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THE ROLE OF KNOWLEDGE IN THE CONTRACEPTIVE BEHAVIOUR OF SEXUALLY ACTIVE YOUNG PEOPLE IN STATE CARE

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Abstract

Aim: To analyse the role of sex-focused knowledge in the contraceptive behaviour of sexually active young people in state care.

Methods: The sample consisted of 19 care leavers (young people previously in state care) aged 18-22 years, 16 females and 3 males. In-depth interviewing was the method of data collection, and a qualitative strategy resembling modified analytical induction was used to analyse data.

Findings: Findings indicated that a lack of information was not the sole, or even the primary reason for engaging in unsafe sexual practices. Other factors such as ambivalence to becoming pregnant also featured in participants' accounts. Several participants conveyed a relatively weak sense of agency about consistently using contraception. A small number of participants expressed a strong determination to avoid pregnancy, and these appeared to have a level of anxiety about becoming pregnant that motivated them to engage with knowledge about contraception and its use.

Conclusion: Lack of sex-focused information is just one aspect of a myriad of complex factors, including socioeconomic disadvantage and/or emotional deprivation, that influences contraceptive behaviour.

Summary statement:

This study contributes to a very limited body of knowledge about the sexual health of young people in state care. Among the young people studied, a lack of information about safer sex was only one of several contextual factors that contributed to risky sexual behaviour.

Key words:

Contraception; Young people in care; Looked-after young people; Sexual health.

Introduction

Young people in state care and those who have previously experienced state care are among groups with a higher rate of teenage pregnancy and sexually transmitted infections and diseases compared to the general population (Boonstra 2011; Dworsky and Courtney

2010). In this article, we report on one aspect of a wider programme of research into the sex education and sexual health needs of young people in state care (YPISC) in an Irish context (the *Sexual Health and Sexuality Education Needs of Young People in Care* SENYPIC study) (Hyde *et al.*, in press (a))¹. The overall aim of the wider programme of research – the SENYPIC study – was to identify the sexual health and education needs of YPISC from the perspective of a range of individuals – service-providers, parents, foster carers and young people themselves. In this article, we focus on one cohort of participants, namely young people aged 18-22 years who had previously experienced state care as children, and address one aspect of their accounts that emerged in data, namely how sex-focused knowledge influenced their decisions about safer sex.

In the absence of evidence from Ireland to provide a basis for understanding what is known already on the topic, we turn to research from the UK conducted on similar cohorts of young people. This research has found that children in state care report gaps in their knowledge about safer sex and lack information needed to access sexual health or contraceptive services (Scott and Hill 2006; Dale 2009). Reasons for these gaps include: poor relationships with parents; missed education and high exclusion rates from school leading them to miss out on the relationship and sexuality education (RSE) provided in schools.

Lack of knowledge, however, is just one factor that appears to influence sexual behaviour. Dale's (2009) Scottish study on YPISC concluded that although participants appeared to have knowledge about the consequences of sex, they still found it difficult to practise safer sex. Chase *et al.*'s (2006) English study of 63 young people with a history of having been in state care found a number of predisposing factors to pregnancy among the sample of which lack of information and support around sexual health and relationships was one. However, the most dominant predisposing factors related to feelings of rejection and abandonment, the experience of disrupted family relationships, poor educational access and attainment, along with practical and psychological barriers to accessing contraceptive and sexual health services. Other threats to the sexual health of young people in state care have been found to arise because their lives are more likely to be mediated by economic disadvantage, drug and alcohol abuse, and mental health problems including self-harming (Department for Education and Skills 2006; Billings *et al.* 2007; Dale 2009).

These contextual factors beyond sex-focused education also tend to be a feature of life, albeit to a lesser degree, for young people outside the care system who experience social exclusion (see Scott and Hill 2006). In spite of empirical evidence suggesting that factors associated with teenage pregnancy are heavily cross-cut by structural disadvantage whether or not one is in state care, knowledge deficits have been singled for special attention in policy documents in Britain as though these are primarily the root of the 'problem' (Middleton 2011). Middleton (2011) points out that policy makers there tended to attribute susceptibility to early pregnancy to 'ignorance, embarrassment and misinformation about sex and contraception for adolescents . . . ' (Social Exclusion Unit 1999, p228). She argues that if preventive interventions are to feature, these should focus on the impact of poverty abuse and adversity.

