

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

# **Teenage and Pregnant:**

## **An exploratory study of pregnant teenagers and their antenatal education needs in the Palmerston North Region**

A thesis presented in partial fulfilment of the  
requirements for the degree of  
Master of Arts in Midwifery  
at Massey University,  
Palmerston North

**Ruth Martis**

**2004**

# **For my wonderful children**

**Hannah, Benjamin, Annie, Solveig  
and special grandsons James and William  
who have enriched our lives forever**

May you search to understand that people do not decide to  
become extraordinary; they decide to accomplish  
extraordinary things.

# Abstract

Teenage pregnancies have become an issue of increasing concern in New Zealand with the second highest teenage pregnancy rate in the world. Pregnant teenagers do not seek early antenatal care for a variety of reasons and are very unlikely to participate in antenatal education. Limited evidence in the literature shows teenage antenatal education can prevent problems developing not only for the teenage mother and her baby's health but also reduce the risks associated with social and maternal behaviours including substance abuse and other addictive behaviours.

This qualitative study aimed to explore needs and issues that might surround and affect teenage antenatal education, and as a result provide midwives and childbirth educators with a clearer understanding of the antenatal education needs and issues as a basis for providing effective antenatal education. 30 participants, distributed over four focus groups, each comprising of 8 - 10 pregnant teenagers or recent teenage mothers, were interviewed in the Palmerston North region, New Zealand. All participants were expecting their first baby or had recently given birth to their first baby and had all attended at least one antenatal education session.

The data identified what participants liked and disliked about antenatal education and described factors that would support the participants having their needs met by antenatal education. Interpretation of these findings formed the basis of recommendations for a teenage antenatal education programme. Overall it showed



clearly that a developmental based programme with a participatory development format is the most effective way of providing antenatal education for pregnant teenagers. This needs to take the form of a teenage support group lasting the whole pregnancy rather than the traditional approach of a set course for a limited time towards the end of the pregnancy.

Detailed topic recommendations were also made by participants including what kind of physical environment would encourage pregnant teenagers to feel 'at home' and what qualities were desirable in a facilitator of a teenage antenatal education programme.

# **Zusammenfassung**

## **Abstrakt**

Teenage Schwangerschaften sind für Neu Seeland ein zunehmendes Problem geworden, denn allein die Statistik weist darauf hin, daß Neu Seeland weltweit gesehen an zweiter Stelle steht. Außerdem ist es eindeutig, daß schwangere Jugendliche oft sehr spät eine Schwangerenvorsorge mit einer Hebamme oder einem Gynäkologen initiieren. Schwangere Teenager nehmen auch sehr selten an Geburtsvorbereitungskursen teil oder kommen einmal und bleiben dann weg.

Es gibt sehr wenig wissenschaftliche Studien und Literatur die sich mit schwangeren Teenagern und deren Bedürfnissen beschäftigen, die vielleicht aufweisen könnten, daß Geburtsvorbereitungskurse vorteilhaft wären und Gesundheitsprobleme wie zum Beispiel Drogenabhängigkeit, Frühgeburten und anti-soziales Verhalten der Mütter verhindern oder verringern könnten.

Diese wissenschaftliche qualitative Studie hatte das Ziel die Realität, Bedürfnisse und Ansichten von schwangeren Teenagern im Raume Palmerston North, Neu Seeland über Geburtsvorbereitungskursen herauszufinden. Die Ergebnisse dieser Studie werden Hebammen, Gynäkologen und Geburtsvorbereitungskursleitern mehr Verständnis einbringen, wenn sie effektive Kurse für schwangere Teenager anbieten möchten.

Vier zielgesetzte Diskussionsgruppen von jeweils 8-10 schwangeren Teenagern wurden auf Tonband aufgenommen und dann analysiert und dokumentiert. 30 Teilnehmerinnen im Ganzen nahmen an der Studie teil. Sie waren alle mit ihrenm

ersten Kind schwanger oder hatten kürzlich ihr erste Kind entbunden. Alle Teilnehmerinnen hatten zumindest an einer Geburtsvorbereitungsstunde teilgenommen.

Die Teilnehmerinnen dieser Studie identifizierten was sie von Geburtsvorbereitungskursen erwarteten und welche positiven und negativen Erfahrungen sie mit diesen Kursen erlebt hatten. Die Interpretation von dieser Information zeigte eindeutig, daß Geburtsvorbereitungskurse für schwangere Teenager seperat von erwachsenen Frauen und Paaren gehalten werden müssen. Die Kommentare von den Teilnehmern zeigten außerdem auch eindeutig, daß Geburtsvorbeireitungskurse für schwangere Teenager nur effektiv sein können, wenn das Program mit den Jugendlichen geplant wird und es auf der Teenage Entwicklungsstufe basiert ist. Es zeigte auch eindeutig, daß ein Kurs zu kurz ist und das ein Geburtsvorbereitungskurs für schwangere Teenager die ganze Schwangerschaft hindurch gehalten werden muß, und nicht wie üblich, dem traditionellen Format von 4-6 Wochen folgen.

Noch weitere Diskussionsthemen und andere Bedürfnisse wurden in Einzelheiten bei den Teilnehmern identifiziert. Zum Beispiel, die Umgebung wo Kurse am besten gehalten werden sollten und was für persönliche Qualitäten und Erfahrungen eine Leiterin solcher Kurse haben müßte, wurden auch beschrieben.

# Acknowledgements

When I started my thesis I was full of enthusiasm and ready to change the world with the findings and saw no limitations in terms of time commitments. Little did I know that the unforeseen, yet amazing arrival of my teenage daughter's second baby and an overseas shift would change my time commitments quite considerably.

I would like to thank everyone who helped me throughout this study. If it were not for your support, encouragement and advice, this thesis would have not been completed. Please accept my heartfelt thanks and know that I really could not have done this without you. I am unable to name everyone here but would like to mention a few especially.

I thank the thirty young women who participated in this study. The enthusiasm shown during the interviews was appreciated. This thesis is a testimony to you. Without you, this work would have not been possible.

To all my friends, especially Denise Nicholson and colleagues in Health Sciences, especially Regina Pernice, thank you for your encouragement and support. Judy Anderson, from the New Zealand College of Midwives has also been a wonderful supporter. I have appreciated the support from all of you by email when distance became an issue.

To my family, especially Albert Martis (Dad) and Margot Riemke (Oma), who reminded me frequently that I would succeed, thank you for believing in me. And thank you to my husband, children and grandchildren for allowing me to take the time to complete this study, when I should have spent the time with you.

To my supervisor Dr. Cheryl Benn, thank you for your time, patience and guidance, when your time commitments were already stretched and for your encouragement to carry on when I felt like walking away. Thank you.

Finally the study grant from Bounty NZ via the Joan Donley Midwifery Research Collaboration and the award from Massey University Graduate Research Fund are acknowledged with thanks.

# Vorwort

Als ich diese wissenschaftliche Studie anfang zu schreiben war ich voller Begeisterung und bereit mit den Ergebnissen die ganze Welt zu ändern. Ich sah keine möglichen Zeitbeschränkungen oder andere Hindernisse, die diese Studie aufhalten könnten. Ich hatte nicht wissen können, daß unsere Teenagetochter ein zweites Baby bekommen würde, welches eine wunderbare Familienbereicherung war und noch immer ist, und daß wir plötzlich ganz kurzfristig von Neu Seeland nach Australien umziehen würden. Dies Umstände änderten alle Zeitverpflichtungen erheblich.

Ich möchte mich bei allen herzlich bedanken, die mir durch diese Studie hindurchgeholfen haben. Ohne Eure Unterstützung, Ermutigung und Ratschläge wäre diese Studie nicht fertig geworden. Ich kann hier nicht alle aufschreiben, die mir geholfen haben und doch möchte ich ein paar Namen besonders erwähnen.

Ich bedanke mich sehr bei den 30 jungen Frauen, die an dieser Studie teilgenommen haben. Eure Begeisterung und Motivation während der Interviews waren eine Inspiration für mich. Diese Studie ist ein Zeugnis dafür und ohne Euch hätte ich diese wissenschaftliche Arbeit nicht schreiben können.

Ich bedanke mich auch sehr bei meinem Freundeskreis. Ein besonderes Dankeschön geht zu Denise Nicholson, Regina Pernice und an meine Arbeitskollegen an der Universität. Vielen Dank für Eure Ratschläge, Ermutigungen

und Hilfeleistungen. Ein Dankeschön geht auch an Judi Anderson von der neuseeländischen Hebammenorganisation. Sie war eine große emotionale Stütze. Es war auch wunderbar Unterstützungen durch email zu erhalten, wenn es mit der Entfernung etwas problematisch wurde.

Ein großes Dankeschön muß an meine Familie gehen, besonders an Albert Martis (Dad) und Margot Riemke (Oma), die mich beide oft daran erinnerten, daß ich es schaffen kann, besonders wenn es nicht so aussah. Danke, daß Ihr an mich und an meiner Fähigkeit es zu schaffen geglaubt habt. Ein besonders großes Dankeschön geht an meine Familie. An meinen Mann, an meine vier Kinder und an meine zwei Enkelkinder. Vielen Dank für Euer Verständnis, wenn ich viel Zeit für die Studie brauchte, Zeit, die ich eigentlich mit meiner Familie verbringen sollte.

Ein Dankeschön auch an Professor Dr. Cheryl Benn. Vielen Dank für Ihre Zeit, Geduld und akademische Führung, besonders wenn Ihre Zeit so knapp und so sehr ausgefüllt war. Vielen Dank auch für die Ermutigung weiterzumachen, wenn ich aufgeben wollte.

Letztlich, vielen Dank für das Stipendium von Bounty NZ durch die Joan Donely Midwifery Research Collaboration und dem finanziellen Zuschuß von Massey University Graduate Research Fund.

# Table of Contents

Abstract.....	iii
Abstract translated into German: Abstrakt – Zusammenfassung.....	v
Acknowledgements.....	vii
Acknowledgements translated into German: Vorwort.....	ix
Table of Contents.....	xi
Guide to Figures.....	xvi

## Chapter One: Orientation To The Study

1.1 Introduction.....	1
1.2 Situating this Research.....	1
1.2.1 The New Zealand Maternity System.....	1
1.2.2 Teenage Pregnancy in New Zealand.....	5
1.3 Aim of this Study.....	13
1.4 Teenage Development Stage.....	14
1.5 Overview of the Content of this Thesis.....	17
1.6 Contribution to Knowledge about Pregnant Teenagers.....	19

## Chapter Two: Literature Review

2.1 Introduction.....	20
2.2 Search Strategy.....	20
2.3 The Pregnant Teenager.....	21
2.4 Antenatal Care Issues for Pregnant Teenagers.....	23
2.5 Historical Perspective of Antenatal Education in New Zealand...	26



2.6 Antenatal Education Programmes for Pregnant Teenagers.....	28
2.7 Summary.....	35

## Chapter Three: Methodology

3.1 Introduction.....	37
3.2 Methodology.....	37
3.3 Focus Groups.....	38
3.3.1 Limitations of Focus Groups.....	40
3.4 Ethical Considerations.....	41
3.4.1 Informed Consent.....	41
3.4.2 Confidentiality and Anonymity.....	42
3.4.3 Prevention of Harm to Participants.....	43
3.5 Recruitment of Participants.....	43
3.6 Planning and Conducting the Focus Groups According to Morgan's Four 'Rules of Thumb' Design.....	46
3.6.1 The Use of Homogeneous Strangers as Participants...	46
3.6.2 Reliance on a Relatively Structured Interview with High Moderator Involvement.....	48
3.6.3 Having 6-10 Participants per Focus Group.....	50
3.6.4 Setting-Up a total of 3 – 5 Focus Groups per Project...	51
3.7 Description of Research Participants.....	53
3.8 Thematic Analysis.....	54
3.9 Summary.....	57

<b>A Guide To The Data Chapters.....</b>	<b>59</b>
--	-----------

## **Chapter Four: Operational Antenatal Education Needs**

4.1 Introduction.....	60
4.2 The Need for a Teenage Antenatal Education Programme.....	61
4.3 The Characteristics of the Facilitator.....	63
4.4 The Venue and Physical Environment .....	66
4.5 Acceptable Participants for a Teenage Antenatal Education Programme.....	71
4.6 Naming the Programme .....	75
4.7 Summary.....	78

## **Chapter Five: Content Needs For Teenage Antenatal Education**

5.1 Introduction.....	81
5.2 Needing a Non-Structured Support Group for the Whole Pregnancy.....	82
5.3 Participatory Development Needs for a Teenage Antenatal Education Programme.....	86
5.4 Content and Resource Needs for a Teenage Antenatal Education Programme.....	89
5.5 Summary.....	95

## **Chapter Six: Psychosocial Needs Of Pregnant Teenagers In The Context Of Antenatal Education**

6.1 Introduction.....	97
6.2 Feeling Safe.....	98
6.3 Self-esteem and Self-Worth Exercises and Emotional Support.....	101
6.3.1 Self-Esteem Relating to Body Image.....	106
6.4 Addressing and Changing Addictive Behaviour.....	108
6.5. Forming Long Term Supportive Relationships.....	111
6.6 Summary.....	114

## **Chapter Seven: Discussion And Concluding Statements**

7.1 Introduction.....	115
7.2 The Aim Revisited.....	115
7.3 Limitations of this Study.....	116
7.4 Discussion.....	117
7.4.1 Teenage Development Stage.....	117
7.4.2 Emotional Needs – Two Levels of Growth.....	118
7.5 Recommendations.....	121
7.5.1 Overall Programme Structure.....	121
7.5.2 Venue and Physical Environment.....	122
7.5.3 Effective Facilitator.....	122
7.5.4 Topics.....	123
7.5.5 Resources.....	124

7.5.6 Naming an Antenatal Education Programme.....	125
7.6 Rigor of this Qualitative Study.....	125
7.7 Implications for Midwives and Childbirth Educators.....	126
7.8 Implications for Midwifery and Childbirth Educators' Continuing Education and Training.....	128
7.9. Recommendation for Future Research.....	129
7.10 Concluding Statement.....	130

<b>References.....</b>	<b>132</b>
------------------------	------------

## **Appendices**

APPENDIX A: Focus Group Questionnaire.....	150
APPENDIX B: Newspaper Advertisement.....	152
APPENDIX C: Participants' Information Sheet.....	154
APPENDIX D: Poster/Flier for Community Notice Boards and for Distribution....	157
APPENDIX E: Consent Form.....	159
APPENDIX F: Confidentiality Agreement.....	161
APPENDIX G: Statement of Non-Disclosure of Information for Typist/Transcriber .....	163
APPENDIX H: Ethics Approval Letter.....	165
APPENDIX I: Research Support Letter - The Pregnancy Trust.....	167
APPENDIX J: Research Support Letter - Midwifery Care.....	169
APPENDIX K: Research Support Letter – Learning and Growing Together Trust .....	171
APPENDIX L: Live Births by DHB Regions for Maternal Age 19 Years and Under in Percentage and Numbers, 2003.....	173

**Guide to Figures**

Figure 1: Teenage Births per 1000 World Wide in 2001.....5

Figure 2: Live Birth Registrations by Age of Mother 1978 –2001.....7

Figure 3: Live Births by DHB Regions for 19 Years and Under, 2003.....10

Figure 4: Actual Physical and Emotional Age of Teenagers.....118

# **Chapter One**

## **Orientation To The Study**

### **1.1 Introduction**

This thesis presents findings of an exploratory study of 30 pregnant teenagers residing in the Palmerston North region, New Zealand and their antenatal education needs. In this study, teenagers who all had been to at least one antenatal class participated in one of four focus groups of varying sizes. Their experiences and discussions in regards to their antenatal education needs were analysed thematically in order to describe their perceptions of their needs.

Chapter one provides an introduction to the study presenting the impetus for this research and its aim. The developmental stage of teenagers and why this is relevant to midwifery practice follows and the chapter ends with an outline of the structure of this thesis.

### **1.2 Situating this Research**

#### **1.2.1 The New Zealand Maternity System**

Maternity care is free for New Zealand citizens, women with permanent residency, and those who have a permit for a stay of two or more years, unless a woman chooses to be cared for by a private obstetrician. All babies born in New Zealand are eligible for free maternity services from birth and postnatally (Ministry of Health, 2003a).

In 1990, the Nurses Act, and necessary related acts and regulations, that enable midwives to legally work and be paid as independent practitioners were amended. As a result Midwives could prescribe medicines for women and babies within their care and scope of practice, they could access diagnostic services and claim the same payments for their services as medical practitioners. Following these amendments, women in New Zealand could choose a midwife as their sole caregiver during pregnancy and for their birth experience. The midwife takes ultimate responsibility for the entire antenatal, intrapartum and postpartum care of 'low risk' women.

As a result of the regained independence, New Zealand midwives had to establish an identity that separated their practice from that of doctors. The term partnership, a woman centred philosophy, and the term continuity of care have been used to describe the ways in which many New Zealand midwives work with women when providing midwifery services (Guilliland & Pairman, 1995). Care within this option can be provided in two ways. The first is by a group of midwives who organise themselves into teams and the woman meets all the midwives of the team; the woman contacts the midwife rostered on call when going into labour. The second option involves an individual midwife taking a caseload of a workable number of women per month, and being identified as the Lead Maternity Carer (LMC). This type of midwifery service is seen as the optimum care for birthing women in New Zealand as it is believed that it will most effectively provide continuity of care based on a woman centred philosophy. Case loading midwives are usually self-employed and set up practice in the community.

However, there are still other opportunities for different types of midwifery practice in New Zealand, which do not incorporate the partnership, woman centred philosophy and continuity of care model. One is termed core midwifery care, as provided within the hospital system. Here, many different midwives throughout the whole childbirth experience may care for the woman, as midwives work according to a roster. A mix of health professionals may mean that the woman does not receive total midwifery care, but receives care from enrolled or obstetric nurses<sup>1</sup>. 'At risk' women are often referred to a hospital clinic to access the free service of an obstetrician and therefore only have the option of receiving fragmented care from a variety of health professionals, many of whom they have not met before. As pregnant teenagers are seen as 'at risk', hospital referrals are frequently made. These teenage women find themselves confused about the fragmented care and non-compliance is often the result (Fleming & Watson, 2002).

Another type of practice that has evolved is a shared care arrangement. This means the woman may have both a midwife and a medical practitioner involved in her maternity care. One of them has to be the Lead Maternity Carer (LMC), who will claim the modular fee for the care provided; pay the other member of this shared care arrangement, and carry the full responsibility for the care. In this arrangement often the medical practitioner tends to be the LMC and continues to control the childbirth and midwifery practice. However, this type of care allows women the flexibility of continuing

---

<sup>1</sup> An enrolled or obstetric nurse has received a maximum of 18 months training and must work under the direct supervision of a registered Nurse or Midwife (Nurses Act, 1977)



with their medical practitioner as well as developing a relationship with their midwife before labour. It also means that high-risk women who must go to a specialist for their pregnancy care can meet and know their midwife before they go into labour. Often this type of care happens in the privately paid sector, which makes it almost inaccessible for pregnant teenagers who cannot afford to pay for such care. They will usually be referred to the public sector and therefore receive fragmented care, when specialist services are required. However a few public hospitals in New Zealand are now offering shared care arrangements as well, which then will be free of charge and will provide some continuity of care for pregnant teenagers.

In September 2003 the Health Practitioners Competence Assurance Act became law in New Zealand (Guilliland, 2003) and with that came the birth of the first Midwifery Council for New Zealand. The Midwifery Council became officially operational on 18<sup>th</sup> September 2004 and is responsible for regulating midwifery separately from nursing. Midwifery is thus recognised as a distinctly different discipline. This means changes for midwifery as a scope of practice is introduced and competency or performance based practicing certificates are required. This will assist in shaping New Zealand midwifery to closer align itself to the midwifery philosophy of providing woman centred and continuity of care and therefore fragmented care options will have to cease, ensuring all women, including pregnant teenagers are able to access a midwife for their pregnancy regardless of their and their baby's well-being (Guilliland, 2003).

### 1.2.2 Teenage Pregnancy in New Zealand

Teenage pregnancies have become an issue of increasing concern in New Zealand, which has the second highest teenage pregnancy rate in the developed world (Coddington, 2001; UNICEF, 2001; Ministry of Health, 2003b: see also figure 1 below, which includes females, aged 15-19 of all countries listed). The United States of America presents with a birth rate of 51.1 as the highest, followed closely by New Zealand with 29.8 and the United Kingdom with 29.7. Canada with 20.2 and Australia with 18.1 have comparably lower birth rates. Japan, since 1950 has consistently had one of the lowest teenage birth rates of 3.9 and since about the mid 1980s countries such as Hong Kong, Singapore and the Netherlands have also experienced declining teenage birth rates below ten births per 1,000 females aged 15-19 years (Condon & Corkindale, 2002).

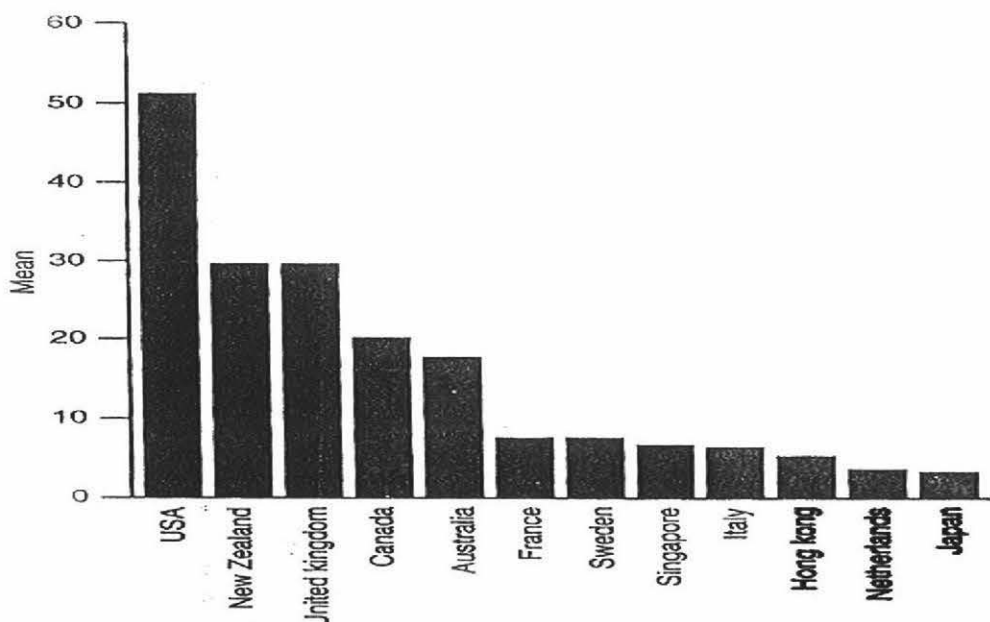


Fig. 1: Teenage Births per 1000 worldwide in 2001 (Condon & Corkindale, 2002)

In 2003 the Ministry of Health (2003b) published its latest Report on Maternity for 2000 & 2001. The statistical trends for New Zealand in 2001

showed a total of 53,805 births. Of these births 7.1% (3,781) occurred for women 19 years and under. Abortions were carried out for 8.5% (3306) of teenage pregnancies in that period and 9% (352) were hospitalised miscarriages for the same age group. This represents a total of 7,087 female teenagers for 2001 that had a confirmed pregnancy. Overall statistical evidence shows in 2001 for every 1000 abortions 23 were teenagers and for every 1000 births 35 were births to teenagers.

According to the Ministry of Health Report (2003b) of the 3,781 young women who gave birth the ethnic distribution was as follows:

1,663 (44%)	Maori
1,417 (37.5%)	NZ European
397 (10.5%)	Pacific People
132 (3.5%)	Other
57 (1.5%)	Asian

In 2004 the New Zealand Health Information Services published a graph (see figure 2 on next page) relating to live birth registrations by the age of the mother for the years 1978 – 2002.

