
</tr>
<tr>
<td></td>
<td>Are the people involved</td>
<td>will be lost as a result of</td>
</tr>
<tr>
<td></td>
<td>knowledgeable and influential</td>
<td>differences that may emerge</td>
</tr>
<tr>
<td></td>
<td>enough to make decisions if</td>
<td>around priorities and</td>
</tr>
<tr>
<td></td>
<td>funding concerns arise?</td>
<td>milestones.</td>
</tr>
</tbody>
</table>

### 4. Support and monitoring

<table>
<thead>
<tr>
<th>Question</th>
<th>Next steps if the answer is:</th>
<th>Next steps if the answer is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has record keeping been considered and systems decided upon?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td></td>
<td>Do all parties involved know what their role is within the report-writing structure? Are they clear on the types of records to be kept, and who and how this will be carried out? Have data protection and confidentiality protocols been written and disseminated?</td>
<td>See the Yes column for what needs to be done</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do all parties concerned in monitoring and evaluation understand and</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>agree on the model being used?</td>
<td>Do you need extra resources</td>
<td>A mutually understood evaluation framework needs to be agreed upon. Its purpose must be clear. The resource implications must be considered and accounted for in terms of time and monetary costs.</td>
</tr>
<tr>
<td></td>
<td>for this evaluation work?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Will independent evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>be needed? Has this been</td>
<td></td>
</tr>
<tr>
<td></td>
<td>accounted for in the budget?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the roles and responsibilities of workers, managers and funders</td>
<td>The regular monitoring</td>
<td>A significant amount of time</td>
</tr>
<tr>
<td>clear?</td>
<td>processes need to keep this</td>
<td>needs to be devoted to</td>
</tr>
<tr>
<td></td>
<td>dimension in mind. Gaps,</td>
<td>clarifying and deciding this.</td>
</tr>
<tr>
<td></td>
<td>confusing overlaps and so</td>
<td>Many projects find themselves</td>
</tr>
<tr>
<td></td>
<td>on can severely debilitate a</td>
<td>embroiled in unnecessary work</td>
</tr>
<tr>
<td></td>
<td>project.</td>
<td>and “heartache” if this stage is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>completed.</td>
</tr>
</tbody>
</table>
5. Setting up the project

<table>
<thead>
<tr>
<th>Next steps if the answer is:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the roles and responsibilities of paid and unpaid workers on the project clear?</td>
<td>Are these written down and agreed? Is there a hierarchical structure? What is the decision-making procedure? How are tasks allocated and by whom?</td>
<td>These need to be considered and agreed as soon as possible. If the team is multidisciplinary there may be different understandings and beliefs about what community-based health work entails.</td>
</tr>
<tr>
<td>Have relationships between the teenage pregnancy project and the other agencies and groups it needs to work with and influence been established?</td>
<td>This suggests that careful planning has already taken place. It places the project in an advantageous position – to be able to ‘hit the ground running’.</td>
<td>Aims and objectives need to be checked and a concerted effort made to identify and meet with agencies and individuals that will be able to support the project. This is likely to be time-consuming but will save time later on.</td>
</tr>
<tr>
<td>Have these key organisations ensured that the aims and objectives of the project are compatible with their own?</td>
<td>This will significantly increase the likelihood of much-needed support and championing of the project. An increased sense of commitment to both the project and its future resourcing is likely.</td>
<td>It may be necessary to help these organisations make the links between their own organisational goals and the project’s goals. It may be helpful to gather and go through relevant documents and draw out these links (e.g. sexual health strategies, strategic partnership plans, Health Improvement Programmes, etc.).</td>
</tr>
<tr>
<td>Have these organisations developed clear pathways of communication that allow the project to feed ideas and findings into their systems?</td>
<td>The agencies may already have a fairly sophisticated and well-planned community involvement strategy – or at least some sections of the organisation that do – e.g. Expert Patient Programmes. Or, there may be one or two particular people who have enough power and commitment to ensure the organisation is pushed to respond productively to the teenage pregnancy project.</td>
<td>Start identifying people with influence within the organisations as well as external sources of pressure to ensure that learning and recommendations are able to be fed back and, where possible, used and acted upon.</td>
</tr>
</tbody>
</table>

Working with whole communities

Since many minority communities work on collective principles as opposed to individual ones, it is vital to attempt to work with the whole community on teenage pregnancy issues rather than solely with young people.

Engaging communities in dialogue

A project working with diverse communities will inevitably mean that a wide range of often deeply held views will be expressed. Hence, consensus should not be expected:

‘When working with diversity, consensus should not be an expected outcome of consultation. People cannot always agree. Enduring misunderstandings and differences of opinion need to be openly and respectfully placed on the agenda and clarified as part of the process … Above all it is useful to remember that misunderstanding is destructive and disagreement is not failure.’ (Blake and Katrak, 2002)
Karamjeet Ballagan has undertaken extensive sexual health work with South Asian communities in Birmingham. She describes this work here.

By engaging the whole community, there are likely to be a number of positive outcomes:

- the community endorses the public health initiative;
- a platform is created to develop more targeted action;
- uptake of existing medical services increases;
- community-owned support services are set up;
- community dialogue is developed on a range of issues;
- useful project information can be disseminated to appropriate professional services.

A clear vision

'You need a clear vision, a good knowledge base and a really good understanding of the issues you are trying to promote, why you are trying to promote them and what is the outcome, is it going to benefit them? That is very important. Also the other important issue for communities is, is this just tokenistic, is it flavour of the month, are they just going to do this to show on their reports that they have done something with our specific community and then just leave it? That was a big concern that came throughout our feasibility study at the beginning, “Where is this going to lead, is this for our community's benefit or really for your benefit?”' (Ballagan)
Checklist
• Reflect and clarify for yourself first why you are asking specific questions.
• Be sure that your rationale is clear and relevant to community groups – what are the issues that you are trying to promote?, why are you trying to promote them and how will the outcome benefit them?
• Ask open questions, and be transparent in your responses.
• Don’t make assumptions that you will get a negative response.
• Be patient when negotiating and, if one representative is resistant, involve others from the community in putting forward the case.

Community ownership
To ensure that community members feel that they own the project, they need to be involved at every stage of the process, and be given opportunities to comment and provide feedback:

‘They need to know what you are going to deliver will be in the interests of their community and is not going to jeopardise their future or their culture. In all the projects that we were involved with, the community had the whole process explained to them, so that they could endorse it. They were aware of the issues and so legitimised the process.’ (Ballagan)

Checklist
• Approach key organisations with meetings or seminars. Provide clear factual information showing evidence of the issues.
• Consultation progress: discuss hopes and fears, past experiences of delivering health work, current capacity, and what support can be offered.
• Ensure community control; establish a steering group. Try to keep a balanced membership reflecting different community organisations and individuals so they can share experiences and take feedback to their group.
• Develop roles and responsibilities based on each other’s strengths – professionals can provide factual information, funding and support, while communities can provide their networks and recruit individuals to attend conferences. Give credit to the communities by stressing reliance on their knowledge and support.
• Organise and fund workshops and conferences to gather lay community feedback. Involve communities in recruiting individuals to attend. Target conferences for different groups (e.g. young people, women, men, whole communities) and ensure there is an incentive to attend such as lunch or entertainment.
• Introduce the communities to the issues and the workers.
• Always be transparent about aims.
• Disseminate outcomes through community organisations that can feedback to the community.
Gaining the support of community leaders

One crucial element of a successful community project is to build good relationships with community leaders. This provides reassurance to community members who are involved in the project. When setting up women's conferences on sexual health, Karamjeet noted that many of the women felt uncomfortable because the discussions were about sex. They thought, ‘What would our communities think about what we are doing?’ If leaders’ support has not been gained, they may act as a barrier to the work – often through not being aware of the issues. Building trust with leaders and being open about the project is also important because historically some communities have felt that local authorities and health departments have had hidden agendas when working with local communities which has led to mistrust and suspicion. Perseverance and skilled negotiation is sometimes needed where a leader feels that an issue is not relevant to the community. Karamjeet highlights a particular instance during her work where a leader did not feel that HIV prevention was an issue for his community:

‘You will go through obstacles and problems, but you have to try and sensitively address those and not take them personally … [the community leader] just wanted to make sure that HIV did not get into the community and he felt the best way to do this was to lock it out. That was his way of protecting his community and I had to show him that there is another way, that you can empower people and still protect them, so that they are in a stronger position.’

After six months of patient negotiation, the community leader agreed and the HIV prevention programme was able to go ahead.

Checklist

- Gain support of community leaders – be patient. If a leader is obstructive, speak to other leaders and key representatives within the community and involve them in putting forward the case.
- Get a community representative to take a lead role as this will increase impact on the target audience.
- Use respected figures in key roles.

Using local media and appropriate resources

Involve members of the community in providing information about the project that is accessible and relevant, for example, ask focus groups for guidance on leaflet design or radio phone-ins, so that the community can ask questions.

Checklist

- Recognise community expertise in understanding information needs.
- Without having some control of the process, communities will not endorse resources or carry on with projects.
- Approach relevant media to promote work (paid and unpaid) – target phone-ins, news or health programmes. Use steering group contacts to access local media.
- Always have two people representing the project – relevant professional for factual information and recognised community member to interpret factual information appropriately.
- Develop drama resources, such as plays, that can be performed in community settings to focus on specific issues.
- Use celebrities from within the same ethnic or faith community who are perceived as important role models to promote messages.
Evaluating the project

Evaluation of the project is vital for showing the community how successful a project is and for gaining their further endorsement. Methods include recording numbers of participants who attended community events, uptake of services, how many people have been reached through media activities (e.g. recording those taking part in radio phone-ins). Evaluation forms can also be used.

It is also important to establish the strengths and weaknesses of the project in terms of future development. Work with community organisations to find out if the original aims were met, to see if they felt that the steering group was effective and whether other ways of working can be developed. Evaluation also helps to create a platform to develop more targeted action. Ballagan points out:

‘We most importantly needed to find out if people’s attitudes and knowledge had changed. Our first year was just about engaging communities in dialogue and creating awareness of the issues, which in itself was a success. The second year was where we decided to hold focus groups to check whether people had changed their attitudes and we used an independent agency and got them to go out into the community using our networks. We could also find out how the community viewed its ongoing needs.’

Checklist

• Use a range of evaluation methods (e.g. uptake of services, evaluation forms, how many reached through the media).

• Continue to work with community organisations and groups of local people to establish whether the aims have been met and how to develop future work.

• Use the results to feedback to the community so they can share in the project’s success.

