Misconceptions

WOMEN'S ATTITUDES TO PLANNING & PREVENTING PREGNANCY

"You don't know how you'll feel until you're pregnant."

"Sometimes you just hope you're not, but in the back of your head you hope you will be as well, and as soon as you find out you're not, you're a bit disappointed."

"She was an accident but it doesn't mean I don't love her."

"If I won the lottery I would get pregnant."

"We were in two minds."

"I was too young to know what was going on."

"If it happens, it happens."

fpa
putting sexual health on the agenda

An fpa report in conjunction with Research Works Limited

Contents

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Management summary

It was clear that women's intentions regarding pregnancy were broadly-based and long-term in scope. Lifestyle factors strongly influenced intentions, which fluctuated rapidly according to personal circumstances.

Many respondents took risks as a matter of course – distancing themselves from any notion of intentionality and seeing those risks as 'justifiable unintentionality'.

All respondents were keen to distance children from any judgements about intentionality and 'unwanted' was definitely equated with 'unloved'. Terminations were much more of an option for BC1 mothers, while C2DE women (and their culture) were strongly resistant to the idea.

The notion of 'unconscious intention' was very common amongst all respondents, with many women believing that their bodies actually determined pregnancy – 'biology over rationality'.

In terms of lifestyle and intentionality, BC1 women demonstrated a more planned approach to the subject of pregnancy with a more limited 'window of opportunity' for childbearing. C2DE women were more reactive, fatalistic and had a much broader window for childbirth.

Seven value groupings were identified which shaped responses to the notion of intentionality and pregnancy:

- *Motivational;*
- *Historical;*
- *Natural;*
- *Lifestyle;*
- *Relationship-driven;*
- *Laissez-faire; and*
- *No choice.*

Women might be affected by different value group motivations at different times in their lives, but each individual pregnancy can usually be attributed to influences from one of the value groupings.

Possible interventions need to take account of: women's lack of day-to-day awareness of the issue of pregnancy; a typical lack of immediate concern about the consequences of pregnancy; a lack of awareness of possible action which might be taken and many women's scepticism about contraception. The tone of any intervention would be very important, emphasising choice and personal empowerment in relation to pregnancy.

In terms of suitable groups which might benefit from interventions, older BC1 women were obviously vulnerable as were virtually all C2DE women. Within the latter segment, the value group 'Laissez-faire' are most in need of intervention – although it must be recognised that the whole lifestyle of this group is chaotic and pregnancy is only one of many factors which seem out of control.

Introduction

Women and men have been using a variety of methods of birth control throughout history. Contraceptive services have been available to some extent since the 1920s and since 1974 contraception has been free and widely available throughout most of the UK. Despite this a high proportion of conceptions continue to be 'unintended'. This piece of research set out to increase our understanding of why there is still such a mismatch between the control women would appear to have over their fertility through contraception and the evidence that suggests that many women are, to a large extent, unable to consistently benefit from this control.

Effective contraception services can only support women in choosing if and when to have children if there is an understanding of how the use of contraception fits in with the real lives of the women who need the services. Clearly an aspect of life which involves sexual need, the emotive business of producing babies and the needs and priorities of another individual cannot be uncomplicated. However, some insight into how women make or evade choices around using contraception can support the development of more appropriate services. To this end, **fpa** commissioned this research to explore the real life relevance of ideas such as 'intended' and 'unintended' in relation to becoming pregnant.

Published research in relation to intentionality has tended to concentrate on the idea of unintended, rather than intended, conception. In *Risks of unintended pregnancy in England and Wales in 1989*[1] Martin AK Allaby uses both termination and maternity data to assess women's risk of 'unintended' conception. This study estimated that 47% of all pregnancies in England and Wales in 1989 were 'unintended'. Other studies have similarly either concentrated on measuring the number of 'unintended' conceptions and/or how they occurred,[2] or the implications for pregnancies and births resulting from unintended conceptions.[3]

Asking women about 'intention to conceive' six months after birth (rather than just after conception) has led to a recognition of the difficulties in defining 'intentions'. Allaby notes that *"women's perceptions of whether or not the pregnancy was intended may change over time"* (p94). Anne Fleissig concurs, writing in the introduction to her 1993 study: *"It is important to distinguish between 'unintended' and 'unwanted' pregnancies. An unplanned or unintended pregnancy may become wanted and accepted, on the other hand, a planned and intended pregnancy may become unwanted."*[4]

These inconsistencies can also be detected statistically. Anne Cartwright's 1988 study found a wide range of views articulated by those whose pregnancies had been described as 'unintended:[5]

- 46% of her sample said they *were* using contraception, and *were not* pleased to be pregnant;
- a further 23% said they *were* also using contraception, and *were* pleased to be pregnant;
- 13% said that they *were not* using contraception and *were* pleased to be pregnant;
- but a further 18% said that they *were not* using contraception and *were not* pleased to be pregnant.

Cartwright concludes that *"… the concept of intention … may not be a realistic one for all couples, as it implies that they have control over the situation"* (p 254).

Thus, women's evidence does not suggest the existence of stable criteria by which a pregnancy may be judged as 'unintended'. It seems that we cannot rely on factors such as the use of contraception, or on instances of not giving birth, or on actual reports by women, as reliable measures of 'unintendedness'. Research is currently underway to develop a measure which aims to distinguish between "unplanned", unintended" and "unwanted" pregnancies in a contemporary demographic context.[6]

The inconsistency of reported attitudes and behaviour has been discussed in previous work. For example, Delbaco et al write about various influences on the rates of unplanned pregnancies – such as health care systems, education, contraceptive knowledge and skill – but also suggest that less mechanistic reasons have an important role to play. They write in their introduction: *"Other possible factors, more difficult to quantify, are the differences in cultural norms or religious values, as well as in the dynamics of relationships between men and women."* [7]

Brown and Eisenburg discuss the psychology of contraceptive use in their book *The Best of Intentions*.[8] They gather evidence from studies which highlight motivational inconsistencies in contraceptive use, the result of which *"can often be pregnancy – not really intended, not really unintended, but somewhere in between"* (p 165). The research which the authors refer to largely focuses on adolescent attitudes – the authors noting that there has been little examination of women over 35, even though their rates of unintended pregnancy are relatively high. A recent British study bears out this evidence of equivocation, with women seeking terminations in Camden and Islington actually expressing a range of positive feelings about being pregnant.[9]

fpa has also acknowledged the complexity of feelings about pregnancy in its publications. A 1989 factsheet states that: *"Psycho-analytic theory warns against making a rigid distinction between chance events and intentional acts"*,[10] while a later factsheet talks about the many intangible influences on the non-use of contraception: religious, cultural and ethical influences; personal attitudes to and acceptance of status of sexual relationship; male/female roles – ability to communicate, power to negotiate; personal attributes such as age, level of education, socio-economic status, self esteem; concerns about side effects and the need to prove fertility; and ambivalent feelings about a possible pregnancy.[11]

The unconscious nature of women's feelings about pregnancy makes these hard to quantify, and yet women are persistently asked to define what their pregnancy means to them. Bodard and Baldwin's experience of asking women how they felt shows how untidy responses to pregnancy can be. *"It would seem that people often wish to give a view on a life experience of their own, as opposed to the experience being referred to in the study…"* [12] The fact that 'intentions' are difficult for researchers to distinguish from other influences suggests that the associated psychology is fundamentally complex.

