Antenatal Education for Adolescents:

A Qualitative Study from a Foucauldian Perspective

A thesis presented in partial fulfillment of the
requirements for the degree of
Master of Philosophy
at Massey University, Albany,
New Zealand.

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2011

Abstract

The purpose of this research has been to explore the arguments around whether antenatal education (ANE) programmes dedicated to adolescents are beneficial. Epidemiological research presents pregnancy during the adolescent years as problematic and positions the pregnant adolescent and her baby at risk for ongoing negative health and social outcomes. In an attempt to increase the uptake of ANE by pregnant adolescents and their partners and therefore improve these outcomes, ANE programmes dedicated specifically to adolescents have been established. Using Foucault's concepts of power, the medical 'gaze', surveillance, and governmentality, a qualitative methodology positioned within a critical paradigm has been utilised to challenge some of the taken for granted assumptions around the delivery of a dedicated adolescent ANE programme. These concepts also enabled antenatal education to be examined from an alternative theoretical perspective and provide an alternative view of antenatal education as a bio-political and disciplinary power that is capable of constructing the individual. One health practitioner, nine female and four male adolescents participated in semi-structured interviews, either individually or as a group, to discuss their views and experience of the ANE programme. Thematic analysis was used to create topic groups that were integrated into themes. The two following overarching themes were identified: bio-politics: how the population of pregnant adolescents are managed and subjected to extra surveillance and intervention; and anatamo-politics: where the health education that the participants received constructed a representation of a normal or ideal birth experience and feeding choice. This thesis argues that an adolescent ANE programme reinforces an identity of difference from other expectant parents and can be a manifestation of the 'gaze', subjecting the adolescents to 'surveillance', which results in increased intervention. It explores some of the strategies used to facilitate the management of this population; identifies some of the techniques that are used in health education to instill self-discipline and gain compliance; and identifies how the disciplinary power of health education is sometimes resisted by the participants.

Acknowledgements

There are many people I would like to thank who have contributed to the completion of this thesis. Firstly, thank you to all the participants whose contribution made this research possible. I am truly grateful for how you all so readily shared your views and experiences with me. To the young parents, I sincerely wish you all a happy and rewarding journey through parenthood.

I would like to express my sincere gratitude and thanks to Dr Annette Huntington whom I feel very privileged to have had as my supervisor. Thank you for introducing me to the work of Michel Foucault which has opened new and interesting ways for me to see and understand so many aspects of nursing and healthcare. You have made this thesis such a challenging and rewarding experience.

Thank you to Dr Denise Wilson for starting me out on this research and proficiently guiding me through the initial stages. Thank you also to Dr Lanuola Asiasiga; your supervision throughout the interviews and report writing was invaluable. I would also like to thank Dr Stephen Neville; I appreciate the time you spent discussing Foucault with me, which kept me afloat while Annette was overseas.

I am truly indebted and thankful to my wonderful family for their continued support which has enabled me to keep going. Thank you for understanding my preoccupation with this work. I am very grateful to my husband, Andy, who has kept the household running so efficiently, and to my children Dylan and Lucy for the sacrifices they have tolerated. I hope I have inspired you to be always wanting to learn.

Thank you also to my good friend Helen for helping me realise that this journey was achievable from the beginning. I am always grateful for the encouragement, interest and understanding that you have provided.

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Chapter One: Introduction

The focus of this research is the provision of an antenatal education (ANE) programme for pregnant adolescents and their partner or support person(s). This thesis will explore the value of ANE programmes dedicated to adolescents and will also examine this area of health education from an alternative theoretical perspective. This chapter begins with a reference to the terminology that will be used throughout the thesis and presents some background to the research before explaining the relevance of the research to nurses and other health practitioners. The structure of the thesis is outlined at the end of this chapter.

Terminology

Education classes held for pregnant women and their partner or support person(s) are most often termed either antenatal education or childbirth education classes. Both are terms used for education classes provided to expectant parents that incorporate information around pregnancy, childbirth and the first days or weeks of parenting. The term *antenatal education* has been used throughout this thesis as it was considered to be a term that reflects that the education provided in these classes encompasses more than childbirth.

The terms young mother, teenager and adolescent and are used interchangeably in the literature when referring to childbearing in younger people. When choosing which term to use throughout this research, *young mother* did not seem appropriate as the research involved young people before they became mothers, as well as after. The term teenager only appeared in the 1940s and, strictly speaking, includes only the teenage years of 13 - 19. As the ANE programme attended by the participants in this study was intended for young people up to the age of 21years, and much of the literature considers the age of adolescence as up to around 22 years, the term *teenager* also did not seem a suitable word to use. The term *adolescent* allows for the lack of defined age parameters assigned to this population and encompassed Geronimus's (1997, p. 405) view of adolescent pregnancy as being "generally earlier fertility-timing distributions relative to the national average". Guided by this, and the median age for childbirth in New Zealand being 30 years, *adolescent* was the term chosen for this research. However, *teenager* and *adolescent* are both used in the literature review to remain in keeping with

the term the particular authors had used. When reference is made to web-pages *teenager* is used as it reflects the fact that they refer to childbearing during the teenage years only. Similarly, when presenting data obtained from Statistics New Zealand the term *teenager* is used as their data is reported using an age band of 15 - 19 years which excludes those who are no longer in their teens.

The ANE programme in this study was delivered by nurses and childbirth educators. To maintain anonymity the health professional who participated in this research has been referred to as *health practitioner*. This term is considered to incorporate all health practitioners who are involved in the provision of ANE programmes.

Background

Pregnancy during the adolescent years is generally considered to be problematic. The ongoing negative effects on the socio-economic wellbeing of the mother and her child mean it is regarded as a "poor life choice" (Statistics New Zealand, 2003, p. 9). The negative consequences of adolescent childbearing are considered to ensue from a failure to achieve educational potential, which results in reduced career prospects and earning potential, and from simply being emotionally and socially unprepared for childrearing (Edmond, 2007; Statistics New Zealand, 2003). This negative view is reinforced by print and television media with statements such as: "[e]very day in New Zealand babies are born into families where parents are too young…these babies do badly." (Wills, October 25th 2011, p. 11); by including the parents' teenage status in certain headlines "Teen parents arrested" (Herald on Sunday, 27 Feb 2011); and by describing adolescents as being "physically capable of producing children before [they are] psychologically capable of caring for them" (Keane, 18 Feb 2009). Young parents also tend to be viewed as different, and separate, to older parents as demonstrated when a TV3 reporter referred to "single parents and young single parents" inferring they are seen as two separate groups of beneficiaries (Campbell Live, 12 Aug 2011). The Kiwi Families website also describes teenagers as being "psychologically and emotionally unprepared for having a child" (Kiwi Families, 2011). In addition to the perceived lack of psychological capability, the New Zealand Government considers mothers under the age of 19 years to be fiscally unprepared for childrearing. The National Party's 2011 welfare election policy intends changing the way that financial assistance is provided to young mothers. The plan aims to change the personal responsibility of finances to a

managed system of payments where essential costs, such as power and rent, would be paid directly on the young mother's behalf. In addition, the introduction of a payment card would control where their money is spent, with a limited amount of money being available to spend at their own discretion (Bennett, 2011). The policy would also require parents under the age of 18 who receive a benefit to be in education, training or work-based learning (National Party, 2011). This reflects how younger parents are not regarded as equal to older single mothers. These policies subject young mothers to more state control as they will no longer be free to choose how to spend their money and denies them the choice to stay home full-time to care for their child.

Adolescent pregnancy

New Zealand's teenage pregnancy rates are among the highest in the OECD countries. As the median age in New Zealand for child-bearing has increased to 30 years, and in Auckland 31years (Statistics New Zealand, 2011), pregnancy and childbirth during the adolescent years has moved further from the norm. Although the teenage pregnancy rate in New Zealand has risen since 1984, the teenage birth rate has been relatively stable since the early 1980s as more teenage pregnancies end in termination. In 2001, teenagers aged 15–19 years accounted for 20 percent of all terminations, and 7 percent of all live births. Māori teenagers are nearly three times, and Pacific Island teenagers 2.4 times, more likely to become pregnant and to carry their pregnancy through than European teenagers (Statistics New Zealand, 2011; The Treasury, 2002). Pregnancy rates are calculated by relating births to teenagers during a given year to the estimated number of teenagers in that year. In New Zealand in 2001 there were 27.7 pregnancies per 1,000 estimated females aged between 15 and19 years. New Zealand's teenage birth rate sits third behind the United States (45.9 per 1,000) and the United Kingdom (29.2 per 1,000), and is significantly higher than the latest rates recorded in France (7.0 per 1,000), Japan (4.9 per 1,000), the Netherlands (5.9 per 1,000), and Sweden (5.0 per 1,000) (Statistics New Zealand, 2011).

Adolescent pregnancy and early motherhood are often associated with a number of negative consequences, including poorer social and health outcomes for both the mother and the baby (Boden, Fegusson, & Horwood, 2008; X. Chen, et al., 2007; Department of Health, 2008). The literature around the social and health outcomes of adolescent pregnancy and parenting is discussed in detail in chapter two. In response to the

research that highlights the poorer outcomes in adolescent pregnancy, services dedicated specifically to pregnant and parenting adolescents have been established. These services attempt to address and improve the outcomes for young mothers and their babies. For example, a dedicated teenage pregnancy clinic in the United Kingdom claimed to have a positive effect on the obstetric and neonatal outcomes by improving the uptake of antenatal care, increasing the rates of breastfeeding and reducing the rates of smoking and repeat pregnancies in the young mothers (Das, Dhulkotia, Brook, & Amu, 2007). In addition, positive effects on child development and maternal–child interactions are claimed as an outcome of parenting and social programmes for adolescent mothers (Furey, 2004). Similarly, ANE programmes dedicated to pregnant adolescents have been developed as an attempt to improve the uptake of ANE by adolescents. The focus of this research is on the provision of an ANE programme that is dedicated specifically to pregnant adolescents in a large urban area of a New Zealand city.

Antenatal education

Preparation for parenthood is important for the health and wellbeing of parents and their babies. Antenatal care, provided during pregnancy and childbirth by a Lead Maternity Carer (LMC), incorporates information around pregnancy and preparation for childbirth and parenting (Ministry of Health, 2011). ANE classes are in addition to, and build on, the education pregnant women receive form their LMCs. They aim to prepare pregnant women and their partners or support person(s) for labour and delivery through the acquisition of knowledge and instilling confidence to make informed choices (Nolan, 1998). Although a Cochrane review failed to find high quality conclusive evidence of their effectiveness (A. Gagnon & Sandall, 2007), many researchers have reported improved health outcomes in pregnancy, childbirth and early parenting as the result of ANE classes (Covington, Peoples-Sheps, Buescher, Bennet, & Paul, 1998; Das, et al., 2007; Ukil & Esen, 2002; VanWinter, Harmon, Atkinson, Simmons, & Ogburn, 1997). Aside from preparing pregnant women and their partners for childbirth and early parenting, ANE classes also provide a network for meeting, and establishing relationships with, other mothers in the local community. The social support and social networking opportunities that ANE classes provide can have a positive impact on psychological wellbeing and preparation for motherhood (A. Gagnon & Sandall, 2007; Giurgescu, Penckofer, Maurer, & Bryant, 2006).

Antenatal education for adolescents

Adolescents are less likely than older women to attend any form of ANE (Department of Health, 2008). Some of the reasons suggested for this are that adolescents often feel uncomfortable attending classes with older women and women with partners (Department of Health, 2008), and that traditional ANE classes fail to engage adolescents (Murphy Tighe, 2008; Tilghman & Lovette, 2008). In order to address these barriers and thereby improve the health and social outcomes for adolescent parents and their babies, ANE and parenting programmes have been developed specifically for pregnant adolescents and their partners or support person(s). Although extensive research has been carried out around the outcomes from clinical antenatal care programmes for pregnant adolescents, there are few published studies looking at the effectiveness of a dedicated adolescent ANE programme (Dwyer, 2009).

Research objective

This research came about from an evaluation of an ANE programme that was designed for and dedicated specifically to pregnant adolescents and their partner or support person(s). The programme is a free, five week educational course run from a suburban centre in a large New Zealand city and includes a range of topics relating to pregnancy, birth, health, life skills and parenting. The purpose of the evaluation was to assess the value of this programme to the participants and present a descriptive report to the service provider. The programme was attended by the researcher prior to the collection of qualitative interview data from 13 ANE programme participants and one health practitioner which provided an insight into the areas of ANE and adolescent pregnancy. A more extensive literature review was then performed and a critical analysis of the data, informed by the work of Michel Foucault, was undertaken. The theoretical approach, utilising Foucault's concepts of power, the medical 'gaze', surveillance, and governmentality, is described in Chapter Three. This approach has allowed some of the assumptions around adolescent pregnancy and the delivery of a dedicated ANE programme for pregnant adolescents to be challenged. It also allowed the contribution of an alternative view of health education by providing an argument around how health education is capable of constructing the individual.

Relevance to health practitioners

Health education is a key component in the role of all health practitioners as education enables people to make choices regarding their health, thus allowing self-management of individual health. As an integral part of the multidisciplinary team of health practitioners, nurses provide health education and health services in a variety of areas at both an individual and group level. Antenatal education programmes are health education programmes that are delivered by a range of health practitioners including nurses, childbirth educators and midwives and are invariably provided in a group setting. This research is therefore relevant to all health practitioners who provide health education to clients but in particular to health practitioners who are involved in health education programmes. Reflecting critically on the services provided, and how they are delivered, is essential because the health practitioners' positioning and beliefs are likely to influence how programmes are structured and the way education is provided.

Summary

ANE classes dedicated to pregnant adolescents and their partners aim to address some of the disadvantages experienced as the result of pregnancy and parenting during the adolescent years. This chapter has described how this thesis arose from a review that was undertaken to assess whether an ANE programme dedicated to adolescents and their partners met their needs. This thesis aims to explore the value of an antenatal education programme dedicated to adolescents. The theory underpinning the approach has been briefly introduced. The structure of this thesis is outlined below prior to commencing the review of the literature.

Outline of the thesis structure

Chapter one: This chapter has defined, and provided some background to, the subject of adolescent pregnancy and antenatal education. It outlines the purpose of the study and the theoretical and methodological approach taken. An explanation has also been provided for the terminology that was chosen throughout the research.

Chapter Two: To place this study in context, chapter two presents a review and discussion of the literature related to adolescent pregnancy and antenatal education.

Chapter Three: This chapter describes the theoretical perspective used to inform this study and the methodology and methods used to undertake the research. It includes the

ethical considerations for the research, trustworthiness in qualitative research and researcher reflexivity.

Chapter Four: The first of two results chapters, this chapter explores and analyses the results from the interviews from a 'bio-political' perspective.

Chapter Five: The second results chapter explores and analyses the results from the interviews from the perspective of 'anatamo-politics'.

Chapter Six: This chapter provides a discussion of the results and analysis using a Foucauldian lens and integrating relevant literature.

Chapter Seven : This chapter provides the conclusion of this thesis. The limitations of the study are identified and recommendations for practice and future research are outlined.

Chapter Two: Literature Review

Introduction

This chapter reviews the literature related to adolescent pregnancy. The literature search techniques that were used are explained prior to presenting some background around the period of adolescence and the history of pregnancy during the adolescent years. The main focus of the review follows and entails a discussion of the key themes that were found in the published literature on adolescent pregnancy.

Literature search techniques

A substantial amount of research literature was found around the clinical antenatal care of the pregnant adolescent. Similarly, there was a considerable amount of literature around the efficacy of parenting programmes for young mothers. Significantly less literature was found that specifically focused on the ANE needs of pregnant adolescents and their partners.

Electronic databases through the Massey University library and the world wide web were searched for this review. The main databases accessed were: Sage Journals On-line, Scopus; PsycINFO; CINAHL; Medline; Google Scholar; Academic Search Premier along with newzealand.govt.nz. The initial search terms were antenatal OR childbirth education AND teenager OR adolescent. However, as few studies relevant to this research were found, the search was widened using additional terms. Prenatal and perinatal were used in addition to antenatal; childbirth training or classes were used in addition to education; young mothers was used in addition to teenagers or adolescents; and a broad search was done using teenage OR adolescent AND pregnancy. The terms were searched for in article titles, abstracts or keywords. Most of the results obtained using these search terms were around the prevention of adolescent or teenage pregnancy or the clinical care of pregnant adolescents. Additional literature was also obtained from the reference list in the most relevant retrieved articles and by searching via the relevant documents link in the library databases.

Adolescence

The term *adolescence* is derived from the Latin word *adolescere*, meaning ‘to grow up or to grow to maturity' (Dolgin, 2008). The concept of adolescence was first described

in the 1880s by G. Stanley Hall, an American psychology professor who, influenced by Darwinism, viewed personal growth and the development of human consciousness in terms of set stages that happen in a particular order. He described what was then referred to as 'youth' as a period of "storm and stress" and "severe crisis" characterised by

> a lack of emotional steadiness, violent impulses, unreasonable conduct, lack of enthusiasm and sympathy. The previous selfhood is broken up and a new individual is in the process of being born. All is solvent, plastic, peculiarly susceptible to external influences (G Hall in Demos & Demos, 1969, p. 635).

Although he was widely criticised by his colleagues, who denied personal growth in terms of set stages, the concept of adolescence is now accepted as a period of physical, psychological and social transition between childhood and adulthood, characterised by changes in social behaviour (Demos & Demos, 1969; G. Holmes, 1995; Sebastian, Viding, Williams, & Blakemore, 2010). Erikson (1994) describes it as a period of developing a sense of personal identity and achieving emotional independence during which time they ask “Who am I?” and “What am I going to do?”. During this time adolescents become more self conscious and concerned with how others perceive them (Sebastian, et al., 2010). Calabrese (1987) has described adolescence as a period of "betwixt and between" thus being a period conducive to alienation. It is during adolescence when people are most likely to be alienated from educational and religious institutions, society in general and from others such as peers (Epstein, 2002). Epstein (2002) describes this alienation as falling into two categories which can and do coincide: social structural alienation involving particular groups in society, and social psychological alienation where an individual internally feels detached and estranged.

Adolescents are not simply older children or younger adults. The period of adolescence cannot be determined purely from the perspective of chronological age, nor does it proceed in a continuous linear manner (Howard-Jones, 2008). It is generally considered to begin between the ages of 11 and 13 when children begin to physically mature, however the upper boundary is less clearly demarcated (Dolgin, 2008). Because of the vast differences between an 11 year old and a 19 year old, adolescence is divided into the three stages of early, mid, and late, adolescence. As the progression between stages is gradual and encompasses physical, emotional, spiritual, social, and intellectual

growth, the age bands are not fixed and the word 'about' is used frequently in the literature. Early adolescence is considered to be from 10/11 to 13/14 years; mid-adolescence from 14/15 to 16/17 years and late adolescence from 17/18 to 20 years and older (Dolgin, 2008; G. Holmes, 1995).

Since the 1970s the period of adolescence has become increasingly prolonged as puberty in industrialized countries has begun earlier, and the age at which adolescents take on adult roles and become financially and emotionally independent from their parents has increased (Arnett, 2001). As the result of this prolonged transition to adulthood Arnett describes the theory of emerging adulthood; a separate period extending from (approximately) 18 to 25 years, conceptualizing it as "the age of identity explorations, the age of instability, the self-focused age, the age of feeling in-between, and the age of possibilities" (p. xii).

Adolescent pregnancy

The post-World War II years in New Zealand saw a shift towards early marriage and childbearing. The pregnancy rate of 18 and 19 year olds doubled between 1929 and the early 1950s before reducing by 50 percent in the 1960s. Births to teenagers then increased by more than 70 percent in the decade between 1962 and 1972. During this time most births were to married (5,100) rather than non-married (3,700) teenagers. By 1971, when teenagers made up approximately one third of all brides, teenage parenting was not considered to be outside society's norm, providing the parents were married. A shift over the next few decades saw less young New Zealand women marrying in their teenage years. By 2001, with a growing proportion of teenagers living in de-facto relationships, married teenagers made up less than 8 percent of all teenagers in a union (Statistics New Zealand, 2003).

The introduction of the Domestic Purposes Benefit[1] into New Zealand in 1973 gave women the ability to parent alone, no longer being forced to choose between marriage, termination and adoption. Over time, as more mothers were able to keep their babies, lone parenting became less of a moral and more of a socio-economic problem as it was considered to lead to a cycle of welfare dependence and poverty. This shift also saw a change of focus from the unwed mother to the teenage mother as the issue needing to be

[1] The Domestic Purposes benefit is a weekly payment from Work and Income New Zealand for sole parents with one or more dependent children.

addressed. In the late 1960s and early 1970s a single concept of ‘teenage pregnancy’ appeared from the combination of the ‘unwed mother’ and ‘illegitimate child’ (Arney & Bergen, 1984). Arney and Bergen's article, *The invention of teenage pregnancy*, points to the fact that rather than teenage pregnancy per se, it was the name 'teenage pregnancy' that was invented in a particular time and place; middle class America in the 1970s. An article published in the 1970s, titled *The pregnancy resolution decisions of unwed adolescents* (Fischman, 1975), focused more on the unwed status of the pregnant women than her age and uses statements such as "For many young girls, illegitimate pregnancy..." and "to reduce the incidence of out of wedlock pregnancy...". This way of reporting their findings implies that it was the unwed status, rather than age, that was the issue that needed addressing. More recent research frames the adolescent's age, regardless of whether she is partnered or unpartnered, as the problem that needs to be addressed.

Constructions of adolescent pregnancy

There is inconsistency amongst the terms used when referring to pregnancy and childbearing during the adolescent years. The terms young mother, adolescent mother, and teenage mother are used interchangeably, regardless of age and marital status, however they all construct the young mother as a woman who becomes a mother between childhood and adulthood (Holgate, Evans, & Yuen, 2006). Younger adolescents are not differentiated from older adolescents; partnered from non-partnered and, as the result, they are encompassed as one entity. The inference from this is the assumption that their outcomes are identical (Wilson & Huntington, 2005).

Professor Arline Geronimus (1997), an extensively published and cited researcher in this area, does not attach age brackets but instead describes the concept of adolescent pregnancy as

> not tied to very specific ages, but to the generally earlier fertility-timing distributions characteristic of poor or minority communities relative to more advantaged communities or to the national average (Geronimus, 1997, p. 405).

Deviated from society's norm

With the median age in New Zealand for child-bearing at 30years, and in Auckland 31years (Statistics New Zealand, 2011), child-bearing during the adolescent years

moves further from society's norm. Having a child during the adolescent years falls outside what is now generally perceived as the traditional family thus making adolescents vulnerable to marginalisation and stigmatisation (Wilson & Huntington, 2005). Campion (as cited in Yardley, 2008, p. 671) states that adolescent mothers are often perceived as a homogeneous group of "immature, irresponsible, single, benefit dependant, unfit parents who deviate from the ideals of motherhood". Hirst, Formby and Owen (2006) found in their exploration of the views and experiences of teenage parents that teenage parents felt stigmatised and discriminated against as the result of the negative images portrayed by society, despite the fact that they perceived themselves equally as competent as older mothers. Similarly, in a study of the perspectives of adolescent mothers, the participants had a perception of being judged and condemned by older mothers however they felt confident in themselves as capable and good mothers and resented the need to justify themselves (Kirkman, Harrison, Hillier, & Pyett, 2001). This stigma can continue throughout the young mother's life with major consequences as it may affect their readiness to seek support and advice (Bynner & Londra, 2004; de Jonge, 2001). These studies indicate that adolescent mothers are often aware of, and sensitive to, the negative stereotypes associated with childbearing at an early age.

Hanna (2001) describes how young mothers who feel stigmatised by community workers avoided using community services as a result. However, as the participants in this study were homeless, engagement with services was likely to be challenging regardless of their adolescent motherhood status. A systematic review of qualitative literature that focused on the perspectives of UK mothers under 20 years (McDermott & Graham, 2005) reinforces this finding of young mothers experiencing stigma and hostility from a range of social services, however there was no mention of any effect this had on the utilisation of such services. Yardley's (2008) qualitative study involving 20 teenage mothers aged between 16 and 19 years found that, although the young mothers experienced stigma from public services (including health services) none of them avoided these services as a result. Rather, these young mothers developed strategies to either insulate, protect or empower themselves to cope with the negative portrayals of adolescent mothers. A limitation of this study was that participants were recruited from formal support services with which they had been engaged for a number

of years. This may mean that those who isolated themselves from such services as a result of stigma would not have been included in the sample.