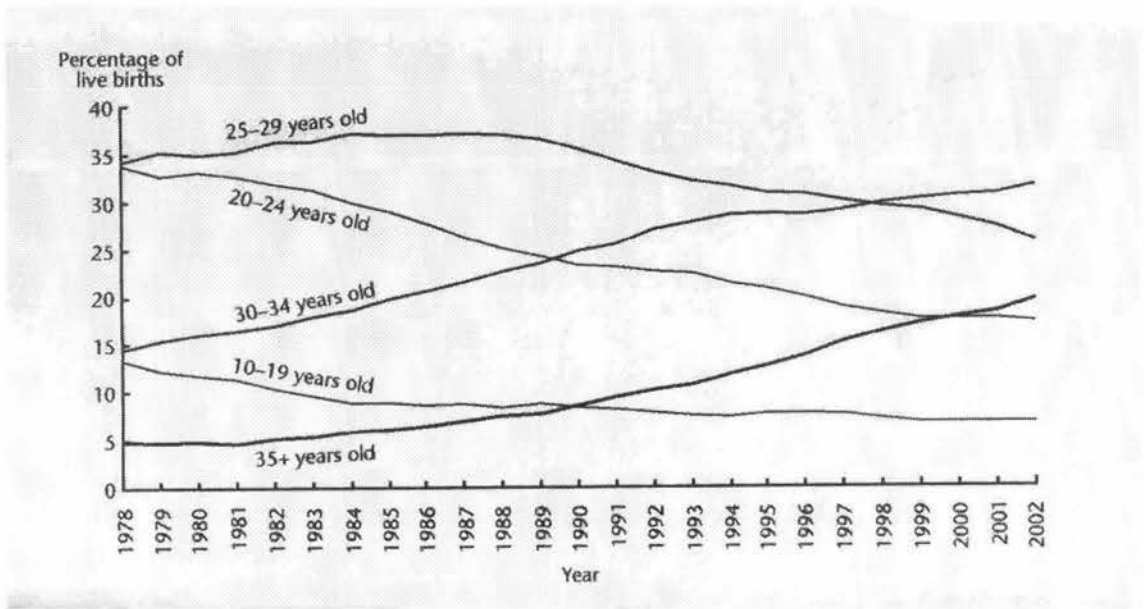


Fig. 2: Live birth registrations by age of mother, 1978-2002  
(New Zealand Health Information Services, 2004)

The New Zealand Health Information Services (2004) comments on p. 15-16 that: “the reducing rate for teenage women is a result not of a declining fertility rate but of an increasing abortion rate, and the birth rate in women under the age of 19 does remain high by international standards. Young pregnant women – especially those without sufficient family support – require significant support from health and social services. In the 2002 Maternity Services Consumer Survey, women aged 15-19 years were less likely than older mothers to have been satisfied with maternity services”. This is of concern and needs to be addressed. One way of addressing this dissatisfaction is by providing sufficient information and education that is appropriate for pregnant teenage women.

New Zealand is divided into 21 District Health Boards (DHB's) and demographically teenage births appear to be higher in the poorer areas of

New Zealand and are not necessarily ethnicity related (see Appendix L for New Zealand demographic DHB map with percentages and figures). Northland, Tairāwhiti, Lakes, Hawkes Bay, Taranaki and Wanganui all have over 10% of their birthing population being women 19 years and under. Figure 3 on the page 10 shows a graph with the percentages of live births for 19 years and under for all 21 DHBs. The figures are for 2003 by DHB distribution (earlier ones were not available) and show clearly the areas of high teenage births. This highlights the need for urgent attention by the respective DHBs and it is hoped that the current study will be able to assist with formulating a strategic plan for the prevention of teenage pregnancy, maternity services offered, including teenage antenatal education programmes, to pregnant teenagers and parenting support for teenage parents.

The New Zealand Health Information Service (2002) identifies that 163 births occurred in 2000 (these are the latest regional figures available) in the Palmerston North/Manawatu region to women aged between 15-19 years accounting for 8.15% of the total births in this area. This is above the national average of 7.1% and provided another impetus for this research.

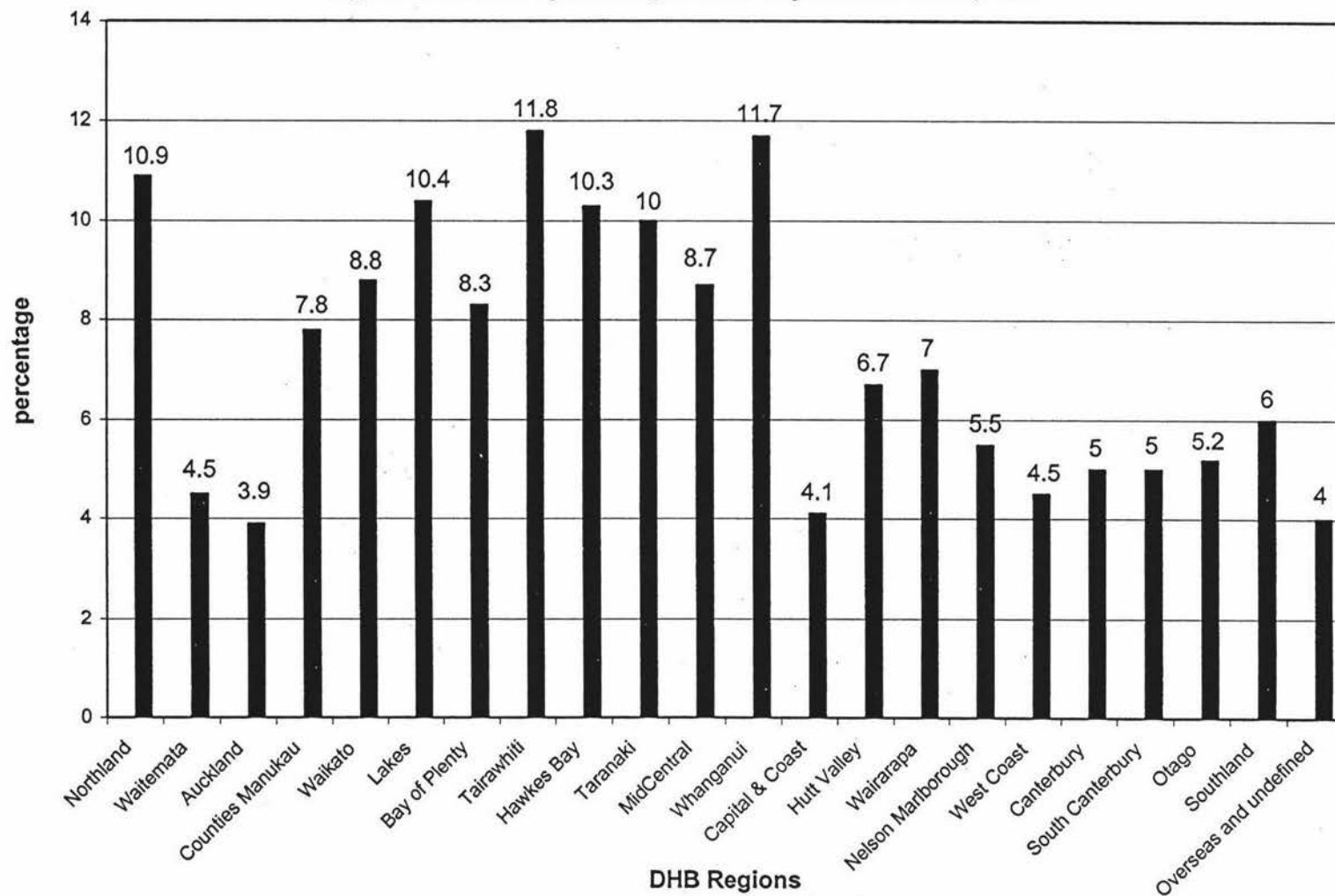
It has been documented in the literature that pregnant teenagers do not seek early antenatal care, placing both mother and baby under greater health risks (Baker, 1996; Wilson, Clements, Bathgate & Parkinson, 1996; Baddiley, 1997; Quinlivan & Evans, 2002). Health risks include mental health issues, e.g. suicide, postnatal depression (Panazarine, Slater & Sharps, 1995), substance abuse effects on the baby, e.g. alcohol, drugs, smoking (Quinlivan

& Evans, 2002), lower birth weight for gestational age (Malchodi, Oncken, Dornelas, Caramanica, Gregonis & Curry, 2003), an increase in prematurity (James, Steer, Weiner & Gonik, 1995), stillbirths (Ministry of Health, 2003), anaemia, hypertension, toxemia and cephalopelvic disproportion (James et. al., 1995) and sexual transmitted infections, especially Chlamydia (Fraser, Brockert & Ward, 1995).

Additionally, pregnant teenagers in western society are often met with judgemental attitudes and pushed into isolation by society as well as health professionals (Baddiley, 1997; Kiddy, 2002; Patterson, 2003; Beckinsale, 2003). Therefore, they are either reluctant to initiate antenatal care, refuse to go back for antenatal checks or do not want to share antenatal classes with married couples, as teenagers perceive married couples to be another judgemental group (Condon & Corkindale, 2002).

Antenatal education is usually provided by the private sector in New Zealand mainly by an organisation called Parents Centre Inc., who has trained childbirth educators providing antenatal classes in 6-7 weeks blocks, late in the pregnancy. The fees range from NZ\$70.00 to NZ\$110.00, depending on the region and if the pregnant woman wants to receive their magazine called Kiwi Parent. Some hospitals provide antenatal classes. They are usually free and run by a midwife in much the same structure as those offered by Parents Centre. Neither programmes focus on single parents or pregnant teenagers, but are in general all set up for couples.

Fig. 3: Live Births by DHB regions for 19 years and under, 2003



In New Zealand it appears there are only a few isolated attempts to provide antenatal education specifically for pregnant teenagers. These are known through anecdotal sharing among midwives rather than through published information.

Overseas literature (see chapter two – literature review) shows, if antenatal education programmes are tailored to meet the adolescents' needs and developmental stage, their regular attendance for antenatal appointments with health professionals will increase and this will affect their long-term health and that of their babies (Lesser, Anderson & Koniak-Griffin, 1998; Koniak-Griffin, Mathenge, Anderson & Verzemnieks, 1999).

As New Zealand has a high rate of teenage pregnancies, it is important that the health risks for this group are reduced. If, as overseas literature shows (see chapter two), these risks can be reduced by offering antenatal education programmes tailored to meet adolescents' needs, then it is timely to find out what New Zealand pregnant teenagers want from antenatal education programmes.

A particular birth in 1993 with a 16-year-old young woman, as well as my own daughter's pregnancy at 17 rekindled my passion and interest in pregnant teenagers and teen mothers. I recognised that their needs are different and not very well met by the health system in New Zealand. This recognition came through observation and long talks with the many pregnant teenagers I subsequently accompanied through their pregnancies and births. In 2002 I set up a pregnant teens support group called 'Youth Plus' followed by a teen



mothers support group called 'Youth Plus out' in Palmerston North. This gave further impetus for advocating research in this area as I listened repeatedly to their perspective of the issues they faced in life and with their pregnancies.

My youth worker training and experience with 'youth at risk' in Germany has assisted me in my work with pregnant teenagers, as has my 22 years working as a midwife. But it was not until I completed my training at Teacher's College to be a primary school teacher with an emphasis on children with special needs in 2000 and worked with children who had foetal alcohol syndrome or foetal alcohol effects that I began to realise that if we do not 'talk' with pregnant teenagers in their language, on their terms, about related health issues during their pregnancies like drinking alcohol and its effects on the baby, New Zealand's morbidity rate for babies of teen mothers will continue to rise. Foetal Alcohol Syndrome is on the rise (Mukherjee & Turk, 2004), which is of course totally preventable; but only if a mother knows what alcohol can do to her baby will she be able to change her alcohol intake.

Most teenage pregnancies are unplanned (Maskill, 1991) and alcohol might still be consumed to varying degrees, for example. Prior to the pregnancy teenagers are busy getting to know themselves, progressing through their developmental stage (see also under 1.4 in this chapter for detailed developmental stage description). Few opportunities for reading literature or seeking out pregnancy information from other sources would have presented themselves, unlike for a woman with a wanted pregnancy. I found many pregnant teenagers, including my daughter, had never thought of anything

related to a pregnancy, like alcohol for example and were unsure of what to do, what comes next and what is expected.

The findings of some retrospective studies (Lesser, Anderson & Koniak-Griffin, 1998; Koniak-Griffin, Mathenge, Anderson & Verzemnieks, 1999; Rogers, Peoples-Sheps & Suchindran, 1996; Martin, MacDowell & Macmann, 1997) about reducing health risks for pregnant teenagers and their babies suggest the need for a large, well-designed clinical trial to answer the question of effectiveness in reducing health risks through teenage focused antenatal education (see chapter two literature review). Conducting such a trial would pose major challenges. Difficulties in conducting a randomised controlled trial would include deciding about what and which teenage population to test, given that antenatal education varies greatly and teenagers not already planning to attend classes are unlikely to attend even if they are randomised to do so. There are also ethical implications of randomising when there is already some limited evidence that health risks might be reduced if pregnant teenagers attend antenatal classes. This study therefore took a qualitative approach eliciting data via focus groups to ascertain what a sample of pregnant teenagers from the Palmerston North region thought their antenatal education needs were.

### **1.3 Aim of this Study**

The aim of this exploratory study was to generate rich and interactive data from pregnant teenagers about their antenatal education needs in the Palmerston North region through focus group discussions. Emerging key

issues are used to make tentative recommendations for a teenage antenatal education programme, recognising that 30 participants in four focus groups comprise a small sample and no generalisable conclusions can be drawn or recommendations made.

## **1.4 Teenage Developmental Stage**

According to Erikson's eight stages of man based on psychoanalytic theory, a child moves into the teenage years roughly at the ages of 12 – 18 (Erikson, 1980) and is termed by Erikson as the fifth stage of man (sic) called **Identity vs. Role Confusion**. Here Erikson identifies that teenagers now can start thinking about other people's thoughts and feelings and wonder what other people think of them. Peers, in particular for girls are paramount. Physical maturation is taking place with new feelings and bodily sensations occurring. As a result of this the teenager develops a multitude of new ways of looking at and thinking about the world. During this period teenagers are getting to know who they are, where they have been and where they are going. Therefore on the positive spectrum the teenager emerges with a focus on ego identity and on the negative a sense of role confusion. It is a huge achievement to bring together all the aspects teenagers learn about themselves e.g. being a daughter, friend, pupil, part time worker and to bring these images into a whole that makes sense of the person she is (Elkind, 1977). David Elkind (1967, 1976, 1978) refers to teenagers' egocentrism as the heightened self-consciousness of adolescents that is reflected in their belief that others are as interested in them as they themselves are, and in their sense of personal uniqueness. The interesting fact about ego identity

and the struggle to become independent is that the process is often too threatening for teenagers to do alone (McCallum, 1990; Dekovic & Meeus, 1997). Therefore teenagers often choose to go through this process in the same way as others in their peer group. They change together. From personal observation the individual becomes a collective 'I' which means they eat the same foods, drink the same drinks, chew gum on the same side of their mouth, wear the same clothes and 'hang out' at the same places. Becoming pregnant can alter the collective 'I' feeling and isolate a teenage woman from other teenagers and therefore affect her becoming an adult (Kuykendall, 1989).

Piaget's theory of cognitive development describes in detail how teenagers think differently from children and about going through a process of becoming an adult thinker (Santrock, 1996). He termed this fourth stage of mankind (sic) the stage of **formal operational thought**. Children are concrete thinkers and limited to actual experiences. Teenagers are no longer limited by this way of thinking. They can conjure up make-believe situations, events that are purely hypothetical or strictly abstract propositions and try to reason logically about them, in particular, verbally.

In summary teenagers<sup>2</sup>:

- Are egocentric – the universe revolves around ‘me’ (Erikson, 1980).
- Seek independence to learn who they are and where they fit (Santrock, 1996).
- Live for today, but are slowly learning about tomorrow’s consequences (Santrock, 1996).
- Learn to individualise within a collective ‘I’ peer group and therefore place great importance on peers, learning about different kinds of relationships (Kuykendall, 1989).
- Enjoy verbal logical dialogues that fluctuate between concrete thoughts, actual experiences and make-believe situations (Piaget, 1954, 1972).
- Learn about effective communication (Piaget, 1954, 1972).
- Place great importance on Self/Body image, maturing their self-esteem (Kuykendall, 1989).
- Are still developing and maturing physically, therefore in great need of food and sleep (Elliott, 1993).
- Engage in health compromising risks because they perceive themselves to be invincible, invulnerable and immune to the laws that apply to others (Arnett, 1992; Elkind, 1967, 1978).

James Kuykendall (1989) argues that the only viable approach to working with teenagers has to come from the developmental approach, especially for young people, who are sick. This approach characterises what is happening

---

<sup>2</sup> Please note this is a generalised summary drawn from the literature. It is of great importance to remember that each pregnant teenager is a unique individual with different needs within the context of her developmental stage.

socially, intellectually, emotionally, spiritually, physically, sexually and psychologically to a teenager. An unintended pregnancy, while not a sickness, will affect all developmental issues for a teenager and Kuykendall encourages caregivers to be very clear about this. Midwives and other health professionals will increasingly care for pregnant teenagers, as well as providing antenatal education for them. When providing midwifery care for pregnant teenagers or attempting to create teenage antenatal education programmes it is critical to understand the development stage of the pregnant teenager. This could result in effective antenatal education, regular attendance at midwifery appointments and possibly affect their long-term health and that of their babies.

## **1.5 Overview of the Content of this Thesis**

In **Chapter one** the background to the current study has been presented. The aim of the study was discussed and an attempt has been made to place this study within the context of New Zealand midwifery and antenatal education, as well as the developmental stage of teenagers.

**Chapter two** provides a literature review. Antenatal care issues and antenatal education programmes for pregnant teenagers, as found in the literature in New Zealand and internationally are presented. The chapter ends with a brief historical perspective of antenatal education.

**Chapter three** is the methodology chapter in which the reasons for choosing a qualitative method, focus group interviews and their appropriateness for pregnant teenagers are discussed. The chapter concludes with ethical

considerations that guided the study and an overview of the method of thematic content analysis.

**Chapter four** presents the first collective theme of this study, called operational antenatal education needs. This includes participants identifying the need for teenage antenatal programmes, personal traits of facilitators, the desired physical environment, who should be able to participate and what name might be appropriate.

**Chapter five** is the second results chapter. Here the participants describe their content needs for a teenage education programme. Participants highlighted the need for a more informal structure and laid back approach with an open-ended topic and time frame driven by them. A variety of topics were also suggested which differed from those traditionally offered through conventional antenatal programmes.

**Chapter six** is the final data chapter and addresses the psychosocial needs of pregnant teenagers in the context of antenatal education. Feeling safe, self-esteem, body image and emotional support, addressing and changing addictive behaviour and forming long-term supportive relationships were identified as important by participants and expected to be met through the antenatal education programme.

**Chapter seven** presents the emotional needs of teenagers and a summary of the tentative recommendations for teenage antenatal education programmes. The chapter ends by addressing the limitations and the rigor of

this qualitative study, implications for midwives and childbirth educators, as well as for their training. The recommendations for future research are presented prior to the concluding statements.

## **1.6 Contribution to knowledge about pregnant teenagers**

This study is part of the body of research into midwifery practice that is growing within New Zealand and internationally. I believe, to the best of my knowledge, that this is the first study in New Zealand to specifically consider the antenatal education needs of pregnant teenagers. The results of the current study will be useful for midwives and childbirth educators who find an increase of pregnant teenagers as their clientele.



# **Chapter Two**

## **Literature Review**

### **2.1 Introduction**

Literature is an important source of knowledge in any study and can assist with the clarification of the topic to be researched. In this chapter I initially describe how I searched for relevant literature. This is then followed by an age definition of teenagers as termed by the World Health Organisation and used for this study. Antenatal care issues and antenatal education programmes for pregnant teenagers are discussed and the chapter ends with a brief historical overview of antenatal education internationally and in New Zealand.

### **2.2 Search Strategy**

To provide some parameters for my search and reduce the quantity of irrelevant literature sources I embarked on a literature search using the following:

Adolescent antenatal education programmes, adolescent mothers, teenage mothers, antenatal education, prenatal education, teenage pregnancy, antenatal care for pregnant teenagers/adolescents, teenage antenatal classes.

I searched the Cochrane database, CINAHL, Medline, OVID database, Web of Science, ERIC, MIDIRS and PsychEd as they give a wide spectrum of

references, with the Cochrane database presenting a systematic review based on sound evidence. Controlled trials in particular are assessed for best evidence. I searched for key articles and studies published between 1990 – 2001. However, ongoing searches were made thereafter to ensure relevant current literature was being accessed.

It was difficult to find studies and articles that related specifically to teenage pregnancies and antenatal education. There were 263 entries and studies relating to the prevention of teenage pregnancy and reasons for non-compliance for antenatal checks, but very little about antenatal education for pregnant teenagers and whether this would increase their attendance for midwifery care, reduce health risks and improve outcomes. There were six articles, but no controlled studies with significant results that I found about antenatal education programmes specifically set up for pregnant teenagers. I also looked at some other studies investigating different approaches to antenatal programmes. They did not consider pregnant teenagers specifically but some of the findings might be relevant.

### **2.3 The Pregnant Teenager**

The World Health Organisation defines adolescence as the period between the ages of 10 and 19 years (Watson, 2001). This is the most commonly accepted age definition, although some studies include pregnant teenagers up to the age of 24 years and others include only those aged 15-19 years. For this study all pregnant teenagers who wanted to participate and were 19 years and under, were included. The age range for this study was 14 -19

years. All participants were expecting their first baby or had recently had their first baby. All had attended at least one antenatal education session.

Often a teenage pregnancy is unintended; limited New Zealand data suggests that the majority of teenage pregnancies are unintended (Maskill, 1991). American data shows that 95% of teenage pregnancies are unintended (Spitz, Velebil, Koonin, Strauss, Goodman, Wingo, Wilson, Morris & Marks, 1996).

Owens (1992) was commissioned by the New Zealand Family Planning Association to review Intervention Programmes in New Zealand for the prevention of teenage pregnancy. He found that teenagers do not utilise adult reasoning in their decision-making, but rather utilise irrational habits of thought, focusing only on the immediate, the concrete, and on short-term goals. The teenage stage is characterised by the transition from a life style where major decisions require parental mediation to one where the teenager is expected to think for herself and take control of her own life. It means that they have not previously been required to think about very long-term outcomes and basically need opportunities to gain experience. It is of no surprise then that pregnant teenagers find it difficult to think ahead, plan for motherhood or for the long term care of their baby which includes attending regular health checks and education programmes. It is much easier for them at this developmental stage to have immediate results, particularly where the results may jeopardise their acceptance in the peer group (see also chapter one, 1.4 developmental stage, p. 14).

Malnory (1996), who looked at the developmental care of pregnant women/couples found like Owen (1992), that human developmental stages need to be recognised and incorporated into health care and educational programmes for health and education programmes to be effective. Malnory did not specifically consider pregnant teenagers in her study, but concluded that every pregnancy that results in a successful birth should also result in the successful birth of a psychologically ready mother. This can only be achieved when the professional care and educational programmes are using tools that assist the developmental needs of the pregnant woman. Within this developmental approach according to Malnory, informality (not a school-like environment) appears to be the prime motivator for pregnant women to regularly attend antenatal education programmes. Drop-in styles and information sharing according to needs arising on a week-by-week basis rated highly in ensuring attendance and making behavioural changes.

Most descriptive services examined for this literature review presented with these findings, and are also shown by Davies (1990). Davies reports on a Midwifery Care Project in Newcastle, which focuses care on pregnant women in the poorest areas of the city, including many pregnant teenagers. They found also that attendance at the local parent craft classes increased dramatically when an informal approach was used and confidence-building exercises were incorporated. Gaining self-respect and self-confidence enabled the young women participating to deal with judgemental attitudes and express their needs more clearly to health professionals.

## **2.4 Antenatal Care Issues for Pregnant Teenagers**

As mentioned earlier, teenage pregnancies have become an issue of increasing concern in New Zealand, which has the second highest teenage pregnancy rate in the developed world (Coddington, 2001). It has been documented in the literature of a number of studies that pregnant teenagers do not seek early antenatal care, thus placing them and their baby under greater health risks (James, Steer, Weiner & Gonik, 1995, Baker, 1996; Baddiley, 1997; Wilson, Clements, Bathgate & Parkinson, 1996, Hall, 1995; Flanagan & Kokotailo, 1999; Williams & Vines, 1999; Crosby, DiClemente, Wingwood, Rose & Lang, 2002).

Fraser, Brockert and Ward (1995) comment that teenage fertility is a public health issue as it is associated with a range of adverse health outcomes as presentation to antenatal care appointments were infrequent. Adverse health outcomes are outlined by Fraser et. al. as an increased risk of hypertension, anaemia and cephalopelvic disproportion in pregnancy, lower birth weight for gestational age, increased risk of prematurity and higher risk of stillbirths.

Adelson, Frommer and Pym (1992) and Mitchell, Taylor and Ford (1992) also found an increased risk of perinatal mortality and cot deaths amongst babies of teenage parents in New Zealand. According to American data (Cates, 1996) the risk of sexually transmitted diseases pose an additional health risk to pregnant teenagers and there is an increase in psychiatric morbidity (Stuart-Smith, 1996).