¹ Anonymised for the review process.

If we draw together the threads of what is known already about why young people with a history of state care have a heightened risk of teenage pregnancy, the evidence suggests that a lack of sex-focused knowledge appears to play a part. However, there is substantial evidence to suggest that teenage pregnancy is socially shaped by wider social, educational and economic disadvantage, and the lives of YPISC tend to be cross-cut by such disadvantage. In this article we attempt to add to this body of knowledge by analysing what a sample of young people who had left state care – a group known to have a higher than average chance of an early pregnancy – had to say about their use of contraception, and the extent to which sex-focused knowledge played a part in their sexual behaviour.

Methods

The aim of this article is to present an analysis of one component of findings from a wider study of the sexual health needs of YPISC, namely how sex-focused knowledge influenced the young people's decisions about safer sex. Ethical approval for the study was given by the university leading the SENYPIC study before conducting fieldwork, and there was adherence to established ethical conduct in research.

Recruitment of participants

Access to the young participants was via service-providers who interfaced with YPISC identified through a scoping review of all providers of services to YPISC in Ireland (see Hyde *et al.*, in press (a) for details). These acted as intermediaries between the research team and potential participants conveying information about the study to the young people. This information was captured on an information sheet supplemented with oral clarification where necessary. Service-providers were employed at various organisations including aftercare/homeless organisations, an advocacy organisation centre, training centres and colleges, family support services, state aftercare services and parenting support services.

Inclusion criteria were that participants be aged 18-22 years, with experience of having been in state care at some stage. The initial design proposed the participation of young people currently in care (those under the age of 18 years), in keeping with the contemporary discourse of children's rights to inclusion; however, consent from birth parents was required and limited resources in terms of service-providers to facilitate this resulted in no minors being recruited.

Data gathering

The data collection technique was the in-depth individual interview except in four cases where the participants requested to be interviewed in pairs (these involved friends with both individuals satisfying the inclusion criteria). Data were collected throughout 2013. The locations of the interviews were the premises of the organisation at which the participant was recruited or a private space provided by the organisation. A topic guide derived from existing knowledge in the field and from information emerging at earlier phases of the SENYPIC study was used to structure the interview. The duration of each interview varied from 40-80 minutes. Interviews were audio-recorded and later transcribed. The transcripts

were anonymised, any obviously identifying features of the participants were removed, and pseudonyms were applied.

Data analysis

A strategy for analysing qualitative data called modified analytical induction (MAI) Bogdan and Biklen (2007) was used to make sense of the interview transcripts. Unlike techniques that involve segmenting data and collating data slices into themes (e.g. grounded theory), MAI proceeds by taking the whole transcript and comparing this with other whole transcripts. With each whole individual transcript, the participant's voice was paraphrased, though with poignant parts of his/her narrative preserved verbatim (and used as evidence in quotations when the findings were reported). As the analysis proceeded, each additional transcript was paraphrased and folded into the emerging collective report. During this analytical process, the overall emerging findings from the studies were modified, corroborated and stretched as subsequent transcripts were analysed and new areas emerged.

Findings

Description of the sample

The sample comprised 19 young people, 16 women and three men all of whom had experienced state care as children and/or teenagers. Recruitment stopped 19 interviews because the research team believed that this generated enough rich data to fulfil the purpose of the research. The preponderance of young women over young men in the sample arose because young women were more willing to volunteer for the study; this gender disparity is a feature of qualitative research more generally (Kristensen and Malin 2015). Participants had experienced a variety of care histories. Initial short-term care placements had been widely experienced followed by longer-term care arrangements in foster and/or residential care; several participants reported having had multiple placements. Among the 19 participants, at the time of the interview, nine participants, seven female and two male participants had already gone on to become parents themselves. In terms of geographical spread, the sample was drawn from a wide variety of rural and urban locations in Ireland.

Emerging themes

In explaining the contraceptive behaviour of participants, data are presented around three themes: (1) Lack of information about contraception; (2) Lack of agency in using contraception; (3) Self-determination around contraceptive protection.