Visit the TPU website for the full interview with Karamjeet Ballagan (see Appendix 3, ‘Useful websites’).
The diversity of teenage pregnancy work

Some current examples showing the diversity of teenage pregnancy work around the country are given in the box below.

<table>
<thead>
<tr>
<th>Tower Hamlets (Campbell Todd, Teenage Pregnancy Co-ordinator)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer education project</strong></td>
</tr>
<tr>
<td>Fifteen young Bangladeshi and Somali women have been funded with Teenage Pregnancy monies to receive peer education. The project aims to address the effects of social exclusion on young women from minority communities (including teenage pregnancy and contraception being taboo), and prevention strategies will also be designed. The group will deliver workshops in schools, youth clubs and colleges.</td>
</tr>
</tbody>
</table>

| Work with faith groups                                      |
| This work is being taken forward by a specialist researcher commissioned by Tower Hamlets. The aims of the work are to identify key groups to take part in the consultation, to set up a forum of faith leaders to review and evaluate the strategy, and to identify mechanisms to feed the views and ideas of faith groups into future developments around teenage pregnancy. |

| A local parents’ advice centre                               |
| The centre has run a seminar for staff on religious and faith issues and engaging with parents. |

<table>
<thead>
<tr>
<th>West Yorkshire (Mary Kiddy, Teenage Pregnancy Co-ordinator, Calderdale)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best practice guidelines</strong></td>
</tr>
<tr>
<td>These guidelines in delivering skills-based relationship education to fit with both Roman Catholic and Muslim beliefs are being developed for schools.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sheffield (Helen King, Consultant in Family Planning &amp; Reproductive Health Care)</th>
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</thead>
<tbody>
<tr>
<td><strong>The Young People’s Health Bus</strong></td>
</tr>
<tr>
<td>The bus visits areas of high teenage pregnancy and social deprivation. In one site it was able to work with young Asian people on sexual health and general health issues. The bus particularly attracts young men so is appropriate for targeting schools with a high BME population.</td>
</tr>
</tbody>
</table>

| Work with the Agency for Culture and Change Management (ACCM) |
| This is a lottery-funded agency working in Sheffield on issues related to female genital mutilation. The ACCM is setting up a referral service for young women wanting help with complications or surgery. |
**Camden and Islington** (Tanya Procter, Teenage Pregnancy Co-ordinator)

**Training project**
The Teenage Pregnancy Strategy has established a training project within the health promotion service and a core team of trainers. They have been trained in religion, faith and cultural issues and will then cascade this training to those working in this area.

**Sexual health needs**
Research has been commissioned by the local teenage pregnancy co-ordinator to find out about the sexual health needs of young Asian people in Camden.

**Minority ethnic health advisor project**
Jointly funded by Excellence in Cities/Teenage Pregnancy Strategy, this project delivers sessions in schools followed by informal drop-in. The pilot project is managed by NAZ and is currently being evaluated.

**Video project**
A Standards Fund project is running in a Camden secondary school where Bangladeshi young women have produced a video for younger pupils addressing sex and relationship issues. The young women are students with English as a second language, and the video is intended for use with other similar pupils.

**Health promotion specialist**
The health promotion specialist working with African Caribbean men has worked with young people to produce a video and CD looking at culturally specific sex and relationship issues. A role model project is also underway.

**Catholic SRE programme**
A Catholic secondary school SRE programme is being developed; the Personal Social and Health Education (PSHE) advisory teacher for Islington has worked on this project.

**Contraceptive service**
A contraceptive service in Camden and Islington has youth-based sessions once a week targeting African Caribbean and Turkish young men. Issues covered include sexuality, sexual health, homophobia and sexism.

**Northamptonshire** (Mary Cooke, Research Fellow)

**Traveller families**
A research project collecting information from traveller families in the Fenland and Eastern Region about their sexual health behaviour, beliefs, rituals and needs was begun.

**Wolverhampton** (Eloise Reece, Teenage Pregnancy Prevention Co-ordinator)
A small grants scheme is available offering up to £250 for minority or faith groups to get involved in teenage pregnancy prevention work by running an information evening or producing leaflets, running focus groups, etc. Nine projects have been funded to date.

**West London** (Jennifer Nsubuga, Project Co-ordinator, Ealing, Hounslow, Hammersmith and Fulham)

**Work with pastors**
The Rain Trust, a voluntary organisation, works with local pastors on issues of sexual health.
Oxfordshire

The Oxford Asian Women’s Helpline
The helpline is exploring teenage pregnancy issues specific to this community and what can be done about it.

Schools survey
A schools survey research project is being conducted in schools with a higher proportion of BME students on attitudes, knowledge and experiences of sex and relationships. This may provide some information about levels of need.

Space Y.P. (Claire Maxwell, Acting Teenage Pregnancy Co-ordinator)
This project, in the local Terrence Higgins Trust office, delivers sexual health promotion groups to young male asylum seekers, specifically to young men who are Kosovan and those who are Farsi-speaking.

Doncaster, Yorkshire and Humber (Andrew Goodall, Teenage Pregnancy Strategy Implementation Officer)

Parent consultation
Consultation is taking place with parents from the BME groups, school pupils and community organisations when delivering SRE. A positive outlook on equal opportunities and cultural diversity will increase parents’ trust regarding the schools’ ability in treating issues of cultural diversity in relation to sex education.

Manchester (Jess Zadik, Teenage Pregnancy Linkworker, Central Manchester Primary Care Trust)

BME working group
A working group is exploring the need of BME young people. The aims of the BME working group are to ensure agencies that work with BME communities are an integral part of the strategy and also to liaise with the other working groups to ensure that the needs of BME young people are developed at a multi-agency level.

Tees (Val Abbas, Lead on Teenage Pregnancy)
Commissioned work with young south Asian men to explore sexual health issues.
3 Working with young people from specific minority communities

This chapter gives guidance on working with young people from a range of different minority communities and explores some of the specific issues that may arise within each community. Each section draws on the perspectives of professionals working with a particular group of young people, notes the implications of their findings, and gives their ideas for developing work with each group.

A full transcript of the interviews carried out for the project is on the TPU website. The ‘Key Implications’ sections throughout this chapter relate to the full interviews.

Working with African Caribbean young people

Building positive self-esteem and self-understanding is an important first step in addressing issues such as teenage pregnancy with African Caribbean young people.

Working with young men

‘Looking at things as they are now, you could take the view that we are heavy churchgoers or rappers in the street. You can narrow black people down to these stereotypes, but for me it is time to collectively stop and look at widening perceptions in terms of what we can do. It is time for black people to take their place in society – autonomous, empowered, clear about who they are, clear about where they have come from and clear about where they are going.’ (Alan Mitchell, Health Promotion Specialist, Camden and Islington Health Promotion Service)
When working with young people in the African Caribbean community, issues of identity, belonging and rejection are all important areas to explore. Alan Mitchell regularly works with groups of African Caribbean young men. He believes that a combination of racial discrimination and social and educational disadvantage has resulted in many young men having negative views about themselves, and ignoring sexual health messages which they see as irrelevant to their lives. Coupled with this is a rejection of mainstream education. The only refuge for many is their peer group where the message is reinforced that they are at odds with the perceived establishment. Mitchell believes that you cannot get the message across ‘if people are in a nihilistic state’. He continues:

‘You can raise people’s awareness but you will have a limited effect because you need to start with individual, spiritual, emotional and intellectual processes. You create an environment where young people can develop a positive mentality and then you can start approaching other things like teenage pregnancy.’

While many young African Caribbean people are aware of the information concerning sexually transmitted infections (STIs) and safer sex, they often mistrust institutions and the information that they offer. The young men with whom Mitchell works have highlighted a series of issues that they would like to discuss, including the police, relationships, condom use, black history and music. Each of these topics can be used as a starting point for more in-depth work, for example, looking at black history and the achievements of the great African civilisations can help to explore identity and self-esteem. Similarly, discussion on relationships can be used to explore gender power dynamics, while talking about the police can trigger discussions about institutional racism and the rights and responsibilities of citizens.

Engaging with parents, other adults and community elders is also important in supporting positive identities for young African Caribbean people.

The stereotypical view is that many young black men base their identities on images of masculinity in rap music, often revolving around aggressive and sexist behaviour. Within this context, teenage pregnancy prevention work needs to look at how young men and women perceive each other and the implications of stereotypical behaviour:

‘If this stereotype can be replaced through education and by utilising different male role models, then young black people could exercise a greater degree of choice to find an equal place in society.’ (Alan Mitchell)

Visit the TPU website for the full interview with Alan Mitchell, as well as the Health Development Agency’s (HDA) Promising Practice Project write up of his work.

Faith communities project

In a different approach, Jennie Harrison works with faith representatives in Lewisham, many from black-led Churches, to develop their skills in supporting young people with concerns about sex and relationships. As a first step she approached faith leaders from a range of denominations to gain their support and build trust:

‘There were some who wanted to know exactly what I wanted to say to young people, so they would ask who was funding me, was I going to be coming into the church with a secular message that “sex is actually OK, so long as you use a condom”. That was their primary concern.’ (Jennie Harrison, from the ‘What’s love got to do with it?’ project)
Key implications

- Professions need to recognise all the ‘information’ contained in the stereotype of black identities and reflect on how this may impact on practice.
- Young people have a range of potential influences – ethnic, religious, peer, discrimination from the establishment, etc. It is useful to consult with them on the interaction between relevant influences.
- Historical and current rejection can have an impact on self-perception and risk-taking behaviours.
- Cultural education based on theories of empowerment can help to develop positive ethnic/cultural identities leading to increased self-esteem.
- Positive self-perception can lead to increased academic achievement and reduce factors that lead to unsafe sexual behaviour.
- Support from faith communities can enable exploration of the potential of the young person and offer guidance for difficult situations.
• Faith identities can help to build self-esteem and reduce peer pressure to engage in unsafe sexual activities.
• Consulting with young people and community leaders requires a knowledge of culturally specific workers and community groups in the locality.
• Well-researched evidence of teenage pregnancy and STIs for particular communities can help in developing dialogue with those communities.
• Identify the support you have and can offer community groups, such as time, training, money.

Development issues

In recognising the links between self-esteem, positive sense of self and definable identities, it is clear that innovative ways of working need to be developed. Working through the negatives to find authentic facts can help to shape values and motivate young people to explore their identities today. Equally, working with concerned and willing community leaders can help to support young people in developing a positive sense of self.