A prospective Australian cohort study (Quinlivan & Evans, 2002) identified the impact of continuing illegal drug use by pregnant teenagers as a significant factor in the increased incidence of threatened preterm labour. They concluded from their findings that good antenatal care might be able to reduce the many adverse pregnancy outcomes in teenagers who use illegal drugs throughout pregnancy, as well as fostering an incidence decrease of threatened preterm labour. However they also expressed concern that the high levels of coexisting psychosocial morbidity are a concern for future mothering. It is disappointing that this large study of 456 pregnant teenagers did not present with specific recommendations on how to address the psychosocial needs of the pregnant teenagers in their study. A general recommendation only of breaking the cycle of homelessness, social isolation and family violence was made.

Lesser, Anderson and Koniak-Griffin's (1998) studied pregnant teenagers' responses to antenatal classes. They proposed that antenatal classes can prevent problems developing not only for the adolescent mother and baby's health but can also reduce the risks associated with social and maternal behaviour problems.

The UK has very similar teenage pregnancy statistics to New Zealand and claims third place in the western world, just after New Zealand (see Fig. 1, p. 5). A recent UK published study (Barrell, 2003) highlighted issues for pregnant teenagers as social, emotional and financial support, importance of relationships with their parents, friends and midwives, being part of a stigmatised group and the perception that motherhood ruins adolescent

female lives. Maria Patterson (2003) at Queen Charlotte's Hospital, UK, has found that a reduction of non-attendance for antenatal appointments among pregnant teenagers correlated directly with them providing antenatal classes specifically set up for pregnant teenagers and providing a continuity midwifery scheme. However, this was a service description only and the completion of the evaluation of the 'young mums' midwifery scheme is still in progress.

## **2.5 Historical Perspective of Antenatal Education in New Zealand**

Historically the existence of structured antenatal education programmes has come about as traditional methods of information sharing have declined. In different cultures antenatal education is less formal and knowledge is passed on from mothers to daughters or from traditional birth attendants. Living arrangements in which several generations share common space also lend themselves to active participation in the birth experience and therefore there was no need for structured antenatal education (Robertson, 1994; Jacoby, 1988). This generational living concept calls for further research to ascertain how well pregnant teenagers achieve in cultural settings where extended family living is a common concept and if living conditions are adequate, what the morbidity and mortality figures are for this high-risk group. To date no research could be found on this topic.

In New Zealand an organisation called 'The Federation of New Zealand Parents Centres' was started in 1952 by a speech therapist, Helen Brew. She saw the need for adequate antenatal preparation for childbirth for both



husband and wife at a time when labour itself was “feared by most women” (Hamilton Parents Centre, 1980, p. 5). Today Parents Centres around New Zealand still provide childbirth education programmes for mainly middle class, married couples. At this stage they are not offering any antenatal education for pregnant teenagers and no formal research has been conducted into the effectiveness of their antenatal education programme. Helen Brew was concerned about the increasing evidence, as are many professionals today, about the mental health situation of children and their parents and argued that childbirth education programmes can make a difference.

The vast majority of the literature that I found on antenatal education describes courses offered typically for well-educated women in the middle-to-upper socio-economic group. It seems, that some educators believe that this advantaged group will do well regardless of which, if any, antenatal education programme they attend (The Cochrane Library, 2001). But where does this leave the at risk population of pregnant teenagers?

Gilkison (1991), a New Zealand author, asks the question ‘Antenatal education – whose purposes does it serve?’ and expresses her belief that women should have the control of antenatal education programmes and their contents. Women should be able to make their own content choices and the programmes should meet those needs. She argues therefore, that the basis for antenatal education should be what the group identifies for their own learning, objectives and topics. It appears that in New Zealand antenatal education programmes are often under institutional control. This means that



women learn what the institution or the person in charge of the childbirth education programme wants them to know. Can providers of these education programmes release that power and let women, including pregnant teenagers, determine the content and place of the midwife/institution's place in childbirth education?

This sentiment is echoed by Nolan (1997) who comments that regardless of the theoretical perspective of an antenatal class the question arises as to whether what is taught in the classes meets the needs of the attendees. Nolan and Hicks (1997) surveyed men, women and childbirth educators who attended an independent private childbirth course in Montreal and found that all three parties had different expectations. However, the content of the classes was directed by the educator's expectation. Nolan (1997) called for evaluating the effects of educational programmes for medically or socially at high-risk women/mothers.

## **2.6 Antenatal Education Programmes for Pregnant Teenagers**

It was difficult to find studies and articles that related specifically to teenage pregnancies in terms of antenatal education. There were 263 entries and studies relating to the prevention of teenage pregnancy and reasons for non-compliance for antenatal checks, but very little about antenatal education for pregnant teenagers and whether this would increase their attendance for midwifery care, reduce health risks and improve outcomes. There were six articles, but no controlled studies with significant results about antenatal education programmes specifically set up for pregnant teenagers. I also

looked at some other studies investigating different approaches to antenatal programmes. They did not look at pregnant teenagers specifically but some of the findings might be transferable.

Mills (1997) in her commentary article 'Taking time to care – making ways to help teen parents' also found that it was very difficult to find literature addressing the needs of pregnant teenagers. My obstetric, midwifery and neonatal nursing textbooks have no entry for teenage pregnancy in their indices. Mills (1997, p.72) says: "I realise that there can't be a section that says (in textbooks), these kids have the world stacked against them – be good to them and do your best," but maybe there should be! She has found that addressing pregnant teenagers' needs by having them tell her what they wanted was the best approach to giving good care. She also found that knowledge about community agencies and support was of great benefit to the teenagers and was a question often asked.

Baddiley (1997) describes an afternoon group that was set up at the Royal Bournemouth Hospital, England, that specifically targets young pregnant women. She found that they had to change the format considerably to enable pregnant teenagers to feel 'at home'. The format was very informal and driven by the group itself, not by the midwife. Once trust was established, the group asked for antenatal checks and became regular attendees for antenatal care. Another 'spin-off' from this antenatal gathering (class) was the support that the prospective grandmothers developed for each other. They often came along to support their children and at Bournemouth they are predicting that soon a 'Grandmother Support Group' will emerge. No

statistical data was available in terms of health risks and outcomes improvement for the attendees of these gathering. However, a significant increase of regular midwifery antenatal checks and other appointment attendance was reported.

Kinsman and Slab (1992) explored the barriers to care as perceived by 101 teenagers who gave birth at an urban university hospital in America. All interviews were conducted within 48 hours after births. Following the interviews, the participant's medical record was reviewed for additional socio-demographic data, obstetrical and medical history, antenatal complications, postpartum events and infant characteristics. The Maternal Health Services Index was then used to divide the participants into those who received inadequate care and those who received immediate or adequate care. This was also based upon the timing of the first antenatal visit, the total number of antenatal visits and the gestational age at birth. The group who received inadequate care identified strongly that no adolescent-only antenatal clinics (and classes) being available was a barrier.

In New Zealand the Plunket Society (Wood, 2001) has been providing some antenatal education. Pregnant teenage women are not singled out in the description of their data, but their recent programme review and evaluation shows that more information about community resources needs to be included in their programmes, something that the following American study found as well.

Lesser et al. (1998) produced a qualitative study, which was anthropologically based and involved 36 pregnant teenagers. They looked at an early intervention programme (EIP) where 'preparation-for-motherhood classes' were a major component. The purpose was to evaluate responses from pregnant teenagers that had attended those antenatal classes. Interaction between participants was limited, as the curriculum did not encourage interaction among the teenagers. This was one area that needed major improvement, as the pregnant teenagers wanted to find out how other teenagers felt about being pregnant and what community resources were available to them. The study did show that most of the girls stopped drinking alcohol, using drugs and smoking, which had a direct link to them attending the antenatal classes. This in turn reduced the health risk for them and their babies.

Koniak-Griffin et al. (1999) also evaluated the effects of an intensive early intervention programme (EIP) in California and compared the effects with those pregnant teenagers receiving traditional public health nursing care. This was a small comparative study with the EIP group having 63 participants and 58 pregnant teenagers. It is a relatively small sample and is difficult to translate into a New Zealand setting where midwives provide maternity care in general. Early findings indicated not only reduced premature birth rates but also fewer days of infant hospitalisation during the first 6 weeks postpartum for the pregnant teenagers that received the early intervention programme. These results are similar to those of Lesser et al. (1998).

The EIP antenatal education programme included a series of four 'preparation for motherhood' classes and 17 home visits by specially trained Public Health Nurses. Classes were restricted to 10-15 participants and included topics such as transition to motherhood, the foetus as an individual, parent-child communication and staying healthy. Teaching strategies included group discussions, role-plays, decision-making exercises and communication games. Considerable time was spent in developing problem-solving skills. Video therapy was also part of the postpartum programme. Each pregnant teenager was encouraged to write a letter to her unborn baby, describing her goals for herself and her child, as well as plans for achieving these goals in terms of education and career possibilities. The pregnant teenagers also identified their needs for an antenatal education programme to include life skill training, in particular decision-making, cooking and how to change an addictive behaviour. These identified needs were incorporated into the programme. Participants successfully gained the requested life skills and changed behaviours for the remaining of the pregnancy and early postnatal period. However in regard to substance use in both groups, many young mothers returned to using substances after the early postpartum period. Further research is needed to ascertain why this was so. The follow-up programme provided focused heavily on parenting skills, using video therapy to assist these young mothers to learn to interact appropriately with their babies. Maybe the focus should have included a strong emphasis on 'keep on staying off drugs'. Another reason could have been that the postpartum programme was too short and offered no childcare facilities; enabling Mum's to have a break.

Rogers, Peoples-Sheps and Suchindran (1996) conducted a retrospective study to evaluate the impact of a resource mothers' programme (RMP). Resource mothers were non-professional caring women who provided social support to pregnant teenagers through home visiting. A total of 1901 pregnant teenagers who had a resource mother were compared to 4613 pregnant teenagers without resource mothers. The findings showed that a higher percentage of teenagers in the RMP than in the comparison group initiated antenatal care early and attended for regular antenatal checks. The individual resource mothers provided antenatal education. Pregnant teenagers commented on how beneficial they found the support and information given. A positive change in smoking, drug use and nutrition was noted, which the researchers attributed directly to the occurrence of the reduced incidence of premature births in this group of pregnant teenagers. This programme was initiated by the Department of Health and Environmental control, Columbia, South Carolina and has a clear American perspective. It is not possible to transfer the results directly into a New Zealand setting but it showed promising results in terms of antenatal education that occurred in an individual relational setting, rather than a group setting. Resource mothers were hired because of their natural supportive character and ability to develop a warm, trusting relationship. The study did not focus on the reasons why it succeeded with an individual relational setting when Chambers, Wakely and Chambers (2001) showed that teenage girls, from a developmental perspective, prefer group settings and it is those group settings that can be highly successful in health promotion. There is a need for further study to explore individual relational programmes for pregnant teenagers. Maybe the 'at risk' pregnant teenager (as opposed to

the non-pregnant teenager entering a normal developmental stage) benefits greatly from a one to one relationship programme and as her individual needs are met she is better able to care for herself and the baby, both antenatally and postnatally, reducing morbidity rates. Maybe at the same time a peer group is still needed to fulfil the developmental requirements and the combination of the two would achieve a better long-term effect.

Another American retrospective study looked at the effectiveness of a teen pregnancy clinic in a managed care setting in the state of Ohio (Martin, MacDowell & Macmann, 1997). The 72 teenagers in the intervention group attended significantly more antenatal visits, more antenatal classes and more postpartum visits than the 33 controls. The small number of participants limits generalisation of the study. The reported significant increase in antenatal classes attendance from 6.1% in the control group to 88.9% in the intervention group was in my view skewed, as a special incentive was used. If the pregnant teenagers attended all the antenatal classes they received a free infant car seat. Therefore it is difficult to comment whether the classes had a direct impact on birth outcomes, breast-feeding rates and parenting attitudes or if it would have happened anyway because of the managed care setting of the teen pregnancy clinic. Overall the intervention group gained more weight and had higher birth weights. No other findings were statistically significant, as the sample was too small.

Enkin, Keirse, Renfrew and Neilson (1995) reference only one source for antenatal classes by Howell 'Biofeedback in prenatal class attendees'. They found that antenatal class attendance results in the use of significantly less



pain relieving medication. The Cochrane team discarded all other non-randomised cohort studies who had reported a variety of other beneficial effects of regular antenatal class attendance, because of major biases. The Cochrane team did not specifically look at antenatal classes in relation to outcomes for pregnant teenagers and their needs, probably because it seems no major controlled studies have been conducted and/or published.

Enkin et al. (1995, p.20) also comment that the actual existence of antenatal classes might be of greater importance than the details of what is taught – that ‘the medium is the message’. Antenatal classes may provide a form of social gathering, which reinforces and supports appropriate behaviour and well-being practises. However, this was argued from the perspective of the developmental stage of adulthood.

## **2.7 Summary**

In summary, there have been no controlled trials conducted in regards to antenatal education for pregnant teenagers and its effect on their and their baby’s morbidity and mortality data. Therefore no recommendations for practice changes can be made at this stage but it does highlight the need for further research. There is also insufficient evidence to determine the effects of person-to-person antenatal education, although the Roger’s et al. (1996) study results sounded promising.

It is difficult to identify sound evidence for or against the provision of antenatal education programmes for pregnant teenagers through the



literature but it is clear that teenagers have different needs in comparison with adults (Santrock, 1996). It seems that no research has been undertaken in which teenagers themselves have been asked about the format of antenatal education and their antenatal education needs.

In this chapter I have presented a relevant review of the literature about teenage antenatal education, highlighting the issues for them, a brief historical perspective of antenatal education in New Zealand and the need for further research in this topic area.

The following chapter presents a discussion of the focus group method used and its application to this study.

# Chapter Three

## Methodology

### 3.1 Introduction

This chapter presents the reasons for choosing a qualitative method; the use of focus group interviews including its limitations and describes the appropriateness of this qualitative methodology for the pregnant teenagers involved. Morgan's (1997) four 'rules of thumb' are applied for the planning and conduct of the focus groups and are described in the light of how it actually happened. The ethical considerations in the planning and conduct of this study are also addressed and followed by an outline of how participants were recruited. This chapter concludes with an overview of thematic content analysis, as the method of data analysis used.

### 3.2 Methodology

Qualitative research considers people's life experiences and the meaning that they attribute to them (Silverman, 2000; Coreil, 1995). It is also used to explore and describe issues that are of a sensitive nature (Berg, 1998; Barbour & Kitzinger, 1999). Qualitative methods are found to be invaluable in discovering new knowledge and to obtain different insights or to conduct a needs analysis into unknown territory (Patton, 1990; Morgan, 1993; Kitzinger, 1995; Minichiello, Sullivan, Greenwood & Axford, 1999). Researchers using qualitative methods increasingly use focus group interviews as a dominant strategy for data collection (White & Thomson, 1995; McDougall, 1999) and it

is advocated as being a useful tool within midwifery (Hughes, Deery & Lovatt, 2002; Barrell, 2003).

The primary purpose of this exploratory study is to identify and describe the antenatal education needs of teenagers who are pregnant. I chose the focus group method to obtain data because teenagers feel more comfortable talking about almost any subject when they are involved in a discussion as part of a group (Burnard, 1990; Robertson, 2001). By means of group interviews a clear view of the thinking, language and reality of the participants' world can be gained (Morgan, 1993, Hughes & DuMont, 1993; Asbury, 1995; Bryman, 2001). This is also a reality for teenagers, as at their development stage, peers are absolutely vital. In a focus group they have the presence and support of their peers, which gives them the feeling of security and the ability to be more spontaneous and also more candid (Elkind, 1977; Santrock, 1996;). I surmised that the interaction among the teenagers in the group would result in them being more talkative as they would also be stimulated by the feelings and comments of others in the group and not only by their own thinking (Morgan, 1997). This would result in generating significantly more information than if they were interviewed individually.

### **3.3 Focus Groups**

McDougall (1999), Morgan (1997), and Morgan and Spanish (1985) indicate that the basic argument for using focus groups is that they reveal aspects of experiences and perspectives that would not be as accessible without group interaction. Focus groups provide opportunities for sharing and comparing

experiences, asking questions and giving answers, agreement and disagreement. Agar (1986) comments that this process of sharing and comparing provides a "rare" (p.20) opportunity to collect direct evidence on how the participants themselves understand their similarities and differences. He sees researchers as trying to understand their data in the same way, searching for the connection among different experiences and perceptions. Therefore the process of sharing and comparing among participants is one of the most valuable aspects of focus groups. A further advantage of group interviews is that they can be used to assist in overcoming literacy, language, cultural and/or power issues between the researcher and participants. Saint-Germain, Bassford and Montano (1993) found that a group setting provided a secure environment that encouraged expression of opinions and drew on the oral tradition of older Hispanic women in Tucson, Arizona. Teenagers, during their adolescent development stage, enjoy talking for long periods of time, using 'their language' and concept of reality. Every detail is important and needs to be verbalised in group settings with their peers (Santrock, 1996).

Focus groups can assist to ensure that the language used in data collection is appropriate and understandable to participants (De Vellis, Patterson, Blalock, Renner & De Vellis, 1997). The use of focus groups has a long history in qualitative market research (Hargreaves, 1967; Willis, 1977; Hammersley & Woods, 1984). It was not until the early 1990s that health research started to incorporate this effective tool into their field, with focus groups being used for evaluating services (Schroeder & Neil, 1992), developing policy (Straw & Smith, 1995), analysing needs (Seals, Sowell, Demi, Moneyham, Cohen & Guillory, 1995) and developing programmes

(Halloran & Grimes, 1995; Straw & Marks, 1995). Needs analysis and programme development for pregnant teenagers are at the core of this exploratory study. As stated by Krueger (1994, p.14): "focus groups are created to accomplish a specific purpose through a defined process". The purpose of this study was to obtain information of a qualitative nature through open-ended questions about the antenatal educational needs of pregnant teenagers by means of four focus groups with 6-12 participants in each group.

### **3.3.1 Limitations of Focus Groups**

All research methods have limitations. This applies also to focus group interviews. As shown under point 3.3 focus group interviews have the advantage of providing the opportunity for huge and varied data through interaction between participants, but this at the same time could also constitute a limitation to the research. This is because the researcher could have less control over the conduct of the interview when compared to collecting data from an individual interview (St John, 1999). Group interaction as well as the cohesion and openness of a focus group may be affected by characteristics of participants and social factors such as class, gender and race (Yelland & Gifford, 1995). Group dynamics could also be affected through group conformity behaviour and the ability of participants to be swayed by others (St John, 1999). There is also a possibility that participants may not voice their true thoughts and ideas in a group setting (Morgan, 1995). Therefore focus group interviews need to be assessed as an appropriate method of addressing a certain research topic and need to be

weighed against the positive aspects of group elaboration and memory stimulation that occur during focus group discussions (St John, 1999). For this study careful consideration was given to the advantages and limitations of focus group interviews. It was decided that focus group interviewing was an appropriate method to use with teenagers to obtain rich volume and unique data required for identifying their antenatal education needs.

### **3.4 Ethical Considerations**

The study was designed in accordance with the ethical guidelines of the Massey University Code of Ethical Conduct (1994). Prior to the commencement of this exploratory study ethics approval was obtained from the Massey University Campus Human Ethics Committee: Palmerston North, PN Protocol - 02/134 (see approval letter Appendix H). The ethics committee required assurance that ethical standards would be maintained. These standards include informed consent, confidentiality and anonymity and the prevention of harm to participants. The ways in which each of these standards were adhered to in this study are discussed in the following sections.

#### **3.4.1 Informed Consent**

Informed consent was obtained through a variety of ways. Initially at the information luncheon the study was explained in depth following the format of the information sheet (see Appendix C) and opportunity was provided for questions to be asked. A copy of the information sheet and the consent form was handed out to interested participants and explained by the researcher

(see Appendix E). Opportunity then was given to ask questions about the consent form.

When the consenting women met for the actual focus groups, the introductory phase of the meeting included another opportunity to go over the information sheet and consent form, just prior to signing the consent form. Further opportunities for questioning were also given at this time.

### **3.4.2 Confidentiality and Anonymity**

The pregnant teenagers and teenager mothers were invited to participate in this study with no compulsion for them to do so. The anonymity of the participants was safeguarded by omitting any identifiable references from the thesis and from the transcripts of the focus group interviews. Any identifying facts about themselves have been removed or presented in an aggregated form. Each participant was informed that by consenting at the beginning of this study, they were also consenting to verbatim quotes from the tapes being used in the thesis and subsequent articles. Additionally, the focus group participants signed a confidentiality agreement (see Appendix F) of non-disclosure outside the focus group. The transcriber of the audiotapes also signed a non-disclosure of information agreement (see Appendix G). She did not know the name of any of the participants and had no access to any information about them. All participants consented to having the audiotapes transcribed. On completion of the transcribing the tapes were returned to me along with the transcription. The computer files and backup copies of the

data were destroyed by the transcriber when the data analysis had been completed.

The transcriptions included no names, only speaker 1 of group 1 or speaker 3 of group 3, for example.

All transcripts, notes and audiotapes are kept secure, with access available only to the researcher. Electronic data can be accessed with a password only known to the researcher and all of the above information will be stored for 5 years after completion of the thesis and then destroyed.

### **3.4.3 Prevention of Harm to Participants**

It was not envisaged that participants would be harmed by participating in this study. In fact quite the opposite seemed to occur. Participants talked about how they had enjoyed thinking of and sharing ideas about what kind of antenatal education programme they would like and what would be of benefit to them. They also felt encouraged that their data could be of benefit for future antenatal education programmes for pregnant teenagers. Making a difference for their future pregnant peers was a great motivator.

## **3.5 Recruitment of Participants**

Participants were recruited by:

Advertising in the free local newspapers, 'Guardian' (weekly on Thursdays) and the 'Tribune' (weekly on Sundays), as well as in the 'Evening Standard' on Tuesdays, Wednesdays and Saturdays, as these days have the highest



readership for this paper (see Appendix B for copy of the advertisement). The advertisement invited pregnant teenagers to phone for more information and/or to come to an information luncheon. The advertisement was placed in the above papers over a period of two weeks prior to the information luncheon.

The 'Pregnancy Centre' (which is run by a local community trust) offers an antenatal education programme for pregnant teenagers and information was sent to the Centre to pass on to the teenagers inviting them to participate. In addition, a personal approach was made by me to further explain the study purpose to the co-ordinator of the centre. (See Appendix C for the information sheet and Appendix D for the poster/flier).

The local 'Karitane Family Centre'<sup>3</sup> (which is run by the local Plunket Society<sup>4</sup>) supports pregnant teenagers and also young mothers. Information was sent to the Centre to pass on to interested teenagers. A personal approach was also made by me to the staff of the centre explaining the study further.

Community Birth Services and Midwifery Care are two places where pregnant women access the services of self employed midwives in the

---

<sup>3</sup> Karitane Family Centres throughout New Zealand are community houses funded by the Plunket Society, which exists to support families with parenting issues. Plunket Nurses and Plunket volunteers are available during working hours at the Centre to support families with infant health checks, play groups, coffee mornings, parent education sessions and other issues like crying and colicky babies.

<sup>4</sup> Plunket is New Zealand's leading provider of well child and family health services. It provides a unique mix of a professionally educated workforce working hand-in-hand with volunteers throughout New Zealand.

([www.plunket.org.nz](http://www.plunket.org.nz))

Palmerston North region. Information was sent to the midwives there to enable them to pass the information on to interested participants. A flier/poster for their waiting rooms accompanied the information and I outlined the study for them at their weekly midwives' meeting.

Other services were approached to assist with recruitment:

Youth One Stop Shop and Drug Arm are two organisations that work predominantly with teenagers at risk and the information pamphlet and poster were sent to them as well.

Whakapai Hauora (Best Care) is a Health and Community service situated on a purpose built Marae<sup>5</sup> in Palmerston North providing for the health and community needs of Maori. The information pamphlet and the poster were left with the practice nurse to pass on to pregnant teenagers.

Posters were also posted out to Palmerston North general practitioners (GPs) and their practice nurses, as often they are the first point of contact for confirming the pregnancy and can appropriately pass the information on. Women reading the posters were asked to contact the researcher or attend the luncheon to find out more about the study.

Most responding teenagers were individually approached through either the Plunket Karitane Nurse, their Lead Maternity Carer (usually a midwife) and

---

<sup>5</sup> Marae is the meeting place or courtyard of whanau (extended family) or iwi (tribe), a focal point of the settlement, usually the central area of the village and its buildings (Ryan, 1994)

through the Pregnancy Centre. None responded to the advertisements in the local papers or the posters in GPs waiting rooms. The majority of the participants sent me a text message on my mobile phone expressing interest in being part of a focus group, necessitating me to learn how to text back. The teenagers loved this approach and responded well to this way of communicating. None of the 'texting' teenagers pulled out of their focus group.