(i) Lack of information about contraception

Lack of information about safer sex and fertility as a basis for non-use of contraception was cited by a few participants to explain risky sexual behaviour; indeed, three of the teenage

mothers foregrounded lack of knowledge as the key reason why they became pregnant. Two of these were young non-Irish national women, each of whom described a closed culture around discussing sexuality within their own ethnic group, particularly with parents. One of these, Amelia, who came to Ireland when she was 13 years old, reported that she did not have any knowledge of contraception, although aspects of sex education were covered in her fourth year at secondary school.

If I had known about contraception before I wouldn't be in this position now. I don't really know much and my parents don't even tell me at this stage you should be doing this. I didn't know much at the time. (Amelia)

Similarly, Florence, also a teenage mother, who came to Ireland when she was ten years old described her lack of knowledge that extended to not understanding the basic physiology of sex when she had intercourse at the age of 12.

It is just so absurd. You would never have the sex ed. talk . . . I had lost it [virginity] anyways but I still didn't know really what had happened or where anything was supposed to go or anything about sex ed. or anything. (Florence)

Another participant, Kylie (an Irish national), attributed her pregnancy at age 18 directly to a lack of knowledge.

And I just kept looking back and saying to myself, 'How did I get pregnant?' . . . Because we were never told that there is a gap in the month where a woman will fall pregnant . . I didn't know fully about the whole sex education until I actually fell pregnant and it was the nurses and midwives in the hospital that filled in the gaps for me . . . (Kylie)

Notwithstanding the contribution that a lack of knowledge played in Kylie becoming pregnant, it appeared from other parts of her interview that a number of factors were also at play in how she approached contraception. Her narrative as a whole indicates that a complex myriad of factors may work together to increase vulnerability to a pregnancy, of which knowledge gaps are but one. The participant's response to the pregnancy (conveyed in the quotation that follows) was one of positive acceptance in the context of chaos and uncertainty in her life (drug use and the threat of homelessness).

Three months after turning 18, I was clean off heroin. I would say about twelve months and a couple of months after turning 18 I fell pregnant on my son. And with that, it wasn't a shock to me because it was something that I wanted and something that would keep me safe and sane. (Kylie)

While these three teenage mothers attributed their pregnancies primarily to a lack of knowledge about sex, there were others among the non-parenting participants who reflected back on their earlier sexual experiences in which they described gaps in their understanding as contributory factors in having unsafe sex. Darina described her first sexual experience, at the age of 14 as, 'Just one of those things that happened very fast.' No contraception was used, and she reported that it never occurred to her to access post-coital contraception, as she had no knowledge of it at that stage since 'nobody talked about it'.

However, overall it appeared that a lack of information was not the sole or even primary reason for engaging in unsafe sexual practices. Some accounts suggested that participants continued to take risks even where they had demonstrated an understanding in their narratives in relation to information about reproductive physiology and methods of contraception.

(ii) *Lack of agency (pro-activity) in using contraception*

Access to and use of all forms of contraception require at least some level of effort and agency on the part of the user, and this may have explained non-use of contraception in some cases. However, even when condoms were easily at the disposal of the user, as was the case for one of the male participants, Ryan, this did not ensure that they would be used. The participant described how his foster mother supplied condoms, yet he reportedly never used them.

Interviewer: And had your foster carer talked to you about...?

She did, yes. She used to buy me condoms and stuff but I never really used it . . . The information was there, you just don't listen, you are cool when you are that age . . (Ryan)

Ryan's observation that information and contraception are available yet not acted upon is an important one, and points to the importance of understanding how young people themselves understand and interpret their motivations to practise safe sex.

Let us consider a few more examples where an apathy towards safer sex was in evidence.

While Darina's narrative suggested that a lack of knowledge about emergency contraception may have had a bearing on her risky contraceptive behaviour at the time of her first sexual experience, she indicated that she had since received sex education, reportedly with an emphasis on STIs, delivered at a Women's Health Centre. She conveyed that she had a knowledge of safer sex and contraception, yet admitted to taking sexual risks 'all the time'.

Interviewer: Did you use condoms at the time [first sex]?

No.

Interviewer: What did you do then? What about the morning-after pill?

No I didn't even know what that was then. Nobody talked about it. I just waited, well I am here so I am all right.

Interviewer: Did you take any risks since then?

