‘I’m good now’: A focused ethnography of pregnant teenagers’ antenatal care needs in a region in Tasmania

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Jenny Kerrison
28 October 2015
Acknowledgements

I am indebted to the teenagers who participated in this study. Thank you for giving me your time and sharing your stories with me. Importantly, your stories will demonstrate that, as one teenage mother said: ... teen mothers ain’t all as bad as what people think they are. Also, your stories will enhance the quality of care of pregnant teenagers in this region and possibly other regions too.

Thank you to the Assistant Director of Nursing and the Nurse Unit Manager at the local hospital who supported this study. To the YMC and the general antenatal care clinic midwives who participated in this study, I am grateful for your collegiality and for sharing with me your knowledge of the teenagers under your care. I am also grateful to the nurses in the cu @ home nurse visiting program who participated in this study. I admire your dedication to the teenagers.

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Abstract

Background

The high teenage pregnancy rate in Tasmania, Australia, has been identified as an important health and wellbeing issue. Much of the international literature tends to problematise early childbearing as social, moral and economic issues. There is paucity of research in Australia, in particular, in Tasmania, on understanding the influence risk factors on pregnant teenagers’ antenatal care needs using interpretive qualitative analysis.

Research aim

This study examined the socio-ecological contexts in pregnant teenagers’ lives (aged 15–19 years) and the influence of these contexts on antenatal care needs in a region in Tasmania, Australia.

Methodology and methods

A two-phased interpretive qualitative exploratory research was conducted using focused ethnography and framed by the socio-ecological determinants of the health framework. Semi-structured interviews was the data collection method applied. The two parts of phase I—(a) and (b)—were conducted sequentially (ante and post birth) with the teenagers. Phase II was conducted with midwives and nurses. Convenience sampling was undertaken with all research participants. All teenagers aged 15–19 years were recruited from a Young Mums Clinic (YMC). Midwives and nurses were recruited at a local hospital and the community-based c u @ home program, respectively. The research participants were 21 pregnant teenagers, 11 teenage mothers, nine midwives and six nurses.

Thematic analysis and coding were conducted on all interview data. Triangulation of the findings from the four participant groups was conducted. The novel application of structuration theory (Giddens, 1984) was important and contributed to current literature in this field of research. Finally, the teenagers’ antenatal care needs were inferred from felt (teenagers) and normative (midwives and nurses) needs (Carver, Ward & Talbot, 2002).
Key findings

Pregnancy was an important time for the teenagers. Many developed social agency, autonomy and control, ontological security and motivation for transformational change. The inferred key antenatal care needs were: access to alternative forms of childbirth education; healthy behaviours in relation to their diet, and cigarette smoking; understanding the realities of breastfeeding; and stress management skills. Social support was also an important need, in particular, short-term and long-term support for meaningful transformational change during pregnancy and beyond. In addition, many teenagers’ were vulnerable to financial, housing, and transport issues. The social stigma of early childbearing was also a concern for some teenagers.

Recommendations

At the micro-level, the teenagers’ antenatal care needs (healthy behaviours on diet, reduction of cigarette smoking, breastfeeding, stress) can be addressed through improved access to quality teen-centred care and childbirth education information using participatory and current information technology and communication strategies. More sustained support and help from social support networks could be useful, to address stress related to childbearing, and for transformational life changes. At the exo-level, midwifery practice could be enhanced at the local hospital through a participatory, teen-centred approach. Macro-level recommendations aim to influence policy level changes, to reduce the socio-ecological determinants’ influence on early childbearing in Tasmania.

Key words: pregnant teenagers; midwives; nurses; socio-ecological determinants of health framework; structuration theory.
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# List of Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>ACE</td>
<td>Adverse childhood experience</td>
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<tr>
<td>ACM</td>
<td>Australian College of Midwives</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ANMAC</td>
<td>Australian Nursing and Midwifery Accreditation Council</td>
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<tr>
<td>ARACY</td>
<td>Australian Research Alliance for Children and Youth</td>
</tr>
<tr>
<td>CASP</td>
<td>Critical Appraisal Skills Program</td>
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<tr>
<td>CHAPS</td>
<td>Child Health and Parenting Service</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index of Nursing and Allied Health Literature</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected date of delivery</td>
</tr>
<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
</tr>
<tr>
<td>FG</td>
<td>Focus groups</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Areas</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MGP</td>
<td>Midwifery-group practice</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>Abbreviation</td>
<td>Meaning</td>
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<td>--------------</td>
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<tr>
<td>NHW</td>
<td>Non-Hispanic white</td>
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<tr>
<td>NYARS</td>
<td>National Youth Affairs Research Scheme</td>
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<tr>
<td>OCP</td>
<td>Oral contraceptive pill</td>
</tr>
<tr>
<td>OMC</td>
<td>Outpatient maternity clinic</td>
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<tr>
<td>OR</td>
<td>Odds ratio</td>
</tr>
<tr>
<td>PYPS</td>
<td>Pregnant and Young Parent Support</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SEDH</td>
<td>Socio-ecological determinants of the health</td>
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<td>SEIFA</td>
<td>Socio-Economic Indexes for Areas</td>
</tr>
<tr>
<td>SES</td>
<td>Socio-economic status</td>
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<tr>
<td>SIMD</td>
<td>Scottish Index of Multiple Deprivation</td>
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<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>US</td>
<td>United States</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>YMC</td>
<td>Young Mums Clinic</td>
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Chapter 1: Overview of Thesis

1.1 Introduction

This chapter provides an introduction to this study, which was conducted to understand pregnant teenagers and their antenatal care needs in a region in Tasmania. The chapter begins with the definition of key terms used in this study. This is followed by an overview of the State of Tasmania (referred to as the State) as the context for this study. The two health care programs (Young Mums Clinic [YMC] and the c u @ home nurse visiting program) for pregnant teenagers in the State are also described in this chapter. Also presented are the research aims, objectives, questions and the significance of this study. This chapter includes a brief introduction to focused ethnography applied in this study. Lastly, an outline of the whole thesis is presented as a guide to the later chapters.

1.2 Significance of Study

Globally, improving adolescent health is essential because young people are the foundation of the future (The Lancet, 2012). With its focus on teenage childbearing, this study contributes to the current global trend to improve adolescent health. Generally, in the past two decades in developed countries such as the United States (US), United Kingdom (UK) and Australia, teenage pregnancy rates (aged 15–19 years) have decreased (Martin, Hamilton, Osterman, Curtin, & Mathews, 2015; Office for National Statistics, 2014). This decline follows the general fertility rate, which has also decreased in these countries. Nonetheless, teenage pregnancy remains an important social and health concern because teenage pregnancy is often a trajectory in life steeped in social inequalities. For example, teenage pregnancy rates are highest in social and economic deprived geographic areas (McCall, Battacharya, Okpo, & Macfarlane, 2014; Robson, Cameron, & Roberts, 2006) that commonly co-occur with a lack of family stability (Corcoran, Franklin, & Bennett, 2000; Hosie, 2007; Quinlivan, Tan, Steele, & Black, 2004; Woodward, Fergusson, & Horwood, 2001). In addition, generally, teenagers have low education achievements (Jaffee, 2002; Mollborn, 2007; Quinlivan & Evans, 2004; D. M. Smith & Elander, 2006; Woodward et al., 2001).
This study is significant to Tasmania, where this study was conducted, as the State has the second highest teenage pregnancy rate in Australia. Also, Tasmania has poor health indicators that reflect health inequalities, which were most likely related to Tasmania’s remoteness and its limited social and economic resources, as presented in section 1.4.1. Thus, understanding pregnant teenagers’ antenatal care needs is important in the State in order to provide appropriate care to this important sub-population group.

Antenatal care is recommended for all pregnant women, to support women to mentally and physically prepare for birth of the baby (S. J. Brown, Sutherland, Gunn, & Yelland, 2014). Specific to this study, the focus on antenatal care for pregnant teenagers was considered essential because early childbearing is often associated with multiple socio-economic and health care needs. For example, teenage pregnancy is commonly associated with poorer neonatal birth outcomes, such as a higher risk of problems such as prematurity (Loxton, Williams, & Adamson, 2007; Quinlivan & Evans, 2004; Robson et al., 2006), small for gestational age (SGA), and stillbirth (Combes & Hinton, 2005; Loxton et al., 2007; Robson et al., 2006; Van der Klis, Westenberg, Chan, Dekker, & Keane, 2002) and neonatal deaths (Loxton et al., 2007). The youngest teenagers have a higher risk of delivering pre-term babies (Chen et al., 2007; Van der Klis et al., 2002). Providing antenatal care to teenagers can prevent many of these health problems (Quinlivan, Box, & Evans, 2003). Further, the complex social and economic contexts within which teenagers’ lives are embedded suggest that teenagers are a vulnerable group (SmithBattle, 2012) and may have specific antenatal care needs.

The current study is relevant to Tasmania because at the time of its commencement, the State had the second-highest teenage fertility rate in Australia of 24.4 births per 1,000 for teenage women aged 15–19 years (Australian Bureau of Statistics, 2013b). Further, the significance of this study is reflected in the recent population health report, whereby teenage pregnancy has been identified an indicator of population health and wellbeing in Tasmania (Department of Health and Human Services, 2013b).

Lastly, as the researcher of this study is a registered midwife in Tasmania, this research aims to make a difference to how midwives perceive and care for pregnant teenagers both nationally and internationally.
1.3 Definition of Terms

A selected number of terms that are frequently used in this thesis are defined below. In addition, other terms applied are defined as required throughout the thesis.

Adolescent and teenager

In this study, teenage pregnancy refers to pregnancy in young females aged between 15 and 19 years (Australian Bureau of Statistics, 2009b). This definition aligns this study with international bodies such as the World Bank Group (2015), the Office for National Statistics (United Kingdom) (2014) and the Centers for Disease Control and Prevention (2014) in the US. In the literature, pregnancy for females aged 15–19 years can be referred to as ‘adolescent pregnancy’ (World Health Organization, 2014a).

In this study, the term ‘teenager’ will be used interchangeably with ‘pregnant teenager’ unless otherwise indicated. In addition, the terms ‘early childbearing’ (SmithBattle, 2012) and ‘teenage childbearing’ are used to refer collectively to the group of pregnant teenagers and teenage mothers. The terms ‘pregnant teenager’ and ‘teenage pregnancy’ have been commonly used in recent Australian (D. M. Smith & Roberts, 2011; J. L. Smith, Skinner, & Fenwick, 2012) and US literature (Meade & Ickovics, 2005; SmithBattle, 2012). As noted in Australia, the term ‘young women’ is used to refer to women aged between 17 and 26 (Keys, 2007) and 14 and 20 years (Blanch & Goodes, 2013). In keeping with these authors, these terms are applied when reporting their findings.

Antenatal and post birth

Antenatal care is care provided to pregnant women. It commences in the first 12 weeks of pregnancy (RANZCOG, 2011) and continues until birth of the baby commonly at full term (40 weeks of pregnancy). In Tasmania, Australia, antenatal care services for pregnant women consist of two components: the ‘antenatal care clinic’, which provides the clinical aspects of care, and the ‘childbirth education program’. Specific to this study, post birth refers to the period between two and five months following the birth of the baby.
Teenage fertility rate

In Australia, the teenage fertility rate refers to the number of live births registered per calendar year to teenagers aged 15–19 years. The rate is expressed as per 1,000 female teenagers in the country for the year the rate was estimated. Pregnancy terminations are not included due to the lack of data in Australia. It should be noted that teenagers younger than 15 years are also included in this category (Australian Bureau of Statistics, 2013c, para.3). In contrast to the US, which has the highest teenage fertility rate in the world of 31 per 1,000 teenage females, Australia’s teenage fertility rate is relatively low at 12 per 1,000 in 2014 (World Bank Group, 2014).

Health care needs

Health care needs are based on individuals’ sociological context (Bradshaw, 1994, pp. 77–78). Two of the definitions of needs used in this study are felt needs and normative needs. Felt needs are self-identified by the teenagers. Normative needs are identified for patients by experts such as midwives (Carver, Ward, & Talbot, 2008, p. 78).

Social inequities

Social inequities or social inequalities refer to ‘systematic’ differences in social status between individuals and groups in society due to differences in their socio-economic status, and they are ‘…systematic, socially produced … and are unfair’ (Whitehead & Dahlgren, 2007, p. 2). This suggests that current social systems favour some groups over others, giving rise to social inequalities between the groups. These inequalities contribute to health inequalities, whereby people living in poverty face higher mortality and morbidity rates than those who are wealthier (Marmot, 2005; Whitehead, Dahlgren, & Gilson, 2001). Given that social inequities affect poor people more than the wealthy, the inequalities are considered unfair (Whitehead & Dahlgren, 2007).

Best practice

Best practice refers to the implementation of clinical practice that is based on evidence to improve the quality of health care such as by nurses (Ring, Cari, Coull, Murphy-Black, & Watterson, 2005). The evidence may come from qualitative, quantitative research and expert opinions (Joanna Briggs Institute, 2014).
1.4 Contexts of Study

In ethnographic research, the research context refers to individuals’ cultural and social environments or milieu, as well as the wider historical, social and economic contexts of their environment (Prentice, 2010). The contexts presented below are the State of Tasmania and the health care programs for pregnant teenagers. The programs are the YMC and the c u @ home nurse visiting program.

1.4.1 State of Tasmania

Tasmania is an island state located south of mainland Australia. Geographically, the State is essentially divided into three regions—south, north and north-west—that were serviced by three separate health organisations for several years. Nearly half of the State’s 511,200 people live in the southern region, and 98 per cent are located in the inner and outer regional areas (Department of Health and Human Services, 2013b). This reflects the State’s remoteness and the attendant limited resources and services affecting the majority of the population (Baxter, Hayes, & Gray, 2011).

In 2012, approximately 4 per cent of Tasmania’s population was Aborigines and Torres Strait Islanders. In the same year, Tasmania’s population growth was the slowest of all jurisdictions in Australia (Department of Treasury and Finance Tasmania, 2012). Further, in 2012, Tasmania had the second-lowest life expectancy at birth in Australia, with a life expectancy of 78.7 years for males and 82.6 years for females born in 2012 (Australian Bureau of Statistics, 2013d). This reflects the State’s poorer health and health inequality, which are most likely related to Tasmania’s remoteness.

Socio-Economic Indexes for Areas

In Australia, the Socio-Economic Indexes for Areas (SEIFA) is a standardised tool used to rank local government areas (LGAs) according to their socio-economic characteristics. Broadly, the SEIFA reveals people’s access to essential resources (materials and social) and their ability to participate in society (Australian Bureau of Statistics, 2013a). Using the SEIFA, the social and economic disparities between the LGAs are clear. In 2012, the local hospital’s (where the current study was undertaken) inpatients statistics in the region revealed that 25 per cent of all teenagers who received
maternity care at the local hospital had residential addresses in the most disadvantaged areas in the region.

**Teenage fertility**

In Tasmania, the teenage fertility rate has been declining over the past 30 years (Combes & Hinton, 2005), and more sharply since 2009 (see Figure 1-1). In 2012, Australia’s national teenage fertility rate was 16.1 births per 1,000 teenage women. Tasmania ranked second highest with a teenage fertility rate of 24.4 births per 1,000 for teenage women aged 15–19 years (see Figure 1-1). The highest teenage fertility rate in Australia was in the Northern Territory (51.4 births per 1,000). Statistics for 2013 show that the teenage fertility rate in Tasmania has decreased to 21.6 per 1,000 teenage women (Australian Bureau of Statistics, 2013b) (see Figure 1-1). Despite this decrease, teenage pregnancy is a significant issue in Tasmania because early childbearing increases pregnant teenagers’ vulnerability for health and social issues.

![Figure 1-1: Teenage fertility rate in Tasmania (Australian Bureau of Statistics, 2013b)](image-url)
Health of Tasmanians

Tasmania is disadvantaged in several of its key health indicators (cancer, heart disease, diabetes and sexual health, of which teenage fertility is an indicator) (Department of Health and Human Services, 2013b). This disadvantage is most likely the outcome of its geographic regionality and the related effects of poorer performance in economics, education and labour force participation. In contrast to major metropolitan areas in Australia, Tasmania’s remoteness is considered a significant contributing factor to the health differentials experienced in the population (Department of Health and Human Services, 2013b). Also, geographic areas with high social and economic deprivations have high teenage pregnancy rates (McCall et al., 2014; Robson et al., 2006). Within this context, the State’s geographic remoteness, socio-economic and health inequalities may be important factors contributing to the high teenage pregnancy rate.

1.4.2 Health Care Programs for Pregnant Teenagers in Tasmania

This section presents an overview of the Tasmanian government’s two teen-specific health care programs for pregnant teenagers. These services are the YMC and the home nurse visiting program.

Young Mums Clinic

The YMC is the only teen-specific public antenatal care service of its kind in Tasmania, and it is available in the north and south of the State. In 2012, the local hospital’s policy was that all pregnant teenagers aged 15–18 years who booked for birth at the hospital were required to receive antenatal care at the YMC. In 2013, the YMC moved from being based at the local hospital, which provided tertiary acute care, to a community health centre. In contrast to mainstream adult antenatal clinics, the YMC is unique in its delivery of teen-friendly services, one-stop-shop approach and individualised care. In addition, the YMC provides childbirth education sessions that run concurrently with the antenatal care clinic.

Pregnant teenagers are referred to the YMC by their general practitioners (GPs). They attend the YMC for approximately six to seven months of their pregnancy. The first clinic appointment for pregnant teenagers is the ‘booking-in’ clinic at the adult antenatal service area, where they register for maternity care at the hospital. Subsequent visits are
held at the YMC. Using a one-stop-shop approach, three key services are provided in one visit from an antenatal clinic midwife, a childbirth educator and a social worker. Pathology services are also available. Pregnant teenagers are encouraged to bring their key social support persons to accompany them at the YMC. A light, healthy lunch of sandwiches and fresh fruits is provided at each clinic. In the past, transport vouchers were provided to teenagers to facilitate YMC attendance. If necessary, teenagers are referred to community-based services such as the c u @ home nurse visiting program, physiotherapy and mental health care at their GPs.

**c u @ home nurse visiting program**

In 2007, Tasmania commenced a State-wide government-funded c u @ home program, which is an intensive parenting program for first-time childbearing teenagers aged 15–19 years (Maning & Grose, 2011). Nurses deliver the program in teenagers’ homes. The program is managed by the Child Health and Parenting Service (CHAPS), which is a community-based service that delivers free, universal child and family health services in Tasmania (Department of Health and Human Services, 2013a, pp. 11–13).

The c u @ home program is a targeted, voluntary, two-year parenting program for teenagers. An overarching goal of the c u @ home program is to provide opportunities to teenagers’ children to develop their potential for a fulfilling adulthood (Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014). First-time pregnant teenagers with little social and financial support, and those with mental health issues, are prioritised for the program. Further, the program is mostly offered to teenagers who live within 30 minutes’ drive of the c u @ home nurses’ office. Following referral to the program, the nurse conducts home visits to the pregnant teenager once a week for six weeks prior to the baby’s expected date of delivery (EDD). Regular home visits are made until the baby is two years old or until the teenager withdraws from the program (Maning & Grose, 2011). In 2014, in the region where this study was implemented, the program provided service to approximately 120 teenagers.
1.5 **Research Aim**

This research study aimed to examine the socio-ecological contexts in pregnant teenagers’ (aged 15–19 years) lives and the influence of these contexts on antenatal care needs in a region in Tasmania, Australia.

1.6 **Research Objectives**

The following research objectives were adopted:

1. To identify the health knowledge, beliefs and behaviours of pregnant teenagers and their influence on teenagers’ antenatal care.

2. To identify family and community factors and their influence on pregnant teenagers’ antenatal care needs.

3. To identify physical and social environmental factors and their influence on pregnant teenagers’ antenatal care needs.

1.7 **Research Questions**

The following research questions were developed to achieve the research objectives and aim:

1. What are pregnant teenagers’ health knowledge, beliefs and behaviours, and how do they influence antenatal care?

2. How do family, neighbourhood, transport and housing factors influence pregnant teenagers’ antenatal care needs?

3. How does social support influence pregnant teenagers’ antenatal care needs?

4. What are midwives’ and nurses’ views of pregnant teenagers and their antenatal care needs?

1.8 **Methodology**

This interpretative qualitative exploratory research was conducted using focused ethnography as the research methodology. Focused ethnography is embedded in
ethnography, and is applied in research to understand behaviour rather than predict it (Agar, 1980). Meanings in social behaviours and relations are studied to understand the ‘what’ and ‘how’ of social behaviours (Hammersley & Atkinson, 2007; Hammon & Wellington, 2013). Unlike ethnography research, focused ethnography focuses on one problem in a specific setting (Higginbottom, Pillay, & Boadu, 2013; J. Willis & Anderson, 2010). Also, only a limited number of data collection methods are applied in the study using focused ethnography. Similar to ethnography, in focused ethnography, the researcher is situated in the social world and is focused on interpreting the social reality of the research participants (Denzin & Lincoln, 2003a; Hammersley & Atkinson, 2007; Maxwell, 2002). In the current study, triangulation was conducted on all focused ethnographic data sources. In this process, the social reality or ‘social ontology’ that emerged in the study was further explicated by applying Giddens (1984) structuration theory and the SEDH framework as explanatory frameworks.

1.9 Brief Description of Study

This study was conducted in two phases. In phase 1 (a), individual face-to-face semi-structured interviews were conducted with pregnant teenagers at the YMC. Phase I (b) was conducted soon after phase 1 (a) with teenage mothers. In phase I (b), the same teenagers were invited to attend a second interview conducted in a community setting. Phase II was conducted with midwives and nurses. Midwives were interviewed using individual face-to-face semi-structured interviews. Nurses were interviewed in a focus group interview that was then followed up with two semi-structured interviews. Thematic data analysis was applied to all interviews. This process generated rich, in-depth key findings on understanding the pregnant teenagers and their antenatal care needs.

1.10 Thesis Outline

This outline provides an entrée into the total research project from the ontological and epistemological underpinnings to the conclusion and recommendations.

Chapter 1 contains the introduction and provides insights into the remaining chapters in the thesis. The study’s significance and context are presented, as well as an outline of
the theoretical frameworks applied in this study. In addition, an overview of the research design is presented.

Chapter 2 presents the literature review on pregnant teenagers and their antenatal care needs. Focusing on broad literature review questions, the integrative review approach is described. A flow-chart and table summarising all studies reviewed are included. The chapter ends by identifying the research gaps identified in the literature.

Chapter 3 presents the theoretical frameworks applied in this research. These frameworks are the SEDH framework and Giddens (1984) structuration theory. The rationales underpinning the use of these frameworks are also included in this chapter.

Chapter 4 focuses on the research methodology and methods applied. Ethnography is explained in detail to facilitate an understanding of focused ethnography as the research methodology used for this study. The development of interview guides and the data transcription and analyses are described. Research ethics and rigor are also presented in this chapter.

Chapters 5 is titled ‘I’m glad that I’m pregnant’ and presents the results of phase I (a), in which individual face-to-face qualitative interviews were conducted with 21 pregnant teenagers between 30 and 40 weeks of their pregnancy. The presentation centres around the major themes and several related subthemes.

Chapter 6 is titled ‘…teen mothers ain’t all as bad as what people think they are’. This chapter describes the results of phase I (b) with 11 teenage mothers when they were between two and five months post birth. The research findings are organised around the major themes and subthemes.

Chapter 7 is titled ‘[Teens] ... are adults with special needs’. It focuses on the results from the phase II interviews conducted with nine midwives who work in antenatal care at the local hospital. The major themes and subthemes identified from the interviews are presented.

Chapter 8 is titled ‘[Teens] ... same as anybody else’. It presents the findings from the interviews conducted with the nurses in phase II. The chapter describes results from the focus group interview with six nurses who work with childbearing teenagers in the c u
@ home nurse visiting program. This interview was used as an opportunity to cross-check and confirm the findings from the interviews with the teenagers in phases I (a) and I (b).

Chapter 9 is the discussion chapter. This chapter focuses on the key findings from the triangulation process and draws upon the relevant literature and the theoretical frameworks to discuss them. Further, this chapter critiques the theoretical frameworks applied in this study. The study’s limitations are also discussed.

Chapter 10 is the final chapter. It presents the study’s conclusions, strengths and recommendations for future research.

1.11 Summary

As an introduction to the whole thesis, this chapter has presented critical information to the reader to provide an understanding of the remaining chapters. It has outlined the study’s significance, definition of terms and the study’s contexts, as well as the research aim, objectives, questions and methodology, including a brief discussion of the two theoretical frameworks.

Chapter 2 presents the literature review that was conducted using the integrative review approach. Importantly, this process has identified key gaps in the current literature that have informed this study.
Chapter 2: Literature Review

2.1 Introduction

This chapter presents the literature review using the integrative review approach (Whittemore & Knafl, 2005, p. 546). Central to this review, two key questions were applied in the literature search for studies related to the social inequities in pregnant teenagers’ lives, as well as the influence of these inequities on their antenatal care. Each study that met the review search criteria was subjected to quality checks using recommended and established checklists.

The integrative review process generated a total of 28 studies, which largely consisted of quantitative studies conducted in the US and the UK with the highest and second-highest teenage fertility rates respectively in developed nations (World Bank Group, 2014). As this study was conducted in Australia, Australian literature was also included in this integrative literature review. Three major themes were generated from this review: social inequities in pregnant teenagers’ lives, antenatal services for pregnant teenagers and adverse birth outcomes. The integrative review highlighted the research gaps in the literature that informed this study’s research design.

2.2 Literature Review Approach

The integrative review approach is applied in this literature review because it provides comprehensive and integrated findings from both qualitative and quantitative studies on the phenomenon researched. This approach is beneficial for developing evidence-based practice in the nursing profession (Whittemore & Knafl, 2005, p. 547) for a comprehensive holistic understanding of clients’ care. The recommended key stages of the integrative review are identifying the problem, conducting a literature search, evaluating the quality of studies for the review, analysing the data from each study and presenting the literature review findings (Whittemore & Knafl, 2005, p. 549).

2.2.1 Identification of problem

The high teenage fertility rate in developed countries such as the US, UK and Australia is a concern because teenage pregnancies in these countries are viewed by governments
as primarily a socio-economic burden on society (Cherrington & Breheny, 2005; McGuinness, Medrano, & Hodges, 2013; SmithBattle, 2000). This attitude creates negative social attitudes and is a stigma on childbearing teenagers. This view is an injustice because it denies that early childbearing is an outcome of complex and long-standing social inequities in the society within which these teenagers were born (Hanna, 2001; SmithBattle, 2009). Thus, the negative political and social attitudes towards childbearing teenagers are socially unfair.

This integrative literature review aims to examine the social inequities experienced by pregnant teenagers and the influence of the social inequities on teenagers’ antenatal care. The key questions broadly applied in the integrative review are:

1. What are the perceived social inequities in pregnant teenagers’ lives?

2. How do the perceived social inequities influence teenagers’ antenatal care needs?

2.2.2 Literature search methods

This section describes the literature search process and presents the search terminologies and the inclusion and exclusion criteria (see Table 2-1). The literature review design is displayed in Figure 2-1.

Most of the studies included in this chapter were from sources published between 2000 and 2014. Two computer-based search engines were the main sources of literature accessed: the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and ProQuest Central. These web-based sites provided access to numerous literature search softwares such as: Ovid, PubMed, Medline, Google Scholar, electronic theses and dissertations. In addition, the ‘ancestry approach’ was used, whereby relevant cited references and footnote references were tracked, analysed and included in the review (Cannella, 2004, p. 61). The key terms used in this literature search are displayed in Table 2-1.

Search terminologies

Several of the terms applied in the current study were defined in Chapter 1 and are revisited in this section to guide the literature search. The term ‘teenage pregnancy’
refers to pregnancy in young females aged between 15 and 19 years (Australian Bureau of Statistics, 2009b). Alternative terms to ‘teenage pregnancy’ that were applied were ‘pregnant teenagers’ and ‘pregnant adolescents’ (see Table 2-1). Some studies on teenage mothers were included because they provided information on teenage pregnancy.

**Table 2-1: Inclusion criteria for literature review (Caldieraro-Bentley & Andrews, 2013)**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
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<tbody>
<tr>
<td>Peer-reviewed scholarly journal articles</td>
<td>Unpublished theses/dissertations</td>
</tr>
<tr>
<td>Terms ‘pregnant teenagers’, ‘teenage pregnancy’ and ‘pregnant adolescents’; aged between 15 and 19 years</td>
<td></td>
</tr>
<tr>
<td>Mainly ‘white’ Anglo British, Americans and Australians; and a few studies with non-white and Indigenous populations</td>
<td></td>
</tr>
<tr>
<td>Social inequities; antenatal care; antenatal needs; birth outcomes; and midwifery care</td>
<td></td>
</tr>
<tr>
<td>Australia, UK, US and Canada</td>
<td></td>
</tr>
<tr>
<td>English language</td>
<td></td>
</tr>
<tr>
<td>Primary research published between 2000 and 2014</td>
<td></td>
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</tbody>
</table>

In Australia, the term ‘antenatal care’ refers to care provided to pregnant women commencing in the first 12 weeks of their pregnancy (RANZCOG, 2011). However, it is recommended that care commences in the first 10 weeks of pregnancy and focuses primarily on the clinical obstetric aspects of care (Australian Health Ministers’ Advisory Council, 2012, p. x). The term ‘prenatal care’ was used interchangeably with ‘antenatal care’ in this review. Other key terms searched for this review were ‘social inequities’ and/or ‘social and economic status’ related to antenatal care. As discussed in Chapter 1, social inequities refer to inequities experienced by people as a result of the social and economic circumstances generated in their society.
Figure 2.1 shows the literature review process undertaken for this study. A total of 28 studies were reviewed, consisting of 21 quantitative and seven qualitative studies. The studies included 10 from the UK, 10 from the US, five from Australia, two from New Zealand and one from Canada. Of the 21 quantitative studies reviewed, there was one randomised control trial, and the remaining studies were cohorts, case-controls, cross-sectional or descriptive designs. Most of the quantitative studies used large population-based samples. Broadly based on the literature search questions, the quantitative studies largely focused on socio-economic disparities and risk factors for teenage pregnancies, as well as the birth outcomes of teenage pregnancies. The seven qualitative studies reviewed included five studies on social inequities and antenatal care. Methodologies applied in these studies were the exploratory descriptive (three studies), grounded theory (two studies), phenomenology (one study) and mixed methods (one study).

It was evident from the initial literature search that there is a large volume of literature on pregnant teenagers in the US and UK published between 2000 and 2014. Thus, it is important to highlight that this literature review cannot claim to cover all aspects relating to social inequities experienced by pregnant teenagers and their influence on teenagers’ antenatal care.
2.2.3 Evaluating the quality of studies

To ensure rigor in the literature review process, all studies were subjected to quality assessments (Whittemore & Knafl, 2005). Two assessments were conducted. Firstly, the study designs were assessed for the level of evidence and were assigned quality ratings of high, moderate or low. For example, all randomised controlled trials (RCTs) were assigned as ‘high’ quality. Observational studies (such as cohort, case-control and cross-sectional designs) were assigned as ‘moderate’ quality. In relation to quantitative research evidence, expert opinions (including qualitative studies) were assigned ‘low’ quality (Nairin, 2014). This is a pragmatic approach to quality assessment of research. A caveat is that by assigning ‘low’ quality to qualitative research will not accurately reflect the quality of qualitative research as qualitative evidence is underpinned by different ontology to quantitative evidence. Also, all studies were assessed for comprehensiveness in the reporting using established appraisal tools (see Table 2-2).

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of study</th>
<th>Tools applied in literature review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RCT</td>
<td>CASP for RCT (Critical Appraisal Skills Program [CASP], 2014)</td>
</tr>
<tr>
<td>2</td>
<td>Cohort study</td>
<td>CASP for cohort study (Critical Appraisal Skills Program [CASP], 2014)</td>
</tr>
<tr>
<td>3</td>
<td>Case-control</td>
<td>STROBE for case-control studies (Strengthening the reporting of observational studies in epidemiology [STROBE], 2007)</td>
</tr>
<tr>
<td>4</td>
<td>Cross-sectional</td>
<td>STROBE for cross-sectional studies (Strengthening the reporting of observational studies in epidemiology [STROBE], 2007)</td>
</tr>
<tr>
<td>5</td>
<td>Qualitative</td>
<td>CASP for qualitative study (Critical Appraisal Skills Program [CASP], 2014)</td>
</tr>
</tbody>
</table>
2.2.4 Analysing the data

Thematic data analysis was conducted on the data extracted from the 28 studies reviewed. Details of the thematic analysis process are presented in Chapter 4. Briefly, this analysis involves a process of coding and categorising the data into themes. Outcomes of this review data analysis are presented as an integrated summary, a flow-chart displaying the broad conceptual relationships between the variables (see Figure 2-2) and a table (see Table 2-3) (Munroe, Curtis, Considine, & Buckley, 2013; Walsh et al., 2009; Whittemore & Knafl, 2005). The Figure 2-2 and Table 2-3 are presented at the end of section 2.2.5 to avoid disrupting the flow of information presented in this chapter. Conflicting evidence in the review was further analysed to identify factors that may have confounded the findings (Whittemore & Knafl, 2005, p. 550).

2.2.5 Literature review findings

In general, the 28 reviewed studies agreed that the majority of childbearing teenagers come from low socio-economic families and experience social inequities prior to pregnancy (Al-Sahab, Heifetz, Tamin, Bohr, & Connolly, 2012; Atkinson & Peden-McAlpine, 2014; Bonell et al., 2003; Corcoran et al., 2000; Hosie, 2007; Jaffee, 2002; McCall et al., 2014; Mollborn, 2007; Quinlivan et al., 2004; D. M. Smith & Roberts, 2011). These social inequities are risk factors for teenage pregnancies (McCall et al., 2014; D. M. Smith & Roberts, 2011). These inequities place pregnant teenagers at further increased risk of adverse birth outcomes such as pre-term births, SGA and stillbirth, and social exclusion (Robson et al., 2006).

The below sections describe the findings under each major theme and broadly address the literature review questions. The teenagers’ socio-demographic data are then presented. This is followed by a presentation of the three major themes in the review: social inequities in pregnant teenagers’ lives, antenatal care for pregnant teenagers and adverse birth outcomes. The major findings are summarised in Figure 2-2, which displays the broad relationships between the major themes. Table 2-3 summarises all of the reviewed studies.
Socio-demographic details

The mean age of the teenagers studied was between 17 and 18 years. Age may be a significant factor in relation to the timing of early childbearing. As noted, older teenagers (18–19 years) are equally at greater risk for early childbearing because they are more sexually curious and sexually active (Upadhya & Ellen, 2011). Thus, in contrast to younger teenagers, older teenagers may be at a higher risk for early childbearing. In contrast to older women, pregnant teenage girls are more likely to be single (Al-Sahab et al., 2012; Chen, Wen, Fleming, Yang, & Walker, 2008; Quinlivan et al., 2004; Van der Klis et al., 2002).

The teenagers’ ethnicity and social-economic status may be risk factors for early childbearing (Al-Sabah et al., 2012). Many of these teenagers from ethnic minority groups were from lower socio-economic families. It has been noted that early childbearing is more common in these groups than in the white ethnic group (Al-Sahab et al., 2012; Mollborn, 2007; Upadhya & Ellen, 2011). For example, African American teenagers of all age groups have higher teenage pregnancy rates and worse birth outcomes than Anglo or ‘white’ American teenagers (Gilbert, Jandial, Field, Bigelow, & Danielsen, 2004). Further, teenage pregnancy is high in the Hispanic ethnic group (Corcoran et al., 2000). Similarly, in Australia, the rate of teenage pregnancy is high for Indigenous Australians (Aborigines and Torres Strait Islanders) (Australian Bureau of Statistics, 2014), who are also at risk for poorer birth outcomes (Robson et al., 2006). In contemporary Australia, the teenage fertility rate is highest in the Northern Territory, where there are large populations of Indigenous Australians (Australian Bureau of Statistics, 2013b).

Social inequalities in pregnant teenagers’ lives

The literature review question that broadly guided this review was: ‘What are the perceived social inequities in pregnant teenagers’ lives?’ Eleven quantitative studies and one qualitative study were reviewed in relation to the review question. In addition, three studies (Atkinson & Peden-McAlpine, 2014; Harding, 2009; Tarrant, Younger, Sheridan-Pereira, & Kearney, 2011) from the literature review of birth outcomes and antenatal care were included.
Poverty is a key factor underpinning social inequities in childbearing teenagers’ lives. A consistent pattern in several studies is that more childbearing teenagers are from low socio-economic families than wealthy families (Al-Sahab et al., 2012; Atkinson & Peden-McAlpine, 2014; Bonell et al., 2003; Corcoran et al., 2000; Hosie, 2007; Jaffee, 2002; McCall et al., 2014; Mollborn, 2007; Quinlivan et al., 2004; D. M. Smith & Elander, 2006; Upadhye & Ellen, 2011; Van der Klis et al., 2002; Woodward et al., 2001). Pregnant teenagers commonly experienced social inequities in the following areas: family instability, low school attainment, low life/future expectations, mental health issues and substance abuse (e.g., cigarettes, alcohol and illicit drugs).

Parental separation and/or divorce are common and contribute to family instability for childbearing teenagers (Corcoran et al., 2000; Hosie, 2007; Quinlivan et al., 2004; Woodward et al., 2001). Family violence is also common, and many have poor relationships with their parent(s) (Quinlivan et al., 2004). Importantly, childhood exposure to parental divorce and/or separation and family violence are noted as ‘strong independent’ risk factors for teenage pregnancy (Quinlivan et al., 2004, p. 201).

Pregnant teenagers may also experience homelessness (Arthur, Unwin, & Mitchell, 2007; Atkinson & Peden-McAlpine, 2014; Hosie, 2007; Quinlivan & Evans, 2004). Homelessness during the antenatal period is defined as currently living in a refuge or shelter, having no residential address or reporting three or more different residential addresses (Quinlivan & Evans, 2004, p. 575). However, more commonly, once pregnant, many childbearing teenagers live at home (MacLeod & Weaver, 2002) with a single parent (Arthur et al., 2007; Corcoran et al., 2000; Hosie, 2007; Mollborn, 2007; Woodward et al., 2001) who is usually the mother (Hosie, 2007). Some of the teenagers’ own mothers had children in their teenage years (Hosie, 2007; Woodward et al., 2001) and had low education achievements (Woodward et al., 2001).

Low education achievements are common among pregnant teenagers (Jaffee, 2002; Mollborn, 2007; Quinlivan & Evans, 2004; D. M. Smith & Elander, 2006; Woodward et al., 2001). Bullying at school may contribute to the dislike of, and disengagement from, school. Chronic disengagement from school is a problem in secondary schools (Hosie, 2007). Disliking school was identified as a risk factor for early childbearing (Bonell et al., 2003). In this situation, early childbearing may be seen to be a more acceptable pathway to a respectable adulthood (D. M. Smith & Roberts, 2011, p. 1057).
Behavioural and mental health problems may be common in pregnant teenagers and may contribute to their dislike of school (Quinlivan et al., 2004). As highlighted in the review, anxiety is common in pregnant teenagers who experience parental divorce and/or separation, family violence and poor relationships with their parent(s) (Quinlivan et al., 2004). In addition, pre-existing background factors in individual (psychiatric/behaviour problems) and family characteristics increase the incidence of teenage childbearing by two to seven times (Jaffee, 2002).

Living in socio-economically deprived family and neighbourhood environments, teenagers may develop a dislike of school, which may result in low educational and future expectations (Harding, 2009; D. M. Smith & Roberts, 2011). Disadvantaged neighbourhoods have a higher incidence of violence and present important predictors for low educational achievements and teenage pregnancy (Harding, 2009). In rural Australia, the disparity in educational achievements was also noted, with worse educational achievements and higher unemployment rates for teenagers living in rural and remote areas than those living in urban areas (Gaff-Smith, 2005). A study in Aberdeen, Scotland, revealed that deprived locations may continue to have high teenage pregnancy rates when there is a general decline in general fertility and teenage pregnancy (McCall et al., 2014). This suggests that social inequality is a common factor in low education attainment and teenage pregnancy.

Likewise, teenagers living in rural locations may experience deprivations in their environments (Robson et al., 2006). For example, in contrast to urban areas, remote and very remote areas in New South Wales (NSW), Australia, were found to have the highest number of younger teenage mothers (aged <16), more teenage mothers with more babies and more childbearing teenagers who smoke (Robson et al., 2006). There were also noted to be higher rates of teenage pregnancy termination in urban areas than in rural areas (Van der Klis et al., 2002, p. 127). This may suggest that rural locations are poorly resourced with fewer family planning and health services for women, in particular, teenagers. Plus there is more of an issue with confidentiality in small rural communities.

Teenagers’ families and neighbourhoods influence early childbearing (D. M. Smith & Elander, 2006). Teenagers in deprived families and neighbourhoods are more likely to engage in early sexual activity. This could be related to peer influence (D. M. Smith &
Elander, 2006; Woodward et al., 2001) and a lack of social norms in teenagers’ families and neighbourhoods in relation to delaying their sexual debut (D. M. Smith & Elander, 2006). In addition, early menarche and behavioural problems may contribute to early sexual debuts and teenage pregnancies (Woodward et al., 2001). Thus, teenagers’ deprived environments may influence their attitudes and behaviours in regard to their futures, sexual relationships and acceptance of early childbearing (D. M. Smith & Roberts, 2011).

Substance abuse (cigarettes, alcohol, illicit drugs) during pregnancy may also be more common in pregnant teenagers from deprived families and neighbourhoods (Quinlivan et., 2004). In several studies, it was noted that cigarette smoking is more common among pregnant teenagers (Chen et al., 2007; Chen et al., 2008; Kaiser & Hays, 2005; Quinlivan et al., 2004; Van der Klis et al., 2002). Teenagers may also consume more alcohol at the start of their pregnancy, and they commonly use illicit drugs (Quinlivan et al., 2004). Likewise, cigarette smoking, use of alcohol and illicit drugs, and unsafe sex are common risk behaviours in childbearing teenagers (Atkinson & Peden-McAlpine, 2014; Kaiser & Hays, 2005). In Australia, the rate of smoking is higher among pregnant teenagers living in more remote areas (Gaff-Smith, 2005; Robson et al., 2006). Often, the risk factors for unhealthy behaviours in teenagers (such as substance abuse) co-exist with other risk factors, such as mental and social risks (Kaiser & Hays, 2005; Quinlivan et al., 2004).

Importantly, the social inequities that contribute to teenage pregnancy can lead to further social inequities in teenage mothers (Mollborn, 2007; Van der Klis et al., 2002). As noted in one study, early childbearing can be a barrier to re-entering the education system, primarily due to a lack of financial resources, child care and unstable housing (Mollborn, 2007). Pregnant teenagers from low socio-economic families may experience further social inequities and disadvantages as teenage mothers (Jaffee, 2002; Mollborn, 2007; Quinlivan et al., 2004). Continuing poverty may have future negative effects on the teenager and her children. This ‘cycle of poverty’ may be observed in several generations within one family and may highlight ‘intergenerational family pathology’ as the root cause of teenage pregnancy (Quinlivan et al., 2004, p. 197).
Antenatal services for pregnant teenagers

In this section, the literature review question broadly addressed is ‘How do the perceived social inequities influence teenagers’ antenatal care?’ A total of nine studies were reviewed, consisting of four quantitative and five qualitative studies. In addition, relevant data from studies reviewed in relation to the other literature review question were also included because the theme ‘social inequities experienced by pregnant teenagers’ is common to all 28 studies included in the review. The integrative review findings reported below are: childbirth education, antenatal clinic and social support for teenagers.

Childbirth education

Childbirth education for pregnant teenagers is an important part of the antenatal services provided to all pregnant women (Pilon, 2011). A common problem experienced by pregnant teenagers is that they do not receive adequate information during pregnancy to support them during labour, birth and parenting (Atkinson & Peden-McAlpine, 2014; MacLeod & Weaver, 2002; Price & Mitchell, 2004). In one study, teenagers felt unprepared for labour and were overwhelmed in the hospital. They did not know what to expect in regard to bodily changes after the birth, such as the amount of bleeding and discomfort when passing urine (Arthur et al., 2007). In another study, teenagers from low socio-economic families had limited sexual and reproductive knowledge (Bonell et al., 2003). This could be because of their age-specific developmental needs. For example, they may not have developed concrete thinking and may have been unable to think of and plan for their future needs (Bensussen-Walls & Saewyc, 2001). Teenagers’ immaturity may contribute to their limited understanding of pregnancy (Atkinson & Peden-McAlpine, 2014) and related information such as parenting and child health and development (Arthur et al., 2007; Atkinson & Peden-McAlpine, 2014). However, a more common cause of the lack of relevant information during pregnancy could be non-attendance for childbirth education (Arthur et al., 2007; Kaiser & Hays, 2005; MacLeod & Weaver, 2002; Price & Mitchell, 2004; D. M. Smith & Roberts, 2009). In contrast, a study found that teenagers (aged 15 and above) were better at attending childbirth education classes than older women (aged between 20 and 35 years) (Al-Sahab et al., 2012).
Other factors that may be barriers to obtaining adequate information during pregnancy include teenagers’ low self-esteem (D. M. Smith & Roberts, 2009), fear of rejection and a belief that childbirth education classes are for adults (Price & Mitchell, 2004), and not knowing about the classes (MacLeod & Weaver, 2002; D. M. Smith & Roberts, 2009). Further, one study reported that teenagers felt embarrassed to attend and believed that childbirth classes were not important (MacLeod & Weaver, 2002). Attending school was another reason that teenagers did not attend childbirth education classes (Price & Mitchell, 2004). Thus, childbirth education attendance may not be the primary reason underpinning teenagers’ lack of knowledge; individual and family factors may be equally influential.

Antenatal care

Antenatal clinic attendance is a concern in the care of pregnant teenagers (for example, Chen et al., 2007; Van der Klis et al., 2002; D. M. Smith & Roberts, 2009). Childbearing teenagers are likely to have inadequate antenatal care (Chen et al., 2007; Van der Klis et al., 2002). This could be related to irregular attendance for antenatal care (D. M. Smith & Roberts, 2009). One study suggested that delayed antenatal care (‘late booking’ for care) is a problem. Delayed care is late attendance for the first appointment for care when the woman is at 20 or more weeks’ gestation, and it may occur for three key reasons (Haddrill, Jones, Mitchell, & Anumba, 2014, p. 2). Firstly, many teenagers’ pregnancies are unplanned (Quinlivan et al., 2004; Van der Klis et al., 2002), and they may not know that they are pregnant (Haddrill et al., 2014). Secondly, some teenagers avoid attendance because they are ambivalent in their decision to continue or terminate the pregnancy (Quinlivan et al., 2004). Thirdly, late presentation occurs because of failures in the health service system. For example, in one study, some teenagers received late notice from the clinic for antenatal care (Haddrill et al., 2014; MacLeod & Weaver, 2002).

Further, most teenagers have limited transport and are dependent on public transport or relatives (Quinlivan & Evans, 2004), or they have no money for transport. This may be an important factor in non-attendance for antenatal care and education. Age, gender and self-esteem are key factors that influence teenagers’ antenatal care needs and experiences (D. M. Smith & Roberts, 2009, p. 620).
Social support for teenagers

Social support for pregnant teenagers can influence acceptance of childbirth education, antenatal care attendance and reduce teenagers’ risk of social isolation (Arthur et al., 2007). This support is important for teenagers who are cognitively immature (Atkinson & Peden-McAlpine, 2014). The involvement of teenagers’ partners in antenatal care is often limited (Atkinson & Peden-McAlpine, 2014) and may be a barrier to antenatal care attendance (D. M. Smith & Roberts, 2009). In one Australian study, pregnant teenagers over estimated the level of social support they would receive in the post birth period. Also, many teenagers had low levels of social support, with fewer than three people helping with the newborn (Quinlivan et al., 2004). Further, when support is available, it is not always provided consistently (Arthur et al., 2007).

Health professionals can be important sources of social support, for example, public health nurses play a pivotal role in providing social support, such as teaching and mental health screening, to help teenagers develop their maternal skills (Atkinson & Peden-McAlpine, 2014). Midwives also play an important role in the quality of teenagers’ maternity experience (Price & Mitchell, 2004; D. M. Smith & Roberts, 2009). However, midwives who work in hospitals may not have the communication skills required to care for teenagers (Arthur et al., 2007; MacLeod & Weaver, 2002; Price & Mitchell, 2004). Some midwives may also not have the competency to provide participatory, teen-appropriate care in the delivery of information (Arthur et al., 2007; Price & Mitchell, 2004).

One study found that teenagers’ age negatively influences the way hospital professionals treat them (Arthur et al., 2007). In another study, most teenagers constantly feel judged by midwives and older mothers (D. M. Smith & Roberts, 2009). Teenagers also experience stigma from midwives and older mothers during hospital care (Price & Mitchell, 2004), feeling that their midwives do not trust them to safely care for their babies. Further, they are often not included in decision-making regarding their care in the hospital. Teenagers’ care lacks the continuity of midwifery care. In one study, it was noted that antenatal care was more focused on medical surveillance that meets the professionals’ needs rather than the teenagers’ needs (Price & Mitchell, 2004). As identified, social support for pregnant teenagers that are consistently provided
by mothers and midwives may be important to increasing antenatal education and attendance (Atkinson & Peden-McAlpine, 2014).

**Adverse birth outcomes**

Seven studies were reviewed in relation to pregnant teenagers and birth outcomes. These consisted of six quantitative studies and one qualitative study. In addition, information specific to birth outcomes was collected from Quinlivan and Evans (2004) in relation to antenatal care.

Two studies noted that all pregnant teenagers are at risk for neonatal mortality (death of newborns aged 0–27 days) (Chen et al., 2008; Gilbert et al., 2004). Teenagers are at increased risk for pre-term births, which may be the primary reason for the higher risk of neonatal death (Chen et al., 2008). Low maternal weight gain during pregnancy may be related to pre-term births. In addition, post neonatal mortality (death of babies aged 28–264 days) is also high for teenagers (Chen et al., 2008). In an earlier study, Chen et al. (2007) noted that pregnant teenagers are more likely to smoke, receive inadequate antenatal care and have less weight gain. Teenagers also experience high rates of very pre-term delivery, very low birth weight (LBW) babies and LBW babies (<2500 g) (Chen et al., 2008; Gilbert et al., 2004). (A glossary of abbreviations and medical terms is available in Appendix 2.1). In addition, the rate of SGA is high in teenagers’ babies—particularly teenagers aged 10–15 years (Chen et al., 2007). In one study, more teenagers experienced anaemia, urinary tract infection and asthma (Van der Klis et al., 2002).

In addition to the greater risks for adverse newborn outcomes, teenagers aged between 15 and 16 years may be at greater risk for seizures (Lopoo, 2011). Further, teenagers aged younger than 15 may experience a high rate of placenta previa (Lopoo, 2011). In contrast, Van der Klis et al. (2002) suggested that placenta previa is also high in teenagers aged 17–18 years. Nonetheless, maternal youth may be an important contributing factor to the higher risk for pre-term birth (<37 weeks) in pregnant teenagers (Van der Klis et al., 2002). Likewise, maternal youth may be the primary factor for the higher risks for adverse birth outcomes rather than socio-economic disadvantage or inadequate antenatal care (Chen et al., 2007).
Inadequate antenatal care may be an important factor in adverse birth outcomes, although this may be only partially explain the increased risks for neonatal and post neonatal deaths (Chen et al., 2008). With adequate care teenagers who attend teenage-specific antenatal clinics may have higher birth weight babies (Bensussen-Walls & Saewyc, 2001) and a reduced incidence of threatened pre-term labour and pre-term prolonged rupture of membranes (Quinlivan & Evans, 2004).

Birth outcomes for pregnant teenagers can be influenced by area deprivation (i.e., living in remote and rural locations) (Robson et al., 2006). As noted, social inequities in access to antenatal services in very remote locations contribute to further increased risk to teenagers for very pre-term births. Due to the limited health resources in rural and remote areas, teenagers are at risk for SGA and stillbirth (Robson et al., 2006). Other problems include high rates of antenatal haemorrhage and diabetes, high rates of pregnancy-induced hypertension, forceps delivery, forceps rotation and fewer normal vaginal deliveries (Gaff-Smith, 2005).

Nonetheless, maternal youth may also be advantageous. One study found that teenagers perform better in labour and births than older women (aged 25–29 years) (Lopoo, 2011). In contrast to Gaff-Smith (2005), Lopoo (2011) highlighted that teenagers have more normal vaginal births and fewer birth problems, including lower rates of premature rupture of membranes, dysfunctional labour, breech, cephalo-pelvic disproportion and cord prolapse, and less febrile labour (Lopoo, 2011). However, the contrast in findings may be related to the different research design and contextual factors. For example, one study was conducted with 116 teenagers in one rural hospital that services rural and remote areas in Australia (Gaff-Smith, 2005). The other study was a five-year longitudinal study with mothers aged from less than 15 years to 29 years (n=1,355,962) from a large urban and rural population database in Texas, US (Lopoo, 2011).

As revealed in several studies (for example, McCall et al., 2014; Al-Sahab et al., 2012; Quinlivan et al., 2004) in the literature review, there exist many complex antecedents of age, individual, family and neighbourhood factors in teenagers’ lives that contribute to teenage pregnancy. Teenagers are also at higher risks for adverse newborn outcomes. These factors suggest that teenagers have specific needs in relation to antenatal care, education and support.
**Flow-chart of the integrative review findings**

A summary of the integrative review findings is displayed in Figure 2-2 using the logic model communicated via the ‘if–then’ heuristic (Whooley, 1994). It is important to note that the broad linkages between the findings have not been tested. Further, the life trajectory of either teenage pregnancy or career may not apply to all teenagers.

Figure 2-2: Broad relationships between the themes identified in the literature review
Fundamentally, as displayed in the flow-chart above, growing up in an impoverished social space may be an important factor in relation to teenage pregnancy and the subsequent challenges associated with teenage childbearing.