The fact that many women decide to have babies resulting from pregnancies defined as 'unintended' (as shown in Ann Cartwright's *Unintended pregnancies that lead to babies*), would appear to question whether a lack of intention is perceived to be as problematic for individual women as it is for society collectively. Ingelhammar et al in a Swedish study contend that:*"Sexuality is one of the primitive driving forces and sexual behaviour is often steered by irrational factors …."* [13] It may, therefore be difficult for us to accept the assertion made by Patricia Nightingale that *"… because of the complex human, medical, social and economic factors involved not all unplanned pregnancies will ever be prevented."* [14]

The implication of this research is to question the feasibility of aiming to make every pregnancy 'intended'. A recent study on childlessness supports the idea of placing less emphasis on 'intentions' *per se*, describing an ongoing series of *attitudes* towards conception which do not rely on a single, isolated decision as its defining criteria. The authors write that: *"The continuum of childlessness has shown that people's decision-making in this area is often not fixed or firm,"* and further that *"making a decision is a process rather than a once-and-for-all event."* [15]

This research reveals that there is a spectrum of 'intention, within which the poles are the more typically understood notions of 'intended' and 'unintended' pregnancy. Each woman's pregnancy is mediated by a host of feelings and circumstances which make it unique. In this sense, it is perhaps not surprising that pregnancies fail to conform to simplistic notions of 'intended' or 'unintended', but rather form part of a continuum of feelings (positive, negative and indifferent) about pregnancy shared by all women. It is hoped that a more sophisticated understanding of women's perceptions about their own pregnancies will allow us to support them in appropriate ways.

1. Allaby M. Risks of unintended pregnancy in England and Wales in 1989. *British Journal of Family Planning*, vol 21 (3), October 1995, pp 93-94.
2. **Incidence of unintended conceptions**

   Allaby M (see note 1); Cartwright (see note 5); Bruce (see note 9); Nightingale (see note 14); Bodard & Baldwin (see note 12); Ingelhammar (see note 13).

   Flessig A. Unintended pregnancies and the use of contraception: Changes from 1984–1989. *British Medical Journal*, vol 302 (19), January 1991, p147.

   Price et al. Use of contraception in women who present for termination of pregnancy in inner London. *Public Health*, vol III, 1997, pp337-82.

   Lyons, C. At risk of an unplanned pregnancy in Brighton Health Authority. *British Journal of Family Planning*, vol 22 (1), January-February 1997, pp25-29.

   Hudson, G and Hawkins R. Contraceptive practices of women attending for termination of pregnancy – a study from South Australia. *British Journal of Family Planning*, vol 21 (2), July 1995, pp 61-64.
3. **Implications of unintended conceptions**

   Fleissig (see note 4); Cartwright (see note 5), Cartmill, RSV and Bromham, DR. The impact of an unplanned pregnancy and termination on intended future contraception: implications for reproductive health promotion. *British Journal of Family Planning*, vol 22 (1), April 1996.
4. Flessig A. A rise in unintended babies: what are the implications? *British Journal of Family Planning*, vol 19 (4), January 1994, pp 260-263.
5. Cartwright A. Unintended pregnancies that lead to babies. *Social Studies Medical Care*, vol 27 (3), 1988, pp249-254.
6. Barrett G et al. *A study of unintended pregnancy: how can unintended pregnancy be defined and measured.* London School of Hygiene and Tropical Medicine.
7. Delbanco, S et al. Public knowledge and perceptions about unplanned pregnancy and contraception in three countries. *Family Planning Perspectives*, vol 29 (2), March/April 1997, pp 70-75.
8. Brown, S and Eisenberg, L. *The best intentions: unintended pregnancy and the well-being of children and families*. Chapter six: *Personal and Interpersonal Determinants of Contraceptive Use*. Washington DC: National Academy Press, 1995.
9. Bruce N. *Reducing unplanned pregnancy: an investigation of high rates of abortion in Camden and Islington.* London: Hampstead Health Authority and Bloomsbury and Islington Health Authority, 1992.
10. **fpa** factsheet H3, January 1989
11. **fpa** factsheet 3C 1992
12. Bodard, S and Baldwin, B. A survey of women with unplanned pregnancies in Avon, January to March 1994. *British Journal of Family Planning*, vol 22 (1), April 1996, pp 42-45, p 44.
13. Ingelhammar, E et al. The use of contraceptive methods among women seeking a legal abortion. *Contraception*, vol 50 (2), August 1994, pp 143-152, p 149.
14. Nightingale, P. Unplanned Pregnancy. *Practice Nursing*, vol 6 (5), 1995, pp 27-31, p 31.
15. McAllister F and Clarke L. *Choosing Childlessness*. Family Policy Studies Centre, July 1998, p 48 and p 27.

1 Research methodology

Objectives

The objectives of the research, as defined by **fpa**'s brief, were broadly:

- to explore and understand the real life concepts 'intended' and 'unintended' conception;
- to provide input toward developing a tool for measuring the degree of 'intendedness'.

2 Research method and sample

The research was conducted in two phases and was undertaken using a qualitative approach. Two different research techniques were used:

- hall test depth interviews;
- focus group discussions.

Hall test depth interviews, lasting approximately 30 minutes, are carried out in town centre locations. Recruiters, using a screening questionnaire, find suitable respondents on the street and invite them into a nearby venue (the 'hall' – often a church hall, library conference room or similar) where research executives are waiting to conduct the interview. The interviews are open-ended, although guided by a pre-agreed topic list. Hall tests are an excellent method for reaching respondents from lower socio-economic groups and ethnic communities. Equally, hall tests allow a reasonably large qualitative sample to be obtained, which was felt to be useful in developing a segmentation of mothers' attitudes.

Focus groups are essentially a discussion forum, in which respondents are invited to express their feelings, opinions and attitudes in a relatively free-form manner. They are quite different from quantitative research and do not involve questionnaire-based responses (except during initial recruitment). Focus groups last approximately 1½–2 hours. They comprise seven or eight respondents and are run by an experienced research moderator, who makes sure that all the research issues are covered and that the group functions productively. Research issues are formalised (by client and research agency) into a 'topic guide' which is used by the moderator to facilitate the session.

