

2015

# Antenatal clinic: Using ethnographic methods to listen to the voices of pregnant adolescents

Deborah Ireson  
*Edith Cowan University*

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# **Antenatal clinic: Using ethnographic methods to listen to the voices of pregnant adolescents**

This thesis is presented in partial fulfilment of the degree of

**Doctor of Philosophy**

**Deborah Mary Ireson**

Edith Cowan University  
Faculty of Health, Engineering and Science  
School of Nursing and Midwifery

2015

## **Abstract**

**Aim:** This research aims to explore the motivating reasons and external influences that affect pregnant adolescents' reasons for attending an antenatal clinic.

**Background:** Pregnancy during adolescence has been researched from perceived 'poor' decision making during pregnancy and postnatal perspectives involving high-risk outcomes for mother and baby. Antenatal clinic attendance by pregnant adolescents is often characterised by late and infrequent attendance, limiting midwifery contact with this inexperienced group. Gaps in the literature exist where the real-time voices of pregnant adolescents offer their current experiences of antenatal clinic as a relevant means to inform midwifery practice.

**Research design:** Using ethnographic methods, this research positioned a midwife to observe pregnant adolescents for a period of nine months while they attended a public antenatal clinic in Western Australia.

**Data collection and analysis:** Data from participant observation was supplemented by in-depth key informant interviews. Analysis of the data was concurrent with data collection and guided by Spradley's Developmental Research Sequence (1980).

**Findings:** Findings revealed four themes influencing attendance for antenatal care during pregnancy: a) connecting with midwives b) the importance of the maternal mother c) supportive relationships and d) engaging with pregnancy. Themes highlighted maternal mothers are pivotal to antenatal clinic attendance; they provide guidance and antenatal advice that pregnant adolescents accept in preference to that of midwives. Adolescents are influenced to attend antenatal clinic by different milestones than those represented in midwifery care; this may provide opportunity for midwives to align themselves alongside adolescents to provide pregnancy education at moments most relevant to them.

**Conclusion:** Information discovered will increase midwifery knowledge of what factors bring pregnant adolescents to antenatal clinic, aiding midwives to influence regular attendance in this group. To increase pregnant adolescents' comfort and perceptions of value, midwives may need to reconsider the traditional environment of the antenatal clinic to make better use of waiting times and become more inclusive of adolescents' supportive relationships. Embracing web-based technology is a pathway, which may effectively assist in the successful provision of antenatal education to this age group.

Non-judgemental midwives offering a caring approach to antenatal care, verifying pregnant adolescents' individual understanding, is identified as essential to engagement with this group.

Keywords: adolescents, antenatal clinic, ethnographic methods, pregnancy

## DECLARATION

*I certify that this thesis does not, to the best of my knowledge and belief:*

- i. incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;*
- ii. contain any material previously published or written by another person except where due reference is made in the text of this thesis; or*
- iii. Contain any defamatory material;*

29/11/2015

## ACKNOWLEDGEMENT

There are many to whom I am indebted for their contributions and support throughout this research. While, foremost, I wish to thank the young women, now mothers, who allowed me to interview them and gave this research the stories of their world, I also offer my gracious thanks to the following:

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- my work colleagues and friends who gave me supportive ears, shoulders and time out
- the staff associated with the ethics committees who kept all things in order.

The support of others around me is equally valued and those unnamed in error are included in my appreciation.

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## USE OF THESIS

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## **Chapter One**

### **Adolescent Pregnancy: a review**

#### **Introduction**

Pregnancy during adolescence continues to be a worldwide public health concern and shows few signs of being successfully addressed in recent generations of adolescents. The cyclic intergenerational effects of pregnancy are associated with costs to both individual health and society (East, Reyes, & Horn, 2007; Smid, Martins, Whitaker, & Gilliam, 2014). The ramifications on the personal health of this group becoming sexually active, pregnant and parenting at an early age are well documented in the literature. The social costs to adolescents and their children may have negative impacts on their lives for many years (Riva Crugnola, Ierardi, Gazzotti, & Albizzati, 2014).

Australia's national average birth rate during adolescence has remained static for the past few years at 16 births per 1,000 nationally; however, the figures vary between states and demographic groups (Australian Bureau of Statistics, 2012). For example, the birth rate for young Australian Aboriginal and/or Torres Strait Islander women (69 babies per 1,000 females) is significantly higher.

The pregnancy experience for these adolescents is arguably more risky than it would be for a more mature woman (Chen et al., 2007; Kim, Connolly, & Tamim, 2014; Malabarey, Balayla, Klam, Shrim, & Abenhaim, 2012) and potentially more costly in terms of health monitoring and service provision before and after birth. Associated health costs, however, may be substantially reduced with the provision of regular antenatal care, screening and appropriate education by qualified midwives (Khan et al., 2011; Vieira et al., 2012). Early sexual activity increases the chances of pregnancy but additionally raises exposure to associated health risks (Faridi, Zahra, Khan, & Idrees, 2011; Tamkins, 2004). The long-term impact on the individual young woman can vary from mental health issues, specifically postnatal depression, self-harm and social isolation, to failure to re-engage with education services (Cook & Cameron, 2015; Wahn & Nissen, 2008). For adolescents, pregnancy may also be accompanied by

emotional confusion and hormonal unpredictability (Breheny & Stephens, 2007; Choudhury, Charman, & Blakemore, 2008).

The impact on society is more extensive, with related low educational achievement resulting in fewer employment opportunities for parenting adolescents and more dependence on welfare (Clark, Cordero, Desai, Drake, & Lim, 2015; Mollborn & Jacobs, 2012). Furthermore, the children of adolescent mothers are reportedly more likely to carry on similar patterns of parenting and social behaviours to which they are exposed (Imamura et al., 2007; Olausson, Haglund, Weitoft, & Cnattingius, 2001; Shaw, Lawlor, & Najman, 2006).

### **Background to the Research**

Regular antenatal appointments monitor the health and wellbeing of mother and baby, identify those at risk, and enable provision of health education. Adolescents are encouraged to take the opportunity to engage with their pregnancy and prepare for parenthood. For some, from cultural groups such as Aboriginal and/or Torres Strait Islander women or refugees, a pregnancy is the first experience they have had with hospital. This may be a fearful event, traditionally associated with sickness or ill health (Scheppers, Van Dongen, Dekker, & Geertzen, 2006). Thus, some adolescents could find attending antenatal appointments more of a social challenge than others.

Often, adolescents may not have accurate menstrual histories and some may be unaware of the symptoms of pregnancy, resulting in late attendance for antenatal care and screening (Gogna, Binstock, Fernández, Ibarlucía, & Zamberlin, 2008; Singh, Fong, & Loh, 2002). In addition to the health risks from an infrequently monitored pregnancy, this brings to question adolescents' ability to choose to continue with the pregnancy, as termination may no longer medically be an option. Consequently, early, regular and, sometimes, motivated attendance at antenatal clinics may not always be as common for these adolescents as with other groups of pregnant women (Myers, Heazell, Jones, & Baker, 2007).

Some adolescents may experience difficulties attending antenatal appointments. These may be simple and obvious practical challenges, or compound individualised issues. The challenge for midwives is in identifying the approach that addresses the complex, and sometimes erratic, health needs of a potentially wide-ranging cultural mix of adolescents, and finding a level that engages them effectively to provide quality



antenatal care. In the relationship developed with midwives, there is the potential to provide for this pregnancy and meet some follow-on health needs for subsequent pregnancies. This additionally ensures that the health needs of their children is given strong foundation (Paranjothy, Broughton, Adappa, & Fone, 2009).

In the researcher's experience of working with adolescents, appointments are frequently full of challenging questions, perceived judgements and physical examinations. This may be regarded by some as embarrassing, intrusive and potentially traumatic, all of which pregnant adolescents may find daunting to deal with. This perception can limit engagement and generate poor clinic attendances (Gogna et al., 2008). Midwives could also assume that, in comparison with older women, antenatal appointments may be challenging for adolescents because attending scheduled appointments may not necessarily fit in well with schooling, youth lifestyles or the wider family structures on which the adolescents may be dependent. Antenatal clinics held for adolescents are said to be successful owing to the flexibility in appointment timing and one-to-one educationally levelled teaching facilitated by adolescents being grouped together (Quinlivan & Evans, 2004; Ukil & Esen, 2002; Viner et al., 2012). Unfortunately, in Australia, specialised clinics are not as widespread as they are in Europe and parts of the United States of America (US).

Pregnant women have been acknowledged as a distinctive culture in society for many years (Hanson, 2004; Martin, 1992). Culture related to pregnancy is regarded as shared understanding, concepts and patterns of behaviour which may be passed from one generation to another (Hahn, 1995). While pregnancy overall is a state of unique good health, that pregnant women need appropriate education, midwifery care and access to antenatal services is widely accepted in community life. However, for adolescent pregnant women, usually experiencing their first pregnancy, there is an increased need for opportunities to meet with midwives and to access services early (Kim et al., 2014). These adolescents may be viewed as a subgroup of both adult pregnant women and adolescent women, who may exhibit different behaviours and understanding of pregnancy, separate from more mature pregnant women (DeCherney, 2007; Herrman & Waterhouse, 2011).

Health care models may be seen to be lacking in the provision of appropriate support for these pregnant adolescents, who are likely inexperienced as mothers, not yet independent as adults, and still developing emotionally, physically and socially.

Traditional models of pregnancy employ a stance that these adolescents should act, understand and participate in, and with, their antenatal care, in the same manner as adult women. It has been argued in the literature that the hegemony of patriarchal medicalisation offers little in its presentation to engage and empower mature women, let alone a pregnant adolescent (Baker, Choi, Henshaw, & Tree, 2005; Benoit et al., 2005).

Longitudinal studies conducted worldwide have explored the complex reasons why adolescents often fail to engage with maternity services. These have identified negative behaviours and subsequent positive interventions that reduce the obstetric risks associated with adolescent pregnancy (Osbourne, Howat, & Jordan, 2005; Quinlivan, Petersen, & Gurrin, 1999; Smith & Pell, 2001). However, related social studies by Crittenden, Boris, Rice, Taylor, and Olds (2009) also highlighted links between pregnancy in adolescence and the reduced spacing interval for subsequent pregnancy, which further impacts upon the adverse social outcomes for the children of these mothers (Sommer et al., 2000).

Regular antenatal care by midwives has been established as being a significant strategy for reducing the maternal mortality rate and improving neonatal outcomes (Downe, Finlayson, Walsh, & Lavender, 2009; Stanton, Blanc, Croft, & Choi, 2006). Maintenance of health during all stages of the pregnancy, and early identification of potential health concerns for the mother and baby, are the focus of care provision. In Australia, the current model of antenatal care has remained essentially unaltered. Established in pre-war United Kingdom (UK) and, despite review over the years (Hall, 2001; Hollowell, Oakley, Kurinczuk, Brocklehurst, & Gray, 2011), the model is recommended worldwide as an approach to ensure improved health outcomes for baby and mother (Bar-Kalifa & Rafaeli, 2014). Alongside education programs, delivered successfully by midwives to women, information is provided to increase knowledge and preparedness for motherhood. This combined effect provides reassurance for women, encouraging the development of ownership and responsibility for women to become equal partners in their pregnancy care.

Midwives have a pivotal role in the successful provision of antenatal care to women: the relationship built with women within their community is the platform which carries this, lending itself well to a partnership approach to midwifery care. However, there are also groups of pregnant women, including adolescents, where many of the health risks originate from psychological and/or socioeconomic issues. These,

when identified and addressed, may reduce the incidence of poor obstetric outcomes (Brubaker, 2007). It is, therefore, logical to assume that, for higher risk groups of women, failure to attend regular antenatal care, where the identification of relevant physical, psychological or social complications affecting a woman's pregnancy takes place, would, in turn, increase the risk of poor obstetric outcomes. Adolescence heightens these risks.

### **Justification for the Research**

The numbers of young Australian women becoming pregnant during adolescence has remained largely unchanged over recent years. This is regardless of steps to reduce pregnancy numbers by raised contraceptive awareness and provision of pregnancy counselling services (Ngum Chi Watts, Liamputtong, & Carolan, 2014). That some adolescents continue to delay seeking antenatal care, and remain erratic attendees at antenatal clinics, indicates a gap within those services intended to ameliorate obstetric risks. In these circumstances, midwives have limited opportunities within which identification of women at risk and antenatal education may occur. Midwives aiming to collaborate with adolescents on their pregnancy journey are failing to engage with those at highest risk. Correspondingly, adolescents who have need of reliable guidance are failing to make full use of the support offered by antenatal clinic and midwives.

### **The Purpose of the Research**

Through the use of ethnographic methods, this research provides an in-depth examination of adolescents' behaviours while attending an antenatal clinic during their pregnancy. Using an approach that captures the cultural interpretations that pregnant adolescents may place on pregnancy and their experiences at antenatal clinic will bring insights to midwives. The insights gained will increase understanding and assist midwives to provide an antenatal service for adolescent pregnant women that more effectively meets their complex needs.

### **Research Questions**

- 1 What do adolescents disclose as the significant influences on their pregnancy which affect their attendance at antenatal clinic?

- 2 What combination of educational and support factors guide adolescents during their pregnancy?
- 3 What do the behavioural patterns, actions and language used while attending an antenatal clinic reveal about adolescents' pregnancy understanding?

### **Significance**

This research will add a qualitative perspective to what is already known about pregnancy in adolescence. An antenatal clinic catering for adolescents provides a unique opportunity for a researcher to collect their cultural views and understanding while they are still pregnant. Using ethnographic methods as the methodology for this research exposes the culturally led behaviours and understanding voiced by these young pregnant women. By the researcher waiting alongside adolescents as they wait for their antenatal appointments, the patterns within observed behaviours produces knowledge from the habits and beliefs distinctive to their subculture. This insight into adolescents' experiences of pregnancy and attending antenatal clinic offers midwives an opportunity to view antenatal services through adolescent eyes. This may better position services to provide midwifery care that engages a wider range of pregnant adolescents and reduces the gaps through which some may fall.

### **Chapter Summary**

The increased obstetric and psychosocial risks associated with a pregnancy in adolescence have been well researched, identifying that concerns for this group remain relevant. Midwives are in a position to provide a reliable source of education and support which may reduce the risks and improve pregnancy outcomes for these pregnant women. However, there remains a proportion of adolescents with whom midwives fail to engage in a manner that encourages early antenatal contact or regular attendance at antenatal clinic. This places adolescents and their babies at increased health risks from poor pregnancy monitoring. Discovering the understanding adolescents have of their current pregnancy needs will extend midwifery knowledge into providing sensitive antenatal care levelled at this group. This, in turn, may reduce avoidance of antenatal services and increase comfort and access to midwives during pregnancy.

### **Chapters to Follow**

The following chapters will explore the relevant literature on pregnancy during adolescence and will discuss ethnographic methods as the most appropriate methodology to illuminate the cultural voices of those adolescents pregnant in Perth, Western Australia (WA). Participant observation will be discussed as the method to gather information and analysis of the data will be followed by presentation of the findings and discussion of the exposed themes. Application of the knowledge gained will be reviewed in the context of improving adolescent women's comfort and access to antenatal clinics and increasing relevant application of midwifery-based antenatal care.

## **Chapter Two**

### **Overview of the Literature**

#### **Introduction**

This chapter provides an overview of the international research literature on personal perspectives of pregnant adolescents. The focus of this literature review was research that reported adolescents' experiences and understandings of their pregnancy and perspectives of antenatal services. Qualitative studies that used ethnographic methodologies to investigate cultural perspectives of adolescent pregnancy were particularly sought. In addition to what is written of the culture and antenatal understanding of pregnant adolescents, this research placed emphasis on the experiences of pregnant adolescents in Australia.

#### **Background**

Multiple and complex social challenges often go *hand in hand* with pregnancy in adolescence, contributing to increased obstetric risk factors (Kaiser & Hays, 2005; Malabarey et al., 2012; McCracken & Loveless, 2014; Nove, Matthews, Neal, & Camacho, 2014; Witt et al., 2014). The physical risks for pregnant adolescents are those of pre-term labour, pre-term delivery and low birth weight infants, alongside the co-morbidities of pre-eclampsia, hypertension and anaemia (Chen et al., 2007; Gortzak-Uzan, Hallak, Press, Katz, & Shoham-Vardi, 2001; Malabarey et al., 2012; Myers et al., 2007). There has been some global improvement in maternal morbidity over recent years as a result of increased antenatal care for pregnant adolescents (Connie, 2009; Hadley, 2014; VanderWeele, Lauderdale, & Lantos, 2013). However, the physical and psychosocial factors that exacerbate health risks continue to be of concern for health care services that provide ongoing pregnancy care for women in this age group, and their babies (Leppalahti, Gissler, Mentula, & Heikinheimo, 2013; Patton et al., 2014; Smid et al., 2014).

Breheny and Stephens (2010) assert the social representation of young mothers has historically been problematic and, in many cultures, adolescent pregnancy may still be regarded as less than ideal. The broader public impact is seen in pregnant adolescents 'dropping out' or being excluded from schools and communities; hence, they are in

jeopardy of becoming marginalised within society. As Crawford, Trotter, Hartshorn, and Whitbeck (2011) and Genest, Decroix, Rotten, and Simmat-Durand (2014) also attest, the social isolation and potential fragility of such adolescents may place them at increased risk for ongoing health issues such as depression and self-harm. Contributions to this state the risks may be further amplified with concealed or rapid repeat pregnancies, which have substantial negative influences upon the ongoing health of the offspring (Crittenden et al., 2009; Huang, Costeines, Kaufman, & Ayala, 2014). Other authors (Chen et al. (2007); Cohen, Lises, Williams, Brunsdon, and Batstone (2011); Doğan-Ateş and Carrión-Basham (2007); Shaw et al. (2006) and Thynne, Gaffney, O'Neill, Tonge, and Sherlock (2014)) argue that risks in adolescent pregnancy are not solely attributed to reduced socioeconomic status and inadequate antenatal care, stating protective factors, including the social behaviours of those around pregnant adolescents, is risk-reducing.

In Australia, the health disparities between pregnant adolescents of various cultural backgrounds is significant, although lack of consistent health care, cultural insensitivity, poor health seeking behaviours, and poor health knowledge is detrimental to all pregnant adolescents (Breheny & Stephens, 2007; Sheeran, Jones, & Rowe, 2013). Pregnant refugees and Aboriginal and/or Torres Strait Islander adolescents, who may be doubly marginalised in the Australian community, may be at increased risk from social isolation and subsequent health disparities (Bandyopadhyay, Small, Watson, & Brown, 2010; Riggs et al., 2012; Rumbold et al., 2011). Reduced social acceptance and the tough community challenges that face pregnant adolescents may result in reduced health outcomes and poor acceptance of their mothering role, which midwives should take into consideration alongside any obstetric risks.

### **Antenatal Challenges**

The time of pregnancy discovery is critical for decision making and taking action for the best health interests of mother and baby. Bunting and McAuley (2004) identified that adolescents are often late in reporting a pregnancy and, hence, may be said to need early guidance to assist them to access appropriate health care. Some adolescents may not realise or deny their pregnancy (Gross, Alba, Glass, Schellenberg, & Obrist, 2012), unwittingly delaying connection with antenatal care that places mother and baby at increased risk (Nirmal, Thijs, Bethel, & Bhal, 2006; Renesme et al., 2013).

Other than by concealing a pregnancy, Hall, Kusunoki, Gatny, and Barber (2014); Imamura et al. (2007) and Whalen and Loper (2014) all agree that pregnant adolescents who are most likely to have limited attendance at antenatal clinics are those with poorer educational and socioeconomic backgrounds. Those pregnant adolescents who are healthy and physically well may also delay contact with midwives, questioning the relevance and access to hospital-based antenatal care and need for frequent attendance (Correa-Velez & Ryan, 2012; Ruiz, Shah, Lewis, & Theall, 2014). Literature using postnatal signposting has provided some direction for antenatal education to prepare adolescents (Cronin, 2003; Peterson, Sword, Charles, & DiCenso, 2007; Redshaw, Hennegan, & Miller, 2014) but little is known as to what actually guides and influences adolescents during pregnancy. Postnatal adolescents appear resilient despite sometimes being ill prepared antenatally; their hard lifestyles may contribute to late and poor connection with antenatal services, thereby increasing risks to mother and baby. Limited participation in antenatal care is implicated in the poor health outcomes, e.g. anaemia, intra-uterine growth restrictions, urinary tract infections, seen during routine antenatal care (Poffald et al., 2013; Young, 2008). This is particularly evident within groups of marginalised Australian women, including adolescents and Aboriginal and/or Torres Strait Islander women (Bar-Zeev, Barclay, Kruske, & Kildea, 2014; Maxwell et al., 2011; Rumbold et al., 2011; Sutherland, Yelland, & Brown, 2012).

Historically, much published information has focused on the perceived poor decision making, negative outcomes and social challenges facing pregnant adolescents and young parents (Boden, Fergusson, & Horwood, 2008; Chen et al., 2007; Singh et al., 2002). There are numbers of studies dedicated to poor antenatal attendance, undesirable outcomes of pregnancy and the long-term sequelae for these mothers. Gomez-Scott and Cooney (2014) illustrate the challenges they face in ongoing education, while De Genna, Cornelius, and Donovan (2009) argue that risk factors increase from illicit substance use in pregnant adolescents despite potentially modifiable effects, and Olausson P, Bengt H, Weitoft G, and Cnattingius S (2001) posit a reduction in socioeconomic status because of adolescent pregnancy. This research about pregnant adolescents, however, is difficult to compare as the studies were conducted in different localities, countries and decades. However, during postnatal interviews, many adolescents have consistently expressed feelings of negativity, confusion and disempowerment during pregnancy, and signposted their lack of preparation for birth



and the challenges of parenthood (Cronin, 2003; Herrman, 2006; Peterson et al., 2007; Redwood, Pyer, & Armstrong-Hallam, 2012; Zasloff, Schytt, & Waldenstrom, 2007).