Overview of studies reviewed

The table 2-3 was adapted (Munroe et al., 2013; Walsh et al., 2009) to display details of the 28 studies reviewed in this literature review. In the column ‘Level of evidence’, the quality of the study design is assigned using high, moderate and low (Nairin, 2014). The quality of implementation/report is also assessed, as indicated by the sign ‘√’ using either CASP or STROBE, depending on the type of study design.
Table 2-3: Integrative literature review: social economic factors, antenatal care, birth outcomes and teenage/adolescent pregnancy

<table>
<thead>
<tr>
<th>No.</th>
<th>Authors, date, country</th>
<th>Study aims</th>
<th>Design/method</th>
<th>Sample, context</th>
<th>Findings</th>
<th>Limitations</th>
<th>Level of evidence</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>(McCall et al., 2014)</td>
<td>(i) Explore the temporal patterns of teenage pregnancy in Aberdeen, Scotland</td>
<td>Cohort, population-based study; three measures of deprivation</td>
<td>n=21,662 teenage first-time mothers with single births (&lt;20 years) (19.4% of births in Aberdeen)</td>
<td>Trend over 60 years in Aberdeen shows that social disparity in teenage pregnancy rate in deprived areas increased, while rate decreased overall. Comparison of most deprived with least deprived areas=adjusted OR of Scottish Index of Multiple Deprivation (SIMD) and teenage pregnancy was 5.72 (4.62–7.09). Socio-economic measures are better predictors of teenage pregnancies ($\chi^2=21.67$, p≤0.0001).</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
<td>Scotland, UK</td>
<td>(ii) Assess discriminating ability of three measures of socio-economic status</td>
<td>Data from 1950 to 2010 Regression models; OR and 95% CI</td>
<td>Data from 1950 to 2010</td>
<td></td>
<td>At risk of residual confounding because the database did not have access to other variables</td>
<td>CASP√</td>
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<tr>
<td>2</td>
<td>(Al-Sahab et al., 2012)</td>
<td>Examine the prevalence and characteristics of adolescent mothers throughout the provinces of Canada</td>
<td>Cohort Telephone interviews Compared teen mothers to average-aged mothers Logistic regression Odds ratio (OR), 95% CI</td>
<td>n=6,188 women weighted to represent 76,110 women aged ≥15 years &amp; average-aged mothers (≥20 and ≤35 years)</td>
<td>Teen mothers=2.9% of sample; average age=18.1 years (SD=1.1). In contrast to older mothers (≥20 and ≤35 years), teen mothers have a low socio-economic status (less household income). OR for earnings of &lt;$40,000 was 6.66 (95% CI: 2.98–14.90); likely to be non-immigrants, have no partner, Aboriginal, two times (OR=2.24, 95% CI: 1.53–3.29) more likely to have a history of physical or sexual abuse. Prenatal class attendance by teenagers is better than average-aged mothers (OR=2.54, 95% CI: 1.74–3.71).</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
<td>Canada</td>
<td></td>
<td>Data from 2005/2006</td>
<td>Data from 2005/2006</td>
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<td>Partly relevant to the current study because it has a high % of Aboriginal population in the sample</td>
<td>CASP√</td>
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<tr>
<td>No.</td>
<td>Authors, date, country</td>
<td>Study aims</td>
<td>Design/method</td>
<td>Sample, context</td>
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<td>3</td>
<td>Upadhya &amp; Ellen, 2011</td>
<td>Determine whether social disparities in rates of adolescent pregnancy vary between early, middle and late adolescence</td>
<td>Cross-sectional survey from the National Survey of Family Growth Logistic regression; OR; p&lt;0.01</td>
<td>n=7,643; 15.1% black; 14.8% Latin; 76.5% white Americans Age range 15–44 years; mean=30 years Teens were aged between ≤14 and 19 at first conception</td>
<td>2.5% first conception before age 15, 14.2% first conception aged 15–17 and 16.6% first conception at age 18 or 19. More black teenagers are pregnant at an earlier age than whites (OR in age &lt;15 years: 3.9), and this difference between black and white teenagers becomes smaller in late adolescence (OR in age 18–19 years: 2.0, p&lt;0.01). Most teen pregnancies occur in late adolescence (aged 18–19) because of strong developmental interests in sexual curiosity. Social disparities contribute relatively more to teen pregnancy rates in early adolescence than in late adolescence.</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<td>Self-reports of first pregnancy—potential for recall and reporting bias</td>
<td>STROBE√</td>
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<td>4</td>
<td>Mollborn, 2007</td>
<td>Examine the long-term effects of teenage parenthood and the extent to which material resources are protective to adolescent parents of worsened life outcomes</td>
<td>Cohort study 1988, 1992 and 2000 National Educational Longitudinal Bivariate and multivariate analyses</td>
<td>n=8,432 (study) n=8,076 (non-parents) teen-parents (males and females) n =356; 2/3 teen parents are white</td>
<td>Teen parents at age 26 have two years less education (p&lt;0.001). This loss is similar for men. Living with two parents, teenage women are more likely to finish 0.42 years more education (p&lt;0.01) than those living with no parent. Have lower average levels of socio-economic status (SES) in the family (p&lt;0.001), lower test scores in eighth grade at school, more behaviour problems at school and lower educational goals for the future (p&lt;0.001). Educational</td>
<td>Ethics not reported</td>
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<td>Does not fully account for selection factors; this may lead to overestimation of findings</td>
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<td>No.</td>
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<td>5</td>
<td>(D. M. Smith &amp; Elander, 2006)</td>
<td>Test the effects of area and family deprivation on six specific proximal risk factors for teenage pregnancy</td>
<td>Case-control</td>
<td>n=201 girls aged 13–15 in deprived and non-deprived families</td>
<td>More girls from deprived areas are in single-parent families (28.1%) and have had sex (33.9%). Living in poor residential areas significantly increases early sexual activity (particularly for girls from disadvantaged families) (p&lt;0.001). Both area and family deprivation significantly reduce life expectation in regards to education and life achievements. More affluent areas may have social norms that protect against early sexual debuts and influence of peers.</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
<td>UK</td>
<td></td>
<td>Descriptive statistics</td>
<td>p&lt;0.05 factorial analyses of variance</td>
<td>Data from two mixed-sex schools</td>
<td>Not documented in study</td>
<td>STROBE√</td>
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<td></td>
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<td>Final sample 128 girls in deprived area; 73 in more affluent area</td>
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<td>Comparison areas and schools not matched</td>
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<td>6</td>
<td>(Quinlivan et al., 2004)</td>
<td>Explore the relative effect of demographic, early interpersonal family relationships and depressive symptomatology as associations for teenagers as compared to non-teenage childbearing</td>
<td>Prospective cross-sectional study</td>
<td>n=50 teenagers &lt;20 years; mean =17.5 years</td>
<td>Significant number of pregnant teenagers have a history of parental separation/divorce in early childhood (&lt;5 years of age), exposure to family violence in early childhood, illicit drug use, idealisation of pregnancy (teenage 52%, control 32%, p=0.05), lower family income (p&lt;0.0001), higher anxiety and depression scores, and a lower level of education (p&lt;0.0001). More teenage mothers smoke and continue to smoke during pregnancy. Unplanned pregnancies</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
<td>Australia</td>
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<td>Discrete data using χ2 or Fischer’s exact tests</td>
<td>n=50 non-teenage (control); &gt;20 years; mean =27.1 years</td>
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<td>Recruitment from one institution—may limit generalisability</td>
<td>STROBE√</td>
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<td>p-value</td>
<td>Mostly Caucasian Australians</td>
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<td>Use of some retrospective data—recall bias</td>
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<td>No.</td>
<td>Authors, date, country</td>
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<td>7</td>
<td>(Van der Klis et al., 2002)</td>
<td>Describe trends in teenage pregnancy rates in SA in 1970–2000 and the characteristics and outcomes of teenage women who gave birth in SA in 1995–1999</td>
<td>Cohort study</td>
<td>n=5,074 teenage women</td>
<td>Trend in teenage pregnancy rate decreased between the 1970s and 1980s. It increased in the 1990s and is now declining. More teenage abortions than births. Younger women (age 13) are more likely to abort than older women ($\chi^2=224.8$, $p&lt;0.0001$). Social gradient in abortion rates. Teenagers who become pregnant are mainly Australian-born, Aboriginal, smokers during pregnancy (47% v. 23%), more likely to have unplanned pregnancies, attend few antenatal visits (18.5% had &lt;7 visits v. 8.8% of women $&gt;20$ years) and have pre-term, SGA and LBW babies and neonatal deaths. Smoking among pregnant teenagers (47% v. 23.5%); 57.1% of teenage mothers of SGA babies smoked.</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<td>South Australia (SA), Australia</td>
<td></td>
<td>Population-based (SA has specific abortion legislation and reliable abortion data)</td>
<td>n=88,067 adult women (control)</td>
<td></td>
<td>None reported in article</td>
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<td>Age categories studied: $\leq 16$ (n=664), 17–18 (n=2,434), 19 (n=1,976)</td>
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<td>CASP √</td>
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<td>8</td>
<td>(Jaffee, 2002)</td>
<td>Test the hypothesis that girls who give birth as teenagers</td>
<td>Retrospective cohort study</td>
<td>n=482 women aged 26 years</td>
<td>By age 26, 26% had given birth (15–26 years). Findings support the hypothesis. Teenage mothers are more likely to have pre-</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<td></td>
<td>New Zealand</td>
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<td>Logistic regression</td>
<td>Categories:</td>
<td></td>
<td>Small size of groups: &lt;20 years</td>
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<td>No.</td>
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<td>Study aims</td>
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<td>differ from women who delay childbearing</td>
<td>models</td>
<td>aged &lt;20, n=36; aged 20–26, n=88; aged 26, n=356</td>
<td>existing risk factors such as history of psychiatric/behaviour problems (OR 7.11; CI 3.16–16.3; p&lt;0.001), low IQ, unsuccessful at school (OR 6.89; 3.14–15.10; p&lt;0.001) and from low SES families (OR 3.05 (1.52–6.11); p&lt;0.01). Pre-existing individual and family background variables increase the odds of teen childbearing by more than two to seven times.</td>
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<td>9</td>
<td>(Bonell et al., 2003)</td>
<td>Develop hypotheses concerning the effect of differing aspects of social exclusion on young people’s risk of teenage pregnancy</td>
<td>Data from 1997 cluster RCT of peer-led sex education</td>
<td>n=8766 students (48% girls and 52% boys)</td>
<td>91% were ‘white’ British. Two dimensions of social exclusion are thought to be socio-economic disadvantage and dislike of school. Low SES is associated with low level of knowledge about sex and contraception (adjusted OR girls 1.81 (1.45–2.27); boys 1.48 (1.22–1.80)); expectation of early childbearing by age 20 (OR girls 2.34 (1.87–2.93); boys 1.91 (1.53–2.39)). Dislike of school is associated with expectations for sex before age 16 (OR 1.68 (1.33–3.19)). Alienation and social exclusion may result in accepting early childbearing as inevitable or favourable.</td>
<td>Ethics not reported</td>
<td>Questionable regarding the validity of some of the measures used (e.g., measure of housing tenure was difficult for students to answer)—recall bias</td>
</tr>
<tr>
<td>10</td>
<td>(Woodward et al., 2001)</td>
<td>(a) Describe the extent and timing of pregnancies</td>
<td>Cohort study</td>
<td>n=533</td>
<td>25% of the sample was pregnant by 17–20 years. Those at risk of early childbearing (&lt;20 years) were early maturing and with</td>
<td>Ethics not reported</td>
<td>Underrepresentation of single parents, Maori,</td>
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<td>No.</td>
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<td>Study aims</td>
<td>Design/method</td>
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<td>11</td>
<td>(Corcoran et al., 2000)</td>
<td>Identify the ecological factors related to adolescent pregnancy and parenting using Bronfenbrenner’s conceptual framework</td>
<td>Cross-sectional study</td>
<td>n=105 teenagers (22% male, 78% female)</td>
<td>Mixed racial groups with 19% white Americans. 66.7% of pregnant teenagers were aged 19–22; macro system: income (OR 0.70 (0.50–0.96); p&lt;0.05) and race are significant predictors; SES is likely to influence early childbearing. Thus, these teenagers may feel that delaying pregnancy has few benefits. More ethnic minorities are at risk for lower SES and early childbearing. Meso: Poor communication between teenagers and families may be a risk factor for early childbearing. Micro: age (OR 1.88 (1.25–2.81); p&lt;0.00) for each year increase in age → risk of pregnancy is increased 1.88 times; high stress (OR 1.04 (1.01–1.07); p&lt;0.00) associated with pregnancy and parenting.</td>
<td>Ethics not reported</td>
<td>Importantly, causal order of findings not discernible—that is, do ecological factors contribute to pregnancy and parenting, or do they develop because of early childbearing?</td>
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<td>No.</td>
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**Antenatal care and pregnant teenagers: Quantitative papers**

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<th>Sample, context</th>
<th>Findings</th>
<th>Limitations</th>
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<tr>
<td>14</td>
<td>(Quinlivan &amp; Evans, 2004) Australia</td>
<td>Examine whether teenage antenatal clinics reduce the incidence of pre-term birth</td>
<td>Prospective</td>
<td>n=731 antenatal teenagers, comprising n=448 pregnant teenagers from teen clinic and n=203 pregnant teenagers from general clinic (control)</td>
<td>Teenage and general clinics—same age range (16–17); 56% Caucasian; 33% Indigenous Australians. At time of study enrolment: 47% smokers; 26% illicit drugs; 19% alcohol. Teenage pregnancy clinic patients were significantly more likely to be swabbed for high vaginal swab for pathogens (OR 15.24 (9.9–23.4); p&lt;0.0001). Teen clinic teenagers more likely to have antenatal care (ANC) assessment of social isolation (96% v. 58%; OR 19.4 (10.6–36.0); p&lt;0.0001). Less likely to present with threatened pre-term labour (15% v. 28%; OR 0.45 (0.29–0.68); p&lt;0.0001), pre-term birth (12% v. 26%; OR 0.40 (0.25–0.62)), pre-</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
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<td></td>
<td>Case-control control</td>
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<td>Not fully matched</td>
<td>STROBE √</td>
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<td></td>
<td>Multicentre prospective study</td>
<td>Data from birth certificate data</td>
<td>used street drugs, nine continued despite pregnancy. Of the 75/145 who smoked early in pregnancy, 39 continued. The majority did not use a condom during last sexual intercourse (STIs during pregnancy → premature labour). Only 30% of teens from clinic sites attended prenatal class/teen parenting. Teenagers’ prenatal health-risk behaviours were related to other psychological and social risk factors.</td>
<td>smoking characteristics</td>
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<td></td>
<td></td>
<td></td>
<td>3 Australian hospitals</td>
<td>52% were white Americans</td>
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<td>Selection bias may account for the differences between the two groups studied</td>
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<tr>
<td>No.</td>
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<td>15</td>
<td>(MacLeod &amp; Weaver, 2002)</td>
<td>Evaluate the psychological effect of antenatal services on pregnant teenagers</td>
<td>Prospective cohort</td>
<td>n=111 first-time pregnant teenagers (14–18 years)</td>
<td>labour, prolonged rupture of membranes or deliver pre-term. More were discharged with contraception. Teenage-specific antenatal clinics may reduce the rate of pre-term birth.</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Structured interviews at 20 and 37 weeks’ gestation</td>
<td>Comparisons between age groups ≤16 and ≥16, and between postal areas</td>
<td></td>
<td>Limitations not mentioned</td>
<td>CASP √</td>
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<tr>
<td></td>
<td>UK</td>
<td></td>
<td></td>
<td>Kingston upon Hull, England</td>
<td></td>
<td>Aims of the study did not match the data presented</td>
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<tr>
<td>16</td>
<td>(Bensussen-Walls &amp; Saewyc, 2001)</td>
<td>Compare outcomes and cost-effectiveness of comprehensive, interdisciplinary teen-centred</td>
<td>Retrospective, case-control with matched-case comparison study</td>
<td>n=106 high-risk, out-of-home teenagers (e.g., homeless)</td>
<td>Majority were white Americans. Teen clinic clients missed fewer appointments (0.96 v. 2.29, t=−2.41, df=27, p&lt;0.05). More teens have vaginal deliveries (90% v. 75%, p&lt;0.05); higher birth weight infants (3330 v. 3084 g, t=2.06,</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<tr>
<td></td>
<td>US</td>
<td></td>
<td>Data from 1996–1997</td>
<td>Teenagers aged 13–18 from</td>
<td></td>
<td>Small sample size in each of the 4 sites</td>
<td>STROBE √</td>
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<td></td>
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<td>Majority matched over</td>
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<td>Retrospective data meant that they were</td>
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<td></td>
<td>prenatal clinics</td>
<td>66% of criteria</td>
<td>prenatal care clinics (teen-specific clinics and adult clinics)</td>
<td>df=42, p&lt;0.05). Postpartum: teen clinic subjects more likely to receive a 48-hour post-discharge home visit (p&lt;0.01) and return for 2-week check (p&lt;0.001). There were high contraception rates by 8 weeks postpartum (teen clinic 87.7% v. adult clinic 64.3%). Also, 62% of teen clinic mothers were breastfeeding. However, exclusive breastfeeding in the first 6 months for teen clinic mothers were at 26.3%. Overall, there were lower costs for teen clinics based on outcomes.</td>
<td>unable to check variations in clinical care provided</td>
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<tr>
<td></td>
<td>prenatal clinics</td>
<td>t-test</td>
<td>n=27; women aged 15–37; parity 0–4; after 19 weeks’ gestation; teenagers aged &lt;18 years (n=4)</td>
<td>Mean age of women=26; 37% married, 37% single, 26% co-habiting. 77% white American. 74% lived in lowest 50% of English neighbourhoods. No one stereotype of ‘late bookers’. Three themes—a taxonomy of late presentation for antenatal care: (i) ‘not knowing’; belief; (ii) ‘knowing’ avoidance (for fear of social consequences of pregnancy and stigma), postponement (reflected ambivalence) and delayed by others; (iii) ‘delayed’ (professional and system failures). Unplanned pregnancy and lack of awareness of antenatal care for young mothers</td>
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<td>17</td>
<td>(Haddrill et al., 2014)</td>
<td>Understand why some women are late to access antenatal care</td>
<td>Semi-structured interviews in community and maternity hospital settings in 2009–2010</td>
<td>Purposive, sampling; snowballing</td>
<td>NVivo 8, thematic analysis and constant comparison</td>
<td>Ethics √</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>UK</td>
<td></td>
<td>n=27; women aged 15–37; parity 0–4; after 19 weeks’ gestation; teenagers aged &lt;18 years (n=4)</td>
<td>Mean age of women=26; 37% married, 37% single, 26% co-habiting. 77% white American. 74% lived in lowest 50% of English neighbourhoods. No one stereotype of ‘late bookers’. Three themes—a taxonomy of late presentation for antenatal care: (i) ‘not knowing’; belief; (ii) ‘knowing’ avoidance (for fear of social consequences of pregnancy and stigma), postponement (reflected ambivalence) and delayed by others; (iii) ‘delayed’ (professional and system failures). Unplanned pregnancy and lack of awareness of antenatal care for young mothers</td>
<td>Ethics √</td>
<td>Limitations within body of report rather than separate section</td>
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Antenatal care and pregnant teenagers: Qualitative papers
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<tr>
<td>18</td>
<td>(Atkinson &amp; Peden-McAlpine, 2014)</td>
<td>Identify the problems, challenges and needs specific to childbearing adolescents in a public health nurse home visiting program, and determine the process by which these problems are resolved in the program</td>
<td>Grounded theory</td>
<td>n=30 public health nurses in a public health nurse home visiting program; 64 stories from their practice with childbearing adolescents (aged 12–19) that describe the challenges, problems and needs, and how they were resolved</td>
<td>Adolescents have ‘incomplete and at risk adolescent maternal development’ consisting of three categories: i) unsupportive life circumstances and high-risk behaviours (low income, lack of social support, lack of involvement of the father of the baby, domestic violence, substance use (alcohol, drug and tobacco use) (p. 170); (ii) limited understanding of pregnancy, parenting and child health and development—mostly first-time parents with an ‘immature’ understanding of pregnancy, how to parent and care for the child, understand child development; (iii) not self-sufficient, limited awareness of access and utilisation of resources (p. 170)—had no plans for the future (of how to support herself and her child) (p. 171).</td>
<td>Ethics √</td>
<td>Potential bias in reporting of stories by nurses</td>
</tr>
<tr>
<td>19</td>
<td>(D. M. Smith &amp; Roberts, 2009)</td>
<td>Study young parents’ (mothers and fathers) antenatal and postnatal needs,</td>
<td>Mixed methods (including Rosenberg Self-Esteem Scale)</td>
<td>n=47 Young parents (15–25 years, mean=18 years)</td>
<td>Mean age=18 years; mainly ‘white British’; FG n=5 (per group). Barriers to receiving efficient antenatal and postnatal support: lack of male involvement, poor</td>
<td>Ethics √</td>
<td>Validity of self-report from participants</td>
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<td>20</td>
<td>(Arthur et al., 2007)</td>
<td>Explore teenage mothers’ experiences of maternity services</td>
<td>Convenience sampling, Snowball for FG</td>
<td>(antenatal and postnatal)</td>
<td>relationship between health professionals and young parents, age restriction of services and lack of knowledge about available support services. Those with lower self-esteem reported that they reacted negatively to society’s attitudes towards them (p=0.04, Fisher’s exact test). Those with higher self-esteem attended antenatal support (p&lt;0.001, Fisher’s exact test). Young parents felt constantly judged by society.</td>
<td>Not generalisable to teenagers in well-off geographic areas in London</td>
<td>Low</td>
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<td></td>
<td>UK</td>
<td>Identify whether maternity services meet the standards set by the Children’s and Maternity NSF</td>
<td>Phenomenologic principles, Semi-structured interviews, Coding and thematic analysis</td>
<td>n=8 Teenagers interviewed over 2005–2006 (12 months); age not specified, but were referred to as teenagers</td>
<td>Theme 1: majority attended GP visits to confirm pregnancy during first trimester; failed to attend antenatal preparation classes. Theme 2: found helpful information on social welfare benefits and Young Mums to Be group. Theme 3: relationships; social isolation is a risk factor in teenage pregnancy. Theme 4: teenagers were not prepared for labour. Little communication from midwives at the hospital. Theme 5: stopped breastfeeding within a few days due to a lack of support and preparation.</td>
<td>Ethics √</td>
<td>CASP√</td>
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<td>None mentioned</td>
<td>Analysis using CASP (2014)</td>
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<td>21</td>
<td>(Price &amp; Mitchell, 2004) UK</td>
<td>Document young pregnant women’s experiences of maternity services and identify strategies to improve services</td>
<td>Grounded theory Recruitment achieved data saturation In-depth interviews Content and thematic analysis</td>
<td>n=10; young women who had given birth before their 18th birthday (age range=14–18); first- and second-time mothers</td>
<td>Theme 1: as pregnant teenagers in the maternity services, they felt overwhelmed with anxieties and fears, stigmatised (and a lack of status when with older women and midwives) and disempowered; not involved in care planning. Theme 2: maternity services were fragmented; lacked continuity of midwives; maternity care was based on professionals’ need for surveillance; and preparation for labour and parenthood was poor. Theme 3: supportive maternity service: relationship with midwives was important; childbearing teenagers wanted to be involved in care; they requested peer-orientated care for antenatal preparation for labour and parenthood.</td>
<td>Ethics √ None reported in the article</td>
<td>Low</td>
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Birth outcomes and pregnant teenagers: Quantitative papers

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<td>22</td>
<td>(Lopoo, 2011) Texas, US</td>
<td>Study the relationship between teenage childbearing and labour and delivery complications</td>
<td>Retrospective cohort study Birth certificate data from 1994 to 2003 Descriptive statistics</td>
<td>n=1,355,962; mothers; first births 25–29 age group</td>
<td>In contrast to mothers aged 25–29, most teenage mothers had better health. Placenta previa: smaller incidence for 15–16 years than 25–29 years (0.07% v. 0.23%); &lt;15 years had higher rate of placenta previa. In contrast, teenagers had lower rates of labour febrile, excessive meconium, premature rupture,</td>
<td>Ethics not reported Foetal deaths as complications were not recorded Some of the measures may not be sufficient to reveal SES</td>
<td>Moderate</td>
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<td>No.</td>
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<td>23</td>
<td>(Chen et al., 2008) US</td>
<td>Determine the potential pathway of the association between teenage pregnancy and neonatal and post-neonatal mortality</td>
<td>Retrospective cohort study</td>
<td>n=4,037,009 nulliparous pregnant women &lt;10–24 years who had a live single birth during 1995–2000</td>
<td>Teenage pregnancy (10–19 years) was linked with increased neonatal deaths (age 0–27 days) (OR: 1.20 (1.16–1.24)) and post-neonatal (age 28–264 days) mortality (OR: 1.47 (1.41–1.54)), even when adjusted for confounding variables. Teenage mothers were more likely to be black, unmarried, smoke tobacco during pregnancy, did not have adequate prenatal care (34% of 10–15-year-olds had inadequate care; care increases with age) and lower weight gain during pregnancy, and had pre-term delivery. Maternal youth may be associated with increased risk of infant mortality.</td>
<td>Ethics not reported</td>
<td>Moderate</td>
</tr>
<tr>
<td>24</td>
<td>(Chen et al., 2007) US</td>
<td>Determine the association between teenage pregnancy and</td>
<td>Retrospective Cohort</td>
<td>n=4,254,751 first-born singleton infants with mothers</td>
<td>Teenage pregnancy associated with increased risks of: very pre-term delivery, pre-term delivery (age &lt;16=RR 1.91 (1.85, 1.96) v.</td>
<td>Ethics not reported</td>
<td>Moderate</td>
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<td>25</td>
<td>(Robson et al., 2006)</td>
<td>Compare birth outcomes of teenagers residing in rural and remote areas with those in larger centres</td>
<td>Retrospective cohort study</td>
<td>n=21,880 all teenage mothers aged &lt;16–19 and &lt;20 years with singleton births</td>
<td>Overall, over period of study: (i) smoking decreased during second half of pregnancy from 19.5% in 1998 to 15.9% in 2003 (p&lt;0.001). (ii) Caesarean section increased from 10.6% to 15.2% (p&lt;0.001). In contrast to teenagers in highly accessible areas, infants of teen mothers in very remote areas had higher rates of very pre-term birth (3.37 (1.54–7.36)), SGA (2.12 (1.33–3.40)) and stillbirth (1.21 (0.17–8.76)). Increased risk for SGA may be associated with very remote areas, first baby, smokers with higher risk for &gt;10/day (2.25 (2.05–2.48)).</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td></td>
<td>NSW, Australia</td>
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<td>Limitations not documented</td>
<td>CASP √</td>
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<tr>
<td>26</td>
<td>(Gaff-Smith, 2005)</td>
<td>Describe the socio-demographic and</td>
<td>Cohort study</td>
<td>n=116 adolescents (15–19 years) (mean</td>
<td>In contrast to NSW teenagers, teenagers at hospital had 4 types of delivery with significantly</td>
<td>Ethics √</td>
<td>Moderate</td>
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<td>Retrospective</td>
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<td>Limitations not reported</td>
<td>CASP √</td>
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<td>27</td>
<td>(Gilbert et al., 2004)</td>
<td>Study the obstetric outcomes of early and late teenagers in California—in particular, evaluate and characterise the racial/ethnic differences in the outcomes</td>
<td>Cohort study</td>
<td>n=31,232 early teens (11–15 years)</td>
<td>Only 15.3% white early teens and 23.9% white late teens (p. 267). Early and late teens had more neonatal (non-Hispanic white (NHW)) early teens (OR=3.1 (2.1–4.7) v. NHW late teens OR=1.9 (1.6–2.2)), infant mortality, major neonatal morbidities with delivery of &lt;37 weeks' gestation (NHW early teens OR=1.9 (1.7–2.1) v. NHW late teens OR=1.33 (1.3–1.4)) and LBW of &lt;2,500g. Results were similar for other ethnic groups. Lower CS in both groups compared to the control. Higher poor obstetric outcomes were noted in all teenage pregnancies.</td>
<td>Higher forceps because the Wagga hospital did not have vacuum extraction equipment</td>
<td>Moderate</td>
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<tr>
<td></td>
<td>US</td>
<td></td>
<td>Population-based, 1992–1997</td>
<td>n=271,470 late teens (16–19 years)</td>
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<td>Ethics not stated</td>
<td>Coding of diagnosis could not be checked</td>
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<td>OR; 99% CI; p-value=&lt;0.01</td>
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<td>Maternal age may not be the only factor influencing adverse outcomes</td>
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<td>Nulliparous teens</td>
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<td></td>
<td>Control group (20–29 years) (n=662,7652)</td>
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<td></td>
<td>Australia</td>
<td>clinical characteristics of adolescent women giving birth at Wagga Wagga Base Hospital, and compared with all adolescents in NSW</td>
<td>Chi-squared analyses</td>
<td>age=17.8; 63.8% were either 18 or 19 years; 67% first pregnancy; other 19% had living children</td>
<td>higher rates: forceps (12.3% v. 4.7%, p=0.0001), forceps rotation (4.1% v. 0.9%, p=0.004), fewer NVD (67.2% v. 80.8%, p=0.006). Also: higher incidence of antepartum haemorrhage, gestational diabetes, pregnancy-induced hypertension, lower pre-labour rupture of membranes &gt;24hrs. Rural adolescents are at risk of birth complications.</td>
<td>Higher forceps because the Wagga hospital did not have vacuum extraction equipment</td>
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<tr>
<td>28</td>
<td>(D. M. Smith &amp; Roberts, 2011)</td>
<td>Investigate young parent’s 21 semi-structured interviews with young</td>
<td>n=21 young parents (16)</td>
<td>Three factors of how young parents understand the social</td>
<td>Ethics not reported</td>
<td>Low</td>
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<tr>
<td>UK</td>
<td>understanding of the social gradient in young pregnancy</td>
<td>parents in 4 London local authorities/areas (2 less deprived and 2 more deprived)</td>
<td>Snowball, Thematic analysis</td>
<td>mothers and 5 fathers (pregnant or parenting—some had babies 10 years ago)</td>
<td>Mean age of conception=16 years for women and 20 years for men</td>
<td>gradient in young pregnancy: (i) the parental relationship status (openness and parent control)—stronger parental control over children in less deprived areas. Lack of parental role models in more deprived areas; (ii) access to education and career—teenagers have abortion in order to pursue their careers; (iii) acceptance of young pregnancy—pregnancy a viable route to adulthood status (p. 1057). Teenagers’ views of early childbearing, education and success in life are influenced by their values and beliefs (p. 1059).</td>
<td>Use of 4 London locations → not generalisable nationally or internationally</td>
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</table>
2.2.6 Gaps in the literature

This section presents the gaps identified in the literature search. A key gap noted was in relation to the research methodology in the studies reviewed. As discussed earlier, the 28 studies reviewed were largely quantitative studies, with only seven studies using qualitative methodology. Central to the quantitative methodology is a positivist conception of social reality that gives rise to generalizable explanations of one's reality (Hammond & Wellington, 2013). In contrast, qualitative methodologies provide subjective understandings, for example, ethnography focuses on understanding the research participants’ way of life and experiences (J. Willis & Anderson, 2010). This finding contributed to the adoption of the qualitative research methodology and methods in this study.

Another gap in the literature reviewed, was that there were no studies conducted to identify the pregnant teenagers’ antenatal care needs in Tasmania, Australia. Further, there were no studies conducted that applied triangulation of data from four data sources (pregnant teenagers, teenage mothers, midwives and nurses), to understand pregnant teenagers’ antenatal care needs. As suggested by researchers, midwives were central to providing quality maternity experience to teenagers (Price & Mitchell, 2004; D. M. Smith & Roberts, 2009); and were sources of social support for teenagers (Atkinson & Peden-McAlpine, 2014). Thus, the use of multiple types of research participants may be useful in developing a rich, in-depth understanding of pregnant teenagers.

Furthermore, in most of the studies reviewed, there was minimal application of explanatory theory or framework. The general lack of application of theories is a disadvantage, as theories and frameworks can be used to explain the observed research phenomena (Patton, 2015, p. 139). In the majority of the quantitative studies, the authors had loosely underpinned their studies on the socio-economic factors in the teenagers’ family and neighbourhood as risk factors for early childbearing (Bonell et al., 2003; Quinlivan et al., 2004; D. M. Smith & Elander, 2006; D. M. Smith & Roberts, 2011; Woodward et al., 2001). Only one quantitative study (Corcoran et al., 2000) applied a theoretical model—Bronfenbrenner’s bioecological model of human development—in the research design. Other studies did not explicitly state the theoretical framework(s) used in the research, such as the SEDH model. This may be
because the use of theories is not standard practice in qualitative research—for example, in grounded theory, which emphasises theory generation from research (Fram, 2013).

Importantly, and relevant to the current study, a noticeable gap in the literature was that no in-depth, theoretically driven qualitative studies published in Australia have explored the antenatal care needs of pregnant teenagers (aged 15–19 years). Likewise, in Tasmania, Australia, where this study was undertaken, there were no published qualitative studies on pregnant teenagers’ antenatal care needs. As noted, ‘More in depth qualitative studies should aim to understand their individual needs’ (Al-Sahab et al., 2012, p. 229). This knowledge gap provided the impetus for undertaking this qualitative-focused ethnography study to understand pregnant teenagers’ antenatal care needs in a region in Tasmania, Australia.

2.2.7 Strengths and limitations of reviewed studies

In general, the integrative review findings are considered dependable because several of the 21 quantitative studies used large, population-based data (Chen et al., 2007; Chen et al., 2008; Lopoo, 2011). A large sampling size reduces sampling errors and produces results that may suggest representativeness of findings (Polit & Hungler, 1997). Another strength of the reviewed studies is the consistent use of nulliparous (first-time) teenage women across all studies. One study (Lopoo, 2011) highlighted that the parity (number of pregnancies) of the teenager is an important consideration in the study design, and it recommended using only first-time pregnant teenagers because, following a birth, there are physiological changes to the uterus, which is larger in shape, size and weight. Further, birth experiences and experiences of newborns are also different for teenage mothers with first-time pregnancy in contrast to subsequent pregnancies (Lopoo, 2011, p. 204). The consistent use of first-time pregnant teenagers in all studies allowed for comparisons of research findings.

Nonetheless, several limitations in the reviewed studies were noted. Firstly, ethics approval was not documented in more than 50 per cent of the quantitative studies and two qualitative studies (see Table 2-3). It was also noted that all checklists (CASP and STROBE) used to assess the quality of the quantitative studies did not include ethics approval. Ethical considerations are a critical component of research and show that
measures are in place to protect research participants from harm (Fontana & Frey, 2003). Thus, the communication of ethics approval is necessary in all reported studies.

All checklists for quantitative studies (CASP and STROBE) highlighted the need to address confounders in the studies. However, as noted in several studies, it was not possible to control all confounders that might be of ‘unobserved heterogeneity’ or the hidden confounding variables (Lee, 2010, p. 705). For example, the retrospective nature of the data meant that the researchers could not control some of the confounders. For example, the retrospective nature of one study meant that researchers could not control for the use of illicit drugs because these data were not available (Chen et al., 2008). In another study, variations in clinical care provided to teenagers could not be checked (Bensussen-Walls & Saewyc, 2001). Therefore, the findings from this integrative review may only reveal some, and not all, information.

Another limitation was that many of the quantitative studies reviewed might suffer from ‘selection bias’ specific to the sampling of childbearing teenagers. Selection bias occurs in the sampling of pregnant teenagers because the majority of pregnant teenagers come from low socio-economic status groups. Thus, a sample with pregnant teenagers and will produce results that are skewed and exaggerated when compared to older pregnant women (Lee, 2010). To address this issue, the use of a matched sample in the research design is recommended. In this approach, the teenagers in the sample and control groups are closely matched on pre-existing known characteristics such as demographic and family factors (Lee, 2010, p. 700). Thus, the presence of selection bias may significantly affect the generalisability of quantitative research studies.

Some of the reviewed studies did not include a section on research limitations. One longitudinal, quantitative, population-based study conducted in SA, Australia (Van der Klis et al., 2002), did not include a section on research limitations. However, some research limitations were highlighted in the research methods section of the study. For example, the authors highlighted that the use of hospital records can be problematic because the data entry of codes relies on accuracy. Further, the authors suggested that under-registration of births by teenage mothers in SA could be as high as 24.4 per cent (p. 129). This implies that the findings may be underestimated and do not reflect the actual situation of pregnant teenagers. In addition, data on spontaneous abortions are likely to be incomplete, and the pregnancy rates that were calculated based on birth and
abortion data are likely to be underestimated. Lastly, although the authors did not mention selection bias, this may be another limitation of the study. As noted, the study compared teenagers (aged<19 years) (n=5,074) with women (aged>20 years) (n=88,067) and found that teenagers experience higher obstetric complications. In view of the selection bias mentioned earlier, the higher percentage of obstetric problems experienced by teenagers may be an overestimation (Van der Klis et al., 2002).

One study (Chen et al., 2008) found that the use of self-reports (such as last menstrual period) can be unreliable, and that controlling for confounding is not always possible. Further, the retrospective data used in the study meant that the researchers were unable to conduct cross-checking of information (Chen et al., 2008, p. 692). Nonetheless, this large population-based study was important in highlighting the relationship between maternal age, neonatal mortality and pre-term births. Likewise, in one quantitative population-based longitudinal study, while the study used robust population-based data, it could not account for residual confounders in the retrospective data used. For example, there was no information on contraceptive use and housing situations for pregnant teenagers (McCall et al., 2014).

In relation to qualitative studies, one study (Haddrill et al., 2014) provided a taxonomy of reasons for the delayed initiation of antenatal care by teenagers. In general, the study met the majority of the CASP criteria. However, the authors did not clearly state the type of qualitative research methodology applied. Notwithstanding, the research methods applied were well described to allow for quality assessment and replication by other researchers. The study encountered problems in the recruitment of participants, which resulted in a smaller number of participants and a 22-month period of data collection. This may have influenced the study’s findings.

2.3 Summary

This chapter described the integrative review approach used in the literature review. The review process commenced with the presentation of the search questions, clear search terminologies, and inclusion and exclusion criteria. A description was provided of the process of identifying the quality of research studies using the CASP and STROBE quality evaluation tools. This review process generated a total of 28 studies, largely consisting of quantitative research studies. A number of gaps in the literature were
highlighted. Importantly, as noted in the review, no qualitative, theoretically informed studies have been published that explore the antenatal care needs of pregnant teenagers (aged 15–19 years) in contemporary Australia, including Tasmania.

Chapter 3 will present the two theoretical frameworks applied in this study: the SEDH framework and Giddens’ (1984) structuration theory. The rationales for the use of these frameworks will also be included in the chapter.
Chapter 3: Theoretical Frameworks

3.1 Introduction

This chapter introduces the two theoretical frameworks applied in the current study. These are the SEDH framework and Giddens’ (1984) structuration theory from his seminal text Constitution of Society.

In the first part of this chapter, the SEDH framework highlights that social inequalities in society are related to structures within society that give rise to poor health outcomes. In this study, the SEDH framework was applied as a broad guide in the research design and in the development of the interview guides. Further, this framework was also applied in the analysis of key findings from the triangulation process. The second part of this chapter focuses on the structuration theory and its utility in this study. This chapter describes the theory’s complex and comprehensive processes embedded in the interactions between social agents and structure in the making of society.

3.2 Socio-ecological Determinants

This section describes the social determinants of health and the influence of the determinants on individuals in society, including an overview of the four levels of the SEDH framework and its utility. Further, the rationales for using the framework are also included in this section.

Since the 1970s, much has been written on social inequities as health determinants or risk factors that influence people’s health. Social inequities are commonly referred to as the social determinants of health (Commission on Social Determinants of Health, 2008; Marmot, 2005; Whitehead et al., 2001), which have direct and indirect effects (Kothari, Edwards, Yanicki, & Hansen-Ketchum, 2007; Taylor-Seehafer & Rew, 2000). In the current study, the phrase ‘socio-ecological determinants’ (Kothari et al., 2007) was used instead of ‘social determinants’ to reflect the comprehensiveness of the SEDH framework. Further, the term ‘inequalities’ was used interchangeably with ‘inequities’ (Whitehead & Dahlgren, 2007, p. 4) to refer to the differences between people or groups of people in relation to, for example, income and health. The social inequities or inequalities that lead to health inequalities are related to the socio-ecological factors or
systemic factors in a society. These systemic factors, such as those related to the education, employment and economic systems, are referred to as the ‘structural’ drivers of poor health in people. That is, individuals who experience failure within these systems, such as a lack of access to resources (e.g., money, education), may develop unhealthy lifestyles that contribute to poor mental and physical health (Marmot, 2005). Fundamentally, as systemic factors, the ‘...determinants of social inequities are all amenable to change’ (Whitehead & Dahlgren, 2007, p. 4). This underpins the need to prevent the development of structural determinants and address these determinants that contribute to poor health.

As a broad framework, the SEDH encompasses multi-level determinants or factors at the individual (health behaviours), family, friends, community and broader socio-political levels. The determinants are also considered ‘nested’ determinants (Bronfenbrenner, 2005; Kothari et al., 2007) because they are located within and between the multiple levels of the individual’s environment. The notion of ‘nested’ is useful because it highlights the interconnectedness between individuals and the multiple layers of environment surrounding them. These determinants are highly influential on the individual and are referred to as ‘layers of influence’ (Whitehead et al., 2001, p. 313). For example, in a US study on intergenerational teenage pregnancy, the authors highlighted the dynamic interactions between young women and their environments that occurred over time and at several levels of their socio-ecological environments (Meade & Ickovics, 2005, p. 675). The layers of influence may have an accumulative effect, giving rise to the notion of accumulation of risk factors for adolescents (Catalano et al., 2012; J. Williams, Toumbourou, Williamson, Hemphill, & Patton, 2009). The interconnectedness flags the complexity of life for the individual and simultaneously highlights the centrality of the environments to individuals’ lives.

### 3.2.1 Four levels of the SEDH framework

As applied in the current study, the four levels of the SEDH framework were modified from key sources, namely the Commission on Social Determinants of Health (2008), Whitehead, Dahlgren, and Gilson (2001) and Kothari et al. (2007). This framework was enhanced with Bronfenbrenner’s (2005) theory on the bioecological perspective of human development. As shown in Figure 3-1, the multi-level factors can be
conceptualised as consisting of four nested concentric circles, with each circle representing one level of determinants.

At the individual or micro level, there is a composite of characteristics, such as teenagers’ personal beliefs, behaviours such as smoking and sexual activities (Whitehead et al., 2001, p. 313), and risk-taking behaviours such as substance abuse (cigarettes, alcohol and illicit drugs) (Commission on Social Determinants of Health, 2008). A child’s intellectual, emotional, social and moral development occurs by taking part in regular and increasingly complex activities over his or her life (Bronfenbrenner, 2005). This interaction occurs with significant people in the child’s life (e.g., parents). The child’s development is influenced by his or her time growing up in the family, as well as their social history. At this level, the SEDH affects the child–carer relationship, which sets the groundwork for the child’s future. A strong emotional bond with the child’s primary carer is central in the child’s development. Genetic dispositions for ‘maladaptive’ behaviours in life may develop because of disruptions to patterns of interactions caused by serious parental ‘neglect, abuse or domination’ (Bronfenbrenner, 2005, p. 12).

![Figure 3-1: Layers of influence—socio-ecological determinants, adapted from Whitehead, Dahlgren, and Gilson (2001) and Bronfenbrenner (2005) (Zhang & Maesako, 2009, p. 127)](image-url)
The second level of the model constitutes the meso-level system (see Figure 3.1). This level emphasises relationships between individuals and those who are important in their society, such as their family, friends, school and community (Whitehead et al., 2001, p. 313). Between the micro and meso levels, the exo level constitutes the third level in the SEDH framework (see Figure 3-1). At this level, individuals are influenced by conditions at work and where they live, including access to essential daily needs and services such as supplies of food and necessary goods, and access to necessary services such as health services (Whitehead et al., 2001, p. 313). The exo-system can negatively affect a child if, for example, the child’s parents are unhappy at their workplace, as this can affect the quality of their interactions with the child at home (Bronfenbrenner, 2005). Thus, understanding the characteristics of parents and neighbourhoods, such as race, age, income, education, occupation and neighbourhood peace or violence, can provide insights into the influences on teenagers’ childhoods (Logsdon & Gennaro, 2005).

Lastly, the macro level is the outermost level (see Figure 3.1) and is seen to mediate the health of the population (Whitehead et al., 2001, p. 313). This level is the site of state governments and their related mechanisms that, in general, have control over individuals within the micro, meso and exo levels in society. In addition, the macro level includes the prevailing norms and values in relation to culture and society that function to constrain or support individuals in that society (Whitehead et al., 2001, p. 313). Thus, culture is also a determinant of the individual’s environment (Kothari et al., 2007; Taylor-Seehafer & Rew, 2000). Cultural determinants are referred to as ‘embedded or implicit’ determinants because they are often hidden in the individual’s social environment (Kothari et al., 2007, p. iii7). For example, the gender culture of sexual abuse and coercion of females by males is an ‘embedded’ determinant of early sexual debut and teenage pregnancy (Taylor-Seehafer & Rew, 2000). The embedded determinants can be difficult to identify because of their hidden nature.

As noted by Bronfenbrenner (2005), macro-level determinants can limit opportunities in the relationships between the child and parents or parent (Bronfenbrenner, 2005, p. 47). For example, a government’s policy for paid maternity leave will contribute to improved quality of time between the child and the mother. In relation to early adolescent development (aged 10–14 years), the macro level is fundamental because it

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influences the contexts that in turn influence the other levels of the ecological framework (Blum, Astone, Decker, & Mouli, 2014). Given their overarching influence, macro-level determinants are referred to as ‘upstream’ factors. Addressing ‘upstream’ determinants is a necessary approach to addressing social inequalities (Quail, 2011; D. R. Williams, Costa, Odunlami, & Mohammed, 2005) in relation to youths (Blum et al., 2014; SmithBattle, 2012). Further, addressing the macro and other levels of determinants can significantly contribute to improving care for childbearing teenagers (Quail, 2011).

3.2.2 Utility of the SEDH framework

This section presents the utility of the SEDH framework as identified in the literature, including raising social awareness, allowing the linking of social and health inequities, and focusing on health.

Social awareness

The SEDH framework can be applied to identify and raise awareness of social inequities that people experience in societies both locally and globally. Social and health inequities are fundamentally social justice issues (Whitehead et al., 2001). This is because these inequities are the result of socio-ecological determinants shaped by dominant social and political ideologies held by people in power. Individuals alone cannot effectively address these determinants in society. The recognition that health inequity exists was noted as early as 1948 with the United Nations Declaration of Human Rights (UNFPA, 2008). Social and health inequities are taken seriously in Australia. In Tasmania, where the current study was conducted, health inequities are tracked yearly (Department of Health and Human Services, 2013c, p. 4). Such social determinants of health are referred to as ‘structural forces’ that affect the population, giving rise to poor health (Department of Health and Human Services, 2013c, p. 4). Thus, it is necessary to identify and challenge these determinants that constrain and shape the teenagers’ life trajectories in society.

Linking social and health inequities

Social inequities affect health either indirectly or directly, giving rise to health inequities or poor health (Australian Institute of Health and Welfare, 2012). For
instance, an individual who lives in constant social, economic and educational deprivation may be at greater risk for poorer health than those in the reverse social circumstances (Baum, Bègin, Houweling, & Taylor, 2009; Commission on Social Determinants of Health, 2008; Gehlert et al., 2008; Whitehead & Dahlgren, 2007; D. R. Williams et al., 2005; World Health Organization, 2011; World Health Organization & Government of South Australia, 2010). Primarily, the SEDH framework promotes the identification of the social and ecological determinants that underpin health inequalities (Allen, Stapleton, Tracy, & Kildea, 2013; Australian Institute of Health and Welfare, 2012; Department of Health and Human Services, 2013c; Marmot, 2005; Whitehead et al., 2001). Thus, in applying the SEDH framework, it reframes and refocuses efforts to improve health outcomes by focusing on social inequalities and modifiable lifestyle factors.

Social participation and inclusion are other important factors highlighted in the SEDH framework. Inequalities in areas such as education, employment and health services result from restricted social participation. Experiences of inequities vary for different groups of people and are dependent on their economic and psychosocial conditions, as well as the available options that predispose them to, or protect them from, poor health (Commission on Social Determinants of Health, 2008). Social development, health and sense of wellbeing are linked to social participation and inclusion, along with individuals’ ability for actions and control in their society (Commission on Social Determinants of Health, 2008). When individuals are socially excluded because of their social position, they risk losing autonomy and decreased social participation, which are critical for health (Marmot, 2005). The social inequalities resulting from one’s social position are central factors leading to health inequalities (Whitehead & Dahlgren, 2007). Thus, the lack of social participation leads to social exclusion, with the attendant social and health problems.

The social inequalities between people in relation to available social, education and economic opportunities are demonstrated in a US study (D. R. Williams et al., 2005). This study identified six key areas of socially embedded conditions that influence the population’s health: neighbourhood living conditions; opportunities for learning and capacity for development; employment opportunities and community development; prevailing norms, customs and processes; social cohesion, civic engagement and
collective efficacy; and health promotion, disease prevention and healthcare opportunities (D. R. Williams et al., 2005, p. S11). The social conditions of cohesion, civic engagement and collective efficacy could be considered the lower-level determinants and a consequence of higher-level social conditions such as unemployment and low education. This suggests that unemployment and low education are fundamental determinants that can result in social disruptions through poverty, lack of civic engagement, and ill health.

**Focusing on health**

The SEDH framework highlights that an individual’s health is a consequence of the micro, meso, exo and macro determinants. Further, the health care system is itself an important determinant of health within the SEDH framework (D. R. Williams et al., 2005). As mentioned above, some of the powerful determinants of health inequities include low living standards, unemployment, health care access and utilisation (Marmot, 2005; Whitehead & Dahlgren, 2007). For example, people may experience difficulty accessing health care either because the care is unaffordable or because they live in rural areas and do not have transportation to the services.

There is growing support for addressing health inequalities through the SEDH framework, as indicated in Tasmania’s public health report (Department of Health and Human Services, 2013c). The use of the SEDH framework reflects a conceptual shift ‘… from disease as a personal problem to health as a social issue…’ (Caira et al., 2003, p. 303). Thus, health problems are the results of one’s social and environmental conditions, which are largely addressed through modified lifestyles and the broader socio-ecological environment.

**3.2.3 Rationales for use of the framework**

The use of the SEDH framework in this study is underpinned by several rationales. Importantly, this framework can be used to identify and understand the determinants at the four levels of the framework, as well as highlight possible links between and within each level (Kothari et al., 2007, p. iii6). As stated, in the SEDH framework, the explication of health inequalities is fundamental to understanding society (Marmot, 2005, p. 240; D. M. Smith & Roberts, 2011). As presented in the literature review in Chapter 2, several authors have highlighted the relationships between the social
determinants of health, such as family, social, economic and demographic factors in teenagers’ childhood, as risk factors for early childbearing (Bonell et al., 2003; Quinlivan et al., 2004; D. M. Smith & Elander, 2006; D. M. Smith & Roberts, 2011; Woodward et al., 2001). Another study highlighted teenage pregnancy as a social inequality because teenagers with a high socio-economic status have the lowest rate of teenage pregnancies and the highest abortion rate (Van der Klis et al., 2002). Further, Corcoran et al. (2000, p. 38) suggested that Bronfenbrenner’s model is useful as a framework to categorise variables at the four levels of the SEDH framework (see Figure 3-1), as well as the links with early childbearing. This multifocal approach is recommended to address individual, family and educational opportunities to reduce teenage pregnancy (Quinlivan et al., 2004).

Midwifery practice can be enriched by using the SEDH framework to bring to the fore the social model of health to complement the medical model of health that dominates the health care system. The SEDH emphasis is important in the midwifery profession (Biro, 2011) because the framework is complementary to woman-centred practice and differentiates midwifery from the medical profession (Johnson, 2011, p. 6). This approach is in line with the Australian national competency standards for the midwife (Nursing and Midwifery Board of Australia, 2006). Further, understanding the SEDH in the lives of pregnant teenagers may contribute to providing them with appropriate and comprehensive care.

Finally, relevant to this study, Epstein (1998) suggested that individuals are inseparable from their socio-ecological environment. Thus, teenagers need to be understood within the context of the influences of their environments (Epstein, 1998). Therefore, the SEDH framework is an appropriate framework to guide the current study and facilitate an understanding of teenagers. More recently, in recognition of the effect of social conditions on health, the SEDH approach has been recommended to understand adolescent health (Viner et al., 2012). Thus, as revealed in Chapter 2, given the complex tangle of social and ecological factors relating to teenage pregnancy, the use of the SEDH framework is appropriate in this study. This approach could lead to identifying socio-ecological determinants that can be modified through actions at the micro, meso, exo and macro levels.
3.3 Structuration Theory

This section presents structuration theory (Giddens, 1984), which consists of three major components: production and reproduction of social practices, dialectic of control, and social agents and their discursive penetration (Morrow & Brown, 1994, p. 176). Other related concepts presented are ontological security, and risk society and shaping of identity. These discussions allow structuration theory to be embedded in Giddens’ more recent work. A brief section is presented on culture and structuration theory as a critical theory. Lastly, this section presents the rationales for the application of structuration theory in this study.

Structuration theory (Giddens, 1984) is a social theory on the constitution of society. The theory is comprehensive and is based on an eclectic collection of major classical works by Marx, Weber, Durkheim and other contemporary theorists (Held & Thompson, 1989). Relevant ideas in psychology from Freud and Erikson are also included in the theory (Giddens, 1984; Morrow & Brown, 1994). The theory was credited for shifting from the influence of a functionalist view on social science, which was then aligned with positivism or empirical science (Bernstein, 1989, p. 21), to an interpretive emphasis on social science (Giddens, 1979).

In the theory, Giddens redeveloped the central sociological phenomena of social agents and agency in social reproduction and transformation in society (Cohen, 1989, p. 12). The social agent was cast as a ‘reasoning, acting being’ (Z. Bauman, 1989, p. 42). This suggests that social agents have agency or power to reason and act or not act. This theory supports a ‘social ontology’ that was explanatory of social behaviours, social systems and institutions (Giddens, 1984). In contrast to the carefully considered philosophical ontologies that deal with the broader questions of reality, social ontology is considered a ‘secondary’ ontology because its central focus is on understanding the social world. Thus, structuration theory (Giddens, 1984) offers a scientific theory to understand social reality by studying the close relationship between social agents and structure. The application of this theory is noted in research projects in various disciplines such as education, social psychology, organisational management and quality improvement in nursing management (Giddens, 1984).
3.3.1 Production and reproduction of social practices

The central tenets of structuration theory are that social agents and structure in society both contribute to the production and reproduction of social practices and social systems, institutions and society in general. This section describes the key concepts of the role of social agents, structure, rules and resources in the production and reproduction of social practices, and the social systems and institutions in society. Engagement in the circular process of production and reproduction is important to create social stability and trust, which allows social agents to ‘go on’ in their social routines with ease (Giddens, 1984, p. 23).

Agents, reflexivity and ‘knowledgeability’

Actors or agents are individuals or individuals within collectives (groups) with the inherent capacity to act in order to achieve their interests. A fundamental notion is that agents have the capacity to develop reflexively—that is, the awareness ‘…to understand what they do while they do it’ (Giddens, 1984, p. xxii). This is referred to as the ‘knowledgeability’ of agents, which is applied to produce social practices to facilitate living in the day-to-day contexts of social life without having to think about what and how to go about these daily social practices (Giddens, 1984, pp. 21–22). Regularised activities are developed that help agents carry out their daily social routines with ease. That is, agents have agency or the capacity to act to transform their capacity into actions (Stones, 2006, p. 3). The outcomes produced are intended and unintended (often unaware) (Cohen, 1989, p. 24). Therefore, the notion of agency is tied with that of power relations, which may be asymmetrical. This implies that all social actors are capable of producing outcomes to serve their own good. This control is achieved through reflexive monitoring.

Reflexivity is not merely being self-conscious; it is the constant monitoring that occurs of one’s actions and the actions of others. In reflexive monitoring, rationalising the intentionality of action takes place continuously and effortlessly to maintain continuous knowledge of actions and the social and physical contexts (Giddens, 1984, p. 5). Intentionality refers to the fact that all actions are underpinned by rationales and that agents have an understanding of their actions and the actions of others. Giddens’ later work on self-identity suggested that self-reflexive monitoring is central in social life.
because social agents navigate and adapt themselves to the ever-changing modern and global societies (Giddens, 1991). At a practical level, Giddens’ concept of reflexivity embedded learning as a central element of social and professional life (Zhao & Biesta, 2012).

Social agents’ knowledge or ‘knowledgeability’ comprises practical and discursive knowledge. Practical knowledge is the non-conscious element of knowledge, as much of the knowledge for actions is not accessed directly through consciousness. A definition of consciousness is the ability ‘…to think about a topic and simultaneously to assess critically how that topic is being thought about’ (Payne, 1996, p. 3). A social agent acquires practical knowledge as tacit knowledge that is mostly taken for granted in one’s daily life (Giddens, 1991, p. 36). This practical knowledge is social agents’ ‘know-how’ of daily social practices (Bernstein, 1989, p. 26) and is a form of knowing (Polanyi & Prosch, 1975, p. 34). This is shared or mutual knowledge that exists between social agents in society. As such, this mutual knowledge is associated with social practices that persist throughout history and exist beyond the current lifetime of agents or groups of agents (Cohen, 1989). For example, the notion of care and caring for a sick person is practical knowledge that is shared and transcends the time and space of any particular social groups in society.

Discursive knowledge is another fundamental concept relating to agents’ knowledgeability. Discursive consciousness is knowledge made explicit in discursive forms such as written or verbal. If mutual knowledge is practical knowledge that is tacit within a society, then memory is discursive knowledge that is explicit. There are no clear distinctions between practical consciousness and discursive consciousness. As stated, ‘…there are only the differences between what can be said [discursive] and what is characteristically simply done [practical]’ (brackets added) (Giddens, 1984, p. 7). Therefore, social agents’ knowledgeability consists of practical and discursive knowledge that can be identified through observations of practice and of verbal or written explanations.

**Structure: Binding of social practices and systems**

Structure is a foundational concept in structuration theory. The notion of structure is as a mental conception that individuals apply and that shapes social interactions, social
practices and systems. This conception of structure suggests that it is ‘virtual’ and does not have a ‘fixed or mechanical character’ as applied in traditional sociology (Giddens, 1984, p. 18). In structuration theory, structure refers to:

... the structuring properties allowing the ‘binding’ of time-space in social systems, the properties which make it possible for discernibly similar social practices to exist across varying spans of time and space and which lend them ‘systemic’ form (Giddens, 1984, p. 17).

This suggests that structure plays a central role in the ‘binding’, ordering or structuring of social practices into social systems that last across generations in time and space. Structure develops through interactions; for example, in contemporary financial systems, individuals receive their pay via an electronic system and can draw upon the money through automatic machines or face-to-face at a bank. These systems are established through regularised social activities, and the structure that exists within this system is virtual because it is experienced or discursively understood when social practices are instantiated or acted out. The notion of structure is as ‘memory traces’ of social actors (Giddens, 1984, p. 17). In structuration theory, both agent and structure contribute to the production and reproduction of social practices.

Rules and resources

Rules and resources have structuring properties and are used by social agents to produce and reproduce social systems. Underpinned by power, structuring properties can dominate decisions on what and which social systems are established in society. The rules can be formulated as law and rules in bureaucracy and are ‘...codified interpretations of rules...’ (Giddens, 1984, p. 21). Agents’ knowledgeability includes knowledge of rules and resources. In the production and reproduction of social systems, rules are grasped tacitly as social agents ‘go on’ in the social routines of life. Rules can exist in various forms, such as tacit, discursive, informal, formal, weakly sanctioned and strongly sanctioned. Rules are important in social interactions because they structure social practices by providing form and sustaining the practices, or they can end or reform these social practices. Ultimately, rules function to maintain agents’ ‘ontological security’. Breaking the social rules of social practices and social systems can destabilise social agents and threaten their ontological security (Giddens, 1984, pp. 22–23). This concept of ontological security is discussed in Section 3.3.4.
Similar to rules, resources also have structuring properties to produce and reproduce social systems. Resources have transformative capacity with two aspects: being authoritative and allocative. Authoritative resources result from the coordination of social actors’ activities. For example, supported by rules and resources in the system, nurse managers have the authority to coordinate nurses to affect quality care for patients. Thus, with the use of rules and resources, social agents have control of production, which may result in meaningful change in social practices and systems (Giddens, 1984, p. 33).

**Social systems and institutions**

Societies comprise social systems with specific structural properties that give rise to groups of institutions over time and space (Giddens, 1984, p. 164). The finance and economic system is one example where similar social practices form social systems and institutions. In social system reproduction, social practices and systems are integrated. Social integration refers to the connectedness or systemness present during individual face-to-face social interactions in the co-presence of others. In contrast, system integration is the interconnectedness between actors who are absent physically in time and space. Importantly, in social integration, social agents exercise a degree of autonomy and dependence, with autonomy traded for dependence where appropriate. The lack of coherence or willingness to give up one’s autonomy for dependence leads to social disintegration. For example, social integration may be unlikely where there are differences in beliefs and values among people with diverse races, religions and socio-economic status (Giddens, 1984).

In structuration theory, social systems are the structures that exist beyond the lives of social actors ‘...in the continuity of *praxis*’ or social life (italics in original) (Giddens, 1984, p. 171). The notion of *praxis* was borrowed from Marx and is:

... synonymous with the constitution of social life, i.e. the manner in which all aspects, elements, and dimensions of social life ... are generated in and through the performance of social conduct ... (Cohen, 1989, p. 12)

For example, continuing poverty in teenage mothers’ lives could be a central aspect of social life or *praxis* that is produced and reproduced. This occurs because many pregnant teenagers come from socially and economically disadvantaged families, and
teenage motherhood commonly leads to further poverty and deprivation (Quail, 2011). However, these social systems are influenced, reproduced and changed over time by social actors.

3.3.2 Dialectic of control

In this section, ‘dialectic of control’ in structuration theory is described by presenting the duality of structure and time and space, which are central to structuration theory.

As detailed in earlier sections, in the structuration process, social agents use rules and resources to structure social practices and systems. Power is exercised through rules and resources, which leads to the domination and control over others by social actors (Giddens, 1984, p. 16). However, all power relations exhibit a reciprocal two-way relationship of autonomy and dependence/control (Giddens, 1979, p. 149), which is referred to as the ‘dialectic of control’. The concept reflects the dialectic between control and autonomy, as social agents inherently strive to maintain autonomy (Giddens, 1984, p. 16). For example, nurses may exercise the ‘dialectic of control’ by applying their professional judgments in patient care to subvert the hospital’s economic measures that seek to control nursing practice (Groves, Meisenbach, & Scott-Cawiezell, 2011).

**Duality of structure**

Social control is generated through the duality of structure mechanism. In the structuration process, the ‘duality of structure’ refers to structures as the ‘ mediums’ and the ‘outcomes’ in social practices to maintain social systems (Giddens, 1984, p. 25). For example, in the teenage-specific antenatal clinic, rules and resources are the structures or mediums that allow teenagers to receive teenage-friendly care (see Table 3-1). Over time–space dimensions, the structure that facilitates the development of teenage-specific care also leads to the reproduction of teenage-specific care for teenagers. The notion of the ‘duality of structure’ generates recursiveness or repetitiveness in social activities because of the structured properties of social life (Giddens, 1984, p. 24).
### Table 3-1: Summary of the duality of structure, adapted from Giddens (1984, p. 25)

<table>
<thead>
<tr>
<th>Structure(s) (medium)</th>
<th>System(s) (outcome)</th>
<th>Structuration process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rules and resources or sets of transformation relations are used to organise social activities; these in turn are organised as properties of social systems.</td>
<td>Reproduced relations between actors or collectivities organised as regular social practices.</td>
<td>Conditions governing the continuity or transmutation of structures, and therefore the reproduction of social systems.</td>
</tr>
<tr>
<td>For example, rules and resources in the teenage-specific antenatal clinic are the structures or mediums allowing teenagers to receive teenage-friendly care.</td>
<td>For example, the teenage-specific antenatal clinic.</td>
<td>For example, the continuity in use of the teenage-specific antenatal care clinic gives rise to the ‘outcome’ of the reproduction of this system.</td>
</tr>
</tbody>
</table>

Duality of structure can be further understood through an analysis of its three dimensions (see Figure 3-2). These dimensions of signification, domination and legitimation are significant and are the ‘structures’ that control the structuration process (Giddens, 1984, p. 29).

Signification refers to a system of meaning and communication. For example, a sign signifies a particular meaning to social agents depending on the social context. In midwifery practice, a woman who is grimacing with pain during labour may communicate that she needs help with pain relief. In social interactions, meanings are communicated between agents using the modality of ‘interpretive schemes’ or mental concepts to understand signs and practice signification. Interpretive schemes are agents’ vast ‘stocks of knowledge’ that allow them to reflexively monitor social interactions (Giddens, 1984, p. 29).
Communication, power and sanction are the outcomes of ‘interactions’ in the structuration process (see Figure 3-2). Communication is not just about communication intent (the primary purpose of communication between agents); in a deeper sense, it is also a way for social interaction to communicate meaning over time and space (Giddens, 1984, p. 29). Domination is another dimension of the duality of structure. As mentioned earlier, social agents experience domination when power is exercised. Lastly, legitimation is another dimension in the duality of structure processes. The notion of legitimation refers to the general acceptance of social practices as social norms in society. In some social groups and contexts, legitimisation is not via legal means, but by social norms and sanctions (Giddens, 1984).

While the duality of structure process begins with signification, it is contended that the process is fluid and there may be interactions between the three dimensions. For example, in Figure 3-2, signification as mediated through interpretive schemes results in communication of meanings, which may give rise to the domination of social agents as power is mobilised. In turn, domination may lead to legitimisation and sanctions mediated by social norms (Giddens, 1984, p. 29).

These three dimensions can be used to analyse the structural properties of social systems and institutions. For example, analysis of contemporary State social policies in relation to teenage pregnancy may reveal that these policies are embedded in the social and public health debates or discourse. This popular discourse drives society’s understanding of teenage pregnancy. Over time and space, the discourse dominates State governance, their institutions and civil groups. Subsequently, signification (communication) and domination (power) lead to the legitimisation (sanction) of
teenage pregnancy as a social and health problem (Shaw, Lawlor, & Najman, 2006). Thus, using the three dimensions, the analysis may reveal that the structural properties linked to the injustice for early childbearing women are located in the State government’s policies that exert influence on, and are influenced by, social agents. Importantly, the social policies will continue to be influential as long as they continue to be relevant to social agents.

**Time and space**

The time and space of social interactions are essential in the production and reproduction of social systems. Time refers to ‘life-cycles’ shared between social actors and within which socialisation occurs, in particular, between the child and parents (Giddens, 1984, p. 170). The study of time–space is relevant to understanding the contexts of social interactions and reproductions, and of social control (Giddens, 1984, p. 286). Social control such as State government policies and programs can occur across time–space boundaries. In a sense, the time–space study is similar to the longitudinal study design where, in general, research participants are studied across time and locality, which is their history, to understand the influences of complex contextual factors on their lives. For example, in a longitudinal study conducted in Australia, time was used to understand the effects of teenage mothering on children’s mental health (Shaw et al., 2006).