The pregnant adolescent stereotype

The pregnant adolescent is exposed to a negative stereotype. Shih (2004) discusses the ways people develop processes to build resilience and overcome stigma and states that individuals who interact with others in the same group are less influenced by the negative messages from others. This, however, is not reinforced in Yardley's (2008) study where some of the young mothers actively distanced themselves from other teenage mothers whom they perceived to be the teenage mother stereotype. This is a significant finding because, as adolescents are still in the process of establishing their identity, they may be more vulnerable to the influence of stereotypes (Kulkarni, 2007). Similar to Yardley's above-mentioned study, in de Jonge's (2001) study with 26 mothers whose median age at childbirth was 17 years, most felt that although they would find support from a group of others in similar circumstances, some expressed a risk of a support group exclusively for teenage mothers increasing stigma. The study participants considered that the name of the group and the inclusion of women in their early 20s were important to reduce stigmatisation. The opportunity to compare oneself to others in similar circumstances may help to recognise self efficacy, thus protecting self esteem and self worth. Additional protective mechanisms described include transferring blame from themselves to the person or groups of people who stigmatise them, thus deeming the critics as the ones in the wrong (Yardley, 2008), and orientating themselves to other identities which are less stigmatised in different social contexts (Shih, 2004). This literature suggests that groups designed to support pregnant adolescents may have a protective effect on self esteem. Alternatively, they may reinforce stereotypes and stigma. Rather than being defined by the single identity of a pregnant teenager, recognition of one's additional identities may have a protective effect in counteracting a stereotyped identity.

Adolescent mothers are considered to deviate from what is constructed as a 'good mother' in many ways. Not only have they rejected the conventional middle class life trajectory of tertiary education, career, marriage and then children, many also may choose to rely on the government, rather than a man, for financial support and are seen as reluctant to form the traditional two-parent family (McDermott & Graham, 2005;

Wilson & Huntington, 2005). Compounding this, the behaviours considered normal for adolescents, including a lack of foresight and ability to plan ahead (Feinstein, 2009; Howard-Jones, 2008), responding more emotionally than logically (Guyer, et al., 2008; G. Holmes, 1995; Monk, et al., 2003; Sebastian, et al., 2010), and being idealistic, egocentric (Dolgin, 2008) and forgetful (Feinstein, 2009), are in contrast to what are considered the attributes of a good parent thus preventing them from being viewed as successful or good mothers (Breheny & Stephens, 2007). The self-sacrificing attribute ascribed to a good mother also conflicts with the self-focus needed if young mothers are to pursue educational and employment options (Kulkarni, 2007).

Adolescent mothers tend to be positioned and typified by their chronological age and subsequent developmental stage. Positioning young mothers as adolescents constructs them as being in transition from childhood to mature adulthood (that is, not there yet) and disregards the maturing effects that pregnancy, childbirth and parenting has (Breheny & Stephens, 2007). When a prominent 16 year old New Zealand actress announced her pregnancy, National MP Paula Bennett (herself a mother at 17), responded:

> ...whichever way you looked at the situation, 16 was far too young to have a baby...there was no way a 16-year-old had the maturity to cope with the demands of raising a baby. You should be worried about pimples, boyfriends and going out, not bringing up a child (Marshall & Cook, 2006).

This positioning often doesn't change at the end of adolescence as those who become mothers at a young age continue to be separated out from older mothers (Breheny Stephens, 2007). This is evident by the many aspects of their, and their children's, lives and long term outcomes that continue to be researched (De Genna, Cornelius, & Donovan, 2009; Eshbaugh, 2008; Fletcher, 2011; Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001; Pogarsky, Thornberry, & Lizotte, 2006; Shaw, Lawlor, & Najman, 2006). This indicates that adolescent mothers are subjected to more scrutiny than older mothers based on the expectation that their outcomes, in so many areas, will be poor.

In their study of New Zealand Health professionals' constructions of adolescent motherhood, Breheny and Stephens (2007) observed that different constructions are

"deployed in different ways to deny adolescent mothers the good mother position" (p.122). Expressing pride and pleasure with their pregnancy was only associated with the good mother construct when referring to older mothers. In adolescents, pride and pleasure was perceived as a "naive and immature reaction that failed to acknowledge the hard realities of parenting" (p.121). Similarly, when the majority of the teenage subgroup in Qunlivan, Tan, Steele and Black's (2004) study, comparing teenagers with older mothers, regarded their pregnancies as "the single most exciting and positive event to have occurred in their lives" (p 202) it was interpreted and reported as idealisation of pregnancy. These studies suggest that health practitioners have lower expectations of adolescents' ability to manage their pregnancy, childbearing and parenting and how the attributes of a good mother are seen to be incompatible with the constructs of adolescence.

Adolescent pregnancy as a public health problem

Researchers from Australia (Gaudie, et al., 2010), Britain (Swann, Bowe, McCormick, & Kosmin, 2003) the USA (Darroch, Singh, & Frost, 2001) and New Zealand (Woodward, Horwood, & Fergusson, 2001) report concerns that their rates of teenage pregnancy are higher than in other developed countries, indicating that they perceive it to be a public health problem. Society and social policies also reflect a negative attitude toward adolescent pregnancy and public health strategies that aim to reduce the rates of adolescent pregnancy (Fitzpatrick, 2003; Ministry of Health, October 2001) reinforce its position as a problem that requires intervention. Many of these policies, which inform the practices of health practitioners, tend to be underpinned by quantitative evidence as it is considered by policy makers to be more rigorous, however this can result in portrayal of only the negative aspects of teenage motherhood as it neglects the qualitative research which often reports positive experiences for young mothers (Duncan, 2007; Wilson & Huntington, 2005). Lawlor and Shaw (2002) argue that it is not teenage pregnancy that is the public health problem but the cumulative effect of social and economic disadvantage to which teenage mothers and their babies are subjected.

Obstetric and neonatal outcomes

Teenage pregnancy and childbirth have been linked with negative medical outcomes for both mothers and babies. For mothers there are reported increases in the incidence of

antenatal complications and postnatal depression (Bynner & Londra, 2004; Department of Health, 2008; Hodgkinson, Colantuoni, Roberts, Berg-Cross, & Belcher, 2010; Rich-Edwards, 2002). Babies of teenage mothers are more likely than those born to older mothers to be born prematurely, be small for their gestational age (SGA) (Department of Health, 2008), have behavioural, educational and cognitive problems and become teenage parents themselves (Rich-Edwards, 2002; Woodward, et al., 2001). These associations imply that childbirth during the teenage years is unfavourable as it causes disadvantage to both mother and baby (Breheny & Stephens, 2007).

Much of the research compares adolescent pregnancies with older women's pregnancies, however, considering all adolescent pregnancies as one group risks masking the variability that may exist among young and older teenagers. To overcome this, some researchers stratify by age although as they are grouped in so many different ways it makes comparisons difficult. Additionally, where age bands overlap broadly the adverse effects that are more frequent among younger teenagers may be diluted by older adolescents whose outcomes are similar to those of older women (Cunnington, 2001). In a Taiwanese study of over one million live births to women aged up to 24 years (C. Chen, et al., 2009), age was categorised as: 10-14, 15, 16, 17, 18, and 19 years with mothers aged 20-24 years as the control group. The authors reported a significantly increased risk of low birth weight, premature birth and SGA outcomes amongst all teenage age groups when compared to the control group. Poorer outcomes were seen in the group aged under 16 years with outcomes improving in the older teenage mothers. Although recently published, the dataset used was from between 1985 and 1997 and the advances in antenatal and neonatal treatments may have since reduced this gap in outcomes. While the researchers adjusted for potentially confounding socio-economic factors, no adjustments were made for some of the known contributors to prematurity and low birth weight such as smoking, alcohol, concomitant obstetric complications and antenatal care. Smoking during pregnancy is a major contributing factor to low birth-weight babies and teenagers are up to three times more likely to smoke during their pregnancy than older mothers (Bynner & Londra, 2004; Department of Health, 2008).

Some researchers consider that young age per se is the pre-determining cause of negative outcomes (X. Chen, et al., 2007; Conde-Agudelo, Belizan, & Lammers, 2005). This view is challenged by the findings of a study into complications in teenage

pregnancy at a university teaching hospital in Nigeria (Loto, et al., 2004). The researchers found significantly higher complication rates of anaemia, premature delivery, neonatal admissions and SGA babies in the mothers under the age of 17 years. After controlling for antenatal care, however, significant differences were found only in the incidence of SGA babies. In Cunnington's (2001) systematic review of the literature around the medical consequences of teenage pregnancy, he found a 1.2 - 2.7 fold increase in premature birth (birth prior to 37 weeks gestation) among the younger teenagers (<16 years) although social disadvantage appeared to have an equally strong association. He concluded that "the most socially disadvantaged who became pregnant the youngest" (p. 40) were at a disproportionately higher risk of premature delivery. Supporting this contention that social disadvantage is a significant factor in obstetric outcomes, when McAnarney (1991) compared the maternal and neonatal outcomes of adolescent pregnancy with those of older women from a similar sociodemographic background, she concluded that many of the reported differences in outcomes disappeared. The significance of socio-demographic characteristics is also reflected by the higher rates of premature delivery, SGA babies, and stillbirth that occurred in rural Australian teenagers than in their urban counterparts who had more access to services (Robson, Cameron, & Roberts, 2006). In contrast, in Israel where pregnancy at a young age is desired and planned in the religious Jewish and Muslim population, it was not found to be high risk as it was likely accompanied by good antenatal care (Geist, Samueloff, & Beller, 2004). These findings suggest that poorer obstetric and neonatal outcomes are more likely to be related to socio-demographic characteristics and poor antenatal care than biological age.

Pregnancy and childbirth at an older age is also associated with increased obstetric and neonatal risk. Maternal morbidity and mortality increases with the mother's age (Cleary-Goldman, et al., 2005; Gilbert, Nesbitt, & Danielsen, 1999; Heffner, 2004) with an increased risk of stillbirth (Reddy, Ko, & Willinger, 2006), miscarriage, low birth weight, premature delivery, hypertension (Delbaere, et al., 2007; Heffner, 2004), and the incidence of type 1 diabetes in the child (Bingley, Douek, Rogers, & Gale, 2000). Lawlor and Shaw (2002) suggest that these risks are disregarded as older mothers are more likely to be better educated, financially independent and from a higher socio-economic group. This view is reinforced by the way in which findings tend to be framed more positively in the literature around pregnancy and childbirth in older,

compared to young, mothers. In a study that showed a significant increase in severe neonatal complications in babies of mothers aged over 40 years, the authors state that still the "vast majority of neonatal outcomes were good" (Gilbert, et al., 1999, p. 13). Similarly, while their findings showed an increase in adverse outcomes with increasing maternal age, the authors state that "patients and obstetric care providers can be reassured that overall maternal and foetal outcomes are favourable in this patient population" (Cleary-Goldman, et al., 2005, p. 989). These studies demonstrate that, despite pregnancy and childbirth in older women carrying its own significant risk, women having babies in their forties are not considered to be the public health problem that is associated with pregnancy during adolescence.

Educational disadvantage

A strong association between teenage pregnancy and poor educational achievement is highlighted frequently in the literature (Arai, 2009; Boden, et al., 2008; Hosie, 2007; Swann, et al., 2003). A New Zealand Treasury working paper (Jacobsen, et al., 2002) states that poor school achievement is a risk factor for early pregnancy. Other researchers take a different view, citing a direct cause-and-effect association of early pregnancy disrupting and limiting educational opportunities (Hofferth, Reid, & Mott, 2001; Moffitt, 2002; Scally, 2002; Woodward, et al., 2001).

In an Australian cohort study, researchers found a significant independent association between a low level of education and teenage motherhood (Quinlivan, et al., 2004). The measures used for education level were not reported so it is not possible to interpret what they considered to be a low level of educational attainment. Furthermore, the demographics of the two groups differed greatly and it is not clear that confounding factors were controlled for in the analysis.

The Christchurch Health and Development Study (CHDS) is a longitudinal study of 1,265 children (635 boys; 630 girls) born in Christchurch, New Zealand, over a four month period in 1977. Using this cohort, Fergusson and Woodward (2000) examined the association between teenage pregnancy (as opposed to motherhood) and educational underachievement in detail. Using three measures of secondary and two measures of post-secondary school achievement, they found an association between teenage pregnancy and educational underachievement. However, the majority who became pregnant under the age of 18 did so after they had left school, supporting other evidence

that many teenagers were disengaged (either formally or self-excluded) from the school system prior to pregnancy so their education was already disrupted (Arai, 2009; Bonell, et al., 2005). Additionally, after adjusting for selection factors Fergusson and Woodward (2000) found a substantial amount of the observed associations were explained; in particular family, living standards, scholastic ability, and conduct problems. This suggests that certain selection factors contribute to the increased risk of both teenage pregnancy and educational underachievement.

Using the same CHDS cohort, Boden et al. (2008) also examined the association between early motherhood and educational achievement. They concluded that those who became mothers prior to the age of 21 were educationally disadvantaged in comparison to those who did not become mothers. Additionally, the earlier the age (<18 years) of becoming a mother the greater the disadvantage that was found. However, as they adjusted for confounding factors such as social, background and family factors the differences were greatly reduced. Socio-economically disadvantaged teenagers are more likely to proceed with their pregnancy than young women with more educational and occupational potential (Bynner & Londra, 2004; Woodward, et al., 2001) therefore it is not surprising that the differences were further reduced after excluding young women who had a miscarriage or termination. What the researchers are unable to show is whether the early disadvantage extends through later life as the measures were done at age 25 when their children were still relatively young. When the educational underachievement of young mothers is the factor that is focused on, with little or no accounting for the effects of personal and contextual factors, different interpretations can be produced (Denzin & Lincoln, 2005). Perhaps when their children are older and they have more freedom to pursue education, the gap may be narrowed even further.

Socio-economic disadvantage

There is increasing recognition that the socio-economic disadvantage experienced by teenage mothers can be both a cause and a consequence of early childbearing (Swann, et al., 2003). As teenage parenthood rates are higher in areas of socio-economic disadvantage (Department of Health, 2008), it is possible that any disadvantage is a reflection of the different types of women who have babies in their teenage years. Several researchers contend that young maternal age is less of a factor than social

disadvantage on the long term outcomes for teenage mothers and their children (Geronimus, 2003; Holgate, et al., 2006; SmithBattle, 2007b).

The figures from the Dunedin Longitudinal Study[2] portray the children of adolescent mothers to be in a position of significant socio-economic risk. The children were more than: 2.5 times more likely to have left school early; 2 times more likely to be unemployed; almost 3 times more likely to become violent offenders and more than 2.5 times more likely to become teenage parents themselves. However, as some of these outcomes are invariably interconnected, many of the children had more than one of the outcomes and, notably, half of the children had none of the four outcomes (Jaffee, et al., 2001).

In what they termed a "natural experiment", Hotz et al. (2005, p. 685) aimed to identify the causal effect of teenage childbearing on the educational and socio-economic attainment of young mothers in America. They used teenagers who had miscarriages as a comparison group for those who became young mothers and found no statistically significant effect of early childbearing on the educational outcome that the teenage mother would have otherwise obtained. The authors concluded that it was doubtful that postponing childbirth would have enhanced the educational attainment, future earnings and levels of welfare assistance to any great extent. Kelly (1996) argues that although most teenage mothers are poor, it is not teenage childbearing that causes poverty and that later in life these women are not economically very much worse off than women who had children at an older age. These studies suggest that the educational and economic disadvantages that are frequently referred to in the literature may be more the result of pre-existing social and economic circumstances rather than early childbearing itself.

For many adolescents, pregnancy facilitates a positive change in their life trajectory as it can provide an incentive to make for a better life. Some of the qualitative research shows that for many adolescents, given adequate support, pregnancy and parenthood fostered a desire to re-engage with education (Hosie, 2007) however many need support to manage competing demands and navigate the education system while pregnant or caring for young children (Cox, et al., 2005; SmithBattle, 2007a). For some, early

[2] The Dunedin Longitudinal Study is an ongoing health and development cohort study of 1000 people born in between April 1972 and March 1973 in Dunedin, New Zealand.

parenthood can have positive benefits such as the re-building of family relationships and providing a close and loving relationship that may be missing from their lives, whereas for others, it can result in a poverty trap with little in the way of support (Bynner & Londra, 2004).

Adolescent fathers

The fathers of babies born to adolescent mothers are not necessarily adolescents themselves therefore there are a lot less adolescent fathers than there are adolescent mothers. The research focused specifically on fathers is less than that on mothers, so even less was found on adolescent fathers. Many of the social services and policies provide for adolescent mothers leaving adolescent fathers vulnerable and isolated if not ignored (Bynner & Londra, 2004; S. Green, 2003; Luketina, Davison, & Palmer, 2009). Much of the literature places the mother at the centre with the father on the fringe, despite other research showing the benefits to children of having their father engaged in their life (Luketina, et al., 2009). In a National Health Service (NHS) review of adolescent pregnancy and parenthood (Swann, et al., 2003), very few studies were found that focused on adolescent fathers, or interventions aimed at them, and the authors recommended that this gap in the research be rectified. What is known is that socio-demographically they are similar to adolescent mothers. They also have lower levels of educational achievement and fewer employment opportunities than those who do not parent in their adolescent years (Arai, 2009; Swann, et al., 2003).

The United Kingdom's Teenage Pregnancy Strategy (TPS) was developed in 2000 as a holistic approach to adolescent pregnancy and the resulting Sure Start Plus initiative to support pregnant adolescents included young fathers in the policy strategy. The Families Commission report (Luketina, et al., 2009) on the roles and needs of New Zealand fathers recommends that New Zealand institute a similar strategy, including ANE, to focus on the needs of adolescent fathers. This is supported by Deave and Johnson's (2008) research into the transition to parenthood for fathers. They suggest that antenatal classes be more inclusive of, and accessible to, fathers and recommend considering fathers-only classes for information that is pertinent to them. In addition, Dwyer (2009) suggests that father-focused discussions in antenatal classes improve partner relationships. At one year only 50% of teenage mothers are still in a relationship with the baby's father (Bynner & Londra, 2004; Department of Health,

2008), and at 15 years only 20% of teenage fathers are in contact with the baby's mother (Bynner & Londra, 2004). This is significant as the involvement of fathers in the pregnancy and birth of their child, and a good relationship between adolescent parents are both correlated to the father being more likely to be involved in their child's upbringing and a lower incidence of maternal postnatal depression (Department of Health, 2008; Luketina, et al., 2009).

Although they are more likely to attend programmes that are dedicated to their needs, more research is needed on how best to support young fathers (Bynner & Londra, 2004). Roye and Balk (1996) reviewed an Australian Hospital's addition of men-only groups facilitated by an experienced father to try to better meet the needs of fathers in the antenatal programme. They found the groups were well received and helped to fill the gaps for fathers after antenatal sessions. In contrast, the fathers-to-be in Svensson's (2005) study welcomed an opportunity to discuss their needs and concerns, although they did not consider men-only sessions as a priority. Other research has found that fathers find themselves in a secondary role and would like to be more included with information addressed specifically to them (Friedewald, Fletcher, & Fairbairn, 2005; Premberg & Lundgren, 2006). Premberg and Lundgren's (2006) study involved 25 to 35 year old men in longer term relationships; Friedewald et al. (2005) only had 3% of their 605 participants under the age of 20 years, and Svensson's (2005) sample consisted of educated, older and partnered expectant parents so the findings are not generalisable to adolescent fathers. Still, it may be reasonable to assume that if these fathers felt it was important to have the opportunity to share experiences, needs and concerns with others in similar situations then the same could probably be said for adolescent fathers. This is particularly relevant when the developmental stage and importance of peer relationships to the adolescent is taken into consideration.

An early transition to parenting

During adolescence peer relationships become increasingly important as adolescents draw on peers to practice and experiment roles as they establish their own identity and prepare for adulthood. Peer relationships help to change the child-adult bond with their parents into an adult-adult relationship as the peer group often acts as the 'parent' (G. Holmes, 1995). Peers, rather than parents, influence the shaping of their social behaviour and help determine a sense of personal self-worth (Sebastian, et al., 2010).

The early transition to parenthood can result in isolation from the adolescent's peer group. Pregnant and parenting adolescents can feel that they no longer have anything in common with their peers (Barrell, 2003; Hirst, et al., 2006). This potential for social isolation is possibly compounded by the hypersensitivity to social rejection that was shown in a study of adolescent reactions to experimentally induced ostracism (Sebastian, et al., 2010). Macleod and Weaver (2003) found in their study into social support during teenage pregnancy that although most of the participants felt well supported by their families, the support gained from their peers reduced over the period of their pregnancy. The development of supportive relationships with others in a similar situation is vital for the prevention of social exclusion. Supportive relationships are able to be formed through meeting other mothers-to-be at ANE classes. The relationship may be with another pregnant adolescent or, when the relationship is with an older pregnant woman, it may be in the form of a mentoring relationship. A natural mentoring relationship is described as one that naturally arises within social networks providing guidance, support and encouragement but with less of the emotional attachment that exists in either parent or peer relationships. A mentor usually has a role-modeling and advocacy function, and often helps to establish and make use of connections in the community (Zimmerman, Bingenheimer, & Behrendt, 2005).

A vulnerable population

Pregnant and parenting adolescents are frequently reported as being a vulnerable group who require additional support. This support is often provided through programmes dedicated to adolescents. Furey (2004) reviewed the evidence on what works in teenage parent support programmes and her findings suggest there are positive effects from parenting and social programmes for teenage mothers on child development, maternal–child interactions and a reduction in repeat pregnancies. She recommends targeted programmes in addition to support programmes to achieve ‘hard’ outcomes in areas such as smoking cessation and breastfeeding rates. The prevention of a repeat pregnancy is often incorporated in the strategies of programmes aimed at adolescent mothers as repeat pregnancies are considered to compound the negative effects of young parenting. One such intervention, The Second Chance Club, is a home-based mentoring programme targeting teenage mothers in an American high school. The programme comprises weekly group meetings, individual case management, home visits, medical

care and a community outreach service for at-risk school girls. The programme was considered successful as, after three years, repeat pregnancies occurred in 6% of the programme participants versus 37% of the case controls (Key, Barbosa, & Owens, 2001). REACHUP, another American program with similar strategies to The Second Chance Club, aimed to reduce first and repeat teenage pregnancies in an at risk teenage population. The authors report that the programme met one of the outcome measures of reducing primary teenage pregnancies however the prevention of repeat pregnancies in the teenagers was not achieved (Salihu, et al., 2011). A long acting hormonal contraceptive implant is seen as an opportunity to reduce the rate of repeat pregnancies as it improves contraceptive compliance among teenagers (Templeman, Cook, Goldsmith, Powell, & Hertweck, 2000). These studies portray how a repeat pregnancy in adolescents is considered to be a problem that requires addressing. The prevention of a repeat pregnancy is considered to be a successful outcome.

Antenatal Education

Antenatal education classes have developed as a way of preparing pregnant women and their partners or support people for labour, delivery and early parenting. The Knowledge-Attitude-Behaviour (KAB) model is a theoretical framework often used in health education programmes and is based on the assumption that the provision of knowledge will lead to a change in attitude and ultimately a change in behaviour (Lupton, 1995). Through the provision of knowledge around pregnancy, childbirth, breastfeeding and early parenting it is anticipated that pregnant women will adopt healthy behaviours that result in optimal health and pregnancy outcomes. A National Institute for Health and Clinical Excellence (NICE) review of seven studies of ANE conducted in the UK, Canada, and Australia found knowledge regarding pregnancy, birth and parenting increased following attendance at antenatal classes. There was little evidence that ANE affected outcomes such as mode of birth or analgesia use (NICE, 2008). By adopting the KAB, or another similar, model ANE programmes aim to improve health outcomes for mothers, their babies and families.

There is a considerable amount of research that states that ANE improves both the physical and psychological outcomes for mothers and babies (Covington, et al., 1998; Das, et al., 2007; Ukil & Esen, 2002; VanWinter, et al., 1997). A Cochrane systematic review, however, concludes that the benefits of ANE are generally unknown as there is

little high quality conclusive evidence of their effectiveness (A. Gagnon & Sandall, 2007). The reasons for this include the wide variation in the structure and delivery of antenatal programmes with the content of the classes often missing from the published articles; the many variables of demographics, expectations and experiences of the women; and the ethical challenges of conducting randomised controlled trials in this area. One of the selection criteria for the Cochrane review was randomised controlled trials which meant evidence from qualitative research was not considered.

Traditionally, pregnancy and childbirth information was passed down through families however, as modern families become more nuclear and new parents are more isolated from the extended family, information sharing amongst families has declined. Abel, Park, Tipene-Leach, Finau and Lennon's (2001) study of infant care practices in New Zealand found that Pakeha parents received less advice and support from their extended families than Pacific and most Māori parents, relying more on the advice of professionals. Family support was equivocal for single, pregnant Pacific women because of the stigma brought to the family, however this was found to only be temporary. Female Pacific and Māori family members were central in providing practical and emotional support during the pregnancy and after the baby was born although their influence and involvement meant some New Zealand-raised Pacific parents were criticised for being influenced by Pakeha ways. As the extended family have an important influence on antenatal and baby care it is important that cultural differences, traditional practices and beliefs are understood and acknowledged in the delivery of health messages. Many Pacific people believe that poor infant health or even death could be caused by deviation from traditional practices. For example, bed-sharing is a strong cultural tradition for Pacific families that is seen to have practical, protective, psychological and spiritual benefits for the baby (Abel, et al., 2001).