### **Main Concerns in the Literature**

The main concerns of previous researchers were the underlying sequelae contributing to pregnancy in adolescence and the social influences that perpetuate what has often been described as a cyclic event (Chen et al., 2007; De Genna & Cornelius, 2014; East et al., 2007; Shaw et al., 2006; Singh et al., 2002; Smith & Pell, 2001). Several authors: Kohler, Manhart, and Lafferty (2008), Commendador (2007) and Smith, Beck, and Davies (2011), have explored interventions that influence pre-pregnancy behaviours, such as contraceptive use (or not) of adolescents. Other studies have focused on the exposure of pregnant adolescents to predictive factors, including the availability of youth support services and social education (Lee, 2009). Focusing on adolescent behaviours has offered further insights into the cultural and decision-making influences in this age group. Researchers have found that pregnant adolescents' insights are largely informed by their interactions with peers, role models and stages of emotional development (Choudhury, 2010; Feldman, 2012; Kohler et al., 2008; Prout, 1985; Sipsma, Ickovics, Lewis, Ethier, & Kershaw, 2011).

Although some researchers have described adolescent perspectives of pregnancy and parenthood, there remains a paucity of literature that captures the valuable voices of adolescents while they are still experiencing pregnancy. As pregnancy during adolescence is likely to be a high-risk, cyclical event, it is important to record the main views and understandings about pregnancy and antenatal preparation for birth and mothering held by pregnant adolescents, in order to gain significant information to enhance their health care (Hanna, 2001; Harlow, 2009; Herrman, 2008; Herrman & Waterhouse, 2011; Jewell, Tacchi, & Donovan, 2000; Mollborn & Jacobs, 2012). Midwives' understanding and appreciation of the influences upon adolescents could pave the way towards holistic health care and, in some instances, promote earlier antenatal connections.

The overt advice that adolescents receive from peers, parents and health educators is not only directed by governments and policy developers, but also by the media and popular literature (Boonstra, 2002; France, Wyke, Ziebland, Entwistle, & Hunt, 2011; Quinlivan, 2000; Viner et al., 2012). Current influences on adolescents via

the World Wide Web have grown exponentially, particularly in Westernised countries (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005; Yee & Simon, 2010). The physical and psychological changes evident from puberty through adolescence also have a major influence on adolescents' levels of cognitive processes and higher social reasoning, including decision making. During this life phase, according to Mulvey and Iselin (2008) and Bell and Lee (2008), unusual events such as pregnancy may affect adolescents' risk taking, egocentricity and learning behaviours.

While much has been initiated over the years to reduce unintended adolescent pregnancy, consenting adolescents who are ambivalent about pregnancy (meaning a wanted pregnancy but perhaps not at this time), or who may have planned their pregnancy, should also be considered (Coleman & Cater, 2006; Hui Choi et al., 2012; Middleton, 2011; Quinlivan, 2004; Sipsma et al., 2011). In contrast to the negativity reported in much of the literature, some adolescents are optimistic that pregnancy is a potentially positive influence on their lives (Sadler et al., 2007; Seamark & Lings, 2004; Smith, Skinner, & Fenwick, 2011; SmithBattle, 2000; Stevens-Simon, Sheeder, Beach, & Harter, 2005). Cultural background and upbringing may influence this attitude; however, these studies recommended that health services support be culturally appropriate to increase positive attitudes that assist adolescents' self-preparation during pregnancy, in addition to providing contraceptive education and planning for subsequent pregnancies. Some obstetric- and midwifery-based research has identified the importance of professionals adopting a positive and supportive approach in their encounters with all adolescents regardless of pregnancy intention (Chantrapanichkul & Chawanpaiboon, 2013; Cohen et al., 2011; Whitworth & Cockerill, 2010). However, qualitative data that uncovers pregnant adolescents' experiences of this type of involvement by professionals is lacking. This research intends to address this gap.

Motherhood and the act of parenting is a culturally defined role; however, adolescents have been accused of possessing unrealistic and romantic views of parenthood. It has been suggested by Katz (2011) that this idealised notion may stem from a desire for "someone to love" or to "replace something lost". Such beliefs are challenged by popular "reality TV" shows aired on Australian television. Adolescents' opinions of, and realities of, teenage pregnancy are portrayed in programs such as the American television documentary *16 and Pregnant* (Bradley, Curry, & Devers, 2007), the British documentary *One Born Every Minute* and the Canadian feature film *Juno*,

which relates the tale of failed contraception (Byrne, Hauck, & Fisher, 2011; Lothian, 2008). Variations in individual maturity and adolescent behaviours are exposed with stark honesty in these programs. This media tool for educating Western adolescents about pregnancy risks and the challenges of pregnancy and parenthood also provides useful insight into some the cultural norms of this age group (Kearney & Levine, 2014).

The review of the literature was directed by two questions. Firstly, what do pregnant adolescents say they need as a group to enhance their antenatal understanding of pregnancy and their preparations for birth and mothering? Secondly, who do they experience as being positioned to provide sufficient support and education to meet their needs? In order to explore the potential experiences of Australian adolescents attending antenatal clinics, a search of the major health databases, CINAHL (Plus with Full Text), Embase, PubMed, Science Direct, ProQuest, POPLINE, and Informit, was conducted. The initial search was supplemented throughout the research by database-connected alerts keyed to the search terms. The search terms used were: pregnancy, pregnant, expecting, adolescent, adolescence, teenage\*, teens, young mothers, prenatal care, antenatal care, prenatal/antenatal clinic, perceptions, perspectives, experiences, qualitative. The search of databases was conducted sequentially, as shown in Appendix I. The criteria for inclusion incorporated full-text, English-language literature with methods that incorporated voices of adolescents. Articles from 1995-2015 were retrieved.

Search results, where 200 or fewer articles were retrieved, were previewed by hand for suitability. A quality review of each article was performed, using a standardised critical approach to assess their topic, qualitative approach, sampling, time period, and findings. Each article abstract and, where necessary, the full article, was read for its relevance. Articles that met the inclusion criteria are shown in Table 1. Eighteen articles were retrieved that met the inclusion criteria: a manual search of reference lists, and Google, uncovered an additional three papers.

In the literature, definitions of 'adolescent' varied between the ages of 12 to 20 years. Pregnancy in this group of adolescents is also referred to in the literature as teenage pregnancy or adolescent pregnancy.

**Table 1.**  
Summary of reviewed articles

Reference	Method	Sample	Time-frame	Main outcomes
Arthur, A., Unwin, S., & Mitchell, T. (2007). Teenage mothers' experiences of maternity services: a qualitative study. <i>British Journal of Midwifery</i> , 15(11), 672-677.	Phenomenological approach using semi-structured and conversational style interviews.	Eight pregnant adolescents.	Six months.	Three themes: one challenged adolescents presenting late for antenatal care; another explored the independence of adolescent mothers, and the last theme exposed a lack of consistency from relationships around them.
Bender, S. S. (2008). Three cases of adolescent childbearing decision making: the importance of ambivalence. <i>Adolescence</i> , 43(172), 861-879.	Case study using qualitative interviewing techniques.	Three pregnant adolescents	Nine interviews over pregnancy.	Themes generated from steps taken in the decision-making process identified ambivalence towards pregnancy. Level of immaturity impacted adversely on decision-making ability and perceived support.
Duggan, R., & Adejumo, O. (2012). Adolescent clients' perceptions of maternity care in KwaZulu-Natal, South Africa. <i>Women and Birth</i> , 25(4), e62-e67.	Focus groups and in-depth interviews of adolescents at a general public hospital antenatal clinic.	Eight clients 15-19 years, all currently pregnant or immediately postnatal.	Eight months	South African adolescents wanted an attitude of caring, shorter waiting times at antenatal clinic and wished to have support with them when in labour. They also wanted to be better prepared by midwives for the changes they face in pregnancy.
Hughes-Lee, S., & Grubbs, L. M. (1995). Pregnant teenagers' reasons for seeking or delaying prenatal care. <i>Clinical Nursing Research</i> , 4(1), 38-49. Florida USA.	Explorative descriptive design from questionnaires with semi-structured approach.	49 pregnant adolescents.	A single, in-depth interview of each participant during her pregnancy.	Reasons for seeking early prenatal care included feeling ill, being worried about themselves, wanting a pregnancy test, and the teen's mother insisting that she begin prenatal care. Reasons for delaying care included not recognising pregnancy symptoms, denying being pregnant; fear of parents' response to the pregnancy, and lack of financial resources.
Holub, C. K., Kershaw, T. S., Ethier, K. A., Lewis, J. B., Milan, S., & Ickovics, J. R. (2007). Prenatal and parenting stress on adolescent maternal adjustment: identifying a high-risk sub-group. <i>Maternal and Child Health Journal</i> , 11(2), 153-159.	Longitudinal cohort group of pregnant adolescents volunteered a series of four structured interviews of 90 minutes' duration.	203 baseline interviews of pregnant adolescents; 154 postpartum interviews.	Interviews commenced in third trimester to 16 months postpartum.	Identifying those pregnant adolescents at risk found emotional stressors during (and after) pregnancy increases risks for poor maternal role adjustment (i.e., fewer positive feelings about motherhood, less infant care, and low parenting competency) and high postpartum stress.
James, S., Rall, N., & Strümpher, J. (2012). Perceptions of pregnant teenagers with regard to the antenatal care clinic environment. <i>Curationis</i> , 35(1), 1-8. South Africa.	Qualitative exploratory descriptive study, semi-structured interviews, observation and fieldnotes; anonymous sample at an antenatal clinic.	12 pregnant adolescents.	Two years (June 2007-June 2009).	Antenatal clinic was experienced as alienating and uncomfortable. Adolescents felt it was a waste of time attending; clinic was poorly organised and did not meet their needs. There was a poor relationship between adolescents and midwives. They also felt there were too few

				midwives for the numbers attending the clinic.
Kaye, D. (2008). Negotiating the transition from adolescence to motherhood: Coping with prenatal and parenting stress in teenage mothers in Mulago Hospital, Uganda. <i>BioMedCentral: public health</i> , 8(1), 1-6.	Qualitative design. In-depth interview during pregnancy. Participants recruited from antenatal clinic. Followed by focus groups within six weeks of delivery. Analysis using grounded theory.	52 pregnant then parenting African adolescents.	Jan 2005-Aug 2005	During pregnancy, adolescents reported increases in anxiety, challenges negotiating support from family and friends, loss of self-esteem and stigmatisation from health care workers.
Lehana, T. V., & van Rhyen, L. (2003). A phenomenological investigation of experiences of pregnancy by unmarried adolescents in Maseru. <i>Health South Africa Gesondheid</i> , 8(1), 26-38.	Phenomenology, incorporating interviews and focus groups.	16 pregnant adolescents sourced from different locations.	Time not specified for data collection. Single participant interviews.	Participants reported disbelief, confusion and shame. Four main categories were identified and positive and negative experiences were described. All participants who were still in school had to drop out. Recommendations: pregnant adolescents who come to the clinic should receive or be referred for counselling. Prenatal education should provide anticipatory guidance related to maternal role issues.
Lesser, J., Anderson, N. L., & Koniak-Griffin, D. (1998). "Sometimes you don't feel ready to be an adult or a mom": the experience of adolescent pregnancy. <i>Journal of Child and Adolescent Psychiatric Nursing</i> , 11(1), 7.	Ethnography conducted in prenatal classes for adolescents.	36 pregnant adolescents who attended.	Summer 1994 -Winter 1995.	Themes of responsibility, respect and reparation were identified. Adolescents revealed increased anxiety during pregnancy with authors recommending early intervention.
Lloyd, S. L. T. (2000). Adolescent perceptions of parent-adolescent communication and adolescent pregnancy. (Ph. D.), University of San Diego.	Mixed-methods incorporation recorded qualitative interviews and thematic analysis.	56 pregnant adolescents from four locations in California.	Convenience sample.	Six themes, including patterns of poor communication, a perception that pregnancy increases adolescent-parent communication and relationships, and poor family connectedness were identified in qualitative analysis.
MacLeod, A., & Weaver, S. (2002). Are expectant teenage mothers adequately informed? <i>British Journal of Midwifery</i> , 10(3), 144-147.	Mixed-methods approach incorporating standardised questionnaire and guided interviews.	99 pregnant adolescents from two hospital sources.	Four months for data collected at 20 and 37 weeks' gestation.	Inadequate antenatal information and barriers from not knowing staff well resulted in poor understanding and preparation.
Maputle, M. S. (2006). Becoming a mother: teenage mothers' experiences of first pregnancy. <i>Curationis</i> , 29(2), 87-95.	Phenomenological approach using unstructured interviews.	14 pregnant adolescents over 36 weeks' gestation recruited from an antenatal	Within two days of recruitment.	Five main themes emerged as the experiences of teenage mothers who were pregnant for the first time: inadequate information/ knowledge, unplanned/planned

		clinic in South Africa.		pregnancy, ineffective communication, under-utilisation of health resources and adequate/inadequate social support.
Michels, T. M. (2000). Patients like us: pregnant and parenting teens view the health care system. <i>Public Health Reports</i> , 115(6), 557-575. California USA.	Face-to-face guided interviews.	17 pregnant, 23 five months post-partum.	13 months.	Based in the US, participants were cared for by doctors, not midwives, who fulfilled a role very similar to Australia. Findings reported adolescents wanted to be given respect and honest information in good surroundings. They felt stigmatised because of attitudes and the babies' health and wellbeing was more of a focus than their own.
Mollart, L. (1995). Pregnant teenagers antenatal education research. <i>Australian College of Midwives</i> , 8(4), 26-28.	Explorative descriptive design from questionnaires with open and fixed questions, given at the antenatal clinic and completed at clinic or at home, focused on adolescent learning needs.	46 pregnant adolescents.	Nine months.	Participants identified their need for increased antenatal education; they preferred education alongside antenatal appointments.
Montgomery, K. S. (2004). Planned adolescent pregnancy: themes related to the pregnancy. <i>Journal of Perinatal Education</i> , 13(4), 27-35. USA.	Phenomenological approach with individual interviews.	Eight pregnant adolescents.	Single individual interviews between 20 and 36 weeks' gestation.	Themes related to planned pregnancy during adolescence included living environment issues, adjustment to the pregnancy, and an increased motivation to do well in school and work to provide a good life for their infants. Individualised approaches are recommended for future care.
Osuchowski-Sanchez, M. A. K. (2011). Teen pregnancy and parenting: Attitudes and behaviours of teenage, long-term Hispanics in northern New Mexico (dissertation/thesis).	Focused ethnography in two hospital clinic locations.	10 pregnant adolescents, 10 adult carers and participant observation.	Sequential interviews during pregnancy, period not stated.	Themes revealed chaos and instability that characterised the homes of youth, low levels of communication related to reproductive issues in homes and schools, disappointment expressed by families and the community in response to pregnancy, and the difficulties experienced on role transitions/career choices teens experience when becoming mothers.
Poffald, L., Hirmas, M., Aguilera, X., Vega, J., Gonzalez, M. J., & Sanhueza, G. (2013). Barriers and facilitators to antenatal care in adolescents: results of a qualitative study in Chile. <i>Salud Publica Mex</i> , 55(6), 572-579.	Grounded theory / interviews and focus groups.	17 pregnant adolescents.	12 months.	Focuses on denial/concealment of pregnancy as a barrier to antenatal care. Identified a trusted facilitator improves access to health.

Rentschler, D. D. (2003). Pregnant adolescents' perspectives of pregnancy. <i>The American Journal of Maternal Child Nursing</i> , 28(6), 377-383.	Grounded theory approach using single individual interviews.	20 pregnant adolescents.	Not specified.	To gain clearer adolescent perspectives of pregnancy and parenting, constant comparative analysis revealed three themes "The pregnant me - unexpected changes", "Transformed relationships" and "Envisioning mothering ."
Skinner, S. R., Smith, J., Fenwick, J., Hendriks, J., Fyfe, S., & Kendall, G. (2009). Pregnancy and protection: perceptions, attitudes and experiences of Australian female adolescents. <i>Women and Birth</i> , 22(2), 50-56.	Qualitative, semi-structured interviews included a component of pregnant teenagers with thematic analysis.	16 pregnant adolescents.	Nine months.	From the perspective of contraceptive use, pregnancy was identified as a positive indicator for high expectations of motherhood.
Symon, A. G., & Wrieden, W. L. (2003). A qualitative study of pregnant teenagers' perceptions of the acceptability of a nutritional education intervention. <i>Midwifery</i> , 19(2), 140-147.	Phenomenological approach using recorded group interviews.	10 pregnant adolescents.	Participants attended a series of food preparation sessions during pregnancy.	Participants revealed they searched for pregnancy information as trust grew in their relationship with the midwife holding the classes. Difficulties were reported in engaging the pregnant adolescents' attention despite the group's exclusivity to adolescents.
Wilson-Mitchell, K., Bennett, J., & Stennett, R. (2014). Psychological health and life experiences of pregnant adolescent mothers in Jamaica. <i>International Journal Environmental Research and Public Health</i> , 11(5), 4729-4744.	Mixed methods, including semi-structured interviews and focus groups.	30 pregnant adolescents interviewed plus 16 in focus groups.	Weeks; exact number not specified.	Findings highlight emotional and psychological distress is increased during pregnancy, as are barriers to self-determination, education and contraception. The author's focus was on family and sexual violence of which there was a significant incidence reported by participants. Participants reported elements of 'caring' by clinic staff and were discouraged by lengthy waiting times.

Of the articles reviewed, 11 came from the Americas (three from Latin America), five from South Africa, three from the United Kingdom (UK), and two from Australia. All of the authors reported a study design that incorporated interviews with pregnant adolescents. The Americas have one of the highest global rates of adolescent pregnancy. This is partly due to overall population representation and partly to the influences of varying social and cultural groups occupying large geographical areas, with variations in the availability and accessibility of services. For pregnant adolescents, access to health services can be inconsistent and varies through North and South American countries (Kearney & Levine, 2012). The main themes in the literature pertaining to the Americas were the identification and influence of quality relationships

supporting pregnant adolescents prior to and during pregnancy. Social stability and degrees of preparedness were highlighted as influencing the ways that pregnant adolescents were reported to pregnancy care services. Disturbances in emotional well-being were also discussed as hindering the adolescents' healthy adaptation to pregnancy and a future mothering role.

Hughes-Lee and Grubbs (1995) approached 49 pregnant adolescents to explore their reasons for seeking and/or delaying early antenatal care. Easy access to services, perceived health concerns for themselves, and maternal influence, significantly prompted early disclosure of pregnancy. Hughes-Lee and Grubbs found that the relationship between the pregnant adolescent and a supportive mother was fundamental to the adolescent accessing quality care during pregnancy. They recommended that signs of pregnancy and early pregnancy information be provided to adolescents *and* their mothers at every encounter to impress the importance of early care in pregnancy and the dangers of delay.

Lesser, Anderson, and Koniak-Griffin (1998) conducted an ethnography as part of a larger public health intervention study that captured a convenience sample of pregnant adolescents over four weeks at prenatal classes. The adolescents recruited came from a low socioeconomic area of California and were involved in the larger study because of their pregnancy. Two categories were derived from the prenatal classroom observations: relationships and maternal role. The themes of responsibility, respect and reparation characterised these adolescents' experiences and reflected personal changes around earlier disclosed childhood abuse and trauma as a form of moving forward. The researchers conducted the short-term classes and were the participant observers, which may have produced some bias and/or power imbalance into the data as they had a limited opportunity to naturalise with the group. However, their findings supported the view that some adolescents regarded their pregnancy as life changing as it aided the development of personal strengths, helped them to implement goals for a constructive change in their life direction, and built "hopeful relationships" with their baby. Lesser et al. recommended early intervention for education with pregnant adolescents as a way of allowing the development of the maternal role and, where possible, suggested involving the pregnant adolescents' maternal parents.

In a mixed-methods study of communication between adolescents and their parents during pregnancy, Lloyd (2000) reported poor patterns of communication and



ambivalent attitudes in pregnant adolescents. The pregnant adolescents perceived that their pregnancy provided a positive initiation of improved communication with their family. Lloyd assumed that good parental communication was influential in preventing pregnancy during adolescence. Lloyd found that having poor hope and poor connectedness with their family contributed to the pregnant adolescents' engagement with their pregnancy. However, their personal motivations or understanding of antenatal care was not included in this study.

As a medical student working in a school program incorporating an antenatal care component, Michels (2000) interviewed 17 pregnant adolescents who were enrolled in the program. Michels also interviewed 23 adolescents who had recently given birth, examining their views on the public health care system as a means to measure quality. Michels reported the aspects of care that influenced the pregnant adolescents' perceptions of a 'healthy' environment and the staff attitudes that added to feelings of stigma when at antenatal appointments. The pregnant adolescents reported that clarity of information and respect from those providing care helped them through the changes that pregnancy brought. Michels recommended extending basic antenatal services to include environments more accessible to pregnant adolescents as a way of increasing quality health provision. While an insightful study, primarily, doctors and other medical students, not midwives, provided the public maternity health care in the program that was studied, which may have influenced the responses by the adolescents.