Young people from the majority community who ‘buy in’ to education or follow a vocational path may build positive identities from these achievements. Those at greatest risk of teenage pregnancy appear to have had fewer opportunities and incentives to build a positive self-image. Engagement with such initiatives as Sure Start, Connexions, the Children’s Fund or school/learning mentors for children and young people who have been socially excluded are showing benefits. Looking at majority cultural identity and religion’s role as a proactive force may be two more choices that could be offered to all young people as ways of reducing sexual risk taking.

Working with British-born Chinese young people

British-born Chinese young people are at low risk of teenage pregnancy according to anecdotal evidence. There are strong cultural and historical reasons for this, believes writer Paul Ho:

‘ … an upbringing in a Chinese family environment is distinctly different to that of an English one. Chinese parents would more likely push their children very hard to perform well academically, to achieve professional qualifications and eventually take up well-paid respectable jobs. They would generally demand their children to be filial, obedient and loyal, and would tell them what is expected of them in life.’ (Ho, 2002, www.britishchinese.org.uk)

This strong emphasis on educational achievement and obedience dates back thousands of years and has become ingrained within the Chinese psyche. The Social Exclusion Report states that low educational attainment is a risk factor for teenage pregnancy. So it could be argued that, because young Chinese people tend to focus on education, they are less likely to take risks with their sexual health.

However, young Chinese people are now feeling more integrated into the wider community and this has led to some changes in behaviour.
Connie Chen works with young British-born Chinese people in the Birmingham Chinese Youth Centre, which was set up 10 years ago:

‘Young people who come to the centre seem more open-minded and don’t necessarily feel embarrassed when talking about sex. But their parents did not have sex education at school and it is not something they feel comfortable with. There may be a general lack of communication between parents and children anyway, not just on issues about sex. Within the Chinese community in Birmingham parents may spend a lot of time working and providing financial security for their families, which reduces the time for talking with their children.’ (Chen 2002)

Although communication between parents and children is often limited, the cultural emphasis on education means that young people are encouraged to develop their critical thinking skills. This also means that sexual matters can be explored more constructively. Within the youth club, information on HIV is available in Chinese and English and in the past condoms and sexual health posters have been placed in the toilet areas.

Some young people attending the centre may have relationships but are ambitious to go to university and become professionals. Girls as well as boys usually aim to establish a career and marry later. Among Chinese families it is becoming more acceptable to marry out of the community. Pregnancy and sex outside marriage is perceived by the community as shameful. Chen explains:

‘We are in some ways quite similar to the South Asian communities in that, if you were a teenager and you got pregnant and people found out about it, it would bring shame to the family. For Chinese people honour and respect are important.’

Visit the TPU website for the full interview with Connie Chen.

Key implications

• Recognise that cultural norms like promoting education and family duty are influential factors in British-born Chinese identities.

• Understand that young people can operate as hybrids of traditional and contemporary British-Chinese culture.

• Access community organisations who have knowledge of their community.

• Use national networks of minority groups to find appropriate community organisations in other areas.

Development issues

As with all young people, it is important that young Chinese people have good SRE before they become sexually active, and understand their rights to confidentiality. It is also important to work directly with young people on particular issues that cross ethnic, cultural and faith boundaries, for example, why it is perceived to be more acceptable for young men to have many sexual partners.

Another useful step is to provide tapes and leaflets in community languages for parents so that they have factual information about sexual health, and details of services outside of their community.
It is also helpful to explore how the emphasis on education, family duty and community acceptance could work to reduce sexual risk-taking behaviour in young people and, at the same time, to think about ways of fulfilling young people’s entitlement to education and development in sexual health work. Creating a dialogue with the community to analyse how ‘messages’ are given and received and finding out if this has wider implications for strategies in mainstream parenting education is useful.

Working with South Asian young people

Many young South Asian people lead a public life based on accepted codes of conduct and the desire to belong, and then lead a more private life based on generalised norms of youth culture. Overall, the sense of being of South Asian heritage is seen as a positive by young people.

Jagruti Duggal is the Project Co-ordinator with 1NATION Cultural Arts Connector, an organisation that uses the arts to explore social issues. She has looked specifically at teenage pregnancy, sexual health and the poor uptake of sexual health services amongst South Asian Muslim, Sikh and Hindu communities (2002).

Using questionnaires and group discussion, the research showed that young people value their relationships with their parents but do not feel able to talk to them about having a relationship because it would be seen as unacceptable. While most initially said that sex before marriage was against their religion, many young men reported being sexually active. Some young women felt pressured into having sex and many said that they did not want to have sex before marriage. It was seen as more shameful for a girl to get pregnant than for a boy to be discovered as having had sex. The young people were worried about using sexual health services in case they were recognised and it would become public knowledge.

Duggal also met with groups of mothers who talked about their fears that their children were engaging in sexual activity, and that this could lead to public shame and community exclusion.

To take the work forward, Duggal used her research to write a play, which was then performed in community settings:

‘The storyline was developed from everything that had been said. I had to put in a clinic scene, a friendship scene and a family scene, a young person, their feelings and emotions on sexual health and on their relationship with their parents. It was very difficult because you had to get it right. Say one wrong thing and you could lose all the parents.’

Members of the audience evaluated the play positively:

‘They said it was well written, very good and it delivered the message well: “Please tell us what does happen next”.’

As a next step, Duggal wrote a sequel about a pregnant teenager and explored some of the issues surrounding teenage pregnancy for parents and young people. This has been touring nationally and has also been positively received by the communities.

Visit the TPU website for the full interview with Jagruti Duggal as well as the HDA Promising Practice Project write up of her work.
Key implications

- Recognition that, in general terms, South Asian communities work on collective structures where family and community have greater significance than the individual.
- When working to raise sexual health awareness with young South Asian people, it is important to also work with their parents and communities to help them to understand the influences and pressures facing young people today.
- It is important to stress confidentiality to all young people and to emphasise that the cultural norm of collectively sharing information about individuals cannot apply to specific health or educational work carried out with individual young people.

Development issues

In European cultures where teenage conception rates are lower than in Britain (for example, the Netherlands) successful programmes rely on empowering parents to talk to their children, as well as better SRE and access to family planning services.

Teenage pregnancy staff are currently encouraging minority group parents and communities to be more aware of the wider cultural influences on young people’s risk-taking behaviour, so that they are able to communicate more fully with each other.

Working with Catholic young people in schools

The importance of setting sexual health and teenage pregnancy work within the context of a clear set of values and self-esteem is emphasised by those working with Catholic young people.

Father Joseph Quigley of the Diocesan Department of Religious Education was involved in developing a resource for primary schools in Birmingham on sex education, *All That I Am* (2001), as described in the extract from an article in the *Birmingham Post*:

*Birmingham Post 8 February 2002*

The Catholic Church has developed a sex education programme for 9-year-olds for the first time in response to Birmingham’s alarming teenage pregnancy rate. The Archdiocese of Birmingham has acted on advice that lessons covering sexuality should begin earlier in a child’s development ... The Church’s new sex and relationships education system, entitled All That I Am, includes a teaching programme for primary schools and a video. Father Quigley said: “We know what children are experiencing on television and in magazines, which means that their maturation is taking place earlier. We don’t want to leave children hostage to society. If we talk about sexuality as a gift, clearly we want to introduce them to that at an appropriate level.”

The Church spoke to Catholic 14- and 15-year-olds in Birmingham about their experiences of sex education in order to produce the programme, which took 18 months to complete. Father Quigley said: “I’m convinced that trying to lower the teenage pregnancy rate is intimately related to trying to improve young people’s self-esteem and their understanding of their dignity. If we reduce the ways of looking at development simply to strategies of saying ‘no’, we are failing to understand the issue of dignity and the gift of sexuality.”
The resource aims to provide teachers with a Catholic context in which to help children learn about personal development and puberty. Local research showed that the subject should be taught in Year 5, otherwise it is too late. Parents were also consulted. The video and teacher’s manual have been well received with only a few critical comments about the teaching of menstruation.

The programme revolves around five key aspects of a person: the individual, physical, social, emotional and spiritual. These are used to explore the whole self. Self-esteem can be developed and maintained through a secure sense of faith identity:

‘If the thesis is about the initial evidence that teenage pregnancy is linked to self-esteem (either gaining self-esteem through having a baby or responding to low self-esteem), then we need to look at when self-esteem is beginning to be built. There is some evidence to suggest that those kinds of indicators begin in Key Stages 1 and 2. There is then a need to ensure that we build on that self-esteem.’ (Father Quigley, 2001)

The resource also highlights a proactive approach for pupils, rather than a restrictive one. It aims to inspire debate about balancing rights and responsibilities, while providing a context in which self-esteem and marginalisation can be discussed. It provides a foundation for factual information that will follow later in the curriculum. Having clear and well-defined philosophical parameters also enables Catholic parents to support the spiritual, emotional, social and physical development of their children.

Visit the TPU website for the full interview with Father Joseph Quigley.

**Key implications**

- This proactive approach to SRE contains the framework of five aspects of the person, which could be adapted for non-faith or other religious schools.
- It demonstrates that SRE within a Catholic context does not mean ‘just saying no’ without building in positives of self-esteem and a sense of identity.
- SRE can be developed in Catholic schools in a way that supports the needs of young people in contemporary society.

**Development issues**

Young people being brought up as Catholics could benefit from faith-focused and proactive SRE programmes. The challenge for professionals is how to use community participation approaches to engage with faith communities in developing locally based programmes of work.
Working with Jewish young people

There is an established Jewish youth club movement in Britain where activities are based on philosophical as well as social issues.

Chris Jennings, Youth Worker for the Birmingham Jewish Youth Trust, works in youth clubs with young Jewish people:

’I like to think that the reason that we run separate youth clubs is so that children can look at all aspects of life within a culturally acceptable setting, so that we can discuss issues of the way that religions look at things and occasionally we will try to set up meetings with youth groups from other faiths.’

Young people may attend youth clubs for varying reasons ranging from parental pressure to valuing their religious identity as something unique and special to them. For these young people, the responsibility of observing religious rules and regulations is not seen as a burden. Being a member of the club can also provide a safe space from religious abuse.

However, some young Jewish people may be more influenced by peer group and popular cultural influences such as the media and advertising. They may feel a sense of being restricted by the codes of conduct. The work carried out by Jennings actively includes a whole range of perspectives and focuses on developing self-esteem through a Jewish identity:

’You get the ultra religious end of the spectrum where people will be very much told, “You don’t do that because it is not allowed”, but our approach is very much about helping young people to develop a good sense of self-esteem, a good sense of self-worth and therefore to make their choices based on the fact that they have confidence to compare the recommendations, if you like, of the religion with the virtual bombardment of alternative values of the secular world.’ (Jennings, 1997)
Key implications

- Judaism contains a spectrum of identities from orthodox to liberal.
- Young people will reflect this, combined to varying degrees with peer cultural identities.
- The value of education, analysis and debate, which develop crucial skills for young people, is an intrinsic part of Judaism.
- Religious teachings are clearly understood, as are pastoral responsibilities: this may mean that different Jewish organisations take on different roles.
- Frameworks for living can provide young people with models for choosing not to take sexual health risks.