Yes, I do all the time. (Darina)

A level of anxiety about becoming pregnant or contracting an STI is arguably necessary in order to be pro-active and ensure consistent access to, and use of, contraception and/or an engagement with information available about its appropriate use. This requires effort and awareness of risk, as was evident in the account of Juliet. She described having been promiscuous in her teens, and having unprotected sex after her first sex at the age of 16 years, because, 'The fear of pregnancy wasn't there when I was 16.' Once the realisation of risk registered, however, she reportedly used the three-monthly hormonal injection and later a hormonal implant (that protects for three years). Another participant, Alicia,

described having become 'scared and panicked' after having unprotected first sex, and this prompted contraceptive use.

Heightened consciousness of the possibility of a pregnancy, which underpins pro-active contraceptive use, is also lacking in the account of Susan. That participant, a teenage mother, recalled the contraceptive practices that led to her pregnancy by explaining that on a night away from home with her boyfriend, she had forgotten to pack her contraceptive pill. The couple had sex, and once back in her home the following day, she resumed taking the contraceptive. Yet, it never occurred to her that she might have exposed herself to pregnancy, and missing a pill did not worry her. Even weeks later when her period did not arrive, the fact that she might be pregnant had reportedly not occurred to her. While this could be interpreted as a lack of knowledge issue relating to how hormonal contraception works, there was no suggestion that the participant pro-actively sought out information as to the implications of a missed pill on the chances of becoming pregnant. In Susan's case, it was the increasing size of her breasts that caused her to consider that she might be pregnant.

I was due my period and I never got it. . . And I just never took any notice about why I wasn't getting them. Then I got these pair of boobs . . . I thought Jesus, something is there . . . So I found out when I was about eight weeks, so it was kind of funny . . . So it didn't even click. (Susan)

That participant (Susan) was pregnant for the second time at the time of the interview because of circumstances not dissimilar to those that brought about her first pregnancy. The second pregnancy arose through a delay in re-applying a transdermal adhesive that releases hormones and it was only when her period was late that she realised that she might be pregnant.

A lack of anxiety about becoming pregnant in the immediate aftermath of having had unprotected sex (during which time emergency contraception could be accessed) was evident in other accounts. Reflecting back on when she first started having sex at 15 years, Germaine had difficulty recalling how she felt after unprotected sex and whether she was concerned about having left herself exposed to pregnancy. It seemed that it was some time later before an awareness of having exposed herself to risk began to set in.

I was 15. . . . It is mad, it is crazy. At the time I don't know if I was worried or not. I was fine. And then everything started dawning on me. Soon after and you start thinking to yourself: that was very silly. (Germaine)

Brenda described a similar response to unprotected sex, and admitted to continuing to take risks. When asked how such sexual risk-taking might affect her future plans to attend college, her response suggested a sense of denial that pregnancy would occur, interspersed with an intermittent realisation that it might.

Interviewer: How does that fit in with your plans [for college]?
Taking risks? You don't even think of it and then you are like, 'Ahhhhhh!!!' (Brenda)

However, Brenda did report having used emergency contraception on two occasions in the previous year, suggesting that she was aware of her fertility on those occasions.

(iii) *Self-determination around contraceptive protection*

Not all participants reported being currently remiss when it came to contraceptive protection, although virtually all had been at one stage or another. A few participants had availed themselves of emergency contraception, demonstrating a level of fertility awareness. What distinguished the small number of participants currently making consistent use of contraception from inconsistent or non-users appeared to be factors associated with the individual, such as the motivation to seek out information and be receptive to it when it was offered, and a clear commitment to act on it.

One such participant was Philipa, who reported having attended her GP 'constantly' since she was about 17 and had been using a hormonal implant. She described being very anxious to avoid a pregnancy, revealing that she had 'a big phobia about getting pregnant. I still don't want to have kids to this day. That is just personal reasons, I don't think I would be able to cope with it'. A small number of others who were anxious to prevent pregnancy indicated that of their own volition, they sought out further, more-refined knowledge around contraceptive protection.

In these narratives – small in number – the determination to use contraception consistently was largely self-directed. For example, Majella's recollection was that nobody had advised her to use contraception; rather, the impetus for this came from her own resolve to avoid a pregnancy and a heightened consciousness of fertility arising from the high number of girls becoming pregnant at her school. Another participant, Norah, also revealed that her use of contraception was intrinsically motivated, during which she became an active learner in taking control over her fertility. This involved her actively seeking out information, including knowledge of reproductive physiology around ovulation.