### **3.6 Planning and Conducting the Focus Groups According to Morgan's four 'rules of thumb' Design**

Prior to setting up for the focus groups I searched for information on how to set up focus groups and the most effective way of moderating the process. Morgan (1997) and St. John (1999) conducted extensive research and suggest that four "rules of thumb" have evolved for planning and conducting focus group projects. Each of these rules is discussed in the following sections.

#### **3.6.1 The Use of Homogeneous Strangers as Participants**

Greenbaum (1988) and Morgan (1997) both stress the importance of choosing an effective group composition to be able to gain the maximum results. Group dynamics can be seriously inhibited if the group composition is not homogeneous and participants are not able to relate to the topic. It would not have been helpful to invite teenagers, who had never been pregnant, to participate in the focus groups as their answers to the questions or discussion topics/segments would have not provided the kind of baseline

perceptions, opinions, beliefs or attitudes that were required for effective data collection. Without these defined boundaries the participants could easily have focused on how not to get pregnant, what to do with boyfriends that are insistent about sexual intercourse or society's attitudes towards promiscuous teenagers.

The rules of thumb favour strangers because, although acquaintances can converse more readily, this is often due to their ability to rely on the kind of taken-for-granted assumptions that are exactly what the researcher is trying to investigate and could also include invisible boundaries around topics that the participants have agreed not to discuss (Agar & MacDonald, 1995). However Morgan (1993) pointed out that acquaintanceship is unavoidable at times and can also assist with issues of self-disclosure. Strangers and acquaintances can generate different group dynamics but this knowledge can direct the researcher to greater awareness on how to conduct the focus groups (Jarrett, 1993) and generate richer data. The key issue is having homogeneous participants and this worked really well with the participating teenagers.

In the four focus groups conducted for this study, the majority of the pregnant teenagers and teenage mothers did not know each other. In focus group one, two young women 'knew' each other from the antenatal classes they attended and from their postnatal stay at the hospital. Focus group two had four pregnant teenagers who knew each other through school and were expelled together, but this experience assisted them to speak more freely about their experiences with the education and health systems and identify

their needs in terms of antenatal education. In group three none of the participants knew each other. Group four had half (six) of the participants knowing each other from a local teenage antenatal support group. All young women participating in the current research project, ranging in age from 15 – 19 years, had the common denominators of either being pregnant or having just become a mother (the oldest baby was 4 months old) and all belonged in the group called 'teenagers'. All were resident in the Palmerston North region and all of them had been to at least one antenatal education session.

### **3.6.2 Reliance on a Relatively Structured Interview with High Moderator Involvement**

I designed a focus group questionnaire that relied on a structured interview form (see Appendix A) for maintaining effective focus, as suggested by this second rule of thumb. However, during the first two focus group sessions it became apparent relatively quickly that a flexible format was more effective in eliciting information from the participants. Therefore the questions were more loosely phrased, for example, instead of asking 'Do you like the term antenatal class?' it became *"I am especially interested in finding a name for teenage antenatal classes. I am interested in finding out what words would draw you to a class and would make you feel comfortable. What can you tell me about that?"* This open ended questioning approach generated good and long discussions among the participants in all four groups. When the discussions turned towards another emerging topic I often took that as a cue to intercept and comment *"this is also something I am definitely interested in hearing and knowing more about. Can any of you tell me more about (for example) what would make you feel more comfortable in an antenatal class?"*

I had written my questions in order from 1 – 11 (see Appendix A). They were designed to build on each other and support the study purpose. However, in conjunction with the above experience this was found to be a far too rigid approach and was abandoned early on at the second focus group. This discussion guide approach often generated discussions that generated its own momentum instead of me having to rigidly adhere to my discussion/question guide and dominate the discussion. Morgan (1997) points out that it is not the moderator that produces the data and therefore participants need to be able to speak freely.

It is of interest to note that the questionnaire was trialled as a pilot exercise with a group of 8 pregnant teenagers prior to the commencement of this study. This did not generate the above constraints that were found with the first two focus groups. It is not entirely clear why it did not elicit the same response as with the actual focus groups. All 8 participants in the group knew each other reasonably well and were also well known to the researcher, who was the childbirth educator for their antenatal education programme. However, Morgan (1997) does also point out that from his experience with focus groups the structure depends on the type of study. Less structured approaches to focus groups are especially useful for exploratory research, as in this study, as relatively little is known about the antenatal education needs of pregnant teenagers from their perspective.

Morgan (1997) also refers to the 'rules of thumb' as being most useful as a point of departure, rather than following them rigidly. He is concerned that some people act as if these rules constitute a standard about how focus

groups should be done rather than taking them as a descriptive summary of how they often are done. I therefore felt quite comfortable making the above mentioned changes.

### **3.6.3 Having 6-10 Participants per Focus Group**

Morgan (1997) indicates that focus groups are usually composed of 6-10 people, but the size can range from 4 – 12 participants, depending on the kind of data that needs to be collected. It is beneficial for the group to be small enough for participants to have ample opportunity to share their thoughts and ideas but also large enough to provide a good diversity of perceptions. If the group is too large it is difficult for participants to 'get a turn', 'to have their say' and valuable data will be lost (Krueger, 1994). Numbers for the four focus groups for this study were largely dependent on the response to recruitment and which date and time for the meeting were most suitable for the individual participant and therefore ranged in number from 5-12 participants. Even though Krueger (1994) is concerned that participants in large groups do not get opportunities to be heard, this was not a problem in the four focus groups in this study.

The largest group with 12 participants (focus group four) managed themselves through their own group dynamics in such a way that often they would encourage each other to speak if a particular participant had been quiet for a while. Additionally there was often group agreement about a particular comment or statement and therefore that did not generate too many lively discussions.



### **3.6.4 Setting up a Total of 3 - 5 Focus Groups per Project**

In this study four focus groups were set up from the total number of 30 respondents according to which date and time suited them best. All respondents met the requirements to be considered for participation and none declined. All of the participants were able to attend. This was mainly, I believe, because transport to and from the venue for the focus groups was provided and 'teenage technology' by means of the mobile phone and texting became an acceptable way to communicate. The participants enjoyed the interaction and 'getting to know each other period' in the van and often arrived at the venue 'chatting' freely with each other.

Picking up the participants, I thought, could be a good icebreaker and would also help me quickly establish an informal but trusting relationship with them. Hawe, Degeling and Hall (1990) and Patton (1990) emphasise that an atmosphere conducive to facilitating trust is essential for focus groups to work. The above approach worked really well. Not only was I able to talk informally with them in the van but also they were also able to relate to each other in this way. It was also a strategy to ensure the teenagers would attend the focus group meetings.

The length of each focus group discussion was for one to one and a half hours, depending on the concentration span of the participants, which can be reasonably short, according to Hayward (2001).



Morgan (1993) suggests focus groups should be held in an environment that is comfortable and accessible to the participants. It is important to consider a room with reasonable acoustics for audio taping, as the quality of the data is critical for the analysis. Inaudible tapes are difficult to transcribe and valuable information can be lost in the process.

I also used the principle of 'hot notes' (Morgan, 1993) and wrote them at the end of each focus group session, while transport was being organised. Morgan describes 'hot notes' as writing summary notes after each focus group to capture the first thoughts on what themes or key issues emerged from the sessions. Henderson (1995, p.467) states that:

"Every moment in a focus group is not productive and to listen to a tape in 'analyst mode' when the group was first heard in "moderator mode" is ultimately boring and can lead to skimming of data, biased listening to confirm existing view, or missing key data buried in a long diatribe that is fast forwarded to get back on track in the discussion".

Additionally I believe that often the tone and mood of the discussion can be lost on the tape, depending on the quality of the recording. For example, were the teenagers laughing or angry, when saying 'it sucked'? hence the use of 'hot notes' for recording mood and tone of the discussions. A video recording of the focus group sessions would have been ideal, although issues of confidentiality, disposal of the recorded data and possible inhibition

to speak freely and of being self-conscious might not have generated valuable data.

All groups met at The Pregnancy Centre in Palmerston North. The lounge was a colourful, warm, carpeted room with a coffee table in the middle, where the tape recorder was placed. Focus group four had 12 participants and this made it more difficult to obtain an adequate recording. I did a trial recording to ascertain the acoustics. On replay I noted which participants were difficult to hear and readjusted the seating accordingly, which made some participants more self-conscious to begin with. However, with a longer period of small talk they soon felt comfortable sharing their viewpoints. Krueger (1994) recommends that topics such as religion, politics or sensitive local issues be avoided during small talk. These could lead to complicated discussions and impact on group dynamics, making it more difficult to generate the desired data. In all focus groups the small talk usually centred on topics like music, pregnancy clothing and boys. These topics allowed for sharing and created a safe environment with a lot of laughter, enabling participants to share openly when questions were posed for data collection.

### **3.7 Description of Research Participants**

Focus group one consisted of seven pregnant teenagers, with one being of Maori descent, one from Malaysia, one from an African country and four describing themselves as NZ European. Focus group two had six pregnant teenagers, all of whom were NZ European. Focus group three had five participants with two being Maori women and three being of NZ European

descent. Focus group four presented with 12 participants. Five were of Maori descent, five identified as NZ European, one from the Solomon Islands and one from the Niue Islands. The variety of ethnic backgrounds enriched the atmosphere and group dynamics of all focus groups positively. The opportunity was given for translators to be present but in each case it was declined, as all participants spoke English fluently. Prior to this I was concerned about how the presence of a translator could affect group dynamics and data collection. Two participating pregnant teenagers from focus group four had known the researcher through an earlier antenatal class and the option was given to them not to participate. However, both participants felt very comfortable to voice their opinions among the other 10 participants and felt that in this group setting they could safely express their opinions and beliefs without feeling coerced or influenced by the presence of a known researcher.

The age range among the total of 30 participants for this study was 14 – 19 years of age.

All participants were either expecting their first baby or had given birth recently to their first baby. They all had attended at least one antenatal education session.

### **3.8 Thematic Analysis**

The focus group interviews generated rich and interactive data. The challenge was to find a way of identifying emerging themes and deciding

what information needed to be included in the analysis. Henderson (1995, p.472) refers to it as “collecting the small gems with high value that relate to the study purpose”. Burnard (1991) offers one way of exploring and categorising data but also cautions about bias. Findings without any sort of manipulation would really not be satisfactory, as a reader would then read all the data collected and have to find their own way of determining the themes. Burnard suggests staying as close as possible to the original material and yet allowing for themes to be generated as this will make sense to the reader and realistic recommendations can be made.

Thematic analysis is a process for encoding qualitative information (Boyatzis, 1998). It allows the researcher, using a qualitative method, to more easily communicate the findings to others who are using different methods (Miller & Crabtree, 1992; Denzin & Lincoln, 1994). According to Miles and Huberman (1994) and Boyatzis (1998) thematic analysis involves three distinct stages. Miles and Huberman present these stages as follows:

Stage 1: data display

Stage 2: data reduction

Stage 3: data interpretation

The above three stages, as described below, were applied to the process of thematic analysis to identify significant themes in the data. These were then organised systematically to address the aim of the study, which was to identify the antenatal education needs of pregnant teenagers in the

Palmerston North region, and use emerging key issues to develop tentative recommendations for an antenatal education programme.

### **Stage 1: data display**

The first step was to transcribe the focus group interviews. Transcription facilitates analysis of the data and provides a more permanent record of the interviews, but is not always complete. I listened to the four tapes twice each with the purpose of correcting spelling on the transcript, adding missing words and in some cases to complete sentences, as well as writing observational notes of any laughter, giggling, coughing or side discussions that were relevant.

### **Stage 2: data reduction**

The second step required me to become familiar with the inductive data. The interviews had generated a large volume of rich data. This included the 'hot notes', as well as the non-verbal observations that I had made during the interviews. The data then needed to be reduced into common ideas and recurrent patterns. I read the transcripts several times and listened to the tapes again, this time with the aim of discovering emerging themes, rather than using a proof reading approach. Following this I attempted to identify key issues and common types of responses to identify emerging themes.

I wrote each one onto a different coloured piece of paper and then re-consulted all the transcripts again. Comments made by the participants were cut up and 'glued' onto the corresponding coloured paper with the fitting theme. At times comments were re-glued to another coloured piece of paper

after re-evaluating the actual meaning. Bernard (1991) states that trying too hard to analyse data sometimes results in the meaning becoming too elusive. The overall aim is to find emerging themes and arrange them meaningfully, attempting to stay 'true' to the data collected.

The themes that emerged were also taken back to 11 teenagers who had participated. They agreed the themes were a true reflection of the focus groups they were involved in (for further details see under point 7.6 p. 124).

### **Stage 3: data interpretation**

The third step required me to interpret the thematic data and develop recommendations for an antenatal education programme, which are presented in chapters 4, 5 and 6 of this thesis.

## **3.9 Summary**

In this chapter I presented the reasons for choosing focus groups as the method of data collection and described the appropriateness of this for the pregnant teenagers involved. This was followed by an outline of how participants were recruited. Morgan's (1997) four 'rules of thumb' were presented and the application of the 'rules of thumb' for the planning and conduct of the focus groups discussed. The ethical considerations in the planning and conducting of this study were also addressed and thematic analysis, as a method of data analysis, was explained following a three-step process recommended by Miles and Huberman (1994).

The next chapter is the beginning of the data chapters and presents the first collective theme identified by the participants as operational antenatal education needs. This includes reasons for a separate teenage antenatal education programme, the personal traits and skills desired in a facilitator and the physical environment important to participants. The questions of who should be able to attend and an appropriate name for an antenatal education programme conclude the chapter.

# A Guide To The Data Chapters

In chapters four to six verbatim quotations are included in the text to illustrate and support the findings.

The following is a guide to the presentation of this data:

- The participants' speech is recorded in *italics*.
- The researcher's speech is recorded in normal type.
- Parentheses (...) indicate where part of the text has been removed.
- Diagonal brackets <> indicate where text has been altered to preserve anonymity or add clarity.



# Chapter Four

## Operational Antenatal Education Needs

*Like an oasis, chaos and desert outside - love and acceptance inside (p.97)*

### 4.1 Introduction

In the last chapter I discussed the qualitative method of this study and its appropriateness for eliciting information from pregnant teenagers about their antenatal education needs. This chapter and the following two chapters are presenting the themes, which emerged, from the data and the interpretation of the data.

Several themes surfaced from the data collected through four focus groups with a total of 30 pregnant teenagers and teenage mothers, aged between 14-19 years. The first collective theme presents the operational antenatal educational needs as identified by the participants and involves how the teenagers perceived their requirements in regards to needing an antenatal education programme, what kind of facilitator they would find appropriate for an antenatal education programme, what kind of physical environment would make them feel comfortable, who should participate and what it should be called.

## 4.2 The Need for a Teenage Antenatal Education Programme

The teenagers in all four focus groups indicated that there is a need for antenatal education specifically for pregnant teenagers. Santrock (1996), Mills (1997), Lesser et al. (1998) and Coddington (2001) identify that pregnant teenagers relate best with their own peer group and therefore are more willing to listen, question provided information and identify their needs through antenatal education focused on them. Lesser et al. (1998) found that non-attendance reduced considerably when an antenatal education programme was offered for pregnant teenagers only.

The need for a teenage antenatal education programme generated a large amount of discussion about the experiences participants had with adult antenatal classes. The majority shared negative experiences and this helped to clarify for them the definite need for separate teenage antenatal classes.

*(...) It was so difficult for me, I couldn't ask questions at all because I was the only young person there and sort of scared. I went to the classes to make life long friends, but nobody talked to me, because all these adults just did not talk, but teenagers talk!*

*I felt left out without a partner.*

*I had this old lady come in talking about exercise and stuff and I could tell she was quite objectionable about my age.*

*She thought I was quite young and I asked her a question and she just kind of fobbed me off, I didn't feel very comfortable when she did that (...). She asked me a question about forceps and I said something like "Oh, I've always thought they were pretty scary and I wouldn't want to use them" and she said "Oh you don't like the spoons do you, ooh", like I was a little kid and I was just like "okay"!*

The responses were very definite in regards to unanimously affirming the need for a teenage antenatal education programme. However, the participants emphasised that such a class needed to be focused around their age group and needs. A number of the participants made the following comments:

*Yeah, I like being able to meet other pregnant teenagers*

*I want to go to one with pregnant teenagers up to 19 years old, so I can be around young people that are going through what I'm going through.*

*Not elderly people in their 30s.*

*I felt a bit down through my pregnancy because all my mates ditched me but going to a teenage thing could help me heaps. My family rejected me at the start because I*

*was pregnant and to go some place where I wouldn't get told off that I was doing the wrong thing or anything like that would be cool.*

#### **4.3 The Characteristics of the Programme Facilitator**

While the participants identified a definite need for antenatal classes it was a surprise for me to see a theme emerge about the kind of facilitator they would wish for and felt they could easily relate to. It had been my thoughts that teenagers relate well to other teenagers or funky young adults that would motivate them into learning. A number of educational studies highlight the need for young teachers as they apparently relate well with young people in the secondary school system (Bowman, 2003; Daugherty, Logan, Turner & Compton, 2003). However, the participants of this study identified an effective facilitator as:

- Someone who has had personal experience with teenage pregnancy.

*I think someone who has actually experienced teenage pregnancy themselves or in their family.*

- Whose age was not perceived as a barrier.

*Age does not matter, no not at all.*

- Ethnicity did not matter as long as the facilitator understood and embraced cultural diversity.

*I don't think it matters if the person is Maori<sup>6</sup> or not.*

*As long as it is someone who is not going to judge, and understand where you are at.*

*Someone who speaks understandably and relates to teenagers without pointing the finger all the time, someone who understands about culture, does not judge people by their culture or where they're from.*

- Whose personality traits included being female, having a good self-esteem, with a good knowledge base and appropriate resources at hand.

*Personally, I think a female.*

*Someone who has a good self-esteem herself because some of the pregnant people have low self-esteems and it would be good to see someone to raise yours.*

*Someone who knows what they are talking about, when we ask questions, they should be able to give us an answer then and there and not a male.*

---

<sup>6</sup> Maori – indigenous people of New Zealand

*I feel it's really important <for her> to be someone who can bring in the resources to help us understand about pregnancy, like at the teenage pregnancy class I go to. (...) and help us understand community resources, which can help us. Like IRD <Inland Revenue Department> or WINZ <Work and Income New Zealand> or something. And talk to us of other community resource people.*

- Someone who is able to be approached on a one-to-one basis by individuals as well as in the group, who is trustworthy, non-judgemental, able to listen and keep confidential information that is shared.

*Not so judgemental of what has happened to us. I'd always been judgemental and thought <about other pregnant teenagers> hell, you must have known how to get pregnant and then I got pregnant I was like – damn! It feels so awful to be judged.*

*Yes, people need to learn to listen to us. They don't know how we got pregnant. Nobody really listens, a facilitator needs to listen and not tell others about our lives. She needs to be trusted.*

*Personable. Someone who can go on a one-to-one approach rather than generalising to everyone completely.*

- Someone who could be contacted any time not just at the time of the antenatal group and who would support pregnant teenagers no matter what. As one participant put it *'love us, warts and all'*. When I pointed out that some facilitators have their own lives as well, the frequent response from participants was that they would *only contact the facilitator in the middle of the night if it really were an emergency*. The preferred method of contacting was identified as being via text messages on mobile phones, as this was a cheap way of contacting someone. It also meant the receiver of the message could deal with the required action in her own time – *'when the moment is right for her'*, as a participant commented.

*At my class I could text the woman <facilitator> any time, she was so cool. I had to teach her first how to do it though.*

*Yeah, you can get the feeling that she <facilitator> actually sort of cared. Like no matter how bad I was, she loved me warts and all. That's what we need.*

#### **4.4 The Venue and Physical Environment**

The venue and physical environment did seem to have a great impact on whether participants went back to antenatal classes or decided to attend one. Again the sharing of mostly negative experiences helped the participants to clarify the needs they had for an acceptable venue and environment. The

participants indicated strongly that the hospital was not the place for them to have a teenage antenatal education programme.

*I hated going to the hospital <for antenatal classes>, it felt like everyone was staring at me and they knew exactly where I was going.*

*No, not the hospital!*

*Too black and white <the hospital>.*

*Too busy <the hospital>.*

*It <the hospital> smells.*

*Lots of people will see you <at the hospital> and see you are pregnant.*

*Don't like the white walls and sheets at the hospital. Sick people go there. It is a public place.*

*You can't talk in an atmosphere like that <the hospital>.*

One participant suggested having the antenatal classes at a pub. This created similar responses to having it at the hospital as it was seen as a public place.



*I mean you're going to be talking about personal things and stuff like that so you don't want to be out anywhere. Say you're at a café or something, looking at the hips <pelvis>, like this is how the baby comes out, like it's not very nice, things like this are private and should not be talked about in a public place.*

*Not a pub, too much drinking and smoking and too public.*

In summary the participants of this study identified an appropriate venue and physical environment as:

- Comfortable and community based, not at a hospital, pub or a very public place.

*It has to be comfortable.*

*I wouldn't like to go anywhere that's crummy.*

*Somewhere in the community.*

- Having a homely and casual atmosphere with lounges and yet private.

*Most importantly, a homely casual atmosphere. Cosy area for sitting, food and drinks. Like Plunket Karitane rooms in town. Somewhere like this <the Pregnancy Centre where*

*the focus groups were held>. Comfortable, laid-back, lounge, like a lounge type thing, but not in the hospital, a public place.*

- Providing funky music and free food.

For some pregnant teenagers it might mean the only nutritious meal they would have once a week.

*My group <antenatal class> made us cook and eat yummy food while we listened to the CD's we brought along. It was like being at home with your mates but without your parents.*

*It was good to come once a week and gobble down the food, which meant I could save some money for the rest of the week.*

- Easy access to a central location.

Participants commented that often they had no transport available to them. Money for public transport was difficult to obtain as most of them were totally financially dependent on their parent(s)/Caregivers/Whanau<sup>7</sup>.

*Yes, there is the problem that most of us can't drive or don't have the money for a car.*

---

<sup>7</sup> Whanau, a Maori word, meaning extended family. A term used frequently in New Zealand (Ryan, 1994).

*So right in town is good.*

*Probably because you have to be around somewhere where everyone can get to easily like I mean the bus (...) depot is just down the road, it's easy from here <where the focus groups were held> because if you're in town you can catch the bus here or walk but if you held it out of town people won't come much.*

- Providing a free pick-up service, was agreed to by participants of all focus groups.

*It is when other people aren't interested in you and you haven't got your own car, they won't take you, so someone else needs to take you. A pick-up service is what I would want.*

*Have it quite cool, food and music stuff like that, getting picked up, most of us don't have transport (...).*

- Free of charge.

*I would not come if I have to pay. Who knows what it is like and then you paid for it. No way.*

*My mother has no money anyway, how could she give me a few bucks for a class, anyway, especially as I have not told her that I am pregnant.*

*I thought maternity service is free, does that not cover antenatal classes?*

*I mean we can't get any money from WINZ until we are 18.*

#### **4.5 Acceptable Participants for a Teenage Antenatal Education Programme**

Condon & Corkindale (2002) examined the trends and consequences of teenage pregnancy in South Australia and identified that little is known about the teenage fathers. They argue that it is known however, that 90% of teenage women are unmarried when they give birth and about 60% have no male partner at that time. Cassie (2002) described a pregnant teenage support group in New Zealand, which is for young women only. She described the high number of pregnant teenagers that had been 'dumped' (p. 6) by their boyfriends and therefore this type of women-only antenatal class emerged. The female-only approach assisted in frankness and easy discussions centred around topics like pubic lice, mucus and leakage, breasts and intercourse among others, issues that would not have been discussed with males present, she argues.

A limited number of international initiatives chose to base their programmes on female-only approaches finding it made a difference among pregnant

teenagers as they were more open, honest and more supportive towards each other (Patterson, 2003; Youngs, Niebyl, Blake, Shipp, Stanley & King, 1977, Rogers et al., 1996; Baddiley, 1997; Klima, 2003;). In all the above programmes, female-only meant including any female that mattered to the pregnant teenager. Grandmothers, mothers, aunties, girlfriends, schoolmates and neighbours have attended to varying degrees. The four focus groups from this study, however, could not come to a consensus about who they wanted to participate. Focus groups 1 and 2 (most of them were in a stable relationship with a teenage boy) advocated for their boyfriends to be included.

*I think it's really good to have partners come.*

*I didn't care that much if the guys were there.*

*(...) He would often say: "I wish you wouldn't go to that <teenage antenatal class> because I want to come as well".*

*Yes, boys should come. They need to know what we're going through, so they've got some preparation for the birth, when we scream at the end and then they know it is not their fault.*

*They <boys> need to know that all sorts of stuff will be discussed, like nipples for example and fannies, that's what they've got to expect.*

In contrast, the members of focus groups 3 and 4, most of whom had no boyfriends, advocated that under no circumstances did they want boys to be present. Some suggested it is because boys were 'stupid' and shy.