### 3.3.3 Social agents and discursive penetration

This section highlights the capacity of social agents for self-reflection, which is inherently part of the reflexive monitoring of social practices. According to Giddens’ (1979) earlier work, ‘discursive penetration’ refers to the self-reflection that social actors undertake in relation to their positions in the social world (Hansen, 1993, p. 7). To be self-reflective is to examine and understand oneself. Self-reflection occurs through discursive means such as writing or verbalising. The self-reflexive notion includes being self-reflective (Hauck, 2013, p. 234). As alluded to in section 3.3.1, social agents develop knowledgeability to facilitate self-reflexive monitoring of their social activities and of those around them. The purpose of self-reflexive monitoring is to allow social agents to adapt to society’s demands (Giddens, 1991). Further, self-
reflection is facilitative of self-development, which may lead to social transformation or meaningful change.

3.3.4 Ontological security

This section presents the concept of ontological security and the overwhelming effects on social actors when this security is threatened or lost. This concept is central to structuration theory because the essence of structuration is to develop a stable, safe and peaceful society.

Ontological security refers to the ‘Confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity’ (Giddens, 1984, p. 375). The notion of trust is central to this definition. This suggests that when trust is removed from social worlds, one will experience ontological insecurity and the loss of one’s identity. Trust is fundamental for the early development of ontological security. The basic trust developed between the infant and carer provides ‘emotional inoculation’ against anxieties that threaten the infant’s core of existence. This trust lasts a lifetime (Giddens, 1991, p. 39). Importantly, this trust functions as a protective shield or protective cocoon that envelops the individual. This cocoon functions to block threats from risks in one’s day-to-day living. The ‘bracketing’ of threats in one’s daily life generates a sense of ‘invulnerability’ (Giddens, 1991, p. 39).

As highlighted, social agents who are ontologically insecure will experience distress. This may be experienced at varying intensity, depending on the ability of the agents to express autonomy and control, the characteristics of their environment, and their personality (Giddens, 1991). For instance, a qualitative study revealed how two siblings coped differently with the loss of ontological security they both experienced when the familiarity of life was disrupted following their mother’s illness with multiple sclerosis and subsequent death. They were 16 and 18-years-old at the time of their mother’s death. For nine years, in their childhood and teenage years, the siblings assumed the role of primary carers for the mother. Following her death, the siblings described feeling an enormous sense of displacement in life, described as a ‘rupture in identity’ and grief such as ‘emptiness’ and ‘numbness’ (Pearce, 2008, p. 131). The sense of loss continued
for several years for the siblings, during which time they looked for new identities to re-establish stability in their lives (Pearce, 2008). While this loss was a hugely negative experience, it also created opportunities for change. Thus, stability in life is fundamental to one’s sense of ontological security and to maintain an intact protective cocoon. However, in the most extreme form of loss of ontological security, there may be no opportunities to reclaim life by developing a new identity. For example, the great dislocation experienced by prisoners of war who were in concentration camps in World War I generated severe loss of ontological security. Within a year, as a result of the loss of autonomy and control over their daily lives, the prisoners behaved as ‘walking corpses’. They had no life in them and no hope; they were resigned to their unknown fate in the war camp (Giddens, 1984, p. 62). This reflects the fundamental influence of ontological security, which is necessary to explicate in understanding social agents.

3.3.5 Risk society and the shaping of identity

A major emphasis in this section is the notion of a modern global risk society and social agents’ response to a world that is increasingly ontologically insecure (Giddens, 1991). The key concepts presented below are social identity and taking control.

In general, the outcomes of structuration are social stability with predictable social practices, social systems and institutions. However, as society shifts from the traditional to the modern and globalised, the social world becomes more interconnected, changes occur more rapidly and there is less predictability because changes in one part of the world affect social agents in distal parts too (Giddens, 1984, 1991). As noted, societies following modernisation in the 1990s are considered to have entered the risk society phase (Beck, Giddens, & Lash, 1994; Giddens, 1991).

Social identity

In the modern global risk society, risks and uncertainty have become the new norms that create ontological insecurity in social agents (Giddens, 1991, p. 4). Within this context, the development of social identity becomes important in modern society (Scott, 2006). In a sense, social identity, like structure, provides ‘virtual’ guidance on how to behave within that society. It also guides social interactions with other social agents because mutual understanding is possible when the ‘standardised markers’ of social identities are universally understood (Giddens, 1984, p. 282). Thus, social identity becomes
fundamental in a modern society that no longer relies on traditions. However, belonging to a society can also constrain and limit one’s social identities (Sen, 1998, p. 26). For example, the social identity of a teenage mother (aged 15–19 years) becomes confused with the often-negative social identity of a ‘teenager’ who is young and immature and has limited capacity for the responsibilities of motherhood. In this case, social agents’ common physiological characteristics, such as age and gender, are their ‘standardised markers’ that reflect their social identities (Giddens, 1984, p. 282).

Social identity is essential in defining social agents. Social agents develop several social identities, and some identities may dominate over others depending on the agent’s choice (Sen, 1998, p. 21). The development of social identity is a ‘reflexive project’ (Giddens, 1991, p. 5). This reflexivity ensures coherence, as the ‘self’ undergoes continuous transformations with a myriad of possible options to choose from (Giddens, 1991, p. 5). These authors emphasise the need for social agents to exercise choice in the development of their self-identity. While there is a need to address the modern insecure world through the development of social identity, at the same time, the need to exercise choice in social identity development can exacerbate the sense of an insecure world. Further, in the constantly changing modern world, individuals are required to pay constant attention to potential risks and possibilities (Giddens, 1991). In an ontologically insecure world, trust in daily routines shifts to trust in experts and specialist systems (Giddens, 1984, p. 82). However, an implication of this trust is that experts such as ‘lifestyle counsellors’ may enhance and/or threaten social agents’ autonomy and control.

Taking control

As explained in structuration theory, social agents reflexively work towards taking control of their lives to balance autonomy and dependence. In a risk society, to take control of one’s life, risk calculations are important and dominate all areas of life. The future is controlled through risk management. This control of time is important and results in the ‘colonisation of the future’, whereby the future is controlled to result in fairly predictable outcomes. Within this context, lifestyle planning is important and adopted by many people. The invasion of the future with counterfactual reasoning such as ‘if–then’ heuristic and risk calculations is part of life planning (Giddens, 1991, p. 125). This life planning is in response to self-reflexive monitoring that not only assesses
current risks, but also considers long-term risks across time–space trajectories in the hope of controlling or ‘colonising the future’.

As mentioned earlier, the protective cocoon brackets out daily threats and gives individuals a sense of invulnerability. Likewise, risks such as dangerous sports may also be ‘bracketed’ by the protective cocoon (Giddens, 1991, p. 130). Further, in some aspects of life, individuals in society may take a fatalistic attitude towards risks, and they may surrender to the attitude that ‘whatever will be will be’ (Giddens, 1991, p. 131). These are all essential mechanisms to protect one’s ontological security and prevent chaos and anxieties in one’s world (Giddens, 1991).

In addition to the need for social identity and risk management, modernity has also changed family composition as the result of a higher divorce rate. As a result, families experience great turmoil from divorce. For example, parental divorce/separation is common and can lead to a ‘rupture’ in social and self-identity resulting from ontological insecurity. In response to the turmoil, new formations in families are created, such as step-families. This too can affect the development of self-identity (Giddens, 1991). Within this context, social identities are shaped by many factors in social agents’ environments.

### 3.3.6 Culture and structuration theory

While the above sections mainly dealt with the sociological aspects of this thesis, the current section highlights that culture is inherently part of the social environment. A description of culture and its relationship with the social environment is presented below. This section draws upon the works of several authors to provide an understanding of culture in society.

The concept of culture is broad and carries different meanings based on the numerous theoretical orientations and understandings (Alasuutari, 1995; Geertz, 1973). In view of this broadness, there are few references to the term ‘culture’ in structuration theory. Further, in structuration theory, the term culture is used interchangeably with society (Giddens, 1984, p. 19). For Geertz (1973), who was a cultural anthropologist, culture is the ‘webs of significance’ that individuals have spun and within which they are suspended (p. 5). A common understanding of culture is as ‘a way of life’, and not just a total of activities (P. Jones, 2006, p. 130). In Raymond Williams’ 1995 seminal text on
the sociology of culture (P. Jones, 2006), culture exists at three levels: culture as lived at that point in time and place, culture recorded as art and other forms, and culture of a particular period. Lived culture refers to culture experienced by individuals in a particular time–space context (P. Jones, 2006, p. 21). According to Geertz, culture is the system of signs and related meanings in social communication (Ortner, 2006), as culture is central to communication using signs, gestures and other systems of signification. For example, winking as ‘a speck of behaviour, a fleck of culture’ can be a code that conveys conspiracy (Geertz, 1973, p. 6) or another nuanced meaning between two individuals from the same culture. The centrality of signification and the use of signs in communication is similarly emphasised in structuration theory.

Culture is everywhere in one’s everyday world, and yet it may be invisible to individuals who are not familiar with that culture—that is, ‘Culture is public because meaning is’ (Geertz, 1973, p. 12). This notion of culture may be compared to that of structure that exists in the ‘virtual’ space etched in the memories of social actors and that becomes ‘real’ when instantiated or reproduced in social practices (Giddens, 1984, p. 17). Culture influences behaviour by establishing the boundaries of social norms of behaviours shared by social actors. Thus, culture contributes to the production and reproduction of social practices and systems. As emphasised, ‘Culture is the objectification of the social’ (Epstein, 1998, p. 8). Further, culture ‘… is a context … that is, thickly—described’ (Geertz, 1973, p. 14). Culture becomes accessible when it is discovered and understood (Geertz, 1973). This implies that culture can be explicated discursively and through observations.

The term ‘culture’ is rarely mentioned in structuration theory. Culture is viewed as synonymous with the social (Giddens, 1984, p. 19). However, it is evident in the theory that culture is embedded in the structuration of society. For example, in the concept of the duality of structure, which is a central mechanism in the structuration of society, signification in the use of language in communication is one of the dimensions that underpins the production and reproduction of social practices. Codes and signs are symbolic mediums of communication (signification) in social interactions and provide clues to social agents’ culture (Giddens, 1984, p. 31). Similar to social production and reproduction, cultural practices can also be produced and reproduced through the duality of structure process. Bounded by the structural properties of rules and resources,
culture and social practices can function as resources and constraints on social actions (Carspecken, 1996; Ortner, 2006). In this context, culture can be a ‘deeply constraining power’ (Ortner, 2006, p. 12) because it underpins most of the individuals’ and groups’ social behaviours and practices (Ortner, 2006, p. 12). Therefore, culture contributes to social agents’ practical knowledge (tacit), which largely informs their knowledgeability. This knowledgeability includes the tacit social rules applied in the production and reproduction of routines of social practices. These social rules are tacit and are responsible for the structuring of daily activities (Giddens, 1984, p. 22).

It is contended that in the modern global society, similar to social practices, cultural practices may also change and become obsolete. In some cases, the change is made through the duality of structuration process, whereby the signification, domination and legitimation of certain cultural norms result in sanctions of social actors to prevent the continuation of the cultural practice. For example, negative views of early childbearing policies were considered ideologically driven to control teenage childbearing in African Americans and maintain the dominant Anglo American cultural values (Geronimus, 2003). This nuanced control in government policies is couched in rhetorical social and economic terms. Further, these policies contribute to the production and reproduction of cultural and social practices through the duality of structuration, which generates the continuing domination of the dominant social groups’ cultural values.

3.3.7 Structuration theory and critical theory

A brief description of critical theory (also referred to as critical social science) is provided in this section, including its relevance to structuration theory.

Briefly, the critical theory tradition first emerged in the 1930s in the well-known Frankfurt School, Germany. Some of the influential key researchers included Horkheimer, Marcuse, Adorno and Habermas. Critical theory aims to develop an awareness that most social practices are ideologically and politically motivated (Alvesson & Sköldberg, 2000, p. 111), and it generated the ‘domination–subordination’ phenomenon (Morrow & Brown, 1994, p. 149). For instance, as mentioned above, there are power-dominated asymmetrical relations between Anglo Americans and African Americans in relation to the timing of fertility in young African Americans (Geronimus, 2003).
Critical social science is focused on revealing oppression in the social world by identifying ‘…a theory which will simultaneously explain the social world, criticize it, and empower its audience to overthrow it’ (italics in original) (Fay, 1987, p. 23). Critical reflection of all social realities is important because they are often accepted unquestioningly (Alvesson & Sköldberg, 2000, p. 111). It is concerning that power distorts communication, leading to self-deception in agents in relation to their interests, needs and perceptions of social reality (Morrow & Brown, 1994, p. 149). Social agents no longer have a voice, so they lose their autonomy and identity and therefore their agency. In extreme cases, this oppression can lead to the loss of the protective cocoon and ontological security. The practical element of critical social science is to motivate social actors to develop a self-understanding of their social world to transform their lives (Fay, 1987, p. 23). In this regard, critical theory emphasises the need to explicate the underpinning processes that may generate oppression in society, such as culture, type of social structure, social agency and power (Carspecken, 1996, p. 3). Thus, in applying critical theory, the primary task is to focus on social change (Alvesson & Sköldberg, 2000, p. 110).

Fundamentally, structuration theory highlights the role of power in the structuration of society. This is well demonstrated in the duality of structure in structuration theory. For example, rules provide meaning in communications and guide social interactions. Rules can generate domination through sanctions if they are not followed. Within this context, social actors’ ability to engage in routine social practices without having to think about them implies that rules are implicitly understood and power is exercised, albeit in a nuanced manner (Giddens, 1984, p. 29). Thus, as suggested by several authors, structuration theory is a critical social theory (Bryant & Jary, 1991; Morrow & Brown, 1994), albeit a weak one, because it has little focus on the emancipation of social agents in society (Morrow & Brown, 1994). Briefly, research using critical social theory must address a crisis in a social system, provide an explanation of the social order, bring ‘enlightenment’ to the individual and practical changes in that social order, and result in ‘emancipation’ through new knowledge acquired and self-understanding (Fay, 1987, p. 30), and through freedom from oppression (Butler & Ford, 2003, p. 10). Enlightenment refers to the use of human intellect through reason (logic and science) to understand the world and move away from the dominant influence of religion and the supernatural.
Related to the emancipation of social agents, the exercise of choice by social agents is important and allows the emergence of one’s multiple identities (Sen, 1998). To deny social agents the opportunity to choose their identity is akin to forms of ‘repression … as well as a source of violence and brutality’ (Sen, 1998, p. 22). Therefore, the expression of choice reflects that social agents have autonomy, control and power. However, these choices can be limited by constraints that originate within the individuals’ socio-political environment (Fleming & Maloney, 1996, p. 119). Within this context, social inequalities as structural constraints in individuals’ lives can prevent the expression of a possible identity and may be considered a form of repression. For example, teenagers may choose motherhood if they have few life resources to complete their schooling and develop their careers (McGuinness et al., 2013; SmithBattle, 2006).

3.3.8 Rationales for use of structuration theory

This section highlights the rationales for the application of structuration theory in the current study. As presented below, these rationales are explanatory concepts, critical social theory to identify sites of domination and pragmatism.

Explanatory concepts

The structuration theory presented above is applied in the current study because of its social explanatory powers in the analysis of research findings in relation to the needs of pregnant teenagers. Social science theory is useful because it provides the explanatory concepts with which to analyse social actors’ practice rationales, intentions and motives underpinning their social actions (Giddens, 1984, p. xix). In the current study, an ethnographic approach was applied as the study’s methodology. It is contended that structuration theory complements the ethnographic approach. Only a brief description of ethnography is provided in this chapter because Chapter 4 details the approach as applied in the current study. Ethnography seeks to present, explain and analyse the culture located within research participants’ experience (P. Willis & Trondman, 2002). Therefore, the application of structuration theory enables an in-depth analysis and explanation of the ethnographic findings in the study. Further, all social research is inherently ethnographic because it emphasises the research’s cultural or anthropological qualities (Giddens, 1984). Likewise, ethnography should be theoretically informed, and the theory should be applied ‘… as a precursor, medium, and outcome of ethnographic
study and writing’ (P. Willis & Trondman, 2002, p. 394). These authors emphasise the need to draw upon appropriate ‘theory’ (not a grand theory) that is useful in the research in order to identify patterns from the descriptive ethnography. The value of theoretically informed ethnography is that it allows the explication and reporting of fine-grained details of day-to-day life and ‘…of how “the meat is cut close to the bone” in ordinary cultural practices…’ (P. Willis & Trondman, 2002, p. 398). Undoubtedly, the application of theory in ethnography adds another layer of analysis to the research data that can be useful in understanding the research phenomenon.

Lastly, in addition to the benefits of explanatory theory in ethnographic research, it is suggested that structuration theory complements the SEDH framework, which was also applied in this study, because structuration theory provides explanatory concepts while the SEDH framework is a broad framework that directs critical analysis at the micro, meso, exo and macro levels. Thus, structuration theory is applicable to understanding how pregnant teenagers, as social agents, affect and are affected by their socio-ecological environments, which are considered the structural properties in their social worlds. Structural constraints on the lives of pregnant teenagers are central notions to this study.

**Critical social theory: Identifying sites of domination**

The use of critical social theory as applied through structuration theory in the current study is essential to understanding the ‘domination–subordination’ phenomenon (Morrow & Brown, 1994, p. 149) in pregnant teenagers’ lives. As noted in Chapter 2, a common thread in the literature reviewed is that many pregnant teenagers come from socially and economically disadvantaged backgrounds. Therefore, a critical social theory perspective is useful to understand locations of power and domination that reflect the nuances in social injustice in relation to pregnant teenagers (social agents) and their socio-ecological environments (social structures). Importantly, the critical theory approach to research will result in practical transformative actions (Giddens, 1984, p. xxv). In the current study, the transformative actions may contribute to improving the understanding of, and antenatal care for, pregnant teenagers in general.
Pragmatism

Finally, it is important to note that the selection of theories in this chapter represents an eclectic mix, which is acceptable if the theories are appropriate for the study’s purpose (Habibis & Walter, 2009, p. 12). Likewise, as noted in structuration theory, eclecticism is acceptable (Giddens, 1984, p. xxii). Thus, given the many benefits of structuration theory and the SEDH framework, pragmatism is appropriate for the current study. Further, the use of structuration theory in this study is a novel approach to the study of pregnant teenagers. Interestingly, the literature review and other readings for the current study revealed that no research has been undertaken in relation to childbearing teenagers and structuration theory. However, in one UK systematic review study, the author applied Giddens’ later works on self-reflexivity and individualism in late modernity (Giddens, 1991, 1992) to examine mothering by socially disadvantaged young women (aged <20 years) (McDermott & Graham, 2005).

3.4 Summary

This chapter described the two theoretical frameworks—the SEDH framework and structuration theory—applied in this study. Other related concepts in structuration theory that were explored included ontological security, risk society, culture and critical theory. The utility of these theories and rationales for their application in this study were also presented.

Chapter 4 presents the research methodology, ethical considerations and research design for the current study. It includes ethical considerations undertaken in the study, as well as the study’s rigor.
Chapter 4: Research Methodology

4.1 Introduction

This chapter presents the research methodology and design applied in this study, which was conducted using a two-phased interpretive qualitative exploratory approach. Fundamental to understanding the research methodology, this chapter begins with a brief discussion of the terms ‘ontology’ and ‘epistemology’. This discussion is followed by a description of ethnography and ‘focused ethnography’ as the research methodology used in this study.

This chapter also presents the ethical considerations and the research design, including details of the four categories of research participants, the sampling process, and data collection and analysis. An overview of the ethnographic writing-up process is also included. Finally, the chapter discusses research rigor as applied in this study.

4.2 An Overview: Ontology and Epistemology in Research

This section presents an overview of the terms ‘ontology’ and ‘epistemology’. These terms are central concepts in general research and underpin all research.

Ontology is concerned with conceptions of existence and reality (Bullock, Stallybrass, & Trombley, 1999). The ontology that underpins most social research is either a subjectivist or positivist conception of social reality. These two dichotomies of objective and subjective positions in relation to social reality reflect the positivist and anti-positivist ontologies that drive the research methodology, methods and outputs. In positivist research, objective and logical analysis, which are cause-and-effect generalisable explanations of the world, are central to the research design (Hammond & Wellington, 2013). Briefly, in positivist research, the researcher is situated outside of the world, and objective approaches are used to generate knowledge of that world. In contrast, anti-positivist or subjectivist research uses an interpretive qualitative approach, whereby the researcher is situated within the world to explicate the meanings and understandings of that world. The essence of qualitative research is to make the ‘world visible’ (Denzin & Lincoln, 2011, p. 3). As noted, researchers are also influenced by their gender and culture (Denzin & Lincoln, 2011). Thus, ontology is a fundamental
driver of all research designs. As suggested, ontology drives the research’s epistemology, methodology and methods (Hammond & Wellington, 2013, p. 115).

Epistemology is another important concept that shapes research. The term refers to conceptions of knowledge, such as the definition of knowledge and the types, sources and limitations of knowledge (Bullock et al., 1999, p. 279). This infers that epistemology relates to knowledge and the acquisition of knowledge. In essence, epistemology is inseparable from its ontology (Hammond & Wellington, 2013). That is, to acquire knowledge of, and understand, the world or the reality (epistemology), there is a fundamental need to understand our conception of existence and reality (ontology). Logically, the epistemology and ontology adopted by the researcher are the underpinnings that drive the development of a research project (Hammond & Wellington, 2013). The ontology and epistemology constitute the paradigm that researchers adopt in their research. For example, the interpretive paradigm is ‘… a view of the world [that] incorporates a set of beliefs about knowledge and how this knowledge is developed’ (brackets in original) (Ryan, Coughlan, & Cronin, 2007, p. 738).

The above account of the philosophical conceptions of ontology and epistemology is brief but necessary because it highlights that all research is underpinned by the researcher’s ontological and epistemological positions. These in turn will influence the researcher’s selection of research methodology and methods.

4.3 Methodology

This section details ethnography and focused ethnography as the research methodology applied in this study. The rationales underpinning the application of the methodology are also included.

The term methodology is defined as ‘… the overall approach to research linked to the paradigm or theoretical framework’ (Mackenzie & Knipe, 2006, para.12). In relation to the current study, the term ‘methodology’ is used in two ways. Firstly, it is applied in a narrow sense to refer to the methods of how the research is conducted. The term ‘method’ refers to the data collection methods and analysis and consists of the ‘nuts and bolts’ of research. Secondly, in the broader usage, methodology includes the
explanatory underpinnings of the research (Bullock et al., 1999). Thus, methodology reflects the ontological underpinnings of how reality is viewed and the epistemology of how knowledge is known (Denzin & Lincoln, 2003a). The methodology used in the current study is focused ethnography that is underpinned by ethnography. The next section outlines ethnography in order to contribute to the understanding of focused ethnography.

4.3.1 Ethnography

This section describes ethnography and the suggested processes in conducting ethnography work (Hammersley & Atkinson, 2007, p. 3). As ethnography informs and shapes focused ethnography, ethnography is presented before a presentation on focused ethnography. Also presented in this section are the contexts and the attention to ‘foreground and background regions’ in ethnography research.

The term ‘ethnos’ refers to ‘culture’, and ethnography is defined by its central focus on the study of culture. Ethnography is a methodology (Hammond & Wellington, 2013) that emphasises individuals’ experience and culture within their day-to-day natural environment, as well as how they feel and think (O'Reilly, 2005). This approach is focused on identifying and describing the social and cultural perspectives of groups of people in society (J. Willis & Anderson, 2010). The emphasis in ethnography is to understand behaviour rather than predict it (Agar, 1980). Importantly, ethnography emphasises the need to learn from people in order to understand them (Spradley, 1979).

In the nineteenth century, ethnography emerged from anthropology, with the term ‘ethnography’ referring to accounts of a far away, non-Western community of culture. Since then, ethnography has been associated with various qualitative social research methods such as fieldwork and case study (Hammersley & Atkinson, 2007). Likewise, it is generally recognised that social studies are partly ethnographic if the researcher is situated in the world and observing the daily routines of its people (Van Maanen, 2002). There is often a blurring of lines between ethnography and qualitative research (Chambers, 2003). This has resulted in a lack of specificity of ethnography research because the application of ethnography and qualitative research is considered one and the same. However, an important distinction between ethnography and other qualitative research is that the essence of ethnography is not its methods, but its ability to describe
accounts of phenomena, including related contextual information, using ‘thick descriptions’ (Geertz, 1973).

In contemporary times, ethnography is considered interpretive qualitative research. Adopting the interpretive stance is to adopt the interpretive epistemological position in the social construction of reality (Denzin & Lincoln, 2003a, p. 30). This suggests that research using ethnography is concerned with the subjectivist position of the conception of social reality. As noted in the study of sociology, the interpretive approach is underpinned by hermeneutic philosophy where ‘… action and meaning are accorded primacy in the explication of human conduct…’ (Giddens, 1984, p. 2). This emphasises that understanding and interpreting human behaviours is intrinsic to all human activities (Bernstein, 1988). Thus, the hermeneutic process in social research is fundamentally interpretive and dialectic. This means that a social agent’s understanding and interpretation are explored dialectically with those of other agents to arrive at a new and higher level of understanding (Guba & Lincoln, 1989, p. 149). For example, in research, the hermeneutic process is applied to gain knowledge through dialogue to compare and contrast between assumptions, theory and data. The dialectical process is an iterative process for ‘making sense of data’ (Fritzsch, 2013, p. 404). This circular process is central to the hermeneutic process (Alvesson & Sköldberg, 2000; Gadamer, 1975), where analysis of the parts contributes to understanding the totality (Gadamer, 1975). Through this process, the individual is understood in relation to his or her environment and outsider views.

When applied to ethnography, interpretive qualitative research focuses on explicating the meanings in social relations to understand the ‘what and how’ of social behaviours (Hammersley & Atkinson, 2007; Hammond & Wellington, 2013). To achieve this, the ethnography researcher takes on the ‘insider perspective’ through immersion in individuals’ social contexts in order to learn the inside knowledge of the group studied (Hammersley & Atkinson, 2007, p. 9). This insider view is acquired through participant observation. However, in ethnography, the social construction of reality can be problematic because the ethnographic accounts can be construed as the researcher’s reconstructions of reality and not valid accounts of the research participants. Nonetheless, the researcher, who is reflexive of his or her effects on the research participants and processes, will ensure that the ethnographic data and findings remain
true to participants’ social accounts (Hammersley & Atkinson, 2007). This reflexivity is akin to the notion of self-reflexive monitoring in social life (Giddens, 1984) and is emphasised as a professional standard applied in the conduct, analysis and writing-up of research (S. G. Brown & Dobrin, 2004). However, reflexivity in research is not used in a critical sense for political ends and emancipation from oppression, but to enhance the practice of giving voice to the research participants (Hammersley & Atkinson, 2007).

The data and information collected in ethnography research are referred to as ‘ethnographic accounts’, which are used to understand and explain the social phenomenon of interest. As suggested, whether the account is true or false or valid or rational is irrelevant because ethnography focuses on discovering, understanding, explaining and accurately representing the observed social phenomenon (Hammersley, 2002). The tacit information (such as practical knowledge) is made explicit in the discursive forms of written and verbal (Emerson & Pollner, 2002). It can be inferred that translation from tacit to explicit discursive knowledge through interviews and observations is an important aspect of the dialectical hermeneutic process that contributes to understanding the parts and the entirety of the social phenomenon. Primarily, the hermeneutic circular approach provides a ‘critical’ perspective in qualitative research that is useful in understanding non-quantifiable characteristics in our social worlds, such as the production and reproduction of structural barriers that give rise to social inequalities (Carspecken, 1996, p. 3).

In ethnography, the researcher seeks to understand the research participants from their ‘emic’ or the participants’ perspectives of reality (Boyle, 1994). However, the ‘etic’ or outsider’s perspective is useful and can contribute to understanding the social phenomena studied. The etic perspective comes from the researcher, research community and includes the theoretical explanatory frameworks on the social phenomenon (Hammond & Wellington, 2013). Both perspectives are essential to understanding the meanings underpinning participants’ behaviours that are explicated through observations and interviews (Boyle, 1994).
4.3.2 Focused ethnography

Focused ethnography is underpinned by ethnography and was the selected research approach applied in this study. A major departure from ethnography was that in this study, participant observation was not undertaken.

Focused ethnography in health care research is a pragmatic approach in research that is constrained by time and resources (Morse, 2007). Therefore, focused ethnography is ethnography using selected ethnography methods and focused on one problem in one specific setting (Higginbottom et al., 2013; Leininger, 1985; J. Willis & Anderson, 2010). For example, in focused ethnography, the researcher does not spend long periods with the respondents and only uses in-depth, semi-structured interviews (Schoenfeld & Juarbe, 2005). Further, the use of focused ethnography is appropriate when studying individual clients’ illness experiences because of the personalised experiences. Given the focus on individualised rather than group experience in focused ethnography, data collection is best conducted via the use of interviews and documents (Morse, 2007, p. 864).

Several key differences between focused ethnography and ethnography are noted. These differences centre on the fact that focused ethnography has a narrow research scope; for example, the focus could be on ‘one problem in one specific setting’. Within this narrow scope, focused ethnography begins with the topics for study, which are predetermined by the researcher (Higginbottom et al., 2013, p. 3). In contrast, in ethnography, the study begins with the exploratory phase, which includes a loosely framed research design and questions (Hammersley & Atkinson, 2007) (see Figure 4-1). Further, in focused ethnography, participant observations may be omitted. However, the researcher may also make short visits to the field (Morse, 2007). This omission is a major departure from ethnography, as applied in this study. In place of participant observations, the researcher may use ‘hypothetical scenarios’ to present sensitive topics (Higginbottom et al., 2013, p. 3). Thus, in contrast to ethnography, the researcher is never fully immersed in the fieldwork.

Fundamentally, the focused ethnography applied in the current study is based on ethnography, and it shares the same ontological and epistemological underpinnings of reality and how knowledge of reality is acquired.
4.3.3 Suggested processes in focused ethnography

In this focused ethnography study, the five key features of ethnographic work (Hammersley & Atkinson, 2007) were applied. As presented in Figure 4-1 and described below, the five key features are identifying the research ‘field’, data sources, data collection, sample size and data analysis.

Similar to ethnography, in focused ethnography in this study, data collection was mainly through interviewing. Unlike ethnography, fieldwork was not conducted in this study. Fieldwork refers to participant observation and involves spending long periods with participants to closely study how they live and the ‘what and why’ of their social actions as informed by their culture. This technique is central to ethnography research (Hammersley & Atkinson, 2007). The tacit information collected was then made explicit in the written, text form (Emerson & Pollner, 2002).

Documents and other relevant objects can also be used to obtain an additional understanding of the research participants (Hammersley & Atkinson, 2007). For example, in the current study, with permission from the teenagers, their hospital digital medical reports (Obstetrix database and digital medical record [DMR]) were also studied.

**Figure 4-1: Ethnographic work based on Hammersley and Atkinson (2007, p. 3)**

- **Ethnographic work**
  - ❶ Research takes place 'in the field'
  - ❷ Data sources - from a range of sources. Mainly - participant observation or informal conversations; interviews
  - ❸ Data collection - 'unstructured'; has no fixed research design; no apriori categories
  - ❹ Sample size - few cases, small scale for in-depth study
  - ❼ Data analysis - interpretation of meanings, functions, and consequences of human actions and institutional practices; and influence on local contexts
**Contexts: Locality and relationships**

The contexts in ethnography is central to understanding the research participants (Lincoln, 2005, p. 33). Social behaviours can only be understood through social contexts because contextual information can contribute to information on the causal relationships of what and why, as well as the circumstances of the behaviours (Boyle, 1994). A focus on the causal relationships of behaviours is appropriate in ethnography (Chambers, 2003). In this study using focused ethnography, the term ‘contexts’ refer to the locality and social relationships within which the teenagers are embedded. Thus, their contexts are the teenagers’ socio-ecological environments.

**Foreground and background regions**

The study of social interactions in ‘horizon’ or virtual space is useful and allows for critical analyses of social interactions. This is undertaken through analysis of the ‘foreground’ and ‘background’ regions of meanings in social actions (Carspecken, 1996, p. 42). The use of the foreground and background is influenced by critical social science epistemology. The foreground is the public or explicit view that social agents present openly via signification—mostly language—during social interactions. In contrast, the background may be hidden from the public and represents the ‘idea in the foreground’ (Carspecken, 1996, p. 103), or the private view (Giddens, 1984, p. 127). The notion of foreground or ‘front region’ reflects the regionalisation of social spaces within which routine social practices occur (Giddens, 1984, p. 119). Both the foreground and background contribute to shared meanings in social interactions (Carspecken, 1996). Fundamentally, regionalisation facilitates social interactions and sustains social agents’ ontological security (Giddens, 1984, p. 124).

In focused ethnography, analysis that focuses on the foreground and background will contribute to explicating the hidden meanings and patterns underpinning social actions. The analysis of the foreground and background may be useful; for example, midwives may present their foreground as professional and non-biased in providing care to pregnant teenagers. However, any negative attitudes towards pregnant teenagers that lay in the background are hidden from public view and are not shared in order to avoid being unprofessional.
4.3.4 Rationales for focused ethnography

A fundamental rationale for using qualitative focused ethnography research is because the approach is appropriate for the research questions and for achieving the research aims (Richards & Morse, 2013). In general, the researcher’s choice of qualitative research is driven by his or her conception of reality and how knowledge of this reality can be acquired. Therefore, the ontology and epistemology subscribed to by the researcher are the primary reasons for selecting qualitative research. In this study, the researcher, as a registered midwife since 1980, adopted the subjectivist position that understanding childbearing women’s social reality was central to understanding and providing appropriate care for them. This interpretive qualitative stance is one of many ontological and epistemological perspectives in research.

The application of the hermeneutic process that underpins interpretive qualitative methodology contributes to the usefulness of focused ethnography in this study. Undoubtedly, a primary reason for selecting focused ethnography is its central function in explicating and understanding the human experience and culture underpinning social actions. Thus, as applied in the current study, focused ethnography was useful in providing ethnographic accounts to assist in understanding pregnant teenagers.

In addition, (presented in Chapter 9), the use of focused ethnography in the current study complements the use of the SEDH framework and structuration theory. As noted, in ethnography research such as focused ethnography, data analysis focuses on the micro and macro levels of human experience (Chambers, 2003). These levels broadly correspond to the four ‘nested’ levels of health determinants within the SEDH framework (see Chapter 3). This suggests that data analysis in focused ethnography and the use of the SEDH framework are complementary. There is also complementarity between focused ethnography and structuration theory (Giddens, 1984) that was applied in the writing up phase of this study. For example, both focused ethnography and structuration theory are underpinned by the hermeneutic philosophy that facilitates an interpretive approach to data analysis. Given this complementarity, the study’s findings can be subjected to further analysis using structuration theory as an explanatory theory to develop a deeper understanding of the focused ethnographic findings arising from the study. This application is evident in the discussions in Chapter 9.
4.4 Ethical Considerations

This section describes the key ethical principles applied in this study, including informed consent, confidentiality and anonymity. Data storage and record retention are also described because they contribute to the protection of research participants.

An ethics application was submitted to two Human Research Ethics Committees (HRECs): the Tasmania Health and Medical HREC at the University of Tasmania and the RMIT University, Victoria. As this study was conducted in Tasmania, ethics approval (HREC reference H12342) (see Appendix 4-1) was provided by the Tasmania Health and Medical HREC at the University of Tasmania and seconded by the RMIT University.

4.4.1 Informed consent

Written information (see Appendix 4-2) on the study was provided to all participants who met the selection criteria. All participants who agreed to participate and who had understood the information provided were requested to sign the informed consent form (see Appendix 4-3). Importantly, the participants were advised that participation was voluntary and that they could withdraw consent at any stage during the study. They were also advised that they would be interviewed in a 30–45 minute session.

All pregnant teenagers were requested to provide informed consent for two interviews: antenatal and post birth. This included informed consent for the use of their paper and digitalised medical records (Obstetrix and DMRs).

Teenagers who were younger than 18 years were considered ‘children’ or ‘minors’ (Tasmanian Government, 1997), and informed consent was required of both the teenager and a parent or guardian. The parent or guardian had to attend the interview. However, as approved by the University of Tasmania HREC, the teenagers could be interviewed on their own without their parent or guardian, if they were living independently prior to the pregnancy and showed an understanding of the research information. A few teenagers who were not ‘minors’ were accompanied by their parents at their own requests. However, several teenagers who were ‘minors’ declined to have a parent or guardian at the interview.
4.4.2 Confidentiality

In this study, confidentiality of information in the ethnographic report was protected by the use of pseudonyms. Prior to obtaining informed consent, all teenagers were advised that the researcher was a midwife in Tasmania and had a mandatory obligation to report child abuse (Tasmanian Government, 1997). Thus, the teenagers recruited for this study were aware that confidentiality of information could not be maintained in situations of suspected child abuse, such as physical abuse or neglect of the baby (Tasmanian Government, 1997, point 4.1). Fortunately, this did not deter the teenagers from joining as research participants.

4.4.3 Anonymity

Anonymity is important to maintain confidentiality. In the quotations used in the reports, pseudonyms were used in place of the participants’ real names. De-identified data without the participants’ real names were shared with the researcher’s primary and secondary supervisors. In addition, in the data collected from the small group of midwives and nurses, information that would easily identify the participants was not used. For example, certain manners of speech and religious undertones in data collected were not reported. These omissions should not affect quality of the research findings.

4.4.4 Data storage and record retention

 Stored data must contain ‘sufficient materials and data’ related to the research and must be accessible (National Health and Medical Research Council, 2007) so they can be used as evidence of the research results, if challenged. In this research, the research data retained were digital audio recordings of interviews, interview transcripts, field notes, demographic details of participants and participants’ pseudonyms. During the research, all data (including electronic), audio-tapes and transcripts were kept in a locked cupboard in the researcher’s office. Importantly, secure data storage protects the confidentiality and anonymity of research participants. Upon completion of this research, consent forms and primary research data (audio recordings and transcripts) will be stored at the RMIT University and kept for five years (RMIT University, 2014). Disposal of these data by RMIT University will be undertaken in line with the state of Victoria’s policy on the disposal of public records (Public Record Office Victoria, 2012).
4.5 Research Design

This section presents the research aims, objectives and questions of the current study. It also outlines the research phases, sampling approach, data collection methods and development of the interview guides. These processes were guided by the SEDH framework presented in Chapter 3. The data transcription and data analysis undertaken are also reported.

The researcher who conducted this study was a midwife at a government-funded public hospital (also referred to as ‘the local hospital’) where this study was undertaken. This hospital was located in a region in Tasmania, Australia. Chapter 1 details the study sites programs where the research participants were recruited.

4.5.1 Research aims and objectives

This research study aims to examine the socio-ecological contexts in pregnant teenagers’ (aged 15–19 years) lives and the influence of these contexts on antenatal care needs in a region in Tasmania, Australia.

The following research objectives were adopted:

1. To identify the health knowledge, beliefs and behaviours of pregnant teenagers and the influence of these on their antenatal care.

2. To identify the family and community factors and their influence on childbearing teenagers’ needs in relation to antenatal care.

3. To identify the physical and social environmental factors and their influence on childbearing teenagers’ needs in relation to antenatal care.

4.5.2 Research questions

To achieve the research aims and objectives, the following key research questions were developed guided by the SEDH framework:

1. What are the pregnant teenagers’ health knowledge, beliefs and behaviours, and what are the influences on antenatal care?
2. How do family, neighbourhood, transport and housing factors influence pregnant teenagers’ antenatal care needs?

3. How does social support influence pregnant teenagers’ antenatal care needs?

4. What are the midwives’ and nurses’ views of pregnant teenagers and their antenatal care needs?

4.5.3 Research phases

This study was conducted in two phases (I and II). Phase I was undertaken as phases I (a) and I (b), which were applied sequentially. Data were collected from pregnant teenagers in phase I (a) and teenage mothers in phase I (b). The same teenagers who participated in phase I (a) were invited for a re-interview in phase I (b) following the birth. Information from phase I (a) supported further gathering of information in phase I (b).

Following completion of the interviews with approximately 50 per cent of the sample group of pregnant teenagers in phase I (a), phase II commenced with the sampling and interviews with midwives. This phase was designed to gather information to provide different views on the pregnant teenagers’ antenatal care needs, and to cross-check or confirm some of the key findings from phases I (a) and I (b). The triangulation of data is described in Section 4.5.7.

4.5.4 Development of semi-structured interview guides

This section describes the development of the semi-structured interview guides used for this study. It includes a discussion of the guides’ content validity and the pilot testing conducted.

The first semi-structured interview guide was developed for the interviews with the pregnant teenagers in phase I (a). Most of the questions in the guide were retrospective questions, with some prospective questions on the teenagers’ future plans. The researcher developed all of the interview guides for this study because suitable guides based on the SEDH framework were not identified in the reviewed literature or elsewhere. An open-ended structure (Hammersley & Atkinson, 2007) was applied to all of the guides because it allows the spontaneous sharing of information from
participants. Further, in qualitative interviews, an open-ended structure allows the researcher to add to the questions during the interview as required (Fontana & Frey, 2003).

The SEDH framework was used as the structure for all interview guides for this study (see Appendix 4-4). The literature provided useful guidance in relation to the types of questions to collect under the SEDH framework. With the structure in place, broad questions were developed based on the research aims and objectives and the literature review. Specifically, in the SEDH framework, broad questions relating to the micro, exo and meso levels were developed in the guide. For example, in the exo and meso levels of the SEDH, it was important to identify information relating to the teenagers’ early childhood, such as family stability (parental separation, poverty and family violence) (Corcoran et al., 2000; Jaffee, 2002; Quinlivan et al., 2004; D. M. Smith & Elander, 2006; Woodward et al., 2001). Questions relating to the macro or political level were not included in the interview guides because the macro level is best investigated through different approaches and with different research participants—for example, staff working in policy development in the government’s population health department. In brief, the guide was developed to collect key information, including the teenagers’ key socio-demographic data; residential address for estimates of the socio-economic index (Australian Bureau of Statistics, 2013e); family structure and childhood experiences; school achievements; mental health; substance abuse; neighbourhood; and social support from family, partner and friends. Antenatal care information was also collected, including antenatal self-care, knowledge and behaviours; antenatal care attendance; and childbirth education attendance. Information collected from the interviews with the childbearing teenagers was mainly retrospective, reflecting the teenagers’ experiences growing up and leading up to the pregnancy, as well as their maternity care experience.

The development of the interview guide for the phase I (b) interviews with the teenage mothers was based on the interview guide for the pregnant teenagers. For example, the teenage mothers were asked to reflect on their antenatal care experience in order to identify additional information or support that might have been useful to them during pregnancy. In addition, they were asked to reflect on their hospital care; and how they managed their parenting and the support required following discharge from hospital.
Likewise, the interview guide for the midwives and nurses was based on the guide for the interviews with the pregnant teenagers. Retrospective data were collected from the midwives and nurses regarding their views of the teenagers under their care. In addition, the guide for the interviews with the midwives and nurses included questions on service delivery and related issues that could affect the teenagers’ care needs.

**Content validity of semi-structured interview guides**

Validity refers to ‘…soundness of the arguments…’ (Carspecken, 1996, p. 55) or quality of the interview guides. This process was necessary to ensure that the questions in the guide were appropriate to generate the required content for the research (Polit & Hungler, 1997). Importantly, the interview guides need to provide relevant and quality data to meet the research objectives and aims. In this study, once the guides were completed, they were checked by subject experts for content validity (see Table 4-4). For each guide, the researcher asked each of the subject experts to consider a key question: ‘Will the interview guide collect the information required for this study?’

Feedback from the subject experts was received via a variety of methods, including face-to-face meetings, emails and phone conversations. The most extensive revision required was on the interview guide for pregnant teenagers. A youth health worker considered the language used in the first draft of the guide inappropriate and too difficult for the teenagers. At the end of this process, revisions were made to the interview guides.

**Table 4-1: Expert panel members who provided feedback on the content validity of the interview guides**

<table>
<thead>
<tr>
<th>No.</th>
<th>Interview Guides</th>
<th>Expert Panel Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pregnant teenagers</td>
<td>1 youth health worker from a local, community-based, youth service organisation in Tasmania</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 social worker, YMC from the local hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 midwife, YMC from the local hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 nurse in the c u @ home visiting program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 PhD supervisors, RMIT University, Bundoora, Victoria,</td>
</tr>
</tbody>
</table>
Australia (1 midwife and 1 medical anthropologist)

2 Teenage mothers

As above

3 Midwives

1 clinical nurse practitioner for antenatal clinics at the local hospital

2 PhD supervisors, RMIT University, Bundoora, Victoria, Australia

4 Nurses

Maternal and Child Health (MCH) Nurse & Lecturer, RMIT University, Bundoora, Victoria, Australia

2 PhD supervisors, RMIT University, Bundoora, Victoria, Australia

Pilot of semi-structured interview guides

The pilot enabled pre-testing and improvement of the interview guides and the interview process prior to full-study implementation (Bryman, 2012). In phase 1 (a), the pilot was conducted with two pregnant teenagers. During the pilot, the researcher looked for aspects in the guide such as clear wording, bias-free and that the interview collected information appropriate for the research (Polit & Hungler, 1997), including structure and flow. Importantly, the teenagers’ understanding of the interview questions was noted, as they may have had low literacy skills if they had not completed schooling. Following the pilot, the interview guides for the teenagers were revised to ensure user-friendliness for the teenagers. The pilot interviews with pregnant teenagers were not included in this study.

The semi-structured interview guides for the teenage mothers and midwives were piloted with one participant from each group. No revisions were required for either of the interview guides piloted. In light of the small numbers of participants in each group, the pilot interviews were included in this study.

Only one focus group interview was conducted with the nurses from the c u @ home program. The implementation of only one focus group interview is appropriate if the interview is conducted successfully (Krueger, 1998). A pilot test for the focus group
interview was not conducted because there was an insufficient number of nurses in the program to conduct more than one focus group.

4.5.5 Sampling approach

This section describes the sampling approaches applied in phases I and II of this study.

Convenience sampling was applied to all four categories of research participants in this study because it is an appropriate method for qualitative research. In this method, sampling of research participants occurs because the participants happen to be around at the time of the recruitment (Saumure & Given, 2008). Further, the participants were sampled because they were willing to volunteer as participants (Teddlie & Yu, 2007). Inclusion and exclusion selection criteria were applied in the recruitment of participants.

Sample sizes for the majority of participants in this study were determined by data saturation (Mason, 2010; Teddlie & Yu, 2007). This implies that recruitment and interviews were stopped when no new data were not found in the data analysis and the emergent data occurred repeatedly in the last several interviews (Teddlie & Yu, 2007, p. 87).

**Sampling in phase I (a): Pregnant teenagers**

Using the selection criteria shown in Table 4-1, the teenagers were identified from the YMC’s electronic clinic appointments database.

**Table 4-2: Selection criteria for sampling pregnant teenagers and teenage mothers**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teenagers aged 15 to 19 years</td>
<td>Ward of the State/State ward</td>
</tr>
<tr>
<td>English-speaking</td>
<td>Unborn child under Child Protection Alert</td>
</tr>
<tr>
<td>Expecting first baby</td>
<td>Known physical and mental disabilities</td>
</tr>
<tr>
<td>Pregnancy gestation between 30 and 40</td>
<td>Known long-term drug abuse</td>
</tr>
<tr>
<td>weeks</td>
<td></td>
</tr>
</tbody>
</table>

The list was then cross-checked with a YMC midwife to discuss the suitability of the identified teenagers for recruitment to the study. The cross-checking was essential
because the antenatal clinic database and the teenagers’ digital medical records had no information on whether the teenagers were State wards under Child Protection or met one of the exclusion criteria. Further, the YMC midwives were able to identify teenagers whom they felt were willing to participate in the interviews. To protect the confidentiality of the research participants, the final list of pregnant teenagers recruited for this study was not revealed to the YMC midwives.

Where appropriate, many of the teenagers who were more than 30 weeks pregnant were recruited and interviewed on the same day. Teenagers who were 26 weeks pregnant were invited to participate and were interviewed when they were between 30 and 40 weeks pregnant. Most of the recruitments and interviews of the pregnant teenagers were undertaken between June and October 2012. In 2013, an additional three teenagers were recruited for the study. The total sample recruited and interviewed were two pilot cases and 21 pregnant teenagers.

**Sampling in phase I (b): Teenage mothers**

The pregnant teenagers recruited and interviewed in phase 1 were invited for a repeat interview post birth when their babies were between two and five months of age. Eligible teenage mothers were contacted by mobile phone to determine whether they were available for the second interview. Interviews with pregnant teenagers commenced in November 2012 and were completed in December 2013.

Nine of the 23 teenagers agreed to the second interview. The remaining teenagers either declined to be re-interviewed or could not be contacted because they had changed their mobile phone numbers. This resulted in a 61 per cent attrition rate of teenagers from phase I (a). As a result of the high attrition rate in phase I (b), the teenage mother interviewed in the one pilot case was included in the sample size for teenage mothers. To achieve data saturation, convenience sampling of a further two teenage mothers was undertaken from the YMC antenatal care database using the same selection criteria (see Table 4-1). Antenatal interviews were not conducted with these two teenage mothers because data from the pregnant teenagers in phase I (a) were considered to have reached saturation and further information was considered unnecessary. In addition, the researcher did not want to discourage their participation in the phase I (b) study by
requesting two interviews. The additional sampling resulted in a total sample size of 11 teenage mothers for phase I (b).

**Sampling in phase II: Midwives and nurses**

Upon completion of the interviews with approximately 50 per cent of the pregnant teenagers, the sampling and interviews of midwives occurred between August and October 2012. The convenience sampling resulted in the recruitment of nine available and willing midwives from an estimated total of 15 midwives who worked at the antenatal clinics. The selection criteria applied in the sampling process is shown in Table 4-2.

**Table 4-3: Selection criteria for the sampling of midwives**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives working in the general and pregnant teenagers antenatal clinics at the</td>
<td>Midwives with no recent or current experience in working</td>
</tr>
<tr>
<td>local public hospital</td>
<td>with pregnant teenagers in the antenatal clinic</td>
</tr>
<tr>
<td></td>
<td>Midwives working in the postnatal and labour wards</td>
</tr>
</tbody>
</table>

With the small number in the sample size, one pilot case was included in the sample size, thereby generating a final sample size of nine midwives.

The nurses in the c u @ home visiting program were sampled and recruited for a focus group interview. There were seven nurses in the program and, on the day of the interview, six nurses were available as research participants. The only selection criterion applied was that the nurses were working in the c u @ home visiting program at the time of this research. A pilot focus group was not possible given the small number of nurses in the program. As a follow-up to the focus group interview, three nurses participated in face-to-face semi-structured interviews.
4.5.6 Data collection methods

This section describes the two data collection methods applied in this study: semi-structured interviews and a focus group interview. An overview of the data collection process is also presented.

**Semi-structured interviews and focus group**

Individual, semi-structured, face-to-face interviews were the key data collection method used with the childbearing teenagers (pregnant teenagers, teenage mothers) and midwives. Data collection with the nurses was conducted through a focus group interview, as requested by the Director of Nursing for the CHAPS.

Interviewing is a key technique in ethnographic research (Spradley, 1979) and was applied in the focused ethnography in this study. One advantage of interviews was that they enabled the study of social interactions, behaviours and beliefs within the participant’s cultural context. In interviews, the researcher is mentally projected into the ethnographic experiences described by the participants (L. J. Bauman & Adair, 1992, p. 13). Further, interviews may be the only method available to collect some types of information that are difficult to obtain through participant observation—for example, in describing events, perspectives and strategies (Hammersley & Atkinson, 2007, p. 102). Thus, the use of interviews is relevant in this study of childbearing teenagers to identify information about their childhood and perspectives on their health.

The focus group interview is a common data collection method in interpretive research to obtain in-depth accounts in order to understand life experiences (Kamberelis & Dimitriadis, 2011), and it is sometimes used in ethnographic research (Hammersley & Atkinson, 2007, p. 112). This method is suited to understanding the group’s collective language, the range of values and meanings, and the reactions within the group to particular issues being researched. Further, in the focus group interview, participants’ responses may trigger more related responses from other participants (Fontana & Frey, 2003; Hammersley & Atkinson, 2007). Thus, as noted in this study, a focus group interview can facilitate the disclosure of more in-depth information than in individual interviews (Lambert & Loiselle, 2007). Nonetheless, this researcher was mindful that a potential disadvantage of the focus group is that the participants may feel inhibited to share their views if they do not feel part of the dominant culture within the group.
(Fontana & Frey, 2003). Also, in this study, the focus group interview was disadvantaged by time constraints as the researcher was provided with one hour for the group interview with six nurses.

The focus group interview was followed up with two semi-structured, face-to-face interviews with three nurses, individually. This second interview allowed the researcher to cross-check data from the focus group interview and obtain further information to fill in the gaps noted from the first interview.

**Data collection process**

Data collection occurred sequentially for phases I (a) and I (b), and was partly sequential between phases I and II. A sequential flow in data collection was important in this study because information collected on the pregnant teenagers was used to inform the data collection from other research participants (teenage mothers, midwives and nurses).

Using an interview guide (Appendix 4.4), the researcher conducted all of the interviews for this study. All interviews opened with a brief reminder to the participants about the research, and their voluntary participation and understanding of the information on the research was checked. An informal talk was used to commence all interviews in order to establish some rapport in the short time available. In the interviews with the teenagers, the researcher was mindful to repeat questions in different ways to foster understanding, avoid using medical terms and avoid probing too deep too early in the interview. Audio recordings were made of each interview with the participants’ consent. Each individual interview lasted between 30 and 45 minutes. The nurses’ focus group lasted up to one hour. At the close of all interviews, the participants were thanked for their time and contribution to the study.

The locations for the interviews varied depending on the category of participants. All pregnant teenagers were interviewed in a single room out of view of other teenagers at the YMC. Based on the teenagers’ requests, the teenage mothers were interviewed either at their home or at a local café close to their home. Only one pregnant teenager who was a ‘minor’ brought her mother to the interview. In the postnatal interviews, one teenage mother was accompanied by her mother and partner. Two teenager mothers were accompanied by their partners, as requested by the teenagers.
All midwives and nurses were interviewed at their respective workplaces.

In addition, as mentioned earlier, other sources of data were used in this study. These were the teenagers’ DMRs (Obstetrix database and DMRs). The Obstetrix is a digital record that contains information on all care provided during pregnancy, labour, birth, postnatal and midwifery home visits. A DMR is a comprehensive and integrated record of each teenager’s current and past encounters at the hospital. It contains records of all admissions, treatments, tests and letters of communication to the local hospital, including the maternity care provided. These documents were used to confirm or identify differences and similarities in some aspects of the interview findings (Higginbottom et al., 2013)—for example, the teenagers’ antenatal care, number of clinic attendances, number of childbirth education sessions, social issues and support provided or required to address these issues.

The researcher also maintained brief reflexive notes of important aspects of the interviews and related research issues (Johnstone, Shahwan-Akl, Holroyd, & Kanitsaki, 2009). These notes provide contextual information to support the data analysis (Higginbottom et al., 2013).

4.5.7 Data analysis

This section presents the data analysis approaches applied in this study. The approaches were thematic data analysis and data triangulation.

Thematic data analysis

All interviews conducted were audio-taped and transcribed verbatim. Transcription was undertaken by a secure online Australian-owned company accessed via the researcher’s laptop using a login and password. The researcher checked all transcripts against the recordings for accuracy.

The thematic data analysis was applied to each data set collected from the interviews with four different categories of participants. This analysis is a systematic process of an iterative and cyclical nature (Higginbottom et al., 2013). Further, the findings were reported in four separate chapters in this thesis. This was methodologically appropriate to maintain group homogeneity in the analysis (Huberman & Miles, 2002).
Fundamentally, in interpretive qualitative research, data analysis is underpinned by hermeneutic philosophy, which emphasises deeper analysis of human behaviours (Bernstein, 1988, p. 113) through interpreting the action and meaning of behaviours (Giddens, 1984, p. 2). However, in ethnographic research, there is no particular ‘recipe’ for the analysis process (Hammersley & Atkinson, 2007, p. 158). Importantly, researchers must be aware of the effect of their presence on the participants and their influence on the data (Hammersley & Atkinson, 2007). In this study, the researcher, as a midwife on postnatal ward at the hospital where the teenagers were recruited, was careful to minimise her influence on the pregnant teenagers. The potential influence was mitigated by informing each pregnant teenager that if the researcher was assigned to provide care for the teenager that she could request care from another midwife. In addition, in the thematic analysis, divergent themes were studied as they provide sharp contrasts to the dominant themes that emerge from the thematic analysis. The understanding of divergent themes was necessary to provide relevant information on social actors’ responses to these unexpected outcomes and contribute to understanding the boundaries of social actors’ lives (Hammersley & Atkinson, 2007, p. 169).

The above considerations were embedded in the three major phases of thematic data analysis undertaken in this study. These phases were: identifying patterns in the data, classifying or encoding the patterns, and interpreting the patterns. Thematic analysis is the main method in qualitative data analysis, and it is rigorous and flexible (Braun & Clarke, 2006).

In thematic analysis, the first reading of the transcribed data was focused on checking the transcript against the audio-tape and then re-reading it to identify general topics (Ayres, 2007). Through the process of reading and re-reading, patterns in the data were identified (Boyatzis, 1998; Braun & Clarke, 2006). Further, another layer of analysis was applied—that is, for each statement in the interviews, analysis of the foreground and background (Carspecken, 1996) was undertaken. The foreground of ‘what is said’ and the background of ‘what is not said’ of the research participants’ meanings in the interviews are essential in the critical analysis of the data.

Fundamentally, in this study, as the emphasis in ethnographic approach was the study of culture, the thematic analysis focused on identifying the childbearing teenagers’ patterns
of beliefs and behaviours that reflected the unique culture of the group (Holloway & Wheeler, 2010, p. 154). These patterns may reflect the teenagers’ antenatal care needs.

Immersion in data through multiple readings is important in qualitative analysis (Braun & Clarke, 2006; Huberman & Miles, 2002; Ritchie & Spencer, 2002) because it enables the researcher to develop a sense of the broad findings within and across the participants interviewed. In this study, the data were re-read a third time (Ayres, 2007). This approach to thematic analysis and coding is an inductive data-reduction process (Boyatzis, 1998; Braun & Clarke, 2006; Patton, 2002). This inductive process facilitates the identification of codes and themes in the data without reference to the theoretical framework underpinning the research (Braun & Clarke, 2006; Patton, 2002). Importantly, in this process, the researcher searches the data for promising or ‘emergent patterns’ (Patton, 2002, p. 468) within and across all interviews.

Themes are patterns identified in the raw data that have the characteristic of organising or describing the patterns. In this study, a matrix was developed to facilitate the analysis and interpretation of the themes (Ayres, 2007; Patton, 2002) using Microsoft Excel. Further refinement of the themes produced themes and subthemes that captured and described parts of the phenomenon (Boyatzis, 1998). The meanings reflected by the themes should be coherent and, at the same time, have clear differences that separate them (Braun & Clarke, 2006). Data from the main themes that were inconsistent were retained for further analysis (Braun & Clarke, 2006; Patton, 2002, p. 466; Silverman, 2005). At the end of this process, each theme was described in relation to the breadth and depth of its content. In using thematic data analysis, the researcher was mindful that this process could only provide descriptions of the data, and that it was limited in relation to interpreting the themes without using a theoretical framework (Braun & Clarke, 2006).

Data triangulation

Triangulation refers to the use of data from multiple sources (Denzin & Lincoln, 2003b; Hammersley, 2002), as applied in this study. This approach addresses the research question(s) from multiple angles using several data sets to reveal a new understanding of the phenomenon of interest (Richards & Morse, 2013). Triangulation is a necessary process in focused ethnography. It aims to increase the accuracy of the data in the
ethnographic accounts (Carspecken, 1996). In this study, the triangulation focused on identifying the convergence and divergence of findings from each research participant (Smart, 1998). Convergence refers to the consensus of findings, while divergence suggests disagreement in relation to findings between the participant groups (Smart, 1998, p. 120). Divergences in findings are welcomed because they provide a more in-depth understanding of the phenomenon of interest (A. Jones & Bugge, 2006). In this study, these processes of comparisons continued within and between the research participants’ interviews, as well as between the four groups of research participants. This process can provide a comprehensive picture of the social phenomenon being studied (Denzin & Lincoln, 2003b; Hammersley, 2002). For example, in this study, the initial findings from the interviews with the pregnant teenagers were triangulated with the findings from the teenage mothers, midwives and nurses to generate a comprehensive understanding of pregnant teenagers and their antenatal care needs.