It is a commonly held belief that pregnant women are focused on labour and delivery and therefore information on parenting and baby care have less of a place in ANE (Wiener & Rogers, 2008). However, in Svensson's (2005) research on ante and postnatal education in preparation for parenting, she found the mothers and fathers-to-be were interested in parenting and babycare during pregnancy and one of her recommendations was to increase the parenting component in ANE. It was also found that their information needs differed depending on the stage of pregnancy. Additionally

her randomised controlled trial of Australian expectant mothers (J. Svensson, Barclay, & Cooke, 2009) compared an ANE programme that integrated parenting and problem solving activities into their standard ANE programme to test whether this strategy made for an easier adjustment to parenthood. Results showed expectant parents were interested in parenting and babycare information and those who attended the programme with more parenting content had increased postnatal parenting self-efficacy scores and many recommended the parenting content be increased even further. The researcher recommends a programme that straddles the ante and postnatal period to optimise learning and enable what has been learnt to be put into practice, although this proved to be logistically prohibitive to implement. In New Zealand there are community-based courses and groups, such as Plunket and Parents' Centre, that incorporate ANE with subsequent parenting education classes and support groups. The participants in the above mentioned research were predominantly partnered, educated women with a mean age of 30 years, meaning the findings are not generalisable to all women.

Antenatal Education in New Zealand

In New Zealand, attendance at an ANE programme is recommended from 26 weeks gestation (MAMA, 2011). There are many ANE providers in New Zealand with District Health Board (DHB) provider arms being the largest. Some other main providers include Parents' Centre, Plunket, Birthcare, SAMCL (Serious About Maternity care) and MAMA (Mothers and Midwives Associated).

Content of antenatal education programmes

Antenatal education providers decide on the content and structure of their classes, with the exception of the DHBs who have contractual obligations meaning they (or their contracted providers) may be audited to ensure their programmes meet the requirements. The specifications for ANE are outlined in the *National Service Specification for Pregnancy and Parenting Education* (Ministry of Health & DHBNZ, 2002) and include:

1. A minimum of 12 hours childbirth education is to be provided
2. Content must cover:
    - Access to maternity services

- Pregnancy care
- Labour and birth care
- Care following birth

3. Content must comply with the Baby Friendly Hospital Initiative and include:
    - the benefits of breastfeeding
    - the importance of exclusive breastfeeding
    - basic breastfeeding management
4. Childbirth educators preferably have a childbirth education qualification
5. Links exist with other services (for example Well Child Providers, Lead Maternity Carers and Family Start
6. Programmes are accessible, acceptable and effective
7. Classes do not exceed 12 pregnant women to enable group interaction

Breastfeeding information is a major component of ANE programmes. Adolescent mothers are more likely to have less knowledge and lower rates of breastfeeding than older mothers (Dewan, Wood, Maxwell, Cooper, & Brabin, 2002). Based on this, and evidence that breastfeeding initiation rates and breastfeeding duration can be improved by interactive antenatal breastfeeding education (NICE, 2008), programmes designed specifically for adolescents such as 'Starting Out' and the 'BEST Club' (Breastfeeding Educated and Supported Teen) have been developed as a strategy to increase breastfeeding initiation and duration in adolescent mothers. The successful increase in the rates of breastfeeding in adolescent mothers is attributed to increased knowledge and confidence, and a change in attitude toward breastfeeding (Greenwood & Littlejohn, 2002; Mossman, Heaman, Dennis, & Morris, 2008; Palda, Guise, & Wathen, 2004; Volpe & Bear, 2000). Other researchers also found breastfeeding education provided to adolescents affected breastfeeding beliefs and attitudes and recommend that such education is likely to have a positive impact on breastfeeding in areas where adolescent pregnancy is more common (Martens, 2001). This literature illustrates how breastfeeding educational programs targeted to adolescents, as a group, are considered

to be an effective way to increase the initiation and duration of breastfeeding in this population.

Antenatal education for adolescents

The literature on ANE was largely centred around educated, older and partnered expectant parents. Although there was a significant amount of literature found around adolescent parenting and the clinical antenatal care for adolescents, there was very little literature on ANE programmes that are provided specifically for adolescents. The lack of studies looking at the effectiveness of adolescent ANE programmes was also identified in Dwyer's (2009) report on *Antenatal Education and Transitions of Maternity Care in New Zealand*. Information on ANE for adolescents was usually embedded amongst research done around clinical antenatal care for pregnant adolescents. ANE is often incorporated into comprehensive programmes for pregnant adolescents, delivered by a specialist teenage pregnancy midwife and encompassing antenatal clinical care, parenting and other social services (Das, et al., 2007).

In addition to presenting later than older women for antenatal care and being less compliant with appointments, adolescents are much less likely to attend any form of ANE (Department of Health, 2008). In MacLeod and Weaver's (2003) study of 99 pregnant teenagers in North England they found that despite more than half the participants reporting a dissatisfaction with the information provided by their midwife, 83% did not attend antenatal classes. These findings are supported by other researchers who suggest that traditional ANE classes can fail to engage teenagers (Murphy Tighe, 2008; Tilghman & Lovette, 2008). Out of 26 mothers, 25 did not attend antenatal classes as they felt inhibited attending with older women and their partners (de Jonge, 2001). Other reasons were, however, also given for not attending (for example, embarrassment from attending any kind of group, mental health problems and time pressures) therefore, even if classes are specifically dedicated to adolescents other factors may inhibit attendance.

Programmes designed specifically for teenagers have been implemented in order to address the barriers to ANE. The United Kingdom's Teenage Pregnancy Strategy (TPS) was developed in 2000 as a holistic approach to teenage pregnancy and the resulting Sure Start Plus initiative aims to support pregnant teenagers and fathers. A review of 10 teenage pregnancy services in the UK found a common theme to be ANE

being incorporated into antenatal care for teenagers and delivered by a dedicated teenage pregnancy midwife. In particular, one centre's Teenage Pregnancy Midwife provided teenage centred ANE classes and both antenatal and postnatal support groups. Another centre runs antenatal classes adjacent to a postnatal support group for young parents and, by coinciding their breaks, allows the young expectant parents to meet young new parents. Additional aspects of these programmes included peer support, peer counseling, a buddy process, contraception, childcare, advice on housing and benefits and fathers only sessions (Department of Health, 2008; Nolan & Foster, 2005).

Covington et al. (1998) evaluated the American 'Baby Talk' adolescent prenatal education programme and, although there was a positive effect on the utilisation of antenatal clinical care, they were unable to show that the programme influenced health behaviours in pregnant adolescents. The retrospective design using historical comparisons means that selection and temporal biases may have influenced the results. At the time this research was undertaken, adolescent focused ANE classes available in Auckland included the Auckland Women's Centre in Grey Lynn, the Salvation Army Bethany Centre also in Grey Lynn and Te Waipuna Puawai in Glen Innes. Te Waipuna Puawai caters for young mothers-to-be only and Bethany Centre caters for pregnant women up to aged 35 years. Bethany's ANE classes are exclusively for the mother-to-be with one-to-one sessions held at another time for couples. However, in August 2011 it was announced that the Bethany Centre would be closing in November 2011, due to financial difficulties (Tapaleao, 2011). DHBs tend to provide classes specifically for young women on a needs basis, that is, if sufficient numbers of adolescents present for ANE then a separate programme will be run for that group.

Social support

Social support and being part of a social network is positively correlated to health and psychological wellbeing and has been shown to have a direct effect on preparation for motherhood (A. Gagnon & Sandall, 2007; Giurgescu, et al., 2006). In their study of teenagers' preferences around ante and postnatal services, Cox et al. (2005) reported that the teenagers would have liked the staff to facilitate relationships with other pregnant teenagers. Similarly, in an article on health promotion for pregnant adolescents, Montgomery (2003) highlights the importance of a support network where pregnant adolescents can exchange information and prepare for the new role of parenting. Klima

(2002) describes a group model of care for pregnant teenagers, 'Centering Pregnancy', and suggests that groups that combine older and teenaged parents-to-be can be beneficial as they provide the opportunity to develop mentoring relationships. Research conducted by Wiggens, Austerberry, Rosato, Sawtell and Oliver (2003) for the Sure Start Plus programme, which provides support for pregnant teenagers and teenage parents in the UK, highlighted issues around housing; benefits; education; health and relationships as the most important for young pregnant women and young mothers. In Dwyer's (2009) report for The Families Commission on ANE in New Zealand, she describes how social support, (which often extends into the postnatal period) rather than knowledge and skills, is one of the main benefits of antenatal classes and considers increased social support to be a worthwhile outcome of ANE classes. She also recommends classes are held for homogenous groups of women to facilitate friendships and social support. These findings demonstrate that the social networking and support gained from ANE classes with both adolescent and older women may be of benefit to pregnant adolescents.

Health and social service programmes for adolescents are constructed around the needs of the target population. Rains, Davies and McKinnon's (2004) comparative case study of three teen social service agencies found that each programme constructed the adolescent in a different way. Although the three programmes served a similar clientele of pregnant or mothering adolescents, they varied in how they interpreted the 'problem' of adolescent mothers. The authors demonstrated how the practices of the different agencies constructed the adolescents in different ways which determined the focus of their services and how their service was delivered. Pregnant and mothering adolescents were constructed as either mothers, problem teenagers/problem mothers, or potential social activists which showed how agencies and practitioners can be definers of problems and therefore possibly reproduce public conceptions of social problems.

Summary

A prevalent theme throughout the literature was the highlighting of the vulnerability to poorer outcomes that result from pregnancy during the adolescent years. Adolescent pregnancy is often portrayed from a deficit perspective where the increased social and obstetric risk results in disadvantage to both the mother and her baby. There is, however, also a significant amount of research which provides conflicting evidence of

this perceived disadvantage, or that the disadvantages are erroneously assumed to be related to pregnancy during the adolescent years rather than background familial and/or socio-economic factors. Adolescent pregnancy is often portrayed as problematic which reinforces the stigma and at risk position of adolescent pregnancy. This positioning has led to interventions which aim to address areas of deficit and risk. This study aims to explore and challenge whether intervention by way of a specific ANE programme for adolescents is beneficial. It also raises the question of whether, because of their perceived shortcomings, pregnant adolescents are subjected to extra scrutiny and surveillance that subjects them to being managed in a way that differs to other pregnant women.

The next chapter discusses the theoretical approach that has been used to inform this study and an explanation of the methodology used to undertake the data collection and analysis.

Chapter Three: Theoretical Approach and Methodology

Introduction

The purpose of this chapter is to explain the theoretical concepts which informed this study, the methodological approach taken and the methods that were used.

A qualitative methodology, positioned within a critical paradigm, and informed by the theory and concepts drawn from the work of Michel Foucault was chosen for this study. The chapter begins with explanation of the critical approach and postmodern perspective taken in relation to this research. A more detailed discussion follows around the theoretical concepts of power, the clinical 'gaze', surveillance, and governmentality which have provided the lens for the interpretation of the data. The chapter then describes the research methodology and methods before concluding with trustworthiness and reflexivity in qualitative research.

A critical approach

Although there is no one definition or unified and specific critical approach, critical approaches generally focus on how issues of power and oppression in society shape people's lives and aim to bring about socio-political change. A critical approach aims to problematise and encourage enlightened thinking around some of the commonly held assumptions in society (Denzin & Lincoln, 2005; Polit & Beck, 2008).

As demonstrated in the literature review in chapter two, the complexities of adolescent pregnancy are often interconnected. This means that when only one factor (such as age, socio-economic status or educational attainment) is focused on the interconnections between all these factors can be either disregarded or overlooked. Researchers can, therefore, produce different interpretations depending on what factor they focus on and how much emphasis they place on the different components (Denzin & Lincoln, 2005). This is evident in the outcomes from many of the quantitative studies reviewed in chapter two which highlighted pregnant adolescents' (and their children's) poor social, economic, educational, and medical outcomes. Mainstream research, therefore, has the potential to perpetuate social oppression as it continues to pathologise adolescent mothers and position them as a social problem. These scientific, social and historical discourses that position adolescent pregnancy as a social problem influence and reinforce the pregnant adolescent's view of themselves as the oppressed so they often

accept their positioning as "natural, necessary and inevitable" (Denzin & Lincoln, 2005, p. 304). Empirical studies often fail to take into account the thoughts and feelings of adolescent mothers (Wilson & Huntington, 2005) or provide an in-depth understanding of their experiences. A critical approach, therefore, enables some of the taken for granted assumptions around adolescent pregnancy to be questioned and provides a lens for other possible interpretations.

A postmodern perspective

In a modernist sense, the universal truth around adolescent pregnancy is true for all adolescents, in all places and in all times. A postmodern position not only attempts to argue against what is considered the one truth, but it challenges the idea of there being one truth. Rather than one truth, knowledge is considered to be full of "contradictions, unanswered questions and cultural prejudices" (Danaher, Schirato, & Webb, 2000, p. 2). The knowledge that prevails over other knowledge, and is therefore accepted as truth, is not necessarily the most valuable. Instead, it is usually just constructed by the most powerful groups (Danaher, et al., 2000). From a postmodern perspective, the knowledge and beliefs that exist around adolescent pregnancy are socially and culturally constructed and, as they are dependent on a certain place and time, are likely transient (Rolfe, 2000). Rather than capturing any one truth, this research takes one of the many positions that a reality can be viewed from (Rolfe, 2000).

Theoretical approach

This study is informed by concepts derived from the work of post-structuralist philosopher Michel Foucault (15 October 1926 – 25 June 1984). His notion of how existing practices and knowledge are not fixed but change over time and his concepts of power, the medical 'gaze', surveillance, and governmentality enable some of the assumptions around the care of pregnant adolescents to be challenged. Many of these assumptions are based on metanarratives that have been created by those in positions of power in healthcare. A metanarrative describes and legitimises a perspective which is accepted as truth as those in power decide what will, and what will not, count as knowledge (Rolfe, 2001).

As Foucault suggests, specific ideas have been chosen from his work and used as a conceptual toolbox :

> All my books... are little tool boxes …if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including those from which my books have emerged … so much the better (cited in Morris & Patton, 1979, p. 115).

A discussion follows on the concepts of power and resistance, the gaze, surveillance, and governmentality which have been used to inform this research and provide a lens for exploring the data.

Power

As opposed to the traditional concept of power as an authoritative and oppressive force that controls the actions and behaviours of others, Foucault's notion of power is related to its capacity to form knowledge and truths which, in turn, shapes the way people think, behave and see the world (Danaher, et al., 2000; Lupton, 1997). He considered power and knowledge to be intrinsically linked (thus often written as power/knowledge) in that power creates knowledge and knowledge induces the effects of power. This power/knowledge nexus is what produces and maintains dominance in healthcare as it constructs specific knowledge that is considered legitimate (Cheek & Porter, 1997; D. Holmes & Gastaldo, 2002). The production of this knowledge, and therefore truth, then creates modes of power which are able to define what is right and wrong, sick and healthy, normal and abnormal (Danaher, et al., 2000; Faubion, 2001; Petersen & Brunton, 1997).

As described in the literature review, adolescent pregnancy is often viewed through a scientific lens and consequently re-defined as a medical and social problem. Medical knowledge, therefore, has the power to shape the way that adolescent pregnancy is understood by health practitioners which, in turn, determines the way it is treated (Cheek & Porter, 1997). Medical knowledge and research shapes adolescent pregnancy so it is understood from the perspective of deficit and risk. Consequently, pregnant adolescents are subjugated by, and subjected to, surveillance and intervention from health practitioners.

Power is dispersed throughout society, flowing between different groups and changing under different circumstances and over time. As it is often disguised through social systems, it contributes to social control as it shapes the way people think and behave (Turner, 1997). Historically, social regulation was controlled by the law and religion with medical dominance later becoming incorporated. Since the 1960s, however, medical sociologists have attempted to challenge and undermine the power and influence of the medical profession in Western society (Lupton, 1997).

Rather than being something that is possessed and held by one individual over another, Foucault considered power to be productive as it produces effects on attitudes and brings about new forms of behaviour (Danaher, et al., 2000). The productive capacity of power is demonstrated when individuals take up the dominant discourses in health promotion and, as a result, modify their behaviour or take up new behaviours.

In addition to being productive, the power that operates in medicine is also a disciplinary power as it trains and enhances bodies through observation (surveillance of at risk populations), examination (the clinical gaze) and normalising judgement (the creation of norms and the use of rewards and punishments) (D. Holmes & Gastaldo, 2002). The clinical gaze and surveillance that pregnant adolescents are subjected to are discussed in more detail later in this chapter. The normalising judgment strategy compares and measures deviations against the established norm, thus encouraging and persuading people into certain ways of thinking and behaving that are considered appropriate for them (Lupton, 1997). As abnormality is in reference to the characteristics of the recognised norm, pregnant adolescents are compared against non-pregnant adolescents, and older pregnant women, and brought into a field of visibility. Paradoxically, the normalizing gaze that pregnant adolescents are subjected to always positions them as abnormal.

> ...if you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing.
> (Foucault, 1975, as cited in Roger-Pol Driot, 2004, p.95)

Disciplinary power is exercised through the everyday practices of health practitioners as it shapes conduct through teaching and instils forms of identities (Faubion, 2001). Health education is a subtle form of disciplinary power as is constructs what is considered by the experts to be an ideal state. Individuals are then encouraged to strive towards achieving this ideal state by choosing certain behaviours. From a Foucauldian perspective, power only acts over free people who have choices and where several ways of behaving are available to them.

> Power is exercised only over free subjects, and only insofar as they are free. By this we mean individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments, may be realized. Where the determining factors saturate the whole, there is no relationship of power; slavery is not a power relationship when man is in chains (Foucault, 1982, p. 790).

Resistance

Power is often silent and difficult to detect unless resistance is encountered. Power is fluid, flowing in multidirectional ways; it can operate from the top-down in the categorisation, normalising judgment, intervention, and surveillance of the pregnant adolescent; as well as the bottom-up as in the resistance of the pregnant adolescent to engage in healthcare strategies (Cheek & Porter, 1997; Lupton, 1997; Manias & Street, 2000). Because power not only produces but also works through and is created by resistance, resistance is endemic in power relations (Lupton, 1997; Petersen & Brunton, 1997). Like power, resistance is a complex network; it is a diffuse, dispersed, and multidimensional process where diverging points disrupt the flow of power (N. Armstrong & Murphy, 2011; D. Holmes & Gastaldo, 2002).

Resistance can be present at micro-levels as people resist strategies and practices by health workers that are designed to influence their behaviour (Lupton, 1997). This can be expressed in various ways such as avoidance, silence, non-attendance of appointments and withholding information in order to set limits around what they choose to disclose (Hughes, 1997; Lupton, 1997).

Pastoral power

Pastoral power is a benevolent power in that it refers to the care of others; where one person acts as a benevolent guide to others (D. Holmes & Gastaldo, 2002). Pastoral power arose in Christian societies circa the third century AD when Christian leaders took care of not only the entire community but also of each individual to ensure salvation in the next world. Over time the objective of pastoral power moved from leading people to salvation in the next world to ensuring health and wellbeing in this world (Foucault, 1982). Foucault's concept of pastoral power is one of the techniques that is employed to regulate bodies through governing practices of the individual body and populations (McNay, 1994). The training and regulation of bodies relies on the health practitioner's evaluation of an individual's knowledge and ability, an understanding of their thinking and an ability to direct it. It cannot be exercised without the health practitioner "knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets" (Foucault, 1982, p. 783). The knowledge that health practitioners gain about individuals becomes integrated into expert discourses such as the at risk and vulnerable status of pregnant adolescents. This knowledge also provides a foundation for categorising individuals, or groups, as normal or deviant and precedes the implementation of interventions (D. Holmes & Gastaldo, 2002).

The clinical gaze

A central theme of Foucault's work is his concept of the medical gaze, derived from the French ‘le regard’. During translation it loses some of its abstract connotations as it is not only an act of seeing, but also a perception (D. Armstrong, 1997). Foucault (1973) describes a philosophical transition from the Enlightenment (early to mid 18th century) through the modern period (19th and early 20th centuries) where methods of observation, specific disease categories and changes in medical discourse came into existence as medicine developed new ways of seeing. More recent movements have been attributed to changes in the gaze (D. Armstrong, 1997).

During this transition from a pre-modern to a modern system, people were made subjects of medical science (Rabinow, 1984; Rich, Simmons, Adams, & Thorp, 2008) or objectified. One form of objectification Foucault described is the method of 'dividing practices' where people are divided into categories and, as a result, given both a social

and personal identity (Danaher, et al., 2000, p. 60). Danaher et al. (2000) explain what Foucault called 'ascending individualism'; the more powerful one was the more differentiated, or individualised, they became. At the same time, the lower down the social scale one was, the more undifferentiated they were. For example, in Feudal societies peasants were viewed as an undifferentiated mob rather than as individuals. In modern western societies Foucault described 'descending individualism', where the further down the social scale you are the more individualised and therefore closely monitored you become. The more influential or powerful one is, the more one will avoid this scrutiny (Danaher, et al., 2000). The individual who deviates from the norms and values of society, such as a pregnant adolescent, is categorised as potentially problematic and consequently singled out, monitored, and subjected to scrutiny by health authorities and health care workers.

The combination of dividing practices and descending individualism illustrates how pregnant adolescents can be objectified and regulated through the authority of the gaze. Just as manipulating people into classified categories results in social exclusion (Rabinow, 1984), the practice of categorising pregnant adolescents may contribute to the social exclusion that is briefly discussed in chapter two.

The gaze sees, interprets and invokes the language that describes what is seen. By saying what one sees, one "integrates it spontaneously into knowledge" (Foucault, 1973, p. 114). The health practitioners' way of seeing and the language they use to integrate their perceptions into knowledge, gives the health practitioner the power to create truths: "this speaking eye would be the servant of things and the master of truth" (Foucault, 1973, p. 115). What was previously unseen and unknown, with no language to describe it, Foucault referred to as "below the threshold of the expressible" (Foucault, 1973, p. xii). The development of the gaze and a language to describe what was seen, changed the invisible into the visible. "A new alliance was forged between words and things, enabling one *to see* and *to say"* (Foucault, 1973, p. xii). As language is a human invention it not only conveys reality but, more importantly, it constructs knowledge and reality (Huntington & Gilmour, 2001; Rolfe, 2000). This language is also used to pass the knowledge onto other health practitioners: "those who know and have not yet seen" (Foucault, 1973, p. 115), which perpetuates the discourses around the problems of adolescent pregnancy.

The clinical gaze constructs pregnant adolescents as being at risk and, as a result, they become the focus of medicalisation. The gaze enables medicine to form one of the fundamental roles in constructing individual identity (D. Armstrong, 1997). Rather than being part of an age continuum, the naming of 'adolescent pregnancy' separates the younger out from other pregnant women, thus creating a separate identity. The power of medical knowledge categorises the pregnant adolescent and divides them from others which imposes a "law of truth" that they recognise in themselves and others in them (Foucault, 1982, p. 781).

The act of the gaze objectifies the person, eliminating or bracketing out the patient and their individual characteristics from the clinical picture, thus constituting them as a subject of knowledge. As patients are moved from being subjects to objects clinicians are able to look past the patient and see only the disease, allowing the disease to "stand(s) out against a background of objectivity" (Foucault, 1973, p. xiv). Consequently the individual's characteristics can become of little significance as they are erased from the picture. The classification of pregnant teenagers into objective categories eliminates the individual experiences that create their life-world (SmithBattle, 2009). When individual characteristics are only taken into account in order to be 'bracketed out', so as not to interfere with the recognition and classification of the disease, the essence of the person (individualities such as age, emotional, mental and social characteristics) is lost. The power of science has enabled clinicians to see through to the hidden truth and the underlying reality; by "abstract[ing] the patient" the essential truth is able to uncovered (Foucault, 1973, p. 8).

The gaze is not carried out solely at an individual level, it can also be a part of a system where it is a principle of surveillance and extends to a surveillance throughout society. People living in slum areas of Great Britain in the 19th century were subjected to the moral gaze of the authorities as surveys looked at the attitudes, behaviours, alcohol and crime of the lower class people and instituted mechanisms to address the problems that were seen as moral threats to society (Danaher, et al., 2000). At an individual level, patients are subjected to an institutionally validated gaze where they are questioned, monitored, observed and evaluated with regard their bodies, behaviours and attitudes (Danaher, et al., 2000). At a societal level, this ever-present gaze is extended and becomes a mechanism for monitoring and controlling public health. "The clinical gaze

is omnipresent and acceptable because its objective is to promote health - as well as to promote a disciplinary society" (Gastaldo, 1997, p. 116).