*That's what was quite good about (...) my teenage antenatal class <female only>. The partners didn't come because they might make some girls feel a bit yeah uncomfortable and they <the girls> wouldn't open up and stuff like that, I thought it was very good.*

*Then you also run the risk <of the class being> from their perspective, the guy perspective and we <the girls> miss out.*

*I think it's a bit unfair on <person's name mentioned> here, who has no partner, then she misses out on her question.*

*I liked sort of coming to it <female only antenatal class> and getting away from him, without having him look over my shoulder and fuck me all the time.*

*The partners came along and I was like (...) you're so lucky and where's mine? I didn't like that!*

*The boys would come and probably sit there and come once or twice and think, this is stupid.*

*No, I reckon they <the boys> won't come the whole time anyway.*

*Yes, I reckon they <the boys> whisper in your ear. Can you ask her? He'd be too ashamed to ask by himself.*

All focus groups however, suggested that if a mixed antenatal class was not possible then there should be another one offered where the boyfriends could attend. This suggests that the participant approach might have to vary according to the needs of different groups attending teenage antenatal education programmes.

*It should be a choice.*

*Before the boys come though, we should talk to the whole group first.*

*Talk to the others <the girls in the group> first and discuss whether they want it or not and if not, don't bring the guys.*

*Maybe every two weeks or something for fathers <to be>.*

*Or once a month have a guy's night, boys night out, something like that.*

*I think it would be a good idea if it could be alternated like girls <only> one week and then with partners the next week and so on.*

#### **4.6 Naming the Programme**

All four focus groups had a great amount of laughter trying to come up with a name that might be acceptable to them and would draw them into coming to a teenage pregnancy programme. Some names were suggested but no agreement could be reached. There are no international studies that I could find that specifically researched, in particular, acceptable teenage terminology for antenatal education programmes. However, all participants agreed that the term 'classes' sounded too much like school and projected an image in their minds that would not encourage them to attend.

*Classes means study hard, if you don't listen you get kicked out.*

*It's funny, my mum goes to me, "if you're late, you won't get anything like a detention or anything?" and I was like, oh God, shut up.*



Furthermore the term antenatal was poorly understood by the participants and they advocated to have it substituted with something relating to pregnancy.

*(...) because I don't even understand what antenatal means.*

*A lot of my friends <other teenagers> ask when you say where you're going and you say 'antenatal class', they go 'what's that?'*

*Some people <teenagers> call it anti, like anti war and anti something with an 'i' instead of an 'e'.*

*I like pregnancy group or teenage pregnancy gathering.*

*Or pregnancy course or teenage birthing course.*

Overall the term teenage(r) was acceptable to the participants of the focus groups, as they felt it identified who they were and separated them from the adult programmes, which they did not want to belong to. This is contrary to a regional study undertaken in New Plymouth, which found that their pregnant teenagers preferred to be called young women (Health Promotion Unit, 2002).

*It's good to have teenage in there (the name) somewhere.*

*(...) because that is what I am <a teenager>.*

*But it <teenage> should be in the name somehow, so it identifies it a bit more clearly.*

Some name suggestions were made with a lot of laughter but most were not acceptable to all participants.

*I used to call mine <antenatal class> 'pizza club', because we often ate pizza there or 'big hip club' but that would not mean a lot to pregnant teenagers out there.*

*Mob Squad, but it doesn't mean a lot for teens out there.*

*Hip Hop and Happening!*

*It would be cool to have a different name but I think only people going to the group would use it.*

*When you are a teenager you are not comfortable saying antenatal class with a stranger or a person who is not fully knowledgeable about your situation. If there were other ways of expressing antenatal class it could be an easier*

*understandable term, like teenage pregnancy group. My friends don't know what it <antenatal class> is.*

In summary it was identified that the word 'class' was not an acceptable term and would discourage pregnant teenagers from coming. The term 'teenage' seemed acceptable and was identified as drawing other pregnant teenagers to the group, as it identified clearly who the group was for. 'Antenatal' was unclear terminology and the term 'pregnancy/pregnant' was identified as being an acceptable replacement. This suggests that when providing teenage antenatal education programmes, these terms should be included but also participatory involvement of naming the programme together with the attending pregnant teenagers might be of benefit. Participating in naming the programme would encourage ownership and a level of acceptance that could foster the regular attendance of pregnant teenagers at the programme.

#### **4.7 Summary**

This chapter presented the operational antenatal education needs as identified by the participants. Pregnant teenagers identified through four focus groups that there is a need for separate teenage antenatal classes.

An effective facilitator was identified as female, with a good portion of self-esteem, regardless of age or ethnicity. Someone who has had personal experience with teenage pregnancy, able to relate well to this age group, is non-judgemental and a good listener was preferred. Confidentiality, the ability

to be contacted via text messages and a knowledge and resource base that can be tapped into instantly were also given high priority.

An acceptable venue and environment, that would draw participants to attending an antenatal education programme on a regular basis, was identified as somewhere in the community at a central location, with a comfortable and relaxing environment, which also provided a free pick-up service, free food, funky music and no fees for the programme. A hospital venue was identified strongly as an inappropriate place for a teenage antenatal education programme.

The focus groups could not come to a consensus in regards to who are acceptable attendees for a teenage antenatal education programme. This related directly to whether participants of this study had boyfriends or not. Two focus groups wanted their boyfriends to attend and the other two focus groups preferred a female-only group, as most of them had negative experiences with the father of their babies. However, all four focus groups suggested that if a mixed antenatal class was not possible, then there must be other opportunities provided for the fathers. This suggests that an antenatal education programme for pregnant teenagers might have to vary according to the needs of different groups and these could be identified at the onset of a programme by the pregnant teenagers.

Another issue identified was what to call an antenatal education programme. Participants were very clear for it not to be called a class, as it had the connotations of school attached to it and would not encourage them to attend

such a programme. The term antenatal was poorly understood and it was suggested that it be replaced by the term 'pregnancy' or 'pregnant'. Overall participants felt comfortable with the term teenage as it identified who they are and differentiated them from adult antenatal classes.

The following chapter presents the second collective theme of antenatal education content and resource needs, which also includes some structural programme delivery recommendations by the participants and discussions on participatory development.

# **Chapter Five**

## **Content Needs For Teenage Antenatal Education**

### **5.1 Introduction**

The previous chapter explored the need for a teenage antenatal education programme and some operational requirements for such a programme as identified by the participants. Chapter one, two and four presented discussions and data findings for a separate developmentally based teenage antenatal education programme. Lesser et al. (1998) showed through their study that attendance of antenatal programmes increased, as did regular attendance for antenatal check-ups when such programmes were developmentally based. The focus group participants of the current study discussed and identified content needs and how such a programme should run.

Comments from participants highlighted the need for a more informal structure and laid back approach with an open-ended topic and time frame driven by participants. In the literature this involvement by participants is often termed 'participatory development' (Owens, Stein & Chenoweth, 1999; Jennings, 2000) and can be a very effective group and programme approach when ownership of the content and the group is of vital importance. A desired flexible time frame was identified as lasting the whole pregnancy not just for a six-week course.

Participants also saw a teenage antenatal programme as enabling them to form long-term friendships for potential support and fellowship after the baby was born. This is discussed further in chapter six, under psychosocial needs. A variety of topics were suggested and when compared with conventional antenatal programme topics it became clear that pregnant teenagers did not consider some of those topics relevant. A variety of other topics outside a conventional programme needed to be included, for example, what are the implications for the father of the baby to be or not to be on the birth certificate or what financial support is available for pregnant teenagers and teen mums.

The pregnant teenagers in this study all believed that they would attend an antenatal programme if it is offered as a support group lasting the whole pregnancy and the content driven by them on a participatory basis each week.

## **5.2 Needing a Non-structured Support Group for the Whole Pregnancy**

Traditionally antenatal classes are offered for couples and over a 4 -7 week time frame, with a starting time from around 28 weeks of the pregnancy (Robertson, 1988). Participants of all four focus groups expressed the view that this was not appropriate for them. Through their comments the need for a support group that would last the whole pregnancy was clearly identified.

*Another thing, I reckon, is coming along to a support group for the whole pregnancy, not like other places where you get excluded. Like when I am up town I get*

*sick of people looking at me and judging me like that, they see my tummy and look at my face and there's all that. This support group would be one place you can come and get treated like a queen, like a princess, like it's your time to say, "Hey, I'm proud of this, I'm pregnant", and just like when older women are pregnant we all have got the same rights and it's only fair that that gets reinforced in an antenatal class. So you need that right throughout your pregnancy, not for the last eight weeks to gear up for the birth. The whole self-esteem goes to pieces when you get pregnant and all that stuff.*

*Not just many weeks <for example 28 weeks into the pregnancy> down the track. There are different questions you want to ask, and there are different things and towards the end, you have different questions. The whole pregnancy, definitely.*

*I think for teenagers throughout the whole pregnancy, because you do antenatal classes at the end, but when you most need it is at the start, when you really need to go through everything with somebody, like, because that's when you know nothing, and everything is so strange and you are crying and feel so isolated.*



*Six weeks is not enough when you think that some of us thought milk only comes from one breast or the baby comes out of the belly button.*

Needing a support group lasting the whole pregnancy was one identified aspect. Additionally it was equally important to participants that the group has a laid back and informal structure.

*If there are cushions and funky music I might have gone back.*

*Not a lot of books, or reading and paperwork, but getting free bee's like nappies and baby clothes, nice food with a cuppa and hearing about other people's problems and then finding they are the same as mine and stuff.*

*It could be a bring-and-share food or baby clothes, but I like the idea also of coming and going, like I don't have to be on time or I can leave earlier to meet my boy friend or something. A nice free meal is also cool.*

Baddiley (1997) found that the informality that was offered through their afternoon group for pregnant teenagers enabled them to 'feel at home'. The teenagers came back once their babies were born and the group carried on as a mixed group supporting each other. A significant increase of regular

midwifery antenatal checks and other appointment attendance was reported. Davies (1990) reported that regular attendance increased dramatically when an informal approach was used for their antenatal education programme.

Participants also commented on the actual time that would suit them best. A considerable number of comments centred on the need for sleeping-in in the mornings and that they would not attend any programmes at that time. Some were still at school, others were working and some wanted to come with their working mothers or other female relatives, hence the best time over all seemed to be around tea time, which of course would fit well with a provision of a free hot meal.

*I like it between 5pm and 7pm because that is when I can get a ride home with my Dad. He finishes around 7pm and I love sleeping in the mornings, which makes Dad mad.*

*I reckon it should be two hours every week for the whole pregnancy around teatime, like 5pm when my Mum knocks off. Then we can talk amongst ourselves, eat and sit and then we can get into it 40 minutes later or so.*

*Yes, my goodness, eat at tea time and then be able to discuss as long as you want to find answers to your questions, my dream come true!*

*I wouldn't say mornings, I like to sleep in. I reckon 5pm  
– 7pm is a pretty good time, because then you can go  
pub-ing afterwards or to the movies or hang out with  
your friends.*

### **5.3 Participatory Development Needs for a Teenage Antenatal Education Programme**

Koniak-Griffin et al. (1999) published a small comparative American study with 63 pregnant teenagers participating in an intensive Early Intervention Programme (EIP). The EIP incorporated the outcome of a content needs analysis by these pregnant teenagers. The comparison group consisted of 58 pregnant teenagers receiving a conventional antenatal education programme via public health nurses. The EIP group showed a reduction in the premature birth rates and fewer days of infant hospitalisation. This was a relatively small sample and it is difficult to translate into a New Zealand setting where midwives and childbirth educators provide antenatal education programmes and midwives provide maternity care in general. However, participants in the current study identified the content of an antenatal education programme needing to revolve around their needs, not what the programme curriculum prescribes. Malnory (1996), in a Canadian context, looked at the developmental care of pregnant women and found that when a drop-in style approach was used and information shared according to needs arising on a week-by-week basis was used in the antenatal education programme, regular attendance increased dramatically.

The term and concept of participatory development has been used in a community development context that had its origins in developing world projects (Reason, 1988). It has also been called human inquiry, participatory research, collaborative inquiry and action research (Reason, 1988). Participatory development promotes equity and accepts that the exercise of decision making power at the local level is as legitimate as it is at the national level (Jennings, 2000; Coupal, 1997). This means involvement by programme participants in the content, conduct and creating of a programme designed to affect their lives (Jennings, 2000). Ownes, Stein and Chenoweth (1999, p. 251) summarise the characteristics of participatory development as follows:

- It provides opportunities for learning and problem solving for all participants.
- It has local significance and application when it is part of participants' activities.
- It is supportive of issues related to social justice, equity and advocacy.
- It allows critical reflection to take place.
- It enhances change processes.
- It empowers participants.
- It has a strong tradition in discourse.

- It develops co-operative, collaborative and interactive relationships among the participants.

Frequent comments made by participants about their need to be consulted and to be involved in choosing how the programme was offered and what topics were covered, showed a high desire for participatory development.

*It has to revolve around us, not what they want to teach us.*

*Talk about what you want to know next week instead of someone telling you what you are going to learn next week. You get to say, oh can we do this, or can we do that.*

*I want to talk and ask questions as long as it takes for me or us to get our questions answered, never mind the topic. My question needs to be answered.*

*(...) people come and they've got all these questions, they need to be answered. You also learn from those answers, as that might've been a question you had.*

*It doesn't matter if you go over the same question twice, like sort of go overboard, that's good too, you get a better understanding of what's going on.*

*They should be <consulting us>, I think, that you should be able to talk about anything and everything that's basically on your mind, about your pregnancy and what you're concerned about and it should be open. It is supposed to be for us, isn't it?*

#### **5.4 Content and Resource Needs for a Teenage Antenatal Education Programme**

This area of enquiry generated a large amount of data. It appeared that participants had almost waited for someone to ask this question. Suggestions and reasons why certain topics were wanted were readily forthcoming and found frequent agreement amongst other participants across all four focus groups. These discussions created an atmosphere of urgency to address these topics and confirmed that participatory development could ensure that these topics were in fact covered and would encourage pregnant teenagers to regularly attend such an antenatal education programme.

Participants of this study identified a range of topics with life skills being on the top of the list. This is congruent with the findings from the Koniak-Griffin et al. (1999) study where the pregnant teenagers on the EIP programme also identified life skills as being a high need. Life skills training identified by both studies included cooking, how to change addictive behaviour, staying healthy, decision-making exercises, conflict resolution, budgeting and available social welfare financial benefits, communication skills and self-esteem building exercises.

*Maybe you do a tour of the supermarket and you show what sort of foods are for what purpose and what's a good alternative and where you find them and that and then how to cook them into a delicious cheap meal.*

*What's budgeting? Yea, I need help with how to organise my money after the baby, when I finally will get some money.*

*Yes. What kind of benefit or income you get when you're having a baby.*

*Confidence or self-esteem learning things (over speaking by others), society tends to hammer you a bit, do you think?*

*I can't cook still.*

*And also like getting a different idea of how to do it (talking to your parents), like how to talk to your Dad about the pregnancy and stuff. And oh, yes, how to tell the father of the baby, to tell anyone really, like the teacher at school or your grandma or sister.*

*How to stay off drugs or smokes or drinks?*

Another area of concern for the participants was legal issues they were not familiar with but knew they would encounter or had already experienced them and found them bewildering to deal with. In particular they mentioned custody issues and protection orders, as well as abortion and adoption issues.

*Formal custody, things like that. Also what happens if he is or isn't on the birth certificate.*

*I had to go to the police. My boyfriend was kicking me but I didn't know my rights. They were not helpful. What can I do to keep him away?*

*(...) I didn't know about parental rights, like I went to see the lawyer when I had issues with (...) <the father of the baby>, about what my rights were and what his rights were and what I had the risk of losing.*

*Because it was quite scary at the time because I had no idea <about custody > and all of sudden it just blew up in my face and I was like, well, I've just got no idea.*

*Please talk openly about abortion and adoption.*

Some suggestions for topics to be included were similar to the traditional topic range of conventional antenatal classes/childbirth education programmes. These included breastfeeding, pain relief, stretching exercises,



perineal massage, birthing positions, breathing, labour and birth complications, premature birth, immunisation, postnatal services explained such as Plunket<sup>8</sup> and PAFT<sup>9</sup> and postnatal depression, as well as the emotional aspect of pregnancy. These suggestions however, need to be considered within a participatory development model and are not necessarily what future pregnant teenage participants of antenatal education programmes would want.

*Breastfeeding. We hadn't really covered that in my class. We had one day where they talked about it, they didn't really say about problems about it or anything. And basically they just sort of said: "this is how you do it" with a video and then after that you have to ask about it otherwise you weren't told anything.*

*Pain relief as well would be good because I didn't know much about all the different things.*

*Stretches.*

*Yeah and perineal massage.*

*Positions.*

---

<sup>8</sup> Plunket is New Zealand's leading provider of well child and family health services. It provides a unique mix of a professionally educated workforce working hand-in-hand with volunteers throughout New Zealand. ([www.plunket.org.nz](http://www.plunket.org.nz))

<sup>9</sup> PAFT is a publicly funded programme providing education and support for parents and caregivers with children under three years of age (Farquhar, 2003)

*(...) I didn't really know breathing techniques.*

*Yes, how it <labour> goes and what can go wrong.*

*Problems with labour, ventouse and forceps, it was kind of scary hearing about it but it did actually help because I just didn't expect to have any intervention, but when it did not go smoothly then I thought back I've heard about the ventouse and I thought okay when the doctor said: "I'm just going to get the suction thing" and I just went okay, oh okay, yeah okay, I know what that is because it was helpful learning about things like that.*

*Every birth is different and a little bit of knowledge about prem babies was alright for me when mine came along. (...).*

*Immunisation or PAFT.*

*Maybe Plunket should come.*

*Because that's a very harsh subject a lot of people don't talk about their emotions and postnatal depression, you don't know what's happening and why and most of the time you end up blaming yourself. You think that*

*something is wrong with you; you're making a big deal out of nothing.*

*I think the emotional aspect of the pregnancy rather than just the scientific bits.*

Suggestions about appropriate and helpful resources were also made by a variety of participants. Hearing birth and breastfeeding stories from other teen mothers and having an opportunity to hold a baby during the pregnancy were suggestions from all four focus groups. Watching videos of pregnancy, birth and breastfeeding situations was something most participants wanted to watch only if they were presented by other teenagers in similar situation to theirs, especially from New Zealand, although some found them helpful regardless. Hands on resources, for example, nappy folding, birthing stools, a female pelvis, gym ball, baby bathing with a real baby and holding forceps were deemed helpful by most participants as well.

*The videos that we watched where the girls were in labour and what they were like, I sort of, when I was in labour I sort of taught myself breathing like her, it was good <watching videos>.*

*I think I watched quite a few movies of older women having babies and that the pain could be quite bad, but they were grown ups. Did not like it so much.*

*I would have loved to have the chance to hold a baby beforehand; I'd never held a baby before her. I really wanted a chance to see another baby.*

*Oh and up the top you should have bathing, bathing babies. (...).*

*(...) It was helpful learning about things like that <ventouse and forceps>, we got to hold the tools and stuff.*

*It would be cool to have young people come through. It was just, we didn't actually have any mothers come in either, and it was just basically the antenatal lady that taught us at the hospital.*

## **5.5 Summary**

In this chapter I have discussed how participants identified the need for a more informal structure and laid back approach with an open-ended topic and time frame through participatory development for a successful teenage antenatal education programme. A desired flexible time frame was identified as lasting the whole pregnancy with a weekly support meeting around 5-7pm to share a hot meal together. A variety of topics were suggested and resources that were helpful to the participants for their pregnancy and birth experience.

The participants in this study all believed they would attend an antenatal education programme if it is offered as a support group, rather than a class with a traditional model of antenatal education and short time frame late in pregnancy, and the content is driven by them on a participatory basis each week. This includes weekly planning ahead but also addressing spontaneous issues arising during the actual group support meeting.

In the next chapter I discuss the psychosocial needs of pregnant teenagers and the importance of addressing these within an antenatal programme. Feeling safe, self-esteem, body image and emotional support, addressing and changing addictive behaviour and opportunities for forming long-term supporting relationships are explored as identified by participants.

# **Chapter six**

## **Psychosocial Needs Of Pregnant Teenagers In The Context Of Antenatal Education**

### **6.1 Introduction**

Eric Erikson (1968) focused on the psychosocial development of people which includes emotional health and how society helps shape personal identity. He based his focus on five ideas. Firstly, people in general have the same basic needs and secondly, the development of self occurs in response to these needs. Thirdly, he believed development proceeds in stages and that each stage is characterised by a psychosocial challenge or crisis, that presents opportunities for development or hinders the development. Lastly, he believed different stages reflect differences in the motivation of an individual.

As has been described in chapter one of this study Erikson termed the teenage years as the developmental stage of identity versus role confusion. This is the period when teenagers experience major physical, intellectual and emotional changes and want to know who they are and what their role in society should be. Teenagers experience new sexual feelings and are not sure how to respond to them. They are concerned with what others think of them and are preoccupied with their looks. They want to assert independence and rebel but also want structure and discipline. This is evident when many teenagers experiment with unusual behaviours, clothing

or ideas in order to make a statement about themselves. Teenagers usually view social needs as being of uttermost importance and often turn to peers for advice, friendship, and recreation, expecting friends to fill virtually every longing they experience thus replacing family in importance (Parker & Williams, 2000).

If a teenager becomes pregnant another crisis that could contribute to role confusion may arise. Therefore it is important that antenatal education programmes are specifically directed to what pregnant teenagers want to know and that the emotional and social needs of young women are understood (Renker, 2002; Bagshaw, 2001; Mills, 1997).

The focus group participants of the current study identified the need for safety, self-esteem/self-worth building exercises, body image issues and overall emotional support within an antenatal education programme for pregnant teenagers. Addressing and changing addictive behaviour and socialising with other pregnant teenagers to be able to form long-term friendships for potential support and fellowship after the baby was born were also very important issues identified by participants.

## **6.2 Feeling Safe**

Maslow (1970), a psychologist, identified a pyramid of human needs to reach ones potential and argued that each level of needs in this pyramid requires to be addressed first before the next level can be attained or the individual can ultimately reach self-actualisation (the process of making maximum use of

one's abilities and potential) at the top of the pyramid. This is only achievable through feeling safe at each level. Erikson and Dryfoos (1998) also identified that feeling safe assists in the process of attaining identity thus completing the teenage development stage.

Participants of this study identified clearly that feeling safe was a big issue for them and while they could not change the unsafe environment at home or in society they wanted a place for a teenage pregnancy support group where they could feel and be safe. The feeling safe requirement for such a group meant something different for different participants but overall it was expressed as physical safety, no physical abuse would be occurring and emotional safety, where participants could express how and what they wanted verbally without needing to modify their emotional or verbal expressions, as well as being accepted for who they are, no matter what they had done or were still doing.

*At least one place where I know I don't get kicked and shouted at, that's what we need.*

*(...) where specifically things related to the mother are discussed, have it that they <boys> don't come, like sexual or physical abuse.*

*One place where I don't have to get stressed out but made to feel special for once.*



*A place where I can come and feel accepted for who and what I am.*

*Yea, a place where no one tells me what I did and do wrong. I know that anyway.*

One participant from focus group one summarised the issue of feeling safe in a long dialogue that was interrupted frequently by other participants because of agreement and similar feelings, thoughts and experiences they had encountered. She had been attending a pregnant teenage support group and said the following:

*I found when I'm there <pregnant teenage antenatal support group> I feel like I am, I feel very honoured because I'm bringing a life into this world. But when I am going out, you know when I'm out, I mean my friends have said to me you know and they're happy I'm having a baby but I feel that this is one place where I am actually honoured for being pregnant, it's like an oasis, even though it was a mistake and I wasn't prepared for it, and neither were my parents you know. I feel it is real and I'm doing something really good and it makes me feel really good about myself because I've been a person who always put myself down and always felt I had no purpose in life and now I just feel wow, I'm actually doing something like you know and I get acknowledged for it there <antenatal support group>. I*

*feel safe there, like an oasis. Chaos and desert outside, love and acceptance inside.*

*When I heard about this teenage pregnancy group (...) I thought okay "for one I won't be judged, there will be other teenage mums there and maybe some understand my situation because of how I fell pregnant, it could be different to the way they fell pregnant and therefore I felt scared <also> because of my <skin> colour because I was afraid of rejection of me being (...) <nationality stated>. I just felt I would be rejected because there'd be everybody, I thought everybody knew everybody and I was a total stranger coming in and because I've already been considered an outcast in other situations I thought I would be discriminated against. But it was not so. I felt totally accepted and safe.*

### **6.3 Self-esteem and Self-worth Exercises and Emotional Support**

Self-esteem according to Santrock (1996, p. 325) is "the global evaluative dimension of the self and is also referred to as self-worth or self-image". For a teenager this might mean that she is not merely a person, but a good person. However, not all teenagers have such a positive image about themselves.