Specific to this study, to generate the teenagers’ antenatal care needs, the researcher applied two additional analysis processes that were not noted in ethnography research texts. First, the key findings generated from the triangulation process were further analysed using two theoretical frameworks (SEDH and structuration theory). The novel application of structuration theory (Giddens, 1984) contributed to a deeper understanding of pregnant teenagers’ antenatal care needs. Second, a final step in the analysis to identify the teenagers’ antenatal care needs was the identification of the discrepancies between the teenagers’ felt needs and the the midwives and nurses’ prescribed or ‘normative’ needs. This needs approach was useful in identifying antenatal care needs (Carver, Ward & Talbot, 2002). In using this approach, the researcher needs to a midwife, as was the case in this study.

Although this study applied two key different data collection methods (individual in-depth interviews and one focus group discussion), data triangulation from these data sources was appropriate because all interviews were conducted within the focused ethnography research and the same epistemological underpinnings (Lambert & Loiselle, 2007). This included data from digitalised medical records and the researcher’s field notes. By developing a comprehensive understanding of the phenomenon of interest, triangulation can enhance the confidence, credibility and trustworthiness of the research.
findings (A. Jones & Bugge, 2006; Lambert & Loiselle, 2007). These concepts relate to research’s rigor and are described in Section 4.7 below.

4.6 Writing the Report

This section provides an overview of the use of writing in this study. Writing is the final phase in thematic analysis, whereby analysis continues in the writing process (Braun & Clarke, 2006). In ethnography, writing ‘…is a key part of the entire research process’ (Hammersley & Atkinson, 2007, p. 191). In this phase, the researcher moves from describing to interpreting and engaging with the reviewed literature (Braun & Clarke, 2006). The data analysis is extended and new ideas may emerge. Data extracts are included as quotations in the report to support the descriptions provided.

The researcher deliberately does not write in the first person, thereby making his or her voice absent. This is one approach to reporting ethnographic accounts, whereby the researcher adopts a subordinate role to that of the research participants (Hammersley, 2002). Writing in the third person enables the researcher to take a detached approach to reporting, suggesting that the ethnographic account is authentic in presenting reality (Konecki, 2008). Further, writing to represent and give voice to the research participants does not have to include lengthy interview quotations (Boyle, 1994). Likewise, it is recommended that the report contains thick descriptions that provides ‘clear levels of meaning’ and does not refer to long, descriptive texts (Lincoln & Guba, 2002, p. 211). It is important to use ‘thick descriptions’ because they provide the contextualisation for the ethnography (Denzin, 2002). This will facilitate applicability (or transferability)—that is, the ability to draw from the report and apply in another, similar, situation (Lincoln & Guba, 2002). The notion of thick description is often misunderstood. Conceptually, writing ‘thick descriptions’ involves ‘thinking and reflecting’, and it is a layered approach to data collection and analysis (Geertz, 1973, p. 10). Fundamentally, this does not refer to writing ethnography using copious quotations.

4.7 Rigor of the Research Process

This section presents the concepts of rigor as applied in this study. These concepts were confirmability, credibility, transferability, dependability and reflexivity.
The term ‘rigor’ refers to the quality of the processes engaged in the research. Rigorous research is synonymous with trustworthiness (Higginbottom et al., 2013). In this study, four criteria of trustworthiness or rigor were applied: ‘confirmable, credible, transferable and dependable’ (Hammond & Wellington, 2013, p. 147). In addition, reflexivity was also applied to increase the rigor of the research (Saumure & Given, 2008).

4.7.1 Confirmability

Confirmability of ethnographic findings refers to whether the findings can be confirmed as valid and whether they are in line with the descriptions and meanings intended by the participants (Sandelowski, 2010). Confirmability of findings is assessed by member-checking or participant validation (Hammond & Wellington, 2013; Sandelowski, 2010) and respondent validation (Hammersley & Atkinson, 2007). Both member-checking and participant/respondent validations involve checking the description and interpretation of the accounts with the research participants. In this study, confirmability of interviews was undertaken with nine teenagers who were interviewed during pregnancy and post birth. Some of the major themes that emerged during the first interview were cross-checked with the teenagers in the follow-up post birth interviews. Member-checking during the post birth interviews contributed to strengthening the rigor of the study.

Further, member-checking was conducted with the nurse participants in this study. Following the focus group, semi-structured interviews were conducted with three nurses who were participants in the focus group. This provided opportunities for member-checking of the nurses’ focus group interview.

In addition, a pragmatic approach to member-checking was undertaken, whereby the member-checking process was integrated with the data collection process. For example, during the interviews in this study, the participants were asked to clarify and/or expand on the information provided, and to consider the accuracy of the summary at the end of the interview. This was undertaken with a few participants from each category of participants in the study (Sandelowski, 2010).

Although member-checking can increase the rigor of this study, the process can be problematic. For example, given the diversity of backgrounds of the researcher and the participants, the researcher’s ethnographic accounts may be different from the
participants’ accounts. This dilemma is referred to as the ‘crisis of representation’ (Sandelowski, 2010). Member-checking may not be successfully conducted because of the different ontological, epistemological and ethical positions that individuals take in their social worlds (Sandelowski, 2010). However, the respondents’ ‘multiple realities’ are acceptable as long as they do not contradict each other (Hammersley & Atkinson, 2007, p. 74). Notwithstanding, the validation process can be a disadvantage if respondents have other motives, such as wanting to discredit the researcher’s accounts (Hammersley & Atkinson, 2007).

4.7.2 Credibility

Credibility refers to the fair and accurate representation of data. A credible study is a valid one and one that is confirmable. Ethnographic accounts or findings can be considered credible if there are data to support them. In this study, triangulation was applied to increase the credibility of the findings (Guba & Lincoln, 1989; Jensen, 2010a). As mentioned earlier, triangulation looks for the convergence and divergence of findings to check the credibility of the findings of the research participant groups (Smart, 1998), and for a more in-depth understanding of the research phenomenon (A. Jones & Bugge, 2006). Further, analysis of negative cases or divergent themes contributes to credibility because divergent themes may demonstrate that the cases or themes do not match the dominant patterns, and therefore the dominant patterns must be valid and credible (Jensen, 2010a; Patton, 2002). Similarly, in ethnographic analysis, it is essential to focus on the divergence of ‘failed performances; unexpected outcomes or crises’ (italics in original) (Hammersley & Atkinson, 2007, p. 169).

4.7.3 Transferability

Transferability or generalisability of research refers to the degree to which research findings can be generalised (Hammond & Wellington, 2013). In this study, the applicability or transferability of findings was made possible through collecting thick descriptive data and providing the inclusion and exclusion criteria (Jensen, 2010b; Lincoln & Guba, 1985). This level of detail is necessary to enable judgments to be made in relation to the transferability of findings to other similar participants and contexts (Hammond & Wellington, 2013; Lincoln & Guba, 1985). Further, generalisability can be improved if the participants in the study and the contexts of the study are similar to
the intended use of the study findings. Thus, it is important to provide a complete description of the participants in, and the contexts of, the study.

It is worthwhile noting that there are two types of generalisability in qualitative research: internal and external. Internal generalisability is when the research findings are applicable to the organisation where the research was conducted. A caution is that the variability of ‘when’ and ‘where’ the research was conducted may be different to the sites within the organisation that were not observed. Internal generalisability in qualitative research refers to the use of an account that may be considered an ‘ideal type’ for that setting. The current study is considered to have ‘internal generalisability’ (Maxwell, 2002, p. 54)—that is, the study findings are applicable to the YMC at the local hospital.

4.7.4 Dependability

Dependability refers to the reliability of the research—that is, if the research was replicated with similar participants and research methods, it would generate results consistent with the original research (Lincoln & Guba, 1985). However, the quality of the ethnographic research cannot be entirely reflected by the notion of reliability because of the influence of temporal changes in the ethnographic research field (Konecki, 2008). To check the dependability of the research findings, the data coding could be undertaken by another coder to check whether similar themes emerged between the two coders (Jensen, 2010a). Further, dependability can be established by analysing the audit trail for the research to demonstrate rigor (Hammond & Wellington, 2013; Lincoln & Guba, 1985; Patton, 2002). An audit trail is the detailed documentation of the research processes, including sampling, data collection, data analysis and theoretical frameworks applied in the research (Hammond & Wellington, 2013; Lincoln & Guba, 1985). In this study, dependability was ensured by establishing an audit trail document that was regularly checked and updated by the researcher. The document contained the following information: categories of data sources, file types (e.g., field notes, electronic files) and evidence relating to the data sources (e.g., completed surveys, audio-tapes, photographs) (Lincoln & Guba, 1985).
4.7.5 Reflexivity

In general terms, reflexivity refers to the self-conscious and continuing self-monitoring of the flow of daily routines in life (Giddens, 1984). Reflexivity is common to many qualitative methods. This process provides ‘transparency’ in representing the research findings (Patton, 2015, p. 137). This study applied ‘epistemological reflexivity’, which refers to the monitoring of decisions made in relation to data collection processes and findings. The researcher maintained reflexive notes of the researcher’s assumptions and behaviours that might influence the interviews (Dowling, 2008). The brief reflexive notes maintained consisted of important aspects of the interviews and related research issues (Johnstone et al., 2009). This reflexivity is important in ethnographic research (Hammersley & Atkinson, 2007) and contributed to the rigor of this study. In this study, as the researcher was a midwife at the hospital where the teenagers were recruited, the brief reflexive notes were important. Use of the notes allowed the researcher to question her influence throughout the data management and writing up process.

4.8 Summary

This chapter described the research methodology applied in this study. A brief overview was presented of the concepts of ontology and epistemology as the fundamental concepts that underpin all research designs, methodologies and methods. The ethical considerations were discussed, and triangulation was presented as it was applied in this study. The processes applied to maintain rigor in this study were described using the five processes of confirmability, credibility, transferability, dependability and reflexivity.

Chapter 5 presents the research findings from the interviews with 21 pregnant teenagers. It highlights the teenagers’ socio-demographic details and the major themes and subthemes generated from the interviews.
Chapter 5: ‘I’m Glad That I’m Pregnant’: Results from Pregnant Teenagers’ Interviews

5.1 Introduction

This chapter presents and critiques the findings from the phase I (a) interviews with the pregnant teenagers (aged 15–19 years) against the existing literature where appropriate. The pregnant teenagers were recruited through convenience sampling from the YMC at a local public hospital in a region in Tasmania. A total of 21 teenagers who were between 30 and 40 weeks pregnant were interviewed between June 2012 and July 2013. Thematic data analysis was undertaken on the pregnant teenagers’ interviews, which revealed several major themes and subthemes, as presented below.

5.2 Research Findings

This section begins with the teenagers’ socio-demographic details and is followed by a presentation of the six themes and 18 subthemes (see Table 5-1) that emerged from the thematic analysis. The major themes are: ‘… [childhood] wasn’t many happy times’, ‘… a lot of bad depression’, ‘[pregnancy] It wasn’t planned …’, ‘I want a healthy baby’, ‘A bit of everywhere [sources of health information]’ and ‘[support person] … [Mum] she’s been top of the world’. Subthemes were identified for several theme, and these are also presented in Table 5-1.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>… [childhood] wasn’t many happy times</td>
<td>My parents broke up …</td>
</tr>
<tr>
<td></td>
<td>… didn’t like going to school</td>
</tr>
<tr>
<td>… a lot of bad depression</td>
<td>I have anxiety and I have depression</td>
</tr>
<tr>
<td></td>
<td>… worrying about everything [during pregnancy]</td>
</tr>
<tr>
<td>[pregnancy] It wasn’t planned …</td>
<td>I wasn’t preventing it either</td>
</tr>
<tr>
<td></td>
<td>I was on the pill …</td>
</tr>
<tr>
<td></td>
<td>I knew the options were there [abortion, adoption]</td>
</tr>
<tr>
<td>I want a healthy baby</td>
<td>Not drinking, staying out of trouble</td>
</tr>
<tr>
<td></td>
<td>I stopped smoking four weeks ago…</td>
</tr>
<tr>
<td></td>
<td>I was eating and doing everything right …</td>
</tr>
<tr>
<td></td>
<td>… breastfeeding is the better thing to do …</td>
</tr>
<tr>
<td></td>
<td>… I just want to do it all natural [labour]</td>
</tr>
<tr>
<td>A bit of everywhere</td>
<td></td>
</tr>
<tr>
<td>[sources of information]</td>
<td></td>
</tr>
<tr>
<td>[support person] … [Mum]</td>
<td>she’s been top of the world</td>
</tr>
</tbody>
</table>

This chapter reports the interview findings using the teenagers’ words where appropriate to emphasise their emic perspective. Further, each teenager, mother and partner is referred to by a pseudonym.

5.2.1 Pregnant teenagers’ socio-demographic details

A convenience sample of 18 pregnant teenagers who booked in to use the maternity services at the local hospital between June and December 2012 were recruited for this research. An additional three teenagers were later recruited in July 2013 in order to achieve data saturation. All 21 teenagers interviewed were Anglo Australians, with the
majority born in Tasmania. Two teenagers were Indigenous Australians. The small number of Aboriginals in this study reflects that approximately 4 per cent of Tasmanians are of Aboriginal and/or Torres Strait Islander descent (Department of Health and Human Services, 2013c, p. 23).

The teenagers interviewed were between 30 and 40 weeks pregnant. There was a wide geographic spread in residential addresses, with a total of 16 postcodes across Tasmania. Some of the postcodes were quite a distance from the YMC, which is situated in a central business centre in Tasmania. One participant’s postcode was located in a rural town about 68 kilometres from the YMC. In view of the small number of teenagers in each postcode, the towns associated with the postcodes are not revealed in order to protect the teenagers’ identity.

In line with the research design, the teenagers’ age range was 15–19 years, with a mean age of 18 years. Most had completed Year 10 of their secondary school education (aged 15 to 16 years). One participant had only completed Year 7 (aged 12 or 13 years). Only three of the 21 pregnant teenagers had completed Year 12, which is a low retention rate. In contrast, in 2011, the Year 12 retention rate in Tasmania was 77.1 per cent for female students. When compared to Australia as a whole, Tasmania has the second-lowest retention rate in secondary schooling (Department of Premier and Cabinet, 2014). The majority of the teenagers interviewed had parents who were divorced or separated. It was noted that the oldest teenagers (19 years old) had completed Year 12 schooling, owned a car and had full-time employment. Unemployment in the group was common. It should be noted that Tasmania has had the highest unemployment rate in Australia since 2006 (Department of Health and Human Services, 2013c). Social welfare benefits were the main source of income for the majority of the teenagers interviewed. Most of the 21 teenagers interviewed lived with their parents; six had set up home with a partner. Many did not have a partner, and none of the teenagers were married.

5.2.2 … [childhood] wasn’t many happy times

This theme reflects that childhood was a difficult and unhappy time for many of the teenagers interviewed. Many teenagers were affected by their parents’ divorce or separation, and their lives that were once structured and familiar became unstructured,
complicated and confusing. In the sections below, the two subthemes related to this theme include: ‘My parents broke up …’ and ‘…didn’t like going school’.

My parents broke up …

Parental divorce was common in the group of teenagers interviewed. More than one in two of the teenagers had parents who were separated or divorced when they were between eight and 12 years old. This divorce rate is comparable to the divorce rate in Tasmania of 53.7 per cent in 2012 (Australian Bureau of Statistics, 2012). In 2012, Tasmania’s divorce rate where children were involved was the highest in Australia (Australian Bureau of Statistics, 2012). Divorce was reported to have caused much trauma and disruption to the teenagers’ previously structured lives. For example, Effie, a 17-year-old, became a State ward when she was 15 or 16 years old. She said:

[childhood]...well, there wasn’t many happy times as I recall cos’ of my anger issues. I had a lot of anger issues. I [would] just be angry out of the blue. Just start chucking stuff, swearing and going out of my head. ... we’re not sure what was causing it [anger]. I was diagnosed with epilepsy when I was 10.... I was very out of hand and ended up in assaulting people; going to court a lot of the times. I started hitting the Carers and going to Court quite frequently, I was roughly 16. ... it all happened when I was 10. It was my parents’ divorce and my Pop died. ... my epilepsy got diagnosed; then depression; then I started going off, so...

Effie did not have a good relationship with her mother. She ran away from home and lived on the streets for some time. Eventually, her grandmother took Effie to Child Protection Services and made her a State ward. In Tasmania, Child Protection Services is mandated by law to protect children and young people who are in situations that predispose them to abuse or neglect (Disability Child Youth and Family Services, 2010). Effie sounded angry as she retold the story of how she became a State ward.

Another teenager, Michelle, a 17-year-old Indigenous Australian, had also just transitioned from being a State ward. She revealed her unhappy childhood:

Well, mum never, never really had anything to do with us and Dad was working so there was no one home. So I was put into welfare. I’m the youngest of 16 kids in three families.
Likewise, Jasmine, a 17-year-old, had experienced major disruptions to her life when her parents divorced. She said:

*My parents broke up when I was about 8... That kind of mucked me around because I ended up moving to [town] with my father while my mother moved to [another town] so, it was an hour’s drive [between the towns] ... I grew up on a farm, and ... all my animals were down there.*

For Brooke, parental divorce and her father’s alcohol abuse were problems that plagued her younger teenage years. She was 13 years old when her parents divorced. She lived with her mother for a while but moved to live with her father because she did not like her mother’s partner. At 13 years of age and with an alcoholic father, Brooke became responsible for her sister, who was then eight years old. Brooke said: ... *back then ... I tried not to show it [that she was upset and depressed] or do anything because I had another little sister and I looked after her a fair bit.* Around this time, Brooke became depressed and developed anxiety.

Alexis’s parents were also divorced, and she grew up in a home with her mother and her mother’s alcoholic and abusive partner. Her home was unsafe. Alexis said:

*...my parents split up when I was young... my mum found another partner and he was an alcoholic and quite abusive... I didn’t have so many good memories as a child.*

Similarly, home was unsafe for 17-year-old Erika. During her younger teenage years, Erika experienced sexual harassment and threats from her brother. According to Erika, her brother *tried to get me to like ... do sexual activity with him and all that. ... And that led to [my] depression.* In addition, Erika was threatened with physical abuse from both her brother and her father. According to Erika’s mother, who was at the interview, they also experienced domestic violence at home.

In contrast, the teenagers whose parents were not divorced mostly had a happy childhood. For example, 15-year-old Allison lived with her parents, who were always there for her. Allison liked school ‘sometimes’ but did not elaborate on what she meant. Likewise, 19-year-old Abbie had a happy childhood. She lived with her parents and had a good relationship with both of them. She is able to talk to her mother if she has problems.
... didn’t like going to school

Obtaining an education is a fundamental need for everyone because it opens up opportunities in life (Australian Institute of Health and Welfare, 2013). In Tasmania, schooling is compulsory and a legal requirement for people aged 5–16 years (Year 10). The highest level of school education attainable is Year 12, and students can then enter higher education at university (Department of Education Tasmania, 2012).

As mentioned earlier, few of the teenagers interviewed had completed Year 12. The lowest schooling attainment of the teenagers interviewed was Year 7 (13 years of age), and the highest schooling achieved was Year 12 (18 years of age). However, pregnancy motivated a small number of the teenagers to continue or plan to continue with their schooling. For example, 18-year-old Anna was keen to complete Year 12 and was studying at home during her pregnancy. However, for some of the teenagers interviewed, their schools were unhappy and unsafe places because they were bullied. Many of the teenagers who were bullied ended up leaving school. The bullying consisted of either perceived or actual physical threats. Chloe, an 18-year-old, said: I quit school as I was bullied. I got depression ... I got bashed and all that [at school]. I felt like killing meself. According to Chloe, the depression improved when she stopped going to school.

Another teenager, Zoe, who was also 18 years old, disliked school from an early age. For Zoe, growing up without parental guidance may have contributed to her dislike of school. As she explains:

I never went to school... because when my parents were divorcing, me and mum and my sister ... were living at home, ... And I always... we grew up without a car and I always knew how to tick mum off. Because she’d always sleep in til like 12 or something, ... I always had to get myself ready, so I’d always get up, turn the heater and I’d watch TV all day. And then she’d get up and yell at me for not going to school and then I’d just sit there and ignore her. ... I just didn’t want to go to school. ... I couldn’t make friends and I just hated it. I was just really badly bullied because of my weight, because I was over 100kgs at primary school.

Similar to Chloe, Zoe was also bullied at school. She was overweight in primary school, and she felt that the bullying and her weight may have contributed to her experience of
anxiety. Academically, Zoe did not do well at school, and this may have further convinced her that she disliked school. Within the trajectory of complex factors in Zoe’s childhood that contributed to her dislike of school, she completed Year 11 and was attending school when she fell pregnant.

The interviews revealed that some of the teenagers endured discrimination from their peers and their teachers. One teenager (Erika) left two schools because of bullying:

They [students] were teasing me just because I was a new kid and all that and I couldn’t handle it and I told the teachers about it and the principal. No one would do anything about it so I told them to go and get stuffed and walked out.

Erika only completed school up to Year 9 and has limited literacy capabilities ... because the teachers in primary school didn’t help me. I’ve got to get mum to read it [school work] and put it into words I can understand. Similarly, 18-year-old Hanna left school in Year 7 and felt that her teachers discriminated against her because she was not a good student. She said that the Teachers didn’t really have no time for students like me. Hanna’s parents separated when she was young, and she lived with her father. Leaving school early was a disadvantage to the teenagers. As noted, Hanna, who left school when she was 13 years old, said that her reading and writing skills were not the best.

Other reasons for not completing school were the long distance from home to school and the quality of education at college. For example, Amber chose to work in a traineeship instead of continuing to Years 11 and 12 because she felt that the standard of education at her college was poor, and she received little guidance from her teachers.

5.2.3 … a lot of bad depression

This section presents the interview findings on pregnant teenagers’ mental health with the theme ‘… a lot of bad depression …’ and two subthemes, including ‘I have anxiety and I have depression’ and ‘… worrying about everything [during pregnancy]’.

Depression and anxiety are general symptoms in many typologies of mental health disorders (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Mental health refers to ‘…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life…’ (World Health Organization, 2012,
During pregnancy, women commonly experience mood changes and physical symptoms such as anxiety, tiredness, tense muscles, lack of concentration, irritability, restlessness and sleeping difficulties (Simpson, Glazer, Michalski, Steiner, & Frey, 2014). These symptoms may be transient or prolonged and debilitating. In the interviews with the teenagers, they were asked to describe their moods using phrases from the Edinburgh Postnatal Depression Scale, such as: ‘have you ever felt that you can’t sleep; were anxious/worried; all feels too much (overwhelmed); and cry for no reason?’ (Cox, Holden, & Sagovsky, 1987).

I have anxiety and I have depression

Depression and anxiety were common among the pregnant teenagers interviewed, with approximately one in two experiencing mental health problems that started in their early teenage years. This is a high proportion of teenagers with mental health problems. In contrast, in 2007, 26 per cent of teenagers aged 16–24 years reported experiencing mental health problems such as anxiety, with more females affected than males (Australian Institute of Health and Welfare, 2011, p. 25). Many of the teenagers interviewed had been diagnosed with depression by their GP, and a few had been treated with antidepressants. Commonly, these mental health problems were triggered by stressful life events such as their parents’ divorce or separation, bullying at school and/or abuse in the family. For example, Alexis, an 18-year-old, said that I have anxiety and I have depression … Since I was 13. She felt that these symptoms started around the time that her mother’s partner was physically abusive towards her. At the interview, she said that she still has depression but said: I’m fine now. Her GP did prescribe medications for her depression. Similarly, 18-year-old Hanna, whose parents divorced when she was 13 years old, said:

I’ve gone through a lot of bad depression and umm… I went really off the rails after I had the car accident in 2009. I tried to [suicide] a lot of times, umm… Yeah, and overdosed and stuff like that. Umm, I was on tablets [for the depression] for a while but what helped the most is having friends that supported me through it.

Hanna lived with her father, and her mother had not been in touch with them. Self-harm, as noted in Hanna’s interview, was common among the teenagers who reported depression and anxiety. This was usually done by slashing their wrists.
Having lived with depression and anxiety for more than four years, 18-year-old Zoe talked about the depression as if it was simply a part of life. During pregnancy, Zoe felt that her depression was ‘normal’ and the same as the depression she had before the pregnancy. Zoe had normalised her depression and anxiety, which might have been a way of coping with her mental health problems. Zoe had been taking medication for her depression and sleeping pills for her insomnia since she was 15 years old.

Depression with co-occurring anxiety can be debilitating. For example, 18-year-old Brooke described her feelings:

... I don’t know if it’s normal or not, but I think of weird things, like sometimes ... [I think] what if, you know, the bus crashes or something, I worry about a lot of things. And like, being in [name of Town], it’s, you know... Like the house, I’m just worried that someone’s going to break in because we’ve had our house broken in to before ...

Brooke’s fears of a break-in at her house may have been because the house was located on the outskirts of a town that was often in the media (newspaper and television) for public housing arsons. Similarly, 18-year-old Kelsey’s anxiety developed when she was 11 years old. Her parents divorced when she was young, and she associated her anxiety with her concerns for her mother as a single parent. She said:

I go to a psychologist because I had anxiety, so yeah. [not on medications]. Well my mum thinks it’s been around like since I was little, she thinks I’ve had a little bit of OCD [Obsessive-Compulsive Disorder], just certain patterns I get into. And then I started, I don’t know, I just started getting really like, really nervous about everything and started breaking down and...

Some of Kelsey’s symptoms during an anxiety attack were …like pains, like where I felt like I couldn’t breathe and stuff, and she said [psychologist] that was definitely a part of anxiety and stuff like that so. In contrast, Abbie and Taylor had not been diagnosed with depression during their younger years; however, they had experienced much sadness related to their unplanned pregnancies. For example, 19-year-old Taylor, who was in a physically violent relationship with her fiancé, said that she felt lonely and blamed herself for the breakup.

In many instances, the teenagers’ mental health improved during pregnancy. For these teenagers, pregnancy was viewed as a positive life event that had changed their lives.
For example, 17-year-old Effie was transitioning from being a State ward and lived with her partner in rented accommodation. She had pre-existing depression. At the interview, Effie said: *I’m good now.* Effie and partner were both happy with the pregnancy, although it was unplanned. She said: *Well, [partner] knew I always wanted a child and…[He] always wanted to be a Dad too.* According to Effie, the pregnancy gave her a focus in life. Similarly, 18-year-old Hanna, who developed depression during her younger teenage years, was happy because of the pregnancy. According to Hanna, the pregnancy was unplanned. She said: *I’ve grown up a lot. … I’m not getting into trouble with the police. Definitely wouldn’t give [baby] it away.* This reflects that Hanna considered motherhood a responsible role and that she had to grow up and behave responsibly towards the baby.

According to 18-year-old Zoe, motherhood was a chance to correct the past. Zoe was happy to be pregnant, even though it was unplanned. She felt that it was a ‘blessing in disguise’ and said:

> *It’s a good feeling [being a mother]. Just to be able to give someone else a chance in life and to kind of fix the mistakes I’ve had in the past. So, like not to belittle them or make them get like big like I did [overweight], had to go through school. I want that to be different. So like in disguise this is kind of, for me, it’s just showing that I can actually be a good mum.*

Importantly, for 17-year-old Jasmine and 18-year-old Anna, pregnancy was a motivation for them to organise their lives. For example, Jasmine said that soon after falling pregnant, she and her partner moved into private rented housing instead of being homeless and ‘couch-surfing’ at friends’ homes. She said: *I am a lot happier …starting to get my life on track again.* Likewise, Anna said:

> *Yah, [pregnancy] it pushed me to do something. Because before I found out I was pregnant I wasn’t really doing anything. And, now, I’ve been doing all my school work and I kind of got myself like…on track, which is good.*

Getting her ‘life on track’ suggests that life became more structured and organised as the teenagers prepared for the baby’s arrival. The pregnancy brought structure to Anna’s life and was the driving force underpinning her happiness and readiness to work hard and do well at school.
Worrying is a common feature of day-to-day living, but excessive worrying is viewed as abnormal and is present in several mental health disorders (Fowler & Szabó, 2013). As stated by Brooke, an 18-year-old with depression and anxiety, the depression was not any worse during pregnancy but *worrying about everything* is a common experience for her. Many of the teenagers interviewed were worried because of complex and multiple problems related to their maternal age, housing, and transport concerns. Some teenagers were also worried about the labour and birth; and financial stress.

As noted in the interviews, being young mothers was seen as a disadvantage and a source of stress for some teenagers. Their age subjected the teenagers to domination and control by their families and health professionals. For example, 17-year-old Hailey experienced pressure from her family and her ex-partner’s family to abort the pregnancy. The lack of acceptance of the pregnancy made it difficult for Hailey to come to terms with her own decision to continue the pregnancy. During this time, Hailey reported several physiological symptoms, such as loss of body weight and thinning of her hair. She also developed a lot of anger and depression.

Further, being ‘too young’ meant that many teenagers experienced housing difficulties. For many teenagers, housing was a major worry and source of stress. The two most common living arrangements for the teenagers interviewed were living at home and living independently with partners. Two teenagers were waiting for public housing approval. In general, in Tasmania, housing is available through homes with private ownership or private rental, and social housing. Social housing is managed by the State and refers to the provision of safe and affordable public housing to people with low incomes (Tasmanian Government, 2012). The wait for housing was stressful for the two teenagers because they were about 10 weeks away from their expected birth date. Hanna, an 18-year-old, who had ‘bad’ depression and anxiety, had little family support and was staying with friends. Her biggest worry was getting settled in a house before the baby arrived. Bella, an 18-year-old, was also waiting for public housing approval and was constantly worried about it. She had depression and anxiety in her younger days. Bella and her partner were staying with her mother and were keen to move into their own housing because of the pregnancy. However, the housing application process was not straightforward. She said:
They [Housing Tasmania] won’t put me in a house unless I...go into a shelter, a women’s shelter for two weeks, and still then it could take up to two weeks to a month to house me. And I’m not doing that while I’ve got a newborn baby.

Transport posed a difficulty for many teenagers. For some teenagers, this difficulty was a worry for them and may have added to existing anxiety and depression. For example, many of the teenagers interviewed did not have their own transport because they were either underage and did not qualify for a driver’s license or did not have the resources to maintain a car. Only three of the older teenagers had a car. An equally small number of partners provided transport for the teenagers. The lack of transport may have reduced the teenagers’ opportunities to participate in the childbirth education program. For example, the lack of transport was a key reason why Jasmine was infrequently attending the childbirth education classes. The majority of the teenagers relied on their mothers/parents for transport. Some teenagers also used public buses. Teenagers who lived in rural towns were structurally disadvantaged because they had to travel long distances. For example, Hanna lived in a rural area about one hour’s drive from the antenatal clinic in the city. A return trip on the bus to the YMC from Hanna’s home would take an entire day. However, Hanna proudly reported that she had not missed any clinic appointments. This could be because she was happy with the pregnancy and the notion of becoming a mother. Hanna no longer experienced ‘bad’ depression, and she was looking forward to motherhood.

Another reason why some teenagers worry was because they were concerned about the labour and birth. For example, 18-year-old Anna was ... a bit anxious about how it’ll go... [at birth] because she was needle-phobic and did not want an epidural. The childbirth education did not help Anna resolve her needle phobia. For one teenager, the childbirth education exacerbated her fears of childbirth. In this case, 18-year-old Chloe became scared after watching a Digital Versatile Disc (DVD) ("Oxford English Dictionary," 2002) on labour with the nurse from the c u @ home program. Chloe said: [it was worrying] Yeah, cos’ she was stand[ing] up ... in labour. She didn’t lie down. ... we’re supposed to lie down in labour. She [was] stand[ing] up and doing it. Chloe had preconceived ideas of how women give birth, and she was shocked to learn about the various possible positions during labour. Unfortunately, the antenatal information Chloe received created additional stress for her.
Some teenagers with depression and anxiety had other pregnancy-related fears. For example, Brooke feared her ‘waters breaking’ (i.e., the water around the baby inside the uterus) in an inconvenient place such as the shops. This fear was debilitating and prevented her from going out. A few teenagers who had pre-existing depression and anxiety mentioned their fear of stillbirth. In addition, Kelsey was worried at 32 weeks of her pregnancy because the baby (foetus) was not growing in line with its age of the pregnancy. She said:

[at 32 weeks] Yeah. I can’t wait for her to be out though. No I’m not sick of it ‘cause I have, I had a few little problems like I’ve been bleeding a little bit. Yeah, but I’ve been, like been to [outpatient maternity clinic - OMC] and they said it’s nothing to worry about, they checked and everything, so. Just a bit stressful and she’s a bit small ... for what she’s supposed to be [at the number of weeks of pregnancy].

Thus, the pregnant teenagers with depression and anxiety experienced multiple sources of stress that could further negatively affect their mental and physical health. These stressors could have important implications for the antenatal care of these teenagers.

Financial stress was another constant source of worry for many of the teenagers interviewed. For many, Centrelink was their only source of income—namely the youth and independent living allowances. Centrelink is a service delivery agency for the Australian Government mandated by the Human Services (Centrelink) Act 1997. Social welfare benefits refer to the ‘pension, allowance, concession or payment’ (Australian Government, 2012). Financially, living at home with mother/parents can be helpful for the teenagers and allow them to save money from social welfare benefits. For example, 17-year-old Erika lived with her mother and step-father and said that she was managing really well financially. She said: ... when [I’m] ... paid [social welfare payment], I give mum $100 for board. And I get... [to] spend $50 and I’ve got $50 left over. This meant that Erika was able to save $50 each week, and there was a sense of pride that she could achieve this. In contrast, Bella and her partner lived at home with her mother and reported that they struggled to manage financially. Bella’s partner was employed but did not contribute financially to preparations for the baby.

A few teenagers were employed in part-time jobs. Most of the jobs were at fast food chains or supermarkets. Only two older teenagers (18 and 19 years old) were working full time in retail businesses. The low level of employment and employment in low-
skilled jobs were to be expected in view of the teenagers’ age and lower educational achievements. However, this disadvantaged them because unemployment is a strong predictor of poverty (Australian Council of Social Services, 2014, p. 31).

Further, some teenagers who lived in rental accommodation experienced additional financial expenses. As reported by 18-year-old Anna, the government’s social welfare benefits for single-pregnant teenagers who live on their own in rental housing may be as much as $520 per fortnight. The risk of poverty was high for pregnant teenagers because of their age. Commonly, these teenagers were unemployed and relied on social welfare. Poverty means that the teenagers cannot meet their basic needs (food, clothing, housing), and they may experience shame, anxiety and social isolation because they do not have opportunities to participate in the community (Australian Council of Social Services, 2014, p. 10). In 2012, at the time this study was conducted, the standard poverty line was $358 per week for a single person (Australian Council of Social Services, 2012). Thus, single teenagers who received an income of $520 per fortnight were living well below the poverty line. This affected the majority of the single teenagers. In contrast, teenagers who were living with partners in rental housing (independent living) could potentially have access to a combined total of $1,000 per fortnight. Thus, couples were in a relatively better financial situation. For example, after paying for rent ($250) and food ($200) each fortnight, 17-year-old Jasmine and her partner could save as much as $560 per fortnight. The social welfare benefits would decrease if the couple declared that they were in a de facto relationship.

Living below the poverty line means some teenagers may live from one social welfare payment to the next, with little expendable income in hand. Chloe, an 18-year-old who lived with her partner in a rental public housing, said that her electricity bill for the winter was $500 because it was a cold winter. In such a situation, the teenagers were predisposed to high levels of stress when they had to pay for large bills, as in Chloe’s case. Pregnant teenagers who live on their own and who do not have a partner and/or parents to support them are probably more vulnerable to financial struggles and may be more financially stressed. Further, the risk of poverty is higher for children of single mothers than children from other types of families (Australian Council of Social Services, 2014, p. 22). Importantly, in contrast to other locations in Australia, Tasmania
has the highest risk for poverty, which is reflective of its high unemployment rate and aging population (Australian Council of Social Services, 2014, p. 29).

5.2.4 [Pregnancy] It wasn’t planned …

Some of the teenagers revealed that they had planned the pregnancy. However, the pregnancy was a shock to many of them and their families. An unplanned pregnancy is unintended and may be wanted or unwanted (J. L. Smith, Skinner, & Fenwick, 2013). This section presents the subthemes of: ‘I wasn’t preventing it either’, ‘I was on the pill …’ and ‘I knew the options were there [abortion, adoption]’.

I wasn’t preventing it either

The majority of the teenagers interviewed had not planned their pregnancy. However, the majority were happy to be pregnant. Teenagers whose pregnancy was unplanned were initially shocked, but over time they grew to accept the pregnancy and looked forward to the baby’s arrival. Their happiness was noticeable in the excitement in their voices as they responded to questions regarding the events surrounding the pregnancy diagnosis and how they felt. As revealed in an earlier section, the pregnancy was a positive influence on many of the teenagers—in particular, teenagers who had pre-existing depression and anxiety. For example, 18-year-old Zoe said: It [pregnancy] wasn’t planned but I wasn’t preventing it either way. I always wanted to be pregnant. Zoe was looking forward to her role as a mother. She said:

I’m a lot happier than I have been in a long time. Just being able to give someone else a chance in life type thing. And that I’m actually able to have kids is a real big thing for me [her mother took a long time to fall pregnant with both her children]. It’s kind of a blessing in disguise. I think it’s a really good feeling. Just to be able to give someone else a chance in life and to kind of fix the mistakes I’ve had in the past.

In addition, 18-year-old Erika said: I wouldn’t change it [being pregnant] for the world. Similarly, 18-year-old Effie said that the pregnancy was unplanned. However, she was happy because … I’ve always wanted to become pregnant. Yes. I always wanted a child. [Partner] always wanted to be a Dad. Her partner was also receiving social welfare benefits. Effie said that it was good to be pregnant because it was something to focus on, and there were many positive changes on her horizon. She was transitioning
from being a State ward and had just moved into subsidised public housing. She was also learning to drive a car.

However, there were two teenagers who had not planned their pregnancy and who appeared to have struggled to come to terms with it. Both teenagers had difficult relationships with their ex-partners. Taylor, a 19-year-old, was happy living with her fiancé. She had left her trainee position to move to another town where he was working. However, he turned violent when she fell pregnant. It took a while for Taylor to develop an attachment to the unborn child. She said:

... like a few months ago, I didn’t feel anything towards it [baby] and until it started moving that I started to feel the connection ... sometimes, I feel really angry [towards baby]. But then I think it’s not it’s [baby] fault. It can’t help it. ... that if I wasn’t pregnant that it [violence] wouldn’t happen. Sometimes I do [blame the unborn baby]. Still like some days I still have those thoughts like feel down and... Yeah [blame myself]. Like what would I have done, ... if I could have done something different would it be ok?

Thus, the baby was a constant reminder of the failed relationship and the life she could have had with her fiancé if she was not pregnant. Likewise, 17-year-old Michelle had not planned her pregnancy. She had been a State ward since she was 11 and a half years old because her mother had left the family home. Over time, Michelle had accepted her pregnancy and was happy with it. She said: It was a bit of shock to get over it at first but I got there and I’m alright now so that’s good. She was no longer in a relationship with her partner, whom she now disliked intensely.

Only two teenagers interviewed (Chloe and Kelsey) openly stated that they had planned to become pregnant. Chloe, an 18-year-old, started trying to conceive when she was 16 years old. She had lived with her partner for four years. Her childhood was traumatic; she experienced bullying at school, and her parents separated when she was young. For Chloe, to be pregnant was ...a dream come true. Kelsey was 17 years old and had also planned her pregnancy. She said: I’d stopped taking it [pill] about 5, 6 months before I got pregnant I reckon. ‘Cause ... we started to try for one [baby]. Pete, Kelsey’s 18-year-old partner, attended the interview with Kelsey. He explained that he had always liked children because he grew up with his nephews and nieces. Both teenagers were excited about their decision to have children.
For the teenagers mentioned above, whether the pregnancy was intended or not may be irrelevant. Importantly, for the majority of the teenagers, the pregnancy was a central driving force of their improved health beliefs during the pregnancy.

I was on the pill …

Many of the teenagers were using either contraceptive pills, a hormonal implant inserted in the forearm, ‘Depo’ (hormone) injections or protective barriers such as the condom. Contraceptive failures were common. A common problem experienced by the teenagers interviewed was forgetting to take the contraceptive pill. Sometimes this was because the teenagers had been drinking alcohol. Erika, a 17-year-old, reported that she was sexually abused by her partner, who had drunk too much alcohol on New Year’s Eve. Bella, an 18-year-old, and her partner were ‘drinking’ and she ‘missed one tablet’. She took two pills the next morning to make up for the one she missed. As reflected in her actions, Bella may not have been well informed regarding how the contraceptive pill worked.

There were other teenagers who also did not understand the use of the contraceptive pill. For instance, 17-year-old Hailey said that I was [on contraceptives] but not when I was up in [mainland]. She may have forgotten to take the pill when she was on the mainland, or she may have thought she did not need to use the pills when she was away. Similarly, 17-year-old Grace had a limited understanding of the contraceptive pill. Grace added, Yes, [on the pill] for a little while but I wasn’t on it really that much… She said: I didn’t really think about it [that I will be pregnant]. Further, a small number of the teenagers did not think they needed to use a contraceptive. Bianca, a 19-year-old, who was in a relationship with her partner for four years, said …just never really thought I needed to [use contraceptives]. Likewise, 16-year-old Nicole said:

No. [never thought she would be pregnant]. Yeah just didn’t even, like everyone was saying, go get on the pill and stuff, but ‘cause it’s coming from your sister or whatever, you’re just like yeah, whatever.

Both Bianca and Nicole may have felt a sense of invulnerability—that pregnancy would not happen to them. In addition, a few teenagers had contemplated using contraceptives, but they had not done anything about it until it was too late—for example, in the case of 15-year-old Allison.
In contrast, a small number of the teenagers did not use contraceptives because of the associated adverse effects. For example, 18-year-old Chloe said she was on the pill and ‘rod’ (implant) but discontinued because of bleeding that seemed to occur most of the time. However, Chloe had always wanted to have a baby, and not using contraception may have been because of her desire to have children. Likewise, 18-year-old Zoe did not use contraception because of adverse effects and because she wanted to start a family. Zoe was anticipating motherhood as a career choice. When asked what she would do in two years’ time, Zoe said: Doing what I do now. Being a mother. Home duties, being a mum, stuff like that. I want a big family... There were similarities between Chloe and Zoe in regard to their childhoods. For example, both teenagers had parents who had separated, they were bullied at school, and both had depression and anxiety in their younger teenage years.

I knew the options were there [abortion, adoption].

Many of the teenagers interviewed were against the idea of terminating their pregnancy. In Tasmania, termination or abortion to discontinue a pregnancy was decriminalised in 2013. Women can undergo termination before or at 16 weeks’ pregnancy. Termination conducted after 16 weeks is considered a crime in Tasmania (Tasmanian Government, 2013). There is one clinic that provides termination of pregnancy services in southern Tasmania (Children By Choice, 2014). Thus, access to terminations may not be an issue. All of the teenagers interviewed were aware of the options other than continuing with the pregnancy. As Alexis said: I knew the options were there [abortion, adoption]. Further, many of the teenagers knew they were pregnant well before 16 weeks of the pregnancy and would have had enough time to undergo a termination if that was their choice. According to 17-year-old Hailey, the process of organising the termination would have been easy. She did not need a GP referral. The cost was $350 paid privately, which includes insertion into the upper arm of the contraceptive Implanon. However, Hailey changed her mind and carried the baby to full term.

There were various reasons why the teenagers would not consider termination. Religion was one reason why 18-year-old Zoe would not consider abortion: Because I’m Catholic, I don’t believe in abortion or adoption or anything like that, so. No. In contrast, Grace, a 17-year-old, said:
My doctor spoke to me about the different options that I could take. I couldn’t get an abortion—I couldn’t do that—and having younger sisters, I couldn’t get rid of the baby.

The teenagers’ common response to termination of pregnancy was that killing a life was ‘morally bad’ and unacceptable to them. The decision to not terminate could have been influenced by the media and family members. In addition, other factors may have influenced their decision to not terminate include the legalities of termination in Tasmania, late diagnosis of pregnancy and financial cost of pregnancy termination.

The teenagers’ strong feelings against termination of pregnancy may be related to the timing of the antenatal interviews, which were conducted between 30 and 40 weeks of the pregnancy. At this stage of the pregnancy, when the babies were close to being delivered, discussing termination may have generated strong feelings against termination. A few of the pregnant teenagers had considered adopting out the baby, but as the pregnancy progressed, they had developed a bond with the unborn baby, and the thought of adoption was no longer tenable.

Thus, understanding whether the teenage pregnancy was planned and wanted or unplanned and not wanted is important because it enables health professionals such as midwives to provide care that is appropriate for the teenagers. For those who had intended to become pregnant, leveraging on this motivation may be an effective approach to shaping their health beliefs (knowledge, attitudes and behaviours) and meeting their felt and normative needs during the antenatal period.

5.2.5 I want a healthy baby

In this section, the theme refers to the teenagers’ desire for a healthy baby and their reported adoption of healthy behaviours. The subthemes presented below are: ‘Not drinking, staying out of trouble’, ‘I stopped smoking four weeks ago…’, ‘I was eating and doing everything right …’, ‘… breastfeeding is the better thing to do …’ and ‘I just want to do it all natural [labour]’.

Not drinking, staying out of trouble

Excess consumption of alcohol or binge drinking was common among some of the teenagers interviewed. The current recommendation during pregnancy is not to consume alcohol because it remains unclear how much and when alcohol causes harm to the
growing foetus during pregnancy. Some of the common effects of alcohol on the foetus, as reflected in the child, are low intelligence, learning difficulties and poor school performance (National Health and Medical Research Council, 2009, p. 73). In Australia, drinking during pregnancy is common, with 96 per cent of pregnant women (aged 14–49 years) consuming one to two glasses of alcohol during pregnancy (Australian Institute of Health and Welfare, 2014). Excessive drinking clouds the individual’s ability to make decisions and may also contribute to more risk-taking behaviours resulting in for example road traffic accidents (National Health and Medical Research Council, 2009, p. 59). As noted in the interviews, the majority of the teenagers gave up alcohol consumption when they found out they were pregnant. This reflected that they knew that the behaviour could be damaging to the growing foetus. For example, Hanna was proud that she was Not drinking, [and] staying out of trouble (brackets not in original). She was motivated to adopt healthy behaviours. As she said: I want a healthy baby. Similarly, several teenagers expressed that they wanted to do the right thing by their baby. However, some of the teenagers may not be willing to share their negative thoughts in the ‘background’ regions of meanings in social actions (Carspecken, 1996).

I stopped smoking four weeks ago…

In addition to binge drinking, many of the teenagers interviewed smoked cigarettes, and a few also used marijuana, an illicit drug. As noted, 19-year-old Abbie, who was working full time, said: ... before I knew I was pregnant, I was probably smoking 50 [a day]. One 'ginormous' big packet a day. I stopped smoking four weeks ago [at 30 weeks' gestation]. A few teenagers testified to using marijuana, an illicit drug. As Bella noted: I ... probably [smoked] a fair bit [marijuana]. More than five ‘cones’ [of marijuana]. Probably to the point where I was drinking and smoking and then just passing out. However, for the majority of the teenagers interviewed, the pregnancy was a turning point for them to adopt a healthy lifestyle. For the few teenagers who revealed their illicit drug use, efforts to stop the drug use were not always successful. For example, 18-year-old Sophie had reduced her consumption from 20 ‘cones’ of marijuana or more per day before the pregnancy to only five per day. She gave up cigarette smoking for four months when she found out she was pregnant. Interestingly, Sophie said that she resumed smoking cigarettes because she was probably bored. When questioned, Sophie said that she knew the effects of marijuana and cigarette
smoking on the baby. However, she remained unable to completely give up both habits, suggesting that she may require more support and help from health professionals. The pregnancy was not planned, but Sophie was happy and viewed the pregnancy as something good that was happening in her life.

*I was eating and doing everything right …*

All of the teenagers interviewed were aware of the need to have a ‘good’ diet. For many of the teenagers, a ‘good’ diet refers to eating three regular meals—breakfast, lunch and dinner—and eating cereals, fruits, vegetables and meat. An important finding in relation to their antenatal care is that for the majority of the teenagers, the pregnancy was a major motivating factor for improving their diet. For example, 18-year-old Bella said: *The only reason I was eating and doing everything right was because of ‘bub’ [baby].*

Thus, as mentioned earlier, for some teenagers, being pregnant was a motivation to change their lifestyle behaviours.

As reflected in the interviews, many teenagers did not always understand the need for an appropriate diet and diet restrictions in relation to Listeria infection. For example, 17-year-old Effie decided that she would not conform to recommended diet restrictions to avoid Listeria infection because the restrictions would place too much stress on her. The infection is caused by Listeria bacteria that are present in soil, vegetation, water, animals and food processing areas. Infection can lead to miscarriage, prematurity or stillbirth of the foetus. To minimise the risk of infection, pregnant women are advised to observe dietary precautions such as avoiding pre-packed salads and cold meats. There are many restrictions, which can be confusing and stressful. However, this infection is not common in pregnant women (Food Standards Australia New Zealand, 2013). Effie also noted the low incidence in Listeria infection, as she said: *… he is perfectly healthy; all doctors have said that he is really healthy, … and well, I’ve continued eating things even though they’ve said you’re not meant to.* The rationales provided by Effie may suggest that she either did not understand the risks for Listeria infection, or she knew the risks but was willing to take her chances. For Chloe, the Listeria diet restrictions were confusing. She said:
I eat meat but sometimes I don’t feel like eating meat cos I don’t know what’s good for the baby or not. Some meats, I got told chicken … are not very good. I’m not a cooker.

This statement suggests that 18-year-old Chloe was unsure of two aspects in relation to her diet: the foods to avoid in relation to Listeria diet restrictions and the types of good foods for the baby. In addition, Chloe did not like cooking and did not know how to cook. The inability to cook may have significantly influenced Chloe’s diet and knowledge of what foods are good for her and her baby.

Importantly, the interviews suggested that some teenagers were unable to apply their knowledge of what constitutes a good diet because they remained influenced by their childhood dietary habits. As reflected in a quotation by 18-year-old Zoe:

I eat fruit, but I will not eat vegetables. I grew up... it’s really bad because I grew up in a house where we only had peas and yellow potato on our plates and we had a piece of meat. But the bad thing is my peas always had sugar and salt in them, and I can’t eat them any other way.

Zoe knew that her childhood diet was ‘bad’ or unhealthy, but she was unable to overcome her strong childhood habits. As mentioned earlier, Zoe was overweight as a child, and she associated her mother’s inability to control her as a child to being overweight.

… breastfeeding is the better thing to do …

The majority of the pregnant teenagers interviewed expressed that they wanted to breastfeed their baby. Many indicated that breastfeeding was best for the baby. This is the general view in the community and is aligned with global and national emphases. In line with global trends, in Australia, breastfeeding is promoted as being fundamental for babies for the first six months of their lives (National Health and Medical Research Council, 2013). Breastfeeding was a topic discussed with the pregnant teenagers in the childbirth education program. A few teenagers’ decisions regarding breastfeeding were influenced by their parents. For example, 19-year-old Taylor, who was close to both of her parents, wanted to breastfeed because her father said it was good for the baby. Another teenager, 16-year-old Nicole, was one of six children in her family, who were
all breastfed. Thus, breastfeeding the baby was a norm in Nicole’s family and for her. In contrast, 17-year-old Erika said:

I don’t really want to [breastfeed] (teen). Cos’ I want to make it so my stepdad can have ...some leeway into helping raise [baby]... So, I reckon bottle feeding would be better ...for that.

Erika wanted To make it fair for her step-father because he did not have children and wanted to be involved in the care of the baby. Erika’s mother, who was present at the interview, was equally keen for the step-father (her partner) to have a parenting role with Erika’s baby. It could be assumed that Erika and her mother wanted to please the step-father and meet his need to be a ‘father’ to the baby. In doing so, they overlooked the baby’s needs. Erika lives with her mother and step-father, and she pays a small amount of money towards rent. They are her only family and regularly accompany her to antenatal care and education sessions. Thus, they are influential in Erika’s life. Her parents’ influence may well have extended into other areas of Erika’s antenatal care and education.

The perceived strong influence and nuanced demands from families regarding breastfeeding may create additional stress for the teenagers—particularly in the post birth period—if they are unsuccessful in breastfeeding.

... I just want to do it all natural [labour]

Many teenagers revealed that they wanted a ‘natural’ labour, implying that they wanted minimal use of pain relief. Childbirth education on pain relief was another key topic discussed in the YMC childbirth education program. As highlighted in the interviews, a common response from the teenagers was that they did not want pain relief. For example, 17-year-old Michelle said: ... I’m going to try and go without pain relief, I’ve decided. Because I just want to do it all natural. At the time of the interview, Michelle had not had the session on pain relief. In addition, 17-year-old Jasmine said: My sister told me to take the gas [pain relief]. Another 17-year-old, Grace, said: A few of my friends just had babies and they only had ‘gas’ and stuff. The teenagers who declined pain relief may have developed a view that childbirth should be natural or they had no conception of childbirth. A problem with this perception is that the teenagers might be disappointed if they cannot endure the labour and birth without pain relief. This attitude
towards natural childbirth may have developed from sources such as the internet, friends, mothers and family members. It may also reflect that the teenagers did not have good knowledge of labour and birth and/or the different methods of pain relief.

In addition, fears of the epidural method of pain relief may be a major barrier to considering pain relief for childbirth. This could be because of the many circulating stories of back pain related to the epidural. As noted, few of the teenagers interviewed had heard about the side-effects of the epidural from friends. Further, the YMC childbirth education session on the epidural pain relief conducted by midwives may have increased their fears. In the session, the teenagers were shown the epidural needle and the long, very fine plastic tubing that is inserted into the back for epidural pain relief. As stated by 17-year-old Hailey, *Epidural sounds rather painful*. In addition, a small number of teenagers who had needle phobia were fearful of the epidural and would not consider this method of pain relief.

### 5.2.6 A bit of everywhere [sources of information]

This theme refers to the myriad sources of pregnancy-related information accessed by pregnant teenagers.

One of the key functions of antenatal care is to provide information to pregnant women to encourage their participation in decision-making regarding their pregnancy care and health care needs (Australian Health Ministers’ Advisory Council, 2012). Thus, knowledge during pregnancy is important and contributes to preparing the teenagers for the birth and care of their baby. The interviews revealed that teenagers accessed health information related to childbirth education from many sources. For example, 19-year-old Abbie said that she received information related to pregnancy from *A bit of everywhere*. She explained that her main sources of information were her mother, printed information from midwives and the internet.

One important source of information for the teenagers was from their own mother. Mothers were a readily and highly rationalised source of information, especially if the pregnancy facilitated a closer relationship between the mother and daughter. Bianca, a 19-year-old with depression and anxiety, lived at home in a rural town and seemed quite isolated from her partner and friends. She had found it difficult to discuss the pregnancy with her mother but said: *I guess I could talk to mum she’s had a few kids so ...* As in
Bianca’s case, many teenagers lived with their mother/parents during the pregnancy and after the baby was born. Thus, unlike health care professionals such as midwives and nurses, the teenagers’ mother was accessible at all times. Some mothers were seen to be highly influential in shaping the teenagers’ behaviours. For example, as mentioned earlier, 17-year-old Erika, who had only completed her Year 9 education and had literacy difficulties, said that her mother had become her ‘translator’ for information she received from the clinics. However, mothers may not necessarily have up-to-date information. Nicole’s mother said:

Yeah, like I can only tell her really what I know. Things change so much though don’t they? ‘Cause I was sure I had to put mine [babies] on their side [to sleep] and change sides ... So now it's all back.

Given that most of the teenagers appreciated receiving advice from their mothers, the recognition that knowledge does not stay constant is important to encourage teenagers to search more sources for the information they need.

Friends who have had babies were also important sources of information for the teenagers because, as Sophie said: … they’ve been through it all. It was noted that the teenagers’ choice of pain relief was often influenced by what they had heard from friends. As stated earlier, a couple of teenagers were reluctant to use the epidural for pain relief because they had heard from friends that it could cause complications. Similarly, 17-year-old Grace said: … I know a few of my friends have had babies ... and she also received information from her mother. With readily accessible sources of information, Grace did not think it was necessary to attend the YMC childbirth education program.

However, friends were also a ‘bad’ influence on the teenagers. As 18-year-old Anna said: …the drinking and the smoking that I don’t do now. [Avoiding] a lot of bad influences like friends... To maintain a healthy lifestyle, Anna stopped going out with some of her friends who were influential on her alcohol and cigarette use.

Many teenagers accessed information from the internet. The convenience, speed and privacy of obtaining visual and written information via the internet was very apparent for this cohort of teenagers, with the internet cited as the most common source of antenatal information for the teenagers interviewed. Internet access was commonly
through the teenagers’ mobile phones. Many of the teenagers reported being avid internet users. For example, 17-year-old Jasmine obtained information from the internet. She said: *I googled everything*. The internet as an information source was also popular with 17-year-old Effie, who said: *I can’t find no internet site that I have not read about pregnancy, … [have researched widely]. I find it more fascinating to look up on the internet anyway*. This suggests that Effie prefers the internet to interacting face-to-face (e.g., at the childbirth education sessions).

Two teenagers (Erika and Michelle) had made online ‘virtual’ friends. Erika, a 17-year-old teenager, proudly exclaimed that *I’ve got about 18 different types of Parenting Groups. And they all … most of them … [online friends] they’ve [been] through what I’ve been through*. These friends were important because Erika did not talk about any other friends in the town where she lived. Thus, the internet, with its ability to connect with virtual friends, can be an important source of information and a strategy for overcoming social isolation.

The Facebook is a free internet application (referred to as an ‘app’) for all computers and smartphones. An app is defined as ‘A piece of specialized software that can be downloaded onto computers and mobile devices’ (O’Connor, Jackson, Goldsmith, & Skirton, 2013, p. 599). A Facebook app called ‘Baby Gaga’ was popular with a few of the teenagers. This amazing interactive app allows users to learn about the foetus’s growth and development by typing in its age. The visuals and the interactive nature of the ‘Baby Gaga’ Facebook app were appealing to many of the teenagers interviewed. Michelle, a 17-year-old, said that she would visit Facebook if the midwives had a Facebook presence. The YMC does not have its own website or Facebook or Twitter social networking accounts to communicate with the teenagers. However, the use of social media was not always popular with the teenagers. For example, 15-year-old Allison did not often use the internet for health information; instead, she relied mainly on information from the midwives and her mother.

Nonetheless, for teenagers with mental health problems such as anxiety, the internet can contribute to enhanced anxiety states. For example, Kelsey, who had anxiety, reported that excessive use of the internet via the computer and her mobile phone made her *…paranoid about everything*. Her partner also became concerned for her.
The YMC was a source of information accessed by many teenagers. As mentioned in Chapter 2, the YMC offers two key services that are run entirely by midwives: antenatal clinic checks and childbirth education. In contrast to adult antenatal care, the YMC group education is conducted concurrently to the antenatal clinic during each visit. The concurrent implementation of both services is a unique feature of the YMC. This approach allows the YMC to have a ‘captive audience’ for childbirth education. Conversely, a disadvantage is that the teenagers who are called out for their antenatal care checks could miss parts or all of the childbirth education session. Further, allowing the teenagers to leave halfway through the education session to attend the antenatal check may send a nuanced message to the teenagers that the childbirth education is unimportant and dispensable.

As noted in the teenagers’ Obstetrix records, some had only attended the antenatal care clinic and had skipped the childbirth education program. The reasons for not attending the education sessions were noted in the interviews. For example, 17-year-old Grace was not interested in the education classes and only attended the YMC to monitor her pregnancy. As mentioned earlier, she felt confident that she had adequate information from her mother and friends. However, another reason for not attending the antenatal classes was because she did not want to be with other pregnant teenagers. She said they were not ... the sort of people I like to ... mix with. She did not provide any reasons why she felt this way.

In contrast, 18-year-old Hanna had not missed any childbirth education session. She said: I’ve got a lot of information from here [YMC]. In addition, being with other pregnant teenagers at the YMC was viewed positively by 18-year-old Amber, who said:

You find out ... more information than what you already know, well you probably think you know but they help you a little bit more. So you were with other people that are the same, around the same. ... age and stuff and the same thing [situation that] you are.

Amber may have felt comfortable with the other teenagers and found the sharing of experiences useful in the group. Another 18-year-old teenager, Kelsey, said:

Yeah, I like coming [to YMC], they’re very informational so it’s good. ‘Cause before, well before I got pregnant I knew like nothing ... I didn’t even know there were
Partner participation was encouraged at the YMC. However, as observed during visits to the YMC, few partners usually accompanied the teenagers. The lack of partners’ involvement may be a barrier to antenatal clinic attendance (Smith & Roberts, 2009). Pete (Kelsey’s partner who accompanied her at the interview) felt left out of the YMC childbirth education because there was nothing for men in the classes. He suggested that the YMC could include the following for partners:

... Just learn how we can help out our partners more ... Well instead of being like ‘young mums’ where it’s just based on the mums it should be ‘young parents’ where it’s based on both.