Development issues

There are positive factors of identity that can steer young people away from behaviours that can put them at risk of STIs or teenage pregnancy. This is based on analysis and informed choice rather than only promoting abstinence as an approach. It is useful to recognise the parallels with Citizenship education which also promotes critical thinking and moral reasoning. Bearing this in mind, perhaps lessons can be extracted to inform wider skills development for all young people in PSHE.
Working with Travellers

‘…the term ‘Travelling People’ is generally used. This is not intended to suggest that they are a homogenous, mono-cultural community; the term is meant by us to encompass:

• The minority ethnic groups known as Gypsies – whether English, Scottish or Welsh – and Irish Travellers; whether mobile, of limited mobility, or no longer living a nomadic way of life but living in housing or in caravans on public or private sites.

• So-called ‘new’ Travellers, some of whom are second, third, even fourth generation Travellers and/or in some cases have Gypsy or Traveller antecedents.

(Traveller Law Centre, 2002, website)

Mary Cooke, Research Fellow at the Centre for Practice Research, University College Northampton has described her research into sexual health issues for young Traveller adults (2002). Working to meet the needs of young people from this minority requires some understanding of the sexual codes of conduct and gender issues:

‘The rules about talking about sex are that it is gender-specific. So in schools, when sex education classes take place, if it is mixed or if the teacher is not female, then the girls will leave the class. Boys do not talk about sex unless it’s with boys/men.’ (Mary Cooke, 2002)

Mothers take a prime role in discussing sexual health, contraception, relationships and sexual activity with their daughters. Information is passed on within the family:

‘Younger girls are expected to listen to these conversations to learn but not to contribute. Rules about behaviour are passed on among the females and are expected to be kept.’
(Mary Cooke, 2002)

It would be permitted for a girl of 14 to get ‘married’ according to tradition and only in this circumstance become sexually active. It may be that young people can be accepted as married if they go away and spend the night together with parental agreement.

‘“Proper” marriages with ceremonies take place if the families want to have them, either before pregnancy or after. But, if the couple sleep together before marriage by going away in an overt “personal” ceremony, then this can take the place of the larger ceremony.’
(Mary Cooke, 2002)

Contraception would generally only be used in marriage and abortion would be prohibited in most circumstances even where disability might be an issue.

Key implications

• Accepted codes of conduct on marriage, relationships, sex education and contraception are clearly defined and differ from many other minority groups.

• The rejection and discrimination faced by Travellers can create a shared crisis of alienation that may cause suspicion of statutory organisations.

• Issues concerning the age of consent for sex may need discussion.
Development issues

Research into the sexual health needs of young people from Traveller communities demonstrates that cultural norms and beliefs have a strong influence on sexual behaviour. It is important to attempt to reduce suspicion of statutory organisations by engaging in dialogue with the whole community. This may help to ensure that positive preventative messages are accepted.

Working with Refugees and Asylum Seekers

Refugees and Asylum Seekers consist of many diverse groups with a wide range of norms and beliefs:

‘The culture and traditions of different ethnic groups need to be examined in order to understand how these factors affect the uptake of sexual health services.’ (Katrak, 1998)

Young people who are Refugees or Asylum Seekers may have experienced poverty, powerlessness, war or social instability. As a result, sexual activity may become a covert means of communication for young men or women feeling displaced or isolated. It may also have become an economic necessity or a means of exploitation. In addition, where young people's main concerns are dealing with insecurity and survival, safer sex and contraception may not be given a high priority.

Issues for young women may include marriage, family planning or childbirth. In order to offer appropriate help, the different cultural and religious norms need to be investigated. Sometimes, there may be concerns that cultural practices contravene British law. In these cases, accessing community views (using one of the approaches described earlier on page XX) in order to bring about acceptable changes, would be important.

Many Asylum Seekers are young men who have left their families in their home countries and may be heavily influenced by the sexual behaviour of young people in the wider society. Safer sex and contraception may not be a high priority. This makes them a target for sexual health and teenage pregnancy work.

As one health worker in Doncaster explains:

‘The Sexual Health Drop-in sees a lot of young men who come from Iran, Iraq and Turkey. Many are from big families and are Muslim. They come here on their own and see behaviour they don’t normally see. They live together in multiple-occupancy accommodation with other lads and experience peer pressure. So they are drinking, which they would not normally do, and they are having unprotected sex.

We did a pilot of giving sexual health advice and condoms at the drop-in and they were very receptive. They trust us now and come in for condoms quite a lot. This project developed from our initial contact of health screening for TB where we talked and let them know about GU medicine.’ (Joanne Ashmore, Specialist Health Visitor, Health Inequalities Team, Doncaster Central PCT)

Key implications

- There is huge diversity within the Asylum Seeker and Refugee communities.
- Sexual health and teenage pregnancy are not seen as key issues.
- Language barriers hinder access to mainstream services.
Development issues

Raising sexual health as an issue requires the involvement of community/refugee organisations. In finding out about the incidence of teenage pregnancy and how it is viewed, community organisations need appropriate support from local teenage pregnancy co-ordinators. This will help to build their confidence in carrying out research and in developing interventions suitable for a variety of minority groups.

Key elements for engaging with minority communities

This final section of the chapter draws together some of the most important elements for engaging with the minority communities that were highlighted in the chapter.

• Reflect on your organisational approach (using the exercise in the box below). Also, anticipate the potential approach favoured by minority groups without acting on assumptions.

• Think about how you use an anti-discriminatory approach (that is, recognising indirect discrimination and developing appropriate strategies for inclusion) in order to clarify assumptions and reduce misunderstandings.

• Recognise the different cultural circumstances in which teenage pregnancy and parenthood occurs, for example, when it is socially sanctioned within marriage.

• Social exclusion, low educational attainment and poverty are linked to adverse effects on health. This can affect both married and unmarried teenage parents.

• The benefits of delaying pregnancy for health, educational or socio-economic reasons need to be openly explained during consultation with community organisations as part of the health agenda.
Statistics about health, poverty and social exclusion need to be researched and framed within each community context and will vary for different sub-groups who make up each community, for example, women and men, parents, young people and community leaders.

Use community participation methods and activities to start the consultation process (see Chapter 2). Mapping the range of community organisations locally is a key early activity.

Engage with a range of community organisations. It will help you to understand local issues and ‘politics’ so that you can remain neutral.

Create focus groups of interested members of community organisations to evolve a clear vision, rationale and strategy for furthering the teenage pregnancy agenda. These groups need to represent a range of appropriate organisations, for example, those involved with young people, women, men, community leaders and parents.

Meet on a regular basis to develop strategies and utilise the expertise of community organisations.

Acting on the recommendation of the focus group, engage with particular community leaders and stakeholders who carry influence and seek endorsement and support for any initiatives. Remember that there are other influential ‘role models’ as well as more formally recognised community leaders.

If some community leaders refuse to engage, then find others to consult with on the advice of the community organisations that you are working with.

Allocate time and resources to support and develop the work.

Develop skills in community organisations, for example, via training, resources, guidance or policy development.

Devise appropriate methods to monitor the work.

Use a range of formal and more creative methods to evaluate your identified goals.
**Exercise: reflecting on your organisational approach**

This is a useful exercise adapted from Faith, Values and SRE (Blake and Katrak, 2002) for helping to ensure that you have a transparent and open agenda with minority communities. It will also help to avoid making assumptions that could lead to stereotyping.

Use the definitions below to think about your organisational approach before you engage with any community, so that you do not unwittingly impose your professional goals, before hearing their concerns.

- Which of the approaches below do you adopt?
- Do you need to include the other approaches in your consultation process?

The **health-led approach** has usually focused on behaviour change for medical reasons. This currently includes the reduction in unintended teenage pregnancy, increased condom use and the prevention of STIs including HIV and reducing shame and stigma to improve mental health and well-being.

The **educational entitlement approach** is concerned with developing personal and social skills as well as beliefs, morality and values frameworks. This enables young people to formulate and live by codes of conduct based on respect for self and others. The approach supports equality and autonomy, personal and civic responsibilities as well as understanding the law. The changing views and needs of children and young people would be ‘factored’ into the explicit aims of this approach. This could be considered to represent a secular perspective.

The **socio-economic imperative** examines the relationships between public spending, social welfare, unplanned parenthood, poverty, unemployment and low educational attainment. It seeks to ensure that educational entitlement will provide equity, in terms of life chances and appropriate skills, for children and young people and ultimately reduce dependency on the state.

**Religious aims** .... will vary according to the faith and even the denomination or movement within that faith. They will prioritise ... the accepted codes of conduct and variety of laws and teachings that tend to focus upon the sanctity of marriage and the procreation of children.
4 Faith and philosophical perspectives from community members

During the interviews outlined in Chapter 3, we found a great variety of interpretation within each faith. Individual members of diverse communities were invited to complete questionnaires giving their perspectives on identity and issues related to teenage pregnancy. Hence, these views expressed below are only a snapshot of each individual’s views, and do not presume to be either authoritative or representative of their faith or philosophy. All the faith and philosophical groups who responded are included here.

Respondents were asked to consider how they would explain to secular groups the fulfilment that belonging brings. The intention was to provide an opportunity for others to hear about the significance of different, deeply held beliefs.