In the 1970s, when early childbearing moved from a moral issue to a scientific problem (Arney & Bergen, 1984), pregnant teenagers became the object of the scientific-clinical gaze; they have since been identified, monitored, researched and managed by health practitioners who are guided by their normalising ideals. A stigmatising gaze, perpetuated by media reports, medical discourses and policies, portrays and emphasises how adolescent mothers fail to measure up to society's norms as numerous studies focus on and report negative outcomes, consequently portraying them as vulnerable to failure. Not only do pregnant adolescents become objects of scrutiny through the clinical gaze, they then also become the object of self-monitoring and self-scrutiny (Wheatley, 2005). A pregnant adolescent's identity is undermined when the focus is on her "risks and deficits" (SmithBattle, 2009, p. 195).

Surveillance

Foucault's panopticon concept is derived from Jeremy Bentham's central tower that was placed in some prisons in the late 18th century. The panopticon was a method used for controlling behaviour as prisoners never knew when they were being observed and therefore adjusted their behaviour accordingly (McNay, 1994). Foucault uses this analogy when discussing how surveillance is a way of managing and disciplining people throughout many areas of society by appealing to their aversion to being considered abnormal. Otherwise interpreted as an authoritative gaze, it operates as a principle of surveillance with the targets of the authority's gaze then internalising the panoptic gaze and becoming the subject of their own gaze. By monitoring their own behaviours in the form of self-surveillance they are rendered 'docile' bodies.

> ...there is a form of surveillance which requires very little in the way of expenditures...Just an observing gaze that each individual feels weighing on him, and ends up internalising to the point that he is his own overseer; everyone in this way exercises surveillance over and against himself. An ingenious formula: a continuous form of power at practically no cost! (Foucault, 1989, p. 233).

This principle of surveillance has been extended to what has been described as surveillance medicine of healthy populations in the name of public health (D. Armstrong, 1995). In *The Birth of the Clinic*, Foucault describes the changes in medical knowledge that appeared over historical periods as the new spacialisation of illness; "primary, secondary and tertiary" (Foucault, 1973, pp. 15-16). Armstrong (1995) explains how, in the early 18th century, illness was a two-dimensional model where the symptom was the illness (primary spacialisation). In the 19th century this was replaced by a three dimensional model; secondary spacialisation, where the illness was in relation to the patient's body. Tertiary spacialisation refers to the illness from the perspective of "health care activity" (D. Armstrong, 1995, p. 395). He proposes that the turn of the 20th century saw a progression to a new spacialisation of illness; that of surveillance medicine which moves outside the three dimensional model of the body to a four dimensional or "extracorporal space" (D. Armstrong, 1995, p. 395). Surveillance medicine targets everyone as it merges the healthy and the sick into its field of visibility. By problematising the normal and determining risk factors, a new space is opened - the possibility or potential for illness (D. Armstrong, 1995). Pregnant adolescents (as a group) are targeted by this concept, as age alone is considered to be a risk factor that places them and their babies in a perpetual at-risk state.

With the paradigm shift of the 20th century came the development of health education programmes which aimed to empower people to control their own health. Health education is clearly beneficial as the information provided enables people to make informed choices and therefore exercise autonomy. However, health education also provides the site for the deployment of surveillance medicine. Health education programmes contribute to the management and control of individuals and populations through subtle strategies that are used to promote self-discipline and the imposition of truths, which hampers choice and the self-governing of health (Gastaldo, 1997; Grace, 1991).

In relation to Foucault's theory, health education is "both empowerment and subjugation" (as cited in Gastaldo, 1997, p. 130) as it both liberates and disciplines at the same time. Empowerment can be considered to be a term that is used so as not to be perceived as being oppressive when, in reality, it can be a coercive strategy used to induce compliance as health care practitioners consider their clients empowered only if

they make the correct choices as defined by the empowerer (Powers, 2003). Individuals opting for unhealthy behaviours after health education is interpreted by health practitioners as irrational, irresponsible and a failure (Gastaldo, 1997; Hughes, 1997).

Governmentality

Governmentality, or the art of government, is about how to govern and refers to the strategies, techniques, and programmes within human science disciplines that aim to shape the beliefs and conduct of the population (Murphy, 2003; Nettleton, 1997). These activities operate through institutions such as hospitals and health education programmes and are directed towards making the population more productive by optimising health and wellbeing (McKee, 2009).

Bio-power

Bio-power or "power over life", is a strategy of governmentality as it refers to the way practices of individual and populations are governed and regulated (Gastaldo, 1997, p. 114; Perron, Fluet, & Holmes, 2005). Governmentality is manifested in special programmes, such as those for pregnant adolescents, and enabled by the techniques and strategies of bio-power. Bio-power is a subtle form of power that aims to produce "a body [that] is docile that it may be subjected, used, transformed and improved." (Foucault, 1977, p. 136). Health education can be considered to be a mechanism employed by bio-power for the management and control of populations and individuals as it uses subtle strategies that invoke self-surveillance and self-discipline to achieve healthy behaviours. The final outcome is the production of docile and useful bodies (Gastaldo, 1997; Grace, 1991). Foucault considered bio-power to have two dimensions: bio-politics, the regulation of entire populations; and anatamo-politics, the regulation of individuals (Lupton, 1995)

Bio-politics

Bio-politics refers to the management and control of entire populations. Health practitioners act as agents, or instruments, of bio-political power as they contribute to the regulation, transformation and improvement of bodies by using an assortment of technologies including engaging in health education (Gastaldo, 1997). The promotion and endorsement of breastfeeding as the superior infant feeding option to achieve good health is an example of bio-political intervention with health practitioners positioned between the state and the individual (Perron, et al., 2005).

Anatomo-politics

Anatomo-politics is the dimension of bio-power that involves the management and control of individuals. Anatomo-politics aims to produce docile, useful bodies by determining what is good or bad, normal or abnormal. By defining and encouraging good or normal behaviours, an individual's body and aspects of their life can be trained and corrected (Foucault, 1977). This can be achieved through health education as health practitioners build up a representation of what is normal or abnormal and the desired way to conduct oneself. Subtle and constant coercion, using a complex system of rewards or gratification, fear and punishments, are used to reinforce these roles resulting in self-discipline (Foucault, 1977; M. Gagnon, Jacob, & Holmes, 2010). These techniques enable health practitioners to control the actions and attitudes of individuals. The power that is gained of the active body results in a hold over others' bodies "not only so that they may do what one wishes, but so that they may operate as one wishes" (Foucault, 1977, p. 138).

The methods used to manage and transform individual bodies, which Foucault called 'disciplines', induces a relation of docility-utility, in that an obedient body is produced that is ready for usefulness (Foucault, 1977). Foucault describes how, to achieve docility-utility, disciplines require *enclosure* or *partitioning*; where a specific space separates one group from another as in the great confinement of vagabonds and paupers and, later, within hospitals. In order to treat and control, there must be a "filter, a mechanism that pins down and partitions" (Foucault, 1977, p. 144). Pregnant adolescents are filtered out from older pregnant women into a separate space where "each individual has his (sic) own place; and each place its individual" (Foucault, 1977, p. 143).

Research methodology

A qualitative methodology was chosen for this study as it allowed for the exploration of perceptions and would take an interpretive, naturalistic approach to a study of the ANE needs of pregnant adolescents in a natural setting (Denzin & Lincoln, 2005). Rather than attempting to produce generalisable knowledge or objective truths from quantifiable data, this qualitative design emphasises the socially constructed nature of a phenomenon and situates the research question among these social constructs. This approach seeks to uncover socially and historically comprised power structures,

discover how social experience is created and the meaning given, and embeds the findings within the context of the social world (Denzin & Lincoln, 2005). The interpretation of data was subsequently informed by the Foucauldian concepts previously described in this chapter.

Research methods

Ethical considerations

Ethical review and approval was obtained from the Massey University Human Ethics Committee: Northern, prior to commencement of the first ANE programme of the year (Appendix A). Written permission from the programme provider to attend the programme and undertake the research was one of the requirements for ethical approval. The key ethical considerations at the time of planning the study were the age of the participants, confidentiality and prevention of harm.

Participants

The most important ethical consideration was that the research involved people under the age of 16 years where parental consent was not sought. People under the age of 16 years can give consent if they are considered by the researcher to be competent to understand the nature, risks and consequences of the research (Ministry of Health, 2009). Should there have been a concern around any potential participant's competence to give consent, consent would be sought from the parent or legal guardian with the participant giving their assent (Appendix D). At the time of applying for ethical approval, it was thought that the young age of the potential participants could mean they had limited experience in making independent choices and this may have increased their vulnerability to involuntary participation. Vulnerable young people may be more susceptible to acquiescence to authority. Many years experience in nursing children and adolescents gave me the confidence to detect any sign of reservations. Participants were reassured about the voluntary nature of participation and that they could withdraw at any time without affecting their care or their relationship with the programme staff.

Confidentiality

To protect their identity, the participants were offered the opportunity to choose a pseudonym. Initially none of them chose to do so, instead asking for their real names to be used. Once the suggestion of using their initials was made, they chose to do this. All

participants were reminded of the confidential nature of the research although, as confidentiality is not absolute, I advised them that this was unless disclosure was necessary to avoid grave harm to themselves or others.

Privacy

The participants' privacy was preserved by keeping all the raw data and signed consent forms in a locked filing cabinet in my home. The interviews were transcribed personally and the digital recordings were deleted at the end of the study. As required by Massey University, the consent forms and interview transcripts will be archived in the Massey University School of Health and Social Services for a minimum of five years before being destroyed by Massey University.

Cultural and social responsibility

During the interviews, participants may have disclosed that they were engaging in health compromising, illegal or harmful behaviours, or were living in abusive circumstances. This was considered to be an important consideration due to their young age. Should I have become aware that any of the participants were at risk of harm to themselves or others, the programme manager was to be informed.

Prevention of harm

A framework needed to be in place for managing anticipated and unanticipated consequences of participating in the research that could potentially lead to harm to the participant (Holloway & Wheeler, 2002; Patton, 2002). Participants were informed that, should the interviews become distressing, the interview would be terminated. Both initial and ongoing consultation was undertaken with the programme staff and manager and it was established that any concerns would be taken to the programme manager. The Centre's specialist social workers, together with the close links they had with Child Youth and Family, meant emergencies would be dealt with in a timely manner.

Participants

A purposive sampling method was used for this research. Although the adolescents who attended the programme may not have been typical of the population of pregnant adolescents, they would best supply the information required to explore the participants' experience of this ANE programme (Polit & Beck, 2008).

The Centre staff introduced me to the programme participants thus bridging the gap between researcher and participants, which facilitated recruitment. As a qualitative sample does not attempt to be statistically representative or generalisable, I invited the participants of two consecutive ANE programmes and two health practitioners to participate (Liamputtong, 2009).

Group one:

I attended the entire first ANE programme in order to understand the programme and to gain trust, and establish a rapport, with the course participants. Six pregnant adolescents aged between 17 and 22 years attended the classes with three having their male partners with them. Four female and three male course participants agreed to be interviewed. Although the two who declined to participate were not asked for reasons, one stated that she was too busy and the other felt she had nothing further to say after taking part in feedback opportunities during the course. This first group were interviewed within six weeks of completing the programme and then a second interview was held between four and six weeks after their baby was born.

I was cognisant of not wanting to appear to be employed by or contracted to the ANE provider, therefore, I chose to sit amongst the participants rather than with the programme staff. If I was considered to be part of the staff, I thought this may hinder some participants' honest sharing of their opinions and thoughts. Over the course of the programme this allowed a trust to be established which is essential for a successful interview (Denzin & Lincoln, 2005). Taking part in the first day introductions, I explained the purpose of my attendance and also reciprocated by sharing who I was as a person. Over a shared lunch I had the opportunity to expand further on the purpose of my study and answer any questions raised. At the end of the first day the course participants and health practitioners were given the written participant information sheet (Appendix B) and consent form to take home (Appendix C). I advised them that they could take as long as they needed over the next four weeks to decide if they would like to participate as the interviews would take place a few weeks after the course finished. I set up a hotmail address so I could be contacted by e-mail at an address that was neither a work e-mail nor one shared by anyone else.

Group two:

Interviewing a second group of programme participants enabled me to gather data from participants prior to as well as after attending the ANE programme. In order to interview a group prior to starting the ANE programme, I attended a baby safety class that was held a few weeks before the second ANE programme started. Attending the baby safety class gave me the opportunity to meet some of the upcoming programme's participants and, during breaks, talk about the purpose of my study and what it would involve if they chose to participate. I provided those who were interested with the written information sheet and arranged to follow-up with them via text or a phone call. Of the five females and two males who attended the baby safety class, four females and one male agreed to be interviewed. This second group were interviewed before the programme started and then again within four weeks of completing it.

Arranging the interviews required a balance of perseverance and prudence to overcome challenges, particularly with communication. All communication to arrange the interview dates and times was via text messaging, sometimes over a reasonably lengthy period of time. It was not uncommon to send a text and not receive a reply for up to 10 days once participants had credit on their phone again. One participant had her own Sim card however, as she shared a phone with a friend, she was unable to send or receive texts for a week at a time.

Of the two health practitioners invited, one declined to participate as her contract finished with the centre at the completion of the first programme. In total, one health practitioner, nine female and four male adolescents agreed to be interviewed for this research.

Data collection

Data was collected primarily through individual semi-structured interviews. One female participant and her male partner, from group two, chose to be interviewed together. The other three male participants, from group one, were interviewed as a group; this is explained on page 56. The interview questions were developed based on the goals of the programme and structured around gaining information in relation to those goals. A semi-structured interview guide was used as a reminder of the topics to be covered during the interview (Appendix E). This ensured that the goals identified in the programme were covered while also allowing for free-flowing conversation.

Interviews were held at a time and place that suited the participants and lasted between 40 and 120 minutes. All participants chose to be interviewed on a week day, with the health practitioner and one adolescent participant choosing to meet me at the ANE premises and the others choosing their own homes. After numerous failed attempts to meet but still expressing a keenness to complete her second interview, one participant discussed her experience of the course by e-mail. Refreshments were provided for the face to face interviews and a $20.00 gift voucher was given or posted to show my appreciation for their time and contribution. With the permission of the participants, face to face interviews were digitally recorded for accuracy and later transcribed. Recording and transcribing the interviews enabled me to concentrate on what the participant was saying rather than on note-taking (Patton, 2002). Prior to a participant's second interview I re-read their transcript from our previous interview and noted any points I wanted to re-visit or expand.

The interviews began with a review of the purpose of the interview prior to all participants signing the consent form. Throughout the interviews I made sure that I used the same terminology that was used during the course to avoid confusion or ambiguity (Denzin & Lincoln, 2005). A laddering technique, where I started with an informal conversation and general questions before gradually moving to more specific or personal questions, avoided intrusion as I could gauge their comfort level as I went (Price, 2002). Probing questions and prompts were used to produce more in-depth data by allowing clarification, elaboration and completion of information (Patton, 2002).

Wishing to avoid the interviewer effect when interviewing the young men, a young male interviewer conducted the interviews with the three young men from group one. This decision was based on my judgment that the young men would likely feel more comfortable, and therefore talk more freely, with another young male. For reasons unknown, an independent decision was made by the interviewer to conduct the interviews in a group and in a public place. Unfortunately the interviews didn't generate data that was usable for data analysis.

Transcription

After the interviews I immediately listened to the recorded interview to get an overall feel for what was said, and later I transcribed them verbatim. The process of listening to and transcribing the interviews enabled me to become very familiar with the data.

Including all the laughter, fillers, and grammar in my transcriptions helped me to re-call the context in which something was said.

Neither the transcripts nor the interpretations of the data were returned to the participants for member-checking. Member checking is considered to authenticate data by taking transcripts and interpretations back to the participants to verify their accuracy (Carlson, 2010). However, returning transcripts and interpretations to participants has been questioned as a method of ensuring validity and may in fact invalidate the researcher's work. Member checks can keep the analysis too close to the data as, in an attempt to deal with any concerns raised by individual participants, the researcher risks confining their results to a descriptive level (J. Green & Thorogood, 2009; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Member checking of transcripts can also pose both ethical and practical problems. While it is acknowledged that the transcripts are owned by the research participant, it can be disquieting, embarrassing or even offensive for participants to be presented with a written account of false starts, pauses, and transcribed laughter as it may appear to portray them as incoherent or inarticulate (Dearnley, 2005; Forbat & Henderson, 2005; Kvale, 1996). Returning the transcripts would have posed an additional problem whereby the participants would have either started the course or had their baby since the interview, which would have influenced their perceptions. With the participants' views expected to have changed over time, inviting them to review and amend the transcripts may have left the original words that were spoken as less true and meaningful than when they were first spoken (Koch & Harrington, 1998). The interviews were transcribed verbatim which was considered to assure verbal accuracy.

Data analysis

Thematic analysis was the qualitative analytic method chosen for this study as it is designed to provide a rich, detailed account of data from the methodical identifying, analysing and reporting of themes (Braun & Clarke, 2006; Burnard, 1991). Virginia Braun's (2006) steps were used as a framework for the thematic analysis. After verbatim transcription of the interviews the transcripts were read and re-read to search for meanings and patterns. Notes were written in the margins of the transcripts which were then collated into topic groups. Contradictory data was also included into the relevant topic group and miscellaneous topics were kept to one side. A list of topic

groups was then formulated with a reference to the relevant extracts listed under each title. The topics were then formulated into potential themes. Continuous re-reading of the theory underpinning this research was undertaken during this process so the data was being read through a Foucauldian lens. At this stage some of the previously labeled miscellaneous topics were moved into a theme. As many of the themes overlapped, a mind map was created to sort how the themes related to each other which resulted in two overarching themes being formed. The first theme related to the way in which both the ANE provider and the participants positioned pregnant adolescents as different from, and consequently not belonging with, other pregnant women which resulted in extra surveillance and intervention. The second theme was how the health education they received built up a representation and shaped their expectations for a birth experience and feeding choice.

Trustworthiness

Trustworthiness refers to the merit of a qualitative study. Lincoln and Guba (as cited in Morse, et al., 2002) defined the criteria of credibility, dependability, confirmability, transferability, and authenticity to achieve trustworthiness in qualitative research. These criteria are considered the parallels to validity and reliability in the quantitative paradigm (Polit & Beck, 2008).

Credibility can be established through the prolonged engagement with the study participants and persistent observation of the situation or phenomenon being studied (Polit & Beck, 2008). In this study, these techniques were incorporated by attending the entire ANE programme with the first group of participants which enabled me to gain an in-depth understanding of the programme and develop a rapport with potential participants. The baby safety class was attended with the second group of participants which enable a rapport to be developed prior to the first interview.

Dependability and confirmability refer to the reliability and accuracy of the data and that it represents the information that was provided by the participants. These criteria have been achieved by providing excerpts of the interviews in the results chapters to back up the findings. All the raw data, in both electronic and hard copies, has been kept which enables it to be reviewed by an independent person if required. My thesis supervisor's review of the developing analysis ensured that the analysis was not going beyond the data.

Transferability refers to how, and to what extent, the findings of the research can be applied to other settings. The way in which universal claims are problematised in a critical approach neither attempts nor allows the findings to be generalised to populations outside where the research is situated (Denzin & Lincoln, 2005). By providing descriptions of the context in which this research was undertaken enables the reader to decide if the findings may be transferable to other settings, groups and individuals (Polit & Beck, 2008).

Authenticity refers to the way a range of realities are presented and is important in a constructivist paradigm (Morse, et al., 2002). It is acknowledged that multiple realities exist and an attempt has been made in this research to convey other possible interpretations of the data.

Reflexivity

Reflexivity is an essential component throughout the qualitative research process as the researcher's position and personal beliefs inevitably influence the collection and interpretation of the data (Finlay, 2002; Liamputtong, 2009). Reflexivity is a tool to acknowledge and analyse how these influences shape the research results (Finlay, 2002). The postmodern perspective that has been used for this research means that, rather than attempting to uncover hard facts or truths, it is recognised that multiple perspectives and understandings of realities exist; hence this research presents only one of many possible positions that can be taken regarding ANE for pregnant adolescents (Cheek, 2000).

Although the interviews were undertaken with no *a priori* knowledge of the Foucauldian concepts that were subsequently used to interpret the data, it is acknowledged that my personal and professional perspectives will have impacted, in some way, on the entire research process. Although an attempt was made to position myself as a researcher rather than a nurse, a nurse-participant relationship was inevitably present to some degree. The participants may have positioned me more as a nurse, and therefore a source of knowledge, than as a researcher. As discussed in the limitations section of chapter seven, some of the participants asked questions during the interviews. Although every attempt was made not to influence their answers, the information I shared with them came from my own professional and personal

experiences, knowledge, and beliefs and so may have influenced the direction that the interviews took.

As different researchers would have had different relationships with the same participants, and asked different questions, they would have most likely obtained different responses (Finlay, 2002). My nursing background would have shaped and directed the types of questions that were asked of the participants whereas researchers from other disciplines may have had a different relationship with the area under study, and therefore a different focus for their questions.

Summary

This chapter has presented the key theoretical concepts used to inform this study and the research methodology and methods undertaken for the participant recruitment, data collection and data analysis.

A qualitative methodology, within a critical paradigm, and informed by the theoretical concepts of power, the clinical gaze, surveillance, and governmentality enable adolescent ANE programmes to be viewed from the perspective of surveillance medicine as pregnant adolescents are subjected to the scrutiny of a clinical gaze. The concept of governmentality allows for the interpretation of health education programmes as a form of bio-power that enables the management and transformation of a population.

The results of the data analysis are presented in the following two chapters.

Chapter Four: Bio-politics "the earlier the better...more important to get in earlier."

Introduction

The next two chapters present the results from the interviews that were undertaken to explore ANE for pregnant adolescents. The Foucauldian concepts discussed in the previous chapter have been used as a lens to explore the data using the key concepts of power, the medical 'gaze', surveillance, and governmentality. The utilisation of Foucault's concepts has provided an alternative reading of the data. The first of the two key areas, presented in this chapter, is bio-politics; where mechanisms are employed to manage the population of pregnant adolescents. Data is also presented here that questions whether there is a need for extra surveillance and intervention. The second key area, which will be presented in chapter five, is anatamo-politics and examines how health education is a mechanism of bio-power to discipline the individual body.

When quoting excerpts from the interviews, each participant's initials are used and the initials HP represent the health practitioner. Three ellipsis points ... have been inserted where words have been deleted from a text in order to make for easier reading. Square brackets [ ] have been used around words that have been either added for clarity or substituted for reasons of anonymity.

The bio-political management of a population

Since the eighteenth century the government has been concerned with the population and its health and well-being. Governmentality, or the art of government, refers to the efficient management of a population and the ways in which aspects of individuals lives are administered to ensure this (Nettleton, 1997). This concept has been used to interpret how pregnant adolescents are managed by firstly defining them as a population group, dividing them from other pregnant women and creating a space where an ANE programme is established, which enables surveillance.

Dividing practices

Foucault (1977) described *dividing practices* as a method of objectification where people are divided into categories or classified groups. In the current research, the separation of pregnant adolescents from older pregnant women was considered in the programme philosophy to be necessary and beneficial in order to meet the adolescent's

unique needs and provide a sense of acceptance which, as the HP explains, may not otherwise be a common experience.

> *They feel totally out of place anyway. Not many people say congratulations – it's 'oh dear'. I make a point on the phone when they ring up to say congratulations by the way, and make them feel from the very beginning that it's ok.* HP

The HP describes how, given sufficient resources, adolescents would then be further separated out from the older adolescents into a separate programme as they are considered to be 'different' from older adolescents.

> *There's a difference when you get the younger ones like 15/16 to 18/19; massively different. With funding we would, absolutely would [run separate programmes]. If you had the time and funding to run two lots of antenatal we absolutely would.* HP

Although it is aimed to better serve the needs of the different adolescent age groups, this model serves as an illustration of Foucault's dividing practices which imposes a personal and social identity. Adolescents are not only divided from other pregnant women, but with adequate funding they would then be sub-divided into age-classified groups, imposing an additional personal and social identity (Foucault, 1977).

Creating a space

The efficient management and discipline of pregnant adolescents is enhanced by the creation of a dedicated space. The physical place the adolescents come to serves as the *enclosure* that Foucault describes as a means of partitioning one group from another in order to treat and control (Foucault, 1977). McNay (1994) describes Foucault's concept of functional sites as being a space heterogeneous to other spaces which allows for the homogenisation of people and activities to ensure order and facilitate surveillance. In the following excerpt the HP describes how the programme provides a separate place for the adolescent to come and be among other pregnant adolescents.