Kelsey suggested that he wanted ‘young dads’. Pete’s suggestion exemplified the negative gender bias that YMC midwives may inadvertently practice towards the partners. This is an important service delivery issue because it suggests a missed opportunity at the YMC to support and develop partners so they can provide important support to pregnant teenagers and their children.

As a major source of information for pregnant teenagers, the YMC may need to review its approach to the childbirth education classes. As Zoe, an 18-year-old with ongoing depression and anxiety during pregnancy, said:

I would have preferred to go do the normal hospital appointments. I feel like, just in the small group (in KYM), I find that when they give you the information it’s more directed as normal information, they’re not just making it special for young people. They’re not ... not dumming it down, but just like simplifying it ...

This suggests that Zoe felt that the level of information provided at the YMC was too simple for her as an 18-year-old. Likewise, Brooke, another 18-year-old, said that she preferred attending the adult childbirth education because I find, you know, their, their age and everything, they [older women] have a lot more information ... [from midwives]. This suggests that older teenagers may have different needs to younger teenagers, and the YMC midwives will need to individualise information according to the teenagers’ age. Currently, the YMC allows teenagers aged 18 and 19 years to attend models of antenatal care other than the YMC.
Outside of the teen-friendly YMC, midwives may not always understand how to interact with pregnant teenagers. For example, at the booking-in clinic (not part of the YMC), 18-year-old Alexis found the midwives quite confronting. She said:

*Just over across at the main hospital, I found that they didn’t explain things enough. Like when they gave me all my ... all my pamphlets for all my blood tests etc, they didn’t explain what all of them were or.... And I found that a lot of the midwives and staff, they were quite judgmental. And because it was my first time being over there and it was my first hospital check. And they were quite confronting. Like I didn’t know anything about pregnancy and I didn’t know anything about babies. Nothing. And they just spoke to you as if like you knew everything.*

In another case, at an OMC (the clinic’s original name is not used in order to maintain the anonymity of its location and staff), Zoe, an 18-year-old with depression and anxiety, felt embarrassed each time she visited the OMC. She said:

*... going to [OMC] I feel bad because I panic a lot [about the foetus], I know that ... I feel really bad going in because I know that I’m overreacting but I just can’t help it. I just so freak out [about the foetus]. I just find, like it’s really... especially if I go in there and it’s one of the midwives that talk really loud. But then they just make, some of them make you feel really silly for going in. I think that’s mainly the fact is, with younger girls, I think they need a different section type thing for young people, because we’re going to freak out. It’s our first kid, we don’t really know if they’re okay.*

These teenagers may have been uncomfortable because they felt self-conscious of their pregnancy. However, they may have felt uncomfortable because the midwives may not have had experience in caring for teenagers, or they may have discriminated against them. The teenagers’ experiences highlight the need for midwives and other health professionals to examine and address staff communications skills in providing care for pregnant teenagers.

Nurses in the c u @ home nurse visiting program were also a source of information for the pregnant teenagers. A key aim of this program was to support first-time childbearing teenagers to develop optimally with positive flow-on effects on the child’s development (Bellis et al., 2014). The majority of the teenagers interviewed were registered for care in the c u @ home program. Some of the teenagers were offered the program but they
declined. For example, 18-year-old Bianca said that ... [I just don’t feel comfortable with someone coming in [to visit her]. Anna, another 18-year-old teenager, lived on her own and had a history of substance abuse (cigarettes, alcohol and illicit drugs). In addition to not feeling comfortable with the nurse in her home, she declined the program because she felt that she was already receiving good support from her parents.

In the main, many teenagers found the cu@home program to be beneficial, and a few enjoyed the childbirth education they received from the nurses. The main focus of the education, understandably, was on parenting. Abbie, a 19-year-old, enjoyed the session and said: It's the best thing I’ve been doing. Similarly, 17-year-old Jasmine said: The [nurse] helps out a lot–she’s bring movies and everything for [Partner]. [Nurse] spoke to me about what to pack. One nurse in the program, who was also a midwife, had discussed birth planning with 17-year-old Effie. Effie knew what pain relief she wanted and which support people she wanted to be present at her labour.

The GP was another important source of health information for some of the teenagers interviewed. Three teenagers with depression and anxiety (Taylor, Jasmine and Brooke) reported that they were seeing their GP regularly. For these teenagers, their GP was an important additional source of information and reassurance that the teenagers and their babies were progressing well. For example, seeing the GP was important for 18-year-old Brooke because: As soon as I hear from a doctor or, that everything’s okay. I stop worrying for a little while. In another case, 17-year-old Jasmine was seeing her GP as well as the YMC. She said:

I’ve been seeing my GP for about 3 months now. She’s fantastic. ... I come for my checks [YMC] and I also get checked out there as well [GP]. Yes, she [GP] likes to just make sure. I don’t mind having both. I like the check-ups. Normally, I see her [GP] every 2 weeks until...I think she wants to see me every week cos’ the baby is closer [to birth].

Jasmine liked the GP and YMC check-ups that involved a medical examination and listening to the baby’s heart rate. However, attending both services may have been difficult for Jasmine because she relied mainly on public transport to get to her appointments. Nonetheless, the attendance at both services may reflect Jasmine’s need to be reassured about her pregnancy. On the other hand, it may also reflect an overservicing of the teenager. Further, as noted in Jasmine’s Obstetrix record, the additional
visits to the GP may have contributed to her missing seven YMC antenatal clinic checks.

5.2.7 [support person] … [Mum] she’s been top of the world

The teenagers’ support people were those who provided support in one way or another during the pregnancy. Mothers were alluded to as the most frequently used source of social support. This support included housing, transport, financial and emotional. For some of the teenagers, as the pregnancy progressed, the relationship with their mother (and sometimes father) improved. The most dramatic change in the mother–teenager relationship occurred for 17-year-old Effie. She felt that the pregnancy had brought her closer to her mother, with whom she could not get along as a child. Effie was a violent child with anger ‘issues’. She said:

... me and [mum] weren’t as close. Ever since she [mother] found out [teenager’s pregnancy] she’s been top of the world, been great ... Yeah. She gave me $500 to go get a pram, frigging gave ... me everything I want and does everything for me.

This was a remarkable shift in the relationship, which she attributed to being pregnant. Similarly, 19-year-old Abbie had a full-time job. Her 17-year-old ex-partner was unsure of the pregnancy and did not stay in the relationship. Abbie said that her relationship with her parents has improved, and that Mum is there to talk to. For 18-year-old Amber, her parents’ approval of the pregnancy was important. She said: ... I’d probably feel different about the situation [pregnancy], if her parents had disapproved of the pregnancy.

Social support was also received from the teenagers’ partners and friends. For teenagers with partners, the partners were either mostly supportive or stressors for the teenagers. The estimated range of the partners’ ages was between 17 and 27 years. Many of the partners were unemployed and received social welfare benefits. Other information on the partners was not collected because this study did not include them as research participants. The researcher observed that few partners attended the YMC with the teenagers. Most of the teenagers with partners received support from them, such as the sharing of household expenses. However, this convenience was not always stress-free. For example, 18-year-old Zoe said that she did not receive much help from her partner in the home. She explained:
He’s 19, but he’s like 3 in the head. He just hasn’t quite grown up yet. I think [the stress] ... it’s the fact also he hasn’t quite clicked to having a baby. And I don’t think he will until she’s here. Just, ‘blonde’. He’s not very smart.

Notwithstanding, Zoe was happy with her partner because he had a job and owned a car. She felt that he was far better than her previous partners. Zoe said: ... he’s more got his head screwed on. Everyone else that I’ve kind of been with have all been dropkicks and useless and that would have just been pointless. She was accepting of his flaws.

Previous partners were a constant source of stress for some teenagers. For example, Hailey wanted her previous partner to be involved in the pregnancy and birth; however, the relationship was complicated. As Hailey said:

...one minute he’s fine here about the baby and stuff and then the next day he texts me and says don’t text me, me and [girlfriend] are working things out... So, I pretty much have to listen to what he says. To tell him stuff about the baby, the certain days and times that I can’t text him and this...stressful!

Previous partners were also a source of stress for Taylor and Erika, who had both previously been in violent relationships. For 19-year-old Taylor, the physical violence from her fiancé commenced when she became pregnant. She said:

My partner was really happy and then it just changed. Yeah, we were engaged and we didn’t find out [about pregnancy] ... until I was 13 weeks pregnant. No [he didn’t like the pregnancy]. And he started getting abusive and that got really bad. Yeah, on 3 occasions, he did [beat me] ...  

Taylor was a quiet teenager. At the interview, her sadness was palpable.

5.3 Summary

This chapter presented the interview results from 21 pregnant teenagers in phase I (a) of this study. Six themes and 18 subthemes were identified and displayed in a summary table. These themes and subthemes highlighted the teenagers’ socio-demographic details, their childhood, experiences of bad depression, motivation for a healthy baby, the many sources of information and their mother as an important support person.
Chapter 6 presents the results from phase I (b), which was conducted with the teenage mothers. The chapter will present the major themes and subthemes that were identified from the teenagers’ interviews.
Chapter 6: ‘…Teen Mothers Ain’t All as Bad as What People Think They Are’: Results from Teen Mothers’ Interviews

6.1 Introduction

This chapter presents the results from the interviews with the teenage mothers in phase I (b), which was conducted sequentially to phase I (a).

A total of 11 teenage mothers aged between 18 and 19 years were interviewed at between two and five months’ post birth. Convenient sampling was undertaken. The interviews were conducted between November 2012 and December 2013. In the post birth interviews, a major departure from the antenatal interviews was that the teenage mothers were able to reflect upon their experiences during the pregnancy, birth and postnatal periods to highlight their pregnancy care needs. Thematic data analysis was undertaken on the teenage mothers’ interviews, which generated several major themes and subthemes, as reported below. This process was broadly guided by the research questions and the themes generated from the pregnant teenagers in phase I (a). Further, the results were analysed against existing literature where appropriate.

6.2 Research Findings

This section presents the teenage mothers’ socio-demographic details and the six major themes and several subthemes identified from the teenagers’ post birth interviews. These major themes are: ‘…[Unhappy childhood]…when my parents split’, ‘[pregnancy] It wasn’t planned …’, ‘I want a healthy baby’, ‘[Sources of information] I’d Google it or I’d ring [my nurse]…’, ‘[Postnatal in hospital] … everything was just so stressful’ and ‘…[teens] they need support’ (see Table 6-1). Subthemes are included where relevant.
Table 6-1: Results from the teenage mothers’ interviews: six thematic categories and subthemes

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<thead>
<tr>
<th>Themes</th>
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<td>when my parents split</td>
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<td>planned …</td>
<td>… she’s a good mum</td>
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<td>I want a healthy baby</td>
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<td>[Sources of information] I’d</td>
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<td>Google it or I’d ring [my</td>
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<td>[Postnatal in hospital]…</td>
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<td>…[teens] they need support</td>
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The phase 1 (b) interviews are referred to as post birth interviews throughout this chapter. In line with the ethnographic approach, the interview findings below are reported using the teenage mothers’ words where appropriate to emphasise their emic perspective. Pseudonyms are used for all mothers interviewed.

6.2.1 Teenage mothers’ demographic details

A total of 11 teenage mothers participated in the post birth interviews. Of these, nine teenage mothers participated in the interviews conducted in phase 1 (a). An additional two teenage mothers were recruited for the phase I (b) interview only. In phase I (b), the teenage mothers’ average age was 18 years. One teenage mother was 19 years old, and the rest were aged 18. Only one of the 11 teenage mothers was an Aboriginal Australian. Six of the 11 teenage mothers’ parents were divorced/separated when the teenager was young. Most of the teenagers had completed either Year 10 or 11. Only one of the 11 teenage mothers interviewed had achieved a Year 12 education. The
lowest school grade achieved was Year 7. None of the teenagers were working in paid employment at the time of the post birth interviews. Two single teenage mothers were in their own rented accommodation.

The teenage mothers’ residential addresses were from five postcodes with varying distances from the city. Given the small sample size, the postcodes are not revealed to protect the teenagers’ anonymity. The shortest distance from a postcode to the local hospital located in the city was 7.5 km, and the longest distance was 85.7 km. Two teenagers were located at postcodes that were 75.9 km and 85.7 km from the city, respectively.

In the post birth interviews, two teenagers indicated that they were financially comfortable because they had both had full-time employment before the pregnancy. They both drove a car and had parents in good employment. Seven of the 11 teenage mothers were living with a regular partner at the time of the post birth interview. One of the seven teenagers was married during her pregnancy. At the time of the post birth interview, another 18-year-old mother was planning to marry soon.

6.2.2 [Unhappy childhood]…when my parents split up

The theme in this section relates to the teenage mothers’ childhood experiences, which were mainly punctuated by an unhappy childhood and not enjoying school.

Many of the teenage mothers interviewed had experienced parental divorce/separation during their childhood. As Anna said in the phase I (a) antenatal interview, the unhappy times were ...when my parents split up...I would have been about 8 or 9 [years old]. Most of these teenagers from divorced/separated families were from phase I (a) and their stories are not repeated here. In contrast, the additional two teenage mothers recruited (Erin and Alicia) for the post birth interview had parents who were still together and did not report an unhappy childhood. The teenage mothers had achieved varying levels of success at school, ranging from Year 7 to 12. Erin’s schooling was interrupted when she fell pregnant in Year 12. She continued to work casual part-time at a food retail outlet; at the time of the interview she was on unpaid leave. Erin and her partner were married just before the baby was born. The other teenage mother, Alicia, dropped out of school early and completed Year 8 through home schooling. She experienced some bullying at school. Her real reason for leaving school could be, as her
mother said in the post birth interview, that Alicia was Very shy. She wouldn’t go to school ... It was noted that the home schooling did not contribute to Alicia continuing beyond Year 8. Except for Erin, the other teenage mothers with partners were not married at the time of the interview.

6.2.3 [pregnancy] It wasn’t planned ...

As noted in the antenatal interviews, the majority of the teenagers interviewed in the phases I (a) and I (b) had not planned the pregnancy. However, the unplanned pregnancy may be desired as some of the teenagers did not prevent becoming pregnant. The theme in this section is described by two subthemes: ‘she planned her baby’ and ‘…she's a good mum’.

Some of the teenagers who had not planned the pregnancy were not on contraceptives to prevent the pregnancy. The unplanned pregnancy may be intended. In phase I (a), Zoe, an 18-year-old, stated that her pregnancy It wasn’t planned but she was not on contraception as she revealed that she wanted to start a family. At the post birth interview, Zoe was keen to have a second baby soon. Also, as revealed in phase 1 (a), Kelsey’s pregnancy was not planned, but she said: we were trying for a bit [to conceive]... At the post birth interview, Kelsey revealed that she was eager to have a baby and felt that ...the time was right ... yeah, ‘cause [Partner] was really keen too ‘cause he loves kids. For Zoe and Kelsey, as revealed in the interviews in phases I (a) and (b), the pregnancy may have been ‘unplanned’ but the ‘pull’ of motherhood was strong for both teenagers. In Kelsey’s case, she said that her partner was really keen too to start a family. This suggests that for some teenagers, their partners may play a significant role in the teenagers’ decision for childbearing.

She planned her baby

Two teenagers interviewed in phases I (a) and I (b) revealed that they had planned the pregnancy. In addition, in phase I (b), one (Alicia) of the two teenage mothers who participated only in the post birth interviews was open about the planned pregnancy. At the interview, Alicia’s mother said that the pregnancy was not a surprise and she was not disappointed when her daughter fell pregnant: Oh no, because [Alicia] wanted her baby. She planned her baby. She wanted to have a baby. Alicia’s partner confirmed that Alicia had been planning the pregnancy since she was 15 years old. They had known
each other for three years and \textit{Since we got together, that’s all she wanted. ... she got it [the Implanon] removed because she wanted a baby [Alicia’s partner].} It was noted that Alicia’s family had three generations of teenage parenting, these being: her mother, daughters and a granddaughter. Alicia’s own mother had her first child at aged 16 years and Alicia’s sister had two children by the time she was 18 years old. Further, when Alicia was pregnant, her 16-year-old niece was also expecting her first child. Intergenerational teenage pregnancy was carried through this family.

\textbf{...she’s a good mum}

The majority of the teenagers who had not planned their pregnancy were proud to be mothers. They may have viewed motherhood as an appropriate pathway in life for them. For example, 18-year-old Hanna had struggled with ‘bad’ depression since she was 13 years old. Her mother left home and she helped her father bring up her younger siblings. Having learned parenting with her younger siblings, Hanna felt that she would make a ‘good mum’ because \textit{...I believe in myself. You can achieve anything if you believe.} Similarly, Bella emphasised: \textit{I don’t care what anyone says or how they look at me because I’m a young mum because I’m proud of it. I wouldn’t take her back for the world. I’m almost 19.} Bella was aware of the social stigma around teenage mothering and was determined to overcome the negativity by emphasising her achievement and social status as a young mother. This may reflect Bella’s confidence that she is a good mother.

Likewise, Anna’s mother said of her daughter that \textit{... she’s a good mum.} Investing in the ‘good mother’ identity may be the teenagers’ resistance to the stigma of early childbearing (McDermott & Graham, 2005, p. 70) and a way of coping with the stigma (Yardley, 2008).

In a sense, the ‘good mother’ identity that some teenagers were keen to emphasise may also be a justification that somehow makes teenage pregnancy acceptable to society because they are ‘good mothers’. All of the teenager mothers revealed that they had embraced motherhood, and none regretted having had a baby. For example, Alicia, an 18-year-old mother who planned her pregnancy, said she \textit{[feels good as a mother] ... great, I love it.} Similarly, Kelsey, who had a stressful time during hospitalisation when she had her baby, was positive about motherhood. She said: \textit{[being a mother] I love it. I}
absolutely love it now... it's just like when you wake up and you get to see her smile in the morning. She just makes you feel all warm. The teenage mothers’ positive attitudes towards motherhood may be their ‘foreground’ view, with the negativity of early motherhood hidden from public scrutiny. This response may have been necessary because the researcher was a midwife at the local hospital and had a mandatory reporting right to report cases of child neglect.

Further, the post birth interviews revealed that motherhood had a positive influence on many teenagers, with some experiencing profound transformational changes. For these teenagers, the pregnancy had ‘forced’ them to ‘grow up’. For example, Chloe commented that she was reticent about getting angry with people and said: ‘when people piss me off, I can’t say things now because I’ve got bubby [baby] in my hands or bubby in my life, so I can’t say things. Likewise, Hanna said she has [grown up] A lot. A hell of a lot. [for example] Um, well not drinking and getting into trouble by the cops. Um, just run amuck like a normal teenager. There was a sense of pride in Hanna as she revealed that, as a mother, she no longer ‘run amuck’, reflecting that she was behaving more responsibly. Of the nine teenagers re-interviewed in phase 1 (b), Hanna appeared to have made the most transformative change after her pregnancy. Her life had turned around because of her baby. She was single, and when asked about her social support, she said: I do everything myself [not dependent on either services, friends or parents]. It’s just proof that teen mothers ain’t all as bad as what people think they are. She was proud of her achievements and her independence. The teenage mothers’ stories suggested that, while they had not planned the pregnancy, they were ‘good mothers’, and this justified their decision for early childbearing.

6.2.4 I want a healthy baby

As presented in Chapter 5, this theme reflects that many of the teenagers knew about the need to stay healthy, which was mostly motivated because, as Hanna said: I want a healthy baby. The teenage mothers interviewed reported improved healthy behaviours, such as improved diet and stopping and/or reducing cigarette smoking and other substance use (alcohol and illicit drugs).

Most teenage mothers reported dietary changes. For example, Erin and Alicia, the two teenage mothers recruited postnatally for the study, revealed that they were aware of the
need for a healthy diet during pregnancy. As Erin stated: *during pregnancy* I tried to eat a bit healthier ...had weird cravings but, tried to...avoid bad stuff, but ended up eating a little bit of junk food. This also reflected the difficulties that Erin faced in trying to maintain a good diet while pregnant. As noted in several of the mothers’ interviews, they were aware if they deviated from a healthy diet. For example, Hailey had sometimes missed meals such as lunch and dinner, and she said: *I suppose that's pretty selfish when you've got something inside you that needs feeding.* Hailey lived with her mother during her pregnancy. She did not offer reasons for missing the meals, except that she did not always feel hungry.

A major concern voiced in relation to diet during pregnancy was the dietary restrictions regarding Listeria infection. Chloe was confused about the dietary restrictions to avoid Listeria infection and remained confused in the post birth interview. She said:

*diet was poor during pregnancy* Because I ate, like junk food. And had drinks and that, because I haven’t ate vegies for years and years now. I hate vegies. I had potato and... No. If I have to I eat cold peas out of a tin. That’s all I eat. And potatoes. No, it was important though. For bub, yeah. But I didn’t. I tried eating vegies, but I keep spewing up all the time.

As noted in the above testimony, Chloe understood the need for healthy eating during pregnancy. However, similar to Zoe, Chloe remained strongly influenced by her childhood socialisation in regard to food.

Cigarette smoking was common among the pregnant teenagers, and some teenagers continued to smoke post birth. Many teenage mothers were aware of the dangers of secondary cigarette smoking and reported that they smoked outside of the house. In relation to substance abuse such as alcohol, Anna said that *No I'm just not really that into it [smoking and binge drinking alcohol] anymore.* She attributed this to getting her ‘life on track’ and was not using alcohol or smoking since becoming pregnant. Likewise, Hanna was drinking a lot prior to the pregnancy and had stopped drinking when she fell pregnant. As a mother, she said that she was not drinking alcohol because she *Don't have time to [binge drink alcohol].* Neither of the two teenage mothers recruited for the post birth interviews smoked cigarettes. Both stopped drinking alcohol when they found out they were pregnant.
With the teenagers’ motivation for a healthy baby, pregnancy is an opportune time for the midwives to work with them to address barriers to good health—for example, a greater focus on smoking cessation support and providing practical hands-on demonstration sessions on eating well during pregnancy.

6.2.5 [Sources of information] I’d Google it or I’d ring [my nurse] …

Post birth interviews with the teenage mothers revealed that they obtained information from a myriad of sources. An important source of information during pregnancy and post birth was the internet, which the teenagers accessed mostly through their mobile phones.

The teenagers’ mothers were also an important source of information. A plausible reason for this was that the mothers were the most accessible source of information. For example, Amber, who lived with her partner, learned a lot from her mother during her pregnancy and parenting—more than other sources of information such as the internet, doctors, midwives and CHAPS. Similarly, Zoe consulted her mother first. If her mother could not help, she would refer to her sister …because um, my sister has two kids… For these teenagers, close family members who had children made them a credible source of information. Further, mothers and sisters were more accessible to the teenagers than, for example, GPs and nurses.

It was noted in the post birth interviews that many of the teenage mothers attended the YMC childbirth education classes. For instance, Hanna, who lived in a rural town some 89 km from the city, made a conscious effort to attend. She had attended ... all the classes that I had to go to. Further, Hanna found online sources of information useful and said: ... internet. Facebook, yeah, that’s really helpful. Facebook is an online social networking site that provides information by users around the world that may have little relevance to the information required for birthing at the local hospital. As noted in phase 1 (a), the teenagers interviewed took a liberal approach to acquiring knowledge about childbearing by accessing online sources and information from their mothers to supplement the formal YMC childbirth education information.

One teenage mother interviewed also found the YMC’s reading materials useful. She had read the information on the baby’s growth several times. However, in the end, it did not matter where the information came from, as Anna said: ... I think a lot of it just
comes naturally. This notion of ‘naturally acquired knowledge’ may have come from the integration of the myriad knowledge sources that Anna accessed during pregnancy, including her mother, friends, the internet and health professionals (GP, midwives, nurses). Kelsey supported this, reflecting in the post birth interview that You learn lots along the way, like, what settles them [baby] and what helps them stop crying. You learn that all along the way so, yeah. Learning ‘along the way’ through practical experiences is important and can enhance teenage mothers’ confidence in their ability to learn and in their acquired knowledge.

The YMC welcomes partners, family and friends to their childbirth education classes. Although a few of the 11 teenage mothers interviewed had partners, only Kelsey’s partner attended the education classes regularly. Non-attendance may be a disadvantage to these partners. For instance, Amber’s partner, who only attended one antenatal clinic when she was 36 weeks pregnant, felt that he could probably have benefited from more information. Amber explained: ... 'cause he watched it come out [birth of baby] and he said he didn't like that. Further, Kelsey felt that the YMC ... was really good for me. Like, I learnt a lot. However, she said:

And I know [Partner] he liked it but he felt a bit like ... a bit helpless ... He was like, 
'What am I meant to do?' like ... He felt kind of just like ...[he was ‘dragged along’ to the YMC].

It was noted in the post birth interviews that a few of the teenage mothers did not attend the education classes regularly for various reasons. For example, during pregnancy, Bella experienced transport difficulties because she lived in a rural location and relied on her mother or public transport to get to the YMC in the city. Bella said: it was hard for me to get down on time, especially when I was having bad days when I was pregnant with her ... I wasn’t waking up until 1 o’clock, so ... In addition to transport issues, Bella experienced ‘bad days’ during pregnancy that prevented her from attending some of the YMC classes. The ‘bad days’ were not explored with Bella in the post birth interview; however, Bella had experienced depression in her childhood and during pregnancy, and her ‘bad days’ may have been related to the depression.

In addition to the YMC, the post birth interviews confirmed that most of the teenage mothers were in the c u @ home nurse visiting program. Kelsey, who lived with her
partner and her single mother, said: *I have a c u @ home nurse. Yeah, ...She's awesome.* The nurse visited more often if the baby was not doing well—for example, experiencing weight loss. Chloe’s baby was in neonatal intensive care for several weeks following birth. The nurse made weekly visits to Chloe at home to *... check [baby] him up, see what was with the weight.* In addition, the nurses were able to link the mothers to available social networking, such as mothers’ groups. Interestingly, 19-year-old Taylor, who lives with her parents, said: *I’ve never heard of c u @ home.* With a limit to the number of teenagers in the c u @ home program, the YMC midwives may have felt that Taylor did not require the program’s support. However, post birth, Taylor received post birth visits from the Aboriginal health nurse who functions as a Child and Family Health nurse.

The teenagers also identified their GP as an important source of information during pregnancy and parenting. The mothers revealed that they visited their GP for the six-week postnatal examination and to obtain their contraceptives and have their baby examined. During post birth, another important role that GPs played was to provide referrals for medical and non-medical resources—for example, to social workers and nurses who could provide support for the teenagers if needed.

Taylor, a 19-year-old mother, was in ‘shared care’, whereby she attended both the GP antenatal clinic and the YMC services. Taylor valued her GP’s knowledge of all aspects of childbearing. In the post birth interview, she said:

*... I had a good doctor [GP]. ...I went back and forward to the clinic and to him. Because I don’t think, when I went down there [the YMC] they didn’t have anything about eating and stuff.*

Taylor said that her GP had given her a lot of information on parenting and childrearing, including the introduction of solids. She felt that the YMC should include this information as well. As suggested by Taylor, the differentiation between the roles of midwives and child health nurses is often blurred. Importantly, Taylor highlighted the need to receive more information from the nurses regarding the care of her baby.

Community social groups for youths are available in most LGAs in Tasmania. Some of the teenage mothers interviewed had received good support from the PYPS Youth Worker from UnitingCare. The PYPS is a community-based program for young parents.
under the age of 25, and it is managed by UnitingCare, a faith-based non-government organisation in Tasmania (UnitingCare Tasmania, 2014). The most useful support provided by PYPS was in obtaining housing. For example, Hanna and Alicia obtained housing to rent through PYPS. Alicia said that she and her partner had found accommodation through PYPS, which referred them to a non-government organisation. She said that the PYPS Youth Worker also …helps me out with food vouchers and stuff. Likewise, Hailey was able to access the PYPS Youth Worker for parenting advice because, as Bella said, the …[PYPS staff] has had kids …… I’d call them… as they could most likely provide advice to the teenage mothers. In addition, the PYPS Youth Worker coordinated with the nurses to provide home visits to Chloe when her baby was discharged following a month in the special care unit at the hospital.

Further, in the community, one of the programs provided by an LGA for young mothers (aged up to 25 years) was on personal development, literacy, health and work. At the time of the post birth interviews, Anna was the only mother who was attending a young mums program in her town. However, the demands of caring for a young baby made it too difficult for her to continue with the program. She said: Because it’s been a bit busy lately and it’s at 9.30 in the morning, which is pretty early and [Baby] has been sometimes sleeping ‘till about 9. Interestingly, Chloe, who lived in the same town as Anna, had not heard of the young mums group in the town. Kelsey had heard about a young mothers group from her nurse and was looking forward to joining it. She said: Yeah, it’d be good to like hang out with other young mums. It was noted that some mothers were not keen to join community groups. For example, Alicia, a shy 18-year-old mother, said that PYPS had a young mums program, but I just don’t want to [attend]. Further, some teenage mothers in rural towns did not have access to community-based young mothers programs because they were simply not available.

6.2.6 [Postnatal in hospital]… everything was just so stressful

The immediate postnatal period at the hospital was marked by intense stress for some teenagers—in particular, for those with a history of depression and anxiety during pregnancy. For example, Kelsey felt that …in the hospital everything was just so stressful in the immediate postnatal period.
Several teenage mothers who experienced depression and anxiety prior to and during pregnancy also developed depression during the postnatal period. Postnatal depression is more common if women have experienced antenatal depression, and it is more common in young mothers than in older mothers (McGuinness et al., 2013). As a first-time mother with a newborn and with experience of depression and anxiety, the early period of adjustment to the new social role of mothering can be extremely stressful, as reflected by Zoe:

> Yeah, it’s just it doesn’t help when I’ve got really bad depression, anxiety, and then mixed with her, so, just, if I’m really upset...about something I just get to the point where it’s just all on top of me, and I’ll be fine...I’ll just be coping, but then she screams and I can’t...help her, then it’ll just crack. [feels down] I usually get Mum to come and help me, usually.

Importantly, Zoe was aware of the effect of her mental health on her ability to cope with the baby. She also experienced anxiety over the baby and said: ... I don’t like her [Baby] out of my sight unless she’s at Mum’s type thing. I get really worried. Similarly, Bella, who had depression and anxiety, was also worried about waking up and finding her baby deceased. This level of anxiety for newborns may be acceptable with all new mothers; however, Kelsey’s anxiety was projected at current and future fears. She said: So I’m just so scared ... she’s going to get kidnapped one day. For these teenagers who have lived in a heightened state of anxiety since their early teenage years, the arrival of the baby compounded their anxiety and made them feel worse.

Nonetheless, a few teenagers had improved mental health by the time of the post birth interview at five months. In an exemplary case, Hanna, a teenage mother who had ‘bad’ depression since 13 years of age, along with self-harm and attempted suicide, said that her ‘score’ (EPDS) was good and that I [am] completely fine, which was good. I’m really, really happy now. She attributed her sense of wellbeing and happiness to the baby and said:

> If I didn't have [Baby], I don't think I’d be here. I was at that stage [of self-harm]. And then as soon as I found out I was pregnant, it was probably the happiest ... Most proudest moment of my life.
As a mother, Hanna felt grown up. She expressed confidence in her parenting skills and was proud that she did not rely on government services, friends or parents. She said:

*I do everything myself. It's just proof that teen mothers ain’t all as bad as what people think they are. I’m a teen mum. And I’m pretty sure I’m doin’ better than most adult, grown up mothers.*

Another teenage mother, Chloe, was treated with antidepressants for depression that developed during primary school because she was bullied. Post birth, she no longer needed antidepressants. This may reflect a lesser experience of depression. However, it may also reflect that Chloe, as a mother, had to shift her focus from her needs to the baby’s needs. As Chloe stated: *... I can’t like do things to myself, like cut myself like I used to do. Got bub now so I’m trying to walk away from it and...* Being a mother, Chloe expressed self-control instead of self-harm in stressful situations.

Another postnatal stress for many teenagers was the unexpected obstetric events that occurred, such as ruptured membranes and birth complications. In an exemplary case, 18-year-old Alicia ‘broke her waters’ and was ‘irritable’ and restless upon admission to the OMC. Her mother and partner were with her. At the OMC, the medical doctor concluded that Alicia’s ‘waters had not broken’, as confirmed by the negative amniotic fluid test and the vaginal examination. However, four hours later, Alicia delivered her baby in the OMC. In the interview, Alicia, her mother and partner remained upset by the whole experience at the OMC as they retold their story. Alicia’s mother said: *...we wanted a better sort of a birth in a way than what they made it be.* She revealed that the *…doctor was a bit abrupt and downgrading.* They were clearly disappointed with the way the medical doctor had managed Alicia. They reported that *Well, [doctor] said she [Alicia] was playing up. [Alicia] does not play up* (Alicia’s mother). The doctor also labelled Alicia as having *…an ‘attitude’ problem* (Alicia). Alicia’s mother intuitively felt that Alicia was in labour, even if the ‘water had not broken’ because Alicia was restless and ‘irritable’. She was ‘irritable’ because she was experiencing labour pain. Alicia’s mother felt that the OMC staff were clouded by the objective information from the tests, the examination and the doctor’s view that Alicia had an ‘attitude’. This labelling was a stigmatising process (Link & Phelan, 2001, p. 367). Underlying the story retold by Alicia and her family was the sense that they had felt the doctor’s domination and that they were unfairly ‘silenced’ by the medical doctor’s practice. This
reflects the doctor’s medicalised view of patients (Conrad & Barker, 2010, p. S74), which gives doctors power in situations such as the one described above.

As first-time mothers, a major source of stress for some teenage mothers was not knowing what to do for their babies in the immediate postnatal period. As stated by Kelsey: ... [Baby] was like, 'cause at first day she would cry a lot. I didn't know what to do. Yeah, I thought I was going to break her because she was so tiny [Baby had low birth weight at birth]. Kelsey had experienced anxiety since childhood and during the pregnancy. This may have contributed to her experience of stress and loss of confidence during the early postnatal period. She said: ... at first I'm just like 'Oh, like I'm so young. Like, I'm only a baby myself and now I've got to raise a baby.' And ... Yeah, it was really overwhelming at first. This experience may have been due to the midwives’ practice, as reflected in the following statement:

Yeah, I kind of felt a bit like ... you had to 'do everything their [midwives’] way’. And they were like 'No, you have to do this, you have to do this, you have to do this’ sort of thing. ... and they were all like kind of telling me different things ... which is a bit stressful ...and it was a really hard thing 'cause like they all, as, you know, like they all kept swapping over. So I’d just gotten used to one nurse and then she’d go and another one would come. And it’d be like ... oh, starting all over again. Yeah, and it was a really hard thing 'cause like they all, as, you know, like they all kept swapping over. So I’d just gotten used to one nurse and then she’d go and another one would come. And it’d be like ... oh, starting all over again. Yeah, and [Baby]...was really, really ... she was really jaundiced at first (Kelsey).

The hospital experience was unpleasant and Kelsey ... felt really uncomfortable. I couldn't wait to get home. Unbeknown to Kelsey, she was developing worsening anxiety and was later diagnosed with postnatal depression by her GP. Thus, her mental health state may have contributed to her sense of insecurity. Other factors may have accounted for her stressful postnatal experience, such as her baby’s jaundice and her breastfeeding difficulties. However, central to Kelsey’s negative experience were the midwives’ dominating practice and the delivery of care model that lacked continuity of the carer’s approach.

The challenges of learning to breastfeed were a source of stress for teenage mothers during their hospital stay. Breastfeeding was a popular choice among most of the 11
teenage mothers. Sadly, only two (Erin and Alicia) of the 10 mothers who wanted to breastfeed were successfully able to do so at the time of the post birth interview. The failure to breastfeed was due to factors such as low breast milk supply and sore nipples. For example, Zoe gave up breastfeeding the baby after six weeks, saying *It got to the point where I wasn’t allowed to anymore, so, I didn’t stop, I just wasn’t allowed to [breastfeed]*. The main reason that Zoe gave up breastfeeding was because the baby was losing weight. As mentioned earlier, Chloe breastfed her baby for six to seven weeks. She was also disappointed that she had to stop breastfeeding:

*[Baby]*… didn’t, like much from the breast so I had to express and that got me tired and, yeah, trying to keep milk up to date and trying to do all the milk for a day that I couldn’t just... He wanted more than a hundred, wanted more than 120. I couldn’t get more milk since his last feed because he was like every three hours. Got really tired and, yeah... In the middle of the night trying to express my milk for him and, I just give up a bit.*

While Zoe and Chloe were able to breastfeed for six to seven weeks, many of the teenage mothers gave up breastfeeding in the first week of birth. As identified in the interviews, Zoe and Chloe stopped breastfeeding because they developed painful nipples. In Zoe’s case, she was advised to stop breastfeeding as the baby was not gaining weight. Anna also developed sore nipples. She was discharged after one day in the hospital and gave up breastfeeding three to five days following her return home. Going home early may have contributed to the early cessation of breastfeeding. The lack of support on the postnatal ward and at home for teenagers may have contributed to early cessation of breastfeeding (Condon, Rhodes, Warren, Withall, & Tapp, 2013). Importantly, the teenagers and their babies missed out on the opportunity to experience the health benefits of breastfeeding (Wambach & Koehn, 2004, p. 366). When asked, Anna said that she felt she had adequate support in hospital. She said: …*the midwives and that were pretty...good. Like teaching me to do it. And they had like a little um... brochures and yeah, pictures and stuff.* Similarly, Bella also experienced painful breastfeeding and gave up when she went home. She said: …*I was using the lotions and everything and it just burnt.* The teenagers had to put their babies on baby milk formulas. This would be additional cost for many teenagers who were on social welfare benefits and have limited financial capacity. As noted in the antenatal interviews, many
of the teenagers expressed that they were keen to avoid using baby milk formulas because of the cost.

In contrast to the above, Erin and Alicia were still breastfeeding in the post birth interview at two months’ post birth. Erin, an 18-year-old mother, had a caesarean section and was in the hospital for four days. She said that she received assistance with breastfeeding from the midwives at the hospital and that Yeah I did [breastfeed], it was pretty good yeah. Erin appeared relaxed and calm during the YMC visits and in the post birth interview. She married her partner (the baby’s father) during her pregnancy. Her calm demeanour and contentment may indicate the required mental state for successful breastfeeding. She said: ...yeah, it’s just easy. I’ve got a lot of milk so.... In another case, Alicia, who was breastfeeding her two-month-old baby in the post birth interview, experienced painful inverted nipples. Her partner said: ... she said it hurt when she was breastfeeding. But they gave her one of them nipple shields. Alicia was shy about breastfeeding in public but felt more at ease when wearing a special top. The teenager’s mother was confident that her teenage daughter would be able to breastfeed. She said: ...but see I fed [Teen] till she was five, so ... Oh, she’s had no trouble whatsoever. Thus, despite experiencing sore nipples at the time of the interview, Alicia persevered with breastfeeding. This could be because of her mother’s influence and support for breastfeeding.

Housing insecurity is common for many childbearing teenagers (Blanch & Goodes, 2013; Quinlivan, 2006) which added to the postnatal stress. Likewise, in the current study, housing posed a major source of stress for some teenage mothers. For example, 18-year-old Bella said that her biggest stress in the post birth period was: Not having a house. Not one that I feel comfortable in anyway, safe ... She obtained a housing commission home but did not feel safe there because the house was located in a socio-economically disadvantaged area well known locally for its petty crimes. Until the current house contract is cancelled, Bella was unable to get another house.

In another case, Anna was planning to move because she had a noisy neighbour who often woke up the baby. The area had no footpaths and Anna could not easily walk her baby to the shops. Another important reason why Anna wanted to move out of the area was because there were many young people in the area using illicit drugs, including her ex-partner. She said: I want to move out like into a more liked district, like country area.
... he can go to like a district school and hopefully he'll like stay out of trouble. Thus, housing security is not just about acquiring a house; it is also about meeting an essential criterion of neighbourhood safety.

In addition, maintaining a home with a baby can be expensive. As identified in the post birth interviews, all single and coupled teenage mothers were on social welfare payments and lived on a tight budget. For example, Hanna, who lived alone in rented accommodation with a five-month-old baby, said:

*Everything goes on [Baby]. He goes through a tin of milk every two to three days. He’s drinking a lot. That’s 260mls each bottle and that’s with Farex. [cost of each tin of formula] ...it’s only like 14 [$].*

In Australia, all first-time mothers receive child-related allowances from the Federal Government, which are disbursed through Centrelink. In the main, as revealed in the post birth interviews, the majority of the teenage mothers were managing well financially on the social welfare payments. However, financial struggles are still common. For example, in 2014, 47 per cent of Parenting Payment recipients lived below the poverty line (Australian Council of Social Services, 2014, pp. 5-9). This could be because the mothers were receiving a supplemental income from the baby bonus payments. For example, post birth, Kelsey was managing well financially. She said: *I actually get a lot more money off Centrelink [social welfare payments] than I did at work.* Kelsey worked 11 hours each week during the pregnancy, and both Kelsey and her partner lived at her mother’s house. The employment and free board would have contributed to her financial stability.

Nonetheless, as identified in the interviews, a few teenage mothers found it difficult to meet their living expenses with social welfare payments post birth. For example, Chloe, who lived with her 19-year-old unemployed partner in rented accommodation, continued to struggle financially in the post birth period. At five months’ post birth, Chloe said that, financially, she was *Not very good:*

*... [her Centrelink income] it’s not really much. So by the time I buy food and that and power and stuff it’s really all gone. [partner is on social welfare too] He’s paid tomorrow. He helps me for bills. Yeah, [electricity] $400 a months, five [$500], and now it’s 300 and something.*
During the interview, Chloe commented that she received $100 towards electricity from St Vincent de Paul. Her mother was supportive but could not help her financially because she was unemployed. One of the contributing factors towards Chloe’s financial struggles could be that she had recently bought some large household items (a fridge and a bed) that she was paying off in instalments each fortnight. In addition, Chloe owed money to a fitness company that she was attending. She said:

So I’m 80 bucks [in debt], I couldn’t afford it, I’m waiting for the debt collectors. No, I told them I could pay it off a fortnight, but no, you’ve got to pay it, like oh, I’ll try. …the other day I couldn’t get a loan because of the debt collectors. So that’s been hard.

With little disposable income, Chloe’s recent purchases may have compounded her financial difficulties.

Alicia, who had similar social circumstances to Chloe, was also struggling financially. She lived with her partner in rented accommodation. Her partner was on social welfare payments and shared expenses with Alicia. Alicia’s mother said: No way, she can’t afford to save. I buy her groceries and things, and I sell … a few things on the auction. No, you can’t [save], at $275.00 of rent. Alicia was unhappy with the relationship with her partner and was unsure of what she would do.

For some of the teenage mothers interviewed, their partners were a major source of stress during post birth, which affected their mental health. For example, Taylor had a difficult pregnancy. As revealed in phase 1 (a), she left her fiancée because he was physically violent towards her when she fell pregnant. In the post birth interview, Taylor was asked how she felt about motherhood. She said: I thought that I’d be married and have a house and then have some kids. She was also upset because her partner had had no contact with them. She said: I’m angry that he doesn’t even want to see her and stuff. However, as noted in the post birth interview, Taylor was happy and was planning to live with her new partner.

In another case, Hailey experienced relationship difficulties with her ex-partner, who left her for another young woman when she was pregnant. In the post birth interview at five months, Hailey was happy because she no longer had to see her partner in relation to the custody of her baby. She had also made new friends, and there was a possibility
of a new romance. Thus, partners can negatively and positively affect teenage mothers’ mental health and wellbeing.

6.2.7 …[teens] they need support…

The majority of the teenage mothers interviewed received support from their mothers/parents, and some received support from their partners. Social support refers to support that was readily available to the teenagers from their social network of people, such as close family members and friends (Corcoran et al., 2000; Feldman, 2007). The teenage mothers were aware and appreciative of the support they received from their families. For example, Amber said:

I just think um they [teens] need support and … For them to be positive really [she knows other young mothers]. … they’re looking for houses and places to stay and stuff like that. Which is hard for them. If I was by myself, like other young mums don’t have support, ... I don’t reckon I would cope very good.

Amber recognised that she was lucky to have parents who were supportive of her in regard to emotional and physical support, such as caring for the baby.

In contrast, Hanna, an 18-year-old single mother, did not have social support. When asked in the post birth interview who her biggest support was, she replied ‘Myself’. At the interview, other than not having adequate financial resources, Hanna reported that she was coping on her own. She had few friends and her ex-partner was planning to move to the mainland Australia soon. She no longer receives support from community groups such as the PYPS. However, Hanna revealed that she had re-established contact with her mother whom she had not seen since she was 12 or 13 years old.

Too much support from parents can be stressful. For example, as mentioned previously, Taylor felt that she needed to move into her own house because she felt that she was unable to build her confidence as a mother by living at home.

Parents also provide support such as transportation for many teenage mothers. In the interview, Anna’s mother said: She can't go too far [move too far away]. Cause she needs me to drive her everywhere. Thus, the lack of transport is socially restrictive and may contribute to the social isolation of teenage mothers.
Some of the partners appeared to provide good support following the birth of the baby. For some teenagers, financial support from the partners was important to help the teenagers cope with costs associated with caring for a newborn baby. Most of the teenage mothers interviewed lived with their partners. Only one teenage mother, Erin, was married to the baby’s father. He was 19 years old and was in the last year of an apprenticeship program. Post birth, many of the partners shared the costs for household expenses. For example, Chloe said: *He helps me for bills. The bills are hard for me to do. He does the bills for me.* Likewise, Alicia’s partner also shared the household costs. He said: *…we pay a week each. ... like she gets paid [social welfare benefits] one week, she buys food, and then I get paid the next week, I pay, I buy food.* It is assumed that the partners’ financial support is a relief for the teenage mothers, who had relied on social welfare benefits as their main source of income. This support may provide a buffer against stress (Pires, Araujo-Pedrosa, & Canavarro, 2014) in the teenagers’ lives by reducing some of the financial burdens related to having a baby.

However, similar to the antenatal finding, current and ex-partners can also be a major source of stress. For example, Anna said that she did not receive support from her ex-partner. According to Anna: *... all his [partner’s] money used to go on that [illicit drugs] and himself really.* However, Anna allowed him to stay with her one or two nights a week. Anna rationalised that *I'm happy for him to be around at the moment because he's behaving himself but if that changes then ....* The constant struggle with the ex-partner was palpable and a problem for Anna in an otherwise positive motherhood experience.

In another case, Bella lived with her partner at her mother’s house. As noted in the antenatal interview, her relationship with her partner was then tenuous. In the post birth interview, Bella’s relationship with her partner appeared unchanged. Bella said: *[relationship with partner is] ‘average’. Yeah, sometimes it’s really good but other times it’s just like ‘whatever’.* The inconsistent support from her partner was unsettling for Bella.

Friends can also provided good social support during the post birth period. As noted in the post birth interviews, Kelsey said that she still had:
...a few like good friends...that I still hang out with who love [Baby] to death. So I still have those few close friends. I lost a few along the way but they obviously weren’t very good friends.

The friends soon stopped seeing Kelsey because having a baby restricted her lifestyle. As Kelsey commented, … they stopped talking to me 'cause … I couldn't go out and drink all the time. I couldn't go out and do this and that. But I don't mind at all. Thus, friends may be lost during pregnancy and post birth because they no longer share common social interests. Likewise, Hailey had lost a few friends and made new ones during the post birth period. She said: I've actually let go of a few friends. I hardly talk to my old friends anymore. She felt that they were ‘interfering’ and were …involved in everyone else's business. Hailey did not expand on what she meant about her friends; however, she appeared to be happy to have new friends who were … ahead of me on a few things. They've all got jobs and their licence and stuff… In the interview, it was clear that Hailey looked up to her new friends as role models for her to emulate. Hailey is keen to work and spoke of her recent interview for a job at a supermarket. She was also keen to get her driver’s license. Having a baby could also attract new friends. As noted, 18-year-old Chloe did not have any friends during her pregnancy. She was bullied at school and developed depression. With a baby, she found it easy to make new friends. She recalled: …before I had bub I had no friends at all, like I was all by myself. Now I’ve got baby they’ll all come near me and that. Because of him, not me. Nonetheless, Chloe found motherhood isolating because she could only go out once a fortnight on her ‘pay day’, when she received her social welfare payment.

6.3 Summary

This chapter presented the post birth interview results from 11 teenage mothers in phase I (b) of this study—nine of whom had also participated in the antenatal interview. A summary table displaying the six themes and the 13 subthemes was presented. Many of the 11 teenage mothers had parents who were divorced or separated. Further, many had an unhappy childhood and had not planned the pregnancy, and they were motivated during the pregnancy to have a healthy baby. The teenagers had access to several sources of pregnancy-related information. Some of the teenagers experienced a stressful time during the postnatal period in the hospital. The interviews also revealed that social
support for teenage mothers is important to help them cope with the stress of motherhood.

Chapter 7 presents the results from phase II, with the midwives who worked in the antenatal clinics, including the YMC. A major focus of the chapter is the major themes and subthemes that were identified from the midwives’ interviews.
Chapter 7: ‘…They Are Adults with Special Needs’: Results from the Midwives’ Interviews

7.1 Introduction

This chapter presents the results from the interviews with the midwives in phase II of this study. A midwife is defined as:

... a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant (International Confederation of Midwives, 2011, p. 1).

In Australia, midwives are the mainstay in the care of pregnant women in public hospitals.

In 2012, nine midwives working in the antenatal care clinics (YMC and general adult clinics) were recruited as research participants through convenience sampling from a local hospital in one region, in Tasmania. Recruitment and interviews were undertaken by the researcher, who was also a midwife on the postnatal ward at the local hospital. The interviews were completed in a three-month period between late August and October in 2012. Thematic analysis was undertaken on the interviews to explore the midwives’ views of the pregnant teenagers’ health beliefs and antenatal care needs. This analysis resulted in several major themes and subthemes, which were elaborated upon in light of the key research questions. Some critiques of the key findings against existing literature are presented where appropriate.

7.2 Research Findings

The next section presents the midwives’ socio-demographic details. All midwives are referred to by their pseudonyms. This is followed by a presentation of the five major themes and related subthemes (see Table 7-1). The major themes are: ‘… some teenagers have… a rough time’, ‘Depression does seem to be an issue …’, ‘… [teens] they are adults with “special needs”’, ‘… it [YMC] is a good model’ and ‘… everyone
… is supporting teenager [social support] …’. Several subthemes were also identified, and these are also presented in Table 7-1.

Table 7-1: Results from the midwives’ interviews: five major themes and related subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
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<td>… some teenagers have… a rough time</td>
<td>Depression does seem to be an issue …</td>
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<tr>
<td>… [teens] they are adults with ‘special needs’</td>
<td>They are teenagers, you know</td>
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<td>… [teens] still … reacting to their own wants [teens] get lots of information …</td>
<td>… it's almost like they think having a baby will make everything okay.</td>
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<td>… they’re not thinking about the birth …</td>
<td>… they’re not thinking about the birth …</td>
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<td>… most of them [teens] are open to the idea [of breastfeeding]</td>
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<td>… it [YMC] is a good model</td>
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<td>… everyone … is supporting teenager [social support] …</td>
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In this chapter, quotations from the midwives’ interviews are used to present the midwives’ emic perspective in support of the research findings.

7.2.1 Midwives’ socio-demographic details

To protect the anonymity of the small number of midwives interviewed, only an overview of the midwives’ demographic details is provided in this section. The average
age of the midwives was 42 years. All midwives were Caucasian/Anglo females. The majority of the midwives were from Tasmania. Most of the midwives were also mothers, and a number had teenage children of their own. The nine midwives interviewed had various levels of experience in working with pregnant teenagers. The majority had worked for long periods with teenagers in the YMC. All had worked in the antenatal care clinics at the local hospital.

7.2.2 … some teenagers have … a rough time

Many of the midwives interviewed believed that many pregnant teenagers had a difficult time growing up because they come from socially disadvantaged backgrounds.

Some teenagers have a difficult time during childhood because many have grown up in single-parent families that were less likely to spend time with them. As one of the midwives, Marie, said: ... one of the things that I really noticed was that most of them came from families where they didn't have their two parents together. This may be a major reason why many teenagers had … a rough time anyway during childhood (Julie). Likewise, Beth said:

... a lot of them seem to come from families where their parents probably haven't been involved in their development as in ... The play side of thing, the interest side of things, and ... there's a handful of them that come from very, very bad backgrounds, you know, neglect. ... parents in prison. Parents umm.. where they've [teens] been removed from them for neglect.

From the interviews, many of the midwives’ considered that the teenagers lacked parenting role models and would require additional social support during pregnancy and after the baby’s birth.

In addition, the midwives highlighted that many pregnant teenagers had not completed their school education. Education is a fundamental human right (UNESCO, 2014) and, as noted in the midwives’ interviews, pregnancy usually brought an end to the teenagers’ schooling. Barb said: Some are still at school but I'd say the majority don't go to school. A few of the midwives noted that some of the teenagers were studying via a flexible mode such as studying at home via distance education offered through the education system. However, a few midwives were sceptical about the value of the
flexible learning and whether the teenagers learned from the program. According to Beth, teenagers who are keen to study … are … from very different families. She suggested that with good family support, they were more likely to continue their education after the birth of the baby. Another schooling option was the ‘young mothers program’ at a local college in southern Tasmania. This college also has the normative streams of schooling up to Year 12 and is funded by the Tasmanian Education Department. In the main, the teenagers considered this program less academic because they learned subjects such as childcare, sewing and cooking.

Fundamentally, the lower schooling achievement is a disadvantage to the teenagers. In relation to their antenatal care needs, their limited education may result in limited health literacy—that is, they may have limited ability to seek, understand and use health information (Australian Bureau of Statistics, 2009a). With low school education, pregnant teenagers may have limited understanding of childbirth education and may not be able to engage in recommended health care behaviours.

7.2.3 Depression does seem to be an issue …

The midwives interviewed believed that depression and anxiety were key problems among pregnant teenagers. According to Barb: … a lot of them [teens] have been diagnosed with depression … you see a bit of anxiety as well. The depression often started during their younger teenage years. As Evi said: … we get a few that have come through that … had depression before they were pregnant. Many of the teenagers may have treated their depression with medication.

As Evi commented, the depression could be … a generational thing [because] … you grow up in that family [family members with depression]. In this situation, the depression manifests in the teenagers’ parent(s) and in the teenager, and it may be due to long-term socio-economic disadvantages in the family. Another contributing factor to depression and anxiety in pregnant teenagers could be that living in a regional location such as Tasmania predisposes them to more stressors. As Julie suggested, depression and anxiety may be outcomes of Tasmania’s depressive characteristics—for example, regional isolation with a higher rate of unemployment than the rest of Australia (except the Northern Territory).
Further, depression and anxiety may be related to the teenager’s experience of socio-economic disadvantage and bullying at school (Beth). Beth suggested that it was also likely that ... sometimes they [GP] are quick to ... diagnose [depression in teenagers]. This may be an important point. Rena felt that Likewise, teenagers may be misdiagnosed as having depression and anxiety because they were more ... melodramatic ... with their emotions and ... things are either great or they’re awful. Rena also believed that teenagers who were ... emotionally needy are probably more likely to get pregnant than teenagers who have good self-esteem ... and self-identity. In defence of pregnant teenagers, a few midwives emphasised that depression was not solely a problem in pregnant teenagers. For example, Julie said: I don't think just because ... they're teenagers... [that] they've got a higher percentage... of mental illness or mental problems. This normalisation of the teenagers’ mental health may reflect that Julie was being protective of pregnant teenagers or she may not be aware of recent trends in relation to teenagers’ mental health in Australia. As noted, in 2007, one in every four teenagers aged 16–24 years in Australia experienced a mental health problem (Australian Institute of Health and Welfare, 2011, p. 25). According to Beth, depression improves as teenagers become more accepting of the pregnancy and ... they seem, yeah a lot happier. Beth believed that ... for some of them [teens] they almost heal through the [pregnancy] process. She recalled one teenage couple and how depression improved during the pregnancy. According to Beth, the teenage couple said:

... 'we're young and we're going to have a baby. But this is for me'. And they seem to be coping better. So you don't seem to see the depression throughout the pregnancy as much. As much as what is reported when they book in. ... [there is acceptance of the pregnancy] I don't know if it's becoming more familiar with the clinic or if it's being more comfortable with the pregnancy and the process and that. At the end of it, [pregnancy] it is a positive thing.

Acceptance of the pregnancy by the teenagers’ family, partner and friends is important to the teenagers’ acceptance of the pregnancy. However, it is not clear whether this positive mental state continues following the birth of the baby, when life becomes stressful and hectic.

Pregnancy may be an additional source of stress for teenagers. A small number of midwives mentioned that teenagers do worry, and this may have contributed to their
worsening depression during pregnancy. However, some midwives’ view was that teenagers are not worried during pregnancy and they do not worry much in general. For example, Beth said: *I have heard people say that young parents stress less. ... they haven’t got all these notions built up about what they want for their child.* In contrast, Evi believed that for the teenagers:

... it's more the worries about how they're going to cope. ... will I cope with the baby and things. [anxiety] And a lot of ... moving house. ... having to separate a bit from her mum.

Housing was a major source of worry for some teenagers. For example, as stated by Beth:

> As opposed to the labour and birth it's like phew that'll be fine. ... we get a lot of, you know, 'I'm trying to get a house, I need a house’... 'I've put in my application.’ ‘Can the social worker help me with that?’ We get a fair bit of that.

Most of the teenagers were on the waiting list for public housing, which is subsidised social housing funded by the federal and State governments (Tasmanian Government, 2012). In contrast to Beth’s comments, according to Evi: *... [housing] doesn't seem to be [an issue]. It seems to be sorted out by the end of their pregnancy.* This contradiction reflects that midwives with different work experiences (clinical versus health promotion) may have different views of teenagers’ social needs.

Several midwives regarded teenagers as financially poor. For instance, Janine said: …*undoubtedly I’d say they would [struggle financially]* because many of the teenagers were dependent on social welfare payments. As Beth said:

... you see more ... lower socio-economic for sure. ... you don't get a lot that are still supported by their parents really, most of them are on independent [social welfare] payments. ... some girls come from ... more middle class ... that's not the norm.

Social welfare payments from the government were often the only source of income for the teenagers.

Midwives also expressed concerns regarding transport for pregnant teenagers. The lack of transport could affect teenagers’ attendance at the YMC. Barb believed that … *transport is probably the biggest one [problem].* Living in a rural area may be a further
disadvantage for teenagers because many rural locations have limited public transport services. Similar to Barb’s views, Angela said: [transport] ... can be an issue ... they come in on the bus and have to spend the whole day in town so they can get the one bus home again. In addition, buses were not popular with the teenagers because they often felt unsafe on buses. As Janine said: ... they [teens] don’t want to get on the bus and have people looking at them going ‘you’re preggers’ .... In contrast, Evi did not consider transport a major concern for pregnant teenagers and their YMC attendance. However, the urgency to address the transport issue was evident. As Julie said: … we need to set up help as far as transport goes. We just need to talk to ... the social worker who will help sort that kind of thing out. The lack of transport appeared to be a continuing concern for the midwives, with few sustainable solutions for the near future.

7.2.4 … [teens] they are adults with ‘special needs’

This theme refers to the midwives’ views that teenagers are not yet adults and therefore, they have specific age-related care needs. The related six subthemes presented are: ‘They are teenagers, you know’, ‘... it's almost like they think having a baby will make everything okay’, ‘... they’re not thinking about the birth…’, ‘...most of them [teens] are open to the idea [of breastfeeding], ‘... [teens] still ... reacting to their own ... wants’ and ‘[teens] get lots of information …’.

Many midwives considered some pregnant teenagers to be knowledgeable about babies because of their experiences with babies in their own families. However, in general, the midwives believed that the pregnant teenagers required a lot of education. For example, Julie said:

...it's all about recognising [that] ...these people [teens] are not adults. It's recognising they are adults with special needs...requiring a lot of, um you know, support and guidance and not to make them feel like...they are lesser because they ... find themselves pregnant.