Focus groups were chosen as an appropriate method for the second phase of research, in order that the topics raised during the hall test interviews could be explored in much greater depth.

Locations for research were chosen in consultation with **fpa**. It was decided to conduct research in three quite distinct locations:

- a major urban centre: Birmingham;
- a smaller town with a high incidence of teenage pregnancies: Barnsley;
- a rural location: East Dereham.

In terms of the research sample, it was decided to interview women aged between 16 and 49 years. The sample was quota-controlled in order to give a spread of socio-economic groupings (SEG), meaning that both 'middle-class' (identified as BC1) and 'working-class' (identified as C2DE) respondents were interviewed. Equally, a spread of life-stages was obtained – meaning that we interviewed young singles with and without children, older women with children of varying ages and some 'empty nesters', whose children may have left home. Sexual experience and activity was also considered as a recruitment objective. One focus group was conducted with women who had had a termination within the last two to three years – four focus groups were also conducted with women who did not reject the idea of terminating a pregnancy.

Overall, the intention was to cover a large part of the female population both in terms of life circumstances and sexual attitude.

The research sample was as follows:

Phase 1 – Hall Days

- 48 face-to-face interviews conducted across three locations: Birmingham, Barnsley and East Dereham
- All women aged between 16 and 49 years old
- Spread of SEG was achieved
- Spread of lifestage was achieved

Phase 2 – Group Discussions

1. Female, 13-15 years old, BC1, sexually experienced
2. Female, 13-15 years old, C2DE, sexually experienced
3. Female, 16-19 years old, BC1, sexually active
4. Female, 20-24 years old, BC1, sexually active
5. Female, 20-24 years old, C2DE, sexually active
6. Female, 25-29 years old, BC1, sexually active
7. Female, 25-29 years old, C2DE, sexually active
8. Female, 30-49 years old, BC1, sexually active
9. Female, 20-24 years old, C1C2, sexually active, to have had terminations within the last two to three years

All respondents in groups 1, 2, 3 and 4 were non-rejecters of the concept of terminating a pregnancy.

3 Main findings

Background

The concept of 'intention' presumes a degree of premeditated thought about pregnancy. It is suggestive of planning, of an aim that is arrived at by careful consideration, worked towards, and achieved ie by becoming pregnant, or remaining consistently not pregnant. 'Intentionality' assumes this kind of premeditated thought about each and every pregnancy.

The research revealed that this process is only true for some women, some of the time. In many cases, 'intentionality' was found to be a concept constantly in motion, rather than a steadily held philosophy.

3.1 'Intentionality' as a concept

Women's intentions towards pregnancy tended to be described in broad terms, indicating a long-term frame of mind. There were women who felt that they wanted children immediately, equally there were others who felt that they wanted children, but not at present. There were, however, a large number of women who demonstrated a more ambiguous attitude towards becoming pregnant, unable to conform to any one point of view. In this sense, intentions about pregnancy were more commonly found in the form of "wishes" or "hopes" rather than decisions made before each possible conception.

The way in which these long-term, and often ambiguous views changed was largely concerned with lifestyle factors. For example, partner status could heavily influence a woman's intention to be or not to be pregnant; so could the individual's financial status, as could the woman's age. It was common for women to become more sympathetic towards pregnancy when finding themselves in a stable relationship.

However, women did not consider these tendencies towards or against pregnancy to be consistent. Intentions were found to fluctuate very rapidly, from month to month, from day to day, even from moment to moment. Women showed that they were conscious of this debate raging within themselves:

> ***"Instead of deciding, "I definitely do want one", I came off the Pill, and it was "I do, no I don't, I do", and then I got pregnant, and it was "I don't want to be now", but it was too late."***

> ***"We were in two minds. After I got off the Pill, I said if I'm not pregnant this month, I'm going back on."***

These examples show the instability of the concept of 'intentionality' even in planned pregnancies. In practice, unintentionality was a term with much more meaning.

3.2 'Unintentionality' in practice

Women's intentions, however insubstantial or fluid, were in many cases found to be largely theoretical. Women became most conscious of their intentions when they were faced by their failure ie unintended pregnancy. It was then that the concept of 'intentionality' became clearest in their minds, mainly due to shock.

"I didn't stop crying for months, I was heartbroken."

"I can actually say I laughed; it was just shock."

When faced by reality, intentions tended to be made redundant. It appeared to be a natural instinct for women, when finding themselves pregnant, to relegate intentions to the past, and concentrate on the needs of the present. The attitude of those who found themselves pregnant when they had not intended to be were, in the main, philosophical:

"I'm one of those people, if it happened I look forward to the baby. I don't want to be pregnant, but then I think well, I can't change it, and I won't change it."

When faced by a reality which contended their intentions, the concept of 'intentionality' weakened. Often women showed how they felt obliged to adapt their intentions, rather than pursue them.

"Sometimes you just hope you're not, but in the back of your head you hope you will be as well, and as soon as you find out you're not, you're a bit disappointed."

Re-writing was necessary to protect women from the implication of not caring for their unborn child. This version of events was often the one that would be told to family and friends. Thus, unintentionality had much more thought put into it, with women taking time to justify their behaviour to themselves, the people around them and even their unborn child.

"We weren't really trying for another baby and we were both surprised … but when we talk about it we always tell her that she was a lovely unexpected present …"

Intentionality (more strictly speaking, thoughts about unintended pregnancy) tended to be raised as a subject on a monthly basis. The appearance (or more importantly non-appearance) of a period prompted thoughts about pregnancy, and crucially, sexual behaviour during the previous month. Women's sexual behaviour did not, it was discovered, necessarily reflect their intentions. It was at this time of the month that the shortfall between intention and behaviour became cause for concern.

This concern about unintended pregnancy was raised by women remembering times during the month in which they had either not used contraception, or knowingly made contraceptive "mistakes". These fears had often been shelved at the time, but now re-surfaced when they realised that the outcome of their behaviour would become physically obvious. It took evidence of a period to prompt some women to think about how they had behaved; what they thought about pregnancy; and how they felt about the relationship between the two. Women were often seen to meditate upon unintended pregnancies, but showed less concern at the time.

A major reason for not thinking about behaviour at the time was the influence of alcohol. Not being able to remember clearly what had happened sometimes had the effect of making women "hope for the best" rather than take emergency contraception "just in case". In this sense, mistakes needed to be obvious (eg split condom) to point to an obvious solution (ie emergency contraception).

Missing a Pill was considered to be a less obvious mistake. Women in stable relationships were unlikely to consider precautions necessary when they had been taking the Pill over a long period of time. This "mistake" was not perceived to rank very high on the contraceptive agenda.