Across all four focus groups the participants asked for self-esteem building exercises, some participants called it self-worth, which according to Santrock is interchangeable. In practical terms this was identified as verbal encouragement, caring for each other through accepting and respecting each other in the group, as well as by the facilitator and through role-plays gaining confidence in dealing with relationship issues in particular with parents, boyfriends and people in the community, who openly rejected them.

*(...) pregnant people have low self-esteem and it would be good to see someone to raise yours <through an antenatal programme> and role-plays.*

*Confidence or self-esteem learning things, society tends to hammer you a bit, do you think?*

*And also like getting a different idea of how to (raise your self-esteem) and then how to talk to your Dad about the pregnancy and stuff and shopkeepers.*

Erikson (1968) emphasises the mutual relationship of teenagers with their social world and community. Identity development is not just an intrapsychic self-representation, but he argues it also involves relationships with people, community and society. Pregnant teenagers can attest to this as they encounter many reactions from people, community and society as they disclose their situations or when starting to show physically they are pregnant. Most of these reactions were negative, as noted by the participants

in the following quotes, which created a feeling of loss and loneliness, low self-esteem and indicated relationship breakdowns.

*(...) she kind of fobbed me off; I didn't feel comfortable when she did that (...) like I was a little kid. <reaction from antenatal class teacher to questions from pregnant teenager>.*

*I felt a bit down through my pregnancy because all my mates ditched me (...) and my family rejected me at the start because I was pregnant (...).*

*It would be nice to have somebody to say, just to tell you what your family's reaction mean and stuff and why they are being so harsh about it because I really did not know (...) and my boyfriend wasn't very nice to me at the start either. It was a bit obviously a huge shock to him as well.*

Being left out of their peer group and community, as well as family activities causes any person to feel lonely and isolated and in teenagers this can lead to severe self-esteem problems if they are unable to solve this issue (Weiss, 1973). Severe low self-esteem consequences are often evident as self-destructive behaviours, alcohol and drug dependency issues, inability to form long lasting friendships and a pessimistic outlook on life (Peplau & Perlman, 1982). There is the potential for negative health consequences and

maladaptive coping strategies when a teenager becomes a mother and has low self-esteem.

*I've been really emotional and lonely. I've found like in the past month or two months like I can't (...) sleep at night because I'm so, I don't know, maybe because my boy friend's gone (...) and lately I've been feeling, I've been blaming myself a lot for my pregnancy and I wish I wasn't pregnant and it just seems you couldn't go through it, it's just so lonely and emotional, it is.*

*I get so emotional over anything, people tell me to sshhh. Oh Mum doesn't, but people get annoyed with you crying all the time, well I don't know why I'm crying like that.*

*Yeah, we all go through a grieving process, well actually it's like something, because the pregnancies aren't planned and you get this huge shock in the beginning and guilt and all this stuff and I sometimes get very angry with society, there is such a double standard, so of course my self-esteem is low. There's sex out there, we see it on TV, see it everywhere and everything free love, you know la la and then when I fall pregnant everyone points the finger at me. Well, it's the consequences of doing what they showed me, so, I*

*reckon, if society allows me to do that <have sex> it must allow me to have a baby unplanned and help me.*

*You're not getting self-esteem support at home because Mum and Dad or whatever are just still trying to come to terms with the whole thing and they don't speak to us or think that we can be good mums.*

*(...) and half the time I didn't even want to even discuss it, like I didn't tell anybody because I just didn't want to have to deal with it and just wanted to pretend it wasn't happening and just carry on my shady lifestyle.*

*Obviously, I mean you're not hurting the child. I always constantly feel under this pressure that I have to do what older and other people consider is right and it's not necessarily right for me.*

*And also like sometimes older people make me feel guilty, because I, I've always sort of been like, I've got my daughter and I'd do anything for her, and she'd always come first but I still need to have my time, by myself, for me, and I've had some people sort of try and make me feel guilty about that, like I'm a Mum and that should be all I do.*

*Yeah, and like I give her to Mum to look after and stuff if I want to go out for the night with my friends, and 'cos it makes the time I spend with her more enjoyable too because I've had that time to myself, but some people do, just sort of look down on it, and be like you know, you're supposed to be at home 24 hours a day, you're not ever supposed to go out, you're not supposed to do anything with your life. I think that's wrong.*

### **6.3.1 Self-esteem Relating to Body Image**

Teenagers place great importance on body image (Kuykendall, 1989) and that does not change when a teenager becomes pregnant. A number of researchers have found that physical appearance is an especially powerful contributor to self-esteem during the teenage years ( Simmons & Blyth, 1987; Harter, 1990; Damon, 1991; Lord & Eccles, 1994). Lord & Eccles (1994) found in their studies, teenagers' self-concepts regarding their physical attractiveness were the strongest predictor of their overall self-esteem. Many participants commented on feeling ugly, fat and unattractive.

*And you do feel kind of ugly when you're pregnant. I did.  
And after you'd had the baby too, like for me I still have issues with that. I just want to get back down to what I was before and then it helps if you can talk to others about this.*

*Because you're so tired too – it's like as if I've got time to put my make-up on in the morning. I'm lucky if I brush my hair when I leave my house. Feeling ugly? Yeah. At the coffee group we all look ugly, so it is not so bad and sometimes the make-up lady comes.*

Stretch marks were a popular topic to discuss at great length during the focus interviews. Often I had to interrupt and guide the interview to another topic area, as otherwise a great amount of time would have been spent on how to treat stretch marks, how to prevent them, how ugly they were, how long they took to disappear, who got the worst stretch marks and how they could ever look sexy again.

*I was so gutted. I had no stretch marks until the last months and then they came. Disgusting, I was so cut up about it. What's the use of buying coconut oil and then it makes no difference in the end.*

*I couldn't believe it. I was ripping under my skin and these ugly red marks came up. Not only on my tummy but also on my bum and thighs. It's so disgusting.*

*My Mum said they'll turn silver, but they'll never disappear. At least at my group there were others who had them too and some were worse off than me.*



Being pregnant is not a permanent physical stage but neither is acne, for example, in the developing teenager. Both situations could affect the self-image of a teenager and if not addressed in a constructive and affirming way can lead to long-term self-esteem problems (Chambers, Wakley & Chambers, 2001). However, the non-permanency of the pregnancy can be of help when addressing body image issues. On the positive side of the spectrum physical recovery after a teenage birth can often occur quicker and more efficiently than that of older women (Eure, Lindsay & Graves, 2002). Antenatal education programmes need to include and address body image issues for pregnant teenagers as this can affect the overall self-concept of the teenager. Teenage mothers with a good self-esteem are more likely to parent their babies successfully and are less likely to become pregnant again (James et al., 1995).

#### **6.4 Addressing and Changing Addictive Behaviour**

Many participants mentioned that they might benefit from support throughout the pregnancy and after the baby is born, especially when trying to address smoking, alcohol and drug issues. While the recognition was there that it was not the responsibility of the antenatal education programme to change their addictive behaviour, it was support, information and links to other community health agencies that was sought.

*(...) because you need support the whole pregnancy and when you are a parent. Especially if you give up smoking, booze and drugs.*

*I don't know about drugs. I stopped because of the baby but my boyfriend is still doing it and I guess I will after the baby is born. I mean how do you stop?*

*Is there any place you can go to for help? I mean where they don't talk to your parents and stuff but are kind of helping you not to take drugs anymore?*

*Man, when I saw that alcohol video and what it can do to babies I stopped right away. But my friends don't understand, they still try and force me to have at least one drink. Going to the group helped me to be strong about it.*

It is documented in the literature that during the teenage years experimentation with health-compromising substances, like alcohol, tobacco, recreational drugs and other risky behaviour like unprotected sexual activities is common (Stein, Roeser & Markus, 1998; Dryfoos, 1990). For many teenagers these behaviours are exploratory and remain within a range that has no apparent consequences for their health (Maggs, Almeida & Galambos, 1995). Although there is extensive evidence that the self-concept changes during the teenage years and that these changes influence behavioural choices (Harter & Monsour, 1992; Orenstein, 1994) little is currently known about the relationship between self-concept and risky behaviour and the role that this relationship plays in stability and change in risky teenage behaviour. Some developmental scientists have also argued in

the literature that risk behaviour can positively assist teenagers to foster bonds with friends, explore their personal identity and express their autonomy (Silbereisen & Noack, 1988; Maggs, 1997), which of course seems a paradox. However, it has been shown that supportive parents, supportive relationships with other adults and extended family may reduce teenage risk behaviour and facilitate a change in at risk or addictive behaviour (Lord, 1994; Maggs, Fromme, Eccles & Barber, 1997).

A pregnancy can be a catalyst for a teenage woman to attempt a change in her addictive behaviour or reduce her risk taking behaviour. She needs support in this situation and clear information and guidelines of how to achieve this. A teenage antenatal education programme can be the catalyst and support she might need to achieve the change or risk reduction of addictive behaviour. Knowledge of local community agencies and specialist health professionals to assist the pregnant teenager in seeking to change the addictive behaviour needs to be an important component of a teenage antenatal education programme. Sometimes the catalyst is a visiting speaker who is requested by participants. A teenage antenatal education programme can then support the decision made by a pregnant teenager enabling her to sustain the decision and change. This can also become a catalyst for other pregnant teenagers attending the programme.

*It would be cool if we all could stop smoking together at the group. The lady from the Quit programme came and talked to us and said we could get the patches for free.*

## 6.5 Forming Long-term Supportive Relationships

Participants across all four focus groups identified the need for socialising with other pregnant teenagers to be able to form long-term friendships for potential parental support and fellowship after the baby was born. It was expressed repeatedly that loneliness and isolation was an issue as shown above, because pregnant teenagers are different from their non-pregnant peers and the participants' suggested a solution to overcoming this was to meet with other pregnant teenagers and teen mums.

*Most people having babies they'd probably be married or in a serious relationship and have you know a house all set up and have money to do lots of things. But with teenagers that have babies, they're either not married or have boyfriends that either leave or are not nice to them. Money is a big thing and so if you make friends with other pregnant teens you could help each other afterwards, like flat together and come to a group to talk about what it's like to be a mum and stuff.*

*They all had partners, and I was single. You know, like I felt different to them, I was quite self-conscious. I'd rather go to a teenage one and make friends and meet with our babies afterwards.*

*A support group for teen mums is a good idea, I think. I went with <antenatal class>, they were older ladies, like 30, they were first babies as well and I did not like to be with them. They worried about other things. They had funny questions. The age difference is a big thing. I think I was a bit scared to ask because young people don't really speak out their problems in front of old ones. Yeah, great to meet with other pregnant teenagers and then we carry on afterwards.*

*I like coming to the teen coffee group with my baby. They showed me how to breastfeed, that helped because I didn't have a clue and at the hospital the midwives did not help. They got annoyed every time I rang the bell for them to help me breastfeed.*

*Yeah, my friends dumped me and I am so stoked that I met other pregnant girls that became my friends. My daughter is teething now and that's going to be another issue for me, then when she starts crawling, when she starts walking, things like safety around the home and that sort of stuff. It's so good to talk to other girls about it and get help with it. It feels great I am not alone. Others have done it, so can I.*

*(...) More teens should come to a teenage antenatal class because basically the factual circumstances in our falling pregnant might be different, but basically all of us were not prepared for it, absolutely unplanned. That's why everyone then would feel more comfortable about not being judged and you can make new friends and help each other and also with babysitting afterwards.*

*And I think that I didn't think I could get pregnant because I didn't know how easy it can be because I'd never had sex and it was more ignorance than anything else and I think it is important to remember that that's all it is like when people are pointing the finger. And learning how it happened to other teenagers helps, they understand my situation and that helps. It's the same for becoming a mum; I need that kind of support.*

*There really is a need for something post-natally that you follow through from the antenatal class and meet all the other teenagers who went through the pregnancy with you.*

*Yes, even up till the first year because that's when most changes and most of the things happen.*

*(...) It would be such a bonus to go to an after class like the older mums do after they had their babies just to chat about their babies really.*

## **6.5 Summary**

This last data chapter identified the importance for antenatal education to include the psychosocial needs of pregnant teenagers. According to Erikson (1968) and Maslow (1970) feeling safe is one key element for mastering the development stage of identity versus role confusion during the teenage years and to achieve self-actualisation. Feeling safe, addressing self-esteem and body image issues, addressing and changing addictive behaviour and creating an environment that presents opportunities for long lasting and supportive friendships among pregnant teenagers and teen mums were some of the psychosocial needs identified for teenage antenatal education programmes. The participants suggested a post-natal support group for teenage mothers as a solution for meeting their ongoing psychosocial needs and support.

The next and final chapter revisits the aim of the current study and its limitations. It presents the emotional needs of teenagers, a summary of tentative recommendations for a teenage antenatal education programme and implications for the practices of midwives and childbirth educators, as well as for their training. The chapter finishes by addressing the rigor of this qualitative study and recommendations for future research prior to the concluding statements.

# **Chapter Seven**

## **Discussion And Concluding Statements**

### **7.1 Introduction**

In chapters four to six emerging themes and needs from four focus groups with a total of 30 pregnant teenagers or recent teenage mothers in regards to antenatal education were presented. The following discussion is set against the background of the literature review and the analysis of the findings and includes tentative recommendations for a teenage antenatal education programme; a summary of the teenage developmental stage and the teenage emotional needs as identified by Mellor and Mellor (2004). Following this I discuss the rigour of this study, provide future research recommendations, discuss implications for Midwives and Childbirth Educators, their training and finish with concluding statements. This chapter begins by revisiting the aim of this study and is followed by the limitations of this study.

### **7.2 The Aim Revisited**

I chose to explore needs and issues that might surround and affect teenage antenatal education using a qualitative methodology. This study aimed to provide midwives and childbirth educators with a clearer understanding of the needs and issues of pregnant teenagers as a basis for providing effective antenatal education. Within the literature review chapter, I identified that a developmentally based antenatal education programme appears more effective in attracting pregnant teenagers to such programmes but also in



reducing morbidity for pregnant teenagers and their babies. Emerging key issues and needs, as identified by the focus group participant were grouped into three major themes relating to the operational/structural education needs, the content needs and the psychosocial needs of pregnant teenagers for antenatal education.

### **7.3 Limitations of this Study**

This study presents findings of a qualitative research project of four focus groups to ascertain teenage antenatal educational needs. The sample was of 30 teenagers only, all from the Palmerston North region. This is a small regional sample and therefore cannot be generalised to the entire pregnant teenage population of New Zealand/Aotearoa. However, some of the findings are echoed in the international literature. Recommendations for a pregnant teenage antenatal education programme can only be made for the Palmerston North region. But it is hoped if a participatory approach is used to set up teenage antenatal education programmes, as identified by the current study, that this approach will identify the needs and issues of any pregnant teenage group in any part of the world and address these effectively.

Furthermore out of the 30 participants, 18 were NZ European, 8 were Maori, 1 from an African country, 1 from Malaysia, 1 from the Solomon Islands and 1 from Niue, which limits the study in regards to antenatal education cultural needs in particular to that of Maori, as the number was relatively small.

## **7.4 Discussion**

The findings of this study are discussed in relation to the emotional needs of teenagers in general, as this contributes greatly to maturing through their developmental stage into adulthood and needs to be addressed through their midwifery care and antenatal education programme. First I summarise the teenage developmental stage, this is followed by a discussion of teenage emotional needs.

### **7.4.1 Teenage Developmental Stage**

It is important to refer back to the discussion about a teenager's development stage because this is an essential component of providing effective teenage antenatal education. Within chapter one I noted how the current thought and interpretation of the teenage development stage is still shaped by Eric Erikson, David Elkind and Jean Piaget. In summary teenagers are egocentric, seeking independence to learn who they are and where they fit and they live for the present. They place great importance on peers and learning about different kinds of relationships. They enjoy verbal logical dialogues that fluctuate between concrete thoughts, actual experiences and make-believe situations. Learning about and refining effective communication skills is of importance to them. They place great emphasis on self and body image, which assists in maturing their self-esteem. They are physically still developing and engage in health compromising risks because they perceive themselves to be invincible, invulnerable and immune to the laws that apply to others. Becoming pregnant does not change the development process, thus making the pregnant teenager an instant adult, but can have an impact

on developmental issues for the teenager, maybe even delaying the process of becoming an adult (Kuykendall, 1989).

Midwives, Childbirth Educators and other health professionals often use an adult approach towards pregnant teenagers seeking health care and education, as the majority of their clients fit into the adult category and it feels comfortable to work within these boundaries. As identified by the participants of the study this approach will not provide a sense of 'feeling safe' and attendance for midwifery appointments and antenatal education programmes will decline, as well as disclosure of any risky lifestyle practices. Additionally it needs to be considered that teenagers' emotional growth is not synchronous with their chronological age.

**7.4.2 Emotional Needs – Two Levels of Growth**

The difficulty in assessing and meeting the emotional needs of teenagers comes from different levels of growth of their emotional age as compared with their actual age as seen in Figure 4 below.

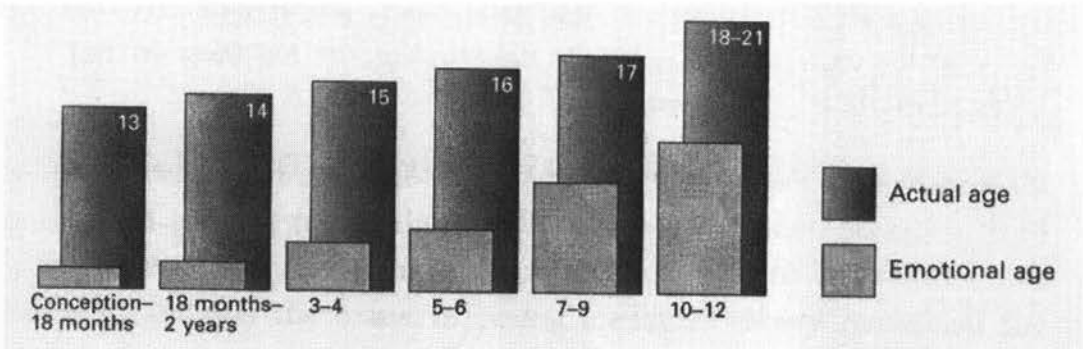


Fig. 4: Actual physical age and emotional age of teenagers  
(Mellor & Mellor, 2004)

This means teenagers need two things. First teenagers need to 'regrow' (Mellor & Mellor, 2004) emotionally through all the younger stages of their lives. The figure above shows the regressed emotional ages and how they correspond to actual ages. Secondly, teenagers need to negotiate the teenage related learning that faces them as they continue to get older (Mellor & Mellor, 2004; Allen, 2003). This is a challenge that becomes even more complex when a teenager is pregnant and faces the relationship breakdowns that seem to accompany this situation. These are relationships that were supposed to provide the emotional support that is needed for her to mature into a well-balanced adult.

At a time when a teenager is requiring to be assisted in her own emotional development, pregnancy and the parenting of a baby require her to actually display adult emotional maturity and give emotional support to her baby. Midwives, Childbirth Educators and other health professionals need to understand this development and adjust their thinking, attitudes, provision of care and educational programmes accordingly. It does mean that pregnant teenagers and teen mothers will require a different focus, an emotional developmental support focus, rather than a service or programme that focuses on information giving, such as a pregnant adult or mother might require or ask for.

Participants indicated that they wanted to participate in and direct an antenatal education programme. They wanted to be able to discuss what was a significant issue for them on the day of the antenatal education session, in particular to be able to air their emotional encounters, which would have hurt

them and/or affected them in some ways. Some topics assisting with emotional well-being were identified by participants as relationship issues, conflict resolution, self-esteem building exercises and to come to a place where they would feel like this following participant put it:

*loved, warts and all, no pressure of having to perform or be good but feeling very honoured because I'm bringing a life into this world.*

Nurturing the emotional needs, which sometimes means mothering and understanding the 'regrowing' of the emotional needs at the teenage stage will assist any health professional supporting a pregnant teenager. It will put into context the emotional outbursts often displayed by pregnant teenagers when pressured to fulfil their responsibilities as perceived from an adult perspective.

Understanding teenage emotional needs and therefore incorporating a different approach into the provision of health care and attitudes of health professionals can assure the teenager she can still develop and mature on an emotional level into a well-balanced adult. It can also ensure that she has an open mind about the information provided through an antenatal education programme and finds it easier to listen. Midwives and Childbirth Educators who find it difficult to understand the emotional needs and the developmental stage of teenagers need to actually own up to it and refer them to someone who does. Pregnant teenagers respond well to sincerity, they do not expect anyone to be always right or perfect, but they expect honesty (Checkley, 1990). Pregnant teenagers detect very quickly if they are liked or not liked by

a midwife or childbirth educator and may never come back for antenatal education or midwifery care.

## **7.5 Recommendations**

Although this study has its limitations as noted in 7.3 and is participant specific, the findings provide useful guidelines and recommendations for teenage childbirth education. One aim of the study was to formulate recommendations that could initiate discourse among antenatal education providers and provide guidelines for starting points when offering antenatal education programmes for pregnant teenagers. My study found that teenagers want their own antenatal education programme with a different programme structure; content and resource needs compared with the traditional adult antenatal education programmes. Pregnant teenagers have different psychosocial and emotional needs compared with pregnant adults and therefore require a nurturing environment that is conducive to meeting those needs. Therefore the following tentative recommendations based on the findings of this study for a teenage antenatal education programme, are made.

### **7.5.1 Overall Programme Structure:**

- Structured through participatory development with the pregnant teenagers
- Developmental stage-appropriate for pregnant teenagers
- Offered as an antenatal support group for the whole pregnancy
- Have an informal and laid back programme structure
- Establish if the antenatal group wants male partners to attend. If not, a separate antenatal education programme with boyfriends might need to be

offered

- Include all significant other females e.g. girlfriends, mothers, grandmothers, aunts or whanau in a female only antenatal education support group
- Create an environment, which fosters opportunities to form long lasting friendships among pregnant teenagers and teenage mothers.

### **7.5.2 Venue and physical environment:**

- Community, not hospital based
- Easily accessible at a central location
- A comfortable venue with a homely and casual atmosphere
- Provide a free pick-up and drop off service
- Early evening is a good time to hold the support group, around tea time, when free food and funky music are provided
- Free of charge
- Identified as a safe and supportive place, away from physical, emotional and sexual violence

### **7.5.3 Effective Facilitator:**

- Female, who has had personal experience with teenage pregnancy
- Age is not perceived as a barrier
- Ethnicity does not matter as long as the facilitator understands and embraces cultural diversity
- Someone with a good self-esteem, a good knowledge base and has appropriate resources at hand when requested
- Someone who is comfortable with a one-to-one approach by individuals, as

well as being approachable in a group

- Non-judgemental, a good listener, unshockable and able to maintain confidentiality
- Able to be contacted at any time with some boundaries and who would support pregnant teenagers no matter what
- Is able to send and receive text messages.

#### **7.5.4 Topics**

- Self-esteem building exercises and communication skills
- Conflict resolution and relationship issues (including sexual relationships)
- Decision-making exercises
- How to change addictive behaviour (smoking, drugs and alcohol)
- Legal issues (custody issues, protection orders)
- Staying healthy and cooking
- Budgeting and available benefits
- Pain relief and breathing exercises
- Stretching exercises and perineal massage
- Labour, birth and birth complications
- Breastfeeding and consistency of different baby stools
- Baby bathing and immunisation
- Postnatal services explained such as PAFT, Plunket and Maori Well-Child Providers
- Postnatal depression and emotional aspects of pregnancy
- Contraception
- Pregnancy choices (abortion, adoption, fostering and keeping the baby)



- Hearing birth stories from other teen mothers
- Having the opportunity to hold a baby during the pregnancy
- Watch and help a baby being bathed
- Seeing other teenage mothers breastfeeding their babies.

### **7.5.5 Resources**

- Baby bath
- Nappies or pictures of nappies with stools of various colours and consistencies
- Birth and breastfeeding videos only if they were presented by other teenagers
- Frequent visits to the birthing hospital including the neonatal unit
- Baby clothes and equipment for bring and swap opportunities
- Female pelvis, gym ball, birthing stools, folding nappies, holding forceps/ventouse, breast pumps and amnihook, contraception devices.

It needs to be remembered that the topics and resources were identified by the participants of this study. A participatory development structured programme will identify what the specific participants' topic and content needs are for each programme and not necessarily follow the suggestions given. In my opinion it is still helpful to look at the identified topics of this study as it could highlight or identify areas for facilitators to increase their knowledge base and possibly the need for further training or resource purchasing.

### **7.5.6 Naming an Antenatal Education Programme**

Naming an antenatal education programme was discussed by participants who highlighted that the term 'antenatal' was not understood or was misunderstood by the majority of participants. All participants favoured the omission of the term antenatal from naming a programme but supported the inclusion of *the obvious*, like *teenage and pregnant* and *support group* rather than class or programme.