A series of common themes emerged:

• The values and beliefs that individuals live by focus on happiness and fulfilment for self and others.
• Sex was seen as a small part of life, set in the much wider context of relationships with God and other human beings, bringing a sense of belonging.
• For most (though not all), sex before marriage was not acceptable.
• Responsible behaviour in terms of contraception or safer sex was discussed if sex before marriage took place (even if the act could not be religiously condoned).
• For some faith perspectives there are clear distinctions between traditional religious teachings and pastoral responsibilities.
• The needs of young people were seen as important and they would not be abandoned if they contravened the rules, but supported to make decisions.
• Guidance and counselling should always be available to young people.
• Of prime importance was to promote a sense of responsibility for self and others.
‘The emphasis is not on ‘do not’, but on trying to help young people experience a sense of belonging, developing their strengths and talents, developing a liking for the person they are, enjoying a range of relationships with God, being given responsibility and support, being allowed to learn for themselves, becoming an active member of the community (church and secular), etc. Being celibate until marriage is just one very small aspect of what we want to impart and that is through example, not preaching. For some this is a natural part of their lifestyle, others make different choices, but all the above remains the same whatever they choose.’ (Andrea Mason, Christian New Church)

**Seventh Day Adventist Church: Family Ministries Department, Nottingham**

**Spiritual fulfilment means ...**
*Developing a growing relationship with Jesus Christ, making him Lord and Saviour of our lives. One should recognise his desire to wish that all his followers should enjoy a happy and healthy existence whilst on earth. We should demonstrate love for God and each other.*

*The Bible does give guidelines for sexual health. It relates to a person holistically. We expound the positive attributes of following the counsel in God's word.*

**Advice to an unmarried teenage woman who is sexually active**
*We would encourage her to consider the pros and cons of what might result due to her sexual activity. We would encourage her to make contact with peers who are not sexually active and share the positive reasons why.*

**Advice to an unmarried teenage man who is sexually active**
*It would very much be the same as mentioned above. Because of the generally accepted stereotype of the acceptance of men who are sexually active, it would help having special men's groups for special education.*

**Advice to an unmarried teenage woman who is pregnant**
*We would offer as much support as possible and give as much information on how to cope and what to do when the going gets tough.*

**Advice to an unmarried teenage man whose partner is pregnant**
*We would offer the same support, but would also encourage the man to take on his sudden enforced role of fatherhood. It may not be best that he marry, but that he should be there for the child and be not become an absent father.*

**Advice on adoption or termination of pregnancy for a pregnant unmarried teenager**
*Our church is very much pro-life and does not advocate abortion unless on health grounds; however the right of the individual to choose is respected. Adoption would be quite acceptable.*

**Advice on starting a family or family planning for married teenagers**
*Using the statistics available, it would be important to show teenage couples the high incidence of marital breakdown when children are born too soon at an early age.*
Religious Society of Friends (Quakers): Bradford

**Spiritual fulfilment means ...**
An opportunity to worship and reflect in community. Space to think about, discuss and deepen values. Support in stressful times. We try to value and accept our young people for what they are and to support them and their families in building a full and rewarding life.

**Advice to an unmarried teenage woman who is sexually active**
Inform yourself and think about the medical and social risks you are running. Is this what you really want (90 per cent sure she will say yes, but ...). Be sure you are not being exploited.

**Advice to an unmarried teenage man who is sexually active**
As above and think about probable power imbalances in the situation.

**Advice to an unmarried teenage woman who is pregnant**
1. Go to antenatal class/clinic.
2. Talk to your family, the father and his family – we will go with you/mediate if you want.
   You could use the meeting house as neutral territory.

**Advice to an unmarried teenage man whose partner is pregnant**
1. Support your partner and child
2. As above.

**Advice on adoption or termination of pregnancy for a pregnant unmarried teenager**
Think and pray, but we respect that it is your decision.

**Advice on starting a family or family planning for married teenagers**
Think and plan and here is the clinic telephone number. Do you want one of us to go with you?

**Other information that you think workers in education, health, youth and community or social care could benefit from**
Our Yorkshire Link (i.e. 13- to 18-year old) group had a very successful ‘Sex, Drugs and Rock n’ Roll’ weekend, planned and run with support locally, by young people. It was very successful but, unsurprisingly, provoked a few irate letters/phone calls centrally (not from anyone in any way involved).

Islam: member of the Muslim Community, London

**Spiritual fulfilment means ...**
Like most world religions, Islam provides its followers with a source of guidance and spiritual fulfilment. The spiritual fulfilment that Islam provides is important in coping with the stresses of daily life as much as it is a source of personal well-being. Furthermore, Islam also helps to connect the here and now (the temporary present) with the hereafter (the permanent present) by making everything that Muslims do in the present life have an impact on what happens to them after death. Living life according to the principles of Islam thereby should give Muslims spiritual fulfilment.

There are no specific teachings in Islam that could guide young people from becoming teenage parents. However, according to Islam, parenthood should only take place within the institution of Islamically recognised marriage between a man and woman. Therefore, if a young adult is not prepared for marriage, then s/he cannot have sex or children outside marriage.
Advice to an unmarried teenage woman who is sexually active
Any sexual activity outside marriage, irrespective of age, goes against the teachings of Islam. Therefore, any unmarried teenager – whether male or female – who is a Muslim, should not engage in sexual activity if it is not within a marital relationship. By permitting sexual activity only within marriage, Islam encourages commitment and with it (hopefully!) love and joy in a relationship.

Advice to an unmarried teenage man who is sexually active
As above.

Advice to an unmarried teenage woman who is pregnant
If an unmarried teenage woman gets pregnant that would indicate that she has had sex outside marriage. This would be regarded as a sinful act in Islamic communities. However, once a woman has become pregnant outside marriage, she should be advised of whatever options are available to her and supported as best as possible.

Advice to an unmarried teenage man whose partner is pregnant
He would be expected to support his pregnant partner, both financially and emotionally, until the child is born. After this, he would be responsible for his child only. The above answer is what I think – not what I know for sure.

Advice about adoption or termination of pregnancy for a pregnant unmarried teenager
Termination/Abortion – This issue is contentious. Some Muslims maintain that abortion is permitted at various stages within the first four months of pregnancy, depending on the interpretation of Islamic texts and traditions. Other Muslims maintain that abortion is a sin at any stage of pregnancy. Among those who allow abortion, it is permissible only under certain circumstances – the most popular one being if the mother’s life is at risk.

Adoption in the Western sense is not permitted in Islam. However, guardianship is. Therefore, a Muslim can bring up a child as his/her own as long as the child is not registered as his/her own. The term that comes closest to describing this situation is ‘legal fostering’. Orphan sponsorship is also permitted in Islam.

Advice on starting a family or family planning for married teenagers
There would be no objections to starting a family, just as there will be few objections to family planning. However, as is always the case, there will be someone objecting to people using contraception.

Other information that you think workers in education, health, youth and community or social care could benefit from
According to Islam, then, if people do not get married, they must abstain from sexual activity.

Hindu Perspective: Bradford Interfaith Education Centre Member

Spiritual fulfilment is ...
A part and parcel of my life.

Our faith doesn’t allow premature, illicit and immoral relationships between teenagers. It is considered a very serious and sinful act on the part of a Hindu. Both parents of the teenagers indirectly make them aware of the social, family good faith to maintain the sanctity of human life and refrain from teenage intimacy.
Advice to an unmarried teenage woman who is sexually active
Parents do advise, especially her mother gives her an insight into the pitfalls of early sexual activity because it is a very shameful act on her part to indulge in love-making with a stranger, as it is an unlawful deed. As a last resort will give her to observe prevention and contraception.

Advice to an unmarried teenage man who is sexually active
Same as above.

Advice to an unmarried teenage woman who is pregnant
To get, in confidence, both partners and their parents together to seek counselling, medical advice and to keep the pregnancy, irrespective of a slur on their part for this deed. They should be allowed to keep the general relationship towards an amicable marriage solution. Both parents must remain supportive and sympathetic rather than being negative and despondent.

Advice to an unmarried teenage man whose partner is pregnant
Similar as above.

Advice on adoption or termination of pregnancy for a pregnant unmarried teenager
Termination is a sin. Try for reconciliation; if not, then give advice for a possible adoption in a Hindu family.

Advice on starting a family or family planning for married teenagers
Family planning is allowed in Hindu culture and faith. They produce one or two children to keep a manageable family size. These teenagers are hopefully aware of it. If they are married then they should observe family planning till they are ready to fully support another child in their family without being a burden on anyone else or the social agencies.

Other information that you think workers in education, health, youth and community or social care could benefit from
These agencies play a very important role in broadening the teenagers’ views, attitudes, parental responsibilities, upbringing of the infants, collective efforts to lead a harmonious life, to meet the immediate needs of the family unit and so on. It is a must be. But still home environment, home background, religious and cultural ties and observances are very crucial to build a good moral character of such children.

Hindu parents are duty bound to guide their children to develop into good citizens of the land, wherever they have settled in the world. Hindu Dharma is a universal faith and respects other faiths as equally good. We don’t believe in conversion or expansion of Hindu Dharma.

Pentecostal – Church of God of Prophesy: Member of Bradford Interfaith

Advice to young people
Best preventable method is just to say no and mean it. Don’t get into a situation where you can be trapped. Listen to your elders, take their advice and counsel; one cannot beat experience, they have gone through it all, therefore it is vitally important.

Advice to an unmarried teenage woman who is sexually active
If sexually active, then please use preventative methods ... but would rather they were not sexually active at such early years; good things do come to those that wait.

Advice to an unmarried teenage man who is sexually active
Use preventative methods, never force yourself on anyone ... all that glitters is not gold, prevention is better than cure. A cure may never be there.
Advice to an unmarried teenage woman who is pregnant
Talk to parents, it might seem hard and difficult, but do talk to your parents or someone, get professional advice.

Advice to an unmarried teenage man whose partner is pregnant
Stand by that girl, don’t run away from your responsibility, it makes it easier for both parties.

Advice on adoption or termination of pregnancy for a pregnant unmarried teenager
We would never encourage termination, unless in extreme cases i.e. danger to life. Bring forth your child, never abort, you see help will be there.

Adoption is something we accept rather than termination, but find it difficult for ethnic people to be accepted as adopters.

Advice on starting a family or family planning for married teenagers
This would depend on the couple. However, we would give advice and counsel. We would advise marriage even at teenagers’ age, rather than the alternative, but we would give the best possible advice and counsel, because this marriage can turn out to be successful.

Other information that you think workers in education, health, youth and community or social care could benefit from
I think we should teach young people more about what the Bible says concerning these things. We have a responsibility as elders to teach our youth. Yes, I think more ethnic people should be included on these panels. God has given us guidelines that we ignore at our peril.

Humanism – Member of the British Humanist Association

Fulfilment from your philosophy means ...
Understanding humanism and knowing that I share that philosophy with others gives me confidence in my beliefs and values, a kind of emotional support. Caring about this life and other people makes one reflect on one’s own actions and their effects.

An emphasis on fulfilment and the happiness of oneself and others and on our human responsibility for the welfare of others and the planet would guide people towards responsible and thoughtful behaviour. Young people should consider how ready they are to become parents.

Advice to an unmarried teenage woman who is sexually active
Be responsible, think about others and the consequences of your actions, be careful and thoughtful.

Advice to a teenage man who is sexually active
Exactly the same! We are very egalitarian.

Advice to an unmarried teenage woman who is pregnant
We would probably advise her to think for herself about the effects of a baby on her life, about the outlook for the baby, and about the possible effects of a termination on her well-being. She would have to weigh all this up and choose responsibly.