Another important factor effective in persuading women not to dwell on potentially risky behaviour was the timing of menstruation. Deciding whether to go for emergency contraception became more equivocal at certain times of the month. There was no real consensus as to *which* times were perceived as being "safer" than others, but individual mentions included when a period was starting, or finishing, or on the 13th day. These comments showed that there was some hazy awareness of a cycle, but little knowledge of distinctions to be made within this cycle, and their effects on conception.

Women tended to distance themselves from forming intentions, or at least overtly articulating these intentions. The reasons for this were unclear, but appeared to be associated with women's fears about the negative associations made with unintended pregnancies.

3.2.1 Terminations

Many women were keen to defend themselves against the implication that an *unintended* pregnancy was suggestive of an *unwanted* baby. The majority of women were very vocal in insisting that the circumstances during which a baby was conceived should not influence how the baby was treated, either in terms of choosing to seek to terminate the pregnancy or in terms of the way a mother loves her child.

> ***"I wouldn't have had two children if I hadn't accidentally. I don't like saying that anyway, I don't want her growing up thinking 'I was an accident' – that's disgusting. She was an accident but it doesn't mean I don't love her."***

Terminating a pregnancy was not seen, for the majority, as part of the child-bearing equation. Many women did not consider terminations to be an option, seeing the appropriateness of their behaviour as a different issue from the resulting unborn baby.

> ***"My mother has got a saying, you should have thought of that before you opened them. You should have thought about it."***

The different outlooks of socio-economic groups was influential in shaping views on terminations. BC1 women tended to have a lifestyle to uphold:

> ***"Pregnancy disrupts life."***

> ***"Not with a child you can't travel about, its not fair on them, they need routine."***

BC1 women were more likely to exercise choice in pregnancy, trying to balance their needs with the needs of a baby. The way they made this choice was on a rational basis, what they perceived was the best for them.

> ***"I could support one child and pay the mortgage and bills … it [the decision to have a termination] was purely financial, not emotional."***

C2DE women were much more likely to perceive pregnancy as a part of the ongoing process of life, rather than adhering to their vision of a particular lifestyle.

> ***"They don't stop me doing anything, they're there, the main thing in my life, if we want to do it, we'll go and do it and the children are there."***

This process was not one of choice making, but a way of managing life events on a contingent basis.

Women who had had abortions did so due to a lack of perceived alternatives: bad health, financial difficulty, lack of a steady relationship. The view of which situations consisted of a lack of alternatives differed however. A lack of money or male support tended to be more negotiable for C2DE women. There were also women who had considered terminations, but felt that they were unable to go through with the process. If deciding to continue with a pregnancy, women had ways of re-writing conception in a more favourable light.

3.2.2 Unconscious intendedness

Women had methods by which they asserted their relationship with a pregnancy and distanced themselves from the negative implications of unintendedness. One important strategy was to assert "unconscious intendedness".

> ***"Secretly I think I wanted a girl anyway. I didn't try for a girl … But when I found out I was pregnant I felt, well, maybe I can give my mum a grand-daughter."***

As a part of this strategy, women often talked about not feeling maternal until they became pregnant:

> ***"It didn't hit me until I'd had him, until you actually see them."***

> ***"I didn't want to know about birth at eight and a half months."***

This perceived change of heart was based on emotions and feelings after giving birth. These feelings overwhelm the former process of deciding whether one wants or does not want a baby, a post-rationalisation. In this way, an "unintended pregnancy" became a pregnancy they hadn't known they wanted.

As an extension of this prioritisation of the body over the mind, women often spoke about their bodies as being in control of pregnancy, rather than their minds.

> ***"I'm just very fertile."***

> ***"My friend is pregnant at the drop of a hat."***

Again, this insistence on the supremacy of biology distanced women from conscious decision-making, and, in a sense, responsibility. An emphasis on biological destiny was apparent amongst most women, but was particularly strong in historical and natural mothers.

3.3 SEG and attendant lifestyle factors

There were broad differences between BC1 and C2DE women in terms of aspiration and where pregnancy fitted in to the realisation of these aspirations.

3.3.1 BC1 Women

BC1 women tended to have a grand plan along the lines of: qualifications, career, house, man, babies. This storyline was in many cases carefully formulated and adhered to. Variations to this plan were not welcomed, particularly in the form of pregnancy.

> *"I'm actually saving for a house at the moment. If I was pregnant I'd have to rush into it. I'd like to settle and have some money there ready for when I was. Then I'd start a family."*

> *"The only time I could see myself having children is when I've been married properly and can afford it."*

> *"In six months I get maternity benefit."*

BC1 women were very conscious of the material needs of children, and saw this as a prerequisite of pregnancy. In most cases the environment the child was to grow up in was prioritised.

> *"If I won the lottery I would get pregnant."*

Pregnancy at a very early age was something respondents had come across at school, but had not directly encountered in their friendship circle. Below the age of 17, pregnancy was, therefore, largely unbelievable in so far as it concerned the individual.

> *"I knew somebody at school who slept around."*

Student years (from 18 upwards) saw pregnancy becoming a more believable phenomena, largely due to more stable sex lives and the commencement of long-term relationships. At this stage, many BC1 women were adamant that pregnancy was not a realistic option and would be very badly timed. This period was seen as an important stage in the individual's 'grand plan' when the foundations for future life (via education) were being laid. Pregnancies occurring at this stage were imagined to be the result of mistakes or accidents with contraception. Any accident or mistake was largely thought of as a mechanical failure – a flaw in the plan.

When certain elements in the plan were in place, it became more readily subject to variation. For example, once education had been completed, the individual had entered the workplace and felt secure in a steady relationship, then many women were more open to the idea of having children. Once a certain level of security had been achieved and certain aspirations satisfied (or at least apparently within reach) some BC1 women considered pregnancy as a viable option. There remained some purists, however, who were keen to wait for specific refinements: eg careers to progress adequately, houses to be bought or the perfect man to arrive.

The onset of a relationship was probably the most significant cue for women to start thinking about pregnancy. A man tended to signal a family stage of life when everything was in place to support a baby. Consciously or unconsciously, women began to think more about pregnancy as an appropriate next step. As relationships matured, the timing of pregnancy became more negotiable. Women acknowledged that they wanted a family eventually and conception was now something that could be sanctioned by the relationship. Thus, the concept of unintended pregnancy was perceived more equivocally, moving from a categorical mistake to being "unexpected" or a surprise. Consequent to pregnancy becoming more acceptable, the use of contraception became less stringent eg not worrying about missed pills.