In her grounded theory study, Rentschler (2003) interviewed 20 pregnant adolescents in their third trimester. The pregnant adolescents expressed a positive anticipation for the future when they had access to supportive relationships. The relationships they found supportive were not just family but school staff, including the school nurse who provided some prenatal education and care and was regarded by the pregnant adolescents as someone reliable. This offers a challenging view that suggests antenatal care for adolescents should not be limited to hospital environments.

Montgomery's (2004) phenomenological study extended the view of connecting with pregnant adolescents by arguing that some pregnancies were actively planned. Montgomery reported increased personal motivation and a positive outlook among the eight pregnant adolescents interviewed. They attributed positive life changes and increases in personal meaning and a focus on self-improvement to their pregnancies.

This small study has considerable relevance, as pregnant adolescents with a positive outlook are more likely to attend early for antenatal care.

In a grounded theory study aimed at assisting child health, nurses identified pregnant and parenting adolescents at higher risk. Holub et al. (2007) interviewed 154 pregnant adolescents a number of times during their pregnancy to a year postpartum. Holub et al. found that increased stressors antenatally translated into postnatal stress that hindered the adolescents' adaptation to a mothering role. They recommended that early recognition of stress and timely intervention prenatally for all pregnant adolescents may reduce their stress and increase the positive feelings they associate with motherhood. Holub et al. extend the view of Montgomery (2004) by suggesting that adolescent-focused parenting programs and mentorship in the adolescents' communities were a means to engage this group.

Bender (2008) utilised a case study approach, concentrating on repeated in-depth interviews with three adolescents to explore their decision-making processes during pregnancy. They identified that levels of ambivalence in this age group were underestimated and that immaturity and poor communication in adolescent pregnancy may increase levels of anxiety. This small group of adolescents initially reported not wanting the pregnancy and were interviewed soon after making the decision to maintain it. Therefore, unresolved stress might have coloured their responses. As this may not be an unusual response in pregnant adolescents, it merits the need for early indication of stress. Bender's research also indicates the need to further understand the decision-making motivators of pregnant adolescents.

A two-year ethnography by Osuchowski-Sanchez (2011), incorporating 10 Hispanic pregnant adolescents, highlighted that pregnancy added to the destabilisation of adolescents who were under-supported during pregnancy and poorly equipped to face the realities of parenting. This adds to the findings of Lloyd (2000) and Bender (2008) that poor communication and support within families impinge on adolescents' behaviour when seeking care during pregnancy. Poffald et al. (2013) examined emotional distress in a group of 17 pregnant Chilean adolescents identified their barriers and facilitators to antenatal care. In interviews and focus groups, the pregnant adolescents expressed that their social support during pregnancy was a facilitator in maintaining antenatal care, whereas denial and concealment of the pregnancy was a major barrier to initiating antenatal care. Poffald et al. claimed that abuse is a common

feature of pregnancy in this age group. In Chile, there is free access to public antenatal health care but the adolescents interviewed faced problems of access, support and stigma similar to those in other studies.

Themes of stressful, chaotic lives experienced by pregnant adolescents were reported by Wilson-Mitchell et al. (2014) in a mixed-methods study exploring a link between suicidal behaviour and adolescent pregnancy in Jamaica. For the qualitative component, they interviewed 30 pregnant adolescents recruited from two antenatal clinics. Like Poffald et al. (2013), Wilson-Mitchell et al. found increased emotional distress in this group of pregnant adolescents and highlighted their increased exposure to family violence. The pregnant adolescents in Wilson-Mitchell et al.'s study also reported positive feelings towards prenatal clinic staff, possibly because of a regular and reliable association where care was focused on their needs. Jamaica has a different social welfare system to Australia and, although Wilson-Mitchell et al. sited their study in an urban area, the social structure and lack of educational support for pregnant adolescents (who were exited from school on discovery of the pregnancy) would increase their exposure to stressors that Australian adolescents would be less likely to experience.

Five articles were retrieved from researchers in South Africa for the same decade, a time when health care in that country was developing post-apartheid (Ruff, Mzimba, Hendrie, & Broomberg, 2011). Most of the pregnant adolescents in the studies were recruited from antenatal clinics that served predominantly black townships, providing a perspective only from that unique population. The themes in these studies were: support for pregnant adolescents and its importance both at home and antenatal clinics, sources of anxiety during pregnancy and its long-term impact, and meaningful patterns of communication in antenatal environments to reduce alienation and increase the emotional comfort of pregnant adolescents who attend.

Using a phenomenological approach, Lehana and van Rhyn (2003) conducted individual interviews and two focus groups with 16 pregnant adolescents recruited from random antenatal clinics. They found that the support by [maternal] mothers for developing a mothering role in pregnant adolescents should not be relied on. Social support during adolescent pregnancy was said to correlate with decreased anxiety and depression. Lehana and van Rhyn also argued that a higher quality relationship with the father of the baby increased self-esteem in pregnant adolescents, with improved feelings

towards the pregnancy and their mothering role. They described the culture from which the pregnant adolescents were recruited as having a strongly patrilineal and patrilocal focus. Therefore, pregnant adolescents isolated from the father of their baby may have felt a level of cultural dissociation that may not be experienced as strongly outside of South Africa. This cultural aspect of connection and/or involvement with the father of the baby should be considered alongside the implications for self-esteem in pregnant adolescents from other countries.

Taking a phenomenological approach, Maputle (2006) collected unstructured interview data from 14 purposively selected pregnant adolescents recruited from an antenatal clinic. The interviews conducted in the homes of the pregnant adolescents were reportedly difficult; Maputle considered that some questions were poorly understood, and that feeling responses and interpretation of context may have been lost during translation from Bantu dialects to English. Nevertheless, Maputle found that some adolescents' friendships were lost as a result of their pregnancy. This may account for delayed antenatal care due to the adolescents' potential reluctance to be separated from peer friendships and subsequent denial and/or pregnancy concealment, though further exploration of this would be necessary.

More recently, Kaye (2008) conducted in-depth interviews with a small number of young African women about their experiences of pregnancy and parenting. In a longitudinal study using grounded theory, pregnant adolescents were followed throughout pregnancy to identify how they managed antenatal stress. Kaye highlighted three themes of coping with stressors: thriving, bargaining and surviving, and despairing. Sources of anxiety included reduced self-esteem, stigma and difficulties in access to social welfare. Among the adolescents who spoke of their personal situation and environment, their initial feelings of low self-esteem in early pregnancy, poor access to tangible support structures and sometimes overwhelming stigmatisation were significant. Kaye found that the pregnant adolescents utilised reactive emotional approaches as they encountered problems during pregnancy and so recommended that midwives use an individualised and sensitive approach to providing pregnancy care to adolescents.

Duggan and Adejumo (2012) and James, Rall, and Strümpher (2012) sought the perspectives of pregnant adolescents about their health carers and the antenatal care environment. In both of these studies, the researchers reported that pregnant adolescents

felt alienated and were distressed by erratic communication in the antenatal clinic. Poor communication increased pregnant adolescents' feelings of stigma, including a lack of respect in their care, and the midwives' body language conveyed a non-caring attitude towards them. Lengthy, uncomfortable waiting times (sat on benches if there was room) added to the negative feelings experienced by pregnant adolescents. Education and preparation for pregnancy, birth and parenting, were said to be lacking by the pregnant adolescents, yet they referred to their maternity care providers as being their main support for this information. Pregnant adolescents in both studies reported that the low numbers of qualified midwives at the antenatal clinics may have contributed somewhat to the inconsistencies in adolescent-friendly care that they received. Maternity care in South Africa, while developing, has some evident gaps in the services available for pregnant adolescents compared with Australia and other developed countries where services are more established.

Adolescent pregnancy is not a new phenomenon in the UK and Europe, with adolescent-only antenatal clinics more common than in Australia and other developed countries, though only three studies on the topic were retrieved. The main themes reported in these studies were: the communication between pregnant adolescents and midwives; searching for maternity-related information and the timing of this in adolescents' preparations; and instability in adolescents' lives from chaotic support structures. Communication between adolescents and midwives in the hospital environment was more likely to be perceived as poor by the adolescents than communication with community midwives, resulting in pregnant adolescents experiencing inadequate preparation for labour and birth in hospital settings. MacLeod and Weaver (2002) used guided interviews with pregnant adolescents in England (United Kingdom), to discover the extent of their feelings of empowerment associated with midwifery support. The adolescents in their study felt they did not know their community midwife well by the end of their pregnancy. As their understanding and preparation fell short of their expectations, they would have liked to spend more time with the midwife during pregnancy to overcome this. Symon and Wrieden (2003) found similarly. In their Scottish study, they utilised midwives to teach pregnant adolescents about nutrition and found that the adolescents used the extra opportunity with the midwife to source maternity information that they would not otherwise have had the opportunity to gain. MacLeod and Weaver (2002) found that midwives, rather than

adolescents, directed the content of antenatal appointments and, consequently, the adolescents subsequently felt they received inadequate information. The unfamiliar medical terminology and the adolescents' low understanding of maternity care structure contributed to their confusion and subsequent poor preparedness during pregnancy.

Arthur, Unwin, and Mitchell (2007), also in England, utilised a phenomenological approach, and found that meeting the needs of pregnant adolescents in antenatal clinics depended on the attitudes of midwives towards instilling a sense of being valued in pregnant adolescents. They found that anxiety from social instability was prevalent among the small number of pregnant adolescents they interviewed, which resulted in their poor uptake of services, especially in the first six months of pregnancy. It appeared from Arthur et al.'s study that, where possible, referral early in the pregnancy to social services may help mitigate the sources of anxiety for pregnant adolescents, such as housing and finance concerns. In order to determine the sources of anxiety for pregnant adolescents and identify their information needs, which will subsequently impact on their pregnancy health, the midwife requires knowledge of, and connection with, the adolescents' cultural supports plus the wider services available for addressing their social issues.

Two articles presented the voices of pregnant adolescents during antenatal care in Australia. Mollart (1995) recruited 50 pregnant adolescents from a general antenatal clinic to study whether their information requirements during pregnancy differed from that of the adult women attending. Sixty-nine per cent of the pregnant adolescents in her study wanted peer group discussions as part of antenatal preparation and 63 per cent wanted parent education classes in conjunction with antenatal clinic. The pregnant adolescents provided a list of 'most wanted' education topics with information on labour and delivery being the priority for 91 per cent. At the time of Mollart's report, there were no antenatal services specifically for adolescents in New South Wales. Mollart recommended that adolescent sensitive antenatal services be established, including a preparation for parenthood program for adolescents tailored around the most wanted list.

In the second study from Australia, Skinner et al. (2009) explored perceptions of contraception among 16 pregnant adolescents. Their findings create the argument that fluctuating attitudes to pregnancy correspond with ineffective contraceptive use.

However, the study offered little to improve midwives' understanding of pregnant adolescents' ambivalent views on current pregnancy in relation to failed contraception.

## **Discussion**

It is difficult to draw firm conclusions about the perspectives that are shared by pregnant adolescents when cultural differences and service delivery varies to such a large degree. Many of the studies reviewed did not report on adolescents' understandings of antenatal care except indirectly (Holub et al., 2007; Lloyd, 2000; Skinner et al., 2009; Wilson-Mitchell et al., 2014) or studies reported pregnancy understanding from non-midwifery perspectives (Michels, 2000; Symon & Wrieden, 2003).

Pregnancy understanding by adolescents, and the ways they prepare for birth and parenting, is responsive to their environmental influences, including cultural support and upbringing. Adolescents generally rely on female relatives for pregnancy support and information and one of the most influential factors for adolescents is protective parenting (Hughes Lee & Grubbs, 1995; Whitfield, Jomeen, Hayter, & Gardiner, 2013). Protective parenting refers to a consistent adult who provides accurate information, participates in honest, relevant conversations, and promotes resilient relationships with their children (Black & Lobo, 2008; Bunting & McAuley, 2004; Doğan-Ateş & Carrión-Basham, 2007; Milan et al., 2007; Pilgrim & Blum, 2012). As little change in sociodemographic factors may be found between generations of high-risk adolescents, this may limit the support available from influential family members that would otherwise promote successful maternal role development. Additionally, as pregnant adolescents may also have maternal role influences from alternative sources, the midwife becomes arguably more important in overseeing the development of this role. Notably, however, previous researchers have not indicated whether adolescents attended for pregnancy care with or without support from parents or reliable adults, which may draw into question the reliability, accuracy and consistency of any pregnancy or parenting guidance (Couch, 2011; Meadows-Oliver, 2006; Saewyc, 2003; Yee & Simon, 2010).

None of the studies explored meanings of preferred support and guidance from the pregnant adolescents' perspectives, though studies that reported on antenatal attendance defend a position of antenatal services targeted to the specific needs of

pregnant adolescents as a means of securing closer engagement (Lehana & van Rhyn, 2003; Montgomery, 2004; Wilson-Mitchell et al., 2014). Though some authors argued family instability and lack of support served to distance adolescents from antenatal care, this was not unassisted as inadequate information and midwifery attitudes increased the space between pregnant adolescents and midwives (Arthur et al., 2007; MacLeod & Weaver, 2002).

The connection that pregnant adolescents have with midwives has the potential to help them attain confidence and competence in their new role. In areas where midwives are readily available to support antenatal health, adolescent opinions about what would enable comfortable access to care and support during pregnancy are lacking. Self-education and the means by which adolescents identify and seek to meet their individual needs during pregnancy are poorly reported. For midwives to improve their role of supporting and providing information to pregnant adolescents, an individualised approach to antenatal services is clearly better, yet rarely implemented. This research explored adolescents' perspectives and experiences of antenatal services in their preparations for birth and their maternal role.

There is reasonable evidence to suggest that sensitive approaches, the inclusion of the maternal mother in antenatal care, and the provision of pregnancy and parenting information aimed specifically at adolescents has a major effect on adolescents' comfort and, hence, positive perceptions of their pregnancy (Duggan & Adejumo, 2012; James et al., 2012; Kaye, 2008; Lesser et al., 1998; MacLeod & Weaver, 2002; Maputle, 2006; Michels, 2000). Early and regular antenatal attendance by pregnant adolescents was identified as a challenge in antenatal care that needed exploring further. However, few studies identified more than fleeting reasons for what motivates adolescents towards antenatal clinic, suggesting that caring staff assisted retention and being directed by maternal mothers encouraged pregnant adolescents into early attendance (Hughes Lee & Grubbs, 1995; Poffald et al., 2013). Pregnant adolescents' negative perceptions of themselves and their pregnancy has been taken as a sign of their being less receptive of the pregnancy and, hence, less likely to engage with midwives and delay attendance for antenatal care (Holub et al., 2007). Many studies did not report on what the most relevant actions are for midwives to take to identify and assess the needs of pregnant adolescents who voiced challenges adapting to their pregnancy. This research addressed



the absence of information about what reasons bring pregnant adolescents to antenatal clinic and towards a positive relationship with midwives.

### **Limitations**

The criteria directing this literature review was limited to adolescent voices during actual pregnancy. Retrospective views of pregnancy may have provided further insights but it was important to gain saturation of adolescent voices experiencing pregnancy. Adolescence is a period of life between the ages of 12 to 20 years; however, in some studies, the age range of participants varied between older and younger adolescents who may experience distinctly different challenges and experiences.

## **Conclusion**

Research in this area contributes to midwives' knowledge about how pregnant adolescents make sense of their pregnancies but the picture is far from complete, particularly in Australia. Adolescents require the same standard of pregnancy care from midwives as do adult women; however, they may feel a lack of respect and experience stigma. They may feel themselves treated differently from adult women. Pregnant adolescents want to be supported and prepared by midwives and receive age-appropriate information free from assumptions about them.

## **Chapter Summary**

This chapter has given an overview of the literature about pregnant adolescents from 1995 to 2014. There is strong evidence as to the health and social disadvantages for parenting at a young age, increasing the significant long-term costs to society if causes of unintended pregnancy are not addressed and pregnancy during adolescence is poorly managed. Despite the focus in clinical practice on improving poor pregnancy outcomes for adolescents, research in this area has identified that many ongoing obstetric risks persist for this group of often marginalised adolescents. Psychological influences and entrenched social factors exacerbate the substantial risk to pregnant adolescents. Antecedent complexities have heralded the way for qualitative research, seeking an in-depth understanding of the lives of pregnant adolescents. The poorly resolved cyclic effect of pregnancy in adolescence, associated with low developmental age, and poor decision and risk-taking behaviours in this cultural group, are major contributors to pregnancy incidence.

The wider social and economic effects of pregnancy and parenting in this age group bring difficult challenges to the adolescent lifestyle, which subsequently impacts on their children and becomes a hard-to-break pattern, even for those adolescents with a positive outlook on pregnancy and parenting. While pregnancy may be regarded as a positive, life-changing event for many adolescents, this is not easily attained without consistent and reliable support figures in the lives of the adolescents, including midwives.

Ethnographic studies have provided some cultural insights into pregnancy in this age group. The use of ethnographic methods in this research will extend and add to the

depth of knowledge already available on this subject. This research assumes that an improved understanding of pregnant adolescents' needs by midwives will contribute towards improved antenatal service provision. This may also result in improved general health engagement for the child and for subsequent pregnancies. Such action may also increase adolescent group trust in midwifery services, communication via word of mouth stimulating earlier access to pregnancy advice and antenatal health care provided by midwives. Early contact with midwives may improve both obstetric outcomes and personal pregnancy knowledge for pregnant adolescents. The following chapter will provide a detailed description of the ethnographic approaches used to gain an insight into why pregnant adolescents attended an antenatal clinic in Perth, Western Australia.

## **Chapter Three**

### **Methodology**

#### **Introduction**

In the previous chapter, the literature related to pregnancy in adolescence was reviewed. Pregnancy and parenting at a young age is said to have considerable impact on health services and communities. Researchers have established that the lack of health education and appropriate supports are among the complex antecedent influences which impact upon an adolescent's ability to cope with pregnancy and parenting (Chen et al., 2007; Maxwell et al., 2011; Sutherland et al., 2012). Adolescents who become pregnant also face complex challenges from interruptions in formal education and ongoing poor social networks that impact both on their health and on that of their babies' (Coren, Barlow, & Stewart-Brown, 2003; Kaiser, 2004).

Further, there is an increased potential for health risks to adolescent mothers and their babies because they often do not engage in antenatal care until a late stage of their pregnancy. Some mothers, family friends and peers who have had similar experiences may be seen as trusted and reliable sources of knowledge (Black, 1979; Cronin, 2003). Therefore, pregnant adolescents may not seek the support of early antenatal care and, in particular, midwifery care. The problem with this scenario is that the young woman may be unaware of any gaps in her knowledge about healthy pregnancy and this lack of knowledge may compromise the health of both mother and baby.

Little is known about the information-seeking behaviours of adolescents during pregnancy, despite retrospective research having been undertaken during the postnatal phase (Cohen et al., 2011; Harlow, 2009; Herrman, 2006). Previous studies of pregnancy during adolescence, using deductive and positivist approaches, have relied on large sample numbers to produce generalisable results (Chen et al., 2007; East et al., 2007; Flynn, Budd, & Modelski, 2008; Herrman & Waterhouse, 2011; Kohler et al., 2008; Kulkarni, Kulkarni, & Sreekantha Avinash, 2014; Malabarey et al., 2012). While valuable knowledge has accumulated about these pregnancies, this type of research has only represented one side of the story. That is, few studies have focused on the voices of

pregnant adolescents. Thus, there remain unanswered questions related to pregnancy, the values, meanings and interpretations held by adolescents who are living the experience, and how these experiences influence their information-seeking behaviours.

This research, therefore, sought to reveal the behaviours of pregnant adolescents at an antenatal clinic in Western Australia, using an ethnographic approach. This approach was taken to capture the unique cultural experiences of these adolescents, bringing their voices to the fore. It would enable the researcher to ‘sit in the seats’ of adolescents, and explore the meanings and interpretations that these women assigned to their pregnancy. In particular, this research provided an understanding into the way adolescents gained their knowledge of pregnancy in the antenatal clinic that was predominantly adult-focused but provided services specifically to adolescents on particular days.

This chapter describes the interpretive framework, using ethnographic methods and the defining characteristics of ethnography: the notion of culture; the role of emic and etic views in ethnographic methods; reflexivity; the importance of key informants; and researcher positioning in the field.

### **Interpretive Framework**

Denzin (2001, p.3) asserts interpretive approaches in qualitative research use embedded knowledge and prior experiences as an essential aspect of the researcher’s search for understanding within any given social reality. The researcher, therefore, brings to the investigation “a basic set of beliefs that guides action” (Guba, 1990, p.17) . Hence, the interpretive process is a philosophical framework and research evaluation tool that seeks to understand and inform research rather than to merely provide a description of social reality (Creswell, 2013).

The interpretive framework is suited to exploring social and health phenomena from within small and often marginalised social groups (Creswell, 2013). Individual, everyday experiences combine to bring meaning to the group as a whole and all actions by group members are considered meaningful. Thus, for outsiders to understand and interpret a group’s dynamic, they require an understanding of human behaviours from within its social context (Heidegger, 1927).

To achieve this, as the researcher, I needed to take an empathetic stance, based on shared experiences, in order to generate an understanding of pregnant adolescents

attending the antenatal clinic. Thus, my interpretive lens looked to capture realities, identify cultural frameworks, group actions and the patterns of adolescent behaviours in order to understand why particular events or phenomena occur within their social context (Geertz, 1973, p.20). In this instance, it was the world and experiences of adolescents during their pregnancy that I sought to examine in order to understand and describe the context of their pregnancy-orientated, information-seeking behaviours in the antenatal clinic. I selected ethnographic methods as the most appropriate way of uncovering the social and cultural context of the behaviours and actions of adolescent women attending the antenatal clinic.