Advice to an unmarried teenage man whose partner is pregnant
That would depend very much on how involved he was likely to be as a father. He should feel responsible and share in decision making and support his partner and the baby if they decide to have it.
Advice on adoption or termination of pregnancy for a pregnant unmarried teenager
They would both be hard decisions to make, not to be entered lightly (and better not to get oneself into the situation where one needs to choose either). But either might be the best choice depending on circumstances.

Advice on starting a family or family planning would be for married teenagers
It is irresponsible in a crowded world not to plan a family. It would be irresponsible to bring an unwanted child into the world, or to have a child that one was not mature enough to make sacrifices for. Parental responsibility never really ends.

Other information that you think workers in education, health, youth and community or social care could benefit from
Never assume that, because someone does not have a religion, they do not have deeply held moral values, strong feelings for other people and a sense of responsibility.

Christian New Church Member

Spiritual fulfilment means ...
An intimate personal relationship with my God to know Him and be known by Him. His presence at all times and involvement in the details as well as the bigger picture of my life. The security that I am loved unconditionally by my creator. A sense of becoming more 'me' with each day that passes, through His spirit working in my character and life. Perhaps it would be summed up in the words 'reconciliation' and 'peace' (wholeness, being set as one), expressed as being set as one with my God, myself and the world.

God's original design for sex to be a physical expression (prophetic statement) of the spiritual union of two people becoming one in a marriage covenant: of two flesh becoming one in the conception of a child. Marriage is designed to be a lifelong covenant, not to be treated casually. Sex is a physical manifestation of that covenant and not to be treated as a leisure activity. Sex was designed by God and is good and meant to bring fulfilment and bonding between two people. It is better to guard it from damaging possibilities with a faithful marriage.

But, perhaps most important, life can be fulfilling and satisfying without sex – an emphasis on the value of each life and the potential for a full and happy life, fulfilling platonic relationships, extended family and acceptance within a loving church can help to diminish the need to enter casual relationships or take risks with partners.

We are a family and practically care for one another. The sense of support and love on a daily basis is incredibly affirming, healing and liberating. In times of crisis there is nothing else like it. It can feel as though you are being carried even in the depths of grief.

Advice to young people
Being encouraged to have a wide range of meaningful, inclusive relationships and avoiding exclusive girl/boy relationships until they meet someone they are considering as a potential marriage partner.

Advice to an unmarried teenage woman who is sexually active
It would depend on the individual and her circumstances in that she would be accepted regardless of what she did with the advice. However, we teach our young people before they are sexually active that it is best to wait until they are married. Our advice would be that the young woman took responsibility for her behaviour and possible consequences. If she persisted in being sexually active, we would advise her to use contraception and we would encourage her to develop a relationship with her partner so that there would be honesty, openness and trust between them.
Advice to an unmarried teenage man who is sexually active

As above.

Advice to an unmarried teenage woman who is pregnant

We would support her in every way we could (practically, emotionally, spiritually) so that she could continue with the pregnancy and have the best possible experience of parenthood regardless of the circumstances. We would encourage her to take responsibility and not become over-dependent on individuals.

Advice to an unmarried teenage man whose partner is pregnant

As above.

Advice on adoption or termination of pregnancy for a pregnant unmarried teenager

We would advise adoption over and above termination, but we would provide post-abortion support for those who have decided on termination, the choice must be the teenager’s, but our preference would be that, if possible, the teenage parents would keep the baby with the support of the church.

Advice on starting a family or family planning for married teenagers

We provide marriage preparation courses during which the couple are encouraged to talk openly with each other about what they are expecting so that they understand where each other is coming from and the facilitator will help them to look at aspects they might not have considered. Ultimately, it would be the couple's choice, but again we would encourage them to take responsibility for planning a family and using effective contraception (e.g. the pill) to prevent unwanted pregnancy.

Other information that you think workers in education, health, youth and community or social care could benefit from

The emphasis is not on ‘do not’, but on trying to help young people experience a sense of belonging, developing their strengths and talents, developing a liking for the person they are, enjoying a range of relationships with God, being given responsibility and support, being allowed to learn for themselves, becoming an active member of the community (church and secular), etc. Being celibate until marriage is just one very small aspect of what we want to impart and that is through example, not preaching. For some this a natural part of their lifestyle, others make different choices, but all the above remains the same whatever they choose.

Christian – Protestant, Church of England Member

Spiritual fulfilment means ...

Spiritual fulfilment lies in the good, which comes from obedience to the two supreme commandments – to love God and love our neighbour as ourselves. We experience the love of God as unconditional and perfect. Just as that love is freely given, so we are free to accept or reject it. I experience that freedom as life-enhancing and yet the command to love God and neighbour as an over-riding imperative in my life.

Advice to young people

In bringing new life into being, we become co-creators with God. Jesus placed a priority on the child – that they are more important and precious in the eyes of God than any adult. It is therefore incumbent on us as Christians to aim to delay having children until we are able to give their parenting a priority in our lives as mature and supported adults.

Advice to an unmarried teenage woman who is sexually active

Our sexuality is God-given and good. The incarnation (or God made human in Jesus Christ) is the basis for the value we place on human experience – including our sexuality. Just as it has the potential to be the source of blissful union with another and the beginnings of new life through pregnancy, so it can also have the potential for life-denying experiences and genuine harm.
Advice to an unmarried teenage man who is sexually active
As above.

Advice to an unmarried teenage woman who is pregnant
The death and resurrection of Jesus Christ is the basis for our understanding of how good can come from evil and nothing is too evil that it cannot be redeemed (transformed into something good or positive). The young woman should be encouraged to seek what (for her and, as far as is possible, the father of the child) seems to be the right solution, in the sense of having the greatest potential for good. She should then be supported by the faith community in realising that potential for good. She should also be encouraged to grieve for the ideal that she cannot realise in her situation. Freedom of choice lies at the root of this approach and is based in the freedom to choose good or evil that God gave to humanity at our creation as embodied in the story of Adam and Eve in the Garden of Eden. It is also based on the supreme example of humanity’s freedom of choice in the risk God faced in allowing his people to choose to accept their Messiah or reject him.

Advice to an unmarried teenage man whose partner is pregnant
As above, with the addition of enabling him to fulfil his responsibilities towards the mother and (if the pregnancy goes to full-term) his child.

Advice on adoption or termination of pregnancy for a pregnant unmarried teenager
As above.

Advice on starting a family or family planning for married teenagers
As in ‘advice to young people’. Protestant Christians have no difficulties around supporting the use of the method of contraception of choice by a young couple.

Other information that you think workers in education, health, youth and community or social care could benefit from
The primacy of the child within the teachings of Jesus Christ.

Freedom of choice and conscience.
All that is implied in Kingdom Theology, and the expression of love of our neighbour through social concern and the promotion of justice in our communities.
Appendix 1: Sexual health of young people from black and minority ethnic groups

Briefing paper on sexual health of young people from BME groups: Nicola Low, University of Bristol (2001)

Introduction

One in every eleven 15- to 19-year-olds in Great Britain is from a minority ethnic group (about 311,000 in total, Table 1). About half live in London, another quarter in the West Midlands, West Yorkshire and Greater Manchester and the remainder in other parts of the country. Young people form a greater proportion of BME communities than they do in the white population and teenagers are at the start of their sexual lives so sexual health issues are important.

Table 1: Teenage population in minority ethnic groups, Great Britain, 2000

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Population 15–19 years</th>
<th>% of population 15-19 years</th>
<th>% of ethnic group</th>
<th>% UK-born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>30,240</td>
<td>0.9</td>
<td>6</td>
<td>94</td>
</tr>
<tr>
<td>Black African</td>
<td>26,180</td>
<td>0.8</td>
<td>7</td>
<td>50</td>
</tr>
<tr>
<td>Black other (non-mixed)</td>
<td>11,160</td>
<td>0.3</td>
<td>9</td>
<td>92</td>
</tr>
<tr>
<td>Black mixed</td>
<td>16,560</td>
<td>0.5</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>75,360</td>
<td>2.2</td>
<td>8</td>
<td>79</td>
</tr>
<tr>
<td>Pakistani</td>
<td>67,100</td>
<td>1.9</td>
<td>11</td>
<td>67</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>30,840</td>
<td>0.9</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Chinese</td>
<td>9,310</td>
<td>0.3</td>
<td>7</td>
<td>52</td>
</tr>
<tr>
<td>Other Asian (non-mixed)</td>
<td>10,850</td>
<td>0.3</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>Other (non-mixed)</td>
<td>16,560</td>
<td>0.5</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Other mixed</td>
<td>17,010</td>
<td>0.5</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>All minority ethnic groups</td>
<td>311,170</td>
<td>8.9</td>
<td>8</td>
<td>70</td>
</tr>
<tr>
<td>White</td>
<td>3,184,920</td>
<td>91.1</td>
<td>6</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>3,496,090</td>
<td>100</td>
<td>6</td>
<td>95</td>
</tr>
</tbody>
</table>


Note: Figures for number of teenagers as a proportion of all people from each ethnic group are from the Labour Force Survey. Figures for the proportion of teenagers born in the UK are from the 1991 Census. Census categories are slightly different from those used in the Labour Force Survey and are for 16- to 19-year-olds only.

We do not have readily available information about the sexual health of teenagers from minority ethnic groups because official data do not collect ethnic group information. In addition, researchers have avoided this area of research because they assume that their questions will not be answered and fear their findings may be misused. People from minority ethnic groups already face discrimination, and...
research about personal and sexual lifestyles could be used to create or perpetuate racist views and negative behavioural stereotypes. Unfortunately, a lack of information about minority ethnic sexual health is also discriminatory because important problems get ignored, resources cannot be appropriately targeted and sexual ill-health is exacerbated.\(^3\)

The Teenage Pregnancy Strategy includes action to improve information about ethnic variation in teenage conceptions and address the needs of minority ethnic communities in local plans.\(^7\) The National Strategy for Sexual Health and HIV plans strategies to address the prevention needs of BME groups.\(^8\) This briefing document explains what we mean by ethnicity and brings together the information that we do have about patterns of teenage pregnancy, STIs and sexual lifestyles amongst teenagers from minority ethnic groups in Great Britain.

What do we mean by minority ethnic groups?

The concept of ethnicity refers to self-identification with a group of people who share characteristics such as skin colour, language, religion, place of birth, food and behaviour.\(^9\)–\(^11\) Ethnicity is fluid: individuals may perceive their ethnicity differently over time and the characteristics defining an ethnic group may change, so context is important.\(^10\) In practice, the officially defined ethnic groups used in Britain are those that were chosen for the 1991 Census and are based on a combination of skin colour and geographic origin (Table 1).\(^9\) The term ‘minority ethnic groups’ usually refers only to those that are visibly different from the majority population in Great Britain.