Once all the elements of the plan had been executed, with particular emphasis on the entrance of a suitable male, women talked of children as part of the fairytale ending. Conditions were now considered appropriate and many women found that this was the time when they were actively intending to become pregnant.

Women in their thirties who had already had children, and who remained in a steady relationship tended to find that once the grand plan had been achieved and executed, it was difficult to alter. Women finding themselves pregnant often felt they had little reason not to have another baby, since the perfect scenario had long since been achieved. At this stage it became difficult to not have a baby, however unintentional.

The effective use of contraception was also questionable at this stage since women sometimes found it difficult to re-discover contraception after a period of child-bearing. This problem was particularly acute for women in new relationships. This was discovered to be an important time of re-adjustment for women that was not thought to be adequately recognised by GPs, particularly in terms of contraception.

3.3.2 C2DE women

Broadly speaking, C2DE women had a different attitude towards pregnancy compared with the child bearing strategy of BC1 women. This attitude was characterised by a lack of planning, and a willingness to be shaped by events as they occurred. This philosophy meant that women's lives tended to be shaped by pregnancy, rather than their pregnancies being shaped by life.

This attitude was in part due to a lack of aspiration felt by women from C2DE backgrounds. Some had left school early and were working in uninspiring jobs, eg factories or supermarkets, with which they felt little attachment. In this situation, having a baby was not seen as a disruption since jobs like these presented few future opportunities. Nor was pregnancy perceived as a surprise, since having babies was generally seen as a very normal part of life, demonstrated by friends, families, and importantly, mothers.

Although women who had children early (or who were from large families) concurred that children made life more difficult, this attitude was characterised by a philosophical stance that clearly stemmed from a lack of confidence in achieving realistic aspirations:

> ***"I wanted my own house, I wanted a Porsche, and now I live on a council house on a shit estate and I have a terrible neighbour."***

A sense of resignation was strongly signalled by the generally held perception that most women tended to have a child-bearing career. With this perception in mind, an unplanned pregnancy was often interpreted as the beginning of an inevitable career. Once women had had one child they often felt more comfortable about having more (either planned or unplanned) – feeling that they had embarked upon the mothering phase of their lives:

> ***"Mine was three, and then I had the other one, if you're stuck in with one, you may as well be stuck in with three."***

Subsequent children were more likely to be perceived as planned, although other accidents were also mentioned.

There was also a sense in which the perception of a child bearing career promoted a role specially created for them in a way that a professional career could never be. This notion was reinforced by the way in which they discussed subsequent pregnancies. Women talked about further births becoming easier and how the experience of a first child was invaluable in going on to have a larger family.

Child bearing careers often came to an end when lifestyle factors which had perhaps been difficult, ceased to be a struggle and became impossible.

> ***"I can't afford any more. I want to give the two that I have got, not everything they want, but I like to dress them nice."***

> ***"I'm only in the three bedrooms with the two, and there's no more room in there. That's why I did go and see about having a termination …. but it was fine."***

Another reason to stop having children was the scenario of mothers with several children becoming fed up with the baby stage of childbirth, enjoying their children more as they grew up, and becoming reluctant to return to a gruelling stage in their lives which they had already experienced several times. In this way, women put a stop to pregnancies after they had experienced several, but showed little incentive to prevent pregnancies along the way.

C2DE women were, on the whole, much more positive about having children. A baby at the age of fifteen was by no means considered a disaster, and this was a more common attitude than amongst BC1 women. Again, pregnancies this early were due to a lack of knowledge about contraception or the effective use of contraception. Importantly, young women did not perceive a reason *not* to have a baby, and were often supported by their families in their decision to continue with the pregnancy.

C2DE women often had babies earlier than their BC1 counterparts, again perceiving children as a normal part of a relationship. Relationships often started earlier, due to women entering the workplace earlier and having fewer aspirations to fulfil in terms of career. Pregnancies from the late teens and upwards were often the result of mechanical failures, either in terms of lack of contraception or failure of contraception. Older women talked about times in their lives when they had been "out on the razzle", with extensive social lives led in pubs and clubs where sex was all a part of a night out.

Women in their twenties tended to be part of a long-term relationship which gave permission for unintended pregnancies. This situation had the potential to continue right throughout the individual's child bearing career and into different relationships during the course of that time. Women in this situation found it difficult to talk about 'unintended' pregnancies within relationships since they felt that this was part of a relationship that did not require questioning.

3.4 Pen portraits

Women were strongly influenced by their social economic backgrounds, broadly speaking BC1 and C2DE, as has been explained above. Individual women's behaviour was more directly influenced by personal values.

The research defined seven broad value groupings by which we can recognise women's attitudes. These values were found to be considerably stronger than intentions, since they often originated from background or life experience.

These value groupings are not static or consistent. Although some women were heavily influenced by a particular value set, others were influenced by several. It was common for women to move between value groupings at different stages in their lives, or to vary between pregnancies.

3.4.1 Motivational mothers

There were some mothers who used pregnancy as a way of manipulating their lives. Some used pregnancy as a way of rebelling, for example, against school.

> ***"It was a way out."***

It was unusual for mothers to be so clearly outcome-oriented. Most first-time mothers at an early age readily agreed that they had little awareness of what they had let themselves in for.

> ***"You think you know better."***

> ***"I was too young to know what was going on."***

In this sense pregnancy was used as more of a general expression of rebellion.

It was reported that some mothers used pregnancy as a way of getting a council house, but there were none that claimed this for themselves.

> ***"One of my friends got pregnant just so she could get a house.***
> ***She wasn't happy at home and felt it was the quickest way.***
> ***And she got everything paid for her."***

In this way, it was more common for women to talk about the pressures of relationships which they felt demanded children. In this sense, pregnancy was used as a way in which women felt they could secure a relationship.

> ***"The third was only because he didn't have any kids."***

It was more likely that being a motivational mother was confined to one pregnancy, rather than being a defining characteristic of a woman's pregnancy experience.

3.4.2 Historical mothers

Historical mothers were often from large families, (perhaps of eight or nine children) for whom pregnancy was a part of family life. For them, pregnancy was seen as normal and natural, a logical consequence for a sexually active woman.

> *"If it happens, it happens."*

It was a characteristic of this group that mothers and daughters colluded in agreeing the natural order of things. It was common for daughters to follow the example of the mothers eg in becoming pregnant early in life. Mothers were most often supportive.

> *"She said, I'm disappointed for you because you could have done so much … but I can't be mad at you 'cos I've done the same thing."*

Some talked of their mothers instinctively knowing when they were pregnant, either by looking (swollen breasts, morning sickness), or some intangible sense, something akin to feminine intuition.