> *The goals for me, at the very least I want them to have had a place they can come to for four or five weeks, feel accepted and get to know other young parents - and just feel maybe a sense of relief over others being in the same*

> *boat as them and develop a sense of connection with other young parents and stay in touch with them and decrease social isolation … And also this is where we run the young mum's support group so they know the venue and when we get our [new] venue the whole teen parent project will move to it - our whole team and all the stuff we do.* HP

The sense of relief that the HP hopes the adolescents will experience suggests there is an assumption that the adolescents will have negative feelings about being pregnant.

In the previous excerpt, the HP explains how the programme operates from a general community venue with plans in place to move to a teenage specific venue. The current venue partitions pregnant adolescents into a functional site according to their common characteristic of age. In doing so it provides a space for monitoring and surveillance (Perron, et al., 2005). The new teenage specific venue will encompass young mothers as well as pregnant adolescents into a space heterogeneous to others. The aim is that the connection with other young parents will decrease social isolation however, as highlighted in the previous chapter, the practice of manipulating people into classified groups can result in social exclusion (Rabinow & Rose, 2003).

Governmentality

In order to efficiently manage a population, knowledge about the population is gathered and analysed, with programmes and policies then being designed and instituted based on this data (Nettleton, 1997). The practice of dividing pregnant adolescents into a functional site enables a dedicated health education programme to be instituted.

The 'big tick list'

The following excerpt from the HPs interview reinforces Nettleton's (1997), McNay's (1994) and Gastaldo's (1997) position that health education programmes are a strategy of governmentality as the Ministry of Health contracts childbirth educators to deliver particular childbirth education.

> *They [The Ministry of Health] have got a big tick list so we have to cover that. The childbirth educator has got certain things they've got to cover in terms of their contract like the actual child birth interventions and breastfeeding, SIDS, all those things.* HP

Included in the contractual obligations covering the content of the ANE delivered is the topic of breastfeeding, which is underpinned by *The Baby Friendly Hospital Initiative* (BFHI). The BFHI is a joint World Health Organisation (WHO) and UNICEF[3] project seeking to increase the rates of exclusive breastfeeding for the first six months and was introduced in New Zealand in August 2000. Contracted maternity service providers in New Zealand are required to work towards becoming BFHI accredited and the content of ANE programmes must comply with the BFHI (Dwyer, 2009). This is an illustration of governmentality with health practitioners acting as a tool of governmentality as they are a point of contact between the BFHI policy and the population (Gastaldo, 1997). An example of this is portrayed in the excerpt below when the HP describes how she wants the adolescents to breastfeed and continue to breastfeed which is in keeping with WHO's claim that "the vast majority of mothers can and should breastfeed" (WHO, 2003, p. 10).

> *I'd want them to be breastfeeding and want to continue and have a generally positive experience ... we don't want them to be giving up.* HP

The reasons for the HP not wanting the adolescents to give up breastfeeding were not ascertained in the interview. However, the HP's aim is consistent with the BFHI and Ministry of Health targets to increase the initiation and continuation of breastfeeding. The following statement from WHO, which places babies who are not breastfed as at risk group, may perhaps also contribute to the motivation of health practitioners to encourage breastfeeding.

> Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system as they constitute an at-risk group *(WHO, 2003, p. 10)*

Through the *National Service Specification for Pregnancy and Parenting Education*, the BFHI determines the information educators and health providers can deliver around formula feeding (Dwyer, 2009). Health educators are employed as agents of the state to deliver prescriptive information around breastfeeding in a manner that is aimed to increase the breastfeeding rates of the population. One of the techniques of this bio-

[3] UNICEF is the acronym for *The United Nations International Children's Emergency Fund* . It is part of the United Nations Development Group and provides long-term assistance to children and mothers in developing countries.

political power is the withholding of information on formula feeding which is outlined in the above-mentioned *National Service Specification for Pregnancy and Parenting Education* (Dwyer, 2009). One of the adolescent participants describes how she sees this strategy as one where health practitioners are controlled by law.

> *They're legally restricted and it's ridiculous cos there are many out there who bottle-feed cos they were trying to breastfeed and their milk supply wasn't enough and their kid was starving and they feel like crap cos there's nothing out there that explains it to them and the doctors aren't allowed to talk to them about it and that's really stupid. But I don't know if you're allowed to do that in antenatal and stuff.* CK

CK's further comments are noteworthy here as they are relevant to Dwyer's (2009) reporting of a common theme in her research being the frustration women experienced at the lack of information on formula feeding provided to them in antenatal programmes. CK explains her experience of the ramifications of this restriction on formula feeding information.

> *I've seen it. I know alot of people cos you don't have much on formula feeding, like when [friend] had her kid she'd make the bottle up in the bedroom with cold water from the taps. No one told her you can't give a newborn that water, that's dangerous. So she'd just have a big bottle of water in the bedroom. She'd have all the things there but wouldn't use hot water and if they used hot water they'd just get it from the tap. He was only four months old when she was doing that. She wouldn't actually use hot water and if she did she's just get it from the tap. Because they're all like you should breast feed and that's the only thing that you can do and if you're not going to breastfeed then we're not talking to you about it. Or when you want to bottle feed you don't feel comfortable enough saying, hey I want to bottle-feed cos everyone's gonna just: 'well why can't you breastfeed'.* CK

Repeat pregnancies

The prevention of repeat pregnancies is considered to be a positive outcome for young mothers who have their first child during their adolescent years (Mackay, 2003).

Although no Ministry of Health or similar policies were able to be found, it is anecdotally accepted that health practitioners should aim to prevent repeat pregnancies in adolescents. In line with this aim to reduce subsequent pregnancies, the HP explains how a free long-acting contraceptive implant is something that is hoped for in the future.

> *In the UK when the implant came out [they] were really pushing that as it's a long term thing. Of course we haven't got that here that's free, so hopefully it will be in the future ... We're having FPC in for a couple of hours so they cover the relationship stuff and contraception.* HP

In the excerpt below, the HP demonstrates her belief that some adolescents wish to group their pregnancies for the same reasons any parent might wish to. One of the benefits of a mother grouping her children together is that it allows a young mother some freedom in the future while they are still themselves relatively young (Kirkman, et al., 2001).

> *From my last job as teenage pregnancy advisor five out of the six of them have had another child already so it's very very common and you can totally understand why, and just like any other parent in terms of grouping your children together so you can move on with your life. So it's an actual choice. Rather than having another kid in 10 years time I want to have one or two now and then I've got my family and then I can move on and go back to school and do all that later.* HP

This quote suggests that health practitioners, like any individual, do not always assent to bio-political strategies. It highlights that, because power is multi-directional and resistance is always present where there is power, the HP is in a position where she can either uphold or resist efforts to reduce subsequent pregnancies in adolescents.

Governing at a distance

Almost 80% of mothers aged 19 years and under receive the Domestic Purposes Benefit meaning most young mothers are economically dependent on Work and Income New Zealand[4] (WINZ) (Ministry of Social Development, 2010). The participants in this

[4] Work and Income New Zealand is a service of the Ministry of Social Development and provide financial assistance and benefits to people who are unable to support themselves.

study recognised themselves as economically disadvantaged, needing input and assistance from WINZ. Despite this, there was considerable distrust of WINZ that was reflected in the attitudes toward the WINZ representative who came to discuss benefit entitlements with the course participants. There was a suspicion with many of the participants that WINZ withheld information from them, or provided them with false information as to their entitlements. The following excerpts provide examples from two of the interviews where the WINZ representative was perceived to be obstructive by either withholding or giving misinformation.

> *The Work and Income lady who turned up to give us a talk, she talked a load of bollocks. Lied through her teeth ... She was telling us how helpful she was and how much they offer [but they] done everything they can not to help us with.* MK

> *She was just yapping on and on the whole time ... Everyone reckoned she was talking a load of rubbish. She was saying something about the benefit like how much money you get. Even [the childbirth educator] was like, oh she's all rubbish like she's a waste of time. It's better to go in yourself and ask your own questions.* AM

EM described how the WINZ representative portrayed WINZ to be a helpful service however her reality was that they had been deliberately obstructive when she had sought assistance from them.

> *She pretty much said like we can help with this and help with that but it's pretty much things we've already asked about that they haven't been helpful with and they haven't wanted to help.* EM

The degree of assistance provided appeared to be dependent on the individual case worker encountered. The individual case workers were seen to have the power to decide and control how much of the entitlements they disclose and therefore allow them to have access to.

> *They will do everything they can to give you as little money as possible and they make everything difficult like even going in to change our address was just – she was just making everything difficult. And we were like what? And*

> *then um there's other people you can get like up at the [local] office there's a few really nice ladies that are helpful and tried to give us the max they could give us. They were like, ok, we can see you are like struggling.* EM

AM also did not trust WINZ as an institution to tell her the truth as they were *" just trying to scare you,*" but when discussing her experience with an individual case worker she described how she found the people to be kind and open about her entitlements.

> *But the WINZ down here, they're kind. I already asked them stuff about the benefit and what we're entitled to.* AM

CK had the confidence to challenge the response she got from the WINZ case worker.

> *I liked my ones after a while - after my boys were about one and I moved office. But the one before then, she told me I had to start saving for the school uniforms now and they were 2 weeks old. I was like what? And she was 'well that's not what we're here for.' And I was: 'well I'm pretty sure it is actually.'* CK

MK also challenged the information that was presented during the ANE programme. The following excerpt demonstrates how he resisted the power he felt they had by stopping listening to her and then leaving.

> *I asked her a couple of questions - she didn't like that. I voiced it to her and she said 'dadada', oh fuck whatever, I'm outa here. If you're gonna lie to me then I'm not even going to bother listening ... She disagreed and had a smile on her face as she said I was wrong. So I was - see ya!* MK

The above data could be interpreted as the participants resenting, and therefore resisting, the vulnerable position they are held in by WINZ. This resistance may be an example of one of the protective mechanisms Yardley (2008) describes when pregnant adolescents transfer blame from themselves to the person or groups of people who stigmatise them, thus deeming the critics as the ones in the wrong.

FP also believed that the WINZ representative withheld information from her although when asked directly, she disclosed an entitlement.

> *You can get up to $1000.00 to borrow. They don't tell you that stuff. We were lucky cos [another participant] told us about that. She [WINZ representative] didn't tell us but we asked her and then she said about it.* FP

McDonald and Marsten (2005, p. 382) demonstrated how government "governs at a distance" through the relationship between case managers and recipients of the unemployment benefit. The following excerpt provides an example of this as the WINZ representative advises the participants of the questioning they should expect from their case manager to confirm their entitlement to a benefit.

> *Then she'd say something about them asking lots of questions about like if you're a solo mother and stuff. They have to make sure it's true, in case it's all rubbish.* AM

Surveillance

As adolescent pregnancy moved from being a moral to a medical and social problem, pregnant adolescents became the target for surveillance medicine. Although surveillance medicine targets everyone (D. Armstrong, 1995), the segregation of pregnant adolescents described earlier in this chapter, facilitates extra surveillance. The service provider modifies the adolescent ANE programme in an attempt to maximise compliance to attendance. Additionally, the increased hours of ANE that are provided are indicative of the extra intervention that the participants are subjected to in comparison to women who attend a traditional programme.

> *There were eight sessions and they found that people were dropping off and then they asked around and chopped it down to four ... we've got 18 hours for the whole programme but it could easily be more, I can always think of more. You could do every day for a year and still not cover it all.* HP

In the following excerpt the HP explains how it is hoped that adolescents are engaged with the service as early as possible in their pregnancy so they can be connected with other agencies.

> *We've got several coming who are not due till October and that's fine - the earlier the better ... more important to get in earlier. We can connect them with [the social worker] and connect them with housing.* HP

Engaging the pregnant adolescent with a service as early as possible brings her into the health practitioners' field of visibility that Armstrong (1995) describes, thus making increased surveillance possible which is justified by their perceived at risk status. This perception of potential risk is reflected in the following excerpt where the HP refers to adolescent fathers' potential for failure.

> *The long term view, what you're hoping, by dad feeling more confident you might have less non accidental injuries, family violence, early childhood deaths, increased connection to services long term.* HP

The young fathers' individual characteristics are bracketed out from the picture and they are brought into a field of visibility and targeted for further surveillance by way of connection to other long term services.

Self surveillance

Not only do pregnant adolescents become objects of surveillance through the clinical gaze, they also become the object of self-monitoring, self-scrutiny and self-surveillance, which is dependent not only on invisible power but also on normalising judgement (Vaz & Bruno, 2003; Wheatley, 2005). Foucault's concept of power is that it is productive in that it brings about different behaviours and creates actions that are based on perceived priorities (Danaher, et al., 2000; Gastaldo, 1997). The following excerpt demonstrates how MM turns the gaze onto herself and creates actions based on her priority to exclusively breastfeed. Her desire to exclusively breastfeed is internally driven rather than being externally imposed which demonstrates the productive and subtle aspects of disciplinary power (Danaher, et al., 2000; Gastaldo, 1997).

> *That was one thing that I was worried about that might not work out cos I was determined that I wanted to breastfeed him exclusively so I wanted to get as much information as I could.* MM

SN similarly turns the gaze onto herself and changes her choice of pain relief as a result. SN had previously thought she would have epidural pain relief during her labour and

delivery as she considers herself to have a low pain threshold. Changing her choice of pain relief demonstrates the productive aspect of power as the internalised gaze results in her changing her attitude and choice.

> *Yeah, I always wanted an epidural cos I'm a wuss. But now I'm gonna make it my last source of pain relief … and I thought I might have a waterbirth.* SN

Self surveillance also extended to the surveillance of others as one of the participants noticed that some of the others were not eating 'properly' and that one of these adolescents was smoking. In the same way that the participants in Wheatley's (2005) cardiac rehabilitation study watched over and attempted to modify each other's conduct, one of the participants in this study attempted to modify the conduct of other participants. The following excerpt demonstrates how she takes up the dominant discourse of the health educators as she passes on information to one of the other adolescents around what she should and should not eat and the detrimental effects of smoking during pregnancy.

> *It kinda surprised me some of the girls there weren't even eating properly. Like I actually had a whole lot of double pamphlets and I banged them in for her and said this is information on what to eat and what not to eat. And I gave her a stack of books and said read through them. It was even stuff like smoke free and that cos she was a smoker…I gave her a pamphlet on it that gave her all the details on what it's actually doing. That way she can read through it all and get an idea of what she's actually doing.* EM

Positioned as different

According to Weeks (as cited in Weedon, 2004, p. 1) "[i]dentity is about belonging, about what you have in common with some people and what differentiates you from others." One of the main attractions of a programme dedicated to young people was that it gave the adolescents a sense of belonging since they would be among other people who were also young, pregnant and not necessarily partnered. As one of the participants explains, being young and pregnant can be isolating because their friends are often not also at home during the day.

> *It's a good experience. You get lonely being pregnant I reckon. You don't get out much. Especially when you're a teenager ... All my friends are at Uni, going out, working.* SN

Similarly, CK describes below how her experience was of being a young mother at home was also isolating until she established some contact with other young parents.

> *It was having constant contact with other teen parents that helped me alot. I used to sit at home all day and do nothing ... Before we'd go and do our shopping really quickly at night time and that was it, our outing for the whole week and we'd just stay home.* CK

These excerpts above demonstrate how isolation and exclusion can lead to the loss of social identity. This finding is supported by other research that found that the support pregnant adolescents gained from peers reduced over the period of their pregnancy (Macleod & Weaver, 2003).

As mentioned earlier in this chapter, one of the aims of the ANE programme is to ameliorate the effects of social isolation. One of the most common questions asked of the health practitioner was how many and how old the others on the course would be as they tried to gauge whether they would belong.

> *As soon as I hear from them I give them a call ... They'll often say how many other people and how old are the other people coming.* HP

The sense of belonging was important to the adolescents as they perceived themselves to be different and separate to older pregnant women. The following excerpts provide two examples of the many participants who expressed a perception that their younger age meant they would have been out of place and not belong in a class of older pregnant women.

> *Especially with the age group thing I mean cos I was the youngest by 10 years at the other [traditional] one so I just sat there quietly like 'oh my god' and I didn't want to ask questions. I didn't know anything but I wasn't going to ask anything in front of them cos there'll all looking at you.* CK

> *I want to go to an antenatal class but I don't want to look like an idiot, you know what I mean, with like older people cos I'm so young.* SN

SN's words demonstrate how she felt she would be subjectified because of her young age. In addition to her youth, the thought of attending a programme without a partner was problematic for her.

> *I wasn't sure whether I wanted to come or not. I was just nervous...Only then [the facilitator] said oh no, some people come with their Mums, with their partners and there are girls that come by themselves as well. And I thought, oh, that's cool ... Well, it's not like I was the only one there without a partner.* SN

All but one of the participants interviewed came from outside their local area to attend the ANE programme with two participants expressing a specific preference for this. For FP this was because it was away from people she had grown up with and she wanted to avoid people from her neighbourhood.

> *There's alot of people[around here] I know from childhood.* FP

AM talked about an ANE programme for all ages that was run in her local community, however the stigma she felt from being young and pregnant meant she chose not to attend it.

> *No, cos it's around here. Too many people around here I know ... They go to my nana's church so I don't want to walk past them. [This course is good] Yeah, cos it's out of my area.* AM

Her pregnancy was not hidden from family but her not wanting to walk past them suggests she expected to be looked at and talked about. She saw attending a group outside her local community as a way to dissociate from the stigma associated with adolescent pregnancy and detach from the close connections between her extended family, the Church and her community.

One participant had attended, but didn't complete, a traditional antenatal course during her previous pregnancy. She attended three of the classes and her partner attended none because when he got there he *"took one look at them and said I'm not going in there."*

The description she gave of her experience illustrates how she found it intimidating and how being young and unmarried positioned her as abnormal in comparison to the rest of the class.

> *There were too many people there. [It was] in a massive hall and everyone was sitting with their partners. They were all happily married couples and blah blah blah and then you're like, ok! and we've got the Mum driving us in and they're all like happily sitting there together and all happy and excited about it and we're like teenagers ... and we're here cos we were just told to come.* CK

CK deviated from the established norm due to her young age and not having her partner there with her, and consequently she felt that she stood out and was subjected to scrutiny by the other class attendees.

> *Like the age of everyone, you just feel like they would all just look at me as soon as I walked in - like it's the 16 year old here again ... I was just sitting there like a sitting duck.* CK

Her use of the words 'sitting duck' to describe how she felt there suggests she felt vulnerable. The feeling of stigma associated with being a pregnant adolescent or young mother is well documented (Hirst, et al., 2006; McDermott & Graham, 2005; Yardley, 2008). A number of participants commented on how, as a group, pregnant adolescents, were stigmatised by society including health practitioners. For example, as CK says:

> *You've got so many people looking down at you. As it is you're all wierded out …. My one, my little evil lady came in and as soon as she walked in she was reading my chart and was blabbering on about 'a 17 year old with twins, what's wrong with this world' blah blah blah- like I wasn't there.* CK

As the average age for child-bearing in New Zealand increases (Statistics New Zealand, 2011) pregnant adolescents move further from society's norm, falling outside what is generally perceived as the traditional family (Wilson & Huntington, 2005). Pregnant adolescents and their partners not only categorised themselves and divided themselves

from others, they equally categorised older pregnant women and their partners which further demonstrates how they position themselves as different. As MK explains:

> *Most of them are probably married and it wouldn't be their first child. They've got their shit sorted out. Even if it isn't their first child or if they don't have children yet they've probably got a freehold house.* MK

CK takes up society's discourse of the normal age for childbearing to be between the ages of 25 and 40 years as she describes how mothers aged over 40 are equally stigmatised due their age.

> *There's always the ones [on-line] looking for either over 40 or under 25 year olds. You probably feel like a teenager all over again - people just look at you and why are you having a kid at that age? Which is like when you're a teenager people think why are you having a kid so young?* CK

One of the participant's quotes shows how she positions herself as different to her pregnant cousin due to her young age. AM comments on how being young is a determining factor in the need to attend the programme, whereas her cousin was 'old enough' and therefore was not going to attend.

> *No, she's old enough - she's not young*. AM

AM takes up the subject position and the identity that goes with that position as she sees herself as someone who has more need than someone who is older. Weedon (2004) states that an identity is often defined in relation to what someone believes they are not. AM's identity is that of someone who is not old enough to go to a traditional programme or not old enough *not* to go to this programme. Her cousin is not just older, she is 'old enough' so will be attending a traditional programme.

Diversity

Pregnant adolescents are a heterogeneous group. Categorising individuals according to age alone can ignore the uniqueness of a person and eliminate the individual experiences that make up the adolescent's life-world. One of the participants highlights this as she talks about her life experiences and says:

I've been through enough stuff that even a 40 year old hasn't been through. SN

The following excerpt reflects how the HP acknowledges the diversity of the programme participants as she talks about this being one of the challenges involved in planning the programme.

> *One of the challenges is not knowing them before they come - having a mixed group, potentially different age ranges, from different educational attainment and different cultures and backgrounds.* HP

The following quote provides an example of the challenges the HP refers to when providing an educational programme for a diverse group of young people as one of the participants thought the classes were not pitched to her level of knowledge.

> *I thought they talked about labour a bit too much - I knew enough from the first time we talked about it. Instead we talked about it twice and once was enough … Nutrition wasn't new. I know what's healthy and what's not.* SN

Many of the participants were pro-active in independently searching out the information they wanted or to expand on the information provided to them during the programme. The following quotes provide examples of this.

> *My midwife was just there to answer my questions but she didn't really tell me anything so, um, I always go on line and stuff to look for anything to do with [pregnancy, labour and delivery]or to help out.* FP

> *I got about 6 books out from the library and I read them ...and stuff from my midwife, my mum and my sister. And the internet. I read everything on the internet. You don't have to have a brain, you just type it in the internet*. SN

Diversity in the group of programme participants extends further than their educational needs. The social diversity that some of the participants notice reinforces how pregnant adolescents are a heterogeneous group therefore categorisation into a programme based on age alone doesn't necessarily achieve a sense of belonging. One of the objectives of the programme is to link up pregnant adolescents in order to decrease social isolation,

however, the following excerpts reveal that this is not always achieved due to their social diversity.

> *It would have been - probably it would have been better if there was, not better people, but more onto it people.* MK

> *There was no one there I'd want to stay in contact with. I'm thinking of doing an older sort of antenatal group to meet some people that maybe already have kids and having more - and are a bit more mature.* EC

> *I haven't met up with any of them, it's a bit awkward ... Awkward because we're all so different, from different areas with different ways of living.* CK

Although MK and EC both completed the programme it is possible that some of those who withdrew, either after they had enrolled or part way through a programme, did so because they resisted being divided into a category that gave them a social identity. As the HP explains in the following excerpt, non-attendance after enrolment was not uncommon.

> *We're used to it that people say they want to come but they move house and don't let us know.* HP

As transport is provided, difficulties with transport can be ruled out as a reason for non-attendance. This means it is possible that these adolescents were exercising their own power, through resistance, by choosing not to attend.

Many of the interviews challenge the notion that pregnant adolescents as a group require extra intervention and education. Several participants portray a sense of confidence in their knowledge and ability to manage their labour and delivery. As these examples show, this confidence is often from the experience of being present at other births.

> *Yeah, I'm fine with all that cos I was there when my mum had my little sister. Mum has home births - I've seen it and I've been there.* LB

> *It's easy to go through the labour and stuff ... I've seen my sister give birth.* AM

I've seen 4 births now - and my own [previous delivery]. CK

A number of participants also portrayed a sense of self-confidence in their ability to care for their baby even if they had been told that they were too young, as was the case for FP:

> *They [family] always say you're too young and all this stuff. [My mother] doesn't really approve of having the baby and stuff. She's like I'm too young to look after it. But I know I can.* FP

FP, along with many of the other participants, had played an active role in raising and caring for younger siblings which instilled confidence in their abilities.

> *Some of my friends have already had kids and stuff so we've been sort of looking after them, and the three younger ones cos my mum's a fulltime chef so I had to look after them so I wasn't really worried about feeding and everything … I'm not worried about it.* FP

> *Yeah, I have raised those ones [siblings]. Youngest is 6 he's still named the baby. Yeah, I know the whole process.* AM

The confidence in their abilities is also reflected in findings from other studies which report how younger mothers perceived themselves to be equally as competent as older mothers (Hirst, et al., 2006; Kirkman, et al., 2001).

The interviews also portrayed how although extra ANE around alcohol and smoking during pregnancy is provided to the adolescents, it is not necessarily age that determines health behaviours during pregnancy. To follow is an example taken from one interview to evidence this.

> *I mean I know so many that are stupid enough to. My cousin who's 27 she went to a party when her son was 2 weeks old and took him with her while she was breastfeeding and couldn't understand why he was tipsy the next day. Drinking is really stupid. I couldn't understand why anyone would go and drink after having a baby anyway. It doesn't really make sense … And it pisses me off cos they tell me I should be drinking or they offer me a smoke."* CK

Summary

This chapter has portrayed how the management of pregnant adolescents is achieved through the utilisation of a functional space and dividing practices. The segregation and grouping of pregnant adolescents together in a programme facilitates surveillance and extra intervention from health practitioners and social services. It is evident from the data presented in this chapter that the programme participants were a diverse group of adolescents with differing experiences and needs. This diversity makes it questionable whether the increased surveillance and intervention that pregnant adolescents are subjected to is justified when it is based on age alone.