This reflects the harsh reality that the teenager is transitioning to motherhood but remains a teenager and is likely to be treated as one. This transition can be confronting for midwives because teenagers do not fit the social expectations of motherhood.
They are teenagers, you know

In general, teenagers who attended the YMC were aged between 15 and 19 years. Several midwives emphasised that the teenagers’ age was a central factor that underpinned much of the teenagers’ health beliefs and antenatal care needs. Throughout the 30-minute interview with one midwife, Julie was firm in her belief that the teenagers’ behaviours were attributed to their age. In her matter-of-fact manner, the midwife did not always use politically sensitive language in sharing her views. Julie said that many of the problems during pregnancy, such as poor diet, were related to the teenager’s age and immaturity. She said:

... if you've got a 13 year old or a 17 year old in your house they probably want to, will eat more junk food...whether they're pregnant or not. And so I think some of them are unhealthy, some of them would prefer just to eat Mars bars and drink Coke and whatever... I think they're immature ...

This link between age and immaturity was viewed as a major factor that underpinned the teenagers’ poor diet. Further, the notion of ‘immaturity’ suggests that the teenagers were unable to make sound decisions. As emphasised by Marie: I think that the [teens] thought process doesn't go that far ahead [to think of the future, their health]. Similarly, Rena believed that the pregnant teenagers were at a life stage where ... they’re still very much in their own body and reacting to their own... wants ... However, there were age differences, and Julie believed that older teenagers were more aware of their pregnancy, their care needs and their responsibilities as mothers.

Weight problems such as obesity and underweight may be an issue for pregnant teenagers, with some midwives reporting seeing more ... teenagers who are morbidly obese ... who we have to send back to the doctor's clinic. Obesity and underweight may be due to poor diet, which is a topic discussed in childbirth education. Angela also felt that there was not enough emphasis on diet and nutrition at the YMC. She said: ... one of the things I'd really like to get into the clinic is some more education ... about diet ... There should be dieticians. ... would be great ... to have cooking classes. Poor diet may be because teenagers have little knowledge of how to maintain a good diet. Some of the midwives believed that reasons for a poor diet could include teenagers’ immaturity, … social disadvantage (Marie); and ... haphazard lifestyle ...[without] ... education in preparing food. Or knowing nutritional value of food .... (Evi). Thus, while the
teenagers reported their desire to adopt healthy diets, they may have experienced barriers that challenged this desire.

… it's almost like they think having a baby will make everything okay.

The midwives had mixed views in relation to whether teenage pregnancies were planned or unplanned. As Janine said: *Yes, a lot of them choose to be pregnant ...* In contrast, a few midwives felt that teenage pregnancy was largely unplanned because planning is not characteristic of teenagers. Angela noted the teenagers’ spontaneity:

> I think it's the total lack of planning. I don't believe they think 'Oh, I'll get pregnant so I'll get a flat and I'll get money from the government.' I just don’t think that's how it happens.

However, teenagers who may have planned their pregnancy may not openly acknowledge this fact. For example, Evi said: *... when you look at it, they say 'well, actually I was off contraception'. You say 'well did you know what might happen?', they said 'yes I did'.* For some pregnant teenagers, discovery of the pregnancy generated shock and disappointment in their families. Over time, as the pregnancy progressed, the teenagers and families became more accepting of the pregnancy and the impending arrival of the baby. As Rena explained:

> Parents eventually come around to accepting the pregnancy. Kids are lovely, it becomes a family affair ... it might be a huge shock for the parents and this is not what we planned for our daughter and all this stuff. But then people actually absorb that baby.

A few midwives suggested that a planned pregnancy was a positive life event for some teenagers. In particular, some teenagers experienced improved mental health during their pregnancy. As Janine said:

> Yes, a lot of them choose to be pregnant, so there’s an empowerment of that, it’s probably ... one of the first times in their life something really big that they have wanted and they are in control and they are creating life, you know? And that’s an amazing...They feel important—that’s amazing for any woman but at that time of their life it could do amazing things for them.
The sense of empowerment came from the teenagers’ ability to create life, which they may see as a major achievement in their lives. However, Evi was less optimistic, saying... it's almost like they think having a baby will make everything okay. Which it doesn't.... Evi believed that having a baby during the teenage years was a mistake.

An unplanned pregnancy could result from non-contraceptive use. According to Marie, the lack of knowledge of contraceptives could be a major reason for teenage pregnancy. Further, Maya said: often a conception can occur when using drug and alcohol. According to Barb, there may also be ... a lot of broken condoms. This may reflect that some teenagers may be blasé about life in general. In addition, unplanned teenage pregnancy could be seen as a failure of the family planning services and health professionals to support teenagers to prevent unintended pregnancies. Marie expressed her frustrations regarding teenage contraceptive services at the local hospital and said: Contraception's really important. But that's not ... that well provided [contraceptive services]. We [midwives] talk about it all the time. But do we do anything about it?!

Marie’s frustration may reflect a deeper problem in the delivery of contraceptives to teenagers. As Marie highlighted, contraception is discussed at four points of service contact with pregnant teenagers:

Booking-in. You talk about it again at 26 weeks, you talk again at 36 weeks. Hoping they're talking about it before they go home. And that there's a plan in place [for contraception postnatally].

The above information may reflect that there is a lack of continuity in providing family planning care for the teenagers between the antenatal, postnatal and community care.

Further, teenagers may have discontinued the contraceptive if they did not understand the related side-effects. She said:

They get an Implanon [implant in the arm] in. Nobody explains to them that they might have irregular bleeding, they go to the GP, the GP takes it out and doesn’t give them anything else.

The lack of coordination between services may be an important contributing factor to teenagers’ early second pregnancy.
An unplanned pregnancy can be managed in several ways, such as termination, adopting out and continuing with the pregnancy. However, the midwives reported that teenagers tend to keep the baby. Two reasons for this were noted in the midwives’ interviews. Beth believed that Families are accepting that [baby]. They are taking the responsibility. ... parents are helping out. This is because termination of pregnancy is not as acceptable in Tasmania. In contrast, Rena believed that the teenagers were not empowered to make their own decision about the pregnancy: And the thing that I think is tragic in Tasmania ... a lot of ... teenagers have babies because they don’t see themselves as having other choices.

… they're not thinking about the birth …

Many midwives believed that the teenagers’ age could function as an important stress buffer protecting them from the stress of the many ‘unknowns’, such as labour, birthing and the future. As Rena said:

_"I think teens, because they do come to it with much less expectation or whatever, they're more likely to...just do it [labour and birth] easily. And you know it might work out and they cope and just, you know... You say to them ... 'how was it?' ‘Oh, it was good.’ You know?"

Thus, in contrast to pregnant adults, teenagers may worry less about the impending labour and birth of the baby and may not seek health information related to these events. This apparent lack of concern for the labour and birth may suggest that teenagers and midwives have different ‘needs’. The midwives’ normative needs for the teenagers were primarily focused on safe birthing outcomes. In contrast, the teenagers’ felt needs may be guided by their age and health beliefs. The midwives’ normative needs and the teenagers’ felt needs are often different and could result in misunderstandings in care interactions. For example, as Beth said, some teenagers may worry more about their immediate needs, such as setting up a house, than about the labour and birth. Alternatively, this attitude may reflect that the teenagers may be avoiding thoughts about labour and birth, which may be associated with a lot of pain and fear. As Rena suggested: ... [pregnant teens] they’re kind of just not actually going there [regarding labour and birth]. She believed that it is important to discuss the birth with the teenagers. Rena said: ... I think ...that they have a fixed view. ... I think we have to find out what their view is about delivery. Because it could be completely erroneous and ....
Labour and birth become more real as the teenager nears the date of birth. As Marie said:

I think that the thought process doesn't go that far ahead. [teens do not think ahead]
... I think when it [baby’s due date] gets closer ... the reality has hit that this baby's coming out.

The teenagers’ lack of attention on the birth and labour may suggest that they may pay little attention if they are presented with this information early in the pregnancy.

…most of them [teens] are open to the idea [of breastfeeding]

Globally and locally, breastfeeding in the first six months of the baby’s life is considered essential (National Health and Medical Research Council, 2013). The midwives believed that many teenagers choose to breastfeed, but few can successfully do so. As Beth said: ... most of them [teens] are open to the idea [of breastfeeding]. Social expectations to breastfeed may be pervasive in society and therefore a reason why many childbearing teenagers want to breastfeed. Breastfeeding may also reduce the financial burden related to artificially feeding the baby. However, according to Beth: ... I don't think cost comes into it [decision to breastfeed] .... It could be that social factors are more influential on teenagers’ decision to breastfeed.

The interviews revealed an inconsistency, if most teenagers are open to the idea of breastfeeding, then the breastfeeding rate should be high. Instead, as Beth said: ... the rates for continuing [breastfeeding] aren’t fantastic. As Marie suggested, the teenagers might find that breastfeeding, ... [is] totally disgusting and couldn't even stand the thought of it. Further, they might agree to breastfeed but then decide against it because the experience is not what they expect. Some midwives believed that teenagers are shy about breastfeeding in public because they view their breasts as sexual organs of pleasure rather than functioning to feed their baby. As exemplified by Maya:

... it's amazing how many teenage mums when you discuss feeding they express that they would like to ... give the baby breast milk but not breastfeed. So actually express the breast milk in private and give ... the breast milk ... in a bottle. ... they see their breast more as a sexual thing than a feeding thing ...
Teenagers’ families may be another barrier to teenagers’ uptake of breastfeeding. As Julie said: *If their mother hasn’t done it [breastfeed] she will empower them not to do it, that it’s easier to bottle-feed your baby.* Motivation may also be a key factor in teenagers’ perseverance in learning how to breastfeed. As Julie explained:

> They would try much harder to learn the keypad on their iPhone or they would try much harder to learn to drive a car, you know. They would go to six lessons and they’d pay for it and they still wouldn’t have their license but they would persevere until they got it whereas they don’t persevere with breastfeeding. Now that’s all to do with maturity.

This may highlight that midwives’ views of pregnant teenagers are measured against normative needs prescribed by midwives. This mindset may reflect the fundamental cultural difference between midwives and teenagers. It may also reflect the midwives’ lack of understanding of teenagers’ views.

*… [teens] still … reacting to their own … wants*

Teenage motherhood was raised with the midwives in the interviews. Many of the midwives believed that the challenges of motherhood may be far from teenagers’ minds. According to Angela, pregnant teenagers do not think about what it means to parent and be a mother before they have a baby. Likewise, Maya believed that some teenagers may view life through *… rose-coloured glasses …* and perceive that motherhood is easy *… especially if they haven’t had experience around them … of seeing mums in action.* Thus, teenagers may have a romanticised notion of motherhood.

According to Evi, many teenagers tend to say *I’ll just go with the flow* in relation to labour, birth and parenting information needs. Similar to the teenagers’ apparent lack of concern about labour and birth, this carefree attitude *I’ll just go with the flow* may be mistaken as a lack of interest and awareness of the reality of parenting. As Angela said: *I don’t think the reality of parenting hits them. … I don’t think they really think past the baby stage.* That is, teenagers can only focus on one thing at a time.

Several of the midwives believed that teenagers are not capable of good parenting. As Marie said: *Also, the fact that … [they have] not got parenting and good role models. Or good guidelines. Or any rules!* Barb said:
... I worry about the care of those little ones [babies] ... and the social ... and economic circumstances that they're brought into. [Also, the babies] They just go with them and you worry about what they witness and they are really looked after.

Another related concern is that teenagers’ mothers often have a strong influence on teenagers. The influence may be neither appropriate nor approved by the midwives. Julie said: ... [teens] they're going to follow a similar pathway [to their parents in parenting]. This suggests that parents and family relationships may significantly influence teenagers. Thus, midwives held deep concerns that teenagers may not have the skills required to parent.

The midwives were asked how pregnant teenagers perceived their future after their baby was born. Knowledge of teenagers’ plans for the future may be useful in understanding their information and support needs. Similar to earlier comments about teenagers’ inability to plan and think of the future, Barb said their attitude is to deal with the here and now to ... just get through this and then ... Likewise, Maya said:

... [teens] often they don't have the maturity to be able to foresee that far in the future about how this will be for them in, after the baby is born, six months, 12 months, five years down the track.

In Maya’s view, the pregnant teenagers’ future is bleak, and breaking this cycle of social and economic disadvantage seems almost impossible.

Health information is important and helps people to understand their medical conditions and concerns (Barrow, 2012). At the YMC, Evi said that her common advice to the teenagers is that ... you'll get lots of information .... In general, the midwives acknowledged that teenagers have access to a lot of information. According to Barb, the common sources of health information are mainly ‘in-house’. Barb added:

... many probably ‘Google’ stuff but there are others who just get it from their family, like their siblings who've had children and their mums and of course some of the mums are still having babies too. So, a lot of it's ‘in-house’, really.

For some teenagers, their family was an important source of pregnancy-related information. Several midwives believed that health information may also come from friends, TV and the internet. However, friends are often the first source of information.
Beth said: *Internet, internet definitely. A lot of them are watching birth stuff. And, bits and pieces on the internet.* A few midwives voiced their concerns about the accuracy of these in-house sources of information (parents, siblings, family, friends, TV and the internet). Angela emphasised that: *... you've got to be a little bit careful about that [in-house sources of information] ...* Likewise, Beth suggested that the information from teenagers’ parents may *... not necessarily always [be] the correct information.* This may reflect the midwives’ professional territorial claim on antenatal information that ‘informal’ sources of health information are suspect.

Given the myriad information sources mentioned earlier, Beth suggested that teenagers should make up their own mind regarding the information that midwives provide. She said: *You can give them the information. ... but it's their life and their choice isn't it, you know.* As mentioned earlier, Evi also felt that teenagers should make their own decisions about what they wanted from all of the information they received. Echoing their sentiments, Janine said:

> ... the choices that women make in their pregnancy and how they are–things like what immunisations they give, active management of the third stage [the afterbirth], what antenatal care tests they have, what model of care they choose. All of those things... I have personal preferences ... but I cannot let my personal feelings influence–it’s completely unprofessional and unproductive for me to do that, because my bottom-line is it is their birth, it is their pregnancy, it is their body–it’s not mine. I’ve had my children, so I really try to separate it.

Thus, the midwives’ approach to providing information to teenagers is, as Evi said, for them to ‘sort it out for yourself’. This suggests that midwives strongly believe that teenagers are primarily responsible for sifting through the large volume information from the myriad sources to make decisions about their care.

### 7.2.5 … it [YMC] is a good model

In this section, the issues related to the YMC’s services and the midwives’ practices are highlighted.

The general consensus among the midwives interviewed was that the YMC is an important source of information for pregnant teenagers. According to Barb *... it [YMC] is a good model.* This is because the YMC provides teenagers with *... a really good*
chance to have an idea of what’s going to happen [in labour, birth, and early parenting] (Rena).

In Australia, midwives are the main health professionals that provide antenatal care to pregnant women. According to Angela, midwives are well situated to care for teenagers. She said:

- I feel like we [midwives] can make a difference ... we only see them for a few weeks really. But just to be able to give them some continuity of care and ... reassurance.
- And I like to try and give them a bit of extra confidence... Some of them are so uncared for.

A central feature of the YMC is that the teenagers are encouraged to bring their key support persons to their appointments. As Julie said: … there is no other group [antenatal services in southern Tasmania]... that actually says bring your family along... Similarly, as Beth said about the YMC: ... It's the best one [model] we can come up with at the moment. It's not perfect in that teens do get removed for antenatal care check-ups. And so they miss bits of education. With the concurrent implementation of the antenatal care clinic checks and childbirth education, many teenagers miss out on childbirth education when they leave during an education session to attend their clinic checks. Likewise, Angela agreed that the concurrent implementation of YMC services could be improved. She said:

- Yeah, ideally it [YMC] would be better if they could hear the whole class and then ... have their appointments that would be much better. If I was a person who'd come along to listen to a lesson on breastfeeding ... I'd want to hear the whole thing ... not be in and out [of education session].

Teenagers are encouraged to select the education sessions they want to attend. Julie said that flexibility allows the YMC to empower [teens] ... to come to the labour talk or to the pain relief talk. ... they [teens] can come to whichever one suits them. However, immature teenagers may have difficulties identifying their information needs. Thus, having flexibility in the childbirth program may be disempowering to teenagers because they may not know what information they need.

Likewise, the teenagers’ age can affect how health information is taught and understood by the teenagers. Beth believed that teenagers have a short attention span of ... about
half an hour, probably. This implies that midwives should present several short sessions instead of one long session. In addition, differences between the younger and older teenagers in their learning should also be noted. As Janine said:

... young teenagers [are]... more willing to come ... [YMC]. ... they attend, they’re enthusiastic and they–they give you a lot back because they don’t mind being there, ... but as they got older a lot of them ... weren’t at school .... They felt that they were adults... and they also had more of a wariness to me as an adult. ... it’s like they know it all and you’ve really got to prove that there’s something that you know that they don’t already know because they have done their ‘research’ in inverted commas and so they’re really looking for something else.

Thus, it is important for midwives to understand teenagers, and particularly the influence of age, if they want to ‘make a difference’ in their care.

The empowerment of teenagers may be an important function of antenatal care. To empower is to ‘allow’ and ‘enable’ by providing skills so teenagers can act for themselves ("Oxford English Dictionary," 2014). For example, as mentioned above, Angela believed that midwives can make a difference to teenagers’ lives by supporting them to build a bit of extra confidence. Likewise, Maya would like to see midwives support teenagers, but for long-term benefits:

I think once you build the rapport and build the trust ... and they see that, yes, you can be a valuable resource to them ... to engage ... and support you through ... this challenging time in your life, and prepare you ... not just for the ... pregnancy and the labour and the birth ... but for the next 15, 20 years.

For example, lifestyle education on smoking and diet may have long-lasting effects.

The midwives spoke about two types of empowerment: empowerment to participate in health care, and empowerment to grow and develop or mature. In empowerment for participation in health care, the midwives’ role is to encourage and facilitate teenagers to focus on self-care. As Evi said: ... promoting that self-empowerment ... that you [teen] need to be ... Looking after your health. Similarly, Julie believed that midwives can ...empower them ... [tell them] you can make yourself be the best mum in the world...if you work at it. In the second type of empowerment—to grow and develop—Rena suggested a deeper, more idealistic notion of empowerment than simply

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participating in one’s health care. She said: ... in an ideal world ... how great for teenagers to actually grow and learn... Through the [pregnancy] experience and to engage and... really feel empowered...

This approach for deeper and more meaningful empowerment may be beyond the scope of the midwives’ practice, which is usually time-constrained. Further, midwives might not want, or might not have the necessary skills, to work with teenagers for this deeper level of empowerment.

Teenage pregnancy can be stigmatising because it may be seen by some people to be against current social norms. Stigma is ‘A mark of disgrace associated with a particular circumstance …’ ("Oxford English Dictionary," 2014, para 1). Janine said:

... [teens] they're stigmatised ... I mean, to be a young person and to be traveling and, they [would] say 'oh, isn’t that courageous’–[but] to be a young person having a baby, [people would say] 'oh, what a silly girl’ you know? It’s not seen as in the same vein.

Likewise, Rena believed that stigma is very real in Tasmanian society. Beth believed that: … there's more a culture of, ‘well, they [teens] shouldn't really be here anyway’. Janine believed that the midwives who find it confronting to work with teenagers have the dominant ‘frame of reference’ of ‘white, Caucasian and middle class’. Similarly, Rena felt that the midwives were ‘middle class’ and might not be able to understand the lives of pregnant teenagers—many of whom come from poor socio-economic backgrounds. Likewise, Maya believed that midwives are: ... older, we're professional [and] ... we're in an institution ... She said that some teenagers may view midwives as: You're a scary concept. ... realistically, they're looking at [midwives] as [in their]... ’nana’ age ... . Maya also suggested that teenagers may find the midwives intimidating because … engaging with ... a health professional is very foreign to them. Thus, some midwives may not be able to empathise with teenagers and provide teenage-sensitive care. Further, some teenagers may feel that midwives have deliberately singled them out because of their age. As Angela said:

...[some teens] felt ... really intimidated by some staff. [For example] ... they've gone into ... [hospital], ... and [staff] keep saying ‘How old are you? How old are you?’ And it's as though they're dismissing them [teenagers] because of their age.
In general, Barb believed that midwives would do their best to provide respectful care for teenagers. She said: *I don't think I've ever witnessed anything that you think 'good heavens, stop!'* Likewise, Julie believed that teenagers do not fear stigmatisation in society because *they have so much support these days... the government [in Tasmania], everyone... is supporting teenagers....* However, while the abundance of support may demonstrate that the needs of pregnant teenagers are being met, it does not necessarily reflect the acceptance of teenage pregnancy.

The midwives’ interviews highlighted that some teenagers do not regularly attend the antenatal clinic. Thus, as Maya suggested, midwives *... have to sell our services... about what we have for you [teens].* Similarly, Janine stated that:

*I think if you can get them there [to YMC] ... so that they can see that it's not stigmatised or that it's not... a place that they need to be fearful... ...um that we do accept them for who they are... ...that we don't judge them then I think ‘yes, they will’ [attend the YMC].*

The YMC attendance is important for teenagers to receive the necessary antenatal care and childbirth education. As Beth said:

*... getting them in here, getting them checked up. Educated, seen by a social worker, bloods done if they need bloods and all of that, any referrals taken care of. I think we need to have that.*

In the interviews, the midwives identified a number of reasons why teenagers may not always attend antenatal care clinics. A lack of trust of the institution may be a reason for non-attendance at the YMC. According to Julie, *[teens] They don't have that trust.* As Janine suggested, some teenagers will not attend YMC if they *... have a history with [social welfare] services and people trying to help them that [they] don’t trust ...* Thus, access to the YMC may be limited by teenagers with greater social and economic disadvantage and antenatal care needs. Further, Maya felt that teenagers may not engage with midwives because of the midwives’ age and their lack of use of technology.

The midwives’ style of communication with teenagers is important. Some midwives perceived good communication as ‘connecting’ with the teenagers. Rena suggested that connecting refers to the ability to reach out to teenagers *... to always find a way in ...[and]... you’ve switched them on to things that they didn’t think they liked or
interested in. Further, according to Rena, the individualisation of care will enable a connection and will result in teenagers’ empowerment and participation in self-care. In a similar way, for Julie, the notion of ‘connecting’ was when she was able to get a message across to a teenager about attending the YMC. She said:

... I've got a young girl [17 years old] I phoned this morning.....she's 'DNAC' [Did Not Attend Clinic] four times... and she's not going to come to Young Mums Clinic, she makes all the excuses under the sun. She's 17. So I told her [teen] quite clearly ‘... we care about you, we want to look after you and your baby, you need to go to the clinic or we'll, you know, we have to report you to child protection. So that means that they're looking at you as not looking after yourself or your baby...' ...and she was very receptive to me......on the telephone. ... It is about connecting. It's about talking to [teens] them and making them [aware] ... ...getting the message across somehow. ...and it's not easy if they won't come. But you cannot force them.

In the situation above, to ‘connect’ with the teenager, Julie used reasoning and presented the fact that non-attendance could result in the teenager being considered unfit as a mother. To encourage YMC attendance, a few midwives emphasised the need to be accepting of the teenagers … to make them feel welcome so they come in [to YMC]. And get their health checks (Beth). However, by being accepting, the midwives may be seen as normalising and encouraging early childbearing. As Beth said, welcoming pregnant teenagers may risk developing ... a culture of acceptance [of teenage pregnancy]. But I don't think we can do it any other way. Than accepting that they're here ... The nuanced notion of acceptance of teenage pregnancy is important and may need to be closely examined and understood by the midwives.

At the YMC, the midwives do not use social media to communicate with teenagers. Social media sites such as Facebook and Twitter facilitate social networking and are popular with teenagers (O'Connor et al., 2013) and teenagers who attend the YMC. As Janine said, the lack of use of technology is a concern:

... I think we need to be texting them to get them to the appointments ... We need a webpage with information, we need to be accessing all this stuff ... I think they must come and think ‘gee they're dinosaurs here, they're nice but they're dinosaurs’ ...
This implies that midwives need to embrace information technology and use social media in the care of teenagers to access and communicate with teenagers outside of the YMC’s limited opening times.

7.2.6 … everyone … is supporting teenagers [social support]

Social support refers to support that is readily available from the teenagers’ network of people, such as close family members and friends (Feldman, 2007). As emphasised by Julie, teenagers … have so much support these days … the government, everyone … is supporting teenagers…. Midwives believed that pregnant teenagers’ social support networks typically include their families—in particular, their mothers, sisters and friends. According to Maya, teenagers with good support are characteristically from … from a well-educated … well-supported family … you know that she has resources. All midwives regarded teenagers’ mothers as the teenagers’ primary social support. Beth affirmed this:

... if there's a good parent behind them it certainly makes us feel better. ... you know that they have got someone a bit more mature to call on because they could have, you know, a lot, a lot of friends but how many friends could they really call on in the middle of the night if they needed some support, you know. Umm that's what we focus on.

As noted by several midwives, the teenager–mother relationship may improve during the pregnancy. However, it is unclear whether the bond lasts after the baby is born.

Many midwives preferred that teenagers receive support from their parents rather than the support provided from their partners (where present) or friends. For example, one midwife noted that: ... what parents say and do and think, even if the teenager just scoffs at it … it does gel, it hits home (Julie). Nonetheless, as highlighted earlier, many teenagers may not have good parenting role models at home, and this may present a challenge to midwives when engaging parents in the teenagers’ antenatal care. Interestingly, as noted by Beth, the teenagers seemed to prefer female support during pregnancy. This gender preference could have developed because, as Beth said: … it's more acceptable for the girls with the pregnancy than the boys becoming dads. … there is a different level there of acceptance … However, the midwives’ preference for
teenagers’ mothers as support persons may have contributed to the gender preference for female support during pregnancy.

For some teenagers, partners also play an important role in their care. Julie said: *I think the partners do um feature fairly strongly in some cases ....* Affirming this, Marie added that *... some of the older partner they're quite supportive.* However, midwives do not believe that partners constitute important support persons for these teenagers, as reflected below:

> ... I’d lastly put the boyfriend [as support person]. Because I think often the boys are freaked out by the whole idea that they’re going to have a baby. They’ve got their whole other stuff going on. There’s very few of them that are mature enough to deal with that [pregnancy]. (Rena).

In general, the midwives believed that partners are not there for the long haul in the pregnant teenagers’ lives, in contrast to the pregnant teenagers’ mothers or parents. As Beth revealed, there are: *... not many teen dads that you could say we’ll rely on him.* Likewise, Rena said: *There are very few boys [partners] that can come to the party [expectations of being a father] at that age ....* That is, partners are less likely to accept the responsibilities of fatherhood. The relationships with partners can be tenuous and unreliable, as Julie explained:

> Now ... it's not going to work [with a partner]. So you've got to, ... always fall back on hopefully the parents ... And, you know, I mean marriages don't [always] work ... so how is a fleeting romance where somebody has sex and they get pregnant how is that going to work when you're only 15 or whatever you are, it's not necessarily going to work. ... we want them to build a good relationship with the people who are going to stick around. Who are always going to be their parents....

Notwithstanding, Janine recalled a positive story of a teenage partner:

> ... I’ve had some incredibly supportive, sweet and beautiful partners and you know they’re really rough around the edges and boys who have said, ‘I cried when ... when she was in labour’ ... [but] in the long run I don’t know how that [relationship] works, because, have they got the skills for just maintaining relationships? ...they’re about to take on one of the biggest challenges any person ever has to do ....
Even though the relationship was positive and the partner appeared to care for the teenager, the midwife questioned the future of the relationship. The midwives’ attitudes towards the partners may be underpinned by an honest pragmatic concern for the teenagers that may be based on the midwives’ own life experiences.

Friends constitute an important social support if the teenagers do not have support from their families or partners. As Maya said: Some have [social support from] family ... and friends. Friends may be a strong influence on teenagers, for example, if the friends have children of their own. This influence may contribute to the influence for early childbearing. As suggested by Beth: The friends are doing it so ... [they want to be pregnant] [because] ’Cause then they're fitting in. ... it gives some of them a sense of belonging. Close friends are considered as important as the family. For example, Janine suggested that ... [social support] it really often comes down to close friends and family and if they don’t have that—’oh boy!’ Even if some friends do not have the same relevance as family members for social support, they may be the only support available to the teenagers.

Teenagers with no social support network rely on community-based support groups and organisations. As Julie suggested ... there are lots [support] out there in the community. This support is identified during the antenatal period through the YMC midwives or the social worker. Julie believed that teenagers ... They need backup because that’s when you get the postnatal depression ... because they haven’t got the support. She also highlighted that Some of them [teenage mothers] are terrible [at early parenting]. Further, parenting is a stressful time, and the social support provided by community-based organisations is important for some teenagers. Janine believed that because teenagers have not developed an awareness of the baby, ... the reality hits home once it's happening and the baby is born. She said: This is why ... you need to make sure that they've got the support groups in place. Like family and friends or c u @ home or Pulse or whoever it happens to be. Thus, midwives view social support as a critical component of teenagers’ care.

A key government-funded community-based program that supports teenagers is the c u @ home nurse visiting program. According to Barb, … I think the c u @ home program is good ... they actually prepare them [teens] for parenting. Teenagers are referred to the program, in particular, if they do not have family support. Likewise, Marie said:
... I really encourage that [c u @ home program] very strongly. I sort of say we have this service and we normally refer [you] to that. We don't make it like 'would you like us to refer you to it?'

According to Marie and Julie, support should be established early during the antenatal period for follow-up care in the community following their discharge from hospital. However, other than the c u @ home program, most midwives were not aware of the suite of community-based programs available for childbearing teenagers in the region. As Janine said: I certainly do not know about ...[community-based services]. According to Janine, it would be important to personally attend these services and programs so that midwives can share their views on how useful these services are for teenagers.

The midwives believed that GPs only play a minimal role for most pregnant teenagers. In Australia, GPs are medical doctors who are based in communities and provide comprehensive health care to individuals and families (The Royal Australian College of General Practitioners, 2014). Beth said: I don't think they're necessarily getting a lot from GPs. This is not a negative reflection of GPs, but of the service delivery design for pregnant teenagers. According to Marie:

I used to say to them at the beginning ...You know now you're booked in with us you don't need to go and see your GP [because] ...Young Mums is the same, basically. But with the extra midwife care.

However, in adult antenatal care clinics, women will attend both the GP and hospital care ... [if] they've got a rapport with their GP... (Marie). The local hospital referred to this service delivery model as ‘shared care’. Angela suggested that ... technically [teens] they could share care. In the ‘shared care’ model, GPs provide most of the antenatal care, and the teenager attends only three appointments at the local hospital. However, at the hospital, this ‘shared care’ model is not available for teenagers aged 17 years and younger. This could be because the YMC has the resources to follow-up and monitor teenagers more closely at the YMC than in community-based GP services. As Angela highlighted:

So, anybody [teens] that has any mental health problems we have to refer them back out to the GP to be seen in the community. But I just don’t think that's going to
According to Angela, providing services to teenagers in a one-stop-shop approach, as at the YMC, is an obvious solution to ensuring that teenagers receive the care they need.

Thus, teenagers receive good support during pregnancy from their own social networks, as well as health professionals. However, the midwives’ preference for adult support for teenagers may have contributed to the unintended marginalisation of teenagers’ partners.

7.3 Summary

This chapter presented the interview results from phase II with nine midwives. The five themes and 17 subthemes generated from the interviews were displayed in a summary table. The major themes from the midwives’ interviews were: some teenagers experienced a rough time during childhood, depression and anxiety are common, and the teenagers are adults with ‘special needs’. Other major themes were that the majority of midwives believed that the YMC is a good model of care for teenagers, and that most teenagers have good social support networks with their mother as the primary support person.

It is necessary to draw attention to the views of one or two midwives who appeared judgemental and negative towards the teenagers. These negativities sit uncomfortably within the context of this ethnographic research to understand pregnant teenagers. Regardless, the findings from this research may contribute to a different but important perspective on teenagers.

Chapter 8 presents the results from phase II of this study, where interviews were conducted with the c u @ home program nurses. A major focus of the presentation is the major themes and subthemes identified from the nurses’ interviews.
Chapter 8: ‘[Teens]…Same as Anybody Else’: Results from the Nurses’ Interviews

8.1 Introduction

This chapter presents the results from the nurses’ interviews conducted in phase II of this study. In December 2012, a focus group interview was conducted with six nurses employed in the community nurse visiting program through convenience sampling. As a follow-up to the focus group interviews, two face-to-face in-depth interviews were conducted eight months later with three nurses to confirm some of the key focus group interview findings. The focus group and interviews are hereafter collectively referred to as ‘interviews’ in this chapter. Thematic data analysis was undertaken on all interview data. The themes and subthemes identified are described in relation to the broadly applied key research questions. In addition, some critiques of the key findings against existing literature are presented where appropriate.

8.2 Research Findings

The research findings from the interviews with the nurses are presented below. Pseudonyms are used for all nurses in the findings. The seven major themes (see Table 8.1) are: ‘… an unhappy childhood’, ‘…[Teens] they all have some level of …depression and anxiety’, ‘…they’re really doting parents’, ‘…[Childbirth education] learning exactly what is going to happen’, ‘…[Social support] someone there just to talk to…’, ‘…they see…[YMC] clinic as important’ and ‘… [Nurses] my little time with her [teen] was really insignificant’. Subthemes are also presented where relevant.
<table>
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<th>Themes</th>
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<td>… an unhappy childhood</td>
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<td>… [Teens] they all have some level of … depression and anxiety</td>
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<td>… [Childbirth education] learning exactly what is going to happen</td>
<td>… smoking’s not good for you</td>
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<td>… you don’t retain information when you’re anxious</td>
<td>… address the social work stuff first…</td>
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<td>… they will do what their mother has said…</td>
<td>… younger teenagers] They just live day-to-day</td>
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<td>… they see …[YMC] clinic as important</td>
<td>the young ones like … going to that setting [YMC]</td>
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<td>… transport is a huge issue</td>
<td>[YMC midwives] working out their communication with teens</td>
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<td>… [Nurses] my little time with her [teen] was really insignificant</td>
<td>… [teens] living with other people 24 hours a day…</td>
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<td>… [contraception needs] …[with] their second baby everything is so much harder …</td>
<td>[use social media]…to get the message across</td>
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<tr>
<td>… [use social media]…to get the message across</td>
<td>I don’t get any [communication from YMC]</td>
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In line with the ethnographic approach applied in this research, the findings are reported from the nurses’ emic perspective using their own words to support the research findings. In reporting focus group discussion findings, the use of individual nurses’ quotations is common practice (Ingham & Stone, 2011).
8.3 Nurses’ Demographic Details

The six nurses who participated in the focus group interview had an average age of 44 years. All nurses were formally trained in Child and Family Health nursing. In addition, three nurses were midwives, and one still practices as a registered midwife. Other qualifications held included: paediatric nursing certificate; tertiary studies in Advanced Nursing, Clinical Nursing and teaching; and short courses in immunisation, perinatal and infant mental health. The nurses’ length of experience in the c u @ home program ranged from two and a half years to eight years.

8.3.1 … an unhappy childhood

This section presents the nurses’ views in relation to the teenagers’ childhood. As Karen revealed, *A lot of mine have ... had an unhappy childhood.* This was a common view among the nurses interviewed, and this could be related to the teenagers’ experience of poverty and being bullied at school.

The nurses believed that intergenerational poverty—that is, poverty experienced from one generation to another—is common among childbearing teenagers. For teenagers from disadvantaged backgrounds, childbearing often increases their experience of poverty (Farber, 2014). As noted by Wendy, *I’ve got a couple [parents] ... from very low working class but ... very much in that [generational poverty cycle].* Once the baby is born, money becomes a major concern for teenage mothers. This could partly be because the main source of income for most teenagers is the State’s social welfare system, which does not leave them with much disposable income.

According to the nurses, other reasons why teenagers have an unhappy childhood are: domestic violence, including *emotional abuse as a child* (Juliet), and *sexual abuse* (Wendy). Family conflicts such as domestic violence may threaten a child’s sense of security. This instability in the family may be related to the family’s low socio-economic status and living with various demands related to day-to-day needs.
Schools may be an ‘awful’ time during the teenagers’ childhood and in their younger teenage years. As suggested by Sophie:

And they’ve had a pretty awful time at school. I think that seems to be a common theme. And then they’ll get depressed and anxious and not want to go to school and ... fall out with their friends. Then end up doing home schooling. And then that doesn’t work and...

The nurses felt that the teenagers’ negative experiences at school were because they did not have the social skills to transition from primary to secondary education. This difficulty at school may be related to family instability resulting from parental conflicts and divorce. These adverse childhood events are threats that can destabilised the childhood.

8.3.2 … [ Teens] they all have some level of … depression and anxiety

Depression is common before and after the birth of a baby (Quinlivan & Evans, 2004). Likewise, as reported by Karen, ...they [teenagers] all have some level of ... depression and anxiety at some stage in their lives. As noted, depression is common among teenage mothers with social and economic disadvantages such as poverty and lower education (Shaw et al., 2006). The nurses reported other reasons for the high incidence of depression and anxiety among childbearing teenagers could include their parents’ separation/divorce, experiences of abuse and poor adjustment to school. The nurses revealed that depression exists prior to the pregnancy for many teenagers. According to the c u @ home program’s psychologist, depression, borderline personality disorders and sexual abuse during childhood may be related problems in childbearing teenagers. Depression may also be related to their very poor coping strategies in life (Karen). Thus, there may be some truth in what Karen said—that is, that teenagers ... who ... [get] pregnant in the first place. ... already have mental health issues... They’re already vulnerable. As noted by the nurses, depression may run in the family and is made worse by the lack of formal and informal support for teenagers experiencing domestic violence and abuse and/or who are under child protection. The nurses also observed that teenage mothers also experience troubling fluctuations in their emotions that may be related to relationship problems. The problems between teenagers and their partners, peers and parents tend to
affect their emotional wellbeing. As noted by the nurses, the teenagers’ emotional state must be considered before nurses can carry out their program plans with them. As Wendy said: ...if it’s [relationships] good it’s good, if it’s bad then ... it affects everything. This finding highlights the fundamental influence of childbearing teenagers’ mental wellbeing on themselves and their engagement in the program.

In the nurses’ interviews, the researcher highlighted that one of the findings from the teenagers’ interviews was that depression seems to improve during pregnancy for some teenagers. According to the nurses, the improved mental health could be because the teenagers, through their pregnancy, are now the centre of attention. As Karen suggested ...it may be the first time in their life anyone’s cared for them or about them. The nurses believed that the pregnancy redirects the teenagers’ attention from themselves to the baby and may also attract attention to them from the midwives. As Karen said: ...I think they enjoy the attention. It’s something to do. A lot of them are really bored. This boredom may be related to their reduced access to resources, including limited financial capacity for social and cultural participation.

However, improved mental health may not be sustained during the immediate post birth period. As Anne suggested, I think then once the baby’s born then I think that reality kicks in and that’s when ... we get the spiralling again of the depression. The stress experienced during this period could lead to the re-emergence of depression in teenage mothers. This post birth period is a challenging time for the teenagers. As ... quite a few relationships fall apart in those first few weeks ... when that baby arrives. And that conflict begins about what babies need (Karen). Further, the partners may add to the teenagers’ stress following the birth of the baby. For instance, Sophie recalled that one of the teenagers had a ... partner who’s been violent or controlling, and ... lots of issues around drugs, particularly marijuana ... and moving house lots. Thus, the teenager–partner relationship during early post birth may be an important contributing factor for depression. On a positive note, Sophie noted that pregnant teenagers with prior depression and anxiety were better informed to recognise postnatal depression and seek help early.
8.3.3 …they’re really doting parents

Like the majority of mothers, the teenagers were proud to have a baby. As Sharon noted, they are excited about having a baby. Yes, I’m a teenager and I can do this as well as the next person. This reflects that the teenagers felt confident about their mothering ability. However, according to the nurses, the teenagers are not taken seriously at the GP clinic, antenatal clinic and postnatal ward at the hospital. Karen suggested that …they [teenagers] need to feel as if they’re not being marginalised. Not being treated differently because they’re adolescents. Sophie added …a lot of girls are …not, not heard which is …really bad. Such testimonies to the behaviours of health professionals may reflect the prejudice and stigma that teenagers continue to experience in society.

The nurses believed that most of the teenagers in the program are ‘doting parents’ and are focused on their babies’ welfare. As Sophie said: …they all want to do better and they want to give their baby more than what they ever had. In this regard, the nurses emphasised that the teenagers are the same as every one of us [women] (Karen).

The nurses also believed that many teenagers view having a baby as a life-changing event and an important turning point in their lives. As reflected by Wendy:

I have got a mum who’s doing really really good saying the baby’s a lifesaver, she was going off the rails and was in a really bad place, and ‘this [baby] has saved me’. [Teen] In a relationship that was quite volatile, emotional and um, verbal, lot of verbal abuse; oh, occasional physical, mainly um, verbal and put-downs and that emotional stuff. Um, the partner smoked lots of drugs and that type of thing so, and she was running with a bit of a rough crowd she said, so the pregnancy, she’s now, you know, moving to, it’s like a little, ah, like a hut out of her grandparents’ place [in rural area], they’re very, you know, like a tin shed type of thing I suppose. But she’s on her own, you know, she’s got the support of them and, and like she’s breastfeeding, she’s doing an awesome job.

In the profound story above, the baby provided an important focus in the teenager’s life, which may otherwise have taken a different and tragic trajectory. The story also reflects the critical transformative change that the teenager experienced as a result of
motherhood. Further, for the teenager, having a good social support network was facilitative of the transformation in life.

8.3.4 … [Childbirth education] learning exactly what is going to happen

This section highlights some of the issues in relation to childbearing teenagers’ learning needs. As identified in the nurses’ interviews, these were: ‘ … smoking’s not good for you’, ‘… you don’t retain information when you’re anxious’, ‘… address the social work stuff first …’, ‘they will do what their mother has said’ and ‘[younger teenagers] They just live day-to-day’.

Undoubtedly, pregnancy for first-time mothers can be a time where a lot of learning occurs as they prepare for the birth and care of the newborn. As noted by Anne, not all teenagers are ready to engage with the learning: …some girls are really interested in, in reading and watching the DVDs and learning exactly what is going to happen. But I’d say that would be a minority. This suggests that the majority of teenage mothers may need a lot of support to prepare for the pregnancy, labour, birth and parenting.

… smoking’s not good for you

One of the facts presented to pregnant teenagers is about cigarette smoking and smoking cessation. In Australia, smoking is banned in all public buildings, and the sale of cigarettes is strictly controlled. Thus, it is common knowledge for all Australians that smoking is synonymous with ill health. As Sharon suggested …I think the education’s out there that smoking’s not good for you. … and you have a little baby if you smoke too much. However, smoking cessation education may have an inverse effect on teenagers. As noted by Karen, some pregnant teenagers may welcome the idea of having a small baby, as If it’s a little baby it’s an easier birth. As Wendy suggested, … I don’t know that they understand it as well as what, what we’re trying to tell them. This reflects a need for all health professionals to determine teenagers’ understanding of the harmful effects of smoking.

Smoking in young people may be related to multiple factors such as social and economic disadvantage and related depression (Shaw et al., 2006). These young people are more likely to take up cigarette smoking (Lawrence, Hafekost, Hull, Mitrou, & Zubrick, 2013). Thus, the teenagers’ inability to give up smoking may reflect that they
were experiencing a lot of stress in their lives. Further, the teenagers’ smoking behaviour may be influenced by their fluctuating emotions such as relationship issues. As Karen said: *Like, if they have a bad day they’ll have a lot [of cigarettes].* The nurses believed that the pregnant teenagers smoke just as much during pregnancy as they do after the baby is born. Therefore, if smoking is an intractable issue, all health professionals may need to further explore other stressors in teenagers’ lives.

*...you don’t retain information when you’re anxious*

Learning in childbirth education classes may be ineffective if teenagers have experienced barriers to learning, such as anxiety. The nurses suggested that anxiety could influence communications. As Juliet noted, *... a lot of them are quite anxious too and you don’t retain information when you’re anxious.* This anxiety may be underpinned by the teenagers’ limited literacy skills. However, women commonly experience anxiety. As Karen suggested, *Antenatally, recovery [postnatal], however old you are, you feel very vulnerable. And little tiny comments often can blow out into really big things in anxious pregnant brains.* Nonetheless, in Australia, mental health problem is common among young people with one in four people aged 16–24 years who experience some mental health issues (Australian Institute of Health and Welfare, 2011, p. 25). Thus, pregnant teenagers with anxiety may well be experiencing a mental health problem, and this factor needs to be considered in the teenagers’ care.

*...address the social work stuff first...*

Another major factor influencing teenagers’ readiness for learning and engagement with nurses is social stability (e.g., housing stability). As Karen advised, *You have to address the social work stuff first...*. This is important because, as Juliet revealed, *...these issues [emotional] are more important and so ... we, they need to be addressed before you can ... talk about baby cues and attachment.* The emotional needs are tied to other needs such as housing and financial. According to the nurses, teenagers’ financial struggles are partly due to their inability to budget and prioritise the use of their limited income. For example, as Wendy stated:

> *A client told me this morning she’s paid off her Christmas lay by [500 or $600]... for all the toys and she’s off to the Salvo’s this afternoon to get a food hamper. And*
she doesn’t have any money for food. Part of a culture of showing people you love them …is that you buy stuff for them.

Budgeting is a difficult concept for teenagers to understand despite having learned about budgeting in the c u @ home program and the PYPS program (run by UnitingCare Tasmania). An inability to budget and prioritise the use of limited income could be related to several reasons. For example, as suggested above, material goods are valued by teenagers because of their related symbolic meaning of love for the baby and of … their status too, like, where they are. Where they stand in the community. You know, the more toys and … mobile phone is really important to them, the TV (Sharon). Thus, their inability to budget, their desire for material goods and the additional expenses related to the care of the baby may contribute to worsening financial struggles in the post birth period.

…they will do what their mother has said…

Teenagers’ learning may be significantly influenced by their mother. As Sharon confirmed: ... [teenagers] will do what their mother has said if that’s a good relationship. ... I don’t know if it’s to do with their [mothers] knowledge and skills about pregnancy and … parenting.... The nurses believed that teenagers cope better if they have good family support. However, Sophie highlighted that mothers can also be a challenge ... [to]... a practitioner. This is because, as Karen revealed, some mothers … bring the messages about their birth to their [teens] own birthing experience so ... ‘Mum’s told me she had four hard labours so it’s going to be shocking for me’. The nurses conceded that mothers are a powerful force in teenagers’ lives, and some mothers had discouraged their teenage daughters from participating in the c u @ home program.

[younger teenagers] They just live day-to-day

Lastly, learning in childbirth education is largely about projected needs. For example, childbirth education provides opportunities to learn about pain relief during labour. Addressing future needs may be difficult for the teenagers because of their cognitive maturity and being more present-focused (Duncan & Young, 2013, p. 590). The present-focused attitude is age-specific, as reflected by Juliet:
[younger teenagers] They just live day to day. Like you talk about big picture stuff and it’s like, no, I just, I’m just going to be here with my baby (Sophie). [And],...older [teens] ...[are] more sure of who they are and what they want. They’ll incorporate the baby better, yeah.

Unlike younger teenagers, older ones can develop long-term goals. The difference in present-focusededness between the older and younger teenagers suggests that their learning needs and ways of learning may also be different.

Thus, within the context of teenagers’ learning needs during pregnancy, the nurses’ interviews highlighted many barriers to learning. For example, teenagers may be more socially anxious, have more social needs, have mothers who negate professional advice and have age-related cognitive maturity and present-focusededness. To engage teenagers in learning related to childbearing, the barriers to learning must be addressed.

8.3.5 ... [Social support] someone there just to talk to...

Social support from the teenagers’ mothers and partners can lead to improvements in pregnant teenagers’ mental health and quality of life (Pires et al., 2014). In the interviews, the nurses unanimously agreed that social support from the family is important in order for teenage mothers to perform better in the program. According to Sophie, ... definitely that maternal support [helps] ... they seem to do much better in the program. Childbearing may bring the teenagers closer to their mothers/parents and families. As noted, the teenagers’ mothers are ... a bit more supportive and a bit more encouraging (Anne). Family support for the teenager is important, as suggested by Sophie:

...[teenagers] they’re living at home ... within the family home, ... and even if there’s siblings around ... you know, that can be really powerful and supportive.... you can call on mum to come and help you and ...you know, someone there just to talk to, bounce ideas off.

However, as Wendy suggested, many teenagers do not receive social support from families because they ...come from, you know, violence and, you know, ward of the states and don’t have a lot to do with their family.... These teenagers may have experienced a difficult childhood and may need support from other sources, including nurses, midwives and community-based programs.
Partners also provide important social support. As noted by Sharon, the partner ... makes a big difference too. Further, Karen believed that some partners contribute to parenting the baby and [have] ... very strong ideas about how babies should be raised. However, not all teenagers have a partner. The nurses also revealed that some partners did not attend antenatal care with the teenagers. Sophie’s view was that some ...[partners] feel uncomfortable going to those kind of sessions, ...and so they won’t go. Others will be dragged along by their partners .... Further, partners may not be keen to attend the YMC because its title is ‘Young Mums’. As Karen said: …‘Young Mums’ kind of implies that young dads aren’t welcome. The majority of nurses agreed that it is important to encourage partners to participate in the baby’s care because they would otherwise hold back. Important feedback for the hospital from the nurses is that some partners had complained about being excluded on the labour ward. Juliet suggested that the labour ward is ... a high sort of anxiety situation for them, and some men do not respond well in this type of situation.

The nurses appeared to have a good understanding of the partners. They also saw quite a few cases of partner violence and sexual abuse. For example, as Sophie recalled:

... She was young, ... 16 with an older partner, and domestic violence was going on quite a lot, and, you know, I’d go to their house and we’d talk about it. She’d be looking out the window waiting for him to walk up the driveway, and she ended up dropping out of the program, and I think that is my experience. ... once he was going through that nasty cycle and being quite violent .... ... he’d take the phone from her and all the rest of it. He went to jail .... She went into a, ... women’s shelter, and we did lots of work and I really thought she was going to break that cycle and she was going to get the strength to leave, but she was only 16, very limited family support, he was her rock in her eyes. Came out of jail, they got back together again.

Given the many social issues facing the teenagers, the nurses found it difficult to engage the teenagers in the cu @ home program. Thus, social support from families and partners is more influential on childbearing teenagers and their success in the program.

8.3.6 …they see …[YMC] clinic as important

The YMC provides antenatal care checks and childbirth education classes at the local hospital. According to Karen, the teenagers attend the YMC because… they see going
to the clinic as important. And something that they have to do. It may also be about receiving attention at the YMC.

This section presents some of the issues relating to attendance at the YMC and the midwives’ practice in the following three subthemes: ‘the young ones like … going to that setting [YMC]’, ‘… transport is a huge issue’ and ‘… [YMC midwives] working out their communication with teens’.

**the young ones … like going to that setting [YMC]**

The YMC provides antenatal care to teenagers aged 15–19 years. However, as noted in the nurses’ interviews, the younger teenagers (< 17 years old) prefer the YMC, while the older teenagers (18–19 years) may not feel as comfortable there. In 2013, a policy mandate at the YMC stated that all pregnant teenagers under 18 years of age would be referred to the YMC. However, this mandate was not popular with some older teenagers (aged 18–19 years), who preferred the adult antenatal clinics. As Sophie confirmed:

...maybe the older girls, like the 18, 19 year olds don’t ... they find it a little bit harder whereas the young ones like ... like going to that setting [YMC] and ... yeah, they [younger teens] really look forward to it. And feel supported. ... because they’re with, you know, like-minded people rather than going to the main antenatal clinic...they feel like they’re being judged there.

The nurses also noted that teenage mothers are good at taking their baby to the GP. As Karen revealed, *They get all their immunisations virtually the day they’re due.* The younger teenagers’ willingness to attend the YMC suggests that the YMC is an appropriate environment to provide health education to younger expectant teenagers.

**… transport is a huge issue**

Transport to the YMC antenatal clinic care and childbirth education is important. Given the teenagers’ youth, access to transport can be a problem. Buses from rural areas are not a good transport option. As Karen revealed, travelling to town on a bus from a rural location is ... an all-day experience ... [and takes] ... an enormous amount of determination on her [teenager’s] part. A major reason that buses are not popular with many pregnant teenagers is because, as Juliet stated ... sometimes they get bullied, particularly if they’ve got a big pregnant belly. According to Sharon, I’ve had clients
who have been assaulted on the bus. And abused. Although many pregnant teenagers consider it important to attend the YMC for antenatal care, transport problems may be a deterrent.

… [YMC midwives] working out their communication with teens

At the YMC, childbirth education is provided by two experienced midwives who have worked with pregnant teenagers for several years. However, the YMC antenatal clinic is staffed by a rotating pair of midwives—some of whom have limited experience in working with pregnant teenagers. The changes in staff are acutely felt by the teenagers. As Anne indicated:

...when they have changes of staff [at YMC] we’re really aware of it because there’s a few little teething problems as they’re working out their communication with teens. And then, [teen said] ‘I’ll never go back there,’ you know, because of, like, a very simple comment that’s phrased in the wrong way.

This suggests that the midwives’ style of communication is critical and may influence the teenagers’ attendance at the YMC. Likewise, Karen believed that the teenagers are sensitive to professionals’ throwaway comments and negative attitudes.

Another concern raised by the nurses was that some of the pregnant teenagers who returned to the YMC with their second pregnancy felt unwelcome. Karen revealed that one teenager … felt very judged going through the young mums clinic. … that was a different experience to her first pregnancy. The nurses’ interviews highlighted that the YMC provides invaluable teen-friendly social and medical services to pregnant teenagers. Importantly, the barriers to the use of the YMC need to be addressed by the midwives to encourage attendance by the teenagers.

8.3.7 … [Nurses] my little time with her [teen] was really insignificant

This section presents key aspects of the nurses’ concerns in relation to the care they provide for childbearing teenagers under the subthemes of: ‘… [teens] living with other people 24 hours a day …’, ‘… [contraception needs] … [with] their second baby everything is so much harder …’, ‘[use social media] … to get the message across’ and ‘… I don’t get any [communications from YMC]’.
… [teens] living with other people 24 hours a day…

In contrast to the teenagers’ social support networks of families, partners and peers with whom the teenagers spend most of their days, the nurses have limited time with the teenagers in the program. As Sophie revealed in relation to the 16-year-old teenager who experienced partner violence, … my little time with her was really insignificant. The teenagers’ ease of access and exposure to their own mothers and families imply that these support people can be highly influential. As Anne suggested, … if you’ve come from a family where this is the way you parent … that’s what sets up our own expectations of parenting. Likewise, in regard to breastfeeding, the nurses believed that the teenagers’ social networks are influential in the success or failure of the teenagers’ attempts at breastfeeding. As Sharon noted, … a very, very small number that will start off but most of them, [breastfeed] maybe for a month …. The nurses believed that the lack of breastfeeding success is because breastfeeding is not common in families. Further, many teenagers hear negative stories about breastfeeding from their families. For example, Wendy revealed that some teenagers heard from their aunt that breastfeeding would give them ‘saggy’ breasts. The nurses reported that the breastfeeding rate is low for teenage mothers, which reflects an important need to examine teenagers’ needs in relation to breastfeeding.

Working with teenagers who are negatively influenced by their social support networks can be challenging. As Karen highlighted:

... There is [limited influence on teen mothers], especially when you’re [teens] living with other people 24 hours a day and we’re there for that limited time … [Also], I think that’s really hard to come in and challenge that [family’s] thinking … and do it differently.

With limited time to influence and support the teenagers, Sophie said that for one of her 16-year-old clients, … her world was so much bigger than what I could ever provide. Despite the challenges, Sophie said that she could see positive transformative changes in some of her clients. Importantly, the difficulties experienced by the nurses reflect the need to engage families to work collaboratively with the program to support the teenagers.
One of the **contraception needs**...**with** their second baby everything is so much harder **...**

A barrier to contraceptive use is that some teenagers, as Anne said: **... [are] risky in their choices.** This perceived risk-taking in contraceptive use may, in fact, be associated with stress and depression (K. S. Hall, Kusunoki, Gatny, & Baber, 2014, p. 62). Most of the nurses suggested that teenagers understand the risks of having a second pregnancy, and that they have knowledge of contraceptives. The nurses revealed that a key reason why teenagers do not use contraceptives is because of the side-effects of bleeding and weight gain. This may reflect a need for follow-up counselling on contraceptive choices by community-based health professionals—in particular, nurses and GPs.

**[use social media] ... to get the message across**

Most of the nurses believed that social media is a good approach for engaging with childbearing teenagers. Echoing the sentiments of a number of nurses, Sophie said: **...we thought we should get with the times and have our own Facebook ....** Social media may be useful in the nurses’ work with teenagers. According to Sharon, social media will **... get the message across to them because they relate to that [Facebook].** However, the use of social media requires professional development support for the nurses because many of them are not familiar with the use of social media. Further, as Sophie said, **... I’d be worried about all the girls [teens] going on there and bagging each other off, or ....** Another barrier to nurses’ use of social media is that program management remains cautious in regard to its benefits for nurses in their work with childbearing teenagers.

**... I don’t get any [communications from YMC].**

The nurses revealed that they work within a network of organisations in the care of childbearing teenagers. For example, in their work with pregnant teenagers, the nurses’ work overlaps with the YMC midwives’ work in the last six weeks of the teenagers’ pregnancy. It was identified in the interviews that an area where improved networking may be needed is between the nurses and the YMC midwives. In specific circumstances, communications occur between the two programs—for example, an
unborn child alert under Child Protection where the baby is taken into care following its birth. However, in general, communication between YMC midwives and c u @ home nurses was limited. As Sophie suggested, *If I’ve got someone with a few issues I’ll often tap into a social worker [at YMC] and then I’ll get some feedback. ... I don’t get any [communications from YMC].* Also, the nurses do not routinely provide information to the YMC. Fundamental to the continuity of care between the community-based and hospital care, the nurses do receive the *Obstetrix* report from the midwives with information on obstetric history and maternity care provided to all teenagers who birthed at the local hospital.

With acknowledged minimal communication between the nurses and the YMC in regard to pregnant teenagers, the nurses do not know what the YMC teaches in the childbirth education program. Wendy revealed that, *I wouldn’t know what’s on the list [at YMC childbirth education program for teens] ... we just go through it [childbirth education] all again with them [teens]... a lot of them don’t have a birth plan ....* The limited communication between the c u @ home and YMC programs suggests missed opportunities for enhancing teenagers’ care. For example, in regard to cigarette smoking by teenagers, the nurses revealed that the teenagers continued to smoke during their pregnancy, while the midwives believed that the teenagers had been successful in reducing or giving up smoking. Regular communication between the two programs may contribute to improving the success rate of smoking cessation.

Lastly, another practice issue noted in the interviews was that the nurses were, at times, required to function in the role of a social worker to address the teenagers’ social issues before they could address their childbirth education needs. This lack of support to meet the teenagers’ social needs may create an additional workload for the nurses and compromise the achievement of the c u @ home program’s objectives.

The nurses’ commitment to the childbearing teenagers was clearly reflected in some of the roles they undertake—in particular, their advocacy role for teenagers. However, there may be missed opportunities for the improved care of childbearing teenagers because of the issues in relation to the delivery and management of the c u @ home program.
8.4 Summary

This chapter presented the nurses’ interview findings in phase II, which generated seven major themes and 12 subthemes in relation to their views on childbearing teenagers. These themes reflected that childbearing teenagers have an unhappy childhood, and they commonly experience depression and anxiety. Despite these negative experiences, the nurses believed that the teenagers are doting parents. Other major themes presented were: childbirth education is important, teenagers need social support and someone to talk to, the YMC is important, and nurses have limited time with the teenagers.

Chapter 9 will discuss the key findings from the triangulation of all data sets. Some of the key findings are explained using the theoretical frameworks that were introduced in Chapter 3.
Chapter 9: Discussion

9.1 Introduction

In this chapter, a summary is presented of the antenatal care needs inferred from the triangulated data by the researcher, a midwife. This chapter revisits the research aims and objectives. An overview of the triangulation process and a summary of the teenagers’ antenatal care needs are provided. These needs are not discussed separately but woven throughout the chapter. Drawing on structuration theory (Giddens, 1984), a major part of this chapter is the discussion of the underpinning explanatory concepts in relation to the teenagers’ antenatal care needs. Importantly, pregnancy had increased the teenagers’ sense of ontological security and motivated them for meaningful, transformational change. As such, pregnancy was an important window of opportunity for the teenagers to get ‘life on track’.

Lastly, in this chapter, a critique of the theoretical frameworks is presented within the context of this study. The novel application of structuration theory was fundamental and contributed new knowledge to existing literature on early childbearing.

9.2 Research Aims and Objectives

This research study aimed to examine the socio-ecological contexts in pregnant teenagers’ (aged 15–19 years) lives and the influence of these contexts on antenatal care needs in a region in Tasmania, Australia.

The following research objectives were adopted:

1. To identify the health knowledge, beliefs and behaviours of pregnant teenagers and their influence on teenagers’ antenatal care.