Ethnographic methods have been used in previous studies of adolescent behaviours and to understand adolescent culture (Herrman, 2006; Hunter, 2007; Kelly, Pearce, & Mulhall, 2004; Osuchowski-Sanchez, 2011; Simmons, 2006; Stevens, 2006; Woodgate & Leach, 2010). These studies demonstrated the chaos, instability and feelings of “*being judged*” experienced by pregnant and parenting adolescents. Moreover, ethnographic methods have been used by several researchers to explore issues of social acceptance and challenges of parenting experienced by adolescents, the results of which have brought deeper understanding about pregnancy among this particular group (Herrman, 2006; Hunter, 2007; Jewell et al., 2000; O'Sullivan Oliviera & Burke, 2009).

The strength of ethnography lies in the unobtrusive, non-disruptive way in which observation of naturally occurring events involving adolescents attending the antenatal clinic can be undertaken. Applying the interpretive lens thus allows the researcher to see and report, plus interpret, everyday commonplace activities to discover how adolescent women adapt to their pregnancies and if any of their perceptions alter during this time (Creswell, 2013).

### **Ethnographic methods**

As one of the oldest forms of qualitative research, ethnography is a field-based research learning from people and informed by cultural concepts. There are several trademark criteria to be considered when embracing an ethnographic approach: a non-contrived or naturalistic environment; context; rich description of the social setting; multiple data sources; small case numbers; 'emic' and 'etic' perspectives, and ethical considerations. The methodology immerses the researcher within the group and social

environment being studied, so that the researcher is ‘one’ with the people within. This ‘oneness’ is achieved by close, detailed observation using the researcher as the primary tool, record keeping and simultaneous interaction, which produces ‘thick’, in-depth, comprehensive information about the group.

Ethnography originated from historical Anthropological traditions (Malinowski, 1978; Mead, [1928] 1963). Traditional ethnographers positioned themselves to observe and describe tribal cultures over a period of years, learning the language and living as one of the group. The approach of spending such periods immersed in a culture, with the researcher as the instrument for the research, is peculiar to ethnographical approaches. Contemporary ethnographers are often preoccupied with recording cultural behaviours, activities and beliefs in smaller, more familiar settings. Using ethnographic methods is defined as “the art and science of describing a group or culture” (Liamputtong Rice & Ezzy, 2002).

Fetterman (2010) asserted that the researcher is required to spend an extended time, greater than six months, in the field to truly capture the essences of culture and thus undertake ethnography as a research method, rather than merely borrowing from ethnographic styles. He conceded, however, that lengthy, continuous immersion in the historical tradition of years was unnecessary when studying one’s own familiar culture (p.8). Hence, it was assumed that, as a midwife, my familiarity with, and prior immersion in, the culture of midwifery would allow me, as a researcher, to achieve meaningful observation of the group in a reduced time.

Ethnographic methods are a generalised approach to develop an understanding of a culture from the insider’s perspective. Multiple methods may be employed to gather data, including participant observation, interviews and field notes, collecting documents, images and/or artefacts. The lens through which such data is viewed classifies the ethnography as critical, focused, historical or interpretive (Boyle, 1994). In this research, I used participant observation as a means of collecting data during fieldwork. Researchers using participant observation gain access to the field by applying to join the group and observing the members from within, recording and reporting the information to others, having gained consent prior to entering the field. The goal of observations was to provide ‘thick,’ rich descriptions of the behaviours and perspectives of the group for subsequent interpretation (Geertz, 1973; Krediet, Kalkman, Bonten, Gigengack, & Barach, 2011; Spicker, 2011; Toffoli & Rudge, 2006).

The research participants are aware of the researcher's intent and observation, choosing what information they give and which behaviours they display. To a degree, participant observation also allows the researcher to be actively involved with the group members. I was not able to share being 'pregnant' but I was able to spend nine months waiting alongside pregnant adolescents at an antenatal clinic. In this particular situation, the researcher is able to build a conversational rapport or consequential presence with members of the group. This means that the researcher becomes steeped in the environment and, therefore, is able to question activities and verify behaviours and understanding.

### **Ethnographic Methods in Nursing Fields**

Contemporary ethnographic methods have seen a shift from the historical philosophy of enquiry by repositioning the methods of traditional ethnography (participant observation, interview and collective fieldwork) to also capture the experiences, shared with the researcher, that construct reality for a group; hence, this enables the creation of researcher interpretations from within the world of participants (Creswell, 2013; Geertz, 1973; Savage, 2006). This methodology has been successfully used to examine modern, smaller, suburban communities, including those found in health care institutions where the researcher is immersed alongside participants sharing their environment (Finkler, Hunter, & Iedema, 2008). Morse and Field (1996, p. 21) describe nursing ethnographies, one of the oldest forms of qualitative research, as "A means of gaining access to the health beliefs and practices of a culture and allows the observer to view the phenomena in the context in which it occurs, thus facilitating our understanding of health and illness behaviour". Hence, ethnographic methods are particularly suited to nursing research where patient cultures are shared and subsequently learned patterns of health values, behaviours and beliefs are studied and interpreted (Arber, 2007; Barton, 2008; Baumbusch, 2011; Cashin, Newman, Eason, Thorpe, & O'Discoll, 2010; Kelly et al., 2004).

Understanding the needs and health beliefs of individuals from a cultural perspective narrows gaps in knowledge and helps health care providers develop ways to meet those needs (Engebretson, 2011; Harrowing & Mill, 2010; Morse & Field, 1996a; Williamson & Harrison, 2010). In this case, the group studied comprised adolescents who attended an antenatal clinic. A deep 'insider' understanding of the pregnancy



culture of the antenatal clinic, as constructed by these adolescents, was obtained by a nine-month period observing, recording and being with pregnant adolescents, sharing aspects of their experiences while waiting at the antenatal clinic.

## **Culture**

The essence of ethnographic methods is their focus on people and their cultures. A singular definition of culture that captures the broad nature of the concept is difficult, as personal assumptions and realities offer differing perspectives. As Savage (2006) explains, ethnographic approaches are informed and differentiated by ethnographers' epistemological (way of knowing, understanding and explaining what exists) and ontological (the nature of existence and of being) perspectives. Nevertheless, Fetterman (2010, p.27) ascertains that, "however defined, the concept of culture helps the ethnographer search for a logical, cohesive pattern in the myriad, often ritualistic behaviours and ideas that characterise a group".

Culture is the common patterns of routine or daily behaviours, group knowledge and beliefs, shared by members of a social group (Fetterman, 2010). It incorporates the defensible core values and social frameworks that define a group or community members from outsiders. O'Sullivan Oliviera and Burke (2009) describe culture as possessing a schema, expressed through boundaries provided by family, religion, art, music and drama and communication methods, dress and health behaviour which create and perpetuate this notion of one's culture over another. Thus, when discussing the culture of pregnancy, one must delve into the meaning of shared understanding, concepts and patterns of behaviour, which give the group a common identity.

Boundaries that naturally evolve within communities may be visualised as *circles upon circles* (Ely, 1991; Morse, 2000). The fluid nature of overlapping boundaries illustrates how community members can participate in multiple subgroups and how knowledge of life events are constructed and shared. Hence, pregnant adult women, as a group, may display shared attitudes and understandings of pregnancy, whilst young or adolescent women share the experience of pregnancy but may also be said to belong to a subgroup based on age. Adolescents may have differing affiliations that are identifiable by associations with style of dress or colloquial language (Saal, 2011).

Ethnographic methods of research create and communicate a cultural portraiture (Fetterman, 2010). In particular, Fetterman maintained that ethnographic methods, as a subtle art, are about illustrating the central importance of the routines and predictable daily lives of those within the groups studied. Exposing the routines of daily life, and discovering the sense and understanding that comes from being in the shoes of the subjects, requires time and scientific persistence (Geertz, 1973). Developing an insider perspective in this way creates a close, empathetic stance for the researcher and is often described as an *emic* and/or *etic* stance.

### **Emic and Etic Views**

Reality is a product of multiple perceptions, including those of the researcher, and is produced by exchanges between the researcher (etic) and group participants (emic) (Fetterman 2010 p.12). As the researcher, I spent a significant amount of time immersed with the group, building a position from which to observe the antenatal clinic waiting room. This achieved a comfortable acceptance of the researcher's presence, having built familiarity and trust with participants. This enabled me, as researcher, to experience the insider emic view, having become as close as possible to sharing the feelings and perspectives of the group members.

The emic perspective lends itself well to the exploration of how this group of adolescents construct pregnancy as it exposes their opinions, belief structure and experiences of pregnancy and participation within the antenatal clinic. In contrast, the etic or outsider perspective supports the knowledge illuminated by the emic perspective through the provision of an objective balance. This means that the researcher is able to step away, re-constitute and re-appraise the purpose of the research, and actually "see the wood for the trees"! Thus, both views are important in enabling us to understand why participants act as they do, considering the emic perspective in the light of the etic view which thus allows the immersed researcher to understand the culture of the group as a whole. It is the relationship between emic and etic observations and conversations that results in the reflexive nature of ethnographic methods (Corbin & Strauss, 2008).

### **Reflexivity**

Ethnographic insights arise because researchers make choices about what they want to research and the interpretation of what they observe and/or hear while immersed within a group. The reflexive nature of ethnography requires researchers to think about

the construction of the culture they study and that, importantly, what is subsequently written acknowledges that the researcher is part of the research. Reporting the “honesty” of ethnographic methods is open to the interpretation of the researcher and how the researcher chooses to represent the voices of the participants (DeWalt & DeWalt, 2011).

Prolonged immersion within the group facilitated being able to become close to the participants studied (Fetterman, 2010). However, ethnographers cannot study people independently of their environments. Therefore, being immersed in this research required that, as the researcher, I did more than just ‘hang out’ with the group. By observing interactions and behaviours of all users of the antenatal waiting area, and listening to the voices of adolescents away from the environment, the likelihood of discovering cultural characteristics was increased. Despite not being pregnant myself, regularly sharing the waiting at antenatal clinic with the adolescents enabled me to become as close as possible to them.

My awareness of the impact of my presence as researcher on the group was essential in negotiating the field and maintaining a continual and honest collaboration with participants. This reflexivity helped me to recognise, report and make transparent within the research my potential effect on the field (Burns, Fenwick, Schmied, & Sheehan, 2012; Marshall, Fraser, & Baker, 2010; Vandenberg & Hall, 2011). Maintaining the clarity of my position in the field was facilitated by keeping separate recordings of my personal thoughts, impressions and feelings in response to the group during immersion. This reflexive positioning was informed by my history and experience of working with adolescents in my professional role of midwife and was considered a strength of the research. Having shared the experiences of adolescents in this way previously enabled me to identify likely key members of the group with whom I could build a deeper rapport.

### **Key Informants**

The lengthy immersion, and close rapport with the group of pregnant adolescents, created a position for me as researcher that enabled the identification of key informants. Key informants are those participants who were aware of the researcher’s interest and willing to offer information. Participants are “key” in two ways. One, they are, as Spradley (1980) describes, “encultured”, meaning that they are consciously aware of their environment and happy to share their local knowledge with the “stranger”

researcher. These informants are easier to build a rapport with and a revisiting researcher can “touch base” and discover “up-to-date” cultural knowledge.

The other key informants are those with whom the researcher only gets to talk to once and has to ask as much as possible in that time frame. These key informants can provide pivotal information. The risk to using the latter of these key informants is that the researcher may not know what questions to ask. This research looked for both types of key informant, cultivating ongoing rapport with key informants at the antenatal clinic and pacing the in-depth interviews throughout the course of participant observation to allow new information to be captured and included in the interviews.

Throughout the research, the researcher took an inductive “bottom-up” approach, seeking to process information by acting as a student with little prior knowledge of what took place at the antenatal clinic. Thus, through casual conversations, ‘participant explanations’ and observations from the antenatal clinic waiting area, informants provided the researcher with the rich, detailed information of their experiences. This basic information, gathered from speech, behaviour and other actions, revealed the hidden cultural patterns of the group. Spradley (1979) described this process as the researcher being *taught* by the researched.

### **Researcher Positioning**

Honest disclosure of the researcher’s position and purpose in the field, while strengthening the validity of this research, may also be described as creating shades of grey as limited or partial explanation may occur. On the other hand, giving a limited description of researcher positioning within the field may be appropriate, depending upon the individual participant or audience at any given time (Murphy & Dingwall, 2010). Therefore, I used researcher positioning and limited disclosure strategically to negotiate the field and maintain access to participants (Burns et al., 2012; Rudge, 1996).

In addition to being the researcher, I am also a midwife and have worked with pregnant adolescents for many years. This experience has provided a lens through which the pregnancy of adolescents could be viewed, and positioned the research in relation to the context of the study. As a midwife, I had first-hand knowledge of an antenatal clinic hierarchy, including being familiar with routines, clinical layout and antenatal care practices. My experienced view, which informed my researcher interpretation of the environmental context, also guarded against any potential breaches

of clinical protocol. My familiarity in working with this age group of pregnant women provided me with a sound insight into the daily issues that many adolescents might face.

First-hand, insider experience assisted my positioning within the group of adolescents that I observed and helped me identify potential key informants, which might have taken an outsider a longer time to achieve. A midwifery perspective also assisted me in 'reading' the participants more accurately in terms of their developing pregnancy, for example, allowing the data collection to be paced according to their gestational stage. An appreciation of the medical context, in conjunction with knowing how to behave in the field, helped me elicit responses and read behaviours, which may not have been apparent to a researcher unfamiliar with this group of participants, topic and site.

Despite the advantage of experience, a degree of naivety was desirable, as the insider perspective can bring a researcher too close, effectively blinding the observer towards unfolding events. Familiarity might neutralise what would otherwise be a new experience. Hence, I deliberately positioned myself as the researcher in an unfamiliar hospital environment, in order to create a new awareness of the antenatal clinic. Consequently, I was able to view the unfamiliar buildings, room layout and staff at all levels with fresh eyes.

## **Chapter Summary**

Rigorous ethnographic methods keep the focus of culture and the voices of the group uppermost. The ethnographer is a reflexive reporter possessing an open mind, who has a role to play in understanding the rhythm and rhetoric of how other people behave and think (Fetterman 2010, p.11). The ethnographic approach was chosen as the framework to learn from participants what was meaningful in their lives. This research combined participant observation with unobtrusive informal interviews; casual conversations on the surface but with a purpose.

In using this approach to gather information and develop themes, the researcher recognised multiple perspectives on reality and the fluid nature of culture, hence capturing the everyday behaviours and lived experiences from within the setting of the antenatal clinic waiting room (Allan, 2006; Barton, 2008; Van Maanen, 2006). Constructing a detailed portrait represented many voices and descriptions of events and behaviours that consolidated the inside views of adolescents' experiences.

As the immersed researcher recording the inside view and lived reality of a group of pregnant adolescents attending antenatal clinic, I was able to absorb the details and perspectives relevant to them. This bottom-up approach to gather rich detail is fundamental to ethnographic methodology. Simple observations of adolescents attending the clinic are thus reinforced by the participation of the researcher. The approach further acknowledged that my perspectives as the researcher potentially influenced the overall portrait. Stepping back out from immersion to view more clearly my position as researcher, and the emerging patterns or themes, formed an essential part of the systematic processes of this ethnographic-based research. Ethnographic methods use physical processes of collaborative research and the processes also become the reported result, that is, a written ethnography (Allan, 2006; Creswell, 2013; Liamputtong Rice & Ezzy, 2002).

This chapter has given an overview of ethnographic methods as the interpretive framework that guided this research. With its focus on human understanding, ethnography is enhanced by an essential view of cultural context shared by the researcher. In the ethnographic approach, it can be seen that using unobtrusive participant observation and the lengthy immersion of the researcher in the field enables the development of a thick description that exposed the ‘lived’ experience of participants. The likelihood of honest and transparent information is then increased. This research illuminated how adolescents made sense of their pregnancies and antenatal care from their cultural perspective. The following chapter explains the procedural processes related to ethnographic methods. Access to the field and the methods employed are described. The chapter is organised around the setting, the sample criteria, gaining access to the antenatal clinic, ethics and data handling.

## **Chapter Four**

### **Method**

#### **Introduction**

When embracing the ethnographic approach as the researcher, I kept uppermost in my mind: the natural environment, context, multiple data sources, maintaining emic and etic perspectives, and ethical considerations. This approach effectively positioned me to share the experiences of pregnant adolescents, listen to their stories and observe their behaviours. The behaviours of individuals within the group combined to display their knowledge and understanding based on cultural similarities and differences. Understanding this cultural perspective increases the opportunity for midwives to appreciate how the experiences, culture and values may influence adolescents to make sense of their pregnancies and reach out to those around them. This chapter details the research design, ethnographic methods and ethical considerations of this research.

#### **Setting Selection**

Public antenatal clinics in Australia provide antenatal health screening, pregnancy advice and maternity care for women. The researcher approached two public hospital sites where antenatal clinics were conducted. However, one site did not incorporate shared appointment times, known as ‘cluster’ appointments for pregnant women, nor offer midwifery participation in either antenatal clinics or antenatal education. Therefore, this clinic was excluded from this research; as were private antenatal clinics because they were mainly obstetrician-led and offered random appointments for pregnant adolescents. Cluster appointments meant that a group of adolescents were in the antenatal clinic waiting room at the same time for a period, allowing behavioural patterns to emerge because of interaction.

The antenatal clinic for adolescents was held on a Friday between 9am to 5pm at a public hospital in Perth, Western Australia (WA). The clinic was selected because it managed pregnant adolescents as a sub-group, allowing them to be observed in the natural setting of an antenatal clinic. This antenatal clinic drew from a mixed lower socio-economic community, which included migrant groups originating from African countries and Europe, in addition to Aboriginal and/or Torres Strait Islander families.

The antenatal clinic provided a specific focal point, recognised in the public, medical and midwifery community, for pregnant women to come together and seek information. Immersion in this environment allowed the researcher to observe closely and spend time with adolescents over the course of their pregnancies.

### **Participants**

Participants included pregnant women unknown to the researcher who attended the antenatal clinic during the nine months of participant observation and focused on key participants who were pregnant adolescents. The antenatal clinic catered for adolescents and young women less than 24 years of age. Other clinics held on that day catered for women of all ages. All participants were English speaking and, in the second phase of the research, key participants, aged 15 years to 20 years, were purposefully identified on reaching their third trimester (28-40 weeks' gestation) to allow prior opportunity for antenatal experiences and deemed to be competent to participate by the midwives running the antenatal clinic. These key informants were also accessible to the researcher for in-depth interview away from the antenatal clinic.

### **Gaining Access**

Permission to undertake this research was granted by the Human Research Ethics Committee of Edith Cowan University and the Higher Research Ethics Committee of the South Metropolitan Health Service where the antenatal clinic was situated. Permission was also granted from the West Australian Aboriginal Health Information and Ethics Committee (WAAHIEC) and was guided by the Australian National Health and Medical Research Council (NHMRC).

Prior to entering the field, clinic managers and the midwives working in the antenatal clinic attended information meetings held by the researcher. The midwives were made aware of the aims of the research, the potential impact on clinic attendees and the focus of the researcher. Midwives were also provided with opportunities to ask questions prior to commencement of the research. Questions raised included privacy of clinical practice and if this research would impact service delivery. This allayed any concerns held by staff at the potential impact that the presence of the researcher in the clinic might have. Furthermore, notices that informed attendees of the research in progress and observational boundaries were displayed in the clinic areas (Appendix A).



## **Ethical Considerations**

This research drew its ethical foundations from the concepts of beneficence, self-determination and justice (National Health and Medical Research Council, 2007). The research plan and researcher conduct was framed within the goals of transparency, confidentiality, and with the voices of participants uppermost.

Reporting the words of others, however objective, may incur risk. This risk may see vulnerable participants, adolescents and Aboriginal and/or Torres Strait Islander participants, possibly compromised by the public exposure the research may bring. This also holds for a public antenatal clinic that engages in care for adolescent mothers and exposes their experiences to scrutiny.

Conducting research in collaboration with unaccompanied minors required constant ethical vigilance to protect their rights in the process (Hemmings, 2009; Holder, 2008; National Health and Medical Research Council, 2007). This was significant as familiarity may develop in ethnographic research and participants may forget the researcher's investigative role over an extended period of time. I remained vigilant throughout immersion in the field to protect the vulnerable status of the participants and acted in a manner that maintained the credibility of the research. Hence, women in the antenatal clinic waiting room were reminded of the researcher's role at each new occasion of conversational interview.

The identification of potential risks to participants is a responsibility maintained during this research. The autonomy of participants and concern to prevent harm to them was uppermost, including informed consent (both immediate and ongoing) and the use of simple language to enhance the readability of the information and consent documents. Confidentiality was emphasised by limiting my observation to public areas at the antenatal clinic and during the process of recruitment and consent to participate in the research (Carnevale, Macdonald, Bluebond-Langner, & McKeever, 2008; Watts, 2010; Wilson & Neville, 2009). Additionally, no action or activity diminished the participant's value in the research.

The Fraser Guidelines and the Gillick Competency assisted in establishing the legal competence of adolescent participants (Freeman, 2005; Thornton, 2010; Wheeler, 2006). To establish competency and 'mature minor' status, the researcher liaised with midwives at the site to identify potential participants whom they considered competent or emancipated minors capable of understanding what the research was about, what

their involvement entailed and that they were capable of making up their own mind in order to legally consent to participate (Hunter, 2007; National Health and Medical Research Council, 2007).