> *"My mum would ring me up at exactly the right time and say 'You're pregnant aren't you?' "*

Coming from a large family did not necessarily lead to an openness concerning pregnancy. Women pregnant at an early age spoke of hiding their pregnancies from their mothers, while others told stories of family members having children in secret. In one case, a mother had given her baby to her mother to look after. In this way, historical mothers were more aware of the constraints of having children than most, but this did not affect their perception of pregnancy and child birth as inevitable and non-negotiable.

Historical mothers were vulnerable in terms of the number of children they had. They tended to prioritise children over everything else, financial problems, health worries or loneliness. Being a mother was seen as the most important thing in life.

> *"I just got on with everything."*

3.4.3 Natural mothers

Natural mothers were in many ways similar to historical mothers. The main distinction was that their tendency towards childbirth was driven by a relationship, rather than family history. Pregnancy was perceived as an ordinary part of a settled relationship, and therefore natural mothers would be less likely to become pregnant at a young age, or outside of a steady relationship. However, these conditions fulfilled, pregnancy was seen (as by historical mothers) as an accepted fact of life. For natural mothers, the distinction between intended and unintended was between conception inside and outside of a relationship.

"She's been out on the razzle and wishing she knew who it were."

Again, as with historical mothers, pregnancy was not perceived to be subject to choice. It remained an unquestioned status which did not allow for distinctions to be made between planned or unplanned pregnancies. The only planning that natural mothers felt was required was a certain stability ie financial, personal.

Natural mothers saw a clear link between their relationship and pregnancy, to the extent that they could perceive children as a requisite along with the house, the man and the steady wage. In many cases, this logic led to women feeling pressured into having more children. This was particularly the case with women entering new long-term relationships.

"We've agreed that he is entitled to his own family."

"I think you oblige don't you. My sister-in-law, she has three girls, he's got five other kids to different people, but they were really considering having another."

"You feel like you have to give him something of his own."

As a natural part of life, difficulties in pregnancy could prove traumatic eg miscarriages. Any interruption in the natural order of things was considered unfair.

"I went to a private clinic and a girl in there, 19, and she'd had four terminations. In the end the nurse actually moved her out of my ward because I was physically going to kill her, she was sitting there blatant as anything."

Historical and natural mothers had many common characteristics

They tended to like children, and being pregnant:

"I enjoy being pregnant."

"I love being pregnant, I love every minute."

"I'm a born mum."

They tended to dissociate themselves from choice in pregnancy, relying on emotions rather than rational choices.

"It grows on you, because it grows in here."

The inevitability of pregnancy was described as an invisible and powerful force, women expressed their sense of biological destiny.

"I was meant to have three."

"My body knows I don't want to be pregnant."

"I trusted my body" (to make the choice for me).

This reliance on destiny seriously undermined the amount of trust placed on human interventions eg contraception. This sense of inevitability shared by mothers and daughters was key to affirming pregnancy as a natural state for women to find themselves in. There was little sense of choice being exercised in pregnancy, and most recoiled from terminations, since this was seen to be an unnatural intrusion into the logical progression of motherhood.

"I still wouldn't have an abortion, because what gives you the right to say, well I've had one, two, three, four and the fifth one gets it. You can't decide."

3.4.4 Lifestyle mothers

Lifestyle mothers were most typical amongst BC1 women. They were characterised by the importance of life events, and their prioritisation over pregnancy. These events were achievements in a life plan – qualifications, employment progression, marriage, house buying. Lifestyle mothers were positive about pregnancy, so long as it was a timed part of the plan. In this situation, the thought of an unplanned pregnancy could be alarming:

"It's definitely put the fear of God in me now, I mean, I'm getting married in December."

Thus, lifestyle mothers had very definite ideas about when pregnancy should occur in their lives. They had a pregnancy 'time-line' ready drawn in their minds, about which they were able to quote specific examples:

"24's a nice age" (to be pregnant).

"35's my stopping point."

Lifestyle mothers were keen to keep to this plan, and therefore were very conscious of the risks of making mistakes which could jeopardise their version of events. This was the group of women most likely to mention the finer points of contraceptive precautions, eg the effect of antibiotics or tummy upsets. Previous scares did appear to have an effect on them – the threat of pregnancy exerting an influence over subsequent behaviour.

"You do take more precautions, and those scares that you have had, you do make sure that you do."

Lifestyle mothers managed their feelings towards pregnancy as well as their practical measures against pregnancy. They were careful to be 'sensible', resisting broodiness and relying on their rational scheme rather than their emotional urges. An insistence on the completion of the rational plan could cause emotional pressure however. This was particularly the case for women perceiving themselves to be at the right age for pregnancy, but not perceiving themselves to be in the right

situation eg not in a relationship. This pressure was heightened by the pregnancies of close friends of the same age.

> ***"If I get to 40, I'll be thinking, "I really should have two by now."***

> ***"I'm the only one out of about five basic friends that isn't actually pregnant and who is going to have children."***

At all times, lifestyle mothers felt that becoming pregnant was their choice. They felt that the decision was very much in their own hands. This was shown by the way in which women pragmatically decided to end their childbearing career.

> ***"My husband will be sterilised shortly."***

At this stage there was little room left for pregnancy, women often taking the final step and undergoing sterilisation as a fail-safe option.

3.4.5 Relationship driven mothers

These were women for whom the driving force towards pregnancy was a relationship. They were similar to "natural mothers" in their acceptance of pregnancy as a very normal part of a relationship, however they differed in that they preferred their pregnancies to be planned rather than "as and when".

The relationship was a key factor for this group. Pregnancy was perceived as part and parcel of the development of a relationship and subject to little further scrutiny. Planned pregnancies were the optimum and timing conception within a secure, long-term relationship became "nice-to-have" rather than essential. Relationship driven mothers were more open in discussing whether a pregnancy was planned or unplanned, and less conscious of the implication of an unplanned pregnancy meaning an unwanted baby.

> ***"It's not brilliant timing."***

The timing of pregnancy was often overwhelmed by the relationship, with women prioritising the relationship over their intentions towards pregnancy. The relationship was felt to secure any pregnancy, and therefore timing became more negotiable.

> ***"I think if you're in a very secure relationship and you're actually living with somebody, the thought of getting pregnant, you think, "Oh at least I've got a partner and we'll get by."***

Common characteristics of lifestyle and relationship driven mothers

Lifestyle and relationship driven mothers tended to assert pregnancy as a natural phenomenon. They were not as open to pregnancy at any time (as were historical or natural mothers) but they still perceived pregnancy as an important part of a woman's life. The idea of "completeness" was expressed,

even amongst those who would not describe themselves as "born mothers". They also described the transformation they felt took place once pregnant, firmly promoting motherhood as a part of the natural order.

"You don't know how you'll feel until you're pregnant."

"I wasn't particularly maternal, but then …. "

3.4.6 Laissez-faire mothers

Laissez-faire mothers are those most likely to become pregnant unintentionally.