The official ethnic group categories are all very heterogeneous and research findings attributed to a group may only be applicable to a sub-group within the main category. For example, a person defining themselves as black African could be from any country from Angola to Zimbabwe and an Indian could be a Punjabi Hindu, Muslim or Sikh, or an East African Asian. On the other hand, most teenagers now from black Caribbean, black other, Indian and Pakistani ethnic groups were born in Britain (Table 1). They have been exposed to many of the same cultural and educational influences and this could diminish differences between and within ethnic groups.

The reasons underlying differences in sexual health status between ethnic groups are a complex mix of cultural, behavioural, social and economic factors. Ethnic group is intimately associated with social position in Great Britain, with people from minority ethnic groups being more likely to live in deprived areas and be poor than the white majority.\(^12\) Social and economic factors account for much of the ethnic variation in chronic disease\(^13\) and much of the geographic variation in rates of teenage pregnancy.\(^14\),\(^15\) They should therefore always be considered, together with cultural, religious and behavioural factors, as possible explanations for ethnic differences in sexual health.\(^16\)

What do we know?

Teenage pregnancy

Ethnic group is not recorded at birth registration or on notification of pregnancy termination.\(^7\) The Teenage Pregnancy Strategy target of a 50 per cent reduction in conception rates to under-18s by 2010 can therefore not be applied to any minority ethnic group, and there is currently no way of monitoring teenage conception rates in minority ethnic groups over time.
Birth rates

National surveys that ask questions about family structure suggest that teenage motherhood is more common in black Caribbean, Pakistani and Bangladeshi than in white ethnic groups. Recent figures from the Labour Force Survey, however, suggest that patterns may be changing (Figure 1). Fertility rates in all South Asian groups have fallen substantially over the past 25 years but have remained stable in white and black Caribbean women. By the 1990s teenage birth rates amongst Pakistani women had fallen by more than half to 30 per 1000, the same as for white women, and the rate among Indian teenagers was only 7 per 1000.

Figure 1: Teenage birth rates, 1976–82 and 1990–96, by ethnic group

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caribbean</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Indian</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Pakistani</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>


Note: These estimates are based on very small numbers of births. The ethnic categories used are from the Labour Force Survey and not the 1991 Census. No data about Africans and Chinese were available.

Abortion rates

There are no routinely available national data about rates of abortion in different ethnic groups at any age. The British Pregnancy Advisory Service (BPAS) carries out about 27 per cent of abortions in women under 20 years in England and Wales and 53 per cent of NHS Agency and non-NHS abortions in this age group (Table 2).

When compared to the ethnic distribution of the teenage population as a whole (Table 1), women from black ethnic groups are over-represented and those from South Asian groups are under-represented. This could reflect the distribution of consultation centres and clinics, although these are well-distributed across the country. One study from Wessex suggested that abortion rates were similar in black and white women but lower in Asian than white women. Although abortion rates in some ethnic groups are higher than average, the actual numbers of terminations carried out are low because the size of these populations is small. This means that even quite large changes in the abortion rate in any minority ethnic group will have only a minimal impact on national figures.
Table 2: Abortions carried out by the BPAS in 15- to 19-year-old women, 1996–2000, by ethnic group

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>1195</td>
<td>2.7</td>
</tr>
<tr>
<td>Black African</td>
<td>990</td>
<td>2.3</td>
</tr>
<tr>
<td>Black other</td>
<td>464</td>
<td>1.1</td>
</tr>
<tr>
<td>Indian</td>
<td>614</td>
<td>1.4</td>
</tr>
<tr>
<td>Pakistani</td>
<td>321</td>
<td>0.7</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>110</td>
<td>0.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>182</td>
<td>0.4</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>1109</td>
<td>2.5</td>
</tr>
<tr>
<td>All minority ethnic groups</td>
<td>4,985</td>
<td>11.4</td>
</tr>
<tr>
<td>White</td>
<td>38,543</td>
<td>88.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43,528</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: BPAS, personal communication.

Note: Ethnic group was not known for 2 per cent of cases.

Attitudes towards teenage pregnancy, parenthood and abortion

Attitudes towards conception in adolescence and whether a pregnancy should be continued or terminated are strongly influenced by social factors. In the most deprived areas, some 25 to 30 per cent of pregnancies are terminated compared with about 60 per cent in the most affluent areas.\textsuperscript{15,19} The importance of cultural rather than socio-economic factors in influencing ethnic differences in teenage pregnancy outcomes is, however, disputed in qualitative studies. Phoenix emphasises similarities between young black (mostly born in the UK) and white working class women in attitudes towards being pregnant themselves and towards teenage pregnancy and abortion in general, and attributes these to similarities in their experiences of growing up in the same country. Ineichen and Skinner, on the other hand, found that traditional Caribbean pro-fertility beliefs influenced the attitudes of young British-born black Caribbean women.\textsuperscript{20,21}

Among many South Asian communities in Britain there is pressure to become pregnant soon after marriage so, if a woman marries young, then teenage motherhood is welcomed. Katbamna found that Gujarati and Bangladeshi women who wanted to delay conception and have small families faced conflicts with cultural and religious traditions.\textsuperscript{22} Unmarried mothers also face strong community disapproval.\textsuperscript{22} Attitudes towards abortion are less tolerant amongst Asian than other ethnic groups.\textsuperscript{23}

Sexually transmitted infections (STIs)

STIs are diseases of the young and the highest rates for most are in teenage women. Table 3 shows that teenage women account for a much higher proportion of STIs than teenage men. STIs affect populations from different minority ethnic groups unequally and differences persist even after taking into account variation in behaviours such as numbers of sexual partners and condom use\textsuperscript{24,25} and differences in levels of deprivation.\textsuperscript{26,27}

Part of the reason why rates of gonorrhoea and chlamydia continue to differ so much may be the fact that, despite the increasing number of inter-ethnic relationships, most people’s sexual partners are from the same ethnic group as themselves (see Table 4 below).\textsuperscript{28} This means that an infection can circulate at high levels within one group and be rare in another, even if levels of sexual behaviour are similar.
Table 3: Number of new cases of reported STIs, UK, 1999

<table>
<thead>
<tr>
<th>Infection</th>
<th>All ages</th>
<th>Women Under 20 years</th>
<th>% of total</th>
<th>All ages</th>
<th>Men Under 20 years</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>5,181</td>
<td>2,089</td>
<td>40</td>
<td>11,285</td>
<td>1,489</td>
<td>13</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>32,542</td>
<td>11,756</td>
<td>36</td>
<td>24,309</td>
<td>3,270</td>
<td>13</td>
</tr>
<tr>
<td>Genital warts</td>
<td>34,463</td>
<td>10,093</td>
<td>29</td>
<td>37,762</td>
<td>3670</td>
<td>10</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>10,787</td>
<td>2,142</td>
<td>20</td>
<td>6,667</td>
<td>384</td>
<td>6</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>823</td>
<td>17</td>
<td>2</td>
<td>1,913</td>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Public Health Laboratory Service (PHLS) and Scottish ISD(D)5 Collaborative Group (2000).29,30

Gonorrhoea and Chlamydia

Gonorrhoea and Chlamydia are STIs caused by bacteria that can lead to infertility and ectopic pregnancy in women. Chlamydia is common throughout the country, but most cases of gonorrhoea occur in inner city areas such as parts of London, Birmingham and Leeds.26,27,31

Teenagers from black Caribbean backgrounds are at highest risk of gonorrhoea and chlamydia per head of population across the country. However, whilst two-thirds of gonorrhoea cases in inner London26 and Birmingham31 are diagnosed in people from black ethnic groups, only a quarter of cases in Leeds are.27

Figure 2 shows rates of gonorrhoea and chlamydia in teenagers from different ethnic groups in Lambeth, Southwark and Lewisham, which has a very high burden of STIs.26 Similar ethnic disparities in rates of infection are also seen in inner city areas in other parts of London,32 Leeds27 and Birmingham.31 The ethnic distribution of these infections is similar in provincial areas but rates are lower.32

Figure 2: Gonorrhoea and chlamydia in 15- to 19-year-olds in Lambeth, Southwark and Lewisham, 1994–95

Source: Low et al., 2001.26

Note: Accurate data on chlamydia in men were not available at that time. Cases from all Asian and other ethnic groups were combined because of small numbers.
Other STIs

Genital warts are the most common STI in the country and are less frequent in all minority ethnic groups than in the white population. Herpes simplex virus is a viral STI that is not common among teenagers and whose distribution does not vary much by ethnic group.

HIV/AIDS

HIV infection is very uncommon among teenagers in the UK (see Table 3 above), partly because symptoms and diagnosis may not occur until some years later. In 2000, only 104 in 20,359 (0.5 per cent) adults receiving care for HIV infection in England and Wales were aged 15 to 19 years. There were, however, a disproportionate number from black African backgrounds (N=42, 1.6 per 1000) compared with white (N=42, 0.01 per 1000).

The most frequent routes of transmission recorded among teenagers were heterosexual intercourse (38 per cent), vertical transmission (19 per cent), sex between men or injection drug use (19 per cent) and exposure to blood products (11 per cent), unlike adults, amongst whom over 85 per cent of cases are due to sexual transmission. Unlinked anonymous testing of blood samples from women in antenatal clinics also suggests a low prevalence with 0.1 per cent of samples in 1999 from women under 20 years in London and none from outside London being HIV positive. Antenatal clinic attenders are not necessarily representative of all young people, but there are no available data from other populations.

Contraception

Qualitative studies suggest that levels of contraceptive use are similar between black Caribbean and white young women who become pregnant as teenagers. Methods of contraception after delivery, however, differ with more young women from Caribbean backgrounds being fitted with intrauterine devices and more white young women being given oral contraceptives. Methods of contraception amongst non-pregnant teenagers from black Caribbean and black African backgrounds are similar to those from white backgrounds (Nicola Low, Improving Sexual Health Study (2001), unpublished).

We know more about contraceptive behaviour among South Asian women than about other aspects of sexual health, perhaps because of an assumption that Asian women have too many babies. As with other ethnic groups, employment and education are major influences on contraceptive use in women from South Asian backgrounds. Many women who were not educated in Britain and are not in employment do not know about contraception before their first pregnancy. Consultation exercises with young people in Bury and Rochdale also suggest that knowledge about contraception and contraceptive services amongst Pakistani school children is poor (Box 1).
Box 1: Bury and Rochdale Teenage Pregnancy Task Group consultations

Teenage Pregnancy Task Group consultations
In November and December 2000, the M6 Theatre Company toured Bury and Rochdale secondary schools with a play about teenage pregnancy and parenthood called 'Forever', part funded by Bury and Rochdale Teenage Pregnancy Task Group.