### **Adolescent Competence**

To address the issue of adolescent competence, previous research undertaken was followed where assessment of adolescent competency was based on levels of cognitive capacity, level of displayed reasonable judgement and the taking of personal responsibility for actions. Gauging sophistication-maturity, including cognitive capacities, was indicated by the extent to which the adolescent engaged in such actions as: plans (for their pregnancy and parenthood), self-reflection (their ability to give thought to the consequences of their pregnancy in a larger frame), foresight, and their general decision-making skills (Salekin & Grimes, 2008; Sterling & Walco, 2003).

Bunting and McAuley (2004) described adolescents attending for antenatal care, both with and without parental knowledge and permission. Although parental support and involvement is the ideal, in some circumstances it would be ethically unsound to attempt parental consent as this may even constitute a breach of patient confidentiality (Hemmings, 2009). While not all the adolescents were estranged from parental guardianship, the issue of confidentiality remained relevant. Therefore, many adolescents attending the study hospital were provided with antenatal services, parenting advice and sexual health advice at their instigation. This demonstrated mature minor status. For the purposes of this research, however, the clinical staff acting as informal gatekeepers alerted the researcher where any adolescents whose competence or cognitive ability to understand the implications of personal risk in this research may have been compromised (Toffoli & Rudge, 2006). These adolescents were subsequently excluded from participating in the research.

### **Power Imbalances**

Steps were included to reduce the risk for potential power imbalances between researcher and participants as familiarity with the researcher's presence at the antenatal clinic grew over time and became part of the normal vista of the clinic. The researcher was mindful that younger women, when talking to an older adult regularly positioned *officially* at the antenatal clinic, may have felt an obligation to talk to the adult and hence may not speak freely (Wilson & Neville, 2009).

The researcher recognised that perceived obligation may be difficult to counter. Therefore, the researcher maintained a relaxed approach of simply waiting in the antenatal clinic, by wearing casual clothing, not carrying obvious note-taking paraphernalia and not acting as a midwife by demonstrating any familiarity or prior knowledge of antenatal clinic routines. The gradual build-up of a conversational rapport from week to week reassured younger participants. Verbal explanations of the researcher's presence in the antenatal clinic were kept simple. The researcher was mindful that too complicated an explanation may have inadvertently *scared off* vulnerable adolescents.

### **Data Collection**

Data collection and analysis took place iteratively, following the guidance of Spradley's developmental research sequence (DRS) (1980) and referring to the companion text for ethnographic interviews (Spradley, 1979). I chose to use Spradley's approach as it offered clear, systematic guidance for the collation and organisation of the bi-phasic data collection. First, an observation and participant observation phase was undertaken, incorporating informal conversations with participants in the antenatal clinic setting. Second, interviews with key informants, identified and made known to the researcher by midwives, were undertaken. The concurrent interview phase of the research involved eight key informants who were interviewed, following a verbal explanation and written consent, participating in a digitally recorded interview at a venue and time of their choosing. The interviews were semi-structured in format, followed an interview guide, and were of approximately one hour in duration.

### **Observation Techniques**

Spradley (1980) describes participant observation as the hallmark of ethnographic methods; it differs from mere observation by specific interactive processes with participants for an extended period (Carnevale et al., 2008; DeWalt & DeWalt, 2011). Used in ethnographic methods, it is more active as a technique than observation alone, involving researcher listening, communication and actions, but remains discreet and natural (Forsey, 2010). In fact, it would be very unnatural behaviour if the researcher were not to converse while mingling with a group. Malinowski (1978) described himself as eventually being of no interest to the people he studied, so accustomed were they to his presence in the field. It is by not disturbing the naturalistic

setting or routines of the antenatal clinic waiting area that both the mundane and peculiar behaviours of the adolescents were recorded, enabling the researcher to empathetically learn from the group members and the experience.

The observational phase in the field was carried out over nine months. This entailed the weekly attendance of the researcher in the waiting room of the antenatal clinic held for adolescents. Using unobtrusive observation and participant observation, using Spradley's DRS, I systematically examined and recorded participants' normal behaviours, actions, interactions and communication methods, without letting my presence alter the behaviours or the natural setting of the antenatal clinic waiting area (Krediet et al., 2011). More than 220 hours of observation was recorded in several chronological notebooks. The extended period of observation provided a continuous, ongoing, baseline of information, or *big picture*.

### **Entering the Field**

Formal and informal gatekeepers were utilised to protect participants. Formal gatekeeping took the form of ethical management approving entry and informal approval was gained by the subtle development of the relationships and rapport between myself and those people (midwives, receptionists) working in the antenatal clinic environment while I was present. This relationship allowed the research to take place unimpeded. When entering the field, I did not disturb the established relationships and interactions of persons in the environment. The adolescents' antenatal clinic was an appointment-based system which was held weekly during office hours (except for public holidays). Other antenatal clinics were held in the same offices on the remaining weekdays. Appointments for all pregnant women occurred at reducing intervals, to meet their gestational requirements.

My initial observations of the waiting and reception area of the antenatal clinic identified the most suitable times to gain optimal exposure to pregnant adolescents attending (Wilson & Neville, 2009). Signage was displayed in the waiting area of the clinic to inform attendees of the presence of a researcher. Waiting areas not included in the research were also indicated in the signage; this allowed those attendees not wishing to participate in the research alternative areas to wait. Over time, observation and analysis of repeated actions, behaviours and relationships exposed cultural patterns, as

Spradley (1980) indicates. Deviations from regular behaviours were also identified and considered.

Periodically, during participant observation, time away from the antenatal clinic was allocated for reflection, debriefing with research supervisors and contemplation of the emerging themes, future approaches and research perspective. This facilitated my etic view of the field; it created the opportunity for refocusing of the research and prevented me from becoming so relaxed in the field as to miss the detection of new patterns.

### **Participant Observation**

In participant observation, the researcher gathers information by observing and interviewing the culture-sharing group. The group of pregnant adolescents was joined by the researcher as they waited at the antenatal clinic and, thus, I shared their experiences in this naturalistic setting. Spradley's (1980) systematic method to record information enabled the exposure of explicit and tacit cultural meanings.

### **Descriptive Observations**

When I first entered the field, the initial descriptive observations were those Spradley (1980) described as the sweeping grand, and the more curious mini-tour, observations. These initial observations gave me an impression of the general workings of the antenatal clinic and the people encountered there.

### **Immersion**

To immerse myself in the waiting room of the antenatal clinic, I continually worked at building an ongoing rapport with the pregnant adolescents. Many pregnant women attended the clinic and keeping track of adolescents during participant observation was challenging. While I was talking with a waiting young woman, several others would come and go in the waiting room, escaping my focus. My attention absolutely remained with the adolescent woman I was with, building the rapport that was so important for them to talk in a relaxed manner from week to week. I talked to many adolescents at different gestations about aspects of their pregnancy and their attendance, gradually filling the gaps in the information I gathered.

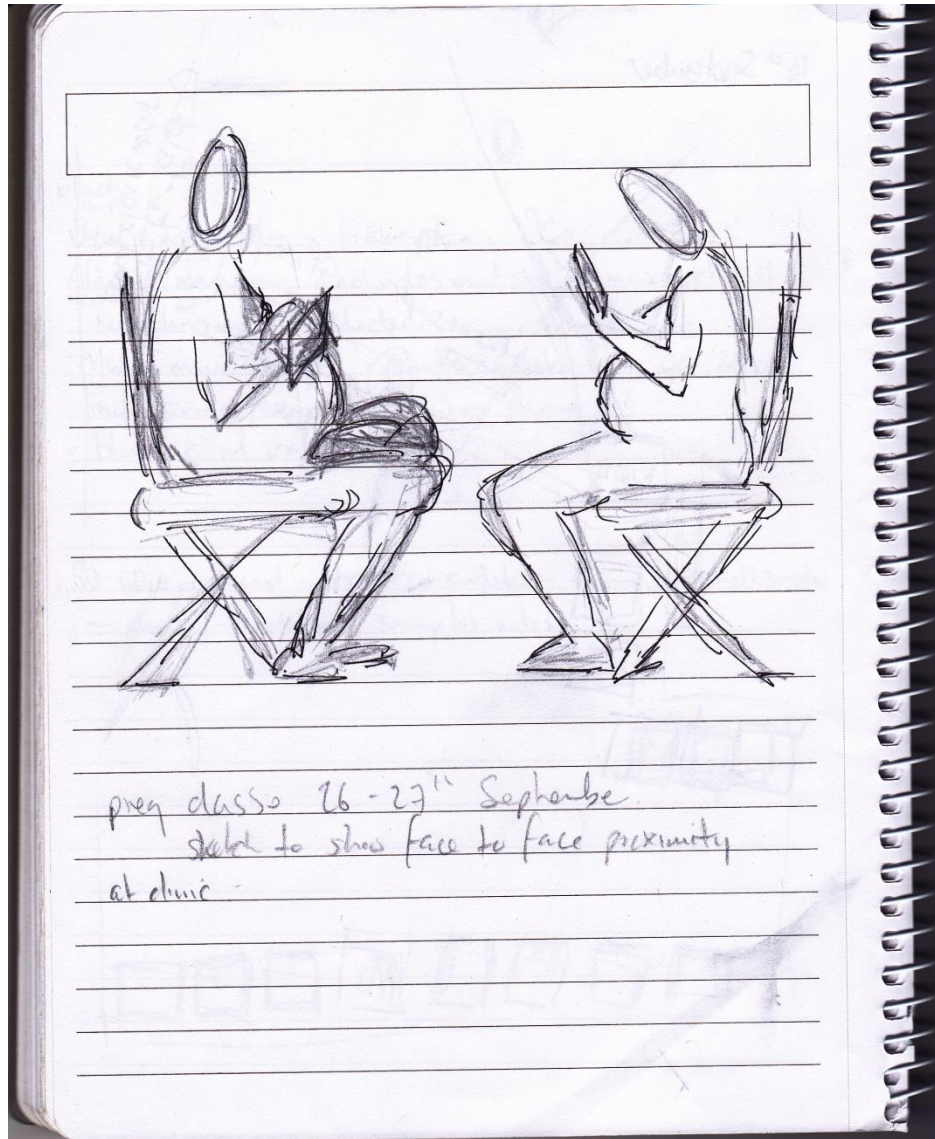
I began by listening to them tell me about the current antenatal visit and, if they had previous appointments, to recall their experiences. Regular conversation with them

enabled the investigation of their first thoughts and impressions and to build an understanding of what was common between experiences. I was not always able to tell which adolescents were on their first visit, though, on identifying those who potentially had more visits to recollect, I could use humorous icebreaker questions that referred to their growing abdomen as an obvious sign of their pregnancy ‘experience’ and my researcher inexperience.

Establishing this rapport made most adolescents smile and they were happy to tell their story so far. If I discovered the age of the women, I isolated the responses of the very young adolescents to compare experiences between younger and older adolescents. However, not all disclosed their age in the waiting room so comparisons were made by using the general observed characteristics expected between younger and older adolescent women, such as style of dress and sometimes, though not always, by the people accompanying them. Many of the adolescents came to the clinic accompanied by their mothers, grandmothers, partners and friends.

Spradley’s (1980) dimensions of social situations directed observations in the antenatal clinic to achieve coverage: space, people present, activities, objects, acts, events, time, goals and feelings. This systematic approach allowed me to consider how each of the interactions I observed was interrelated and provided for descriptive thoroughness. The waiting room was so small and, when full, the adolescents waiting were so close to each other that conversations were not private (Figure 1). On occasion, two or more pregnant adolescents were involved in conversation with me; this allowed for comments being considered and verified against each other. Additionally, if one adolescent woman was called into her appointment, then the conversation did not have to cease.

Waiting alongside the pregnant adolescents and being empathetic as they recounted their understanding of experiences provided a wealth of information and the basis of identifying key themes.



*Figure 1. An original sketch to show the proximity of adolescents to one another while waiting in the antenatal clinic.*

### **Data Analysis**

Data analysis and data collection occurred iteratively as an active process throughout this research. Wolcott (1994) describes this as a series of inductive processes, building a clear picture from researcher observations of patterns and regularities in the data. Similarly, Spradley (1980, p. 85) defines ethnographic analysis as “a search for the parts of a culture, the relationships among the parts, and their relationships to the whole”.

Being guided by Spradley’s (1980) developmental research sequence (DRS) as a practical approach to participant observation and concurrent data analysis involved my careful recording of descriptive information chronologically, additionally focusing on

key events to uncover any differing perspectives of participants. Recording events and conducting analysis as they occurred enabled the analysis to be an equal part of the records. Spradley described this development and sorting process of notes and analysis as sequential cyclic steps to guide participant observation towards exposing patterns and regularities and, hence, cultural relationships.

Prior to moving forward, it was necessary to begin analysis of the amassing of descriptive information. Initial domain analysis (Spradley 1980, p.89) of the antenatal clinic, to uncover the structure of the organisation, was the first ethnographic step into the search for patterns in behaviour and organisation that existed in the data collected from the antenatal clinic. This process moved the research from describing the social scene of the antenatal clinic to discovering the cultural domain.

The cultural domain is described as consisting of categories of cultural meanings that contain other smaller categories (Spradley, 1980, p.93). These were identified by semantic relationships and cover terms as names were assigned to each category, as were named links identifying relationships between categories. Semantic relationships within the domain analysis were identified by collections or grouping, for example: types of emotions displayed; kinds of clothing worn by pregnant adolescents; items brought to the antenatal clinic linked to ways in which they were used; also conversations were categorised to identify topics raised; and the variety of people who used the antenatal clinic was noted. Categories and groups were then explored further. An example of this is *feeling judged (kinds of feeling) is a (reason) to get mad (emotions displayed and actions explored)*. A key informant illustrated this during an interview, recalling an incident that made her angry during her pregnancy:

When we went to the clinic the midwife gave us the pamphlet on contraception and said ‘read this as I don’t want to see you back here’... That’s what makes us feel kinda judged and very unwanted... Like you shouldn’t be here but we will tolerate you till you go... I, like, even said that to her... I said to the midwife, to the midwife (repeated) I said that I didn’t feel very welcome... she said, you know, I guess that’s something she would work on... I said, yeah, you’re grumpy but, (sic) you should!

(Key informant 3: Dawn, 27 November 2012)



Spradley (1980) recommended that the researcher then use focused observations to discover the categories that created the cultural scene and reflected the aims of the research. This then allowed the discovery of cultural meaning from the organisation of cultural domains. Spradley terms this organisation a taxonomy. Similar to the construction of a cultural domain, the creation of a taxonomy reveals subsets in the cultural relationships within the antenatal clinic waiting area and the ways these were related to the whole.

A taxonomic analysis searches for larger, more inclusive domains under new group titles created from participant words or analytical headings derived from interpretation. In this research, a combination of both headings was used. From the taxonomic analysis, additional focus questions to take back to the field were determined and used to verify the taxonomy: “Did other participants experience or voice judgement?”; “Who did not experience judgement?”; “What variety of circumstances led to angry responses?”; “Who accompanies pregnant adolescents?” A complete taxonomy only approximates the cultural knowledge revealed by participants and further selective observations were utilised, both in the informal interviews of participants attending the clinic and the in-depth interviews of participants.

Spradley (1980 p.128) describes the three kinds of observation as a “funnel”: broad, descriptive observations narrowing to more focused observations which, in turn, manifest at the narrowest point into selective ethnographic observations. Selective observations search for the differences between specific cultural categories. Spradley identified three ways to search for differences: making focused observations or talking to participants about specific differences that were noted; developing contrast questions that are used as selective, focused observations and, where two or more contrasts are discovered in a domain, verifying that they apply to remaining parts of the domain.

The goal of selected observations to reveal the differences between cultural domains required careful planning and some contrast questions were organised in advance. Hence, the periodic stepping away to contemplate what had been observed: the etic perspective, and the use of a checklist guide for in-depth interviews. When answers to selected research questions were made evident by observations, this led to the next phase of componential analysis.

Componential analysis, as Spradley (1980, p.103) terms it, was the systematic search for the attributes (components of culture not always visible to someone from another culture) that were collected from the words and phrases used by participants and associated with cultural categories. This enabled the detailed investigation of central domains pertinent to adolescent attendees, while maintaining a general description of the cultural scene occurring at the antenatal clinic. Performing componential analysis enabled me to identify cultural themes in three ways: the examination of contrasts found within domains, developing my tacit knowledge from repeated sayings or observations and, finally, revealing the connections between domains. Table 2 below demonstrates the DRS sequence of steps taken during this research.

**Table 2.**  
Developmental Research Sequence and Research Phases

<b>Developmental Research Sequence</b>	<b>Phase of Research</b>
1. Selecting a social situation	Preparing for research: identification of gatekeepers
2. Doing participant observation	Data collection at the antenatal clinic
3. Making an ethnographic record	Data collection at the antenatal clinic
4. Making descriptive observations	Data analysis
5. Making a domain analysis	Data analysis
6. Making focused observations	Data collection at the antenatal clinic
7. Making a taxonomic analysis	Data analysis
8. Making selective observations	Data collection at the antenatal clinic
9. Making a componential analysis	Data analysis
10. Making a theme analysis	Data analysis
11. Taking a cultural inventory	Writing the report
12. Writing the ethnography	Writing the report
<i>Source: Adapted from Spradley (1980, p. 103).</i>	

## Fieldnotes

Fieldnotes were used to maintain the ethnographic record. Three principles guided my note taking: concrete, descriptive language, using the terminology of informants and verbatim quotes. Handwritten notes were recorded chronologically in a series of notebooks. Observations and fieldnotes were gathered from the morning, afternoon and full day observations to give as broad a picture as possible of the culture of the antenatal clinic waiting area for pregnant adolescents. The fieldnotes represent a systematic recording of important points and routines, which, much as Morse & Field (1996b) and Fetterman (2010) describe, I often snatched at moments in an empty

waiting area or at coffee or phone breaks. At the end of the observation period, I had a 30-minute travel from the site. Therefore, initial aide memoire notes were made before leaving the site. These jotted notes represented the lived experiences of people present at the antenatal clinic that day, which were rewritten in greater depth and detail on returning to base.

## **Memos**

My potential researcher effect in the antenatal clinic waiting area was not ignored. To supplement systematic recording of events and observations, a separate perspective on the data was provided by a subjective record of researcher reflections or memos distinct from the observational notes. The memos contained my personal beliefs, impressions and some emotional responses to events and interactions. This is relevant as aspects of context and personal meaning within events could be explored. Acknowledging my own feelings from events, while capturing expressions from participants, enriched the depth and quality of data. Phase Two expanded the information gained in Phase One, with eight in-depth, semi-structured interviews with key informants (Sandelowski, 1995).

## **Development of the Interview Guide**

Spradley's (1979, 1980) systematic approach to discovering common meanings also gave structure to the interview guide. Following componential analysis of the field in Phase One, initial key themes were identified and added focus to the Phase Two interviews. The research questions also guided the interviews that were semi-structured to allow the key informants the opportunity to express new ideas and themes (Appendix B).

## **Semi-structured Interviewing**

Semi-structured interviewing, as Morse (1996, p.76) described, is best employed when the researcher "knows what questions to ask but cannot predict the answers". Questions in the form of open-ended prompts encouraged key informants to relate stories freely, explaining their beliefs and personal experiences, without the restraint of rigid questioning. This enabled them to reveal their individual understanding of pregnancy, antenatal health and antenatal care, explaining in their own words their plans and preparation for parenthood.

Creating a prior plan of research categories to explore occurred at commencement of key informant interviews: this was refined throughout the series of interviews by the collection of further data. Information was enhanced at the conclusion of interview by asking key informants, “Is there anything else you would like to tell me?” Interviews were spaced apart, scheduled for approximately 60 minutes, and were digitally recorded and transcribed verbatim.

Data analysis commenced as I concluded each interview. The recorded interviews were listened to repeatedly and verbatim transcription by myself maintained connection to the context. Following the detailed writing up of observations, I revisited notes, self-memos and the interview transcriptions numerous times to gain a full appreciation of the participant stories in context. Each review of the recorded notes retained the context of the data and facilitated understanding. Information gained from similar questions in the semi-structured interviews was analysed for categories. The application of cover terms, phrases and, as Spradley (1980) describes “folk terms” to the data, focused organisation, uncovered meanings from within and assisted the formation of researcher interpretations, building the cultural picture of what it means to be an adolescent at antenatal clinic.

### **Cultural Description**

A large amount of data was gathered using Spradley’s (1980) DRS, which rapidly needed to be analysed and focused to avoid becoming cumbersome to handle. Using the applied cover terms, phrases and folk terms, were the first steps in analysis to refine and reduce the meanings in the data collected. Participant observations were continually analysed. Cultural patterns and behaviours identified from the participant observations focused in-depth interviews. The in-depth interviews were analysed individually, compared to each other, then compared to the ongoing participant observations. At final analysis, the material presented from the participant observations was consolidated with the detailed information from in-depth interviews.

To understand the context, the researcher repeatedly read and compared the observations and recorded notes, categorising the persistent words, phrases or patterns. Gaining of familiarity with the context enhanced the analysis process. More cover terms were assigned as deeper meanings and patterns emerged. Meanings were often illustrated using participants’ own words, which kept their voices central to the data.

Sequential analysis revealed the culture of the adolescents at the antenatal clinic from the common values they assigned to their pregnancy and how they spoke about their experiences.

The cyclical approach commonly utilised in reviewing data to reveal patterns and themes in qualitative research is also described as a constant, parsimonious distillation of codes and categories, searching for meanings (Corbin & Strauss, 2008; Morse & Field, 1996, p.108). The rich information, stories and repeated explanations gathered from participants at the antenatal clinic permitted contextual interpretation and cultural description. Using systematic methods to store and organise the collected notes, transcripts and memos, facilitated the process of searching the data.