This chapter also conveys how the information delivered by the health practitioners is determined by the Ministry of Health and informed by national and international policies. It portrays how health education programmes can be seen as a strategy of governmentality with the health practitioners positioned between these polices and the programme participants.

The next chapter presents the health education that the participants received from an anatomo-political perspective.

Chapter Five: Anatamo-politics *"I really want to do the proper thing"*

The previous chapter discussed how bio-politics as an art of government involves managing the population of pregnant adolescents through various technologies, including: creating a space; dividing practices; surveillance; and utilising health practitioners as agents of the state. Informed by Gastaldo's (1997) position that health education programmes are a bio-power strategy, this chapter will explore how health education can be seen as a mechanism to discipline individual bodies; anatamo-politics. It will examine how health education can shape conduct and examine some of the techniques employed by health educators to gain compliance.

Pastoral power

Foucault's concept of pastoral power is one of the techniques employed to undertake bio-power (McNay, 1994). Pastoral power facilitates discipline and the management of individual conduct as it draws on the benevolent positioning of health practitioners. It cannot be exercised without the health practitioner's "knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets" (Foucault, 1982, p. 783). Perron et al. (2005) state that the training of bodies relies on the evaluation of an individual's abilities and knowledge and knowing them "better than they know themselves" (p. 539). As demonstrated in the following excerpt from the HP, building rapport prior to questioning is seen to be more important with adolescents than with older people. Questioning from health practitioners is used to evaluate knowledge, attitudes and behaviours and building rapport is a way to increase disclosure.

> *I do think probably it's more important with the younger parents to make sure you build that rapport before they really start getting in there and asking the questions and stuff. More say than with older ... Definitely behind the scenes there's family issues and financial stuff and alot of relationship issues*. HP

AM shows her discomfort with the questioning from her healthcare provider and she questions the relevance of the information she seeks.

> *"My midwife always asks me questions – some weird questions too. Out of it stuff. I was like do you have to ask me that?"* AM

As her comment was not explored further in the interview, it is not known whether this participant chose to disclose the answers to what she thought were weird questions.

Empowerment

Empowerment is a complex, multi-dimensional, contested concept and remains a preferred model for health education (Piper, 2010). It is partly an educational process in that, through education, individuals are empowered to make choices for themselves. Choice is a process that involves the personal judging of the qualities of different options and making a selection that one feels is the best or correct decision for them. In order for an individual to make a choice, not only must two or more options be available to them, but they must also have the freedom to choose from these options. On the other hand, coercion is a process of subtle manipulation into making choices which are usually pre-determined by others. Coercion aims to induce compliance or transform a person's way of thinking or behaving. Coercive strategies are a method of controlling and disciplining bodies and are used under the guise of empowerment to subtly gain cooperation and induce docility (Foucault, 1977; M. Gagnon, et al., 2010; Gastaldo, 1997). In the present study, the health practitioner describes how her goal is for the adolescents to have a sense of empowerment enabling them to exercise autonomy by making their own choices. She sees that providing knowledge and a deeper understanding around the choices available will facilitate this.

> *The goal for me - a sense of empowerment and a deeper knowledge and understanding of childbirth and the choices that are out there for them that they feel they can actually make those choices themselves.* HP

The deeper knowledge that is acquired around childbirth has a liberating potential for the adolescents as they are empowered through being provided with information that will enable them to make their own decisions. However, the following quote is an example of how health education can be questioned as empowerment as EC describes how she wants to do 'the proper thing' after the childbirth education she has received.

> *I really want to do the proper thing ... I know now what I want ... I've got more of an idea of what I'm going to be doing.* EC

Although EC is empowered to make her own choices, her wanting 'to do the proper thing' suggests a compliance to conduct herself in a certain way that is considered correct. Childbirth education has constructed for her what she considers to be the 'proper thing' and the choices she makes around her labour and delivery are directed at achieving this.

Rewards and punishments

A series of power processes, including using rewards and punishments, are exercised by health practitioners to induce submission (Foucault, 1982). In health education, rewards and punishments are attached to different options in the form of either beneficial or adverse effects on their, and their babies, health in order to gain compliance.

Breastfeeding

In this research, breastfeeding was presented with an association to the rewards of its numerous benefits. One of the rewards of breastfeeding is that it affords the mother the identity of the 'good mother' position in today's society (Knaak, 2010). Breastfeeding has become what Wall (2001) refers to as one of the standards of exclusive mothering and the measure of the mother. This is reflected by CKs comments when she infers that breastfeeding is one of the requirements of being an 'awesome' parent. Additionally, she considers that women who do not breastfeed are considered slack mothers.

> *"Unless you're insanely determined to be that awesome parent. They're all like: either you breastfeed or you're a slack mother."* CK

In response to how CK sees formula feeding mothers are constructed, she rejects that it questions her ability to be a good mother.

> *I was the bad parent cos I didn't do it ... it doesn't make me a bad parent just because I didn't breast feed.* CK

The above excerpt also provides an example of resistance to a discourse. CK considers that mothers who don't breastfeed are perceived to be bad parents which does not conform to her own parenting experience and beliefs (N. Armstrong & Murphy, 2011).

Other rewards of breastfeeding that were used to coerce the participants into choosing to breastfeed included having a healthier baby, losing weight, and contraception. The following excerpts provide examples of where the adolescents identified these rewards.

> *[I learnt] about the colostrum and all that, the benefits for breast milk and all that."* MM

> *I'm going to breastfeed. It's good to. I think it's healthier if I breastfeed my child .... In the 1st three months or few months of breastfeeding it protects you or something ... only feeding nothing else it can't go on the bottle or the pacifier, you have to just breastfeed ... [And] breastfeeding after you give birth, it slows down your periods and they say it makes you lose weight.* AM

> *I'm going to breastfeed cos the babies always seem healthier and stuff.* LB

The participants' statements that breast fed babies are healthier demonstrates how they take up the dominant discourse emphasised by the World Health Organisation that "Breastfeeding is one of the most effective ways to ensure child health and survival" (WHO, 2009).

Formula feeding, however, was often associated with adverse effects on the baby's health. CK, who had twins and was attending the course during her second pregnancy, had felt blamed by some of her health practitioners that her babies were getting sick because she had not breast fed them. The consequence (or punishment) for not breastfeeding was having sick babies.

> *They were: Oh yeah they're sick now, they've probably got a runny nose cos they weren't breastfed properly. And it turns out they were just allergic to cow's milk. And they were always like it's cos you didn't breastfeed, it's cos you didn't breast feed. (CK)*

The adverse health effects that were presented as the result of choosing formula feeding included an increased risk of developing a childhood cancer. The examples that were

given to the participants by the health practitioners were leukaemia[5] and bottle-rot[6]. The following two participants accepted the knowledge claim that formula feeding would be detrimental to their baby as it would result in bottle-rot.

> *I got alot more information about the formula. Like you know how it contains a lot of sugars and bottle rot and everything - it's bad for their teeth.* MM

> *The reason I think bottle-feeding isn't very good is because they will probably get bottle-rot and stuff.* SN

Interestingly, despite the fact that one would consider childhood cancer to be more serious than dental caries, none of the participants mentioned the association that was given between childhood cancer and formula feeding. This may be because the issue of dental caries is more real to them than childhood cancer or it may be that they made a distinction between the knowledge claims they accepted and those they rejected. This replicates Wheatley's (2005) finding that individuals are not passive recipients of disciplinary power, rather they actively evaluate the information and recommendations they receive.

The promotion of breastfeeding is an example of bio-political intervention. Mothers are subjected to powerful medical discourses that pressure them to conform by choosing it as the exclusive method of feeding their babies (Murphy, 2003; Perron, et al., 2005). As the only participant who chose to fully formula feed her baby, CK spoke frequently of the attitudes of different health practitioners towards her feeding choice which made her feel disapproved of and on one occasion, denigrated. This pressure is illustrated in the following example:

> *[She] seemed pretty against it- bottle feeding. I mentioned it ... that I wasn't going to be breastfeeding and you know she didn't seem comfortable with that. She seemed a little crabby ... that was one thing I*

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[5] A systematic review with meta-analysis in the International Journal of Cancer (Int J Cancer. 2005 Dec 20;117(6):1020-31) states that having *ever* been breast-fed is inversely associated with acute lymphoblastic leukemia. A non-causal explanation could not be ruled out and the researchers determined that, even if causal, the public health importance of these associations may be small.

[6] Bottlerot is a colloquialism for severe early childhood caries. It is associated with prolonged contact of sweet fluids with the teeth and an overgrowth of streptococcus mutans and Lactobacillus organisms which results in dental caries.

> *noticed she wasn't so open on … In the hospital I refused to breastfeed and the midwife said to me that I was just one of those bitches that just wanted to keep my tits up ... I was just like, whatever.* CK

A further example of how information presented by health practitioners can influence attitudes and choice is when one of the participants understands breastfeeding to be the 'best' contraceptive if strictly adhered to.

> *It was interesting. Breastfeeding is best. If you get up for every feed - you can't put it off. There's no waiting 10 minutes. As soon as baby's hungry, feed it. She said solidly breast. You can't even put the breast pump on - you've got to do it straight from the breast.* MK

EC however resists the health practitioner's knowledge claim that breastfeeding is a reliable contraception.

> *She did talk about the breastfeeding contraception. She said that it does work but I know that it doesn't work. My mum got pregnant 6 weeks after she had her baby and she was full-on breastfeeding. I did bring it up and said well actually, my mum, it did work every other time but it was her 4th baby and she got pregnant …. I think it [works for] 6 mths. You've got to feed the baby every time it needs to be fed ... I'm not going to risk it.* EC

As Lupton (1997) states, resistance is present at micro-levels as people resist strategies and practices from health workers that are designed to influence their behaviour. EC demonstrates that she is not a passive recipient of the information provided as she rejects the claim that breastfeeding is a reliable contraceptive method.

Challenging the dominant discourse

Women are exposed to authoritative discourses that define breastfeeding as the correct feeding choice (Murphy, 2003). Despite these prevailing dominant discourses around breastfeeding and the sense of disapproval one participant felt from her health care practitioners, she had the confidence to construct herself as someone who had made a choice not to breastfeed. Her decision was made prior to the ANE programme and did not change afterwards.

> *I'm not breastfeeding. Everyone I know that hasn't breastfed had a really good reason as to why they wouldn't - like me - I just can't do it, I don't like it, it's disturbing.* CK

Sensing their disapproval as described above, CK chose to not attend the class when breastfeeding was covered. Her following quote demonstrates how she is able to resist the bio-political strategy in the form of a breastfeeding seminar for the adolescents.

> *I missed the breastfeeding one. I actually missed that decision. But the whole breast is best thing does piss me off.* CK

CK's non-attendance at the breastfeeding seminar was a way to neutralise the power without directly challenging it. In doing so she demonstrates her resistance to any perceived or expected attempts to control or influence her feeding choice. Wheatley (2005) also reported non-attendance as an evasive response to disciplinary power in order to diffuse its effects. When discussing the breastfeeding information given to the course participants, CK referred to the seminar as the breastfeeding 'decision'. Her choice of words imply that rather than being given information to make a choice, a verdict is delivered as to the most appropriate method of infant feeding.

Despite her awareness that pre-determined assumptions had been made around her reason for not breastfeeding, she resisted by withholding rather than divulging the information to the healthcare practitioners that explained her decision. In doing so she appears to be setting boundaries around what the health practitioner knows about her.

> *I wasn't going to tell her why I wasn't breastfeeding my children. CK*

As mentioned in the previous chapter, withholding of information or remaining silent have been identified as common forms of resistance (Hughes, 1997; Lupton, 1997).

One participant demonstrates her autonomy by choosing to both breast and bottle feed to maintain some independence after the birth. As she weighs up the practicalities, she sees breastfeeding as time consuming and potentially restricting of her ability to go to work and to socialise, which were important to her.

> *I am keen to breast feed and use the bottle. I'm going to try after a month to get her to have both because I don't want to be stuck at home for the rest of*

> *my life. I want my Mum to be able to take her and look after her so I can get back to work. And I don't want it to take over my life - breastfeeding.* SN

SN's statement is in keeping with the findings of Schmied and Lupton (2001) who found that many women choose not to breastfeed as they sought to gain control over their lives and bodies and retain a sense of autonomous self. At her second interview, four weeks post-natal, SN had introduced formula feeding earlier than initially planned. She explained the detrimental effect that not being able to breastfeed had on her mental wellbeing.

> *The first couple of days the breastfeeding was horrible. Actually, no, the first week it was horrible. I had like a breakdown. I had a mental breakdown [because] I can't breastfeed. It was like, k, we need to go get some formula and I'll try her on the bottle and she took it the first time.* SN

This statement is consistent with Dwyer's (2009) findings that a large number of women reported feeling guilty for not breastfeeding and recommends that health practitioners take care not to provide breastfeeding information at the expense of the mother's health.

Labour and Delivery

The power of the health practitioner lies with their ability to form knowledge and truths which, as it is considered to be legitimate knowledge, has the capability to shape and normalise individuals' views and conduct (Cheek & Porter, 1997). This is evident from the following excerpt that portrays how many of the participants made a choice to experience a water birth after seeing a video depicting different delivery methods (a water birth, a vaginal delivery in the supine position on a bed and a caesarean delivery).

> *I've never seen a waterbirth before and I was thinking about it that time and just watching it, that's when I really wanted to do it.* FP

Watching a waterbirth video provided this participant with a new knowledge, bringing it from what was previously invisible to her and revealing it as something visible through the act of seeing it. This new reality that has consequently been created for her constructs what she now considers to be the ideal birth experience.

When discussing the labour and delivery video, FP talks about how the woman having the waterbirth appeared calm whereas the delivery on the 'table' looked really hard. For FP the reward for a waterbirth was to experience an easier delivery; for CK the reward was that her labour would be halved, allowing her to be discharged from hospital sooner.

> *She looked really calm and stuff and the second birth when she was on the table and she was lying down on her back, that looked really hard.* FP

> *What am I going to do now, cos I want to get in there out there as soon as possible, which is why I'm seriously contemplating a water birth since [childbirth educator] kept saying it cuts your labour time in half.* CK

Language not only conveys a reality but it also constructs a knowledge and reality (Huntington & Gilmour, 2001). The alliance created between words and things (Foucault, 1973) was able to construct and convey a new knowledge and a new reality and therefore influence the choices made by the participants. Through language, the health practitioners have the power to bring a truth to light for those who have not seen or experienced a waterbirth. For example, MM has had her view of waterbirth shifted after waterbirths were explained to her.

> *I learnt alot about a water birth. Like I didn't realise how it was like quite similar to an epidural, like a natural one and all that, it like shifted my view a bit, you know like more keen.* MM

CK's choice of delivery style was similarly influenced by talking with one of the childbirth educators about waterbirths and her views were then reinforced by watching a video.

> *I'm fairly certain that I'm going to ditch the epidural and try a water birth just because after talking to [childbirth educator] she was all for it and really happy. Watching the video as well, [because] I haven't actually seen a water birth - so it was good to see. The other one was alot of screaming and I thought: Oh my God I'm not doing that. I don't want to do that!* CK

Disciplinary power also works through strategies of normalisation with the health practitioners acting as one of the 'judges of normality' (McNay, 1994, p. 94). CK

describes how the childbirth educator made a waterbirth sound normal where she previously had perceived it as something that 'weird' ladies do. The normalisation of waterbirth contributed to her choosing it as her preferred delivery method.

> *Water birth was sort of the hippy thing, it wasn't something I was going to try. To me it was just one of those weird things ladies do when they just want to ditch the pain killers and stuff but she made it sound normal ...She was real positive about it so I'm keen on trying it.* CK

The language the childbirth educator used around waterbirth passed on knowledge in a form that participants previously did not have thus conveying and constructing a new reality for them. The participant no longer thought of a waterbirth as the hippy thing that weird people do as the childbirth educator has constructed it as something that was 'normal' and therefore something she decided to try. This is supported by Gastaldo's (1997) view that scientific knowledge entitles health practitioners to determine the boundaries of normality and therefore construct a 'normal' body.

Pain relief

Many of the participants did not want to have interventional pain relief, in particular epidurals, due to the associated risks and dangers.

> *I don't want that [epidural] either. You get back pain later on ... It's better to do it naturally.* AM

The punishment of experiencing back pain from having an epidural has induced compliance in AM as she now decides it is better to deliver naturally than have an epidural. The ANE which AM has received has contributed to the management of her body as she determines what is best and what is right for her. Similarly, another participant talks about the dangers of an epidural. The threat of putting herself or her baby in danger during the labour by having an epidural is not worth the risk to her.

> *Not the epidural or anything like that. No way, I heard such bad things about that. Like you can't feel when you need to push and it can be quite dangerous so I thought I'm not going to risk it. They said you can get this but it's your choice.* EC

EC's words demonstrate how the coercive strategies of health education can be exercised. Although she is told it is her choice, she identifies the consequence of having an epidural may be that she has an unpleasant and unsafe experience. This led EC to form the opinion that an epidural is dangerous and not worth the risk and so decides it is not the most appropriate or best choice for her.

In the name of empowerment the participants were given information about the different modes of delivery and pain relief to enable them to make their own choices. However, the health educators determined how they presented the knowledge and this determined how the adolescent engaged with it. When information is presented in a way that portrays some choices as being better than others it becomes a coercive strategy to direct decisions and thereby induce compliance (Powers, 2003). Utilising the concept that power only exists where there is freedom (Foucault, 1982), it is evident that although the adolescents have the freedom to make their own choices, the health practitioners who hold the knowledge have the ability to pass that knowledge on in a way that can influence the choices that are made (Powers, 2003). The result is that the participants appeared to make the choices the health practitioners wanted them to make.

One of the participants talks about how she made her decision as to whether she planned to have pain relief during her labour. Prior to the ANE course she makes the following statement which indicates that she is worried about the pain of childbirth:

> *I'm still all worried about the whole thing - lots of pain - it sounds like it's really painful and it's gonna really hurt. [My sister] said it would. She rang me from Oz and asked if I was alright. She said it's going to be really painful.* AM

However AM later decides that it is better to choose a position to deliver her baby in than to have medicinal or interventional pain relief. The way she now thinks and plans to behave raises the question of whether she has been coerced into managing her body in a pre-determined way.

> *Yeah I don't want any of it [pain relief]... She said I wouldn't be needing it. It's better to do it naturally. They said it's better the position you choose. Squatting is easier makes the pelvis area wider for the baby - gives it more room to come out. So I'll think of a good position ... And my midwife said*

> *Island people are really good at breathing and breathing is good pain relief and then easier to push out the baby. And I was like, ok .* AM

AMs comments *'She said I wouldn't be needing it'*; *'they said it's better' and 'my midwife said'* positions the health practitioner as an authority. A possible reading of her comment *'and I was like, ok'* is that she has internalised the observing gaze of the authorities and taken up their construction of positioning and breathing as the best method for her to manage pain during childbirth. The compliance to the health practitioner's wish for her to deliver her baby 'naturally' demonstrates how she has been rendered docile.

The following excerpt from the same participant illustrates how she has perceived the different pain relief options that have been presented. Her perception, and what is the reality for her, is reflected in the language she used to describe them and demonstrates the way she has engaged with the information presented.

> *I learnt some of the pain relief they give you ... there's that other stuff where they numb you and use the thing to suck the baby's head out and then pull the rest of the body out. And then they said something about a needle being injected into your spine. Yeah, I don't want that either - and they said the gas doesn't work.* AM

According to Foucault's theory, health education cannot be solely liberating, it is also disciplinary as complete autonomy and liberation are not possible in individuals (Gastaldo, 1997). Through learning about the different pain relief options AM has been liberated and disciplined at the same time. She demonstrates self-governance and autonomy by deciding she doesn't want to have any of the pain relief options that she has learnt about. However, her choices can also be seen as an example of how she has been disciplined.

Resistance

Power and resistance are fluid, flowing in multidirectional ways. As power and resistance co-exist, bio-power is not absolute in the production of docile bodies. Resistance to bio-power takes many forms and in this study it manifested in some of the participants refusing to engage in healthcare strategies (Manias & Street, 2000; Petersen & Brunton, 1997). The following quote provides an example where one of the

participants stops listening when told about the adverse effects of cigarette smoking during pregnancy.

> *She said it can make your baby's weight go smaller and brain damage and hard to come out. I think she told me a little bit more but I wasn't listening anymore.* TC

Similarly, another participant chooses to stop paying attention when asked whether the course covered information around drinking alcohol during pregnancy.

> *Yeah, some stuff but I didn't pay attention.* AM

The way these participants stopped listening can be seen, in Foucauldian terms, as using evasion as a form of resistance to discipline and portrays how individuals don't necessarily submit to health authorities (Wheatley, 2005). Further examples of evasion as a form of resistance are when these two participants are selective in what they choose to read, and not to read, of the written material provided around pregnancy care.

> *She gave me alot of stuff. The only stuff I read is this and that [indicating two brochures on diet]. Only the bits I like.* TC

> *I'm not bothering. I've just read a little bit but not all of it ... I don't really like reading.* AM

Family members also had an influence on the choices the participants made which had the potential to reinforce, destabilise or negate the messages given by the health practitioners. AM spoke of how she was given different advice from numerous family members as well as health practitioners before then making a decision to follow what her mother does.

> *My sister got injected in her thigh. My cousin got the epidural in her spine and my aunty went on the gas ...They all give me different advice. I just follow what Mum does.*

A further example of resistance is demonstrated when one participant decides to wait a while before her baby receives the six week immunisations.

Not just yet, I want to wait a little while before I get them [immunisations] done. (CK)

Although CK's reasons for delaying the vaccinations were not explored further, based on Gross and Shuval's (2008) typologies of resistance in the area of risk-medicine, (which includes vaccinations) it may be that she wishes to exercise her autonomy and draw on her right to self determination and free choice by resisting complying with the timings of immunisation schedule. Alternatively, after weighing up the risks and benefits of the six week vaccinations she may have decided that in waiting a while she is in fact avoiding risk to her baby (Lupton, 1995).

Summary

Anatomo-politics refers to a form of bio-power which employs mechanisms to manage and discipline individual bodies. The data from this chapter presents how health education potentially shaped the expectations and views of the adolescents and constructed for them what they considered to be normal or abnormal. Using the topics of breastfeeding, labour and delivery, and pain relief the data portrays how health practitioners use a variety of strategies to gain compliance. Facilitated by pastoral power, strategies such as coercion, reward and punishment are utilised to instill a self-discipline and construct an ideal birth and feeding experience according to the health practitioner. Resistance to these technologies of power were evident throughout the interviews which demonstrates how power is multi-directional and where there is power, there is resistance.

Chapter Six: Discussion

Introduction

This research does not attempt to discredit or disagree with antenatal education or health education programmes. On the contrary, health education and health promotion are clearly beneficial as they are associated with improved health status. The intention of analysing the research data through a Foucauldian lens is twofold. Firstly it is to question the assumption that an ANE programme dedicated to pregnant adolescents is solely beneficial or, whether by focusing on and categorising them as a group, it contributes to the construction of this group as problematic and therefore subject to increased surveillance and regulation by health practitioners. Secondly, the analysis has explored how health education can be viewed as a disciplinary power as it provides guiding principles about the way people should regulate their bodies.

The 'enclosure'

An ANE programme specifically for adolescents is based on the premise that adolescents are a special group who have unique needs and the assumption that they will not fit in with others at a traditional ANE programme. The separation of pregnant adolescents from older pregnant women was reflected in the programme philosophy as necessary and beneficial as the programme would provide a place where they felt accepted. However, from a Foucauldian perspective, the geographical site from where such a programme is run could be seen as a tangible manifestation of the gaze and surveillance to which pregnant adolescents are subjected. This space serves as the *enclosure*, where a space is set apart from others to allow for the assessment, judgment and control of individuals and implementation of the disciplinary techniques of health education (McNay, 1994). Pregnant adolescents are segregated from other pregnant women as a mechanism to effectively treat and control them as an at risk population. This analysis is supported by Foucault's work related to mechanisms of control (Foucault, 1977). The position of risk justifies the implementation of these special programmes that aim to address the issues considered to contribute to, and result from, their at risk status. In doing so, however, it is possible that a special programme for pregnant adolescents portrays them as a problematic group who are in need of additional care, supervision and education. The separate physical venue and a special programme mirrors the way historical residential homes for unwed mothers represented

a stigmatised depiction of the single mother. Emulating Rains et al.'s (2004) contention that the practices of social services have the ability to publicly portray a social problem, this research argues that special programmes for pregnant adolescents publicly constructs them as a problem that requires attention.