Within two weeks of seeing the play, 1397 Year 10 pupils in 14 schools completed an anonymous questionnaire about contraceptive knowledge and attitudes: 14 per cent of respondents were from Pakistani backgrounds and 80 per cent were white.

Knowledge about contraceptive methods
Pakistani girls and boys showed consistently poorer knowledge about contraception and STIs, with 40 to 70 per cent classified as having low knowledge levels compared with 10 to 20 per cent of white girls and boys. Pakistani young people were, however, more likely to say they had learnt a lot from school sex education.

Attitudes towards relationships and teenage parenthood
There were few ethnic differences in attitudes: 61 per cent overall thought that having a baby at 16 is not a good thing, although Pakistanis were less likely to think it OK for young mothers to go back to school (56 per cent) than white young people (74 per cent).

Fewer Pakistani young people (43 per cent) thought it would be easy to talk about sex with your partner than whites (57 per cent).

Sexual lifestyles
There are few detailed sources of information about sexual lifestyles and attitudes in minority ethnic groups. Some surveys avoid questions about sexual health, while others have too few respondents to allow detailed analyses. The available data show that levels of sexual behaviour and sexual lifestyles do differ between ethnic groups but, again, it is not clear how much of this variation is due to cultural or to social and economic factors.

Box 2: The Improving Sexual Health Study (2001), Lambeth, Southwark and Lewisham

Improving Sexual Health Study, London
Lambeth, Southwark and Lewisham in south London have probably the highest burden of STIs in the country with 13 per cent of all reported gonorrhoea and the largest number of people living with HIV infection in the country. Also, 25 per cent of the population are from minority ethnic groups and, among this diverse population, people from black Caribbean backgrounds have rates of gonorrhoea more than 10 times higher than whites and black Africans have rates of HIV 5 times higher than whites.

The Improving Sexual Health Study received funding from the Department of Health and aimed to investigate these inequalities in a series of linked studies in 16- to 25-year-olds from black Caribbean, black African and white ethnic backgrounds from 1998–2001. One study used focus group discussions to examine group norms about sexual relationships, sexual health and service use. Another interviewed a representative sample of 469 heterosexual 16- to 25-year-olds living in the area with the highest rates of sexually transmitted infections.
Among this group of young people from a very deprived part of London in the Improving Sexual Health Study (2001), there were some marked differences between the three ethnic groups (Table 4). Black African women reported much lower levels of sexual experience than either Caribbean or white women. Among the men, white men had the least experience. Concurrent partnerships were common among all those who were sexually experienced, with at least 1 in 5 in all ethnic groups reporting sexual relationships with more than one partner at the same time. Black Caribbean men reported the most concurrent partnerships. Table 4 also shows the choice of sexual partners’ ethnic group. In each ethnic group, most sexual partners are from the same ethnic group, although black Caribbean and African men are quite likely to have white female partners.

Among South Asians, young women are also less sexually experienced than white women, whereas South Asian and white men are similar. In this group, which was mostly Muslim, only about 1 in 10 unmarried women had had sex.

Table 4: Selected sexual behaviours in participants in the Improving Sexual Health Study

<table>
<thead>
<tr>
<th></th>
<th>Black Caribbean</th>
<th>Female African</th>
<th>White</th>
<th>Black Caribbean</th>
<th>Male African</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>All participants, N</td>
<td>117</td>
<td>89</td>
<td>47</td>
<td>105</td>
<td>75</td>
<td>30</td>
</tr>
<tr>
<td>Age in years, mean</td>
<td>19</td>
<td>20</td>
<td>19</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Age at first sex, mean</td>
<td>15.9</td>
<td>16.8</td>
<td>16.0</td>
<td>15.0</td>
<td>15.7</td>
<td>16.2</td>
</tr>
<tr>
<td>Ever had sex (%)</td>
<td>80</td>
<td>61</td>
<td>83</td>
<td>84</td>
<td>69</td>
<td>80</td>
</tr>
<tr>
<td>Lifetime partners, mean</td>
<td>4.7</td>
<td>2.2</td>
<td>10.1</td>
<td>10.1</td>
<td>8.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Sexually active participants, N</td>
<td>93</td>
<td>54</td>
<td>39</td>
<td>88</td>
<td>52</td>
<td>24</td>
</tr>
<tr>
<td>Concurrent partnership (%)</td>
<td>23</td>
<td>21</td>
<td>19</td>
<td>42</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Ethnic group of last sexual partner (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>77</td>
<td>42</td>
<td>17</td>
<td>63</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Black African</td>
<td>13</td>
<td>56</td>
<td>7</td>
<td>6</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>10</td>
<td>2</td>
<td>76</td>
<td>31</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>Been to genitourinary clinic (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In last year</td>
<td>36</td>
<td>19</td>
<td>24</td>
<td>25</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>1–5 years ago</td>
<td>13</td>
<td>15</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Never, but sexually active</td>
<td>51</td>
<td>66</td>
<td>71</td>
<td>67</td>
<td>81</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: Improving Sexual Health Study (2001). 37

Sexual orientation

There are very few data about young gay men and women from minority ethnic groups. Tolerance of homosexuality is lower amongst most ethnic groups compared with whites, although women are more accepting than men. 38 Religious reasons often underpin these attitudes.

Attitudes

Differences in attitudes and beliefs about sexual behaviour between young people from different ethnic groups are less marked than differences in reported behaviours or differences between men and women. 38–40 Religion plays a strong role in influencing attitudes towards behaviours such as pre-marital sex and homosexuality, so young people brought up in strictly observant households tend to hold less permissive attitudes. Country of birth is also important, with those born and educated in Britain holding similar views about sexual relationships and condom use. 38,40
Conclusions

Teenage women account for around 8 per cent of all maternities, 20 per cent of all terminations, 40 per cent of gonorrhoea and chlamydia cases and 0.5 per cent of HIV/AIDS cases. There are no routinely available sources of information about the ethnic distribution of sexual health indicators such as these, and data from different sources cannot always be compared because they use different ethnic group or age categories. The data presented here show that there are striking ethnic differences in rates of bacterial STIs and HIV/AIDS, and more modest differences in reproductive events. The reasons underlying these ethnic differences include differences in levels of material deprivation, education, racism, sexual and contraceptive behaviours, cultural traditions, contemporary cultural and peer influences and religious upbringing, the relative contribution of which may differ according to the outcome. We need a better understanding of how these factors act to produce ethnic differences and this may help in the development of appropriately targeted interventions to reduce inequalities and improve sexual health.

References


Appendix 2: Ethnic diversity and religious discrimination

The following documents give useful background information on ethnic diversity and religious discrimination.

Ethnic diversity

Extract from factsheet from the CRE, revised 1999. For the full facts see www.cre.gov.uk. The Census results for 2001 will soon demonstrate more accurately the ethnic make up of Britain today, since the category changes are more precise, including an option for religious identity.

Extract

- At the 1991 Census, just over 3 million (5.5 per cent) of the 55 million people in Britain did not classify themselves as white, half of them are South Asian (that is, of Indian, Pakistani and Bangladeshi descent), and 30 per cent are black.

- Nearly 4 million people (7.3 per cent of the total population) resident in Great Britain at the 1991 Census had been born elsewhere in the world (including Ireland, North and South). The majority of them (61 per cent) were white.

- There is a rich diversity in Britain’s minority populations. However, the figures do not show the true size of the communities, as they exclude British-born members of these groups. For example, Indians born in India represent only 37 per cent of the Indian group; 41 per cent were born in the UK, 17 per cent in the East African Commonwealth countries and 5 per cent elsewhere. Moreover, the figures include people born overseas to white British parents.

- In 1991, nearly half of Britain’s non-white population had been born in the UK, and about three-quarters of them were British citizens. The overwhelming majority of non-white children under 16 were born in the UK.

- People of European origin account for the majority of the rest of those people born outside Britain. People from Ireland (North and South) make up the largest group of these – 1.5 per cent of the population, or 4.5 per cent if their children are included. People born in Germany are the largest group from other countries in the European Community, while Poles who settled in Britain after the war make up the majority of people from Eastern Europe.

- British Jews number about 285,000.

- There are around 63,000 Gypsies in England, 53,000 of whom are Romanies.
Religious discrimination in England and Wales


Points from the summary

- Ignorance and indifference towards religion contribute to an environment in which discrimination of all kinds (including ‘unwitting’ and institutional discrimination) is able to thrive.

- Other people based their views on pre-conceived ideas and stereotypes and seemed to neither know nor care about the things that are central to the experience of those for whom religious identity constitutes an important, or the key, aspect of their lives.

- Some progress was being made in reducing unfair treatment and a degree of religious pluralism was beginning to develop, although much remained to be done.

- Religious discrimination was experienced in education, employment and the media.

- Ethnic minorities frequently reported unfair treatment in areas such as immigration, policing and prisons.

- Religions with large numbers of visible minorities, such as Muslims, Sikhs and Hindus, reported the most discrimination overall and research participants who belonged to these minority groups often identified a degree of overlap between religious and racial discrimination.

- A number of interviewees pointed out that, while there are those who see religion as an intrinsic or important part of their identity, the rest of society tends to think of religion as optional and may therefore assume that religious requirements can be negotiated.

- It was felt that employers and educationalists, in particular, could do more to accommodate religious diversity, and in a less grudging way.
Appendix 3: References and useful resources

References


Duggal, J (2002) Young Asians Sexual Health Report. Walsall Health Authority


North West Lancashire Health Promotion Unit (1997) *Mazhab and Sexuality (Faith and Sexuality)*. A Discussion Paper on Sexual Health for Community Workers from Four Faith Perspectives. North West Lancashire HPU.


**Useful resources**


Teenage Pregnancy Unit:

*Guidance for Developing Contraception and Sexual Health Advice Services to Reach Black and Minority Ethnic (BME) Young People* (2001).


**Useful websites**

- www.blackhealthagency.org.uk
- www.cabinet-office.gov.uk/seu/
- www.cre.gov.uk
- www.hda-online.org.uk
- www.homeoffice.gov.uk
- www.minorityhealth.gov.uk
- www.nch.org.uk
- www.multifaithnet.org
- www.naz.org.uk
- www.partnership.org.uk
- www.teenagepregnancyunit.gov.uk