In addition to the compilation of information in systematic matrices (Spradley, 1980; Miles & Huberman, 1994), basic demographic information was entered into a spreadsheet. The data reviewed remained in hard-copy format for comparative reading, cover-term application and concept development. Use was later made of the computer software program NVivo (QSR, 2012) which assisted with the handling of observational data, data from in-depth transcripts and reflective notes for searching and comparing data. In this way, NVivo contributed to the discovery of patterns and connections in the data.

### **Saturation**

Data collection continued until thematic saturation was achieved (Oliffe, 2005). Saturation of data meant that no further new concepts were discovered, and existing information was reinforced and consolidated. The number of in-depth interviews (eight) was sufficient to obtain data that was easily comparable but judged as providing depth and quality to the information gained (Creswell, 2013; Hammersley & Atkinson, 2007; Morse, 2000).

### **Trustworthiness**

Subjective interpretation of participant voices by the researcher is acknowledged, as text is always said to include multiple meanings (Lincoln & Guba, 1985). Trustworthiness in this research relied upon approaches to establish credibility, transferability, dependability and confirmability (Coren et al., 2003; Patton, 1990; Shenton, 2004).

## **Credibility**

The focus of this research was to illustrate the cultural understanding and beliefs of the participants. Ethnographic methods are recognised as a reliable methodology for exposing cultural knowledge (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2010; Creswell, 2013; Fetterman, 2010). Obtaining cultural knowledge requires participants' voices remain central to the research. This research gathered prolonged participant observations for a period of nine months in order for the researcher to share the depth of pregnancy experiences by participants. The reflexive positioning of the researcher provided contextual support to the participant observation in the form of self-memos, gathering of explanatory artefact and sketches of the environment. Recording of the observational data took place chronologically in an efficient and systematic manner.

Midwife gatekeepers identified and introduced suitable pregnant adolescents as key informants to the researcher. Recording in-depth key informant voices took place using spaced, semi-structured interviews away from the antenatal clinic area which offered variation in perspective and period during the research. The iterative approach to participant observation and in-depth interview also included relevant participant validation and feedback, which contributed towards credibility within the research.

Cover terms were verified by the review of transcribed interviews for similarities in interpretation. To support credibility with single researcher perspective, a group of post-graduate research students and an expert member of university staff applied terms to a clean, transcribed interview. The resulting terms were measured for comparison and similarity to the researcher's application of terms (Coren et al., 2003). This process may have had limited use, as prior influential life experiences on interpretation are inherently different between colleagues, regardless of their ability and experience in qualitative analysis. However, it did display reassuring similarity in coding of the transcript.

## **Transferability**

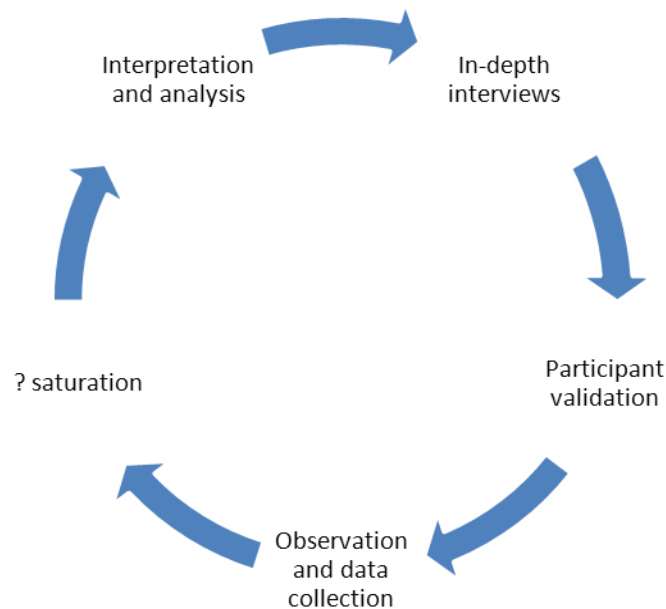
The element of transferability and applicability to other qualitative researchers was an inherent consideration of the thick description during this research. The clarity of the data collection, analysis processes and the focus on keeping the voices of participants central, helps deliver an accurate and clear representation of the method, and interpretation of the participants' perceptions in context. While the research

approach and environmental context may be applicable to antenatal clinics and other organisations supporting adolescents, it is for the reader to decide if the approach meets his or her requirements.

### **Dependability**

Repeated comparison of data obtained from observations, casual interviews, researcher memos and formal in-depth interviews was the approach used to gain deeper meaning (Figure 2). In-built occasions where the researcher stepped away from the field allowed for separation and enabled a distant view of the data. This was a useful way of dispassionately assessing the interpretation and seeking supervisory feedback. Triangulation of data resulted in changes to approach; for example, the development of main-strike focus questions, which provided consistency between informal interviews (Patton, 1990).

The cyclic process of reflection and constant comparison of events was also used in relation to in-depth interviews. Interviews with key informants were spaced over the course of the data collection. The referral of key informants by midwives at the clinic took into account the advancing gestation and suitability of the adolescents, providing a broad representation of the antenatal clinic. The spacing over a nine-month period allowed time for the generation of the cultural description from the concurrent observations and informal interviews. The continuation of observations and informal interviews during this time, in addition to reflection on prior validated interviews, resulted in an increased depth to enquiry in subsequent interviews with key informants.



*Figure 2.* The cyclic process of constant comparison leading to saturation and subsequent report.  
Source: Adapted from Corbin and Strauss (2008).

### **Confirmability**

Confirmability refers to the neutral position of the research, with findings shaped from participant voices and not driven by researcher bias or motivation (Lincoln & Guba, 1985). This research has emphasised the voices and explanations given by the participants from their individual contexts and experiences. The researcher encouraged the voices of participants by acting as though she were unaccustomed to the antenatal clinic. Potential for bias was guarded against in the initial basic interview guide that was informed by prior research and the researcher's midwifery experience. This was refocused early in the research as participant observations quickly added to this prior knowledge and guided the contextual positioning for ongoing, in-depth interviews. The constant stepping back from the research to check researcher positioning maintained objectivity.

### **Leaving the field**

When it came time to leave the field, this was confidently facilitated in three separate ways. First, there was characteristic saturation of data. No new patterns emerged and conversations in the waiting room became repetitive. These gradually



became more evident in the last weeks of the participant observation and final in-depth interview.

Another pertinent and natural position from which to leave the field was the nature of the antenatal clinic itself. There was no strict continuity of patient appointments as each pregnant adolescent attending was at a different point on her gestational calendar. Hence, this meant that, for the last month of the research, the researcher was gradually in a position to say goodbye to some of the participants, though many others had already said goodbye to the researcher previously as they delivered their babies and had no further contact with the clinic.

Some of the adolescents (including fathers) specifically brought their new babies back to the antenatal clinic to show me. Others sent text messages, birth notifications and first photographs. These actions demonstrated the positive relationships developed with participants during the data collection.

Lastly, a change in the clinic itself made it appropriate to leave the field. The previous regular midwives had been redeployed and one of the main midwives left. This meant new midwives in the clinic and the day on which the clinic was held also changed. The only remaining continuity was that of the receptionists.

It was an appropriate time for me to leave the field as the changes may potentially have caused some disruption to the adolescents' experiences, which may have altered the ethnographic picture. I said goodbye to regular staff members I had encountered, to let them know I was not returning to the clinic: all of those I met were very supportive of midwifery research.

## **Chapter Summary**

This method chapter has outlined the steps in carrying out this research. It covers the selection of competent, mature minors as participants, the antenatal clinic setting for data collection, gaining access to the group and key informants utilising clinic midwives as gatekeepers, and the approach to data analysis. This ethnographic research had a bi-phasic structure in which data were collected by means of participant observations (recorded in fieldnotes and supplemented by reflective memos) and in-depth interviews with key informants. Data collection and data analysis were integrated and iterative processes. This chapter also presents the strategies that were used for ensuring the trustworthiness of this qualitative research. Data analysis used Spradley's

(1980) guide to participant observation and developmental research sequence which gave a clear pathway from fieldnotes to cultural analysis and, hence, a cultural description of pregnant adolescents at antenatal clinic.

The following chapter will provide descriptions of participant observations and examples from conversations and interviews, to help readers understand the perspectives of participants during their pregnancy.

## **Chapter Five**

### **Findings**

#### **Introduction**

The preceding chapters described ethnographic research and its methods as the most appropriate for asking, listening to and revealing pregnant adolescents' unique voices. Participants described their experiences during pregnancy, both actual and anticipated events from the antenatal clinic waiting room. Ethnographic methods successfully positioned me within this group of pregnant adolescents to share their experiences over time. To illustrate the experiences of adolescents, I describe the environment of the waiting room as it appears to those waiting and present themes and recollections from the waiting room that highlighted the perspectives of those using the area (Spradley, 1980; Walcott, 1990). In-depth interviews with key informants will be discussed later in this chapter. Thus, this chapter begins the journey by which the reader can understand what pregnancy is like for an adolescent attending an antenatal clinic.

The following excerpt from my fieldnotes is an example of the types of interaction in the waiting room that formed the foundations of enquiry for this research:

A pregnant adolescent accompanied by her partner and a friend come in to the waiting room. The partner and friend sit down while the adolescent books in at reception and heads off to the toilet. When she returns, they all sit together in the corner with their feet up on the seats opposite, while they are eating and drinking from large bags containing fast food. The waiting area smells of fresh cooked burgers and French fries. I smile and introduce myself, asking how her pregnancy is going? She laughs, "When they show pregnant women in the movies, they don't show all this boring shit!" They all laugh together. I ask her which bits are the boring ones. "You know, waiting around and having to pee in pots!" They all laugh louder, the other two calling the pregnant woman names like "You're pregnant, cow!" The young woman did not appear to take any obvious offence at being called names and, as they

did not object to my conversation attempts, I continued (Fieldnotes 22<sup>nd</sup> March 2013).

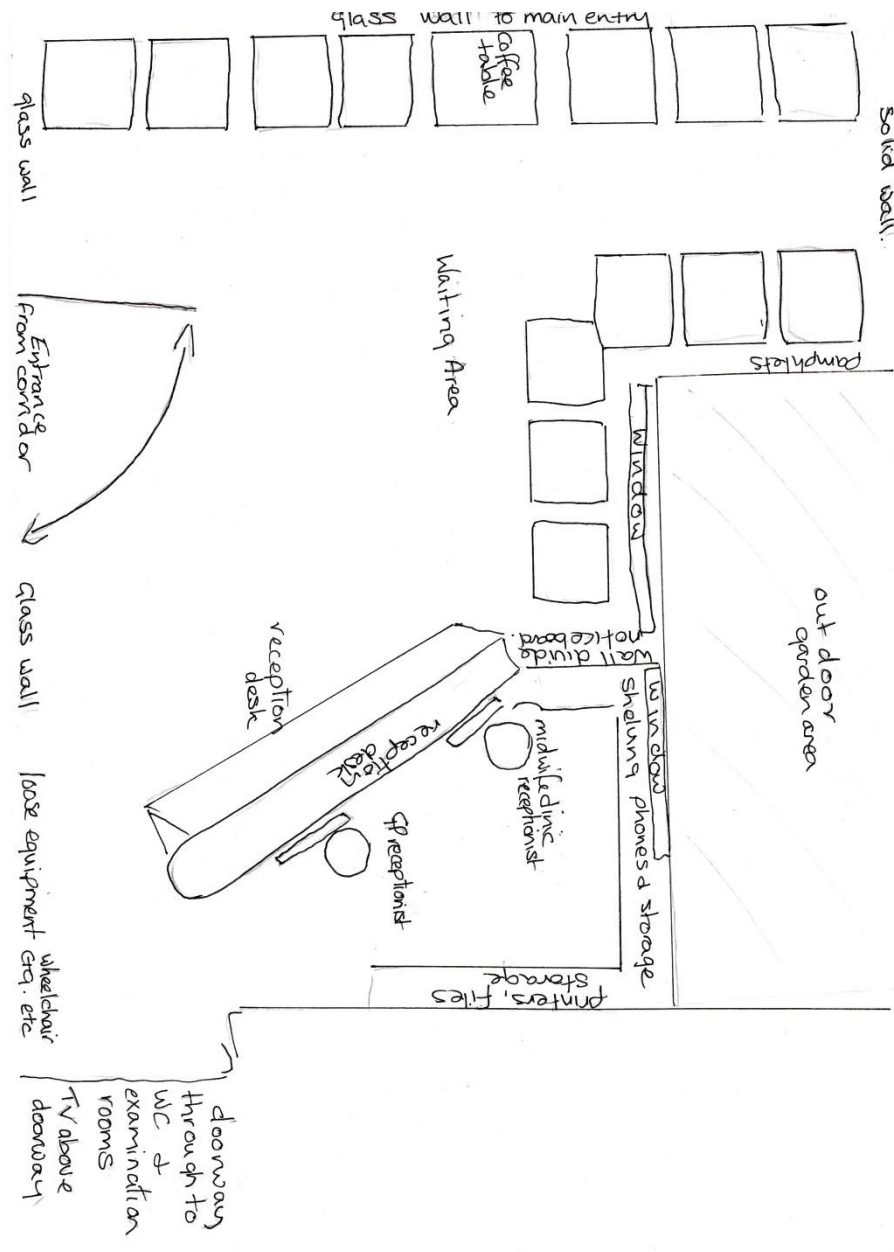


Figure 3. Field note sketch: Antenatal clinic layout and observed areas at antenatal clinic.

The antenatal waiting room (Figure 3) imposed physical patterns on the interactions between participants and the public spaces they could use. The public areas of the antenatal clinic comprised the waiting area, reception area and surrounds visible to the general public.

### **The Waiting Room of the Antenatal Clinic**

A door from the main hospital corridor provided access to the modern, glass-walled waiting room that was the first in a suite of rooms. Several similar suites of outpatient clinic rooms were grouped either side of the corridor. Outside the clinics, a number of fixed seats were positioned to provide extra seating. The antenatal clinic waiting room was a smallish, irregularly shaped, carpeted room that held 13 worn plastic chairs for the women to use (Figure 3). The inter-connected chairs were placed in groups around the glass half of the room's perimeter, with the reception desk along the adjacent side and the entrance on the other. This left a central space in front of the reception area where women could queue. The reception desk was 3 metres long and 1.5 metres high, angled to face the entrance door. A receptionist sat behind this at each end, one for the midwives' clinic and the other, nearest the entrance, for the general practitioners (GPs). As the receptionists typed and answered phones, all that was visible of them to the women entering the room was the top of their heads.

Centrally on top of the narrow reception desk were various items that changed according to the season: hand sanitiser and tissues for the flu season, questionnaires for in-house quality audits, and, at Christmas, a tree and decorations. Regular objects were a plastic wastebasket containing new urine specimen pots, and a cup holding several ballpoint pens. I rotated sitting in various seats during each period of observation to increase my view of the room as women came through. The sometimes-stuffy room had a subdued but not wholly quiet ambience. The glass walls tended to make sounds reverberate. There was an air conditioner running quietly and a small television positioned on the wall above reception which added background noise to general talking and the noises made by the people present and those passing in the corridor outside. I regularly changed position to help improve my ability to hear clearly.

The antenatal clinic for adolescents and young women aged 24 years and under was conducted weekly on a Friday between 8.30am and 4.30pm. On my first day of observation, 20 adolescents in various stages of pregnancy were booked into the antenatal clinic with a similar number of pregnant women booked in to see the GP. Initial observations of the waiting room, without interaction or participation with those attending, enabled a feel for the flow of the people. Introducing myself to the receptionists prior to the commencement of appointments allowed me to settle down and quietly observe the surroundings.

My purpose was to determine regular routines and familiarise myself with the everyday running of the clinic from the waiting room aspect. This also allowed the staff working at the antenatal clinic to adjust to my presence. For the first occasions I visited there, I carried out observations while sat in the waiting room for the full length of the day; later I gradually isolated types of observation between morning and afternoon sessions to gain a focused view and feel of the clinic. This allowed me to compare differences in the environment as staff changed shift and compare the atmosphere between morning and afternoon activities. I observed mornings were busier as, for example, deliveries were made, and files transported, which added to the workload of receptionists and reduced their interaction time with adolescents. However, the afternoon receptionist spent longer away from the desk due to filing and sorting activities, which increased the time adolescents stood at reception waiting.

Two other antenatal clinics took place on the same day with all pregnant women, and those accompanying them, sharing the often-overflowing waiting room. One clinic was held by midwives, and the other by GP Obstetricians (general medical practitioners with obstetric specialty). There was a degree of cross-clinic attendance where women saw the GP at set points in their pregnancy and at any other occasion at the request of midwives from other clinics held. There was a wide mix of pregnant women accompanied by support persons who utilised the waiting room. Figure 4. shows the taxonomy of people who utilised the waiting area, including some who infrequently came into or passed through the waiting room.

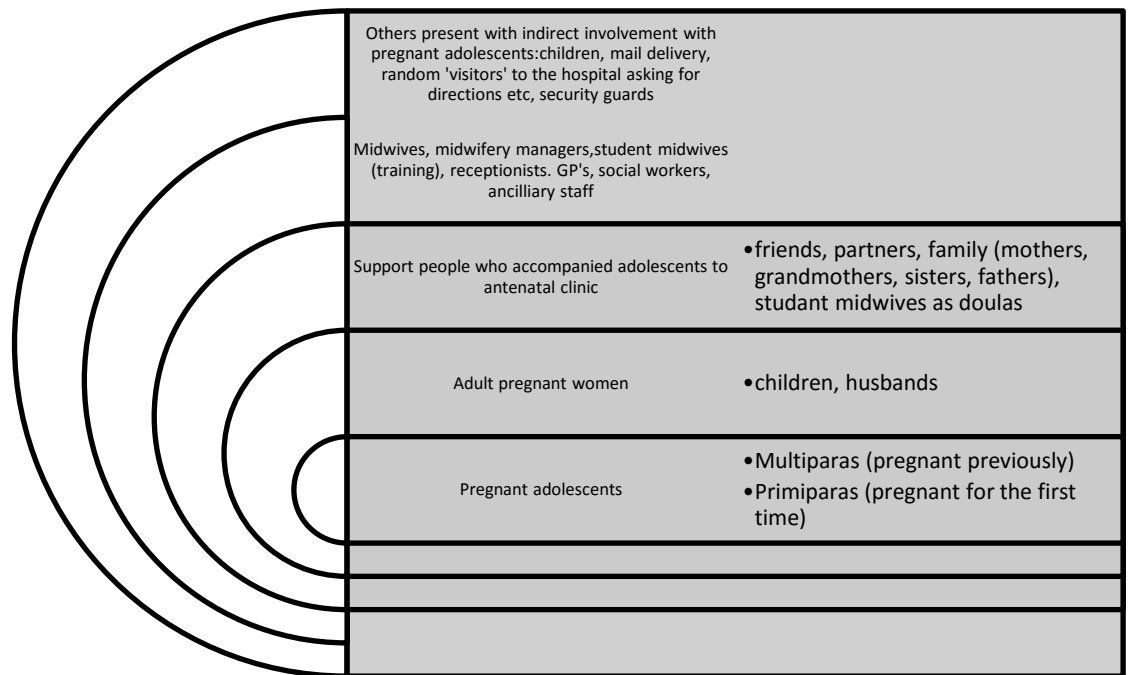


Figure 4. Taxonomy of people found at the antenatal clinic.

Most of the women who attended the antenatal clinic followed the same routine procedures. They arrived at the clinic usually just prior to their appointment time, waited a varying amount of time, saw the midwife or GP and left after making follow-on appointments. An exception to this was a group of pregnant (Aboriginal and/or Torres Strait Islander) women, who, if they chose to, could access a dedicated antenatal service run by a small group of midwives. Attached to this was also a clinic 'drop in' facility, in which midwives cared for pregnant Aboriginal and/or Torres Strait Islander and/or Torres Strait Islander women of all ages in order to maintain the cultural needs of the group.

There were ebbs and lulls in the flow of clinic appointments, reflected by the numbers of pregnant women waiting in the waiting room. When any of the midwives or GPs were running behind time, the numbers of people waiting built rapidly in the small waiting room. The booking times started off as congruent times, that is, the midwives commenced their first appointments at 8.30am and the GPs commenced at 9am or whenever they arrived. Although it did not take too long to become uncoordinated, the midwives appeared to adhere to their time slots more than GPs. The women waiting seemed to be more tolerant waiting for GPs even though they demonstrated signs of

impatience. If they were aware that the GP was called “upstairs” to the delivery ward, they waited mostly without complaint.

All pregnant women received their appointment notification in the mail. The first, more detailed booking appointments were allocated a 45-minute time slot with the midwife; subsequent allotted times for appointments were 15 minutes. On their arrival, the women checked in with the receptionist and were instructed to take a urine sample pot from the basket and directed to provide a urine sample. On this first attendance, the women were also handed a battered wooden clipboard with a pen attached to it by a piece of string. On the clipboard were hospital confinement booking forms, including the medical insurance details required by the hospital: the women were requested to complete these while waiting. This routine of filling in official forms appeared to be an unexpected event for some adolescents and their partners. On several occasions, adolescents and partners, when faced with the forms became quite agitated with each other.