### **7.6 Rigor of this Qualitative Study**

Sandelowski (1993, 1986) addresses the issue of rigor in qualitative research through arguing that there is a danger of succumbing to the illusion that the rigor techniques are the end to a means. She suggests that the term rigour implies a rigidity and uncompromising harshness that might threaten qualitative research and deviates from the 'artfulness, versatility, and sensitivity to meaning and context that mark qualitative works of distinction' (p. 1).

Sandelowski (1993) and Mishler (1990) both propose that validation of qualitative research should be viewed as a culturally and historically situated social process rather than being based on rules assumed to be sufficiently abstract and universal to be applied to every project. They argue (p.2) 'it is less a matter of claiming to be right about a phenomenon than having practiced good science'.

For the current study I sought validation from participants to ensure the findings were a true reflection of the discussions and comments made by members of the focus groups. I took the emerging themes and issues back to 11 teenagers, who had participated in this research. The 11 participants were the only ones that responded to a text message request or phone call for an informal follow-up focus group meeting to discuss the emerging themes and issues for validity. The process was one of self-selection and it eventuated that three participants from focus groups one to three each attended and two participants from focus group four. This meant a fair distribution across the participants. It was agreed by the participants that the themes and issues (as presented in chapters 4 and 5 of this study) were a true reflection of the discussion in the focus groups they were involved in and commented on how reassuring it was to be part of this process, as they now understood that other focus groups had the same issues and needs as themselves and their focus group. A comment was made by one of the participants in regards to domestic violence and that she felt this topic should have featured more prominently amongst the issues identified. However, although discussed in chapter 6 under 'feeling safe' as an emerging theme, it was an issue among many issues during the focus group discussions and I had to explain that in hindsight more emphasis cannot be added, as the data collected suggested a different emphasis, with which she agreed.

## **7.7 Implications for Midwives and Childbirth Educators**

The relevance of this study for midwives and childbirth educators is significant. Firstly, it is essential to note that the findings of this research

indicate an overall emphasis on building effective relationships between midwives and pregnant teenagers, as it enhances the understanding of the developmental stage of teenagers. These improved relationships in turn have been documented in the international literatures (Chen, Telleen, Mitchell & Chen, 1992; Lesser et al. 1998, Koniak-Griffin et al., 1999; Dipti Ukil & Esen, 2002; MacLeod & Weaver, 2002; Scarr, 2002; Gee & Lackey, 2002; Klima, 2003) as increasing antenatal care attendance and the potential for decreasing pregnancy and neonatal complications and poor outcomes for pregnant teenagers and their babies.

Secondly, the findings will have a major impact on antenatal education programmes for pregnant teenagers as their structure and content deviate considerably from the conventional style of antenatal education programmes in New Zealand. Traditionally an antenatal education programme is offered towards the end of the second trimester or at the beginning of the third trimester of a pregnancy and usually in a 6-week block, aimed at usually 10 couples attending. The findings of this study support an antenatal education programme for pregnant teenagers that is offered for the whole pregnancy, is participatory and developmentally based and free of charge. Topics identified by participants of this study also highlight a diversion from the traditional topics usually offered during antenatal education programmes. Midwives and childbirth educators need to include life skills, relationship issues and conflict resolution training, how to change addictive behaviour, legal issues like custody issues and protection orders, abortion and adoption information, financial information and the traditional topic range of conventional antenatal

classes. This means further training in this area for both professional groups is necessary.

The New Zealand College of Midwives has been developing evidence based consensus statements for midwifery practice, however there appears to be no general consensus on information that should be provided to women about aspects of their pregnancy and childbirth during antenatal education programmes or research being undertaken to assess how much of this evidence is being incorporated into practice. Relating this to teenage antenatal programmes it must be remembered that the participants of this study identified a participatory approach for an antenatal education programme and therefore such a programme cannot be delivered in a prescriptive manner. However, any information that is being asked for by participants needs to be presented with an evidence based approach by midwives and childbirth educators.

## **7.8 Implications for Midwifery and Childbirth Educators**

### **Continuing Education and Training**

Continuing education of all Midwives and Childbirth Educators needs to be expanded and developed within New Zealand. Women, of all ages, expect and trust Midwives and Childbirth educators to provide them with a safe service, yet there are no professional requirements to attend formal refresher courses or even study days and no guaranteed audits of the information provided for women during antenatal education programmes. With the recent establishment of a Midwifery Council in New Zealand this will hopefully change, as portfolios for evidence of competency based midwifery practice

will become a requirement for obtaining an annual practicing certificate. Nearly all Childbirth Educators obtain their certificate or diploma of Childbirth Education through Aoraki Polytechnic in Timaru, South Island. There is no requirement of renewing the certificate or diploma but some individual employment contracts for Childbirth Educators stipulate ongoing education as a workplace requirement. Parents Centre is a large national organisation in New Zealand that has an abiding interest in Childbirth Educators training and ongoing professional development. Parents Centre also employs the majority of Childbirth Educators in New Zealand. At present the organisation is looking at developing a code of practice for Childbirth Educators to ensure accountability, professionalism and consistency.

Midwifery and Childbirth Educator education institutions also need to assess their curricula and ensure that teenage pregnancies feature in it. It is vital that the teenage developmental stage is understood and placed in the context of a teenage pregnancy to enable practitioners to provide safe and meaningful midwifery care and education. It would be beneficial for midwifery and childbirth educator students to follow through a pregnant teenager to understand the complex needs of young pregnant women. Antenatal education training must include different models of delivery for antenatal education programmes and not just focus on the widespread and acceptable traditional (mostly didactic) way of providing antenatal classes.

## **7.9 Recommendations for Future Research**

There is abundant scope for further midwifery research looking at the attitudes and beliefs that young women have in relation to antenatal

education programmes, their pregnancies and becoming a mother, as well as attitudes and beliefs towards and of health professionals, in particular midwives and childbirth educators. Due to the small regional sample further midwifery research that explores antenatal education needs of pregnant teenagers in a national context would be beneficial, as well as exploring in more depth cultural identification for pregnant teenagers. Cultural needs might vary significantly among different nationalities and focus groups specifically set up for Maori or Pacific Island People or Chinese could ascertain the specific cultural needs in more depth for data analysis. Participants of the current study were predominately NZ European, which limits the data to include Maori needs for antenatal education and how to address it.

Participants of this study identified little significance for cultural safety other than recommending the facilitator is able to work with a culturally diverse group, being non-judgemental and culturally safe. This is in direct conflict with Tangata whenua and trends within New Zealand, where it has been identified that Maori need Maori health services for Maori by Maori (Bazley, 1985).

## **7.10 Concluding Statements**

The focus group interviews generated rich and interactive qualitative data. Through the four focus groups data were collected which showed that the participants saw a definite need for a separate teenage antenatal education programme. Through the emerging issues and needs participants indicated



that an teenage antenatal education programme needs to have an informal approach where it is easy to establish long lasting friendships and an atmosphere of acceptance and be free of charge. The topics covered needed to be according to the actual needs of the pregnant teenagers at the time and be participatory in nature. Participants called for an open flexible support group type programme lasting for the whole pregnancy rather than a six weeks prescribed traditional format for antenatal classes. Inclusion of life skills teaching was requested frequently and the need for an acceptable, central and safe venue for pregnant teenagers, not the hospital, was identified as important to facilitate increased regular attendance.

Midwives and Childbirth Educators must focus on empowering pregnant teenagers to make decisions during their pregnancy and birth. Midwives and Childbirth Educators have a responsibility to acknowledge any woman's differences, in particular with pregnant teenagers they must acknowledge that their developmental stage is different from that of adult women and therefore that they need participatory developmentally focused antenatal education and health care. This responsibility also extends to further their understanding about teenage pregnancy through study and training courses to be able to fully comprehend the teenage developmental stage and the level of growth of teenage emotional needs. Promoting teenage centred antenatal education in tune with what pregnant teenagers want will contribute to the well-being of both, the teenage mothers and their babies.



# References

- Adelson, P. L., Frommer, M. S., & Pym, M. A. (1992). Teenage pregnancy and fertility in New South Wales: an examination of fertility trends, abortion and birth outcomes. *Australian Journal of Public Health*, 16, 238-244.
- Agar, M. H. (1986). *Speaking of ethnography*. Beverly Hills, CA: Sage.
- Agar, M. H., & MacDonald, J. (1995). Focus groups and ethnography. *Journal of Human Organization*, 54, 78-86.
- Allen, E. J. (2003). Aims and associations of reducing teenage pregnancy. *British Journal of Midwifery*, 11 (6), 366-369.
- Arnett, J. (1992). Reckless behaviour in adolescence: a developmental perspective. *Journal of Developmental Review*, 12, 339-373.
- Asbury, J. E. (1995). Overview of focus group research. *Qualitative Health research*, 5 (4), 414-420.
- Baddiley, C. (1997). The afternoon group. *MIDIRS, Midwifery Digest*, 7 (2), 214-215.
- Bagshaw, S. (2001). Consent and confidentiality in adolescent health. *New Ethicals Journal*, (March), 21-25.
- Baker, T. J. (1996). Factors related to the initiation of prenatal care in the adolescent nullipara. *Nurse Practitioner*, 21 (2), 26-42.

- Barbour, R. S., & Kitzinger, J. (1999). *Developing focus group research. Politics, theory and practice*. London: Sage.
- Barrell, M. (2003). Adolescent motherhood in an inner city area in the UK: Experiences and needs of a group of adolescent mothers. *The Practising Midwife*, 6 (3), 21-24.
- Bazley, M. (1985). A real need for understanding. Meeting the health needs of New Zealanders - Maori and Pakeha. *Kai Tiaki*, 77(13), 5-7.
- Beckinsale, C. (2003). Why choose motherhood? The older teenage client's perspective. *The Practising Midwife*, 6 (3), 10-13.
- Berg, B. L. (1998). *Qualitative research methods for the social sciences* (3rd ed.). Boston: Allyn & Bacon.
- Bowman, R. F. (2003). Reframing the dialogue about committed teaching. *Educational Forum*, 68 (1), 52-61.
- Boyatzis, R. E. (1998). *Transforming qualitative information. Thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Bryman, I. (2001). *Social research methods*. New York: Oxford University Pr.
- Burnard, P. (1990). Group discussion. *Nursing Times*, 86 (37), 36-37.
- Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today*, 11, 461-466.
- Cassie, F. (2002). Filling the niche needs of pregnant teenagers. *Midwifery News*, (December), 4-7.

- Cates, W. (1996). Contraception, unintended pregnancies and sexually transmitted diseases: why isn't a simple solution possible? *American Journal of Epidemiology*, 143, 311-318.
- Chambers, R., Wakley, G., & Chambers, S. (2001). *Tackling teenage pregnancy: sex, culture and needs*. Abingdon: Radcliffe Medical Press.
- Checkley, G. (1990). Talking to teenagers. *Healthright*, 9 (4), 25-27.
- Chen, S. P. C., Telleen, S., Mitchell, D. R., & Chen, E. H. (1992). Factors influencing visits to school nurses by pregnant adolescents. *Pediatric Nursing*, 18 (4), 355-360.
- Coddington, D. (2001). All screwed up. *North & South*, (May), 36-46.
- Condon, J. T., & Corkindale, C. J. (2002). Teenage pregnancy trends and consequences. *New Ethicals Journal*, (April), 45-51.
- Coreil, J. (1995). Group interview methods in community health research. *Journal of Medical Anthropology*, 16, 193-210.
- Coupal, F. (1997). Participatory monitoring and evaluation for community driven projects. *On Track*, 3 (3), 1-3.
- Crosby, R. A., DiClemente, R. J., Wingwood, G. M., Rose, E., & Lang, D. (2002). Correlates of continued risky sex among pregnant african american teens. *Journal of Sexually Transmitted Diseases*, 30(1), 57-63.
- Damon, W. (1991). Self-concept, adolescent. in R. M. Lerner, A. C. Petersen, & J. Brokks-Gunn (Editors), *Encyclopedia of adolescence* (Vol. 2). New York: Garland.

- Daugherty, M., Logan, J., Turner, M., & Compton, D. (2003). Associations among preservice teachers' psychological traits and classroom performance ratings. *Teacher Educator*, 38 (3), 151-168.
- Davies, J. (1990). Against the odds. *Nursing Times*, 86, 29-31.
- Dekovic, M., & Meeus, W. (1997). Peer relations in adolescence effects of parenting and adolescents' self-concept. *Journal of Adolescence*, 20, 163-176.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook for qualitative research*. Thousand Oaks, CA: Sage.
- DeVellis, R. F., Patterson, C. C., Blalock, S. J., Renner, B. R., & DeVellis, B. (1997). Do people with rheumatoid arthritis develop illness-related schemas? *Journal of Arthritis Care and Research*, 10, 78-88.
- Dipti Ukil, & Esen, U. I. (2002). Early teenage pregnancy outcome: a comparison between a standard and a dedicated teenage antenatal clinic. *Journal of Obstetric and Gynaecology*, 22 (3), 270-272.
- Dryfoos, J. (1990). *Adolescent at risk: Prevalence and prevention*. New York: Oxford University Press.
- Dryfoos, J. G. (1998). *Safe passage. Making it through adolescence in a risky society*. New York: Oxford University Press.
- Elkind, D. (1976). *Child development and education: a piagetian perspective*. New York: Oxford University Press.
- Elkind, D. (1967). Egocentrism in adolescence. *Journal of Child*

*Development*, 38, 1025-1034.

Elkind, D. (1977). Erikson's eight ages of man. in Hetzel D. *Readings in human development: contemporary perspectives* (9th). New York: Harper & Rowe.

Elkind, D. (1978). Understanding the young adolescent. *Journal of Adolescence*, (13), 127-134.

Elliott, D. S. (1993). Health-enhancing and health-compromising lifestyles. in Millstein S.G., Petersen A.C., & Nightingale E.O. (Eds), *Promoting the health of adolescents*. New York: Oxford University Press.

Enkin, M., Keirse, M. J. N. C., Renfrew, M., & Neilson, J. (1995). *A guide to effective care in pregnancy and childbirth* (2nd ed.). New York: Oxford University Press.

Erikson, E. H. (1980). *Identity and the life cycle* (2nd ed.). New York: Norton.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: W.W. Norton.

Eure, C. R., Lindsay, M. K., & Graves, W. L. (2002). Risk of adverse pregnancy outcomes in young adolescent parturients in an inner-city hospital. *American Journal of Obstetrics Gynecology*, 186 (5), 918-920.

Farquhar, S. (2003). *PAFT: Early childhood development programme*. Wellington, NZ: Ministry of Health.

Flanagan, P., & Kokotailo, P. (1999). Adolescent pregnancy and substance use. *Clinics of Perinatology*, 26, 185-200.

- Fleming, T., & Watson, P. (2002). Enhancing compliance in adolescents. *Current Therapeutics*, 14-18.
- Fraser, A. M., Lockert, J. E., & Ward, R. H. (1995). Association of young maternal age with adverse reproductive outcomes. *New English Journal of Medicine*, 332, 1113-1117.
- Gee, L., & Lackey, J. (2002). Service evaluation of the teenage clinic. *British Journal of Midwifery*, 10 (9), 560-564.
- Gilkison, A. (1991). Antenatal education - whose purpose does it serve? *New Zealand College of Midwives Journal*, 4, 13-15.
- Greenbaum, T. L. (1988). *The practical handbook and guide to focus group research*. Lexington, Massachusetts: D.C. Health and Company.
- Guilliland, K. (2003). A separate reality. *Midwifery News*, 31. 4-6.
- Guilliland, K., & Pairman, S. (1995). *The midwifery partnership. A model for practice*. Wellington: Victoria University.
- Hall, W. (1995). The public health significance of cannabis use in Australia. *Australian Journal of Public Health*, 26, 235-242.
- Halloran, J. P., & Grimes, D. E. (1995). Application of the focus group methodology to educational program development. *Qualitative Health Research*, 5, 444-453.
- Hamilton Parents Centre. (1980). *Expecting a baby? A prospective parents' guide to ante-natal and post-natal experiences* (2nd ed.). Hamilton: Hamilton Parents Centre Inc.

- Hammersley, M., & Woods, P. (1984). *Life in school*. Milton Keynes: Open University Press.
- Hargreaves, D. (1967). *Social relations in a secondary school*. London: Routledge and Kegan Paul.
- Harter, S. (1990). Processes underlying adolescent self-concept formation. in R. Montemayor, G. R. Adams, & T. P. Gulotta (Editors). *From childhood to adolescence: A transitional period?* Newbury Park, CA: Sage.
- Harter, S., & Monsour, A. (1992). Developmental analysis of conflict caused by opposing attributes in the adolescent self-portrait. *Developmental Psychology*, 28, 251-260.
- Hawe, P., Degeling, G., & Hall, J. (1990). *Evaluating health promotion*. Artarmon, NSW: MacLennan and Petty.
- Hayward, S. (2001). Responding to a new challenge. Lead project midwife for teenage pregnancy. *The Practising Midwife*, 4 (7), 16-19.
- Health Promotion Unit. (2002). *Taranaki young mum's project 2002*. New Plymouth: Taranaki Health.
- Henderson, N. R. (1995). A practical approach to analysing and reporting focus groups studies: Lessons from qualitative market research. *Qualitative Health Research*, 5, 463-477.
- Hughes, D., Deery, R., & Lovatt, A. (2002). A critical ethnographic approach to facilitating cultural shift in midwifery. *Midwifery*, 18, 43-52.
- Hughes, D., & DuMont, K. (1993). Using focus groups to facilitate culturally

- anchored research. *American Journal of Community Psychology*, 21 (6), 775-806.
- Jacoby, A. (1988). Mothers views about information and advice in pregnancy and childbirth: findings from a national study. *Midwifery*, 4, 103-110.
- James, D. K., Steer, P. J., Weiner, C. P., & Gonik, B. (1995). *High risk pregnancy management*. London: W.B. Saunders & Co.
- Jarrett, R. L. (1993). Focus group interviewing with low-income, minority populations: A research experience. in Morgan D.L. (Editor). *Successful focus groups: Advancing the state of the art*. Newbury Park, CA: Sage.
- Jennings, R. (2000). Participatory development as new paradigm: the transition of development professionalism. *Conference Proceedings: Community Based Reintegration and Rehabilitation in Post-Conflict Settings*, (October), 1-10.
- Kiddy, M. (2002). Teenage pregnancy: whose problem? *Nursing Times*, 98 (4), 36-37.
- Kinsman, S. B., & Slap, G. B. (1992). Barriers to adolescent prenatal care. *Journal of Adolescent Health*, 13, 146-154.
- Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal*, 311, 299-302.
- Klima, C. S. (2003). Centering pregnancy: A model for pregnant adolescents. *Journal of Midwifery & Women's Health*, 48(3), 220-225.
- Koniak-Griffin, D., Mathenge, C., Anderson, N., & Verzemnieks, I. (1999). An early intervention program for adolescent mothers: a nursing



- demonstration project. *Journal of Gynecology and Neonatal Nursing*, 28 (1), 51-59.
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Kuykendall, J. (1989). Adolescence: Teenage trauma. *Nursing Times*, 85 (27), 26-27.
- Lesser, J., Anderson, N. L. R., & Koniak-Griffin, D. (1998). Sometimes you don't really feel ready to be an adult or a mom. *Journal of Child Adolescence Psychiatric Nursing*, 11 (1), 7-16.
- Lord, S. E. (1994). *Parenting in impoverished urban context: Implications for adolescent adjustment*. University of Colorado: Unpublished doctoral dissertation.
- Lord, S. E., & Eccles, J. S. (1994). *James revisited: The relationship of domain self-concepts and values to black and white adolescents' self-esteem*. San Diego: Authors, paper presented at the meeting of the Society for research on Adolescence.
- MacLeod, A., & Weaver, S. (2002). Are expectant teenage mothers adequately informed? *British Journal of Midwifery*, 10 (3), 144-147.
- Maggs, J., Almeida, D., & Galambos, N. (1995). Risky business: The paradoxical meaning of problem behaviors for young adolescent. *Journal of Early Adolescence*, 15, 344-362.
- Maggs, J. L. (1997). Alcohol use and binge drinking as goal-directed action

- during the transition to post-secondary education. in J. Schulenberg et al. (Editors), *Health risks and developmental transitions during adolescence*. New York: Cambridge University Press.
- Maggs, J. L., Frome, P. M., Eccles, J. S., & Barber, B. L. (1997). Psychosocial resources, adolescent risk behaviour and young adult adjustment: is risk taking more dangerous for some than others? *Journal of Adolescence*, 20, 103-119.
- Malchodi, C. S., Oncken, C., Dornelas, E. A., Caramanica, L., Gregonis, E., & Curry, S. L. (2003). The effects of peer counseling on smoking cessation and reduction. *The American Journal of Obstetrics & Gynecology*, 101 (3), 504-510.
- Malnory, M. E. (1996). Developmental care of the pregnant couple. *Journal of Obstetric Gynecologic and Neonatal Nursing*, 25 (6), 525-532.
- Martin, R. D., MacDowell, M., & Macmann, J. M. (1997). Effectiveness of a teen pregnancy clinic in a managed care setting. *Managed Care Quarterly*, 5 (3), 20-27.
- Maskill, C. (1991). *A health profile of New Zealand adolescents*. Wellington: Health Services Research, Department of Health.
- Maslow, A. H. (1970). *Motivation and personality*. New York: Harper & Row.
- Massey University. (1994). *Code of ethical conduct*. Palmerston North: Massey University.
- McCallum, I. (1990). Growing pains. *Nursing Times*, 86 (34), 62-64.

- McDougall, P. (1999). Focus Groups: an overview of their use as a research method. *Community Practitioner*, 72 (3), 48-49.
- Mellor, K., & Mellor, E. (2004). *Teenstages. How to guide the journey to adulthood*. Lane Grove, NSW: Finch Publishing.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills, CA: Sage.
- Miller, W. L., & Crabtree, B. F. (1992). Primary care research: A multimethod typology and qualitative road map. in Crabtree B.F., & Miller W.L. (Editors), *Doing qualitative research: Research methods for primary care* (Vol. 3). Newbury Park, CA: Sage.
- Mills, C. B. (1997). Taking time to care. Making ways to help teen parents. *Lifelines*. (10), 69-72.
- Minichiello, V., Sullivan, G., Greenwood, K., & Axford, R. (1999). *Handbook for research methods in health sciences*. Sydney: Addison-Wesley Longman Australia PTY Limited.
- Ministry of Health. (2003a). *Your pregnancy. To Haputanga*. Wellington: Ministry of Health.
- Ministry of Health. (2003b). *Report on maternity 2000 & 2001*. Wellington: New Zealand Health Information Service.
- Mishler, E. G. (1990). Validation in inquiry-guided research: the role of exemplars in narrative studies. *Harvard Education Review*, 60, 415-442.
- Mitchell, E., Taylor, B. J., & Ford, R. P. K. (1992). Four modifiable and other

- major risk factors for cot death: the New Zealand study. *Journal of Paediatric Child Health*, 28, 3-8.
- Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). Newbury Park, California: Sage .
- Morgan, D. L. (1995). Why things (sometimes) go wrong in focus groups. *Qualitative Health Research*, 5, 516-523.
- Morgan, D. L. (1993). *Successful focus groups: Advancing the state of the art*. Newbury Park, CA: Sage.
- Morgan, D. L., & Spanish, M. T. (1985). Social interaction and the cognitive organisation of health-relevant behaviour. *Sociology of Health and Illness*, 7, 401-422.
- Mukherjee, R. A.S., & Turk, J. (2004). Fetal alcohol syndrome. *The Lancet*, 363 (9420), 1556.
- New Zealand Health Information Service. (2000). Palmerston North/Manawatu region birth 19 years and under. *Request@nzhis.govt.nz* (20th February 2002).
- New Zealand Health Information Service. (2004). *Report on maternity. Maternal and newborn information 2002*. Wellington: Ministry of Health.
- Nolan, M. L. (1997). Antenatal education - what next? *Journal of Advanced Nursing*, 25, 1198-2004.