There was much silence around this issue, with mothers willing to disclose how their pregnancy had occurred, but not why. Laissez-faire mothers were most likely to come from a C2DE background.

At a fundamental level there are some laissez-faire mothers who do not perceive sex as having an end product – ie pregnancy. There was a lack of awareness of outcome or consequences amongst this group. While the latter attitude was common amongst women generally, in the case of laissez-faire mothers it appeared to become debilitating, with women taking little or no precautions against a concept which they had difficulty in understanding in theory, let alone in reality. This 'conception blindness' was often contrary to their own experience, seeing women around them becoming pregnant unintentionally.

Environment was also a consolidating factor in the lack of thought given to pregnancy at the time of conception. Having children was generally seen as acceptable – there was little social taboo against having children, even in the case of parents, who, angry at the time, often proved supportive in the long run. Further, women did not articulate strong ambitions, or ambitions they felt were achievable.

"I'd like to be able to go away with my mates."

"I'd like to say 'I had a good time'."

Job prospects were not motivating for those working in factories or supermarkets, and they saw little future for themselves in terms of a career. In this situation, having children was not perceived to be a particularly bad option. Having had children, women often wanted time to themselves, but had little aspirations beyond having enough money to go around, "to get by".

Against this background, the practicalities of taking precautions was what lead to most unintended pregnancies. Many women found it difficult to remember to take the Pill regularly, neglecting to treat contraception with a degree of seriousness. Other methods, eg condoms, were also subject to this careless approach and therefore often proved ineffective.

Laissez-faire mothers did not feel in control of their intentions. This was an extension of their perception of the way in which life *happened to them*, rather than themselves personally making their lives happen. This sense of powerlessness also contributed to a perception of contraception as something about which to be sceptical. They had a very strong sense of things happening *despite* one's wishes, an attitude that undermined confidence in contraception. Women also seemed

less aware of the part they had to play in achieving successful contraception, an attitude which went some way to ensuring that contraception was indeed unreliable. Experience also supported this view, with women telling stories of becoming pregnant whilst on the Pill. These shared histories were cited as evidence against their control over pregnancy, and the strength of the forces conspiring against them.

"What can I do? I've tried everything."

3.4.7 No choice mothers

No choice mothers were those who had become pregnant against their wishes. Some had suffered violence (rape) or had been the victim of contraceptive failure (illness).

The women who did not have abortions when faced with an unintended pregnancy did so for a variety of reasons. Some simply could not face terminating a pregnancy, while others felt a certain sense of "just desserts" delivered as a pregnancy, particularly young women out having a good time.

"I'd lucked out for two years."

Unlike laissez-faire mothers, No choice mothers tended to have just one unintended pregnancy. The experience was often a shock, and some women took steps to make sure it did not happen again, eg tighter contraceptive control. Young mums could find it difficult with an unexpected child on their hands at a time when they were unprepared. This could prove off-putting for later pregnancies:

"I'm not a natural mother. I love him to bits if I'm at work, but I couldn't have another one."

3.5 Intervention

Intervention into unintended pregnancy would be likely to be extremely problematic, and needs to tackle several important issues.

Lack of awareness

Currently, thought about pregnancy is post-conception. This is a time where women re-write what has happened to them, but do not want to dwell on why it has happened. Most women showed themselves to be working in the present, finding it difficult to project thought into the future to assess outcomes or consequences.

"I don't think you can actually say until it actually happens to you."

The timing of intervention needs to be pre-conception. The first task is to create a realisation in women of the potential of pregnancy.

Consequences

Once women are aware that they could become pregnant, the next task is to tackle consequences ie pregnancy. The difficulty here is that certain types of women generally saw pregnancy as a good thing, particularly those in relationships who saw child birth as a normal part of a developing relationship: historical, natural and relationship driven mothers. Further, there was a feeling amongst C2DE groups that pregnancy was a very usual occurrence, and not something that was particularly to be avoided.

Messages advising against pregnancy would not be welcomed by these groups. To suggest this would be to force a social agenda familiar to BC1 groups, particularly lifestyle driven mothers, which is alien to most others. This kind of message would need to be launched tangentially egempowering women to articulate what they want to limit the number of children, or to assert a woman's right to time the births of her children.

Action

Women tended to assert the need for information once pregnant. There was enthusiasm at this stage for learning about the baby and what was happening inside their own bodies. This interest and enthusiasm needs to be harnessed prior to conception so that contraception can become a part of the child bearing experience.

Effective action

One way to action this choice process might be through information on contraception. The range of contraception remains an area of confusion for many women. The Pill remains most women's idea of effective contraception.

> ***"There's not a lot out there if you're not on the Pill."***

The importance of this gap in knowledge was highlighted by the number of women claiming to have allergies to the Pill or monthly injection. Common symptoms included being sick, putting on weight or behaving aggressively.

> ***"I've tried so many pills and found out I'm OK for the first couple of months and then I end up bleeding half way through and have to try a new one."***

Injections had been tried by several as a different method of contraception. However, the side-effects of this method also caused problems.

> ***"I only had one and that was it. I put two stone on, looked pregnant to look at, I was depressed, I wouldn't let my husband touch me, I couldn't stand the smell of him, I was crying for no reason … my hair was falling out."***

Not being able to take the Pill had adverse effects on some women. Some perceived their inability to take the Pill fatalistically:

> ***"I just stopped taking it, and I was all right for two years, and then I got caught out."***

It is important that contraception is made relevant to all women, an important, ongoing and active part of their lives. There was interest in new developments in contraception, eg Persona, and this topic could be re-launched to try to get women to look at different options as products.

Making advice actionable will also be important. Young women in particular need help in achieving their intentions, both in terms of contraception, and the language with which to discuss what they want. Currently there is a gap between *"What I want … "* and *"It can happen …"* and this gap needs to be closed by some practical tips.

Practical and friendly advice will also ensure that young women are not daunted by talking about difficult issues or seeking advice when necessary. For example, friendly tips were very much appreciated eg taking the Pill at night in order to reduce nausea.

Women need information about alternatives to the Pill; for those allergic to the Pill, and for older women who are re-assessing their contraceptive needs. There was interest in new developments, eg Persona, and this kind of news may help to make contraception more relevant.

Women currently question the reliability of contraception, perceiving pregnancy as a powerful and inevitable force of nature. Some women feel that using any contraception at any time is "showing willing", a gesture towards acknowledging that contraception might have a part in the process. There is a tendency to address any contraceptive failure as the fault of the contraceptive, rather than perceiving the individual as having a role to play in its effectiveness. Women need to have these perceptions challenged by demonstrating that contraception can be made effective.