When the appointment was available, the midwife called the woman’s name from behind the reception area. It was at these times that I noticed how the physical layout reinforced the power imbalance between staff and the attendees of the waiting area. The way in which the young women were called, and the mannerisms of staff towards those women attending the clinic, bore witness to the underlying power relationships in the antenatal clinic waiting area. This may be seen in the following observation:

The receptionist indicated by a wave of her hand, to the specimen bottles kept in a basket on the reception desk, to a new pregnant patient. The receptionist told her to use the toilet around the corner. The receptionist was looking at the computer screen, appearing to pay more attention to the screen while talking to the patient who nervously then took a plastic pot and hesitantly walked out of the waiting room back into the main hospital corridor searching for the public toilet. [Memo: the toilets for patient use in the clinic are a short distance, about two steps behind the reception desk, but there is no sign indicating this.] The receptionist realised what had happened but the pregnant woman was out of the door before she could be called back. The receptionist shrugged and went back to her work. (Fieldnotes 27 July 2012)



Being aware of the power balance in the clinic encouraged me to set my conversational and interview approach towards adolescents from an open and transparent position.

The women and any accompanying support then followed the midwife through the doorway at the rear of the reception desk through to the examination rooms. Occasionally, the midwife walked into the waiting area to confirm the name of the woman she had called; this was the case with difficult or unusual names to pronounce. To avoid this, one of the midwives carried a patient sticker and approached waiting women, asking, “Is this your name?” Sometimes, midwives introduced themselves; more often, they just said, “Hello, have you done a sample for me?” or “Do you have your notes for me?” The following memo excerpt reflects my thoughts on an early observation:

Another midwife comes out into the waiting area, she does not even really smile or introduce herself to the woman whose name she calls, and her acknowledgement is just a brief nod of the head. I wondered if they were worried about me? Maybe they will relax and become more natural as they get used to my presence. It is interesting seeing how distant the midwives sometimes are and how they present themselves, they don't appear friendly, maybe this is reserved for within the consultation. (Memo: personal notation 20 July 2012)

This point of contact in the reception area was the first occasion that adolescents had to meet the midwife.

### **Adolescents and Their First Visit to Antenatal Clinic**

Depending on the gestation when they first booked at the clinic, pregnant women could anticipate up to 10 routine appointments from 18-20 weeks of pregnancy to post-term at 41 weeks. Adolescents seemed nervous about this first visit as though concerned about the midwife judging them for being young and inexperienced. The reception with which they were sometimes greeted in the waiting area did little to alleviate this. The greetings observed from midwives who were friendly, that is, those who smiled, made eye contact and greeted the women familiarly by name, also received smiles from other women waiting. This appeared to lessen the atmosphere of anxiety in the waiting room. This is an important contact, which can set the scene for ongoing

attendance. I became familiar with the faces of midwives at the clinic during my weekly attendance. I also observed staff changes over the months which indicated that adolescents, on a sliding scale of appointments associated with their pregnancy (monthly, then three weekly, then fortnightly to weekly at term), were very unlikely to meet with the same midwife more than once or twice.

Adolescents left their first appointment juggling lots of papers, an orange plastic folder and a blue shopping style bag with “Bounty Bag” written on the outside. They balanced the items at the reception desk to make their next appointment. On subsequent occasions, the adolescents were asked if they would explain the significance of the items: “I’ve got all my appointments recorded in the (orange) folder so I don’t forget” and “Handheld notes make it easier for the staff as all your information is in one spot”. The free Bounty Bag contained non-specific pregnancy information, promotional pamphlets and samples of items such as nappy rash creams or hand wipes. One adolescent woman smilingly commented: “I like those bags! I look through all those samples and read everything!”

When the appointment was over, the adolescents made follow-on appointments at the reception desk: “The receptionists are really helpful, they just help you organise your next appointment”. At this stage, the pregnant adolescents appeared excited but my impression was that they were happy that the long 45-minute appointment was over and relief for some adolescents that it was not the bad experience they anticipated.

This research revealed that the pregnant adolescents experienced complex, multiple issues that affected their pregnancy and attendance at the antenatal clinic.

Four major themes were identified with associated subthemes:

1. Connecting with midwives

- First antenatal appointment: State of mind
- Subsequent antenatal visits: Reflections of Confusion and Judgement

2. The importance of the maternal mother

- Midwives as a source of information
- Family and friends
- The internet and social media
- ‘It’s not like they show on TV’

### 3. Supportive relationships

- Midwifery support
- Mothers
- Friends
- Partners

### 4. Engaging with pregnancy

- Social challenges
- Attending late
- “growing up”

## **Connecting with Midwives**

I captured the voices of the clinic attendees as I waited, alongside pregnant adolescents in the waiting room, for many hours on the day the adolescents’ antenatal clinic was held. I sat, as they did, on uncomfortable plastic seats, often too closely to someone with a cold, body odour or so overweight she encroached on my seat. I deliberately positioned myself to share as much of their experiences during this time as was possible. The pregnant adolescents’ state of mind during their waiting room experiences became apparent, revealing feelings of anxiety and perceived judgements which appeared to be influenced by power relationships found at the antenatal clinic. Two separate categories were recorded: first-time experiences of adolescents attending the antenatal clinic revealed initial anxiety, and follow-on visits by pregnant adolescents reflected on confusion and perceived judgements. The snap shot question: “Does ‘clinic’ make a difference?” captured ongoing reflections of appointments through the pregnancy.

## **First antenatal appointment: state of mind**

The following sample of fieldnote observations and voices from anonymous adolescents captures their first experiences of waiting at the antenatal clinic. Discovering adolescents’ distinct first impressions in the waiting room was important, as this initial impression was observed to be very influential on them and set the scene for successful ongoing appointments. Many adolescents were very nervous and self-conscious while waiting. The following describes an adolescent’s first experiences and thoughts while waiting for her initial meeting with the midwife:

I observed an adolescent filling in the booking forms [two pages]. She was struggling with details and appeared uncertain of understanding. Her partner was with her but he did not know what to write and walked out of the waiting room, leaving her alone. The midwife called her in for the appointment before she completed the forms. The young woman appeared relieved when the midwife said she would help her out with them. She was in the appointment for 30 minutes and came out, making a follow-on appointment and an ultrasound scan. She appeared much happier in demeanour. I was able to ask her how she found her first encounter at antenatal clinic. She tells me excitedly how she was given a bounty bag. "It's good! I want lots of information, there's lots of baby stuff and pamphlets" [rummaging in the bag]. She pulls out sample of Bepanthen [antiseptic cream], "We have lots of this already!" I asked her if she has bought it in preparation for baby. "No, for us," she laughs, "our tattoos need it, and glad wrap." She pauses for a moment. "I've got to get him [partner] to stop smoking now. The midwife talked about stuff like the baby being small, I have to check it out some more." (Fieldnotes anonymous Friday 13 July 2012)

This adolescent was initially frustrated and confused while she waited for her antenatal appointment. However, when she came out of the appointment, she was relaxed and enthusiastic about the items she had been given. She also presented her new knowledge on smoking and its effect on her baby, which the midwife had just provided her. I could see that she was keen to learn more by her excitement over what was in the bag of "goodies" but it could also be seen that she was intending to influence her partner in regard to smoking. The feelings adolescents voiced while they were waiting for their appointments reflected their anxiety: "This is my first visit. I am so nervous, I don't know what the midwife is going to do" [18 years old, 24 weeks' gestation in her first pregnancy] (Fieldnotes anonymous 27 July 2012). For some adolescents, this anxiety had not lessened following previous appointments: "Confronting - you don't know what to do or what to ask just in case they think you are stupid" [19 years old, 37 weeks' gestation first pregnancy] (Fieldnotes anonymous 27 July 2012). This feeling was retained towards the end of the pregnancy even where adolescents had experienced multiple appointments or attended other hospitals:

A young couple sat in the waiting area; they are sat next to me so I can hear them quite clearly. They have been at the tertiary hospital until now (30+/40), and this is their first visit to this hospital. They came via public transport. I know this because I can see the screen on the partner's phone as he is sitting next to me and he is still holding his bus ticket in the same hand. There is a strong smell of cigarette smoke and body odour from him. The very young woman looks and sounds stressed and angry. She is wearing loose clothing and a long knitted cardigan; she has long, loose un-dyed hair that she flicks back in an irritated manner. She is filling in the forms with short sharp, "What do I say here?" to her partner who, after a fleeting glance replies, "Dunno". The lack of assistance or engagement [as he is on Facebook] makes the young woman angry, she replies, "Fucking useless!" The form filling is then loudly punctuated by, "What the fuck!", "Fuck!", as she progresses through the two pages of forms. She asks him another question and, from his wallet, he passes the health care [insurance] card, which accidentally is dropped to the floor in the process. The agitated young woman says loudly, "Why do you always have to throw shit at me all the time?" The partner did not reply but kept his eyes on the floor and, when not on the phone texting, was cracking his knuckles with his legs stretched out into the centre of the small waiting room space, as if unconcerned. The midwife [maybe in response to the noise] came over from behind the reception area; she had a stethoscope and a tape measure draped around her neck; she asked how they were going filling in the forms and did they have their previous medical notes [hand-held] from the tertiary hospital. The young woman did not offer any verbal reply to the midwife but reached into her bag and handed over some creased notes from the previous hospital. The midwife took those notes without further comment and left the young couple to carry on filling out the forms [collected as artefact] (Fieldnotes 10 August 2012).

I obtained a copy of these booking forms and the receptionists had helpfully highlighted the boxed areas that all clinic attendees were required to complete. The information requested included the details of next of kin, the regular medical

practitioner and standard identification details. There did not appear to be anything that was unacceptable, just rather unexpected for some adolescents not used to such forms.

The following comments revealed the first visit was not challenging for all adolescents. Those adolescents who had someone with them who actively supported them with tangible help and participation appeared to cope better, appearing less confused and of a more relaxed and happy demeanour:

This is an adolescent couple on their first visit; she is Caucasian, 17 years old, neatly dressed in tight jeans and a lacy top. Her hair is tied up in a ponytail; she is carrying a big handbag and her paperwork [I can see ultrasound and blood results]. The couple have just finished filling in the forms on the clipboard so I am able to chat a little with them and begin to build up a rapport with them which would enable me to approach them easily on subsequent appointments. He is a dark-skinned Aborigine and/or Torres Strait Islander, also neatly dressed in jeans and a canvas jacket. Both are friendly and engaging when I explained who I was and my role at clinic. She tells me she is 24 weeks pregnant now [found out at 10 weeks] and described her pregnancy experience as “terrible”. She explained this to mean she has continuing sickness, not just in the morning but all the time and she feels “pretty miserable”. She was actually smiling ruefully while she said this; her body language implied that she is just getting on with it as an acceptable part of the pregnancy, “maybe this is happening because it’s a boy?”

“We are all prepared,” they tell me: “he” has more stuff than us! He will be called “XXXX”, we picked it together, we wanted something different. The partner was frowning at the noisy young children that had come into the waiting room with another pregnant woman. The young woman asked me, “what do you do?” I explained that I was waiting at clinic to talk to women about their pregnancy and clinic experience and that likely she would see me again when she came for subsequent appointments as I would be interested to hear about her experiences as she attends for more appointments. She was nodding that that was “OK” when the midwife called her name. They were in the appointment for 45 minutes (Fieldnotes 10 August 2012).

### **Subsequent visits: Reflections of Confusion and Judgement**

The question “Does coming to clinic make a difference to you?” provided an overall snapshot of adolescents’ reflections and perspectives on attending antenatal clinic on several previous occasions. Often, their responses revealed their state of mind while in the waiting room, and provided an indicator of their perceptions associated with their pregnancy and coming to antenatal clinic. Some adolescents voiced their dislike of the long waiting time prior to a short, seemingly irrelevant appointment: “I’m not sure how useful appointments are, you are in and out so quick, it feels like they haven’t done much!” (Fieldnotes 13 July 2012) and “It [appointment and waiting] was a waste of time, we walked out several times!” (Key informant 3: Dawn 27 November 2012).

Some other adolescents expressed their confusion:

“I don’t know why they want it [urine sample] all the time, I am over it... I give them as little as I possibly can in the pot and think to myself ‘here, knock yourself out!’” (Fieldnotes 22 February 2013). “I just sit there usually, not knowing what to ask!” (Fieldnotes 14 September 2012).

Other adolescents considered their reasons for discomfort while waiting:

“Well, they [other pregnant women waiting] didn’t look at me and judge me in any way [her body language implied this was anticipated] but I still felt that people would start to look at me differently because I was young, and I was afraid to stand up! (Key informant 7: Hayley 22 February 2013).

Another explicitly mentioned feeling judged during the appointment: “I felt judged and unwelcome, I felt like I don’t matter and they don’t care” (Key informant 3: Dawn 27 November 2012). Others also disliked antenatal clinic but recognised their need to attend: “I don’t really like it; I wouldn’t come if I didn’t have to” (Fieldnotes 13 July 2012). Nevertheless, this dislike and perceived irrelevance was not common to all adolescents. When asked what difference coming to clinic made to them, some responded positively, giving an insight into what brought them regularly to appointments:

“Heaps! I know heaps more now than I did... about what to expect.” I [researcher] asked if she could tell me what it was, she had learned.

“Well, I knew nothing about this stuff [meaning having a baby, labour and the birth]. It’s been good to come here and have it all explained. We have managed six visits so far, [boyfriend] has missed one, but it makes me feel more confident and excited about having a baby” (Fieldnotes 22 February 2013).

The midwife helps me go through ‘stuff’ (Fieldnotes 7 December 2012). Talking to the midwife, it’s always good to hear that everything’s ok! (Fieldnotes 4 January 2013).

Adolescents reflected on previous appointments: “I find out something useful every time I come” (Fieldnotes 11 January 2013).

Another adolescent explained why a midwife was important to her although, when they first met, she thought that the midwife was judgemental: “It’s important to have that personal relationship with your carer in pregnancy” [I felt she was trying to describe the importance of investment by the midwife in her and her pregnancy] (Key informant 3: Dawn 27 November 2012).

Adolescents expressed polarised opinions about the value of attending the antenatal clinic. The waiting room, however, lacked privacy and comfort to enable in-depth exploration at that point in time. I had also had begun to feel, as my rapport increased and key informants were recruited, that some adolescents actually wanted to talk more about their pregnancy but were restricted by the waiting room environment.

It was possible that some comments were deliberately voiced by adolescents, knowing the likelihood of others present in the waiting room listening. Comments were offered to me, the researcher, as something the participants felt I wanted to hear that was a *significant* comment. This was indicative of power imbalances, as those adolescents were comfortable stating this to me in the clinic where they felt they would be overheard by the staff. The in-depth interviews supported this hunch; however, these were conducted in a private location as part of the adolescent’s story where no one else could overhear.

### **The Search for Information**

Adolescents were exposed to many sources from which they could choose to gather information about their pregnancy and coming mothering role. Adolescents in



the waiting area spoke about the knowledge they had gained on their pregnancy and birth planning. Data was gathered on the most influential sources stated. Adolescents identified four major categories towards planning for birth: midwives, family and friends, the internet and social media and antenatal classes. While family and friends were the most influential sources of information, web-based information such as phone ‘applications’ and social media such as Facebook were very popular sources of information and support in addition to the clinic (Table 3).

**Table 3:** Information sources named by adolescents

Key informant	Midwives	Paper	Web-based	Mother	Other family	Friends	Other source	Classes	Bounty bag
Amber	✓	✓	✓	✗	✓	✓	✗	✗	✓
Claire	✓	✓	✓	✓	✓	✗	✓	✗	✓
Dawn	✗	✓	✓	✗	✓	✓	✗	✓	✗
Emma	✓	✓	✓	✓	✓	✗	✗	✗	✓
Fiona	✓	✓	✗	✓	✓	✗	✗	✓	✗
Gina	✓	✗	✓	✓	✓	✓	✓	✗	✗
Hayley	✓	✗	✓	✓	✗	✓	✗	✗	✗
Jessica	✗	✓	✓	✗	✗	✗	✗	✓	✗

### Midwives as a Source of Information

Midwives were named as a source of information during pregnant adolescents’ appointments. There were, however, complaints about appointment times with the midwife being too short. In addition, some adolescents were confused about what they felt they “should” know: “when I first came, they [midwives] gave me some information and pamphlets but, other than that, you have to ask what you want to know; it makes it hard when you don’t know what’s important to ask!” (Fieldnotes 23 November 2012).

Adolescents seemed to like the personal one-to-one contact, with midwives providing information that they felt was just for them:

Erm, yeah, she [midwife] tells me stuff... most of the time when she is checking the heartbeat she, erm, they have charts and stuff like that, but it’s better when they tell you stuff like that. I find that really helpful and

interesting, stuff like that, cos it's cool when to know when they [babies] open their eyes and stuff like that. And then when they [midwives] tell me, erm, when to start looking for kicks and what they would feel like. Cos they have said that the first time you don't actually realise it is and you don't actually realise it's a real baby until you are further along (Key informant 2: Claire 2 October 2012).

Other adolescents also appreciated being treated as an individual, and having access to experienced midwives for information: "Hmmm, probably the midwives, they know a lot about babies". "The midwives explain it better though, and it's usually in ways that are important to me and what's happening in my life" (Fieldnotes 13 July 2012). Adolescents had certain expectations about their appointment:

The midwife, she checks my blood pressure, how baby's sitting by feeling my tummy, she checks my wee, [laughs]... well, that gets hard so far along [laughs], meaning my aim and not being able to see what you are doing to pee in a cup over the toilet! (Fieldnotes 13 July 2012).

By the end of their pregnancy, adolescents had learned what was normal:

I have only seen her [the midwife] once and she just pressed my stomach and listened to the heartbeat, you can buy apps that listen to the heartbeat. I know someone who has bought one of those things that listen to the baby [sonicaid-type device]. I have got so used to my baby's heartbeat. I can tell the difference between my pulse and baby's heart by the speed. A doctor was listening to my baby's heart once but it was really my pulse. It was so slow, I told him it was my pulse but he said, "no, that's baby". I wasn't worried because I could feel the baby moving, but I thought, "whatever, I'm never coming to see you again! You know nothing!" (Fieldnotes 27 July 2012).

Other adolescents expected to get practical information from the midwife: "They [midwives] don't so much give information but fill in gaps about what you need to know more about" (Fieldnotes 27 July 2012). Others, however, did not appear to have given any thought to what they could talk to the midwife about: [Researcher asked:] "Can you ask the midwife questions about any pregnancy or labour thing you might want to know when you see her?" [Non-committal answer and shrugged:] "I suppose" (Fieldnotes 30 November 2012).

Two adolescents in the waiting room shared their thoughts about midwives as a source of information. The adolescents were not together but talked to me as a group conversation for a time. Both said information from the midwives was “not a lot”. The younger of the two said that the midwives: “gave me lots of pamphlets in the beginning, on vitamin K and hearing tests for the baby, but didn’t really explain them to me.” This was something she felt she would have liked. I asked the young woman if there was “anything she wanted to know” from the midwife. She said, “no, not really”.

### **Family and Friends as a Source of Information**

Many of the adolescents waiting at the clinic stated they obtained most of their general pregnancy information from family and friends. Often, this took the form of anecdotal stories to which the adolescents could relate. Adolescents paid attention to relevant examples from family and friends who had children or were pregnant:

Lots [of information] from mum, I will ask her first (Fieldnotes 13 July 2013).

I ask my mum about it and if I... sometimes I ask his mum about it cos she’s had about seven or eight kids... so she’ll know a lot (laughs) (Key informant 5: Fiona 12 December 2012).

The pregnancy and birth experiences of people the pregnant adolescents relied on were an important part of their search for knowledge. Family advice was more available than appointments with midwives and easily absorbed by the adolescents. Anecdotal stories were shared at informal moments, including in the waiting area at the antenatal clinic. However, some adolescents voiced their frustration at the anecdotes: “They [family and friends] just love to tell you stuff and not all of it is good! Sometimes they seem to be deliberately scaring you!” (Fieldnotes 23 November 2013).

Being in accord with those around them and, hence, comfortable, appeared to make adolescents keen to listen to advice, including that of other adolescents who have experiences of pregnancy: “My friend she had just the gas and she said it didn’t do much good, so to get the epidural... so I think I will! (laughs)” (Fieldnotes 20 July).

Adolescents seemed reticent about questioning the information given by their mothers or close family. This may be an adolescent age group perspective that these are authoritative ‘teachers’ and not to be questioned. It may also be an as yet not equalised shift in relationship dynamics where the adolescents are accepted into the cultural

pregnancy group, a transitional shift indicated by the older women sharing stories. One of the adolescents described her confidence in her mother. I (researcher) asked if she was upset or thought something may be wrong, where would she go or who would she ask?: “I ask mum; she says, ‘you’re OK, its normal’, and I don’t worry anymore!” (Fieldnotes 23 November 2012).

Midwives can reasonably expect that adolescents will be more engaged if they are comfortable. Additionally, other secondary pregnant adolescents may listen to that advice in the future. However, their mothers, though supportive, may provide false reassurances with inaccurate advice: “I didn’t go for a while [missed at least two appointments at clinic], my mum couldn’t take me, but she said I was OK cos my belly was growing. My mum said I wasn’t [going to miss out], she said all they were going to do was feel my belly. I was hell scared that I wouldn’t feel her moving!” (Key informant 6: Gina 6 January 2013).

### **Making Use of the Internet and Social Media**

The knowledge that pregnant adolescents acquired from the experiences of their family and friends was reinforced by connections with social media and smart phone technology. The adolescents in the waiting area were enthusiastic in explaining how they accessed knowledge and shared information between their peers. Adolescents used social media to communicate daily with people around them and also to access online sites. Many of the adolescents utilised electronic phone applications (apps) that sent daily information about their pregnancy, gestationally targeted to adolescents on joining. One young woman described her use of social media:

I get together with a regular group on Facebook, ‘mums from 95’; some of them have had babies, then there’s me and another girl who is due in three weeks, we all live locally. I get lots of information from them, especially the ones who have had their babies recently. (Researcher asked for an example:) I had pain up here (indicating epigastric area) and I asked the girls on Facebook about it before I rang the midwife. They (girls) told me it was just my ligaments stretching; it saved me coming all the way in to the hospital. I rang the midwife and told her, she just told me to lie down and see if it went away, it did (Fieldnotes 14 September 2012).