- Nolan, M. L., & Hicks, C. (1997). Aims, processes and problems of antenatal education as identified by three groups of childbirth teachers. *Midwifery*, 13, 179-188.
- Nurses Act. (1977). *Nurses Act*. Wellington, N.Z.: Government Printer.
- Orenstein, P. (1994). *School girls: Young women, self-esteem, and the confidence gap*. New York: Doubleday.
- Owens, J., Stein, I., & Chenoweth, L. (1999). Action Research. In Minichiello, V., Sullivan, G., Greenwood, K., & Axford, T. (Eds.), *Handbook for research methods in health sciences*. Sydney: Pearson Education
- Owens, J. C. (1992). *Achieving effectiveness in intervention: a literature review for the prevention of adolescent pregnancy*. Auckland: New Zealand Family Planning Association.
- Panazarine, S., Slater, E., & Sharps, P. (1995). Coping, social support, and depressive symptoms in adolescent mothers. *Journal of Adolescent Health*, 17, 113-119.
- Parker, D., & Williams, N. (2000). Teens and breastfeeding. *Lactation Consultant Series Two*, 298-3 (February), 1-16.
- Patterson, M. (2003). Case Study: Queen Charlotte's one-to-one 'young mums' midwifery scheme. *Midwives, Journal of the Royal College of Midwives*, 6 (2), 63.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

- Peplau, L. A., & Perlman, D. (1982). *Loneliness: A sourcebook of current theory, research, and therapy*. New York: Wiley.
- Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.
- Piaget, J. (1972). Intellectual evolution from adolescence to adulthood. *Journal of Human Development*, 15, 1-12.
- Plunket. (2004). Plunket on line: Who are we? Retrieved July 1, 2004, from [http://www.plunket.org.nz/Who\\_Are\\_We\\_Page.htm](http://www.plunket.org.nz/Who_Are_We_Page.htm).
- Quinlivan, J. A., & Evans, S. F. (2002). The impact of continuing illegal drug use on teenage pregnancy outcomes - a prospective cohort study. *British Journal of Obstetrics and Gynaecology*, 109, 1148-1153.
- Reason, P. (1988). *Introduction: Human inquiry in action development in new paradigm*. London: Sage.
- Renker, P. R. (2002). Keep a blank face. I need to tell you what has been happening to me. *Journal of Maternal and Child Nursing*, 27 (2), 109-116.
- Robertson, A. (1994). *Empowering women: teaching active birth in the 90's*. Camperdown, Australia: ACE Graphics.
- Robertson, A. (1988). *Teaching active birth. A handbook for childbirth educators and midwives*. Forest Lodge, NSW: ACE Graphics.
- Robertson, A. (2001). Working with the young and pregnant. *The Practising Midwife*, 4 (2), 36-37.

- Rogers, M. M., Peoples-Sheps, M. D., & Suchindran, C. (1996). Impact of a social support program on teenage prenatal care use and pregnancy outcomes. *Journal of Adolescent Health, 19* (2), 132-140.
- Ryan, P. M. (1994). *Dictionary of modern Maori* (4th ed.). Auckland: Heinemann Education, a division of Reed Publishing Group NZ LTD.
- Saint-Germain, M. A., Bassford, T. L., & Montano, G. (1993). Surveys and focus groups in health research with older Hispanic women. *Qualitative Health Research, 3*, 341-367.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advanced Nursing Science, 8*, 27-37.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advanced Nursing Science, 16* (2), 1-8.
- Santrock, J. W. (1996). *Adolescence*. Dubuque, IA: Brown & Benchmark.
- Scarr, E. M. (2002). Effective prenatal care for adolescent girls. *The Nursing Clinics of North America, 37*, 513-521.
- Schroeder, C., & Neill, R. M. (1992). Focus groups: a humanistic means of evaluating an HIV/AIDS programme based on caring theory. *Journal of Clinical Nursing, 1*, 265-274.
- Seals, B. F., Sowell, R. L., Demi, A. S., Moneyham, L., Cohen, L., & Guillory, J. (1995). Falling through the cracks: social service concerns of women infected with HIV. *Qualitative Health Research, 5*, 496-515.
- Silbereisen, R. K., & Noack, P. (1988). On the constructive role of problem

- behavior in adolescence. in N. Bolger et al. (Editors), *Persons in context: Developmental processes*. New York: Cambridge University Press.
- Silverman, D. (2000). *Doing qualitative research. A practical handbook*. London: Sage.
- Simmons, R. G., & Blyth, D. A. (1987). *Moving into adolescence*. Hawthorne, New York: Aldine.
- Spitz, A. M., Velebil, P., Koonin, L. M., Strauss, L. T., Goodman, K. A., Wingo, P., Wilson, J. B., Morris, L., & Marks, J. S. (1996). Pregnancy, abortion, and birth rates among US adolescents: 1980, 1985, and 1990. *Journal of the American Medical Association*, 275 (13), 989-994.
- St John, W. (1999). Focus group interviews. in Minichiello V., Sullivan G., Greenwood K., & Axford R. (Editors), *Handbook for research methods in health sciences*. Sydney: Addison Wesley Longman Australia Pty Limited.
- Stein, K. F., Roeser, R., & Markus, H. R. (1998). Self-schemas and possible selves as predictors and outcomes of risky behaviors in adolescents. *Nursing Research*, 47 (2), 96-104.
- Straw, M. K., & Marks, K. (1995). Use of focus groups in program development. *Qualitative Health Research*, 5, 428-443.
- Straw, R. B., & Smith, M. W. (1995). Potential uses of focus groups in federal policy and program valuation studies. *Qualitative Health Research*, 5, 421-427.



- Stuart-Smith, S. (1996). Teenage sex. *British Medical Journal*, 312, 390-391.
- The Cochrane Library. (2001) <http://gateway2.ovid.com/ovidweb.cgi> [Web Page]. [Issue 2].
- UNICEF. (2001). Teenage births in rich nations. *Innocenti Report Card*, (3), 1-32.
- Watson, P. (2001). Adolescent health in NZ. *New Ethicals Journal*, (February), 23-26.
- Weiss, R. S. (1973). *Loneliness: The experience of emotional and social isolation*. Cambridge, MA: MIT Press.
- White, G. E., & Thomson, A. N. (1995). Anonymized focus groups as a research tool for health professionals. *Qualitative Health Research*, 5 (2), 256-261.
- Williams, C., & Vines, S. W. (1999). Broken past, fragile future: personal stories of high-risk adolescent mothers. *Journal of Social Pediatric Nursing*, 4, 15-23.
- Willis, P. (1977). *Learning to labour*. London: Gower Press.
- Wilson, N., Clements, M., Bathgate, M., & Parkinson, S. (1996). *Using spatial analysis to improve and protect the public health in New Zealand*. Wellington: Ministry of Health.
- Wood, B. (2001). Plunket antenatal education programme review and evaluation. *Plunket in Touch*, 10.

- Yelland, J. & Gifford, S.M. (1995). Problems of focus group methods in cross-cultural research: a case study of beliefs about sudden infant death syndrome. *Australian Journal of Public Health*, 19, 257-263.
- Youngs, D. D., Niebyl, J. R., Blake, D. A., Shipp, D. A., Stanley, J., & King, T. M. (1977). Experience with an adolescent pregnancy program. *Journal of Obstetric and Gynecology*, 50 (2), 212-216.

# **APPENDIX A**

## **Focus Group Questionnaire**

# Appendix A

## Focus Group Question Guide

1. Have you ever been to any antenatal classes?
2. If no, what have you heard about them? Would you go?
3. If yes, what did you like and dislike about those antenatal classes?
4. What topics do you think are a 'must' and need to be included into the programme?
5. Do you like the term 'antenatal classes'? What would you call it? Some have suggested 'preggy disco' or 'teen café'? What do you think?
6. If you wanted to attend antenatal classes, where would you like to go? Some suggestions have been 'a pub', 'a night club', 'Plunket rooms' or someone's cosy lounge?
7. How would you like to see the programme being run? Some suggestions have been 'cooking a meal and eat together', 'having a dance disco and discussions at intervals', 'very informal approach, just chatting together'?
8. What is a good time to hold them? For example, in the mornings, afternoons or evenings?
9. How long should they be? 1, 2, 3 hours or longer?
10. Should it be restricted to a once weekly meeting and say 6 weeks or be continuously running for the whole pregnancy? Why?
11. Who else should come apart from the pregnant woman? The boy friend? Whanau?

## **APPENDIX B**

### **Newspaper Advertisement**

# Appendix B

## Newspaper Advertisement

### **Teenage and Pregnant - Information Luncheon -**

My name is Ruth Martis. I am a midwife working in the Manawatu and currently undertaking an exploratory study as part of my Master of Arts degree in Midwifery.

In this study I want to find out what pregnant teenagers want to know about pregnancy and birth, coping strategies for labour, preparing to care for the baby and anything else that might be of help to cope with and enjoy the experience of becoming a mother.

If you are pregnant and 19 years and under, live in Palmerston North and would like to take part in this study or find out more about the study please contact:

Mrs. Ruth Martis  
School of Health Sciences – Midwifery  
Massey University  
Tel. 06 350 5799 Ext. 2249  
Mobile 021 109 5152  
Email: [R.Martis@massey.ac.nz](mailto:R.Martis@massey.ac.nz)

### **or come to an information luncheon:**

Monday 9.12.02  
12.00 – 13.30pm  
(lunch will be provided)  
3 Amesbury Street, P. Nrth.  
'The Pregnancy Centre'

If you need transport to come to the meeting contact me.

This study had been approved by the Massey University Human Ethics Committee (PN protocol 02/134)

## **APPENDIX C**

### **Participants' Information Sheet**

## Teenage and Pregnant



## Information Sheet



School of Health Sciences  
Private Bag 11 222,  
Palmerston North,  
New Zealand  
Telephone: 64 6 356 9099  
Facsimile: 64 6 350 5688



**What is the study about?**

My name is Ruth Martis. I am a midwife working in Palmerston North and currently undertaking an exploratory pilot study as part of my Master of Arts degree in midwifery. In this study I want to find out what you want and need from an antenatal education programme. Antenatal education includes learning about pregnancy and birth, coping strategies for labour, preparing you for caring for your baby and anything else that you think might help you to cope with and enjoy the experience. Antenatal means before the baby is born).

**Who is the researcher and the supervisor and where can they be contacted?****Researcher:**

**Ruth Martis**  
Midwife  
School of Health Sciences  
Massey University  
Palmerston North  
Ph. 06 350 5799 Ext. 2249  
Mobile: 021 109 51 52  
Email: [ruth.martis@clear.net.nz](mailto:ruth.martis@clear.net.nz)

**Project Supervisor:**

**Dr. Cheryl Benn**  
Associate Professor  
School of Health Sciences  
Massey University  
Palmerston North  
Ph. 06 350 5799 Ext. 2543  
Mobile: 027 242 3394  
Email: [C.A.Benn@massey.ac.nz](mailto:C.A.Benn@massey.ac.nz)

**What will I have to do?**

Answer some questions about yourself, any previous experiences of antenatal education, your thoughts about antenatal education and what sort of antenatal education you would like. This will be discussed in a group of about 8 -10 participants (called a focus group), who are all young women just like you. Transport will be provided if you need it. Once you have agreed to take part in the study you will be advised of a variety of dates to choose from for the group meeting.

**Do want to find out more?****Come to an information meeting on:**

**Monday 9.12.02 at 12.00 – 13.30pm, lunch provided, at 3 Amesbury Street, P. Nrth. 'The Pregnancy Centre'. Phone 354 2273 if you need transport. See you there!**

**If I agree to take part, how much time will be involved?**

Talking and meeting with the group will take about 1 hour. The group discussions will be audiotaped if everyone in the group agrees to it.

**What are the benefits of the research?**

You will be helping us to learn about what is important for young pregnant women wanting to attend an antenatal education programme. This will assist anyone providing antenatal education programmes to provide a better service for you and for other young pregnant women. If requested, I will send you a brief report on the study when it is done.

**If you take part in this study, you have the right to:**

- refuse to answer any questions or stop participating at any time
- ask any questions you want to about the study
- not be identified in any presentation or publications using the information from this research
- hear about the findings of the study when it is finished.

Please be reassured that the audio tapes will be destroyed when no longer needed, and know that ethics approval for this study has been reviewed and approved by the Massey University Human Ethics Committee (PN Protocol 02/134).

**If you take part in this study, you will have to:**

- sign a form (consent form) that you are willing to participate
- sign a confidentiality form agreeing not to discuss with those outside the group information that was shared or who was there
- attend a focus group meeting of 1 hour and share your ideas, feelings and thoughts about antenatal classes.

## **APPENDIX D**

### **Poster/Flier for Community Notice Boards and for Distribution**

# Appendix D

## Teenage and Pregnant

### - Information Luncheon -

My name is Ruth Martis. I am a midwife working in the Manawatu and currently undertaking an exploratory pilot study as part of my Master of Arts degree in Midwifery.

In this study I want to find out what you want and need from an antenatal education programme. Antenatal education includes learning about pregnancy and birth, coping strategies for labour, preparing you to care for your baby and anything else that you think might help you cope with and enjoy the experience.

If you are **pregnant and 19 years and under, live in Palmerston North** and would like to take part in this study or find out more about the study please contact:

**Mrs. Ruth Martis**  
School of Health Sciences – Midwifery  
Massey University  
Tel. 06 350 7099 Ext. 2249  
Mobile 021 109 51 52  
Email: [ruth.martis@clear.net.nz](mailto:ruth.martis@clear.net.nz)

**or come to an information luncheon:**

**Monday 09.12.02**  
12.00 – 1.30pm  
(lunch will be provided)  
3 Amesbury Street, P.Nrth.  
'The Pregnancy Centre'

If you need transport to come to the meeting contact me.

This study has been reviewed and approved by the Massey University Human Ethics Committee (PN Protocol 02/134)

# **APPENDIX E**

## **Consent Form**

# Appendix E

## Teenage and Pregnant - An Exploratory Study of Pregnant Teenagers and their Antenatal Education Needs in the Palmerston North Region.

### Consent Form

1. I have read the information sheet and have had the study explained to me. I understand what this study is about, and I know I can contact Ruth Martis to ask any questions.
2. I have had an opportunity to ask questions about participating and have had those questions satisfactorily answered.
3. I understand I am free to withdraw from the study at any time and to decline to answer any particular questions.
4. I agree to provide information to the researcher on the understanding that my name will not be used and I will not be personally identifiable in published results without my permission.
5. I agree/do not agree to the interview being audio taped. I understand that I have the right to ask for the audiotape to be turned off at any time during the group interview.
6. I agree to participate in this study under the conditions set out in the information sheet.
7. I would like a written summary of the findings:  

☐ Yes☐ No

**Name of participant:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Contact:** Ruth Martis  
Massey University  
as above  
Ph. 06 350 5799 Ext. 2249  
Cell phone: 021 109 5152  
Email: [ruth.martis@clear.net.nz](mailto:ruth.martis@clear.net.nz)

**Or:** Dr. Cheryl Benn  
Massey University  
as above  
Ph. 06 350 5799 Ext. 2543  
cell phone: 027 242 3394  
Email: [C.A.Benn@massey.ac.nz](mailto:C.A.Benn@massey.ac.nz)

## **APPENDIX F**

### **Confidentiality Agreement**

# Appendix F

## Teenage and Pregnant - An Exploratory Study of Pregnant Teenagers and their Antenatal Education Needs in the Palmerston North Region

### Confidentiality Agreement

I, \_\_\_\_\_, agree not to disclose any name, information and experiences shared in the focus group discussions that would lead to the identification of the participants in the study being undertaken by Ruth Martis.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **APPENDIX G**

### **Statement of Non-Disclosure of Information for Typist/Transcriber**



# Appendix G

## Teenage and Pregnant - An Exploratory Study of Pregnant Teenagers and their Antenatal Education Needs in the Palmerston North Region

### Non-Disclosure of Information Typist/Transcriber

I, \_\_\_\_\_, agree not to disclose the name or any information that would lead to the identification of the participants in the study being undertaken by Ruth Martis. The audio tapes, transcripts and computer disks will not be made available to anyone but the researcher or her supervisor and will be kept securely while in my possession. I will not retain any copies of the audiotapes, computer disks, transcriptions or copies of the data on the hard drive of my computer.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix H**

### **Ethics Approval Letter**

# Appendix H

Massey University Campus Human Ethics Committee: Palmerston North (HEC: PN)  
Old Main Building, Turitea Fax: 64 6 350 5622 <http://www.massey.ac.nz/~muhec>  
Dr Gurjeet Gill, Deputy Chair Miss Karen A Kahukoti, Secretary  
Telephone: 64 6 350 5799 x3215 Telephone: 64 6 350 5573  
Email: G.Gill@massey.ac.nz Email: K.A.Kahukoti@massey.ac.nz



5 November 2002

Private Bag 11 222,  
Palmerston North,  
New Zealand  
Telephone: 64 6 356 9099

Ms Ruth Martis  
Health Sciences  
TURITEA PN351

Dear Ruth

Re: **HEC: PN Protocol – 02/134**  
**Teenage and pregnant: An exploratory pilot study of pregnant adolescents**  
**and their antenatal education needs in the Palmerston North region**

Thank you for the above protocol that was received and considered by the Massey University Campus Human Ethics Committee: Palmerston North at their meeting held on Tuesday 15 October 2002.

The protocol was unconditionally approved with the following suggestions:

Information Sheet - Appendix 2

- suggest that the word antenatal be followed by the sentence '(before the baby is born)', for potential Participants who do not know what the word antenatal means,
- include the Committee's complete approval statement "This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/134. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz".

The Committee would also like to commend the applicant for the effort put into putting the application together.

The protocol meets the requirements of the Massey University Human Ethics Committee and the ethics of the protocol are approved.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

Yours sincerely

Dr Gurjeet Gill, Deputy Chair  
Massey University Campus Human Ethics Committee: Palmerston North

cc Associate Professor Cheryl A Benn  
Health Sciences  
TURITEA PN351

---

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

# **APPENDIX I**

**Research Support Letter**

**The Pregnancy Trust**

# Appendix I



The Pregnancy Centre  
A free service for all aspects of pregnancy

3 Amesbury Street Palmerston North

Phone: (06) 354 2273

Cellular: 025 6285847

27.09.02

**Re: Ruth Martis's proposal for an exploratory pilot study of pregnant adolescents and their prenatal education needs in the Palmerston North region, as part of her Masterate Study Programme.**

The Pregnancy Centre provides a free service for all aspects of pregnancy for the Manawatu. This includes pregnant adolescents. Through our service we have come to realise that pregnant adolescents need a different antenatal education programme than women over 20 years of age and have started to offer an alternative antenatal programme for them. We think it will be a great benefit to this particular group because it will reduce the health risks for the young mother and her baby.

We would like to offer our support for the above pilot study as we think it will provide vital information for a wide spectrum of health care and antenatal education providers. The results will also be useful for our own antenatal programme.

Using the focus group methodology approach makes sense, as teenagers enjoy being and talking in groups and discussion results will be greatly enriched through it.

We are looking forward to receiving a summary of the results.

Regards

Dr. M. Shaw

Chairperson

The Pregnancy Trust

## **APPENDIX J**

### **Research Support Letter**

#### **Midwifery Care**

# Appendix J

*Midwifery  
Care*



a Group of Independently  
Practising Midwives

Cnr. Grey St and Martin St.  
Palmerston North  
Phone 06 - 355 4547

Sunday, 29 September 2002

***Re: Proposal for an exploratory pilot study of pregnant adolescents and their prenatal education needs in the Palmerston North region, as part of her Masterate Study Programme, by Ruth Martis.***

On behalf of the Midwives working from the Midwifery Care Rooms in Palmerston North, I endorse the exploratory pilot study that Ruth Martis is conducting for her Master Thesis, researching pregnant adolescents in the Palmerston North region.

From experience we have learnt that pregnant teenagers find joining with other, established antenatal groups for adults in the region do not meet their needs, nor do they feel comfortable attending them.

We have had positive feedback already, from several of our adolescent clients, attesting to the validity of Ruth Martis' research.

Elizabeth Holleman

Independent Midwife (LMC)

# **APPENDIX K**

## **Research Support Letter**

### **Learning and Growing Together**

#### **Trust**



# Appendix K

## *LEARNING AND GROWING TOGETHER TRUST* *Strengthening Families and Futures*

*PO Box 5510  
Palmerston North  
Email: lgtt@inspire.net.nz*

To Whom It May Concern:

**Re: Proposal for an exploratory pilot study of pregnant adolescents and their prenatal education needs in the Palmerston North region.**

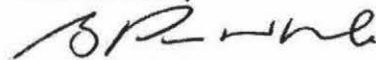
The Learning and Growing Together Trust is currently forming a Young parent Education Centre. This Centre will provide a service of alternative education for adolescent parents and their children. It is possible that in the future the centre could also be involved in providing pre natal education for teenagers.

It is concerning that pregnant teenagers do not access the full support and education available to them when they are pregnant. They are often more vulnerable than older parents and have a higher need for this information.

Just as in returning to school, pregnant teenagers will see barriers to accessing prenatal education and services. It is important to gather their views on these barriers to be able to develop a comprehensive antenatal education programme that will meet their needs and thus be used by them.

A study that gathers adolescent views on antenatal education, in an appropriate and safe manner, has the support of the Trust.

Yours faithfully



Brenda Pomana-Whale  
Project Co-ordinator

## **APPENDIX L**

**Live Births by DHB regions for  
maternal age 19 years and under  
in percentage and numbers,  
2003**

# New Zealand

## District Health Boards

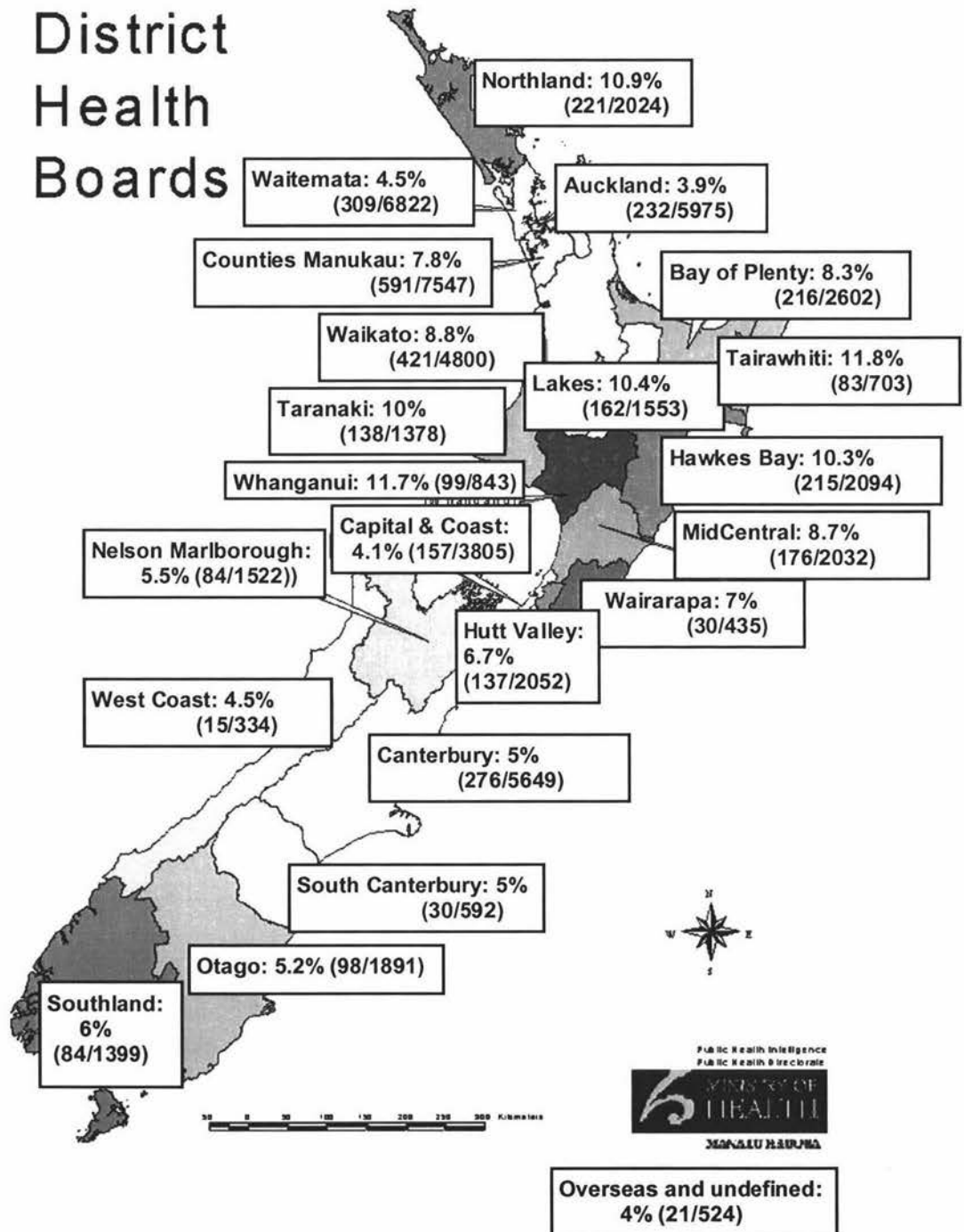


Fig. 1: Live births by DHB region for maternal age 19 years and under in percentage and numbers, 2003

(New Zealand Health Information Services, 2004)

designed by Ruth Martis, 2004