Social identity

The above mentioned public representation of a group who require special treatment can create and reinforce a stigmatised perception of the pregnant adolescent. This concept of how an ANE programme specifically for adolescents potentially constructs them as a stigmatised group is supported by de Jonge's (2001) research that showed some adolescent mothers felt a support group exclusively for teenage mothers increased stigma. Yardley (2008) also found that some of the young mothers in her study actively distanced themselves from other young mothers to avoid the teenage mother stereotype as well as from support groups that reinforced the stereotypical identity of the pregnant adolescent. While the participants in this study did not express a wish to distance themselves from other adolescent mothers to avoid stereotypes and stigma, the way some participants saw that attending a programme outside their local areas was preferable demonstrates that they were aware of and sensitive to the stigma associated with adolescent pregnancy. This raises the question of whether an adolescent ANE programme reduces the opportunity for them to orientate themselves to identities other than that of the stereotyped pregnant adolescent.

Personal identity

Additional to creating a social identity, an adolescent ANE programme that divides pregnant adolescents from other pregnant women has the potential to instill and reinforce a particular personal identity. Identity is acquired over the period of one's life and is affected by time, place and culture (Danaher, et al., 2000; Erikson, 1994). According to Weeks: "[i]dentity is about belonging, about what you have in common with some people and what differentiates you from other people (as cited in Weedon, 2004, p. 1).

When an individual takes up a subject position they become "tied to [their] own identity by a conscience or self-knowledge" (Foucault, 1982, p. 781). This was evident in this research when the participants identified themselves as being different and feeling that they would not belong with older pregnant women, which was the basis of their

reluctance to attend a traditional ANE programme. There was a pre-conceived notion that women in a traditional ANE programme would all be married or partnered, and/or financially secure so the participants felt more comfortable attending and actively participating in an adolescent ANE programme as they were less likely to feel out of place. However, contradictory identities were demonstrated when, although the participants considered themselves different from and not belonging with older mothers, they also considered themselves to be competent and were confident of their abilities. For example, one participant, despite accessing a substantial amount of information through her midwife, books and the internet and demonstrating considerable confidence with her sound knowledge base, still feared she would look like an idiot if she attended a traditional ANE class with older women. The participants could take up and resist different subject positions or be positioned by another person such as being seen as too young to have and care for a baby. Regardless of this subject positioning, the data portrays many of the participants as having a strong sense of self, being confident in their own ability and having a sense of agency that was demonstrated when they made active decisions.

Despite the bio-political strategies of health education which had the potential to shape their views and behaviours, the participants often deferred to others such as family members, or to alternative sources such as the internet, for information around pregnancy, labour and delivery. It was evident that they were active in processing the information that was provided to them; some of which they accepted and some they rejected. Consequently they were not always passive recipients of information.

A perception of being different from older pregnant women came through strongly in the interviews. As discussed in chapters one and two, this perception of difference is perpetuated not only by the media but by medical and nursing research as they construct adolescent mothers to be separate and different from other mothers (Breheny & Stephens, 2010). Other researchers have reported that adolescent mothers felt inhibited attending ANE classes with older women (de Jonge, 2001), judged by older mothers (Kirkman, et al., 2001) and stigmatised and discriminated against as a result of the negative images associated with early childbearing portrayed in society (Hirst, et al., 2006; Kirkman, et al., 2001).

While a separate programme provides an adolescent-friendly environment and the opportunity to compare themselves to others in similar circumstances (that is, a similar age) it could be argued that, as identities are constructed, the segregation of pregnant adolescents into a separate ANE programme ties them to an identity. It potentially perpetuates a personal identity of difference from other childbearing women, particularly as it occurs at a time when they are in the process of establishing their own identity (Erikson, 1994) and are perhaps more vulnerable to stereotypes (Kulkarni, 2007). It is possible that this is also exacerbated by adolescents' consciousness of how others perceive them (Sebastian, et al., 2010). The opportunity is also reduced for these young women to orientate themselves to other less stigmatised identities which has been found to be a protective mechanism for self concept and self worth (Kulkarni, 2007; Shih, 2004; Yardley, 2008).

As the average age for childbearing increases, pregnant adolescents move further from society's norm. On this basis, a separate ANE programme aims to provide a sense of belonging for adolescents who are pregnant. However, it needs to be considered whether its existence creates a perception of pregnant adolescents as a special group who sit outside society's childbearing norm and reinforces their perception of not-belonging in the world of other childbearing women. It is possible that the practice of manipulating the adolescents into a classified group results in social exclusion as it perpetuates their positioning as the 'other' in society (Rabinow, 1984). This is worth particular consideration as adolescence is a time when young people are susceptible to social structural and psychological alienation (Epstein, 2002) meaning they are prone to feeling detached and alienated from others both as a group and as individuals.

Social support

Linking the adolescents up with other pregnant and parenting adolescents for social support is one of the aims of an adolescent ANE programme. An assumption is made that through attending the ANE programme, the adolescents will connect with other young people and develop relationships which will provide ongoing socialisation and support during their pregnancy and after the baby is born. The Families Commission report (Dwyer, 2009) on ANE in New Zealand describes how increased social support (which often extends into the postnatal period) is one of the main benefits and worthwhile outcomes of ANE classes. The report also recommends classes being held

for homogenous groups of women to facilitate friendships and social support (Dwyer, 2009). This view supports the grouping of adolescents together into an ANE programme if age alone is considered to be what makes a group homogenous. However, as this research has shown, pregnant adolescents are a heterogeneous group and the interpretation of homogenous in this way risks defining adolescents by a single identity of the pregnant adolescent. It neglects to take into account the life experience and life skills that make up the individual.

Pregnancy and parenthood during the adolescent years can be an isolating experience. The support that pregnant adolescents gain from their peers often reduces over the period of their pregnancy and they can feel they no longer have very much in common with them (Barrell, 2003; Hirst, et al., 2006; Macleod & Weaver, 2003). Some of the participants in this study also described the loneliness and social isolation that they had experienced as a result of being at home pregnant or with a young baby. Attending the ANE programme provided an opportunity to meet other young pregnant women, however, as this centralised ANE programme was based on age alone, it meant that the participants came from vastly different geographic areas in a large city. The diversity, therefore, in socio-economic status and personal circumstances meant the participants were quite a heterogeneous group. Because age may have been the only thing that some of the adolescents had in common, ongoing friendships and socialisation did not necessarily result. This was evident when one couple decided to also attend a traditional ANE programme in the hope they would meet people more like themselves as they did not meet anyone in the adolescent programme with whom they wished to keep in contact. Similarly, another participant described how it was awkward to keep in touch with the other adolescents as they were all so different. It was, therefore, not surprising to find that contact had often ceased after conclusion of the programme. Two couples who lived in neighbouring suburbs had met up socially before their babies were born although this contact had eased off after the babies were born and at the six weeks post-natal interview they had not seen each other. Geographical proximity is relative to the situation so, although these participants lived in neighbouring suburbs, a bus or car was still required in order for them to see each other. Before the baby is born this may have been straightforward but with a new baby this may not be so easily achievable. Along with the possible reduced support from their peers, the lack of ongoing socialisation with other adolescents from the ANE programme can leave the new

mother isolated until such a time when she is able to meet other new mothers in her local area. This may not happen until she is introduced to a coffee group through a community centre or the Plunket Society, or she begins to attend a community playgroup. With the first visit from the Plunket nurse aimed at being between four and six weeks postnatal (Plunket, 2011), this can mean little, or in some cases no, social contact with other new mothers during the early weeks of parenting. All but one of the participants in this research left their local communities to attend the ANE programme, meaning they were denied the early opportunity to meet and develop relationships and support networks with other pregnant women within their own communities. Attending an ANE programme in their own communities, however, would provide an opportunity to meet other pregnant women from a similar socio-economic group. This may be more conducive to establishing and maintaining ongoing relationships as they are likely to have other factors in common with the other new mothers regardless of their age.

The interaction with other women at an ANE programme in their own geographical area not only enables contact with others from a similar socio-economic area, it also opens the opportunity to develop a mentoring relationship with an older pregnant woman. In a mentoring relationship an older adult takes the time to provide ongoing guidance, advice, and encouragement to help an unrelated, younger person learn as they are developing their own identity (Baker & Maguire, 2005). A supportive mentoring relationship would provide guidance, encouragement, emotional support and role-modeling to the adolescent mother. Klima's (2002) experience of seeing older women commonly providing support and guidance to younger pregnant women in pregnancy programmes suggests ANE classes with mixed ages may be a natural way for adolescents and adult mentors to interact. Because a successful mentoring relationship needs to be ongoing and sustained (Rhodes, Bogat, Roffman, Edelman, & Galasso, 2002), developing and sustaining a relationship may be easier when people live in the same area as regular and informal interaction is more likely to occur.

This discussion raises the question of whether an adolescent ANE programme fulfills its aim of facilitating ongoing social support. Paradoxically, the social exclusion and social isolation that these programmes hope to address may in fact, be reinforcing it.

Surveillance

Epidemiological research highlights areas of risk in health. Policies and programmes based on these risk factors are then implemented that target particular populations. This research suggests that pregnant adolescents are managed as an at-risk population as they are engaged in ANE as early as possible in their pregnancy rather than at the recommended time of 28-30 weeks gestation (MAMA, 2011). They also receive more hours of ANE than they would in a traditional programme which also suggests that pregnant adolescents are targeted as a group requiring extra education and intervention. This extra education and intervention that pregnant adolescents receive associates adolescent pregnancy and motherhood with risk. Problematising the normal and determining risk factors creates the possibility for illness, which then opens the space for surveillance medicine where all pregnant adolescents (based on age alone) are deemed at risk and merged into surveillance medicine's field of visibility (D. Armstrong, 1995).

Attending the ANE programme also enables the adolescents to be put in contact with a social worker and reinforces the close ties a centre may have with Child, Youth and Family Services (CYFS). This enables the efficient referral of anyone identified as requiring their intervention. Adolescents who attend the ANE programme are then encouraged to progress to attending additional seminars, such as baby safety; relationships, bonding and caring; breastfeeding; and young parenting courses. This ongoing access to the adolescents by health practitioners ensures that they remain under their gaze and subjects them to ongoing surveillance. It also reinforces their position as an at risk population requiring additional education and intervention to enable appropriate parenting. As other research asserts, parenting problems relate more to the background of the woman than to the age at which she starts childbearing (Geronimus, 2003; Holgate, et al., 2006; Hotz, et al., 2005; Kelly, 1996; SmithBattle, 2007b), and therefore raises the question as to what extent age can be determined as a risk factor that justifies this ongoing surveillance.

The perceived need for early engagement with the ANE provider and the provision of extra health education suggests that health practitioners have lower expectations of an adolescents' ability to manage their pregnancy, childbearing and parenting. These lower expectations have previously been demonstrated where health practitioners' constructs

of pregnant and parenting adolescents have denied young parents the 'good mother' position (Breheny & Stephens, 2007; Quinlivan, et al., 2004). The data from this research challenges whether a group that are defined purely by age require this additional intervention and surveillance. Many of the participants had been present for the birth of their siblings and had played an active role in raising and caring for these younger siblings; they drew on this experience and demonstrated a confidence in caring for their own baby. Other research also challenges the notion of whether adolescents, as a group, require this special attention as they report that many adolescent mothers consider themselves to be equally as competent as older mothers but are subjected to judgment, discrimination and stigma (Hirst, et al., 2006; Kirkman, et al., 2001).

Health Education as Biopower

As discussed, the grouping together of pregnant adolescents subjects them to the scrutiny of the gaze and surveillance by health practitioners. It also enables the discipline of health education to regulate and manage their conduct more effectively. Health education is clearly beneficial as it has been shown to improve clinical outcomes in conditions such as heart failure, asthma and diabetes (Koelling, Johnson, Cody, & Aaronson, 2005; Liu & Feekery, 2001; Rickheim, Weaver, Flader, & Kendall, 2002; Salinero-Fort, et al., 2011). However, health education also contributes to the management and control of individuals as it defines what are considered good, or normal, behaviours and the desired way to conduct oneself in order to achieve and maintain good health.

Empowerment

Health education aims to increase autonomy by empowering individuals to make their own decisions around their health. Feste and Anderson (1995) describe empowerment as an educational process designed to help individuals develop the knowledge, skills, attitudes, and degree of self-awareness that is necessary to successfully assume responsibility for decisions regarding their health. In this research, one of the main aims of the ANE programme was to provide education to empower the adolescents to exercise autonomy by making their own choices. Many of the participants reported one of the main benefits of attending the programme was the education they received about self care during pregnancy, breastfeeding, pain relief, labour and delivery and how this knowledge enabled them to make choices. The deeper knowledge which the

participants acquired had a liberating potential as they were provided with information which could empower them to make their own decisions. Alternatively, health education can be viewed as a bio-power strategy given that it opens a space that allows for the management and control of individuals into behaviours that are considered appropriate by health practitioners. When viewed from the perspective of bio-power, the health education that the participants received could either empower or subjugate as they were both liberated and disciplined at the same time (Gastaldo, 1997). Because health education provides guiding principles as to the way people should regulate and manage their bodies, it has the potential to construct an individual who self-regulates, self disciplines and therefore, voluntarily conforms (Gastaldo, 1997; Grace, 1991).

In this research, a degree of anatomo-political compliance was demonstrated when some of the participants voluntarily conformed to the representation of what was expected in the best interests of their own and their baby's health. The power/knowledge nexus that exists in healthcare means the health educators had the ability to define what is the normal or abnormal, right or wrong way to conduct oneself in childbirth, thus building up a representation of what is expected (Foucault, 1989). This was particularly highlighted when one of the participants described how after the ANE course she now knew what she wanted in order to do the proper thing in childbirth. As the decisions she made were directed at achieving the representation of what is considered correct, this indicates a self-discipline that has shaped her conduct.

Gaining Compliance

Normalisation

A disciplinary society operates through strategies of normalisation, where behaviours are influenced by appealing to people's desire to be like everybody else, or normal (McNay, 1994). In this research some of the participants' views and behaviours were influenced and regulated through standards and values that are related to normality. For example, the World Health Organisation states that "Breastfeeding is the *normal* [emphasis added] way of providing young infants with the nutrients they need for healthy growth and development" (WHO, 2011).

Reward and punishment

Health education has a coercive aspect as it sets out to normalise conduct by influencing and manipulating attitudes and behaviour (McNay, 1994). The subtle, coercive strategies which are used in health education are a form of social control as the result is the production of self-disciplining, docile, productive and useful bodies that serve the needs of a capitalist society (Foucault, 1977). The attempts made by health educators to shape choices and control conduct are disguised and justified by using the health and wellbeing of the mother and baby as a reason for compliance (Lupton, 1995). The findings from this research suggest that the health education the participants received was able to gain compliance and cooperation by influencing the choices and decisions that were made around labour, delivery and infant feeding. While the participants were given information so as to make their own choices, attaching benefits and adverse effects to these choices potentially shaped the decisions they made. When truths around the different options are imposed, choices become controlled both from the outside (health educators) and from within (self surveillance and self discipline). When most of the participants wanted to experience the benefits of a water birth and avoid having an epidural due to the associated risks, this raises the question of whether they were empowered or if they had conformed to the objectives of the health educator to choose the right choice or the desired behaviour.

The participants also identified ways that breastfeeding provides numerous benefits to the mother and baby. Similarly they discussed the punishments, in the form of potential harm (such as dental decay) of formula feeding their babies. From this perspective, health education reduced autonomy as it restricted choice by presenting options with benefits and risks attached to them. This finding was also demonstrated by Fahy (2002) who found that certain rewards such as a safe pain-free birth, and punishments such as death or damage to the mother or baby, were subtly used by health practitioners to gain compliance with pregnant adolescents. Powers (2003) has also contended that the underlying intention of empowering individuals through health education is that the individual will make the choices the health educator wants them to make. When one of the participants in this research sensed disapproval from her health practitioners about her choice to formula feed her baby it suggests that she did not meet the health practitioners' expectation that she would make the right choice, that is, to breastfeed her baby.

Guilt

Breastfeeding is one of the norms that has been established to optimise the health of the population and consequently a certain amount of guilt is instilled in people to breastfeed their baby (Tierney, 2004). Lupton (1995) identifies mechanisms of self surveillance and evoking feelings of guilt as ways in which individuals voluntarily conform to health objectives and behaviours so as not to appear deviant or abnormal. Along with the previously mentioned benefits of breastfeeding and risks of formula feeding, some of the participants felt a sense of responsibility to breastfeed. Instilling a sense of responsibility for their babies health in the form of breastfeeding can result in a sense of failure for not conforming to this norm. Guilt and a sense of failure were evident when one participant equated her feelings of not being able to breastfeed as that of having a mental breakdown. As Canadian philosopher, Ian Hacking, has been quoted "It is seldom force that keeps us on the straight and narrow; it is conscience" (Hacking, 1986; as cited in Vaz & Bruno, 2003). The pressure on women to breastfeed has been raised as ethically problematic because collective wellbeing is not balanced with an individual's own wellbeing and need for free choice (Nihlen Fahlquist & Roeser, 2011).

Resistance

Utilising disciplinary power, health education opens a space that allows for the management, control, and transformation of bodies (Gastaldo, 1997). The pregnant body in particular is considered to be a target of disciplinary power but, as resistance is prevalent within power relations, it is also a point where the techniques of disciplinary power are resisted (Faubion, 2001; McNay, 1994). Despite the bio-political strategies of health education, which often resulted in the participants conforming to the objectives of the health educators, the participants also displayed a resistance to some of the authoritative and disciplinary aspects of health education. Resisting attempts to regulate their conduct they took up alternate subject positions and practices of the self. In doing so, they asserted their individuality (Lupton, 1995). Some of the strategies that were used by the participants to resist included evasion, non-conforming, withholding of information, choosing what to read and what not to read from the material provided, and non-attendance at the breast feeding seminar. There are many possible reasons why the participants practiced these various modes of resistance. It is possible they resented being told what to do or that they gained more gratification from "other practices of the self" (Lupton, 1995, p. 133).

One participant resisted the disciplinary nature of health education as she stopped listening to the health education offered to her around the adverse effects of cigarette smoking while pregnant. She resisted conforming as she chose to continue smoking during her pregnancy. Similarly, when AM described how she didn't pay attention to the information around alcohol in pregnancy she too may have been resisting conforming, thus being regulated. These findings are in keeping with Lupton's (1997) views that in order for an individual to consent to being governed they must first be willing to exist as a subject and that individuals resist strategies and practices by health workers that are designed to influence their behaviour. They also replicate Wheatley's (2005) findings that rather than being passive recipients of disciplinary power, individuals actively evaluated the information they received and do not always acquiesce to medical authority.

One participant exercised her autonomy when she chose to wait a while before her baby received the six week immunisations. She had been provided with information around vaccinations which empowered her to make her own decision. As her decision meant she did not comply with the timings of the immunisation schedule, she could be considered to be a non-compliant mother whose baby is at risk of the possibility of illness. Alternatively, her behaviour may demonstrate how she had become an autonomous self who had been empowered to make her own decisions.

These examples of the participants exercising their autonomy do, however, raise the issue of balancing individual autonomy with the non-maleficence or 'do no harm' duty of health practitioners. Health practitioners have a responsibility to respect people's choices and their right to exercise autonomy but not without regard for the possibility of causing harm (Chiovitti, 2011).

Governmentality

The education provided in ANE programmes is specified in policies such as *The National Service Specification for Pregnancy and Parenting Education* (Ministry of Health & DHBNZ, 2002), the *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women* (Ministry of Health, 2006), and the *Baby Friendly Hospital Initiative* (WHO & UNICEF, 2009). These policies aim to transform and improve the population by providing a framework to shape the conduct of both individuals and entire populations. From a Foucauldian perspective, health education that is

underpinned by such policies is a form of governmentality as it involves techniques that aim to manage individual behaviours in order to achieve improvement. The Ministry of Health not only determines what knowledge will be taught to pregnant women, they then seek to ensure that all women access ANE programmes to make certain this information will be passed on to them (Ministry of Health, 2002).

The breastfeeding information presented during pregnancy is underpinned by several policies. At an international level, *The Global Strategy for Infant and Young Child Feeding* (WHO, 2003), the above mentioned *Baby-friendly Hospital Initiative* (WHO & UNICEF, 2009), the *International Code of Marketing of Breast-milk Substitutes* (WHO, 1981) and the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* (UNICEF, 1990) all state interventions and guidelines to ensure that all health services protect, promote and support exclusive breastfeeding as "the vast majority of mothers can and should breastfeed…" (WHO, 2003, p. 10). In New Zealand, national policies are developed from these international policies and includes *The National Strategic Plan of Action for Breastfeeding 2008–2012* (National Breastfeeding Advisory Committee of New Zealand, 2009).

The implementation of these policies relies on an intermediary to support their claims and to institute their recommendations. Particularly in their role of providing health education, the health practitioner becomes this intermediary as they mediate between the policy makers and the target population. It is the health practitioner through whom the power passes thus making them "links in a set of power relations" (Lupton, 1997, p. 99).

Health practitioners are in a privileged position because, in addition to their expert positioning, they are also granted a social mandate of caring (Perron, et al., 2005). This position of a carer who has their clients' best interests as their priority, along with their expert knowledge, potentially increases their capacity to influence individuals to whom they provide health education. As in most healthcare settings, the health practitioners in this study worked to establish rapport and gain the trust of the participants. Utilising their benevolent or pastoral power possibly facilitated the changing of attitudes and shaping of individual conduct, further demonstrating how health practitioners are suitably positioned to act as agents of the state (Perron, et al., 2005).

In this research, an example of the bio-political strategy of employing health educators as agents of the state was demonstrated by the education the health practitioners provided to the participants around breastfeeding. The *National Strategic Plan of Action for Breastfeeding 2008–2012* (National Breastfeeding Advisory Committee of New Zealand, 2009) states that the role of both hospital and community health practitioners is central to the promotion of breastfeeding due to their contact with pregnant women and new parents (National Breastfeeding Advisory Committee of New Zealand, 2009). In addition, the *National Service Specification for Pregnancy and Parenting Education* (Ministry of Health & DHBNZ, 2002) recommends that women breastfeed their babies and that health practitioners promote breastfeeding. In other words, the health practitioners were well positioned to manage and influence the participants into making the choice to breastfeed their babies.

The *National Strategic Plan of Action for Breastfeeding 2008–2012* (National Breastfeeding Advisory Committee of New Zealand, 2009) also states that all women, fathers/partners and whānau are to have access to the benefits of breastfeeding and the risks of artificial feeding in order to make fully informed decisions about infant feeding. While the ANE providers adhered to this guideline, this research questions whether the participants were actively empowered to make authentically and fully informed infant feeding choices given that the options were presented in the form of the benefits of breastfeeding and the risks of formula feeding.

These above mentioned policies also state that information and instruction for breastfeeding is to be provided without information on the use of infant formula and that group talks are not given routinely on the use of infant formulae or bottlefeeding (Dwyer, 2009). In this research one of the participants described how she felt her health practitioners didn't want to discuss formula feeding with her. In order to be empowered to make a choice, information needs to be provided around all the options available for infant feeding. The withholding of information on formula feeding, unless it is in association with risk, could be considered an example of what Grace (1991) describes as the controlling rather than empowering practice of health education.

When one of the participants in this research sensed that choosing to formula feed rather than breastfeed her babies was an unacceptable decision to her health care practitioners, this is indicative of the fine line between caring and discipline described by Holmes and

Gastaldo (2002). It could also be argued that complying with the *National Service Specification for Pregnancy and Parenting Education* can place health professions in a position that is contrary to the NICE (2008, p. 12) guidelines which state that "[w]omen's decisions should be respected, even when this is contrary to the views of the healthcare professional."

Although no Ministry of Health policies or guidelines could be found that directly outlined the objective of preventing a subsequent pregnancy in adolescent mothers, a common success criteria stated by researchers of adolescent programmes is the prevention of subsequent pregnancies in adolescent mothers (Das, et al., 2007; Furey, 2004; Key, et al., 2001; Salihu, et al., 2011; Stevens-Simon, Kelly, & Kulick, 2001). This objective of reducing subsequent pregnancies in adolescent mothers provides an example of a metanarrative in that medical experts have legitimised this assertion so it has become accepted as truth. In this study it was evident that, although the health practitioner considered that adolescents just like older women might wish to group their pregnancies, she upheld this metanarrative by advocating for the implementation of a free, long-acting contraceptive as a successful way to reduce subsequent pregnancies in adolescent mothers (Kaunitz, 2007; Stevens-Simon, et al., 2001). This raises the question as to whether health practitioners uphold or resist bio-political strategies that aim to manage and control individuals when the objectives do not correspond with their own social beliefs.