2. To identify family and community factors and their influence on pregnant teenagers’ antenatal care needs.

3. To identify physical and social environmental factors and their influence on pregnant teenagers’ antenatal care needs.
9.3 Overview of the Triangulation Process and Key Findings

Triangulation refers to the use of multiple data sets (Denzin & Lincoln, 2003b; Hammersley, 2002) to address the research questions (Richards & Morse, 2013). In this study, the triangulation drew upon four data sources: pregnant teenagers, teenage mothers, midwives and nurses. The process involved comparing and contrasting the major themes to look for convergence and divergence of information that addresses the research questions. The convergent key findings are patterns among the major themes related to the pregnant teenagers who were interviewed. Further, divergent findings are discussed throughout this chapter because they provide sharp contrasts to the convergent key findings and highlighted relevant information regarding social actors’ responses to these unexpected outcomes (Hammersley & Atkinson, 2007, p. 169).

This triangulation process generated several key findings, which were then contrasted with the existing literature and explained through the use of the theoretical frameworks. Importantly, this process contributed to a philosophical understanding of this cohort of pregnant teenagers and their associated health and social care needs within contemporary Australian society.

9.3.1 Teenagers’ Antenatal Care Needs

A recurring theme from the four data sets (pregnant teenagers, teenage mothers, midwives and nurses) was that social inequalities were common for pregnant teenagers. Many teenagers’ lives were marked by structural constraints such as: parental separation, low education attainment, welfare dependency, and depression and anxiety.

Using structuration theory, teenage pregnancy is understood as the teenagers’ expression of social agency, autonomy and control. Importantly, the teenagers experienced increased ontological security and motivation for transformational change. However, pregnancy was also a challenging time of heightened vulnerability in view of their age and other socio-ecological influences.

The teenagers’ antenatal care needs were inferred from the triangulated data by the researcher, a midwife. These needs were identified from felt (teenagers) and normative needs (health experts) (Carver, Ward & Talbot, 2008, p. 78). The inferred care needs were: access to alternative forms of childbirth education; healthy behaviours in relation
to their diet, and cigarette smoking; understanding the realities of breastfeeding; and
stress management skills. Social support was also an important need, in particular,
short-term and long-term support for meaningful transformational change during
pregnancy and beyond. In addition, many teenagers’ were vulnerable to financial,
housing, and transport issues. The social stigma of early childbearing was also a
concern for some teenagers.

As inferred from the interviews, alternative forms of childbirth education are preferred
by teenagers to the current face-to-face education programs at the YMC. The childbirth
education classes were not well attended by pregnant teenagers. This could be because
many teenagers had access to childbirth education through a variety of sources and
delivery modes. Thus, non-attendance at childbirth education classes may not be a
problem. However, the quality of information from informal sources may be
questionable if obtained from the internet, and outdated knowledge from their mothers.

Dietary concerns from the teenagers, midwives and nurses, were commonly expressed
in the interviews. A majority of teenagers wanted a “healthy baby” and were motivated
to seek information such as healthy diet during pregnancy. However, it was often
difficult for the teenagers to maintain a healthy diet for reasons such as: lack of dietary
knowledge and cooking skills, their financial constraint, and childhood food
preferences. Many teenagers and their own mothers were confused in regards what
foods to avoid, to prevent Listeria infection. Also, for many teenagers, the strong
culture of childhood dietary preferences were difficult to overcome during pregnancy for
example, using canned peas instead of fresh green vegetables.

Many teenagers continued to smoke cigarettes during pregnancy. As noted in the
interviews with the nurses, some teenagers may smoke more than what they revealed to
the midwives. However, many teenagers were motivated to reduce or cease cigarettes
smoking. With the motivation for transformational change, pregnancy is an important
window of opportunity for midwives and nurses to develop intense collaborative efforts,
to help teenagers reduce or cease cigarettes smoking.

A deeper understanding of the realities of breastfeeding was inferred as a key antenatal
care need for the teenagers by this researcher. Many teenagers wanted to breastfeed,
have access to internet resources and/or attended childbirth education class on
breastfeeding. However, in this study, the breastfeeding dropout rate in the early postnatal period was high. This could be due to several reasons. For example, the teenagers interviewed were able to express the popularised view of breastfeeding as ‘breasts are best’. However, they may not have had knowledge of the realities of breastfeeding and overcoming the challenges. Also, the teenagers’ stressful environment during the immediate postnatal period may have impacted on their learning, as highlighted in several teenagers’ postnatal interviews. Some teenagers may not have received adequate support or felt comfortable to receive support for breastfeeding during the immediate postnatal and postbirth periods.

Stress management skills were also inferred as a need for many teenagers. As noted in the interviews, many experienced a lot of stress during early pregnancy, immediate postnatal and postbirth periods. These stresses were related to many reasons such as discord in family and partner relationships, financial constraints, housing, and transport issues. In this study, several teenagers had experienced depression and anxiety prior and during pregnancy. Their poor mental health may have contributed to their experience of spiralling stress during pregnancy and postbirth. With many life stresses, many teenagers may have found it difficult to maintain a healthy diet, cease or reduce cigarette smoking during pregnancy, and focus on childbirth education during pregnancy.

Social support was an important need for the teenagers during pregnancy and postbirth. For teenagers who have a social support network, this support was found to be important to help minimise stress. Social support can also minimise the stress of social stigma. As noted in this study, the stigma of teenage pregnancy was experienced by a few postnatal teenagers in the hospital. This could have increased the teenage mothers’ experience of postnatal stress.

These antenatal care needs are expanded in sections below.

9.4 Theoretical explanations: Teenage pregnancy and care needs

Drawing on the SEDH framework and structuration theory, the explanatory concepts underpinning the teenagers’ key antenatal care findings are presented in this section.
These are the structural constraints in teenagers’ lives, and teenage pregnancy as a period of transformative change.

9.4.1 Structural Constraints in Teenagers’ Lives

Structural constraints are constraints or ‘structural forces’ in society that affect disadvantaged individuals and groups (Department of Health and Human Services, 2013c, p. 4). These structural constraints are discussed within the micro, meso, exo and macro contexts of the SEDH framework.

At the micro or individual level, the teenagers’ age appeared to be a major structural constraint on the teenagers interviewed. As noted, age is one of the factors that can influence variations in one’s human development and life trajectories. Other influencing factors on the individual included gender, social and cultural alliances, biological, cognition, physical and psychological makeup (Bronfenbrenner, 2005). Therefore, in contrast to adults, teenagers may experience more pronounced structural constraints because of their age and age-related biological, cognitive, physical and psychological development. Further, the teenagers’ age may be influential in the timing of early childbearing. As noted in this study and the integrative review, there is a higher rate of childbearing among older teenagers. This could be because older teenagers—particularly those aged 18 and 19—have greater sexual curiosity and sexual activity than younger teenagers (Upadhya & Ellen, 2011).

Fundamentally, this study revealed that the structural constraints experienced by teenagers began during childhood. For many teenagers, childhood was not a happy time and space. Many of the teenagers’ parents were divorced or separated, and several of the teenagers experienced behavioural and mental health issues following this major life event. In 2011 in Tasmania, 53.7 per cent of total divorces involved children under the age of 18 years (Australian Bureau of Statistics, 2012). Further, two pregnant teenagers interviewed were in the Child Protection system. Given that the child is vulnerable to influences from their carers and environment (Bronfenbrenner, 2005; Browne & Jennifer, 2012; Giddens, 1984), the parental divorce/separation would have caused severe ruptures in the teenagers’ lives. As noted, family determinants such as parental influence at the meso and exo levels of the SEDH framework are highly influential on the future of children and teenagers (Bronfenbrenner, 2005). This is because at the meso
(family) level, socialisation takes place and involves the co-presence of the infant/child and parents with the sharing of mutual time and space through their ‘life-cycles’ (Giddens, 1984, p. 170). This may have generated an ‘intergenerational family pathology’ such as the ‘cycle of poverty’ in families, which was considered the root cause of teenage pregnancy (Quinlivan et al., 2004, p. 197).

At the meso level, the teenagers’ relationships with relevant others (parents, families, peers, communities, schools) are influential on the growing child (Bronfenbrenner, 2005). Importantly, parental divorce/separation or absence and neglect during early childhood years are serious problems and are considered ACEs (Bellis et al., 2014). ACEs can lead to adverse health behaviours during adolescence and adulthood. Further, they may influence teenagers over time and at several levels, resulting in the accumulation of risk factors for adolescents for negative social behaviours (Catalano et al., 2012; J. Williams et al., 2009). Similarly, ACEs contributed to 37.6 per cent of unintended teenage pregnancies (Bellis et al., 2014). Further, family conflict and divorce are antecedents to problems during adolescence and adulthood such as depression, self-harm (Stanley, 2007) and early childbirth (Bellis et al., 2014; Jaffee, 2002; Quinlivan et al., 2004). Therefore, family factors are highly influential on adolescents for healthy adolescent development (Blum et al., 2014, p. 1).

Likewise, intergenerational teenage pregnancy—that is, the history of early childbirth in several generations—may occur in families (Meade & Ickovics, 2005, p. 675). In this study, four of the pregnant teenagers had mothers who commenced childbearing during their teenage years. For example, 18-year-old Alicia has three generations of teenage pregnancy in her family. In these families, the female child of the teenage mother is at a greater risk of teenage pregnancy (Van der Klis et al., 2002). Intergenerational teenage pregnancy may be a phenomenon associated with social and economic disadvantages (Meade, Kershaw, & Ickovics, 2008, p. 419).

The exo-level determinants are embedded in the living and work conditions, and include access to services (education, health, transport, housing). These determinants are also influential on the child. Education was a structural constraint experienced by many teenagers in this study. Concurring with one study (Kaiser & Hays, 2005, p. 490), the majority of the teenagers interviewed had left the education system before their pregnancy. This suggests that the timing of pregnancy for older teenagers is when they
are not engaged with the education system. Further, as highlighted in this study, failure at school is a risk factor for teenage pregnancy (Combes & Hinton, 2005; Farber, 2014; Meade & Ickovics, 2005; Meade et al., 2008; Quinlivan, 2008; Quinlivan et al., 2004; SmithBattle, 2006, 1994; J. Williams et al., 2009). In addition to teenage pregnancy as an outcome of low education, other outcomes were also noted. For example, low education associated with low socio-economic status (a social determinant) can contribute to higher alcohol and mental health comorbidities (Salom, Williams, Najman, & Alati, 2014, p. 151). These teenagers are also disadvantaged by their limited career opportunities. Therefore, teenagers’ structural constraints that contributed to low education attainment could further lead to low career opportunities, unemployment and worsening social inequalities. Further, relevant to this current study, teenagers’ health literacy may also be limited.

Further, financial constraints during pregnancy and post birth were common for many of the teenagers interviewed in this study. Given the teenagers’ youth, limited education and high unemployment, their experiences of financial difficulties were expected. The low socio-economic status appears to be a common problem for childbearing teenagers (Al-Sahab et al., 2012; Atkinson & Peden-McAlpine, 2014; Bonell et al., 2003; Corcoran et al., 2000; Hosie, 2007; Jaffee, 2002; McCall et al., 2014; Mollborn, 2007; Quinlivan et al., 2004; D. M. Smith & Elander, 2006; Upadhya & Ellen, 2011; Van der Klis et al., 2002; Woodward et al., 2001). Compounding the teenagers’ financial struggle, the nurses’ interviews revealed that many teenagers were unable to budget and prioritise the use of their limited income from social welfare.

Housing was also a structural constraint for some of the pregnant teenagers interviewed. Many of the pregnant teenagers lived at home with their mothers/parents, and some lived with their partners. A few of the teenagers expressed frustration because they were waiting for housing support from the government. As noted in the midwives and nurses’ interviews, the search for housing can be stressful for teenagers, and this often distracted their attention from their antenatal care and education needs.

Yet another structural constraint was transport—particularly for teenagers who lived in rural areas. In light of their age and limited income, the majority of the teenagers interviewed did not have their own transport. Likewise, most of their partners were teenagers themselves and were not able to provide support with transport. Thus, the
teenagers’ age and the attendant disadvantages of age contributed to their dependency on their mothers/parents in relation to housing and transport.

At the macro-level of the SEDH framework, government policies and programs are influential on how people live and work. Relevant to this study, an important macro-level determinant is culture that determines the prevailing norms and values in one’s environment (Whitehead et al., 2001). For example, pregnant teenagers in this study were constrained by the way of life or culture in their families. They may be influenced by their childhood and family practices, for example, intergenerational teenage pregnancy may be viewed as a norm for some teenagers. These cultural determinants are often embedded and not clear to people outside of the family (Kothari et al., 2007).

In this study, a notable pattern in the trajectory of the teenagers’ lives was that social inequalities predisposed them to further inequalities. For example, financial constraints may contribute to chronic poverty, social economic disadvantage and associated anxiety and/or depression and aggressive behaviours (Salom et al., 2014; Wadsworth & Berger, 2006). Further, with increasing socio-economic disadvantage, there may be higher rates of maternal smoking and binge drinking in pregnancy, as well as maternal depression and anxiety (Salom et al., 2014). These disadvantages have many negative flow-on effects that may not be reduced through healthy maternal behaviours (Salom et al., 2014, p. 151). Undoubtedly, there is a strong link between teenager’s socio-economic status and teenage pregnancy (McCall et al., 2014, p. 51). Thus, for the teenagers interviewed in this study, the stress from financial constraints may have contributed to increased stress during pregnancy, which may affect the current and future wellbeing of the teenagers and their children.

Finally, this study suggests that the structural constraints that characterised the teenagers’ lives may have contributed to shaping their perceptions of early childbearing. For some of the teenagers interviewed, it is contended that teenage motherhood was a cultural choice because early childbearing was considered an acceptable ‘way of life’ (P. Jones, 2006, p. 130) in their families. Similarly, in intergenerational early childbearing, the culture of teenage pregnancy embedded in the teenagers’ lives may exert a strong influence on them. For example, the ‘pull’ of three generations of early childbearing in 18-year-old Alicia’s family may have influenced her to accept motherhood as ‘…a normative, valued and respected life choice…’ (Yardley, 2008, p. 228)
Thus, early childbearing is the self-identity that shapes the teenagers and how they perceive their social world, thereby contributing to their ‘webs of significance’ that facilitate communication within their societies (Geertz, 1973, p. 5). In line with the notion that ‘Culture is the objectification of the social’ (Epstein, 1998, p. 8), early childbearing may be the objectification of structural constraints in the teenagers’ lives. In structuration theory, constraints are also considered opportunities as well as the medium that enables social actions (Giddens, 1984). This suggests that for some teenagers, the structural constraints in their lives have mediated their early childbearing.

9.4.2 Teenage Pregnancy: A Period of Transformative Change

‘Pregnancy is a condition that transforms a woman into a mother. [It] … is experienced as a life-changing event’ (Côté-Arsenault, Brody, & Dombeck, 2009, p. 70). This suggests that pregnancy provides pregnant teenagers with a new social position of motherhood.

In this section, it is argued that many of the childbearing teenagers interviewed were able to express their social agency through pregnancy and motherhood. The key findings presented in this section are pregnancy as an expression of social agency and pregnancy as ontological security. These findings are important and their application will facilitate improved antenatal care for the teenagers. The midwife and nurses can harness the transformational change during pregnancy, to provide teenage-appropriate care.

It is highlighted that the notion of ontological security is a novel use of social theory that is, structuration theory (Giddens, 1984), to understand pregnant teenagers and their antenatal care needs. Within this context, this study has contributed substantively to existing literature on early childbearing.

**Pregnancy as an expression of social agency**

Pregnancy and motherhood may be the result of the teenagers’ self-reflexive project to develop their own self-identities (McDermott & Graham, 2005, p. 72). One’s social agency or capacity to produce social actions such as motherhood is based on knowledgeability of one’s social contexts, such as limited opportunities for a career in life. This knowledgeability facilitates reflexive monitoring (Giddens, 1984, p. 3). This
implies that some of the teenagers interviewed may be expressing their knowledgeability of their current social circumstances of structural constraints and may have accepted motherhood as the best option for them, albeit tacitly. For many of the teenagers interviewed, motherhood is a resource that enables the expression of their social agency in order to control their futures within existing structural constraints. For teenagers with ‘impoverished social spaces’ (McDermott & Graham, 2005, p. 72), such as limited resources of education and employment, their sexual and reproductive capacity for motherhood may be the only resource available to them. They may also idealise pregnancy as the best thing that has ever happened to them (Quinlivan et al., 2004). As noted in the current study, the majority of the teenagers interviewed with planned and unplanned pregnancies were happy to be pregnant and were looking forward to motherhood. Some pregnant teenagers experienced improved mental health. Likewise, in the post birth interviews, a few teenage mothers no longer had depression, which they had experienced prior to their pregnancy. Pregnancy provided hope and expectations in the teenagers’ young lives for a different, if not better, future to what they had experienced prior to the pregnancy.

Concurring with several studies, through motherhood, teenagers developed maturity and became responsible and caring (Afable-Munsuz, Speizer, Magnus, & Kendall, 2006; Keys, 2007; McDermott & Graham, 2005; J. L. Smith et al., 2012). In this study, the teenagers reported avoiding risky behaviours, such as consuming excessive amounts of alcohol, in order to acquire responsibility and stay out of trouble. Further, as reported by other authors (Keys, 2007; J. L. Smith et al., 2012; SmithBattle, 1994), in the current study, a few teenagers reported greater independence and a sense of power and direction in their lives. The nurses who were interviewed also reported similar transformations in some of the teenagers in their program. As noted in another study, teenage motherhood is viewed as a ‘lifeline’ that generates positive changes in teenagers’ lives (J. L. Smith et al., 2012, p. 181). This transformation is akin to a ‘metamorphosis’ from the past life into a new life that opens up new opportunities. This transition enables teenagers to demonstrate to society that they are good citizens and mothers (Hanna, 2001). However, in contrast to the nurses interviewed, the midwives did not report the same positive outcomes for some teenagers. This could be because the nurses were based in the community and had the opportunity to conduct follow-ups with the teenagers for up to two years following the birth of the baby. Importantly, as identified in a study (Keys,
2007), some of the young women (aged up to 23 years) who had children as teenagers continued to value the changes in their lives that were brought about by teenage mothering.

In line with several authors (Afable-Munsuz et al., 2006; Keys, 2007; J. L. Smith et al., 2012; SmithBattle, 1994), the current study supports the notion that for the majority of teenagers, motherhood is a valued self-identity that motivates transformative lifestyle changes. This self-identity project through reflexive monitoring is fundamental to social agents because they strive to shape and re-shape their self-identity lifestyle choices in society. The ‘making and remaking’ of self-identity is essential for the ‘continuing sense of ontological security’ (Giddens, 1984, p. 82). Specific to teenagers, the self-identity project of motherhood may be more profound because they shift from being teenagers with uncertain futures to motherhood. Thus, based on structuration theory, motherhood may be a positive identity for many of the teenagers interviewed. Viewed in this way, motherhood may well be a viable life path for these teenagers (SmithBattle, 2012) and an important choice to support their transition to adulthood (J. L. Smith et al., 2012, p. 185).

**Pregnancy as ontological security**

In the previous section, irrespective of whether the pregnancy was planned or unplanned, many of the teenagers interviewed in this study experienced positive changes to their lives as a result of their pregnancy. Motherhood was a ‘turning point’ (Yardley, 2008) in their lives, perhaps resulting from the development of ontological security. As presented in Chapter 3, ontological security refers to the trust in our basic trust system, which is founded on a life characterised by control and highly routinised that is sustained through reflexive monitoring (Giddens, 1984, p. 64). The trust envelops the individuals as a protective cocoon and gives them a sense of invulnerability (Giddens, 1991, p. 39).

In the late twentieth century, individuals experienced more ‘personal meaninglessness’, where life was empty and an ‘existential isolation’ related to individuals’ lack of access to resources for a fulfilling existence (Giddens, 1991, p. 9). This meaninglessness threatened individuals’ ontological security. In the twenty-first century, the notion of personal meaninglessness remains relevant. For many of the teenagers interviewed, the
personal meaninglessness may have developed from lives structured by social and economic disadvantage. For example, parental divorce/separation was common among the teenagers interviewed, and the attendant family instability may have led to a ‘rupture’ in social and self-identity, resulting in ontological insecurity. In this sense, motherhood may be existentially fulfilling because the teenagers achieved meaning through their new self-identity with their expression of social agency, autonomy and control. Trust is developed in the social world that subsequently leads to ontological security. As noted in an autoethnography, the rupture to the protective cocoon was a vitally important moment for radical transformative change to one’s identity (Pearce, 2008, p. 142). For the pregnant teenagers in this current study, regaining the protective cocoon and ontological security were reflected as moments of transformative change during pregnancy.

9.5 ‘Colonisation of the Pregnancy’: Navigating Risks

This section broadly discusses the research questions in relation to teenagers’ antenatal care needs within the context of their socio-ecological environments. Further, this section confirms the importance of the social support network for teenagers.

The notion of ‘colonisation of the pregnancy’, as coined in this study, was based on the concept of ‘colonisation of the future’ (Giddens, 1991, p. xx). To colonise the future is to take control of one’s life and to minimise risks so that life results in fairly predictable outcomes. This control is driven by a risk approach to life. In the modern world post industrialisation, social agents have become more focused on managing risks in their lives. This is because of the loss of traditions, increased sense of insecurity and lack of trust in one’s daily routines. The insecurity has contributed to the shift to placing trust in experts and specialists’ systems—for example, experts are consulted in relation to how best to live one’s life (Giddens, 1991). This may have driven the overemphasis on medical risks during antenatal care and education (Hanson, VandeVusse, Roberts, & Forristal, 2009, p. 461). In the current study, the risks approach may have driven teenagers’ motivation to have a healthy baby and underpinned the midwives’ emphasis on minimising medical risks in maternity care.
9.5.1 Heightened vulnerability and antenatal care needs

Pregnancy positions teenagers in a state of heightened vulnerability that contributes to their antenatal care needs. This vulnerability refers to the increased possibility for harm or risk (Aldridge, 2014, p. 113) related to their structural constraints, which many teenagers in this study experienced. Access to alternative forms of childbirth education; healthy behaviours in relation to their diet, and cigarette smoking; understanding the realities of breastfeeding; and stress management skills. Social support networks from family, health staff and community services were important for the teenagers. Also discussed is teenagers’ vulnerability to stigmatising behaviours by health professionals. The social stigma of early childbearing was also a concern for some teenagers. Fundamentally, the discussion on the antenatal care needs focuses on the ‘what’ and ‘how’ of social behaviours (Hammersley & Atkinson, 2007; Hammond & Wellington, 2013), which reflects teenagers’ culture or ‘way of life’ underpinning these needs. Culture or the ‘way of life’ can be influential on teenagers’ antenatal care needs.

‘…more fascinating to look up on the internet’: Low childbirth education attendance

Childbirth education is important to promote a positive transition to motherhood (Kaiser & Hays, 2005, p. 485), and it is a critical component of antenatal care (Hanson et al., 2009, p. 458). The health knowledge gained from the childbirth education program contributes to women’s knowledgeable (Giddens, 1984) to develop strategies of control (Cohen, 1989, p. 44) such as decision-making on health care and engaging in healthy behaviours. The YMC program was conducted in the face-to-face mode only. This current study revealed that some teenagers were not regularly attending childbirth education classes, and a few teenagers did not attend any of the sessions. The popularity of the internet as an important source of antenatal information for teenagers may have contributed to the lack of and non-attendance for childbirth education by teenagers interviewed in this current study.

Teenagers who do not attend childbirth education may have had limited knowledge (Arthur et al., 2007; Kaiser & Hays, 2005; MacLeod & Weaver, 2002; Price & Mitchell, 2004; D. M. Smith & Roberts, 2009) to support them during their labour, birth and parenting (Atkinson & Peden-McAlpine, 2014; MacLeod & Weaver, 2002; Price & Mitchell, 2004). In this current study, teenagers’ knowledge was not tested. However, it
could be inferred from their interviews that they were aware of current recommendations in relation to, for example, cigarette smoking, drinking and conforming to Listeria diet restrictions. In contrast to the teenagers’ interview findings, the nurses’ view was that the majority of teenagers are not interested in learning about labour and birth.

Concurring with a study in the US (Ybarra & Suman, 2006), the internet was a popular source of antenatal information for the teenagers interviewed. Several reasons may account for the internet’s popularity with teenagers. In Australia, the internet is easily accessible to teenagers aged 14–17 years in their homes (Raco, 2014, para.6). Thus, the ease of access to information may be an important contributing factor to internet popularity. Further, as noted in the current study, convenience was a common reason for using the internet for health information (Ybarra & Suman, 2006, p. 38)—that is, information is immediately available when and as required. Further, some teenagers who used the internet may feel more comfortable in learning health information at their own pace. They may also dislike face-to-face interactions with health professionals, either because they are not familiar with them or because they may feel that these services are inherently discriminatory towards childbearing teenagers (Yardley, 2008). One reason for using the internet could be that the teenagers enjoy the interactivity of the internet—for example, a social media Facebook app called ‘Baby Gaga’. Notwithstanding, as noted in this current study, a problem with the use of the internet is that health information is seldom shared or validated with health professionals for their accuracy (Hanson et al., 2009, p. 463).

Other barriers to childbirth education attendance were related to teenagers’ socio-economic issues and relationship problems, which are influential on teenagers’ behaviour during pregnancy (Blanch & Goodes, 2013, p. 66). In the current study, the barriers to childbirth education included transport difficulties; social problems such as housing concerns, which take precedence over childbirth education; and the strong influence of teenagers’ social support networks—in particular, their mothers/parents. Teenagers’ age may also be a contributing factor to non-attendance for childbirth education. Developmentally, younger teenagers may not have the cognitive maturity for decision-making; they are present-focused (Duncan & Young, 2013) and have not yet developed concrete thinking (Bensussen-Walls & Saewyc, 2001; Montgomery, 2000).
Teenagers’ age may have influenced their behaviours and their way of life. Thus, with these developmental factors, teenagers with low education attainment may need information presented to them in an easy-to-understand format because of their low literacy skills (Hawkins, Kantayya, & Sharkey-Asner, 2010, p. 731).

Importantly, non-attendance at the YMC childbirth education program may not be an issue of age and way of life; rather, it may reflect teenagers’ learning styles. This highlights the need for the YMC and nurses to examine how childbirth education is currently delivered and to meet the challenge of delivering information to teenagers who are at different age and stages of cognitive development.

‘I don't know what’s good for the baby…’: Dietary knowledge

This study suggests that some teenagers require support in relation to dietary needs, such as knowledge of food types and food preparation. Likewise, a study (Porteous, Palmer, & Wilkinson, 2014) identified that a lack of knowledge regarding nutrition and healthy diets is a problem for childbearing women aged 18 and over. The women did not know their goals for gestational weight gain and did not have good-quality diet in relation to daily serves of fruits, vegetables and dairy. In addition, some of the women surveyed gained weight above the target range (Porteous et al., 2014). Overweight and obesity during pregnancy may contribute to increased mortality for mothers, pre-term births and increased mortality for infants (R. E. Black et al., 2013).

Specific to Tasmania, obesity in pregnant women may be an emerging problem. The State has the second-highest obesity rate of 28.8 per cent in children/teenagers aged five to 17 years. Further, 50.8 per cent of Tasmanian women (aged 18–34 years) were overweight (BMI 25–25.9) or obese (BMI 30 or higher) (Department of Health and Human Services, 2013c, p. 13). As reported by a few midwives in the current study, they have noticed more overweight pregnant teenagers at the clinics.

The teenagers interviewed had experienced several barriers to observing a good diet. In particular, observing dietary restrictions in relation to Listeria infection was difficult and caused confusion for many teenagers. They were unsure of what foods were considered safe and unsafe. According to some midwives, many teenagers cannot afford a good diet because of their limited financial capacity. Thus, as noted by the nurses
interviewed, many teenagers may resort to canned and fast foods for the convenience and low cost.

The use of canned foods may not be an issue of convenience, but it reflects a deep cultural practice embedded in childhood. This highlights that parents have important roles in their child’s health trajectory and habit development (Anzman, Rollins, & Birch, 2010, p. 1122). Individuals in a culture or subculture hold values and ideas acquired through learning from other members of the group (Holloway & Wheeler, 2010, p. 154). The family influence was evident for a few teenagers interviewed in relation to their dislike for vegetables. Interestingly, the child’s preference for foods begins inside the womb (in utero), suggesting that maternal influence begins during the antenatal period (Anzman et al., 2010, p. 1118). This suggests that addressing dietary needs during pregnancy is a fundamental antenatal care need for all women. Further, given the obesity statistics in Tasmania, pregnant teenagers’ dietary information needs require specific attention by YMC midwives and other health professionals. This antenatal care need is not new information to the YMC midwives and nurses interviewed. However, it may challenge them to work in different ways—in particular, the strong family influence on diet during antenatal care may be a focus of antenatal care and childbirth education.

‘...if they have a bad day they’ll have a lot’: Cigarette smoking during pregnancy

Many teenagers reported ceasing or reducing smoking and ceasing their consumption of alcohol and illicit drugs. These teenagers’ use of a combination of the three substances (cigarettes, alcohol and illicit drugs) appeared to be common and was often a social activity undertaken with partners and friends. A few teenagers interviewed reported that this cultural practice continued until the pregnancy was diagnosed. However, in contrast to the teenagers’ claims of cessation or reduction in cigarette smoking, the nurses revealed that many teenagers continued to smoke just as much during pregnancy. The smoking increased if they had a ‘bad’ day. More importantly, smoking may be symptomatic of stress related to the teenagers’ social and economic disadvantage and mental illness (Lawrence et al., 2013; Shaw et al., 2006).

Smoking during pregnancy is related to LBW in babies (Chan & Sullivan, 2008; Li, Zeki, Hilder, & Sullivan, 2012), premature birth (<37 weeks), neonatal death (G. C. S.
Smith & Pell, 2001) and SGA babies (Robson et al., 2006; Van der Klis et al., 2002). In 2010 in Tasmania, cigarette smoking during teenage pregnancy was a problem, with 46.8 per cent of teenage mothers continuing to smoke during pregnancy (Department of Health and Human Services, 2013c, p. 11). Nationally, a small reduction of 0.9 per cent was reported in the smoking rate among teenage mothers between 2010 and 2011 (Li, Zeki, Hilder, & Sullivan, 2013). Nonetheless, a large population-based study in Australia (Chan & Sullivan, 2008) confirmed that pregnant teenagers make behavioural changes, with one in 15 pregnant teenagers ceasing smoking between the years 2001 and 2004. Importantly, in the current study, the contradiction between the teenagers and nurses in relation to cigarette smoking highlights that teenagers may need more support from midwives and nurses, including their families, to cease or reduce cigarette smoking during pregnancy. In Tasmania, the high percentage of pregnant teenagers who smoke reflects that cigarette smoking is an important antenatal care need.

‘… a bit anxious about how it’ll go… [at birth]’: Stress during pregnancy

In the current study, the antenatal period was a stressful time for many teenagers. Fear of the impending labour and childbirth is expected. According to some midwives, fear of the labour and birth is an adult concept, and they believed that teenagers do not have preconceived notions about labour and birth. However, in contradiction, many teenagers expressed concerns about the labour and birth. Some feared the use of the epidural because of needle phobia and the potential adverse effect of back pains, and some were worried about their ability to give birth naturally.

Further, a few older teenagers were worried about how they would be as mothers, as well as the stigma of single, teenage childbearing. The experience of stress during pregnancy may be related to the teenagers’ structural constraints in their lives. Housing was a worry for a few of the teenagers interviewed. Many were experiencing financial stress, and this may be related to the fact that they were receiving social welfare payments. As noted in one study, financial stress experienced by recipients of social welfare payments can lead to poor mental health (Kiely & Butterworth, 2013, p. 264). The stress may be challenging for teenagers to manage because many may not have adequately developed coping styles and strategies (Myors, Johnson, & Langdon, 2001, p. 24) because of their youth.
Depression is common for teenagers in lower socio-economic status groups (Mission Australia, 2014, p.21); among pregnant teenagers (Logsdon & Gennaro, 2005; Mead, Brooks, Windle, Kukielska, & Boyd, 2005; Quinlivan, 2006); and in the teenagers interviewed in this study. Anxiety may co-exist with depression (Slade, Johnston, Teesson, et al., 2009). Most teenagers had experienced depression that was diagnosed during their younger teenage years by their GPs. It is important to explore the roots of depression and anxiety because these may be related to the structural constraints in the teenagers’ lives. As suggested in one study, Australians with lower educational levels and who are unemployed, single and homeless are susceptible to mental health disorders (Slade, Johnston, Teesson, et al., 2009). It was highlighted in the literature review that anxiety was common among pregnant teenagers who had experienced parental divorce and/or separation, family violence and who had a poor relationship with their parent(s) (Quinlivan et al., 2004). Further, pre-existing background factors in individual (psychiatric/behaviour problems) and family characteristics were noted to significantly contribute to teenage childbearing by two to seven times (Jaffee, 2002).

For many teenagers with experiences of depression and anxiety, the stress experienced during pregnancy could worsen their mental health during pregnancy and post birth. This may have resulted in some teenagers resuming treatment with antidepressants in the post birth period. In addition to depression and stress, teenagers’ age may also be a contributing factor to stress during pregnancy because maternal youth (aged under 20 years) is a risk factor for poor postnatal mental health in teenagers who experienced social disadvantage (structural constraints) during their childhood and teenage years (Schmied et al., 2013a). This includes the social disadvantage of exposure to child abuse, family instability and unhappy relationships with partners (Schmied et al., 2013a, p. 167). Importantly, maternal depression during or prior to pregnancy can continue to affect women for many years, such as up to 14 years post birth (McGuinness et al., 2013).

Finally, it is contended that teenagers’ stress during pregnancy may be ‘layered’. For example, stress related to their experience of depression and anxiety may be layered with their socio-economic stress, such as financial constraints, housing needs and transport. These effects of chronic and acute stress may have accumulative effects. Within this context, acute life events may be perceived as more stressful when the
mothers are also experiencing chronic stress (Schmied et al., 2013b, p. 174). While pregnancy was a happy time for the majority of the teenagers interviewed, it was also a highly challenging time of heightened vulnerability in view of their age and other socio-ecological influences.

‘…tried to [breastfeed] when he was first born’: Breastfeeding difficulties

Concurring with a study (P. H. Smith, Coley, Labbok, Cupito, & Nwokah, 2012), the midwives and teenagers’ interviews revealed a high unsuccessful breastfeeding rate by teenagers; many gave up breastfeeding during the first week following the baby’s birth. For example, Hanna said she ... tried to [breastfeed] when he was first born but she gave up breastfeeding because the baby was not gaining weight. In contradiction to the teenagers’ reports, the nurses believed that few of the teenagers commenced breastfeeding, and those who breastfed may have done so for a month. This contradiction may be because by the time the nurses commenced care for the teenagers in the late postnatal period, the teenagers may have already established artificial feeding for the baby. The nurses believed that a common reason for early unsuccessful breastfeeding was because breastfeeding was not a cultural norm in the teenagers’ families. Successful breastfeeding by teenage mothers requires reliable support from families (P. H. Smith et al., 2012, p. 1). This reflects the strong cultural influence of families on some teenagers.

In the current study, some of the breastfeeding problems experienced by the teenagers interviewed were weight loss in the newborn babies, the baby’s health, nipple trauma (bleeding) and the lack of postnatal breastfeeding support. Further, the lack of breastfeeding success may be related to some of the teenagers’ poor mental health. In addition, as noted in the midwives’ interviews, the teenagers’ views ‘could be completely erroneous’ in regard to breastfeeding that is popularised in society as being healthy for the baby. The teenagers may have little understanding of the challenges of learning to breastfeed.

However, the lack of successful breastfeeding by the teenage mothers interviewed may not be specific to teenagers. Globally, only an estimated 37 per cent of mothers achieve exclusive breastfeeding in the first six months of the baby’s life (World Health Organization, 2014b, p. 9). Nonetheless, the large number of teenagers interviewed who
were unable to breastfeed suggests two important problems: a limited understanding of the challenges of learning and establishing breastfeeding, and issues in relation to breastfeeding support from midwives at the local hospital.

‘…they shouldn't really be here anyway’: Stigma of teenage pregnancy

Stigma is experienced when individuals are treated negatively because of their ‘mark of disgrace’, such as teenage pregnancy. In the stigma experience, individuals are subjected to the stigmatising processes of labelling, stereotyping, and categorising that highlights his or her differences, discrimination and status loss. Further, the stigma subjugates individuals to domination in a power situation (Link & Phelan, 2001, p. 367).

In the current study, the stigma related to early childbearing may be experienced by teenagers because of their stigmatising markers of maternal youth, social economic disadvantage, single status and dependence on social welfare support. The stigma may be driven by issues of social values about morality. Early childbearing is viewed as a problem in developed societies, largely because these societies consider adolescence a transitioning stage to adulthood and are not accorded the rights as fully participating citizens in relation to, for example, voting rights (R. Black, Walsh, & Taylor, 2011, p. 43). Thus, the common understanding of adolescents is that they are immature, as noted in the midwives’ interviews in the current study. This deficit view of adolescents is influential in society (Bahr & Pendergast, 2007). Examples of situations of stigma described by the teenagers in the current study were looks from people in the community, pressure to terminate the pregnancy and the dominating behaviours of medical doctors and midwives. Dominating behaviours are demeaning and are considered stigmatising (SmithBattle, 2013, p. 238). This study’s findings suggested that pregnancy also positions teenagers in ‘publicly examined lives’ (Hanna, 2001, p. 456) that contribute to their heightened vulnerability to stigma from the public and health professionals.

Maternal age is an important factor contributing to the stigma of early childbearing. As noted, the age of a social agent functions as a ‘standardised marker’ of social position in the virtual time–space within social systems (Giddens, 1984, p. 282). Teenagers’ age
contributes to their discrimination as the ‘Other’ in relation to adult childbearing women.

Social self-identity is shaped by our awareness of our differences in social and cultural societies in relation to others (Giddens, 1984). As the ‘Other’, the teenagers exist in the margins of society. Most telling of the notion of pregnant teenagers’ ‘Otherness’ is the midwives’ language noted in the interviews in the current study. Similarly, in another study, nurses felt that teenagers were ‘immature’ in their understanding of pregnancy because of their incomplete maternal development due to their age (Atkinson & Peden-McAlpine, 2014, p. 170). However, none of the teenagers interviewed referred to themselves as ‘immature’. For example, Kelysey, one of the teenage mothers, revealed that because she was so young, she felt that the midwives were dominating and had little engagement with her. This discrimination and domination during the immediate postnatal care may have contributed to her loss of status as a mother (Link & Phelan, 2001). She also lost confidence in breastfeeding her baby.

Some midwives who were interviewed believed that they can make a difference to the teenagers by helping them feel empowered to grow and develop with the pregnancy. However, some of the midwives’ cultural view was that they did not believe that teenagers should be pregnant. Culture underpins most of the social agents’ behaviours and practices as individuals or as a group (Ortner, 2006, p. 12). As revealed in the midwives’ interviews, the cultural differences may be due to the midwives’ limited ‘frame of reference’. Further, most of the midwives at the local hospital were ‘white, Caucasian and middle class’ older professionals. The midwives believed that there is a tendency by some staff to ‘look down’ on the teenagers because of their age, and this may have contributed to the teenagers feeling intimidated by some staff. This reflects that teenagers are subjected to the ‘…stigmatization as inappropriate mothers’ (McDermott & Graham, 2005, p. 69). Within this context, one midwife revealed that it would be hard to convince her that teenage pregnancy has any positive influence on the teenagers. This midwife worked mainly with adult pregnant women, and her attitude was different to Beth, who worked mainly with teenagers in the YMC. This difference between the midwives may reflect that midwives who regularly work with pregnant teenagers are more understanding of the teenagers than midwives who mainly work with adult women.
In general, the midwives’ culture that contributes to the stigma of childbearing teenagers may have been shaped by midwifery knowledge and practice that is embedded in biomedical sciences and aligned with the risks approach to care. As mentioned earlier, in a risks society (Giddens, 1991), social agents focus on minimising the risks in society. In the health system, pregnant teenagers are viewed as a high-risk group for poor pregnancy outcomes (Chen et al., 2007; Chen et al., 2008), and they are not good at attending antenatal care clinics (Arthur et al., 2007; Haddrill et al., 2014; D. M. Smith & Roberts, 2009). These risks contribute to a greater need for surveillance for health problems and the ‘medicalisation’ of care (Conrad & Barker, 2010; Nettleton, 1995). Likewise, this medicalised view underpins midwives’ prioritisation of surveillance in antenatal care clinics (Price & Mitchell, 2004). Fundamentally, surveillance engenders discipline and is a medium for the exercise of power (Giddens, 1984, p. 136). Within the risks approach to care, midwifery practice may become task-focused and depersonalised, as experienced by a few teenage mothers in this study.

Lastly, it is necessary to highlight the notion that stigma may be reflected as structural violence through the application of rules and resources in the health and political systems (Ellison, 2003) that may contribute to the domination of some social groups. Structural stigma contributes to social inequalities and increased stigmatisation of teenage childbearing (SmithBattle, 2013, p. 237). For example, at the YMC, not allowing teenagers to choose where they wanted to receive antenatal care may be seen as a structural stigma. Another example is the social pressure from the family to terminate the pregnancy (Ellison, 2003), which one teenager experienced in this study.

This study found that maternal youth can negatively influence midwives’ practice at the local hospital, and this has also been reported in other studies (Arthur et al., 2007; McDermott & Graham, 2005). In the current study, the midwives’ practice may suggest a lack of communication skills to care for the teenagers (Arthur et al., 2007; MacLeod & Weaver, 2002; Price & Mitchell, 2004). Importantly, the presence of stigma suggests that teenagers are vulnerable to disrespect at the local hospital, and this vulnerability is an important need for the teenagers. For this reason, it is critical that midwives, as a central part of the health care system for all pregnant women, are aware of their role in how early childbearing stigma is produced and reproduced.
9.5.2 Social support during pregnancy

Social support refers to support that is readily available to the teenagers from their social network of people, such as close family members and friends (Corcoran et al., 2000; Feldman, 2007). This support can be beneficial to the teenagers (Arthur et al., 2007; Atkinson & Peden-McAlpine, 2014), reduce their sense of social isolation and improve their antenatal care attendance (Arthur et al., 2007). Social support is particularly relevant for younger teenagers (Atkinson & Peden-McAlpine, 2014). In this current study, the teenagers’ mothers were a common source of support for the teenagers. This support may be a strong buffer against stress (Devereux, Weigel, Ballard-reisch, Leigh, & Cahoon, 2009; Schmied et al., 2013b). The teenagers who were interviewed reported receiving social support from their families and friends in various forms, including accommodation, transport and company during YMC visits. The nurses who were interviewed unanimously agreed that family is an important source of social support, and that this support contributes to teenage mothers’ progress in the c u @ home program. At the YMC, midwives valued the inputs of mothers/parents over partners or friends because of the important influence they have over their daughters. Also, they felt that adults are considered more reliable than partners or friends. This highlights the midwives’ risk approach to the care of teenagers, which may be underpinned by their doubts of teenagers being good mothers.

However, the effects of social support on minimising stress may be short-lived (Devereux et al., 2009, p. 442). This implies that the teenagers may experience stress despite receiving good social support. Further, having social support does not always imply that the support will be provided consistently. Inconsistent support can contribute to social isolation (Arthur, Unwin, & Mitchell, 2007, p. 672). For many of the teenage mothers interviewed, social support from their own mothers continued following the birth of the baby.

Conversely, the strong influence of teenagers’ social support networks may also be a barrier to teenagers achieving their goals in the c u @ home visiting program. One nurse’s heartfelt comment was that the teenagers’ world of social and cultural relationships was much more influential than what she (the nurse) could provide because she only had limited access to the teenagers in the program. In contrast, many families, partners and friends have continuous access to the teenagers. Paradoxically,
too much support from parents can be stressful. For example, Taylor, a 19-year-old teenager, felt that her parents were taking over the care of the baby, and this prevented her from building her self-identity as the mother of the baby.

Partners can also provide good social support to buffer the effects of stress for teenagers (Pires et al., 2014). As revealed by the nurses and some midwives, partners can provide good support in the teenagers’ antenatal preparations. However, in practice, partners were seldom seen at the YMC. Concurring with a study (Atkinson & Peden-McAlpine, 2014), the current study revealed that teenagers’ partners were only minimally involved in antenatal care and childbirth education. However, one teenager’s partner often accompanied her to the antenatal care and education classes held at the YMC. In the interview, he poignantly observed that the YMC childbirth education does not help men in regard to supporting the teenagers. He felt left out in the education classes and wanted ‘young dads’ classes. His dilemma exemplified the gender bias towards partners that YMC midwives have inadvertently practiced by focusing on the teenagers’ mothers to support the teenagers. The lack of involvement of partners at the YMC is an important service delivery issue. Further, it is a missed opportunity to include partners in supporting the teenagers. As noted, their support may contribute to reducing depressive symptoms in the teenagers (Pires et al., 2014, p. 797).

While some partners may be important as support people, they can also be a constant source of stress for the teenagers, and this is often related to relationship problems. For example, as supported by some authors (Hanna, 2001; McDermott & Graham, 2005), many teenagers in this study revealed a lack of financial support from partners for the baby. As noted by the nurses, relationships commonly break down during the postnatal period. One teenage mother interviewed revealed that she was unhappy in her relationship with her partner, and may consider separating from him. No explanations were offered for the disharmony. Partner violence is common for some young women (Keys, 2007; Quinlivan, 2006; Schmied et al., 2013b), and it is more common for women with an unplanned pregnancy (Schmied et al., 2013a, p. 174). As noted in the current study, a few teenagers experienced partner violence that ended their relationships. The effects of violence may continue to be felt for a long time. As experienced by one teenager who separated from her partner because of partner
violence, in the post birth period, she continued to blame herself and the baby for the relationship breakup.

According to the nurses interviewed, teenagers with no social support commonly come from unstable family backgrounds—for example, teenagers with a history of family violence or Child Protection. Thus, social support during pregnancy and post birth is essential for teenagers—particularly those with few social support networks.

9.6 Teenage Motherhood as a Representation of Social Inequality

This section proposes the notion that teenage pregnancy is a social injustice (Geronimus, 2003; Hanna, 2001; SmithBattle, 2012) because teenage motherhood may be a trajectory in life shaped by social inequalities (McDermott & Graham, 2005, p. 72).

Whether the pregnancy was intended or not, motherhood as an expression of social agency gives teenagers a choice in life. For some teenagers, motherhood may support their transition to adulthood (J. L. Smith et al., 2012, p. 185) and to fast-track adulthood (Yardley, 2008, p. 680). However, as highlighted in the integrative review and in the current study, many childbearing teenagers experienced structural constraints in their lives. The teenagers’ self-reflexive monitoring of their social world may have generated tacit awareness of their disadvantage and poverty and their acceptance of teenage childbearing as an appropriate choice. Thus, teenage pregnancy may be an outcome of teenagers’ self-reflexivity that shaped their desired identities to achieve stability in their social world. However, early childbearing is a threat to teenagers’ continuing poverty and further social inequalities (Casad, Marcus-Newhall, Nakawaki, Kasabian, & LeMaster, 2012; Farber, 2014; Mollborn, 2007; Van der Klis et al., 2002). For these teenagers, poverty becomes their ‘enduring disadvantage’ that continues to affect their lives and those of their children (SmithBattle, 2012, p. 446). Therefore, teenage pregnancy can produce and reproduce the ‘cycle of poverty’ that deepens the social injustice in teenagers’ lives.

Nonetheless, as social agents with the power ‘to act otherwise’ (Giddens, 1984, p. 14), teenagers can decide to act or not act. They need not continue with the pregnancy, as other options, such as termination of pregnancy and adoption, are available. Ultimately, for some teenagers, the decision to have a baby may be intended because pregnancy is
an embodiment of their reproductive rights—of their social agency (Giddens, 1984). Through self-reflexive monitoring, teenage motherhood may be the teenagers’ way of responding to the social constraints and displaying the ‘dialectic of control’ phenomenon (Giddens, 1984, p. 16). This phenomenon inherently occurs in all power relations, as social agents reflexively strive to maintain their sense of autonomy within situations of domination and power, such as social inequalities (Giddens, 1979, p. 149). Thus, choice is always available in life (Sen, 1998, p. 22). However, to choose motherhood within a life of structural constraints denies the teenager the opportunity for free choice. The lack of choice could be conceived as ‘denying’ choice, and it is an act of repression and violence (Sen, 1998, p. 22). Thus, teenage motherhood as a trajectory in life shaped by socio-economic disadvantages is considered socially repressive and violent.

9.7 Critique of Theoretical Frameworks

This section presents a critique of the two key theoretical frameworks applied in this study in respect to the guidance they provided in addressing the research questions and cultural nuances. In addition, this section highlights the complementarity of the two frameworks within the context of addressing this study’s key research objectives.

9.7.1 Socio-ecological determinants of health

The SEDH, or the ‘social determinants’ of health framework is a useful framework in health care as it shifts the health professionals’ mindset from treatment of illness to prevention of illness. Importantly, these determinants are modifiable through, for example, policy changes, to prevent social and health inequities (Lavery et al., 2005; Marmot, 2005; Whitehead et al., 2001). Concurring with several authors (Allen et al., 2013; Australian Institute of Health and Welfare, 2012; Blum et al., 2014; Department of Health and Human Services, 2013c; Marmot, 2005; SmithBattle, 2012; Whitehead et al., 2001), the application of the SEDH framework in the current study was significant in locating the socio-ecological determinants of teenage pregnancy. In the context of the current study, the use of the socio-ecological framework highlighted a ‘multifocal’ approach to addressing individual, family and educational opportunities to reduce the rate of teenage pregnancy (Quinlivan et al., 2004). The ‘multifocal’ concept is inline with the SEDH framework that encompasses the four key levels of determinants on the
individual, as described in Chapter 3. These determinants are the individual factors; relationships with family, friends, and community; the living and work conditions; and systems determinants that exert overarching control over individuals (Bronfenbrenner, 2005).

As described in Chapter 3, the utility of the SEDH framework is reflected in its contribution to three elements: social awareness of social inequities that highlight social injustice, linking social inequities to health inequities, and the focus on health. Of these three elements, the most applicable construct was that of raising social awareness that teenage pregnancy is mostly associated with social inequalities and that it is a social justice issue. Social awareness may contribute to challenging the social structures that influence life choices (Lavery et al., 2005, p. 612). For example, it is essential to develop social awareness of the government policies and programs that may have produced and reproduced social structures that generated Tasmania’s social and economic inequalities, which can inadvertently reduce opportunities for life choices for teenagers. Likewise, the application of social awareness may reduce the problem of the stigma of early childbearing by addressing structural violence that can be perpetuated through rules and resources in the socio-ecological environments; including in the maternity care settings.

At the micro or individual level, age, attitudes, health knowledge and behaviours posed as influential factors for these teenagers and had the potential to influence significant others in their environments. For example, the teenagers’ ‘youth’ may have been a key individual factor that triggered the midwives’ stigmatising behaviours at the local hospital. Importantly, the role of primacy of carers (parents/carers) in a child’s life, as well as the child’s social history, are critical influencing factors in the child’s development (Bronfenbrenner, 2005). Understanding the micro-level SEDH contributed to the current study’s understanding that teenage pregnancy is associated with social inequalities related to the teenagers’ socio-ecological environment within which they were born.

Meso-level factors refer to the factors in teenagers’ relationships with primary carers such as parents—in particular, their mothers—and significant others such as friends, community members, schools and religious members, which are influential on the developing child and the emergent teenager. In this study, understanding meso factors
such as family instability and parental divorce/separation was critical in understanding the far-reaching influence of parental divorce, namely depression, anxiety and self-harm (for some teenagers), which may be experienced for decades after the event. Therefore, it is not surprising that parental divorce is considered an ACE (Bellis et al., 2014). As noted in the current study, school is also a meso-level determinant that significantly influences teenagers’ opportunities for a fulfilling life because the lack of schooling posed a social constraint.

At the exo level is the environment that influences the meso and micro determinants, such as the social and economic status of parents and neighbourhoods. The exo system’s unsatisfactory working conditions for parents may lead to unhappy interactions with the child at home (Bronfenbrenner, 2005). Therefore, in using the SEDH framework in the current study, the research identified that the teenagers’ social history influences their childhood. Understanding their past is fundamental to understanding their present needs as pregnant teenagers. Within this context, SEDH aligns with structuration theory by acknowledging the value of time and space and their influence on social agents.

Fundamentally, the use of the SEDH framework facilitated a conceptual shift of childbearing teenagers from a personal issue to that of teenage childbearing as a social inequality issue. This shifts the blame and responsibility from the individual to a shared social responsibility that sits with all levels of the SEDH framework. Within this context, these issues are outcomes of one’s social and environmental conditions that can be addressed by modifying these conditions.

A major limitation in the application of the SEDH framework in the current study was the broadness and complexity of the multi-level framework of the three SEDH levels (micro, meso, exo) that were applied in the development of the research design and the semi-structured interview guides. This resulted in too many determinants for data collection. In retrospect, given the broad framework, it may have been more effective to limit the study to one level of the SEDH instead of applying all four levels. For example, limiting the application of the SEDH to the micro level only may generate a richer and deeper understanding of pregnant teenagers. This may have generated more information regarding the teenagers’ knowledge, beliefs and behaviour in relation to
risk-taking behaviours such as cigarette smoking and the use of alcohol and illicit drugs that preceded the pregnancy.

In the current study, the teenagers’ culture as a way of life was reflected in their lives of social and economic disadvantage, of social welfare dependency, dependency on their mothers/parents, housing needs, and their acceptance of early childbearing. The teenagers’ socio-ecological environments impact on their lives and influenced their antenatal care needs. However, the SEDH framework does not provide an approach to the identification of the teenagers’ culture in relation to how they lived their lives and their antenatal care needs. This was largely because culture is an ‘embedded’ determinant at the micro level of the SEDH (Kothari et al., 2007; Taylor-Seehafer & Rew, 2000). The hidden nature of culture means that culture is largely invisible in day-to-day social activities until it is displayed in signs that signify their cultural differences (Geertz, 1973). In structuration theory, the embedded culture is part of the social agents’ practical knowledge of clinical practice. This practical knowledge is largely tacit and made explicit only through discursive means (Giddens, 1984).

Culture is an important social determinant, and its ‘hiddenness’ often lessens its significance in understanding many social actions and meanings. The tacit nature of culture as practical knowledge is made explicit through interviews and observations. It may be problematic that, in focused ethnography, participant observation was not considered a vital data collection method. The use of participant observation would have significantly contributed to a better understanding of the teenagers’ culture that constrained or enabled aspects of antenatal care and contributed to their care needs. The broadness of the SEDH framework also contributed to the lack of time for in-depth contextually aligned emic information from the teenagers, midwives and nurses interviewed. Chapter 10 recommends improvements in the use of the SEDH framework.

9.7.2 Structuration theory

This section presents the strengths of structuration theory (Giddens, 1984) and recommendations that may further improve its use. While this social theory may appear dated, the results from the current study suggest that this theory remains useful as an explanatory frame in understanding pregnant teenagers’ antenatal care needs in
contemporary society in Australia. As noted, structuration theory was recently applied in an Australian study of a nursing workforce (Xiao, Willis, & Jeffers, 2014).

Fundamentally, the application of structuration theory has contributed to a deeper understanding of the current study’s findings. The theory enabled the researcher to understand that pregnancy may be a display of teenagers’ social agency shaped by their social inequalities in their socio-ecological environments. Motherhood as a self-identity becomes a ‘reflexive project’ developed through reflexive monitoring that draws upon teenagers’ knowledgeability of largely practical (tacit) knowledge of their social circumstances in life. The knowledge that social agents ‘…possess is not incidental to the persistent patterning of social life but is integral to it’ (Giddens, 1984, p. 26). Fundamentally, motherhood may be perceived as an acceptable pathway to a respectable adulthood (D. M. Smith & Roberts, 2011, p. 1057) by teenagers because this self-identity contributes to stability, trust and the deep sense of ontological security in life. The notion of ontological security related to changes in self-identity is, by far, the most useful concept in structuration theory as applied in this study.

Relevant to this study, the development of oppression of social agents can be explained through the three dimensions of the ‘duality of structure’: signification, domination and legitimation (Giddens, 1984, pp. 25–29). For example, midwifery practice underpinned by the nuanced ideology that teenage pregnancy is a social deviancy can result in social sanctions of childbearing teenagers. This occurs through the signification systems that communicate and legitimise this ideology. Social sanctions occur if the social norm is violated. Within this context, the stigma of early childbearing is a social sanction that is communicated and legitimated in society. This legitimation contributes to the production and reproduction of the stigma in society. Concurring with Morrow and Brown (1994), the focus on power as one of the elements of the structuration process highlights that domination and power are central concepts in structuration theory (Morrow & Brown, 1994, p. 177). Concurring with a few authors (Bryant & Jary, 1991; Morrow & Brown, 1994), this study has demonstrated the utility of structuration theory as a critical theory. However, the structuration theory applied in this study has not resulted in the enlightenment and emancipation from oppression that are central to critical theory (Fay, 1987, p. 30). This may be the reason why structuration theory was considered a ‘weak’ critical theory (Morrow & Brown, 1994, p. 188).
A few limitations in the use of structuration theory were noted. Firstly, structuration theory is highly abstract and complex, as reflected in its voluminous text, *Constitution of Society* (Giddens, 1984). This was a major disadvantage in the ease of use and application of this theory in the current study. Further, in structuration theory, culture is considered synonymous with the social (Giddens, 1984, p. 19), which is a limitation because the explication of culture from the social becomes problematic. This coupling of culture and the social reflects that ‘Culture is the objectification of the social’ (Epstein, 1998, p. 8) and implies an intertwined relationship between the culture and the social. Thus, the study of culture contributes to the understanding of the social and vice versa. Within this context, the use of structuration theory may not have sufficiently contributed to understanding the teenagers’ culture underpinning their social actions. Chapter 10 provides recommendations to improve the use of structuration theory.

**9.7.3 SEDH and structuration theory**

In the current study, the use of the SEDH and structuration theory is complementary. The inclusion of Bronfenbrenner’s bioecological model in the SEDH framework was relevant to the current study because it brought the bioecological theory of human development to the SEDH framework. The focus on the individual’s development as an outcome of the individual domain and relationships with social networks (family and friends) was important for this study.

Unlike structuration theory, the SEDH framework is not explanatory of the dynamic social interactions between individuals and their environments. However, it was important because it provided the study with a broad guiding framework with which to identify the structural constraints in teenagers’ lives. The framework shifted the focus from blaming the teenager as the cause of the illness to blaming its environmental determinants. While these two frameworks may provide varying degrees of explanatory power, importantly, they are not conflicting in explaining this study’s findings.

Further, it is contended that the use of SEDH and structuration theory as explanatory theories have contributed to extending the understanding of this study’s findings. Without these theories, the findings would not have resulted in a deeper level of understanding of pregnant teenagers and their care needs.
9.8 Limitations

This section presents the study’s limitations, focusing on the limitations in the study’s methodology and methods.

In this study, focused ethnography as a research methodology was a pragmatic approach that provided sound data to answer the research questions and achieve research objectives. The methodology is necessarily limited in scope and in the methods used for data collection. For example, participant observation, a key data collection method in ethnography, was not included in this study. Thus, the usefulness of focused ethnography was also its limitations. The use of participant observation would have facilitated the ‘insider’ perspective for a more indepthy study of the research participants that would generate a richer understanding of the group studied (Hammersley & Atkinson, 2007, p. 9). This understanding would contribute to greater knowledge of the way of life that is the culture underpinning the pregnant teenagers’ social behaviours.

Another limitation was the sampling process. Teenagers who did not attend the YMC were not sampled for this study. Further, as noted in the researcher’s field notes, the YMC liaison midwife identified the teenagers for the researcher to invite into the study based on their ‘willingness’ to participate. Thus, the sample of teenagers recruited for the study may be biased towards teenagers with fewer social problems. As noted in one midwife’s interview (Janine), motivated teenagers would have fewer social problems, be engaged with school, receive support from their family and be more willing to accept help from midwives.

Another limitation was the high attrition rate (estimated 57 per cent) of teenage mothers in this study. There were fewer teenagers for the second interview conducted post birth. The high attrition rate was largely due to a loss of contact with the teenagers following the birth of their baby because many of them had changed their mobile phone numbers. This difficulty in recruiting teenage mothers is not unique to this study; it was also noted in commissioned studies in Tasmania, Australia (Blanch & Goodes, 2013) and NSW, Australia (Loxton et al., 2007). In one study, the health care providers considered the young women ‘transient’ because they moved homes frequently and the health providers had difficulty keeping in contact with them (Loxton et al., 2007, p. 57).
Further, in one study in Queensland, Australia, attrition analysis of the characteristics of the participants who could not be followed up revealed that the participants were younger mothers, had maternal depression and anxiety, the mother and partner were unemployed, and they had low education (Salom et al., 2014, p. 151). Likewise, one international study reported on the difficulty of recruiting early childbearing teenagers (Corcoran et al., 2000). To minimise the loss in the current study, two additional teenage mothers were recruited for the post birth interview.