Tone

Tonally, intervention should stress women's choice, and their ability to look after themselves. Women need to be reassured about feeling happy with their choices. Respondents mentioned that pressure during pregnancy and birth made them feel as if they didn't have choices eg around breast feeding, painkillers during birth.

To this end, messages should insist that contraception can be effective if the individual *wants* it to be, and together can prevent unintended pregnancy. Tone will be very important for a campaign, since respondents were aware of lots of information available for them to look at.

Specific targets for intervention

BC1 women

It is the older BC1 women who are most vulnerable to unintended pregnancy. This group is most in need of interventions which specifically concern contraception. They would be best served by an approach, targeted at both doctors and women, which supports them in identifying changing sexual health and contraception needs.

recognition – of post-childbirth or post-relationship adjustments in sexual behaviour;

awareness – of the need to reconsider contraception;

education – as to what contraceptive choices are available.

C2DE women

It is the C2DE audience as a whole who are most vulnerable to unintended pregnancy. The youngest age group requires intervention in terms of:

empowerment through education – which encompasses assertiveness, negotiation and self-respect, the right to say no and information about contraception;

alternatives – at present, there are few drawbacks perceived to having children, and fewer that are not able to be neutralised by the supportive family and particularly mothers who may have been in a similar situation themselves.

The older teens are vulnerable to unintended pregnancies resulting from their social lives. Drinking is an important factor, as are social situations eg pubs and clubs. These women need intervention that:

raises awareness – of their vulnerability;

prompts concern – about consequences.

Motivational mothers

Intervention would be very difficult in these cases, since individual pregnancies were targeted at specific outcomes and with extremely personal motivation. This process was not often totally pre-meditated, but started with an unintended pregnancy that was then understood to have potential as a solution to other situations.

Advising against pregnancy in these cases is unlikely to be successful, since the reasons for having the baby are likely to outweigh the reasons for not having a baby.

Natural and historical mothers

Interventions suggesting not becoming pregnant would be directly in conflict with the philosophy of historical mothers. Unintended pregnancies were not perceived negatively for being unplanned, pregnancy in general was perceived as a good thing. To make a distinction would be perceived as "unnatural" and therefore would be likely to be rejected.

Historical and natural mothers were much more interested in health during pregnancy, for example how one plans for a birth, particularly pain relief. They agreed however, that young women should be the emphasis for health information. Intervention at this stage would serve to stall the inevitable process until later in life.

Lifestyle mothers

This is the group of women least needing intervention. They perceive themselves to be wholly in control of their intentions towards pregnancy.

Relationship driven mothers

Interventions for this group of women could concentrate on achieving intentions ie safeguarding against mistakes. Women tended to be in contact with health services regularly since they tended to be having planned births, and contraceptive advice in between pregnancies could concentrate on eliminating mistakes and streamlining contraception. Contraception within relationships could sometimes be relaxed, due to the faith women had in the safety of their partners in terms of sexually transmitted infections.

Laissez-faire mothers

The reliance on fatalism *"If it happens it happens"* was the most often quoted example of this reliance on fatalism. Intervention needs to mount a strong challenge to this stance which is currently undermining the power of contraception. The insistence on fatalism protects the individual from taking responsibility.

- Threatening women with consequences eg being left on their own with a baby, being tied down, only makes women defensive. They assert their power to survive on their own, not rely on men, have a career later in life.
- Importantly, the subject needs to be discussed, since at the moment women are wary of talking about unintentionality at all.
- Women need to be convinced that they do have an element of control over their own bodies. For example, women often said that they did want children, just not so soon. Managing intentions towards pregnancy and managing contraception would assist women in taking control.

No choice mothers

Interventions for these women can only re-emphasise what they already know. They are victims of the risk element of contraception or sexual activity and this cannot realistically be eliminated.

4 Conclusions

The research findings outlined above have implications for policy makers and for commissioners and providers of health and education services. The challenge is to identify areas where change is feasible, and to work creatively and in partnership to bring about such change.

To aim for a situation where every pregnancy is a planned pregnancy is unrealistic. What is more, the research shows that for women themselves, such an objective is undesirable. There will always be some ambivalence associated with seeking to control such a biological but equally socially-determined event as parenting a child.

The research findings illustrate once again that work on women's choices around pregnancy and parenting cannot be seen in isolation from broader issues of social exclusion and deprivation. Neither should women be seen as a homogeneous group – there is no universal panacea which will prove influential for all. Instead, a package of policy measures and practical interventions should be developed to support and empower women to make decisions about timing, spacing or avoiding pregnancy.

The complexity of the issue of pregnancy choice is reflected in the overlapping territory between education, service provision, social norms and government policy. Although the recommendations are categorised, only a strategic, comprehensive and socially-inclusive approach, developed in partnership with women themselves will make change possible.

fpa's recommendations

Government

- Extensive media campaigns should be funded to reach post-school age men and women who clearly lack accurate information.
- A statutory, comprehensive PHSE programme based on core skills such as assertiveness, respect and self esteem should be implemented.
- Sexual health should be made a government priority with national and locally set targets.
- Clear guidance should be issued regarding the commissioning and funding of abortion services to facilitate speedy and equitable access.

Health, education and social care professional regulatory bodies

Pre- and post-registration training should include a sexuality component which covers:

- information about the full range of contraception methods;
- communication skills training;
- examination of attitudes to sexuality and reproductive choices including abortion.

Health and social care services

Generic services

Community and social services should maximise opportunistic work with men and women on sexual health and contraception issues.

Specialist contraception and sexual health services

- Carry out targeted work with those groups indicated by the research eg older BC1s and CD2Es.
- Maintain or develop mainstream services to improve accessibility and encourage positive attitudes towards contraception in the whole community.
- Develop services along the lines indicated by user and non-user feedback.
- Balanced information about abortion should be easily available and referrals streamlined.

Further research

- Research is needed into the attitudes of women who have chosen abortion. The emphasis of this work was on the attitudes of those women who continued with their pregnancy. Further research is needed into women who terminate their pregnancy to establish whether their attitudes are any different.
- Research and monitoring of the success or failure of different sorts of interventions and combinations of interventions and the impact of these on choices.

Innovative interventions should be funded and supported which:

- develop experiential active learning methods;
- increase fertility awareness in all women;
- develop community support.

Misconceptions

WOMEN'S ATTITUDES TO PLANNING & PREVENTING PREGNANCY

Between a third and a half of all pregnancies in the UK are unintended and one in five pregnancies ends in abortion.

fpa set out through this research to explore the real life relevance of ideas such as 'intended' and 'unintended' in relation to becoming pregnant.

This work has implications for government policy, sexual health and sex education strategies, and the day-to-day work of health and social care professionals.

Research Works Limited

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