You see I researched myself, and I still do to this day, I would research everything myself and I know what contraceptives to be on and when I have to take it and how it affects me and what days you can be pregnant and the likes of that. It is kind of my own research, really . . . No one advised me, my foster parents wouldn't have advised me. I think my social worker went over it with me at the start of care but I can't really remember, but it wasn't brought up again. (Norah)

There was also an indication from an account from Kylie (referred to earlier) that where the type of contraception was determined by others rather than the young person herself, the motivation to consistently engage in using that method became problematic. Kylie described the pitfalls of failing to take responsibility for contraception, which in her case appeared to be determined and driven by service-providers. She described her own concerns as having been discounted by staff and she discontinued using the contraceptive.

And it was the staff that made the decision of what contraception you were going on. I was on the pill. I kept forgetting to take the pill. Then I was put on the injection and the injection just completely disagreed with my body and I was trying to explain it to the staff and the staff were like, 'Don't be ridiculous, just because you don't want to be on any contraception, it is better

than getting pregnant.' So I took myself off it because I was getting awful migraines from it.
(Kylie)

Kylie subsequently became pregnant.

Discussion and conclusion

Our findings indicate that lack of knowledge about how sex happens and/or about contraception was a key reason why participants in our study had unprotected sex in a very small number of cases, mainly confined to non-Irish nationals whose background was such that sex was a taboo subject in their culture. In a small number of other instances where lack of knowledge was cited as a key factor in unprotected sex, other factors such as ambivalence to becoming pregnant also featured in participants' accounts. In most accounts from participants, lack of knowledge about contraception did not feature as a key reason for engaging in unsafe sex. Several participants conveyed a relatively weak sense of agency about consistently using contraception, and difficulties with using hormonal contraception were a dominant feature of data. The sense of apathy to risk-taking resulted in pregnancy for some participants. A small number of participants expressed a strong determination to avoid pregnancy, and these appeared to have a level of anxiety about becoming pregnant that motivated them to engage with knowledge about contraception and its use.

Our data suggest that being exposed to information about sex does not guarantee that that information will be taken up and processed by those at whom it is directed. Some young people in our study indicated that they had exposure to information about sexual health but appeared to either not actively engage with it, nor operationalise the knowledge gained. This suggests that for YPISC and care leavers, there needs to be a process of first understanding what sexual readiness, safer sex and good (sexual) relationships mean to them so that a dialogue is opened between young people and their carers about how their perceptions of sex and relationships fit in with their broader life goals. Teaching and learning strategies which clearly acknowledge young people's understandings of sexual readiness and their reasons for practising unsafe sex, as well as their intentions to have a baby in the context of their overall life and aspirations, offer a point of departure for learning. Our study contributes to the growing body of knowledge that recognises that lack of information is just one aspect of a much more complex myriad of factors that explain why teenage pregnancies happen (DiCenso et al 2002, Dale 2009, Billings *et al.* 2007, Brown and Guthrie 2010).

Our references to factors associated with the individual may erroneously be read to lay the blame for early pregnancy with the individual, but this is not our position. Rather, we argue that wider issues such as socialisation, socioeconomic and/or emotional deprivation, such as parent-child connectedness, have a pervasive effect on motivation and self-determination, and these may present greater challenges for YPISC than those not in care. The population trends identifying a younger age at first sex and a higher rate of teenage conception among young people in circumstances of socio-economic and/or emotional deprivation suggests that 'being carried away' in an intimacy is socially shaped: for more socially privileged young women and men, discourses that have pervaded their socialisation

and shaped ambitions about college and career may well compete to spoil the moment or perhaps prepare differently for it. Other aspects of socialisation associated with a more privileged upbringing (self-confidence, emotional security, assertiveness and so forth) also play a role in negotiating safer sex, sex refusal or dealing with sexual coercion. We conclude that while sex-focused education is essential to facilitating sexual competence in YPISC it is not sufficient and wider factors that limit their choices about fertility also need to be addressed. Interventions that include building self-confidence, enhancing feelings of security and addressing socio-economic disadvantage should be an important component of improving the sexual health of YPISC.

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