Financial dependence

As mentioned in chapter one, young mothers may soon be subjected to extra financial scrutiny with the external control of their finances being undertaken by the government. This economic control, disguised through the social system of WINZ, contributes to the social regulation of young mothers (Petersen & Brunton, 1997). As all the participants in this research were economically dependent on WINZ, they were held in a dependent position to the state. Although the WINZ representatives portrayed themselves as providing a helpful service, this was not the reality for the participants. There was a sense of suspicion expressed by almost all of the participants that the WINZ representatives were not divulging all the information they needed or providing all the assistance they were entitled to. This demonstrates how WINZ can be viewed as a technology of power and an institution of economic control with the WINZ

representatives having the ability to control the financial assistance received through sharing some, and withholding other, information. This power to control the information, and therefore the financial assistance, received by pregnant and parenting adolescents keeps the participants in an even more dependent position.

However, in a manner similar to the resistance to bio-political strategies of health education, the participants contested the top-down power of WINZ as they challenged what the WINZ representative was telling them. When one of the participants expressed his displeasure by walking out of the seminar, his actions can be seen as a refusal to engage with an identity of a submissive and dependent recipient and a resistance to being governed (McDonald & Marston, 2005; McKee, 2009).

Summary

This chapter has discussed how bringing together a group of pregnant adolescents into an ANE programme is a manifestation of the gaze and surveillance to which pregnant adolescents are subjected. It is argued that grouping pregnant adolescents together, based on age alone, constructs them as vulnerable and potentially problematic thus creating and reinforcing a stereotyped identity for both the adolescents themselves and society in general. It has raised the question of whether such programmes risk compounding rather than ameliorating the social exclusion that pregnant adolescents experience. This chapter has also presented, from a Foucauldian perspective, how the regulation, transformation and improvement of bodies is achieved through the bio-political power of health education. Health education has been portrayed as a disciplinary power which has the capacity to interfere with individual choice. This research has also demonstrated how individuals do not always conform; rather they exercise their own power through resisting the disciplinary strategies of health education.

The next chapter summarises this thesis and identifies the limitations of the research, the implications for nursing practice and makes recommendations for further research.

Chapter Seven: Conclusion

Introduction

This chapter presents; a summary of the thesis background; aims and findings; the study limitations; and discusses the implications for nurses and other health practitioners. The chapter concludes with recommendations for possible future research.

Pregnant adolescents are seen to have needs that are unique to other expectant parents. This, and the epidemiological research that associates adolescent pregnancy with risk, has led to the development of ANE programmes dedicated to adolescents. Dedicated programmes are expected to increase the uptake of ANE by pregnant adolescents which is then expected to improve the health and social outcomes for them and their babies. (Ministry of Health, 2011; Nolan, 1998). In addition, a dedicated adolescent ANE programme aims to facilitate social support by providing networking opportunities for pregnant and parenting adolescents.

This thesis came about after a review was undertaken to assess the value of a dedicated adolescent ANE programme for the programme participants. From a post-modern and critical perspective, Foucauldian theory provided the lens for the interpretation of the study data. Using the overarching framework of bio-power and the integration of the study's data with other relevant literature, the taken for granted assumption that a programme dedicated to pregnant adolescents is solely beneficial has been challenged. Within this framework of bio-power, the bio-political nature of antenatal health education has been examined.

Within the overarching framework of bio-power, the concepts of bio-politics and anatamo-politics have been used to inform the two themes discussed in chapters four and five. Firstly, the concept of bio-politics has made possible an alternative view as to whether the provision of antenatal education programmes dedicated to adolescents are beneficial. It is acknowledged that there are certainly pregnant adolescents who are vulnerable as the result of disadvantaged socio-economic circumstances and that safeguards rightfully are, and certainly must be, in place to support and protect them. This study has not aimed to dispute that. The desired outcome of this thesis has been to explore the power structures and subjective perceptions of health practitioners and

institutions which contribute to the construction of adolescent pregnancy, and therefore pregnant adolescents as a group, as a social problem.

This thesis has argued that adolescent ANE programmes, based on age alone, publicly construct pregnant adolescents as a problematic group who are susceptible to failure and therefore require extra intervention. This construction justifies and subjects them to extra scrutiny and additional intervention which was evident by the increased amount and type of education that was provided in the programme. It also subjects pregnant adolescents to ongoing surveillance from health practitioners and social services, suggesting there is an expectation that adolescents are less able to adequately manage their pregnancy, childbearing and parenting. The findings from this thesis have presented pregnant adolescents as a heterogeneous group with a variety of life experiences, life skills, educational attainment and socio-economic backgrounds. With this in mind, and considering that young maternal age is regarded as less of a factor than pre-existing social and economic disadvantage for adverse outcomes, it is difficult to justify this increased surveillance based solely on age.

This study also contends that the segregation of pregnant adolescents into a centralised programme places adolescents at risk of social exclusion during their pregnancy and the early weeks of parenting as they are dislocated from the potential support networks that may have otherwise developed from attending an ANE programme in their local communities. The interaction with other expectant parents in their community that attending a local ANE programme would provide, creates an opportunity to develop relationships in the form of friendships or mentoring relationships with older women. There was no evidence from this research that ongoing relationships and social support were an outcome of a centralised programme. It is not known if this was a short term phenomenon only as the follow-up in this study was no later than six weeks after the birth of their baby. It is possible that the heterogeneity of the group, compounded by the vast geographic area the participants came from, were reasons for the reduced levels of contact. Even if contact between the programme participants was resumed at a later date, it still may mean that many young mothers are alone in their own community during the first few months of parenting.

The second concept of anatamo-politics enabled the next outcome of this thesis, which was the deconstruction of antenatal education from a bio-political perspective. Although

the acquisition of knowledge from ANE classes prepares pregnant adolescents and their partners for labour, delivery, and early parenting by enabling them to make informed choices, this thesis has demonstrated the capacity health education has to be an authoritative and disciplinary power. Options and choices were presented to the participants in order for self-determination and autonomy to be exercised around their labour, delivery and infant feeding choices. However, in order to achieve what are considered to be ideal health outcomes for the participants and their babies, the choices considered by health practitioners to be correct are sometimes pre-determined. This research has demonstrated the coercive aspects of the ANE education which the participants received. As the intermediary between the Ministry of Health policies and the participants, the health practitioners disseminated certain knowledge and normalised certain behaviours which had the capacity to shape the attitudes, and therefore conduct, of the participants.

This thesis questions whether the participants were in fact empowered or whether the normalisation of certain behaviours, and the provision of certain knowledge that health practitioners believed they needed, is a power technique that had the ability to coerce the participants into managing their bodies in a pre-determined way. However, it was also established that the participants did not always acquiesce; rather they resisted some of the disciplinary aspects of health education. An insight has been provided into the varying ways in which the participants resisted being engaged in some of the strategies to manage their conduct, which has demonstrated how power and resistance in health education are a complex network of relationships.

Limitations

As with all research, there are limitations to this study. As the participants were self-selected and socio-economic data was not collected, it cannot be determined if they were the socially deprived adolescents that the literature refers to as being a disadvantaged and vulnerable population. Equally, the characteristics of those who declined to participate in the research are not known, therefore, it cannot be established how or whether they would have affected the findings. It is also possible that those who had more confidence in their understanding of childbirth and early parenting were more likely to consent to participate. Although this research did not attempt to be representative of pregnant adolescents, these limitations mean the findings can only be

associated with this group of participants, at this ANE programme and at this period in time.

During the interviews it was not uncommon for the participants themselves to ask questions as they considered me, as a nurse, to be a source of information. Britten (1995) suggests that questions can be answered at the end of the interview, however, it is not ideal as it may affect the participant's willingness to answer later questions. A sense of reciprocity meant the questions were answered as they came up during the interviews which meant there was a risk my views possibly influenced their responses. Every attempt however, was made to avoid subjective answers that may have affected their responses.

There is the possibility that social desirability bias occurred in this study. Social desirability is the tendency for participants to provide responses that are considered more socially acceptable than their true answer would be (Callegaro, 2008). Over reporting socially desirable behaviours and under reporting socially undesirable behaviours is a commonly acknowledged challenge in research (Stuart & Grimes, 2009). Considering that many of the participants in this study had experienced the stigma of being a pregnant adolescent, this may have made it more likely that they responded in a way that would be viewed favourably. However, the openness that characterised their interviews suggests that if this were the case, it was likely to be to a minimal degree.

A descriptive report of the ANE programme was required by the service provider which meant the data collected needed to serve both the report and this thesis. This is both a strength and limitation of this research. As the interview data was collected prior to incorporating the critical approach and theoretical concepts, the interviews were less likely to be influenced by any *a priori* knowledge. However, it also meant that some areas were left under-explored in the interviews.

Recommendations

The findings of this research have implications for all health practitioners, including nurses. Based on the findings the following recommendations have been developed:

1. An increased emphasis in undergraduate and postgraduate nursing, and other health practitioners' education programmes, be placed on how healthcare and social services contribute to the construction of groups in society.

Targeted health programmes may be instrumental in the construction and stigmatisation of certain groups of people as a problem. This construction can then influence practice and subject individuals to unjustified scrutiny and surveillance.

2. ANE providers could consider adapting the promotion and delivery of ANE programmes in a way that engages adolescents, thus facilitating the integration of adolescents into local classes with women from their own communities.

The inclusion of pregnant adolescents into ANE classes with older women may have social benefits as it allows an opportunity for the adolescents to develop and maintain ongoing relationships with other pregnant women in their own community.

3. The development of a mentoring programme to facilitate the development of relationships between pregnant adolescent and older pregnant women.

The development of mentoring relationships between an adolescent and an older pregnant woman would provide support guidance, instruction, and encouragement (Baker & Maguire, 2005). Mentoring may also aid resilience and have a positive influence on a pregnant adolescent's identity (Zimmerman, et al., 2005).

4. Continued promotion of consumer engagement in the development and delivery of health education services.

The importance of working in partnership with consumers of health services in a meaningful and collaborative way is well recognised in most healthcare settings. Frameworks for the development of decision making relationships between providers and consumers could possibly be included in undergraduate and/or postgraduate nursing programmes.

5. Nurses and other health practitioners be encouraged to reflect critically on the implications of their practice and how their role possibly influences the attitudes, choices and behaviours of their clients.

Nurses, through the provision of health education, aim to optimise the health and wellbeing of the populations and individuals they work with. As this invariably involves achieving compliance by individuals to healthcare strategies, all health practitioners may wish to reflect on how and whether their own knowledge and beliefs impact on their interactions with clients. Respect for individual choice and the right to exercise autonomy needs to be balanced with the health practitioners duty of non-malfeasance.

6. It is recommended that nurses and other ANE providers reflect on whether they want to act uncontested as agents of governmentality.

Nurses and other health practitioners are positioned as the link between Ministry of Health policies and the individual. This position means some nursing practices, for example health education, may contribute to social regulation and the building of a normalised society. Nurses are encouraged to evaluate and assess critically the policies and guidelines that underpin the healthcare and health education which they deliver to their clients.

7. Nurses, both as a group and as individuals, should continue to make submissions on consultation documents for policies, strategic plans, education programmes and action plans in health.

As has been demonstrated in this research, nursing is not a powerless profession. Nurses are encouraged to view their power as productive and recognise that they are able to utilise this power to bring about change. Policies in health should not go unchallenged by the very group who will be implementing the strategies within them.

Possibilities for future research

1. Further research is recommended into the ongoing social support needs of pregnant and parenting adolescents.

There was no conclusive evidence that ongoing relationships and social support were an outcome of the adolescent ANE programme in this study. As the second interviews were undertaken within six weeks of the participants' babies being born, it is not known what social support was in place for the participants after this time. Although it appears unlikely from the data in this study, it is not known whether the adolescents reconnected with the other ANE programme participants at a later date or whether they established a support network within their own communities.

2. Research such as Action Research, in partnership with pregnant adolescents, is recommended to develop initiatives and make recommendations to ANE providers in New Zealand which may enhance the uptake of traditional ANE classes by pregnant adolescents.

The participants in this research expressed a strong sense of not belonging in a traditional ANE programme with older expectant parents. This research was undertaken with interviews only; focus groups held with pregnant adolescents may draw more in depth data in this area.

3. Research is needed in the New Zealand setting on how best to support young fathers during the antenatal period.

As discussed in chapter two, other researchers have suggested that more research is needed on how best to support young fathers. It is also suggested that antenatal classes are more inclusive of, and accessible to, fathers with fathers-only classes for information that is important to them. How best to achieve this is an underexplored area.

4. Research is recommended that could include exploring whether social and health services for pregnant adolescents contribute to the construction of adolescent pregnancy as a problem.

Concluding statement

Antenatal education programmes dedicated to pregnant adolescents, although beneficial in many ways, may be unintentionally complicit in reinforcing the positioning of pregnant adolescents as different and therefore abnormal. Rather than being just one of the factors that makes up her individuality, the adolescent's age becomes a defining characteristic during her pregnancy. Likewise, shaping certain behaviours is beneficial in many ways as it goes toward optimising health outcomes, yet in doing so, nurses and other health practitioners may unintentionally contribute to the social regulation of individuals.

Overall, this research has contributed to knowledge in the area of ANE for pregnant adolescents. It is hoped that further research can contribute to development of appropriate, empowering support for these young people.

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Appendix A: Ethical approval

MASSEY UNIVERSITY
ALBANY

10 December 2009

Anna Brown
c/- Dr D Wilson
College of Humanities and Social Sciences
Massey University
Albany

Dear Anna

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 09/061
"Evaluation of a Teen Antenatal Programme"

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

DH Gardner

Dr Dianne Gardner
Deputy Chair
Human Ethics Committee: Northern

cc: Dr D Wilson
College of Humanities and Social Sciences

Te Kunenga ki Pūrehuroa

Office of the Assistant to the Vice-Chancellor (Research Ethics)
Private Bag 102 904, North Shore City 0745, Auckland, New Zealand Telephone +64 9 414 0800 ex 9539
humanethicsnorth@massey.ac.nz

Appendix B: Participant letters of invitation

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Teen Antenatal Programme Evaluation

Dear

My name is Anna Brown and I am a nurse studying towards a Masters degree at Massey University in Albany. As part of my degree I am evaluating the Teen Antenatal Programme at the Auckland Women's Centre and I would like to invite you to participate. To do this evaluation I will be gathering information to see if the course is meeting the needs of people like you and find out if there are ways to improve it. I will then write a report about the findings.

You are invited to participate in the study because you are one of the people attending this antenatal course for teenagers. Taking part in the study is completely your choice so you don't have to take part if you don't want to. If you decide you do not want to take part, it won't affect the care you are given in the antenatal course. You may also quit being in the study at any time, without giving a reason, or decide not to answer any question you are not comfortable answering. If at any time you find the interview distressing you can ask for it to be stopped and, if you wish, I can refer you directly to a specialist or social worker for ongoing help.

You may take this information sheet and consent form home to think about it, or talk about it with your family or friends, before you decide to take part**.**

Taking part means I will ask you to meet with me to talk about the course. In particular, you will be asked questions about what you would like to get out of the course and we will discuss how you are finding the course and how helpful the information is to you that you are given. I would also like to contact you after your baby is born to talk about your views on the programme and how you think it helped you and ways that it could be improved.

There will be two meetings that will take place at the Auckland Women's Centre or, if you prefer, I can come to your home at a time that suits you. The meetings should last about one hour and will be audio taped so that I can accurately recall what we talked about. You can ask for the recorder to be turned off at any time during the meeting.

The tapes will only be listened to by me and the person who will transcribe them. They can then either be returned to you or be destroyed.

If you decide to take part you will receive a $20.00 gift voucher to reimburse you for your time and travel expenses. I can reassure you that the information you give me will remain confidential unless required by law to prevent serious harm. Nothing that could identify you will be used in the evaluation report. Your study information will be coded and stored in a password protected database that is only accessible to me and my research supervisors. It will be stored in an offline (not accessible over the Internet) location for five years and then destroyed.

Although you probably won't benefit directly from taking part in this study, we hope that others who attend this course in the future will benefit as a result of the information you give.

If you choose, I will post you a summary of the findings when it is finished. Please keep your address updated with the Auckland Women's Centre.

I am happy to answer any questions you have about this study. You can contact me:

1. **Anna Brown** phone: 486 8920 ext. 3108 or Mob: 021 114 2972
   Email: brown.anna07@gmail.com

   Or one of my supervisors:

2. **Denise Wilson** phone: 414 0800 ext. 9070 or Mob: 027 407 0022
   Email: D.L.Wilson@massey.ac.nz

3. **Lanuola Asiasiga** phone**:** 366 6136 or 414 0800 ext 41341
   Email: L.Asiasiga@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/061. If you have any concerns about the conduct of this research, please contact Dr Dianne Gardner Deputy Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x41225, email humanethicsnorth@massey.ac.nz

Thank you for considering this. If you would like to take part, please sign the attached consent form and give it to me at the course or post it to me in the enclosed envelope.

With kind regards

Anna Brown

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Teen Antenatal Programme Evaluation:

Letter of invitation: Staff

Dear

My name is Anna Brown and I am a registered nurse studying towards a Masters degree at Massey University in Albany. As part of my degree I am evaluating the Teen Antenatal Programme at the Auckland Women's Centre and I would like to invite you to participate. To do this evaluation I will be gathering information to see if the course is meeting the needs of the pregnant teens, their partners and/or support people and find out if there are ways to improve it. I will then provide the Auckland Women's centre with a report on the findings.

You are invited to participate in the study because you are one of the staff members facilitating this antenatal course for teenagers. Taking part in the study is completely voluntary and if you choose not to participate it will not affect your employment or relationship with the Auckland Women's Centre. You may also withdraw from the study at any time, without giving a reason, or decide not to answer any question you are not comfortable answering. If at any time you find the interview uncomfortable you can ask for it to be stopped.

You may take this information sheet and consent form home to think about it, or talk about it with your colleagues, family or friends, before you decide whether or not to participate**.**

Participation will involve meeting with me to discuss the course. In particular, you will be asked questions about the course content, delivery and ways that you feel it could possibly be improved.

There will be two meetings that will take place at the Auckland Women's Centre or, if you prefer, I can come to your home at a time that is convenient for you. The meetings should last about one hour and will be audio taped so that I can accurately recall what was discussed. You can ask for the recorder to be turned off at any time during the meeting. The tapes will only be listened to by me and the person who will transcribe them. They can then either be returned to you or be destroyed.

If you decide to take part you will receive a $20.00 gift voucher to reimburse you for your time and travel expenses.

I can reassure you that the information you give me will remain confidential unless required by law to prevent serious harm. Nothing that could identify you will be used in the evaluation report. Your study information will be coded and stored in a password protected database that is only accessible to me and my research supervisors. It will be stored in an offline (not accessible over the Internet) location for five years and then destroyed.

Although you won't benefit directly from taking part in this study, we hope clients who attend this course in the future will benefit as a result of the information you give.

If you choose, I will post you a summary of the findings when it is finished. Please keep your address updated with the Auckland Women's Centre.

I am happy to answer any questions you have about this study. You can contact me:

1. **Anna Brown** phone: 486 8920 ext. 3108 or Mob: 021 114 2972
   Email: brown.anna07@gmail.com

   Or one of my supervisors:

2. **Denise Wilson** phone: 414 0800 ext. 9070 or Mob: 027 407 0022
   Email: D.L.Wilson@massey.ac.nz

3. **Lanuola Asiasiga** phone**:** 366 6136 or 414 0800 ext 41341
   Email: L.Asiasiga@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/061.

If you have any concerns about the conduct of this research, please contact Dr Dianne Gardner Deputy Chair, Massey University Human Ethics Committee: Northern;

Telephone 09 414 0800 x41225, email humanethicsnorth@massey.ac.nz

Thank you for considering this. If you would like to take part, please sign the attached consent form and give it to me at the course or post it to me in the enclosed envelope.

With kind regards

Anna Brown

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Teen Antenatal Programme Evaluation

Letter of invitation: Fathers

Dear

My name is Anna Brown and I am a nurse studying towards a Masters degree at Massey University in Albany. As part of my degree I am evaluating the Teen Antenatal Programme at the Auckland Women's Centre and I would like to invite you to participate. To do this evaluation I will be gathering information to see how helpful the course is for you as a support person and preparing you to become a father. This will help find out if there are ways to improve it. I will then write a report about the findings.

You are invited to participate in the study because you are one of the people attending this antenatal course as a father or support person. Taking part in the study is completely your choice so you don't have to take part if you don't want to. If you decide you do not want to take part, it won't affect the care you are given in the antenatal course. You may also quit being in the study at any time, without giving a reason, or decide not to answer any question you are not comfortable answering. If at any time you find the interview distressing you can ask for it to be stopped and, if you wish, I can refer you directly to a social worker for ongoing help.

You may take this information sheet and consent form home to think about it, or talk about it with your family or friends, before you decide to take part**.**

Taking part means I will ask you to meet with me to talk about the course. In particular, you will be asked questions about what you would like to get out of the course and we will discuss how you are finding the course and how helpful the information is to you that you are given. I would also like to contact you after the baby is born to talk about how things are going for you, your views on the programme, how you think it helped you and ways that it could be improved.

There will be two meetings that will take place at the Auckland Women's Centre or, if you prefer, I can come to your home at a time that suits you. The meetings should last about one hour and will be audio taped so that I can accurately recall what we talked about. You can ask

for the recorder to be turned off at any time during the meeting. The tapes will only be listened to by me and the person who will transcribe them. They can then either be returned you or be destroyed.

If you decide to take part you will receive a $20.00 gift voucher to reimburse you for your time and travel expenses.

I can reassure you that the information you give me will remain confidential unless required by law to prevent serious harm. Nothing that could identify you will be used in the evaluation report. Your study information will be coded and stored in a password protected database that is only accessible to me and my research supervisors. It will be stored in an offline (not accessible over the Internet) location for five years and then destroyed.

Although you probably won't benefit directly from taking part in this study, we hope that others who attend this course in the future will benefit as a result of the information you give.

If you choose, I will post you a summary of the findings when it is finished. Please keep your address updated with the Auckland Women's Centre.

I am happy to answer any questions you have about this study. You can contact me:

1. **Anna Brown** phone: 486 8920 ext. 3108 or Mob: 021 114 2972
   Email: brown.anna07@gmail.com

   Or one of my supervisors:

2. **Denise Wilson** phone: 414 0800 ext. 9070 or Mob: 027 407 0022
   Email: D.L.Wilson@massey.ac.nz

3. **Lanuola Asiasiga** phone**:** 366 6136 or 414 0800 ext 41341
   Email: L.Asiasiga@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/061. If you have any concerns about the conduct of this research, please contact Dr Dianne Gardner Deputy Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x41225, email humanethicsnorth@massey.ac.nz

Thank you for considering this. If you would like to take part, please sign the attached consent form and give it to me at the course or post it to me in the enclosed envelope.

With kind regards

Anna Brown

Appendix C: Participant Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Teen Antenatal Programme Evaluation

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:…… Date: ……..……..

Full name - printed:……..……

Appendix D: Parental Consent / Participant Assent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Teen Antenatal Programme Evaluation

Parental Permission Form

Researcher: Anna Brown

I have read the information contained in the letter about the above titled study, which describes what my child will be asked to do if (s)he wants to participate in the study; and,

□ Yes – I give permission for my child to participate in the study.
-OR-
□ No – I do not give permission for my child to participate in the study.

_____ _____
Parent/Guardian Signature Date

_____ _____
Child's Name Age

Assent
I have read the information contained in the letter about the above titled study, which describes what I will be asked to do if I decide to participate. My parent/guardian has given me permission to participate. I have been told that the decision is up to me, and that I do not have to participate, even if my parent/guardian says that it is okay. I have been told that I can stop participating at any time I choose, and no one will be mad at me.

□ Yes – I want to participate in the study.
-OR-
□ No – I do not want to participate in the study.

Child's Signature _____ Date _____

Age _____

Appendix E: Interview Guide

Staff

Programme goals

Programme structure

Programme topics

Programme delivery

Strengths of the programme

Organization involved for each course

Resources

Access

Barriers and challenges

Pre-course:

How did you hear about the course

How easy/difficult was it to get into?

Expectations/hopes from course

Other options

Pregnancy care

- Nutrition
- Smoking/alcohol/drugs

Labour and delivery

Breastfeeding

Parenthood

Post-course:

Views of the course

Accessibility- transport, location, time, cost

Information provided

- timing
- relevant/useful
- referring back

Preparation for childbirth and parenthood

Lifestyle changes

- Nutrition
- Smoking/alcohol/drugs

Topics and presentation

Course facilitators

Environment

Best things

Other services

Contraception

Male only sessions

Postnatal :

Views of programme

How prepared for labour and childbirth

Topics not covered

Enjoyment and confidence with baby

Registered with a family doctor

Health problems since the birth

- Breastfeeding
- Immunization
- Contraception

Lifestyle changes since programme

- Smoking/alcohol/drugs

Joined other programmes

Support

Relationships with other teens