Another limitation in this study was that a third person (for example, the teenager’s mother) was included in a few interviews with the teenagers. The presence of a third person could have influenced the depth and coverage of information provided voluntarily in the interviews. For example, one 15-year-old teenager, as a ‘minor’, was accompanied by her mother. The teenager was 30 weeks pregnant at the time of the antenatal interview. This teenager may not want to share information on sensitive issues with the researcher in front of her mother. Similarly, two teenage mothers were accompanied by their partners and they may not feel at ease to share information in front of their partners, in particular, if the information was in relation to how they feel about the partners. Thus, the teenagers may be more likely to share ‘foreground’ information instead of the ‘background’ information. Information in foreground is the public or explicit view that social agents willingly share with others (Carspecken, 1996; Giddens, 1984).

Yet another limitation was the overly broad interview guide that was developed based on the SEDH framework. As a result of using this broad, multi-level framework, the interview guide had too many determinants for data collection. This issue was not revealed in the pilot studies. Thus, the research question on neighbourhood factors could not be answered because insufficient data were obtained from the teenagers as a result of insufficient time during the interviews.

Another limitation was that the current study was not designed to generate evidence to support the midwives’ and nurses’ practice issues that emerged in the study. Therefore, insufficient data are available to report on the midwives’ and nurses’ practice issues.

Further, the timing of the interviews with the teenagers in this study could be a limitation. For example, the teenagers at the YMC were interviewed between 30 and 40
weeks’ gestation. At 30 weeks, the teenagers were at a stage where they had come to accept their impending motherhood, and many of the teenagers and support members were excited. However, if the interviews had been conducted earlier, some teenagers may have still been experiencing the shock of the pregnancy and may not have come to accept the pregnancy. Thus, the timing of the interviews may have influenced the study’s findings. This suggests that the findings may only represent experiences at a particular point in time.

In this study, researcher bias may be a potential limitation. The researcher, as a practising midwife at the local hospital, was the interviewer for all participants in this study. This may pose a threat to the completeness and reliability of data from the interviews as the teenagers may have only revealed the ‘foreground’ information and not the ‘background’ information. In particular, as a midwife who is a mandatory reporter of potential child abuse, the teenagers may not discuss their consumption of illicit drugs or excessive alcohol. Likewise, as the researcher is a colleague to the midwives and nurses, interviews with the midwives and nurses may only generate information that they want the researcher to know. In addition to researcher bias, the researcher with her own subjectivities of different social and cultural space and time, may have different interpretations of the research findings (Hammersley & Atkinson, 2007).

Lastly, while the use of the theoretical frameworks was important, a major limitation was the lack of focus on ‘culture’ and the ease with which culture was explicated from the social aspect.

**9.9 Summary**

This chapter discussed the teenagers’ antenatal care needs inferred from the triangulation process, which was broadly guided by the key research questions. Informed by theoretical frameworks, the discussions included structural constraints in teenagers’ lives, teenage pregnancy as a period of transformative change, ‘colonisation of the pregnancy’ and teenage motherhood as a social injustice issue. The teenagers’ inferred antenatal care needs were discussed throughout the chapter.
Lastly, a discussion was included on the critique of theoretical frameworks and the study’s limitations. Importantly, the use of theoretical frameworks has added depth in the understanding of pregnant teenagers and their antenatal care needs. This study has contributed new knowledge and has extended the current literature in this field.

Chapter 10 concludes this study and presents the study’s strengths, including major policy, practice and education recommendations. Recommendations for future research are also included.
Chapter 10: Conclusions and Recommendations

10.1 Introduction

This concluding chapter presents an overview of the study and a summary of its key findings. The study’s strengths in relation to the research methodology and methods are highlighted. Specifically, it is highlighted that the novel application of the structuration theory has extended existing literature in the care of pregnant teenagers.

Guided by the SEDH framework, recommendations are made to address the micro individual-level that focuses on the teenagers’ antenatal care needs; the exo-level that targets improvements in midwifery practice; and the macro-level ‘upstream’ policies. Recommendations are also included for modifications to the two theoretical frameworks applied in this study. Finally, several future research directions are recommended.

10.2 Overview of Study

This study was undertaken to meet a research gap highlighted in the integrative literature review presented in Chapter 2. Specifically, no published qualitative research has focused on teenagers’ antenatal care needs in Tasmania, Australia. Given the need for a more in-depth qualitative research methodology to understand the individual needs of pregnant teenagers (Al-Sahab et al., 2012), this study applied focused ethnography to understand pregnant teenagers’ antenatal care needs at one public hospital in a region in Tasmania.

The research’s aim was to study the socio-ecological contexts in pregnant teenagers’ lives (aged 15–19 years) and the influence of these contexts on antenatal care needs in a region in Tasmania. A two-phased interpretive qualitative exploratory research was conducted using focused ethnography and framed by the SEDH framework. The two parts of phase I were conducted sequentially (ante and post birth) with the teenagers. Phase II commenced following phase I and was conducted with midwives and nurses. Convenience sampling was undertaken with all research participants. All teenagers aged 15–19 years were recruited from a YMC. Semi-structured interviews were conducted with pregnant teenagers at the YMC, and teenage mothers were interviewed in community settings. Midwives and nurses were recruited from the local hospital and the
community-based 
c u @ home program, respectively. In phase II, semi-structured interviews were conducted with midwives, and the nurses were interviewed via a focus group and two semi-structured interviews. The research participants included 21 pregnant teenagers, 11 teenage mothers, nine midwives and six nurses.

Thematic analysis and coding were conducted on all interview data. Triangulation of findings from the four participant groups was undertaken. The teenagers’ antenatal care needs were inferred from the triangulated data. This process was greatly facilitated by the application of the SEDH framework and structuration theory. The novel application of the structuration theory (Giddens, 1984) to understanding pregnant teenagers and their antenatal care is new to existing literature on early childbearing. Given this novelty, this study has extended the literature in antenatal care of pregnant teenagers.

10.3 Summary of Findings

The majority of pregnant teenagers interviewed experienced structural constraints in their socio-ecological environments during childhood. These teenagers’ lives were marked by parental separation, low education attainment, welfare dependency, and depression and anxiety. For many teenagers, these structural constraints may have contributed to early childbearing. These structural constraints in the teenagers’ lives are the socio-ecological determinants of early childbearing. The social inequalities experienced by teenagers are reflective of Tasmania’s regional location with the attendant disadvantages in its economics, education and high unemployment rate. Thus, this study concurs with the literature reviewed (for example, McCall et al., 2014; Al-Sahab et al., 2012; Upadhya & Ellen, 2011) that the teenagers’ socio-ecological environments contributed to their heightened vulnerability and influenced their antenatal care needs. The majority of teenagers were accepting of early childbearing. Many of these teenagers had not considered a career for the future and welcomed early childbearing as an alternative pathway for them. Childbearing may also be the way of life that is, a cultural norm among their friends and families.

During pregnancy, with established social routines in life, these teenagers developed stability, trust and ontological security. The new self-identify of motherhood motivated many teenagers to improve their health behaviours. A few teenagers reported transformative changes to their lives, including improved mental health and a sense of
power and direction in life. This ‘turning point’ highlighted opportunities for a new life for many teenagers. In this sense, motherhood may be existentially fulfilling for the teenagers, who expressed social agency, autonomy and control.

As inferred from the triangulated data, the teenagers’ antenatal care needs were: access to alternative forms of childbirth education; healthy behaviours in relation to their diet, and cigarette smoking; understanding the realities of breastfeeding; and stress management skills. Social support was also an important need, in particular, short-term and long-term support for meaningful transformational change during pregnancy and beyond. In addition, many teenagers’ were vulnerable to financial, housing, and transport issues. The social stigma of early childbearing was also a concern for some teenagers. As revealed in this study, health professionals’ stigmatising behaviours in the teenagers’ care can threaten the teenagers’ self-identity as a new mother, their ontological security and motivation for transformational change.

Also, midwifery practice needs that addressed the care needs of teenagers were also inferred from the triangulated data. For the teenagers, pregnancy was a time of increased ontological security and readiness for transformational change. An important implication for midwives and nurses is to view pregnancy as an important window of opportunity to help and guide childbearing teenagers to meet their needs. Further, the antenatal care of teenagers could be improved by increasing health professionals’ awareness that stigmatising behaviours directed at teenagers do exist at the local hospital. In the interviews, many midwives believed that the teenagers’ antenatal care needs were closely associated to being a teenager. This view may highlight that pregnant teenagers are immature and irresponsible. While this view can facilitate appropriate care for the teenagers, for example, increased social support, it can also generate a narrow conception of early childbearing that emphasises the negativity associated with teenagers. Another midwifery practice need is in relation to the lack of use of social media by the midwives and nurses. This is a concern because many childbearing teenagers interviewed preferred the use of social media to access information on childbirth education.

This study also highlighted that, for many teenagers, motherhood was a life trajectory borne out of social inequalities. Within this context, teenage motherhood was not a free choice. Thus, for many teenagers, early childbearing was a social injustice. Further,
childhood social inequalities may contribute to further social inequalities for teenage mothers, which have negative consequences for them and their children. With the second-highest teenage fertility rate in Australia, early childbearing in Tasmania reflects that social injustice exists and that it affects youth.

10.4 Strengths of the Study

This is the first study in Tasmania and Australia to apply an in-depth, theoretically driven qualitative methodology to explore the antenatal care needs of pregnant teenagers (aged 15–19 years). Thus, this study has provided important insights into teenagers’ needs and midwifery practice in a region in Tasmania. Fundamentally, this study has highlighted the social inequalities in teenage pregnancy and raised awareness of early childbearing as a social injustice. The research gap in understanding early childbearing in the State was addressed and will contribute to improving maternity care for teenagers.

The focused ethnography facilitated the collection of rich data that contributed to understanding the pregnant teenagers’ experiences prior to pregnancy, during pregnancy and post birth. The hermeneutic process is fundamental to the ethnography approach. It is an iterative circular process of part–whole dialectic that guides the discursive explication of actions and meanings of human behaviours. As noted in this study, through the circular hermeneutic process, findings from each part of this study contributed to understanding the totality of the teenagers’ experiences and antenatal care needs.

In addition, a strength of this study is its use of a second interview with the teenagers. The second interview provided additional depth and rich information on the teenagers’ experiences during labour and post birth. These post birth findings contributed to confirming the antenatal care needs retrospectively. In addition, the teenagers’ interviews at post birth reflected the care they had received from the midwives at the hospital.

Above all, the triangulation of the data from multiple sources provided a richer and more in-depth understanding of the pregnant teenagers and their needs. Therefore, the data triangulation significantly contributed to this study’s credibility. Importantly, the
triangulated convergent and divergent data confirmed that the themes from the teenagers’ interviews were a fair and accurate representation of the interview data. The identification of felt and normative needs (Carver, Ward & Talbot, 2008) was useful in identifying the teenagers’ antenatal care needs.

Lastly, another major strength of this study is the application of theoretical frameworks to provide plausible explanations for the deeper and richer information regarding the pregnant teenagers and their care needs. The SEDH framework was useful in understanding the teenagers’ influential socio-ecological factors within which they were embedded. For many teenagers, these factors were also their determinants of early childbearing. Importantly, these factors are modifiable by, for example, implementing ‘upstream’ strategies such as policy changes. In addition, the SEDH framework can be applied to reduce social inequalities and improve lives. The application of structuration theory also contributed to the study’s strengths. The application of ontological security in this study was unique. No evidence was found in the integrative review or any of the references used in this study of the application of structuration theory and the concept of ontological security to understand early childbearing. Therefore, far from ‘forcing the data’ and creating researcher bias, the use of theories was fundamental in this study.

10.5 Recommendations

Using the SEDH framework, recommendations are made at the micro-level (teenager), exo-level (midwifery practice), and the macro-level ‘upstream’ policies. The upstream policy recommendations are necessary to highlight the contribution of macro-level determinants of early childbearing. Finally, suggested modifications to the theoretical frameworks applied in this study are also presented.

10.5.1 Micro-level recommendations: Addressing teenagers’ antenatal care needs

This section presents the recommendations to address the inferred key antenatal care needs for the teenagers, as identified in this study. These needs were: access to alternative forms of childbirth education; healthy behaviours in relation to their diet, and cigarette smoking; understanding the realities of breastfeeding; and stress management skills. Social support was also an important need, in particular, short-term and long-term support for meaningful transformational change during pregnancy and beyond. In
addition, many teenagers’ were vulnerable to financial, housing, and transport issues. The social stigma of early childbearing was also a concern for some teenagers. In addressing these needs, the recommendations emphasise the need to maximise on the teenagers’ sense of increased ontological security and motivation for meaningful, transformational change in life.

*Improving access to quality childbirth education*

The YMC is the only teenage-specific antenatal clinic that provides comprehensive antenatal care services for pregnant teenagers in this region in Tasmania. However, while all teenagers interviewed attended the antenatal care clinic, some teenagers did not attend the childbirth education program. Many had access to alternative forms of health information, namely social media via the internet, and their mothers and friends. However, these informal and popular sources of information are not always evidence-based, and they may not adequately prepare teenagers for childbirth and parenting. Thus, a recommendation is that the current childbirth education program be offered through a mixture of online and face-to-face approaches to cater to the teenagers’ different learning styles, and that it be presented in easy-to-understand language. This program could be established and moderated by YMC midwives. As many teenagers frequently accessed the internet via their mobile phones, the programs may include online ‘support groups’ specific to the teenagers’ age group. The online delivery could be advantageous for pregnant teenagers who lived in rural locations. Online programs could include online discussions that are moderated by the YMC to ensure that information posted online is appropriate and evidence-based. In view of the voluminous amount of childbirth education information received by teenagers, midwives and nurses could provide more help to teenagers to access and understand information. This will facilitate teenagers in making sound decisions on their care.

Pitching information at an appropriate literacy level (reading and writing skills) is important for the teenagers, many of whom had achieved Year 10 schooling. Also, participation of teenagers is a fundamental principle underpinning all programs developed for pregnant teenager. This suggests that teenagers will be included in the design and implementation of the online program. Some could also participate in running face-to-face components of the program with the YMC midwives’ support.
Further, this online mode may be promoted as an appropriate alternative to the current face-to-face YMC childbirth education program.

Projecting into the near future, this online childbirth education program could be developed as part of ‘integrated pregnancy health information website’ containing information from and for health professionals working with teenagers, including midwives, GPs and nurses.

**Changing diet and eating habits**

This study highlighted that many teenagers may need knowledge and support to adopt good eating habits during pregnancy. Thus, the mixed-mode childbirth education program mentioned above should include a series of online short classes designed for teenagers on good diet during pregnancy, simple cooking techniques, practical guide to avoid Listeria infection and maintaining a good diet on a tight budget. YouTube is a popular social media tool for all ages and could be easily accessed by teenagers to share recipes and ideas. Likewise, health professionals could present simple, short videos of practical recommendations via YouTube. Some face-to-face sessions should be included to give teenagers opportunities to validate the information they obtain from other sources.

**Smoking cessation/reduction**

In Tasmania, all health professionals are encouraged to support a State-wide cigarette smoking cessation for patients and clients (Tobacco Coalition, 2010). Interviews with the nurses suggested that cigarette smoking may be more prevalent among teenagers than reported by the teenagers and midwives interviewed. Thus, YMC midwives should review the current implementation of the Tasmanian smoking cessation guidelines with a view to developing teenage-specific smoking cessation/reduction guidelines. The guidelines should include the identification of life stresses and mental health issues for teenagers who find it difficult to cease cigarette smoking.

As noted in this study, pregnancy is an opportune time to initiate reduction or cessation of cigarettes smoking. There is limited research on effectiveness of nicotine replacement therapy (NRT) for pregnant women (Trivedi, 2013). However, psychosocial strategies such as counselling, providing incentives, feedback, strategies
and social support in late pregnancy may be effective to support women in smoking cessation, and reduce low birthweight and preterm birth (Chamberlain C, 2013). These strategies may also be effective for pregnant teenagers. As recommended, the program needs to aim for smoking reduction in pregnant teenagers if smoking cessation is not possible (Chan & Sullivan, 2008, p. 396).

In addition, a strategy that midwives and nurses could implement is the use of a form to document smoking cessation progress. This form could be given to teenagers in a handbook for them to document smoking behaviours and barriers to smoking reduction or cessation. Using this documentation may facilitate continuity of care between midwives and nurses in relation to the teenagers’ smoking status, intentions and actions to reduce or cease smoking, and related barriers. In the future, with funding support, this form could be provided as an ‘app’ (program) for mobile phones. This form is shared with midwives and nurses and discussed with the teenagers at each visit, for example, at the antenatal clinic appointments and home visits. Also, barriers to smoking need to be identified and support provided to pregnant teenagers, for example, to address their sources of stress and mental health.

**Stress management**

As noted in this study, pregnant teenagers experienced many social stress factors related to their pregnancy, for example, many experienced strained partner relationships; financial, transport and housing difficulties; and social stigma. As many teenagers also experienced poor mental health prior to and during pregnancy, it is recommended that stress management for pregnant teenagers be provided by specially trained counsellors, mental health nurses, and psychologists. This care could be followed up by the midwives and nurses. For example, at each YMC visit, the midwife takes time to discuss the teenagers’ mental health and assess need for further support from mental health trained specialists or for other support such as transport, housing, and financial support. This form could also be used post birth, to continue efforts for reduction or cessation in cigarettes smoking.

In addition, a general stress management could be implemented by midwives and nurses for pregnant teenagers in the YMC childbirth education program. This program could include generic coping strategies and coping resources for example, increasing social

Further, the sharing of information on stress and mental health should be encouraged in online ‘support groups’. Face-to-face support groups should be provided at the YMC and facilitated by an appropriately trained nurse or midwife. This program should be implemented for six months and then evaluated and improved prior to rolling it out to the local hospital, other regions and the rest of the State. For teenagers with mental health issues, the stress management program may already be included in the care from their GPs. However, this care is often not shared with the midwives and nurses who care for the same teenagers. Thus, this stress management program should include regular meetings for all health professionals with the teenagers using a case management approach so that some of the strategies can be collaboratively reinforced.

**Deeper understanding of breastfeeding**

Breastfeeding education is an important antenatal care need. This study highlighted that the majority of teenagers were unsuccessful in breastfeeding, and many switched to artificially feeding their babies in the first two weeks following birth. One of the reasons for this could be that the teenagers had no understanding of the realities and challenges in learning to breastfeed. Also, they may have been overly eager to embrace breastfeeding because of the popularised view that breastfeeding is best for the baby. Thus, breastfeeding guidelines for all midwives should be revised to include guidance on the responsible promotion of breastfeeding to teenagers and information on the rewards and challenges of breastfeeding.

Further, breastfeeding information should be developed for inclusion in the online childbirth education program mentioned above. The use of YouTube for visual presentations of breastfeeding information could be included. Teenagers could be given the option to attend face-to-face sessions to learn basic breastfeeding skills using anatomical babies and breasts. Support for teenagers to breastfeed needs to be commenced during pregnancy and continued in the postnatal and postbirth periods. The midwife, nurse or lactation consultant could take on this support role. As noted in interviews with teenage mothers, support in the immediate postnatal care is essential.
and this recommendation needs to be prioritised in the feedback to midwives and nurses. Importantly, as family and peers are influential on the teenagers, their key social support members could be included in these programs.

Breastfeeding teenage ‘role’ models could be introduced as part of the support program for teenagers in order to improve the overall breastfeeding rate. Breastfeeding support is critical during the first few weeks following birth (H. Hall, McLelland, Gilmour, & Cant, 2014, p. 263). This support should be coordinated between health professionals to ensure that information is shared at each period of transition of care, such as following discharge from the hospital to community care. Follow-up would include home visits by midwives and nurses, and regular online communication with the teenagers. This program should be implemented for six months and then evaluated and improved prior to rolling it out to the local hospital in this region in Tasmania.

**Social support**

The teenagers’ own mothers and/or parents were important social support for the teenagers, as identified in the interviews with the teenagers, midwives and nurses. This suggests that pregnant teenagers who do not have good social support networks may need to be referred to community-based organisations. For example, as mentioned in Chapter 6, in Tasmania, the UnitingCare’s Pregnant and Young Parent Support (PYPS) provides care for childbearing young women up to age 25 years.

As revealed in this study, partners can provide good social support to pregnant teenagers. However, many of the midwives interviewed do not consider partners as reliable support for the teenagers. To increase the partners’ role as support persons for the teenagers, the midwives could offer partners a separate partner’s childbirth education program. This program needs to be developed collaboratively with partners, midwives, nurses and other health professionals. The focus of this program would be on the partners’ current and future needs and be implemented by YMC midwives at the local hospital in collaboration with nurses in the community. Some of the topics in the program could include the roles and expectations of fathers, mental and physical health, smoking cessation (if appropriate), and stress management. Further, relevant topics that are developed for the online and face-to-face childbirth education program for teenagers should also be offered to partners. Some joint face-to-face sessions could be designed to
allow attendance by both teenagers and their partners. The partners’ program would include referrals by midwives and nurses to health and social resources in the community to address partners’ social and future career development needs.

10.5.2 Exo-level recommendations to enhance midwifery best practice

This section presents recommendations for the enhancement of midwifery best practice. This addresses the study’s research aim to contribute to midwifery best practice care of teenagers (aged 15–19 years). The recommendations in this section include addressing the teenagers’ antenatal care needs identified in this study.

Critical to improving the midwifery profession, the application of teen-centred care underpinned by woman-centred care for teenagers should be promoted. Woman-centred care refers to midwifery practice that places the health needs, expectations and aspirations of women at the centre of midwifery care. Currently, woman-centred care is provided in the caseload midwifery practice model. In 2014, in the region where this study was conducted, caseload midwifery practice model was introduced for older teenagers. However, this model is not widespread and does not include younger teenagers (aged 15–17 years). Practicing woman-centred care is in line with the ACM’s current directives and the national competency standards for the midwife (Nursing and Midwifery Board of Australia, 2006, p. 3). To progress this recommendation for teen-centred care, a literature review is recommended to identify caseload for midwives working with teenagers who are younger than 18 years of age. This recommendation should focus on improving midwifery care for teenagers over the longer term, recognising that changing practice may take time. The literature review could be followed by a pilot intervention on teen-centred caseload midwifery practice model.

Sharing this study’s findings is important to disseminate the use of a teen-centred care approach in midwifery care. This study’s findings could be disseminated to midwives in the region and State, as well as nationally and internationally, via presentations, workshops and publications (news and social media). The target audiences are midwives at the local hospital and other hospitals in the State, at other states and national Australian College of Midwives (ACM) conferences, and at International Confederation of Midwives (ICM) conferences. Further, meetings could be conducted with midwives in Tasmania to discuss the findings in greater depth, explore practice
barriers and discuss the strategies that midwives can use to improve their practice in the care of teenagers.

**Practice enhancement through education**

Another approach to enhance midwifery practice in the care of pregnant teenagers is through the education of midwives in Tasmania. According to the midwifery accreditation standards, all midwifery education courses are mandated to adopt woman-centred care as the education curriculum’s conceptual framework (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2014, p. 14). Thus, it is important to disseminate this study’s findings to relevant educational institutions and programs regarding teenagers’ antenatal care needs and, in particular, the midwifery practice issue of limited understanding and operationalisation of woman-centred care for teenagers in this region. To achieve this, meetings and workshops should be conducted with the State and national ACM Board of Directors and their educational standards committees. Meetings should also be conducted with lecturers and clinical teachers who are responsible for the Graduate Diploma of Midwifery course at the University of Tasmania. In addition, meetings should be conducted with midwifery clinical teachers in the hospital’s continuing professional education program with the aim of raising awareness of teenagers’ antenatal care needs, woman-centred care and other midwifery practice issues.

**10.5.3 Macro ‘upstream’ policy level changes**

The targets for policy level changes are the heads and staff of public health at the Tasmanian Department of Health and Human Services (DHHS). Pragmatically, within the scope of work for this researcher (a midwife at the local hospital), dissemination of this study’s findings and recommendations to DHHS policy level staff and managers could be provided through a succinct report such as a policy briefing paper. Currently, the Tasmanian DHHS adopts the ‘Health in All Policies Collaboration’, which focuses on addressing the social/SEDH for social and health equality (Department of Health and Human Services, 2013c, p. 27). The dissemination should focus on the implications of the findings for health policy and program development. Addressing the social determinants of health will have flow-on effects on the social determinants of early childbearing.
In support of ‘action on the social determinants’, which emphasises collaboration across all government, public and private stakeholders, and local communities (World Health Organization, 2013), dissemination meetings to address the social inequalities that contribute to teenage pregnancies. In the region in Tasmania, these groups are faith-based organisations, namely Anglicare, UnitingCare and City Mission; local governments associations; Tasmanian Council of Social Service (TasCOSS); Family Planning Tasmania; the State government’s ‘Link Youth Health Service’ and PULSE Youth Health Centre; and Primary Health Tasmania, which is a non-government organisation.

Specific to addressing social inequalities in school and the problem of bullying at schools, a policy brief could be prepared for schools and the Tasmanian Department of Education’s policy-level staff. Further, a recommendation should be made for current policy support for the teenagers’ continuing engagement with the education system. This will address the needs of some of the pregnant teenagers who were motivated to complete their schooling. A recommendation is that each local government geographic area with a high teenage pregnancy rate establishes the ‘return to school’ program for teenagers. An example of this program is the Tasmanian government’s current Claremont College Young Mums program (Claremont College, 2012). As implemented at the Claremont College, this program could be provided over two years to first-time teenage mothers aged 15–19 years with babies younger than two years old. The learning of life skills such as parenting and childcare constitute a large portion of the program’s curriculum. It is recommended that this program be expanded to provide more academic subjects, as highlighted by some teenagers during the researcher’s visit to the program in 2012.

10.5.4 Suggested modifications to the SEDH framework

To increase the utility of the SEDH framework, a fundamental recommendation is to include a stronger emphasis on the culture or way of life of individuals and groups by making culture ‘visible’ as a layer encompassing all other layers/levels of the SEDH diagram (see Figure 10-1). This approach will highlight the fundamental role of culture not only as a determinant at the micro level of the SEDH (Kothari et al., 2007; Taylor-Seehafer & Rew, 2000), but also as a determinant at other levels. As noted, the macro level or upstream determinants include the prevailing norms and values in relation to
culture and society (Whitehead et al., 2001, p. 313). Thus, the recommendation to include culture as encompassing all SEDH levels will strengthen the focus on culture as a determinant of teenage pregnancy, the family’s cultural influence, the cultural underpinnings of social stigma and the sources of stigmatising behaviours at the macro level as the site for the production and reproduction of cultural norms and values in society. This notion of culture as ‘encompassing’ aligns with Geertz (1973, p. 5) notion of culture as the ‘webs of significance’ that individuals have spun and within which they are suspended. In a sense, culture is not a ‘level’ because it does not refer to systems such as the micro, meso, exo and macro levels. However, the inclusion of culture as the ‘webs of significance’ within which other levels are suspended may be an appropriate conception of culture as being central to understanding social actions and meanings. The extension of the SEDH to include culture needs to include details on how culture can be made visible and separate from social actions.

Another recommendation is that the SEDH be reframed as the socio-ecological ‘determinants of teenage pregnancy’ (McCall et al., 2014, p. 49). This approach will draw attention to ‘pregnancy’ instead of ‘health’ as the focus of analysis.

Lastly, when applying the SEDH framework in a study such as this one, more time should be allowed in the data collection process to explore each of the SEDH levels in greater depth.

Figure 10-1: Modified SEDH framework with culture as an embedded factor
10.5.5 Suggested modifications to structuration theory

As an explanatory theory, structuration theory has provided important insights into understanding pregnant teenagers and their antenatal care needs. To increase its utility, the theory should provide greater clarity in relation to the nuanced differences between culture and society. For example, what are the markers of culture in the signification/communication systems, and how can culture be explicated from social agents’ knowledgeability of largely practical (tacit) knowledge? One approach to improving the application of structuration theory would be to use structuration theory with another theory that provides a stronger focus on culture. For example, Bourdieu’s *habitus* theory, which is the social agents’ disposition that underpins social actions (Bourdieu, 2010), may have greater explanatory powers in understanding teenagers’ culture. The *habitus* refers to the deep-rooted disposition to respond in a particular way that is habitual and developed throughout childhood. Consumption patterns (material goods, food, music, clothes) are influenced by individuals’ culture, social position and identity and are underpinned by the *habitus* (Habibis & Walter, 2009, p. 227). Analysis of teenagers’ ‘consumption’ of health information, health services and health care behaviours may contribute to understanding their antenatal care needs.

10.6 Future Research

The following recommendations are made:

- Research should be undertaken to identify effective approaches to childbirth education for teenagers. Using mixed methods of quantitative and qualitative interpretive methodologies, this research should be conducted with pregnant teenagers aged 15–19 years at the YMC and other midwifery care models at the local hospital. Research questions should relate to identifying the meaning of childbirth education, the notion of ‘partnership’ with teenagers in childbirth education and teenagers’ learning styles.
- A literature review should be conducted to identify the safety of the midwifery-group practice (MGP) model as teen/woman-centred care for younger teenagers (aged below 18 years). A pilot intervention program could be developed and tested as a follow up to the literature review.
• Research should be conducted to study why the breastfeeding rate is low for teenagers. The research should aim to develop a specific program to address the barriers to successful breastfeeding by teenagers. A mix of quantitative and qualitative interpretive methodologies would be appropriate. The research participants would be teenage mothers aged 15–19 years who birthed at the hospital, midwives at the hospital and nurses in the community. Structured and semi-structured interviews, including participant observation, are recommended. The clinical sites for this research should be public hospitals and teenagers’ homes.

• Lastly, research should be conducted with partners and other key support members to examine the role of social support and how to enhance existing social support networks to effectively support teenagers. A qualitative methodology such as ethnography would be appropriate. The research should target teenagers’ partners and other support members who register for antenatal care at the YMC. Other participants should include midwives, nurses and social workers, who would provide rich and in-depth data for the study.

10.7 Summary

The concluding chapter to this study presented an overview of the study, a summary of the findings and a discussion of the study’s strengths. Recommendations were also presented, and these were targeted at micro or individual level, at midwifery practice and education, and at the macro or ‘upstream’ policy levels. Further, recommendations for modifications to the SEDH framework and structuration theory were included. Finally, several future research recommendations were highlighted to improve the care of pregnant teenagers in Tasmania, Australia.

This study has highlighted that the teenagers’ age and social inequalities in their socio-ecological environments were major influencing factors on their antenatal care needs. A major contribution of this study to existing literature is the finding that motherhood contributed to establishing social routines, stability, trust and ontological security for the pregnant teenagers. Thus, while early childbearing should be avoided as a life choice, it need not be a negative experience for affected Tasmanian teenagers.


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## Appendixes

### Appendix 2-1: List of abbreviations and medical terms

<table>
<thead>
<tr>
<th>Terms</th>
<th>Definitions</th>
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</thead>
<tbody>
<tr>
<td>Very low birth weight</td>
<td>live infant weight&lt;1500 g at birth (Chen et al., 2007)</td>
</tr>
<tr>
<td>LBW</td>
<td>low birth weight&lt;2,500g at birth (Chen et al., 2007; Katz et al., 2013)</td>
</tr>
<tr>
<td>SGA</td>
<td>Small for Gestational Age babies (&lt;10th percentile for gestational age and sex) (Chen et al., 2007; Katz et al., 2013)</td>
</tr>
<tr>
<td>very pre-term or early delivery</td>
<td>live infant delivered at less than 32 weeks’ gestation (Chen et al., 2007; Katz et al., 2013)</td>
</tr>
<tr>
<td>Prematurity / pre-term delivery</td>
<td>infant born at &lt;37 weeks’ gestation (Chen et al., 2007; Katz et al., 2013)</td>
</tr>
<tr>
<td>Premature rupture of membranes</td>
<td>The rupture of the membranes that surround the foetus and this may occur for more than 12 hours prior to start of labour (Lopoo, 2011)</td>
</tr>
<tr>
<td>Meconium</td>
<td>Meconium is the shedding from the foetus’ gastrointestinal track into the amniotic fluid that surrounds the foetus (Lopoo, 2011)</td>
</tr>
<tr>
<td>Cephalo-pelvic disproportion</td>
<td>The foetal head is disproportionate in relation to the maternal pelvis and prevents cervical dilation and foetal head descent (Lopoo, 2011)</td>
</tr>
<tr>
<td>Cord prolapse</td>
<td>The umbilical cord is outside of the birth canal before birth of the foetus (Lopoo, 2011).</td>
</tr>
<tr>
<td>Placenta previa</td>
<td>Abnormal implantation of the placenta within the uterus that is close to or across the opening of the cervix (Lopoo, 2011)</td>
</tr>
<tr>
<td>Post neonatal mortality</td>
<td>Death of babies aged 28 to 264 days (Chen et al., 2008)</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td>Death of babies aged 0 to 28 days (Chen et al., 2008)</td>
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</table>
Appendix 4-1: Human Research Ethics Committee (HREC) Approval:
Ref No. H12342

In the HREC letter of approval below, the names of persons are deliberately omitted so as to maintain anonymity of location of the Young Mums Clinic (YMC) and the local hospital where this study was conducted.

6 June 2012

Dr Linda Jones
Discipline of Nursing and Midwifery
RMIT Bundoora Campus
Bundoora VIC 3083

Student Researcher: Dr Jenny Kerrison

Sent via email

Dear Dr Jones,

REF NO: H12342
TITLE: Understanding pregnant teenagers' antenatal care needs in Tasmania: A socio-ecological determinants of health perspective

- Application Form- NEAF revised version dated 8 April 2012
- Protocol
- Participant Information Sheet and Consent Form for Teenagers, Version 5 dated 17 May 2012
- Participant Information Sheet and Consent Form for Parents/Guardians Version 5 dated 17 April 2012 (revised 17 May 2012)
- Letter of Support, Tasmania Area Health Service, Women’s Health Clinics
- Letter of Support, Tasmania Area Health Service
- Semi structured interview guide
- Letter of Support, Tasmania Area Health Service
- Participant Information Sheet and Consent Form Midwives & Family and Child Health Nurses

The Tasmania Health and Medical Human Research Ethics Committee considered and approved the above documentation on 21 May 2012.

This approval constitutes ethical clearance by the Health and Medical HREC. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities are required. It is recommended that the proposed research should not commence until you have satisfied these requirements.
All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the National Statement on the Ethical Conduct in Human Research (NIMREC 2007 updated 2009).

Therefore, the Chief Investigator's responsibility is to ensure that:

(1) The individual researcher's protocol complies with the HREC approved protocol.

(2) Modifications to the protocol do not proceed until approval is obtained in writing from the HREC.

(3) Section 5.5.3 of the National Statement states:

Researchers have a significant responsibility in monitoring approved research as they are in the best position to observe any adverse events or unexpected outcomes. They should report such events or outcomes promptly to the relevant institution's and ethical review bodies and take prompt steps to deal with any unexpected risks.

The appropriate forms for reporting such events in relation to clinical and non-clinical trials and innovations can be located at the website below. All adverse events must be reported regardless of whether or not the event, in your opinion, is a direct effect of the therapeutic goods being tested. [http://www.research.unimelb.edu.au/human_ethics/medical_forms.htm](http://www.research.unimelb.edu.au/human_ethics/medical_forms.htm)

(4) All research participants must be provided with the current Patient Information Sheet and Consent Form unless otherwise approved by the Committee.

(5) The Committee is notified if any investigators are added to, or cease involvement with, the project.

(6) This study has approval for 4 years contingent upon annual review. A Progress Report is to be provided on the anniversary date of your approval. Your first report is due 21 May 2013. You will be sent a courtesy reminder closer to this due date.

(7) A Final Report and a copy of the published material, either in full or abstract, must be provided at the end of the project.

Should you have any queries please do not hesitate to contact me on (03) 6226 1956.

Yours sincerely,

Adele Kay
Ethics Officer
Health and Medical Human Research Ethics Committee
Human Research Ethics Committee (Tas) Network
Appendix 4-2: Written Information on Study

(A) Research participant information for pregnant teenager/parent/guardian (version 3, 6 April 2012)

Invitation to Participate in a Research Project

Research Title:
Understanding pregnant teenagers' antenatal care needs in southern Tasmania: A socio-ecological determinants of health perspective.

Investigators:
- PhD candidate: Dr. Jenny Kerrison; D.Ed, Registered Midwife
- Primary Supervisor: Dr. Linda Jones, PhD, Midwifery Program Director; RMIT University Discipline of Nursing and Midwifery

Invitation to participate:

Dear Participant,

You/your daughter/ward are invited to participate in this research project, which is being conducted in order to understand the experiences and needs of pregnant teenagers (aged 15–19 years). Interviews will be held at the Hospital and at the Child Health and Parenting Service (CHAPS). Please take time to carefully read the following information. If you have any questions about the project, please ask Jenny Kerrison (contact details above).

Why is the research being conducted?

Pregnant teenagers need care that is different to pregnant adults. This research can help us understand and improve the support we provide pregnant teenagers, as they prepare for the baby’s birth.
Why have you been approached?

You/your daughter are invited to participate because you are of the right age and are having your first baby.

What does participation mean?

Participation is voluntary. Two interviews will be conducted; each lasting 30–45 minutes. The first interview is conducted at the Hospital when you are between 34 and 38 weeks pregnant. The second interview is conducted when your baby is 4 and 8 weeks old, at a Family and Child Health Clinic. All interviews will be audio-taped and transcribed. Following each interview, Jenny will share the interview transcripts with you/my daughter/ward and allow time to cross-check information on the transcripts. Please allow 15 minutes or less to cross-check each interview.

Also, I will collect your/her personal information (for example: age; education; income; health history; health behavior risks; and social history) from your/her medical records and other records held at the Hospital.

If you are under 18 years of age and you wish to participate in the research project: I will need you and your parents/guardian to sign a Consent Form. Consent from your parents/guardian is not required, if you do not wish to have them/him/her provide consent; if you are living independently of your parents/guardian; and you fully understand the research.

What is the project about? What are the questions being addressed?

This research is conducted to develop a better understanding of the needs of pregnant teenagers (15–19 years old). At the interviews, I will ask questions and seek information from you such as:

- What does it mean to be healthy?
- What help have you received/will receive to prepare for the baby’s birth?
- Who are you close to? Tell me about your relationship with people that are close to you.
- Tell me about the area where you live and transport to friends and doctors/nurses’ appointments.
- What are the things that worry you the most?
What are the possible risks or disadvantages?

There are no risks or disadvantages to you/your daughter/ward participating in this research.

During the interview, I will ask you/your daughter/ward to share some personal information including your life experiences and health behaviours during pregnancy. If you become worried by a question, you can tell me to stop and move on to the next question. You can also tell me to stop the interview or withdraw from this research. If you feel upset because of the interview, you may wish to have a chat with a Social Worker or relevant staff at the organisation where the interview is being conducted. Please let me know and I will contact the person for you/your daughter/ward.

What are the benefits associated with participation?

Your/your daughter/ward information is important for the health of future pregnant teenagers and their babies. The research will not directly benefit you.

What will happen to the information you provide?

All information provided will be kept confidential. Only my two supervisors (Dr. Linda Jones and Professor Eleanor Holroyd) and I will have access to your/your daughter/ward de-identified information. The research data will be kept securely at RMIT University for a period of 5 years after publication, before being destroyed.

Any information that you/your daughter/ward provides can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) she provides the researchers with written permission.

Results from the research will be published in reports; academic journals and presented at meetings and conferences. You/your daughter/ward cannot be identified from the results published.

What are your rights as a participant?

- The right to withdraw from participation at any time.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not cause any risk for the participant.
- The right to have any questions answered at any time.
Whom should I contact if I have any questions?

For further questions, you may ring:

- Researcher - Dr. Jenny Kerrison, Registered Midwife (phone number provided at interview)
- Research Supervisor - Dr. Linda Jones, Supervisor, RMIT University. (phone number provided at interview)

This study has been approved by the Tasmanian Health and Medical Human Research Ethics Committee and the RMIT University Human Research Ethics Committee. It is supported by the Hospital and Child Health and Parenting Service. If, later, you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H0012341.

Thank you.

If you are happy to take part in this research, please sign the attached consent form. If you are under 18 years of age, you may need consent from your parents/guardian before you can take part in this research project.

You may keep this Information Sheet.

Yours sincerely

PhD Student:
Dr. Jenny Kerrison D.Ed, Registered Midwife

(Signature)

Primary Supervisor:
Dr. Linda Jones PhD, Midwifery Program Director

(Signature)

Secondary Supervisor:
Professor Eleanor Holroyd PhD

(Signature)
Invitation to Participate in a Research Project

Research Title:
Understanding pregnant teenagers’ antenatal care needs in southern Tasmania: A socio-ecological determinants of health perspective.

Investigators:

- PhD student: Dr. Jenny Kerrison; D.Ed, Registered Midwife
- Primary Supervisor: Dr. Linda Jones, PhD, Midwifery Program Director; RMIT University Discipline of Nursing and Midwifery
- Secondary Supervisor: Prof. Eleanor Holroyd, PhD; RMIT University Discipline of Nursing and Midwifery

Invitation to participate:

Dear Participant,

I am Dr. Jenny Kerrison, a PhD student and a Registered Midwife at the Hospital. In fulfillment of the PhD degree, I am conducting a research project at the Hospital (RHH) and Child Health and Parenting Services (CHAPS), to understand the experiences and needs of pregnant teenagers (aged 15–19 years) during their pregnancy. Supervision for this project is provided by two expert researchers from the RMIT University, Melbourne (see names listed above).

You are invited to participate in this research project because you work with childbearing teenagers. Please read this sheet carefully. It is important that you fully understand the information provided on the research before deciding whether to participate. If you have any questions about the project, please ask Dr. Jenny Kerrison (contact details above).

Who is involved in this research project? Why is it being conducted?

Dr. Jenny Kerrison, the PhD student, currently works as a Registered Midwife at the Hospital. She has many years’ experience in the nursing and midwifery professions and taught undergraduate nursing for several years in Tasmania. Dr. Linda Jones and
Professor Eleanor Holroyd are lecturers at the School of Nursing and Midwifery, RMIT University, Melbourne. They will provide research supervision to Jenny. During data collection at the RHH, Jenny will be assisted by Chris Bodger, Clinical Nurse Consultant, Women's Health Clinics, Hospital.

This research project is conducted in Tasmania, as the State has a high teenage pregnancy rate with 27 babies per 1,000 women aged 15–19 years. The national teenage pregnancy rate is 17 babies per 1,000 teenage women. To date, there has been little research conducted on pregnant teenagers and their antenatal care needs in Tasmania. Pregnant teenagers need care that is different to pregnant adults. This research can help us understand and improve the support we provide pregnant teenagers, as they prepare for the baby’s birth.

**Why have you been approached?**

You have been approached to participate in this research as you work with childbearing teenagers at the RHH and at CHAPS. Thus, you will be able to share with me your experiences and views on caring for childbearing teenagers and the needs of pregnant teenagers.

**What is the project about? What are the questions being addressed?**

**Brief description:** This research is conducted to develop a better understanding of the needs of pregnant teenagers. I will talk to pregnant teenagers (15–19 years old) to ask them to share their knowledge, feelings, and behaviours during the pregnancy. Also, I will ask teenagers what help they feel they need most from family, friends, neighbourhood, hospital staff and the State Government. A second interview will be conducted with the same teenagers at 4 to 6 weeks postnatal. Interviews will also be conducted with RHH Midwives and CHAPS Nurses. In addition, the State Government staff will be interviewed to obtain information on State policies and/or programs relevant to pregnant teenagers that may be available over the last five years or are currently being developed.

**Core research questions:**

1) What are the health belief systems (knowledge, beliefs and behaviours in regards health) of pregnant teenagers and the influence on antenatal care?
2) How do the family determinants of health (family factors) influence pregnant teenagers' needs for antenatal care?
3) How do the neighbourhood determinants of health (neighbourhood factors) influence pregnant teenagers’ needs for antenatal care?
4) What are the influences of transport and housing on pregnant teenagers’ needs for antenatal care?
5) What are the influences of social support on childbearing teenagers’ needs for antenatal care?
6) What are midwives and family & child health nurses’ views in relation to pregnant teenagers’ worldviews and care needs?
7) How has the State Government responded to the needs of pregnant teenagers over the last five years?

If you agree to participate, what will you be required to do?

Participation is voluntary. If you agree to participate, you will be interviewed once only at a location at the Hospital/CHAPS. For CHAPS Nurses, a focus group discussion (FGD) may be conducted instead of individual interviews. In a focus group discussion, staff will be interviewed in a group of eight to 10 participants. The individual interviews and FGD will last about 1 hour.

All interviews will be audio-taped and transcribed. Your name will not appear in tape and a code will be used to replace your name on any of the documents produced. The code allows me to identify you, if I need to follow up to cross-check the interviews. The tape will be kept safe in a locked cupboard for 5 years or more and then destroyed.

I will also collect information from you such as: age, workplace; number of years of experience; and professional qualifications. You will also allow me to use quotes from the interviews in my PhD research report.

What are the possible risks or disadvantages?

There are no risks or disadvantages to you by participating in this research.

Your work performance will not be measured. All data from participants will be combined and analysed for themes. Thus, participants cannot be identified from the interview transcripts, research report and related publications. If direct quotes are used in the research reports, your name will not be included. The interview results will not be given to your employer. At completion of the research project, a copy of the final research report (with de-identified information) will be given to your employer.

During the interview, if you feel upset, concerned or uncomfortable, you can tell me to stop the interview and move onto the next question. You can also withdraw from this research at any time during the interview.
What are the benefits associated with participation?

There are no direct benefits to you by participating. However, I will use the research information to develop advice on how to provide better and coordinated care for pregnant teenagers. Your information is important for the health of future pregnant teenagers and their babies.

What will happen to the information you provide?

All information collected from you will be kept confidential. Only my supervisors (Dr. Linda Jones and Professor Eleanor Holroyd) and I will have access to your information. Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.

The research results will be shared with others in a PhD research report, paper for publication, conference and professional development workshops/training. You will not be identifiable from the results published. If quotes and stories are included in the publications, false names (pseudonyms) will be used. The research data will be kept securely at RMIT University for a period of 5 years after publication, before being destroyed.

What are your rights as a participant?

- The right to withdraw from participation at any time.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.

Whom should I contact if I have any questions?

For further questions, you may ring:

- Researcher - Dr. Jenny Kerrison, Registered Midwife (phone number provided at interview)
- Research Supervisor - Dr. Linda Jones, Supervisor, RMIT University. (phone number provided at interview)

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee; the RMIT University Human Research Ethics Committee; Hospital
and Child and Parenting Services. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H0012341.

What other issues should I be aware of before deciding whether to participate?

None.

Yours sincerely

PhD Student:
Dr. Jenny Kerrison D.Ed, Registered Midwife

(Signature)

Primary Supervisor:
Dr. Linda Jones PhD, Midwifery Program Director

(Signature)

Secondary Supervisor:
Professor Eleanor Holroyd PhD

(Signature)
Appendix 4-3: Consent Form

(A) PARTICIPANT / PARENT / GUARDIAN’S CONSENT FORM

Please circle the relevant subject in this consent.

1. I have had the project explained to me, and I have read the information sheet.
2. I agree to my daughter’s participation in the research project as described.
   I agree for my daughter to be interviewed twice (once during pregnancy and once after the birth of the baby). I also agree for the interviews to be audio-taped and for Jenny Kerrison to collect information and use information from my daughter’s medical records (from RHH) and hospital databases. In addition, I agree for Jenny Kerrison to share de-identified information with her supervisors. All relevant de-identified information and quotes from the interviews can also be used in journals and other academic publications.
3. I acknowledge that:
   (a) I understand that you/your daughter’s participation is voluntary and that she is free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
   (b) The project is for the purpose of research. It may not be of direct benefit to my daughter.
   (c) The privacy of the personal information she provides will be safeguarded and only disclosed where I have/she has consented to the disclosure or as required by law.
   (d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to the Hospital, Child Health and Parenting Services and the RMIT University. Any information which will identify me/my daughter will not be used.

Participant / Parent / Guardian’s Consent

Where participant is under 18 years of age:

I consent to the participation of ______________________________ in the above project.

Signature: (1) (2) Date: ____________

(Signatures of parents or guardians)

Witness: ___________________________ Date: ______________

(Witness to signature)

This study has been approved by the Tasmania Health and Medical Human Research Ethics Committee and the RMIT University Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [H0012341].

Participants should be given a photocopy of this PICF after it has been signed.
(B) MIDWIVES / NURSES PARTICIPANT'S CONSENT

1. I have had the project explained to me, and I have read the information sheet
2. I agree to participate in the research project as described
   I agree to be interviewed (individual and/or focus group discussion). I also agree for the
   interviews to be audio-taped and for Dr. Jenny Kerrison to collect personal information from me.
   In addition, I agree for Dr. Jenny Kerrison to share de-identified information with her
   supervisors. All relevant de-identified information and quotes from the interviews can also be
   used in journals and other academic publications.
3. I acknowledge that:
   (c) I understand that my participation is voluntary and that I am free to withdraw from the
       project at any time and to withdraw any unprocessed data previously supplied (unless
       follow-up is needed for safety).
   (d) The project is for the purpose of research. It does not have direct benefit to me.
   (c) The privacy of the personal information I provide will be safeguarded and only disclosed
       where I have consented to the disclosure or as required by law.
   (d) The security of the research data will be protected during and after completion of the
       study. The data collected during the study may be published, and the PhD research report
       will be provided to the Hospital, Child and Parenting Services, and RMIT University.
       Any information which will identify me will not be used.

Participant’s Consent
Participant: ___________________________ Date: ___________________________
(Signature)

This study has been approved by the Tasmanian Social Sciences Human Research Ethics
Committee and the RMIT University Human Research Ethics Committee. If you have
concerns or complaints about the conduct of this study, please contact the Executive
Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email
human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive
complaints from research participants. Ethics reference number H0012341

Participants should be given a photocopy of this PICF after it has been signed.
Appendix 4-4: Interview Guides for Research Participants

PROJECT TITLE:
Understanding pregnant teenagers' antenatal care needs in southern Tasmania: A socio-ecological determinants of health perspective.

OBJECTIVES

The research will achieve the following objectives:

1. To understand the health knowledge, beliefs and behaviours of pregnant teenagers and the influence on antenatal care.
2. To understand the family and community factors and their influence on childbearing teenagers' needs in relation to antenatal care.
3. To understand the physical and social environmental factors and their influence on childbearing teenagers' needs in relation to antenatal care.
4. To understand Midwives' and Family and Child Health Nurses’ views in relation to pregnant teenagers' care needs.

CORE QUESTIONS

1. What are the health belief systems (knowledge, beliefs and behaviours in regards health) of pregnant teenagers and the influence on antenatal care?
2. How do the family determinants of health (family factors) influence pregnant teenagers’ needs for antenatal care?
3. How do the neighbourhood determinants of health (neighbourhood factors) influence pregnant teenagers’ needs for antenatal care?
4. What are the influences of transport and housing on pregnant teenagers’ needs for antenatal care?
5. What are the influences of social support on childbearing teenagers’ needs for antenatal care?
6. What are Midwives' & Family and Child Health Nurses’ views in relation to pregnant teenagers’ worldviews and care needs?
YOUNG MUMS CLINIC: PREGNANT TEENAGERS

The questions below will be used in individual interviews with pregnant teenagers. In subsequent interviews, these questions could be modified based on findings from preceding interviews.

**DEMOGRAPHIC & HEALTH DATA:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Code:</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Age:</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Single/Living with partner</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Education level:             Are you attending school? Yes/ No</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Type of accommodation:         Own; With partner; With Mother; With Father; With Grandparents; Others: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Type of transport:           Own car; Friend's car; Partner's car; Public; Others: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Type of Obstetric Care:       Shared Care (GP and hospital); Antenatal Clinic RHH; Young Mums’ Clinic; CU@Home; None</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Number of antenatal care checks: Location of checks: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Number of childbirth education classes: Location of checks: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Number of visits to GP last year before pregnancy: ………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Employment:                  Yes/ No ; Type of employment: …………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Key source of income:        Own; Partner; Mother; Father; Grandparents; Others: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Are you currently working? Yes /No How many hours per week? ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Main health problems:        ………………………………………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>History of Depression/self-harm: ………………………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Antenatal depression assessment: Yes/ No Scores: ………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Smoking:                    Yes / No; amount per day: …………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Alcohol:                    Yes / No; amount per day: …………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Drugs:                      Yes / No; Name: …………………………………………; amount per day: …………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Current pregnancy:           planned/unplanned</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Contraceptive use prior to current pregnancy–Yes/No Type: …………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Key support person:         ……………………………………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
<tr>
<td>Plans for future:            ……………………………………………………………</td>
<td>………………………………………………………………………………………………</td>
</tr>
</tbody>
</table>
CORE QUESTIONS: ANTENATAL

1. Individual factors - Mental health, physical and health related to pregnancy:
   (i) Tell me about your childhood life?
   (ii) How was life for you before you got pregnant? Were you happy in your childhood and early teen years?
   (iii) What did you experience/feel that made you think you were pregnant? How did you feel about being pregnant then? And now?
   (iv) Tell me about your health before you were pregnant. How is your health now? What have you noticed about some of the things that you used to do and are not doing now because you are pregnant?

2. Proximal factors: social support
   (i) Tell me about your family. Did your parents fight a lot? Did you ever feel scared for your safety? How did they respond to you being pregnant?
   (ii) Do you have a partner? Tell me about your partner; and your friends. Do you believe that the relationship is working out? Do you have teenage friends with babies?
   (iii) Who is the most important person to you now? Why?
   (iv) In the area where you live, do you believe that it is a good place to live? Will you live here after the baby is born? What would you like to see improved where you live? How do you get from home to the City?

3. Health system
   (i) How many antenatal checks and education visits did you manage to attend?
   (ii) Tell me about your experiences at the antenatal care clinics at your GP; midwives; Hospital. Could this experience be improved for you and family/partner? How?
   (iii) What is your biggest health worry about being pregnant?
   (iv) Tell me what you think about the health care services.

4. Distal factors: economic, political
   (i) Tell me how you manage with day to day spending. What are the things that you have to go without?
   (ii) What support do you get from the government now? What support will you get from the government after the baby is born?
   (iii) What other support do you feel you need, to prepare for the baby?
   (iv) Of all the things we have discussed, what do you feel is the most important need for you right now? What is stressing you out the most now?
TEENAGE MOTHERS
This is an interview guide for the follow-up interview with same childbearing teenagers and is developed to address the objectives listed above. The questions may be changed depending on findings from the first interview conducted with them during the antenatal period.

DEMOGRAPHIC & HEALTH DATA: POSTNATAL
Some of the data will be collected again during the second interview, as the teenage mothers’ circumstances may have changed following birth of the baby.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Code: .............................................................................</td>
<td>Age: .................</td>
</tr>
<tr>
<td>Single/Living with partner</td>
<td></td>
</tr>
<tr>
<td>Education level: ............................................................................</td>
<td>Are you attending school? Yes/No</td>
</tr>
<tr>
<td>Baby’s Birth Date: ................................................. Number of weeks postnatal: ............... Sex of baby: .........................</td>
<td></td>
</tr>
<tr>
<td>Are you in the same address as when you were pregnant: Yes/No. Where are you living now? .......................................................... And with whom? Own; With partner; With Mother; With Father; With Grandparents; Others: .................................. Type of accommodation: ..........................................................</td>
<td></td>
</tr>
<tr>
<td>Type of transport: Same / Different Own car; Friend's car; Partner's car; Public; Others: ..........................................................</td>
<td></td>
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<tr>
<td>Employment: Yes/ No ; Type of employment: ..................................................</td>
<td></td>
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<tr>
<td>Key source of income: Own; Partner; Mother; Father; Grandparents; Others: ......................... Are you currently working? Yes/ No</td>
<td></td>
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<tr>
<td>Main health problems ...........................................................................</td>
<td></td>
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<tr>
<td>History of Depression/self-harm: ..........................................................</td>
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</tr>
<tr>
<td>Postnatal depression assessment: Yes/ No  Scores: ...............................</td>
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<tr>
<td>Smoking: Yes / No; amount per day: ..................................................</td>
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<td>Alcohol: Yes / No; amount per day: ..................................................</td>
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<tr>
<td>Drugs: Yes / No; Name: .................................................................; amount per day: ..................................</td>
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<tr>
<td>Key support person for mother &amp; child: ...............................................</td>
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<tr>
<td>Career plan: .......................................................................................</td>
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CORE QUESTIONS: POSTNATAL

1. Individual factors- Mental health, physical and health related to pregnancy:
   (i) Tell me about the birth of your baby. Do you believe that you have been helped to learn all that you could learn, to prepare for the birth? What else do you feel you needed to learn?
   (ii) Now that you are a mother, how do you feel about the pregnancy? And the baby?
   (iii) Have you completed the postnatal depression questions? How do you feel now after the baby is born?

2. Proximal factors: social support
   (i) The support you had when you were pregnant, did that continue after the baby was born? Do you feel supported since the birth? Who helps you the most now? Where would you get more support if you need to?
   (ii) Do you believe that you are managing well with the baby?
   (iii) Tell me how you feel living where you live?
   (iv) Tell me how you get about to do shopping and visit friends? Do you feel that you are seeing friends and families as much as you were when you were pregnant?

3. Health system
   (i) Do you believe that the midwives and doctors helped you learn about yourself, your pregnancy, birth and the baby?
   (ii) Anything else you want to tell me about your experiences at the antenatal care clinics at your GP; midwives; Hospital? How could this experience be made better for you and family/partner?

4. Distal factors: economic, political
   (i) Tell me how you manage with day to day spending. How often do you go out now?
   (ii) What support do you get (or will get) from services now that you have a baby?
   (iii) What other support do you feel you need from the services?
   (iv) Of all the things we have discussed, what do you feel is the most important need for you right now? What stressed you out the most now? What is your biggest worry now that you have had your baby?

5. If you have your life again, what would you do that was different?
INTERVIEW GUIDE (1) MIDWIVES & (2) FAMILY & CHILD HEALTH NURSES
This interview guide is developed for use in individual interviews with Midwives working at the RHH and with Family & Child Health Nurses working with CHAPS. Some of the questions may be altered based on findings from the interviews with childbearing teenagers.

DEMOGRAPHIC DATA:
Participant Code: ………………………………………. Age:……………………………………
Where do you work (ANC, Young Mums Clinic, c u @ home):
……………………………………………………………………………………………………………..
Number of years’ experience in the workplace:
……………………………………………………………………………………………………………..
Number of years working with pregnant teenagers:
……………………………………………………………………………………………………………..
Professional qualification(s):………………………………………………………………..
……………………………………………………………………………………………..
CORE QUESTIONS:
1. General feelings about pregnant teenagers:
   (i) Tell me about your experiences in working with pregnant teenagers.
   (ii) Describe how you work with the teenagers. What do you believe has informed the way you work with teenagers?
   (iii) What comes to mind when you first meet a pregnant teenager?

2. Individual factors of Pregnant teenagers:
   (i) Tell me your concerns in relation to pregnant teenagers health—starting with: (a) mental health, (b) physical and (c) health related to pregnancy.

   (Midwives only)
   (ii) Do you believe that this Hospital is meeting the needs of pregnant teenagers? If not, what do you think needs improving? If yes, how?

3. Proximal factors: social support
   (i) Tell me what you know about the support that teens receive from their networks.
   (ii) How do you think the support networks help the teens?
   (iii) What are the issues regarding pregnant teenagers’ network of social support? Do you see them texting and using facebook? Are they potential support for teens? How?
   (iv) How have the antenatal care services address the social support needs of pregnant teenagers? What else could be done?
(FCHN only)

(v) Are antenatal support networks different to postnatal networks?

4. Distal factors: economic, political
   (i) Tell me about pregnant teenagers’ experiences in regards financial, transport, and education?
   (ii) What do you think the government needs to do, to provide greater support for teens?

(FCHN only)

(iii) If there were concerns in relation to these factors (economic, political), how have these concerns influence services provided to childbearing teenagers?

5. As a Midwife/FCHN, what do you think are some of the things that worry you about the hospital antenatal maternity services for pregnant teenagers? What are the influences of these concerns on teenagers’ antenatal services utilisation?

6. Can you summarise for me what you think are the most worrying in regards pregnant teenagers’ needs (from a wide perspectives such as personal, social, family, environment, including health)?