By “get together”, this young woman meant communicating online. The group did not meet face-to-face. Other adolescents described the applications as useful as they could relate the information to what they were experiencing at that time.

During data collection, there were few people, whether pregnant or their accompanying support, who did not, at some point, use their phone or other electronic device in the waiting area, including the receptionists. Some participants played games, others were seen on social media or messaging. Participants may also have been accessing information sites though I was unable to tell with certainty:

There seems to be more than just boredom or passing the time. Is it a social crutch for some women or are they simply finding out what they want to know about their pregnancy, and cutting down the time they spend with the midwife?” (Memo personal notation 1 February 2013).

An adolescent waiting for her appointment had her smart phone open and I engaged her in a conversation about her pregnancy journal. She told me it is something you buy as a paper journal but she found it is easier to download and keep on a smart phone or tablet as it became a daily diary and daily downloads. She showed me pictures she had entered from her earlier ultrasound scans and the comments she has filled in for daily entries. I could see the diary entries for each day were her record about feelings and actions. She pointed out there were interactive sections where questions can be typed in and ‘sent off’ for a later reply: “I have used this to see if I could eat soft cheese, the answer that came back confirmed what I knew already but I just wanted to check” (Fieldnotes 1 February 2013).

Few adolescents waiting were observed not using their devices for an extended time. The waiting room had an unstimulating atmosphere, little in the way of reading material and few pregnancy-related pamphlets. A small noticeboard advertised community groups and parenting classes. The notice was not on display for long and was not age-specific.

### **Antenatal Classes**

Antenatal classes were held at this hospital to assist women in general and their partners to prepare for labour and birth. The adolescents demonstrated their awareness of such classes: “We haven’t been to classes and haven’t really talked to anyone about

labour” (Fieldnotes 30 November 2012). Other adolescents felt they received enough information without classes:

Google! (laughs). I Google everything! I have Facebook apps I get emailed every day and from the phone too. [So] I am not going to bother with classes, the midwife just tells me about the tests I have to have and listens to the baby’s heart (Fieldnotes 27 July 2012).

For some, the midwife provided enough information to help them prepare; for other adolescents in the waiting room, it was evident that many could “not be bothered” about formal classes as part of their search for education: “I don’t think I need classes. I have a mental list of what I want to know from the midwife” (Fieldnotes 27 July 2012).

I felt the adolescents’ thoughts on antenatal classes reflected the degree of family involvement:

Well, last night was actually our first class and they just... pretty much, it was like a Human Biology class: this is where the baby sits and this is the bladder, and all this stuff, which is good cos I didn’t really know that everything is all squished up together. Which is good cos it explains why I always need to go to the toilet (laughs). Oh, and she went through stages of labour which gave me some ideas, you know, things that you can do when you’re in labour like going in at the hospital with all the lights dimmed down and you know that stuff. I can go in there now and not expect nothing. I can now have some back-up stuff (information not just from Mum) to help me get through it (laughs) (Key informant 8: Jessica 5 March 2013).

Another key informant also mentioned the school-style format of delivery. She found classes uncomfortable to attend and not a useful source of information:

We got referred to go to the antenatal classes; we went to the first two but then, after that, we didn’t want to go to anymore cos [it was very lecturing] ‘this is how it should be done’, ‘here is what you should do’, ‘water birth is the best way to go’. It was very... ‘This is what I did so this is what you have to do’. And it was very like... you didn’t ask questions because you wouldn’t get a very good answer... you know? (Key informant 3: Dawn 27 November 2012).

The classes were also described as confronting by the youngest of the key informants:

Last night at the antenatal class, we saw a movie about birth; it was so...

It was just... [awful] I don't want this! I want it to materialise out of me somehow... I am so much worried about the pain and how I am going to get through it! (Key informant 7: Hayley 22 February 2013).

Yet another told me she took direction from her mother when she contemplated attending: "They [Mum and Nan] said that I don't need to do antenatal classes because anything that I don't know, they can teach me... like women were able to give birth for years..." (Key informant 6: Gina 2 January 2013).

The adolescents often did not appear to take much away from the offered antenatal classes. Antenatal education in many forms contributed to the body of knowledge that adolescents utilised during their pregnancy to form their plans for birth and motherhood. However, classes were cancelled during the period of data collection, restricting this as a context.

### **Planning for Birth**

"Planning for birth" referred to the conscious path taken towards the birth event and becoming a mother; rather than the specific written plans pregnant women are encouraged to have on labour, birth and immediately following. Adolescents' considerations for birth revealed the extent of connections they experienced with people around them and indicated the importance they placed on the occasion. The vision of planning for birth was not overtly apparent in the waiting room observations. However, it was embedded in adolescents' thoughts and subtle purpose in attending antenatal clinic, and referred to, though separately, in terms of gaining knowledge and support: "We knew nothing about this stuff [meaning having a baby, labour and the birth]. It's been good to come here and have it all explained" (Fieldnotes 22 February 2013).

Adolescents I identified to be more advanced in their pregnancy were observed for evidence of planning for the birth and motherhood. These adolescents usually sat waiting with the *casual circular rub of the belly* that women appeared to do in their last trimester. I discovered that some pregnant adolescents applied more attention to forward planning than others did. One young woman talked ruefully about not yet being in labour but she had thought about this and planned for differing outcomes:

An adolescent talked about starting her labour and ways to do that [laughs at herself], saying she took castor oil: “Mum told me not to bother but I tried anyway, it tasted awful and gave me the shits! Mum just tells me to stay on my feet and keep moving. The midwife did a stretch and sweep last week and said I was four centimetres dilated [cervix] but nothing has happened. I am here to see the GP today, for him to do another one and maybe book me in [for induction]” (Fieldnotes 13 July 2012).

Other adolescents were not as ready: I [researcher] asked if preparations for the baby’s birth were going to plan? “No, not much... it will be ok” (Fieldnotes 1 February 2013). Others appeared not to have planned at all: “I don’t really know. I guess I will do whatever I need to do when I get there” (Key informant 3: Dawn 27 November 2012).

Another young woman was unenthusiastic:

[Memo personal notation: Neither the partner or this young woman were working. They were both 18 years old and they had not considered what baby items would be needed.] They stated unenthusiastically, “We will think about it when it gets here”. (Fieldnotes 30 November 2012).

This adolescent, who was with her boyfriend, revealed her arms covered in scratches that I discovered were from a new kitten. This young couple presented themselves as far more engaged with the kitten than planning for the pregnancy or birth. Although she was close to term, they had made no plans or preparations at all for this baby’s arrival. Part of this appeared to be a lack of income or its management; both were on government basic payments and looked unkempt. My impression was also that they had a poor grasp of the reality that having a baby entails. I found it difficult to tease out details of her birth plans in the waiting area because her remarks about her pregnancy were very brief and expressed negative and dismissive thoughts. In trying to talk to this adolescent, I talked about the kitten, which brought her attention back to the pregnancy:

[The adolescent is lounging over several seats in the waiting room.] I ask her if it is her pregnancy that is making her tired? She smiles and says, “Yes and no... pregnancy is a pain! I can’t get comfortable but we have a new kitten that is keeping me up and disturbing us in the night”. She talks about kitten antics and shows me scratch marks up her arms.



The partner sits there laughing at her; she riles up, saying, “It’s all his fault!” I ask in what way and the boyfriend said that he *made* her get the new kitten while she was still interested and he had to ‘strike’ while the iron is hot. I did not understand what he meant and he explained that they had a kitten previously but it was run over by a car and they were very upset. The young woman said it was the worst thing she had seen. I empathised and asked how long ago this had occurred; four days ago, they said. She told me “the new kitten was to help keep her occupied till the baby arrived so we got another one” (Fieldnotes 30 November 2012).

This encounter initially looked as though the adolescent did not want to or was avoiding talking to me about her pregnancy. However, I felt certain this was not the case, even though she presented her pregnancy using tone of voice and body language that projected not being interested. With extended conversation, I found this young woman displayed signs indicating a lack in concentration and attention that reflected poor educational attainment. I felt that she and her partner had very few future considerations in place for a baby and a limited grasp on the reality of having a baby: “The baby will be able to play with the kitten”.

Other adolescents revealed detailed plans for their labour, describing the content of the bags they packed for both themselves and baby. They told me of the knowledge they had on pain relief and labouring and they shared their anticipation of equipment and social considerations for when they returned home following the birth. In discussing their plans during pregnancy and changing lifestyle, the occasional adolescents voiced the sentiment: “It’s not like on TV” (Fieldnotes March 2013). One of the key informants described this further: “Mm, I never really thought about it [before the pregnancy], I just saw it on TV and stuff, erm, it’s always a happy ending when the baby is born, they don’t show it much about how they [pregnant teenagers] felt when they were pregnant”. She went on to describe the way her reality of being pregnant was different from the television: “They [pregnant teenagers in the show] all seem so happy and have got so much energy... you DON’T have much energy!” [laughs ruefully]. My impression was that she did not feel that sense of happiness either (Key informant 4: Emma 6 December 2012).

## **Supportive Relationships**

Adolescents tacitly knew they needed support in pregnancy. However, support for pregnant adolescents was, as I found on asking, an ill-defined concept: “For a while there, it was all such a big mess, about half way through [the pregnancy] huh... but then support, yeah, support makes it all better, yeah, definitely” (Key informant 8: Jessica 5 March 2013).

Gaining adolescents’ descriptions of what they regarded as supportive was difficult for them to label. For some, this meant practical organisation; for others, this referred to validation of their decisions and had to be viewed in their personal context. Midwives, when escorting adolescents from the waiting room, would often say, “Your support person can come in too if you want”. I interpreted this in general context to mean that adolescents required someone to be with them while they were in the appointment or maybe it was just company for the prior waiting. Three elements stood out in adolescents’ discussion of their support: who was most important in supporting them and in what way, what support the adolescents felt they needed and what would happen in the absence of support. The manner in which adolescents connected with those who offered support was evidenced in statements regarding midwives, mothers, friends and partners.

## **Midwifery Support**

I noticed, as I sat in the waiting area, that, except for the initial booking interview with the midwife, the follow-on appointments attended by the adolescents were on average 10-15 minutes in length. It seemed a short period of time to incorporate any form of education other than limited questions. Some adolescents, however, appeared to enjoy the support offered by midwives:

It was better being looked after by the midwife because they tell you more information and seem like they care about you more. The midwives talk more about the position of the baby and what will happen in the hospital when I come in in labour (Fieldnotes 28 December 2012).

Support from midwives was described by adolescents in terms of the extra reassurance and information obtained in individual appointments rather than midwives who “just did what they needed to do”. When adolescents described the practical

content of their appointments, the medical content was thought of as necessity rather than supportive. Adolescents often described their contact with the midwife as basic: “[Midwives check] my weight, listen to the heartbeat, not much else” (Fieldnotes 23 November 2012).

The adolescents, though, said that they were happy if they saw the same midwife each time they came to antenatal clinic. This seemed to be something they found comfortable, mainly because they did not have to repeat stories. Some also mentioned supportive telephone reassurance after hours (unknown midwives). They had access to a phone number so they could ring and talk to a midwife if they experienced pregnancy-related concerns. One described what happened when she thought she was in labour: “I had a constant ache in my back... [I rang] the midwife, yes, she just told me that it’s normal and you can have some Panadol, take a warm bath and try sleeping with some hot packs... yeah, it helped” (Key informant 4: Emma 6 December 2012).

### **Support from Mothers**

The prime person pregnant adolescents named as supportive was their mother or someone in that role. Mothers and partners were the most common person seen in the waiting area with the adolescents. However, grandmothers, sisters, friends and occasionally fathers also brought adolescents to clinic. When adolescents were asked who their most important support was, the majority stated their “mum”. Though they were not the first person the adolescents disclosed their pregnancy to, mothers were considered the most influential:

“My mum! She’s had 10. I am the youngest and the only one at home”  
Fieldnotes 27 July 2012)

“My mum, cos she had really complicated pregnancies. Erm, I would probably say mainly my mum but I would ask my sister a bit but mainly my mum, yeah” (Key informant 2: Claire 2 October 2012).

Adolescents rely on their mothers for sound information: “I ask mum, she says ‘you’re OK, it’s normal’, and I don’t worry anymore” (Anonymous 27 November 2012).

The tangible aspects of physical support were commented upon by the adolescents: “They [parents] have been really good to us. They bought us a new washing machine and some stuff for baby’s room and things like that” (Key informant

3: Dawn 27 November 2012); and “My mum, yeah, she has told me about my breathing and what I need to do and everything!” (Key informant 7: Hayley 22 February 2013).

Other adolescents reported difficult relationships with their mothers. Some had trouble from conflicting information between their own and their partner’s mother: “Well, they hate each other because his mum says that my mum is all wrong about everything she says to me... I just listen to my mum cos she’s got more experience!” (Key informant 6: Gina 6 January 2013).

One grandmother bringing an adolescent in her second pregnancy to clinic was left in the waiting room while she attended her appointment. The grandmother had this to say about her teenage granddaughter, which really encapsulated the facets of support:

She is a good little mum; she is fantastic with the little one. It has really calmed her [behaviour] down, given her someone to look after. Mind you, she was not wild like her sister... it was too hard on them, their parents gave up on them when she was 12 [years old]; her mother is an alcoholic and her father is in Queensland. When she got her baby bonus last time, that’s what she spent it on... a ticket to Queensland to show her dad the baby... then she came back to us. We help all the time, pay her bills too. We do her grocery shopping every week, not that we begrudge it... mind you, since she got this new young man, we don’t seem to be helping out as much as we did. It will be hard with the two young ones, though. I still worry about her sister [16] running wild (Fieldnotes 14 September 2012).

When it occurred, adolescents found the withdrawal or absence of supportive relationships difficult. Estranged from her parents and experiencing physical isolation, one key informant described how this affected her during her pregnancy:

Not [from] my parents, just because they’re in another country, my mum here is very unsupportive. I do actually have my mum here... we had a falling out a year ago sooo... she sort of comes in and out of our lives, so she isn’t really a solid support figure... I can’t really go to her, though I’d like to. I find it hard on some days being a mother... or I did in the first year of my first pregnancy I’d have little crying breakdown moments. Having them [younger brothers] around makes me realise how lucky I am to have them, to have someone there. I don’t think I

would be able to cope if I was a solo mother (Key informant 1: Amber 28 September 2012).

Other adolescents also spoke about the emotional consequences of not having support:

I didn't have many friends as they were all out partying and things were hard with mum and dad not being supportive. And then I got really depressed and, on my lowest day, I just tried self-harming myself. I just wanted everything to just go away, it was too much, the depression. I was getting bigger, I didn't feel pretty anymore, we had no money and erm... (Key informant 8: Jessica 5 March 2013) .

Loss of supportive relationships had deeper mental health impacts on how adolescents experienced their pregnancy; in particular, adolescents' feelings of poor self-image were significant:

I think being a first-time mum, it changes your self-esteem a little bit... your whole body image changes... you put on weight... you change from that [person you were], into someone who's tired, and put on weight... you just don't feel attractive when you do go out like to do what you've gotta do... you just can't be bothered to like... care and stuff... (laughs). I don't even look in the mirror when I leave the house sometimes... (Key informant 1: Amber 28 September 2012).

Pregnant adolescents with a poor self-image appeared as lacking confidence and self-conscious when talking to adults, which inhibited their attendance at a public antenatal clinic, especially if they were alone.

### **Utilising Friends**

I found adolescents also understood support as emotional, having someone present for them to talk to about their pregnancy and plans for the future. Close stable relationships with family and friends was an obvious source of support but, while families provided a combination of practical and emotional support, friends provided the emotional support needed to connect them to their age group. The pregnant adolescents said they found the loss of their previous identity difficult. They sometimes felt left out and isolated from their peer social group:

I was really different before I got pregnant, really different. I had a lot of friends before I fell pregnant. I've got a few friends who have just had a little baby, two of them, but friends like, from school, they don't talk as much, I don't hear from them as much anymore. Pretty much as soon as they found out I was pregnant, 'she can't come out with us anymore, she can't do they things that we do'. They just thought 'she doesn't want to come out with us no more', they don't call or text me or Facebook me anymore... but my other friends who have had babies, they talk to me and ask me how I am going all the time, they talk to me, and they're my age which is nice. But my other friends who I was really good friends with at school, they just don't contact me... cos I can't do what they do (Key informant 7: Hayley 22 February 2013).

Well, they never invite me out and, when they do invite me out, we just stand around talking and I get really pissed off with that so I say no anyway when they ask me out... unless they invite me to the beach or something like that... or the movies or something like that (Key informant 5: Fiona 12 December 2012).

The worst thing about being pregnant is the feeling sick and not being able to do what I want. Like they [boyfriend and friends], will go to the river, have a drink, and then go to friends to drink even more, and then I see her [referring to her ultrasound picture]... but it sucks. It is sometimes [ok for me to go] when he's [boyfriend] not drunk... (Key informant 6: Gina 6 January 2013).

These adolescents referred to being excluded from activities previously engaged in, like "partying". Since becoming pregnant. their desire to participate in old behaviours and activities had changed:

Yeah! I used to wake up in the morning, have a glass of alcohol... or, you know, just things like that. I would go out all the time. I would spend money when I wanted. I was quite carefree and would go out and party and do all sorts of things and now I don't even really want to (Key informant 3: Dawn 27 November 2012).

All the key informants were of the view that pregnancy had changed their attitude to life, although not all participants felt that they would lose friends. One key

informant, who concealed her pregnancy from friends as well as family, relayed how they were disbelieving of the pregnancy. When asked about changes to friendships, she said, “No, not really, cos I am still going to try and associate with my friends” (Key informant 4: Emma 6 December 2012).

In this need for peer group connection, social media appeared to fill a niche for the pregnant adolescents. Support from friends on Facebook was described as “being there” for them if they needed anything. This meant that the friends replied to messages and ‘chats’ if the young woman sent them. They confirmed, however, that they did not often meet Facebook friends in person. More than one adolescent told me she had created a Facebook page just for her unborn baby.

The pregnant adolescents talked about comments people make on Facebook and how it is hard to remind yourself that it is not really meaningful reality. An example given was a friend who said, *‘you are not my friend if we aren’t friends on Facebook’*. The young woman said to me this was stupid: “What did friends do before Facebook?” Adolescents talked of the support they could not manage without from their mothers and other significant parental figures. Their friends and peer group, despite altered self-perceptions and relationships attributed to the pregnancy, were nonetheless spoken of as a significant emotional support. They described their first contact on discovering their pregnancy as their best friend or their partner. This was meaningful as it indicated the importance of their support even when this support was a new relationship.

### **Supportive Partners**

Some pregnant adolescents mentioned a partner as being supportive. However, many of the adolescents had partners who were similar ages, also still living at home, attending school and being parented themselves. Hence, the support these partners could offer remained limited. Some adolescents had been in relationships only for a few weeks prior to discovering the pregnancy and others did not have a partner at all, sometimes declining to name the father of the baby.

When adolescents did tell their boyfriends about the pregnancy, they often reported not being believed: “I called [boyfriend] straight away and told him... he didn’t believe me. He didn’t for a very long time, yeah. Until finally he did after the first ultrasound” (Key informant 7: Hayley 22 February 2013).

Some adolescents reported relationship difficulties as a result of the pregnancy:

[On discovering the pregnancy:] Exciting but my boyfriend broke up with me because of it, but then he got back with me. He stayed with me once I told him, for a little while once I told him but then he went, ‘no, I can’t do it. I will still support you and everything like this but’, I thought, ah, whatever... well... but then, after a week, he got back with me (Key informant 5: Fiona 12 December 2012).

One key informant regarded the potential loss of support from her partner in a different way:

[I didn’t have many friends as they were all out partying and things were hard with mum and dad not being supportive and then I got really depressed and, on my lowest day,... I found out that he had cheated on me when he was at his mate’s. So that was the first time we had been through a bad patch and it was all such a mess... we came back here and everything was such a mess and I think I was quite depressed at that time cos I didn’t really have anyone there [for me] (Key informant 8: Jessica 5 March 2013).

This adolescent’s feelings of loss of support led her to an incident of self-harm, which indicates the depth of emotional support needed in pregnancy. The individual circumstances of adolescents explain much about the vulnerabilities in their support network. Adolescents’ self-image during pregnancy indicates their emotional vulnerabilities and the depth of their reliance on peers for support.

### **Engaging with Pregnancy**

Engaging with pregnancy refers to adolescents who acknowledge their pregnancy, to themselves and others, making significant efforts to maintain their pregnancy health, and taking steps to acquire some birth and parenting knowledge to plan for their future. The challenges that adolescents sometimes experienced in their pregnancy had a detrimental effect on their health in pregnancy and restricted their ability to plan easily for their future. This resulted in delayed and infrequent clinic attendances. The range of challenges noted include physical or emotional trials, social and personal issues that were sometimes ‘copeable’ and experienced daily, whereas



others were significant hurdles that required interventions. Adolescents described the experience of pregnancy as “having to grow up quick!”

### **Social challenges**

Some adolescents experienced challenges attending the antenatal clinic associated with their age group. It was not uncommon for pregnant adolescents to *not* be in a stable relationship with the father of the baby. Yet, not all adolescents regarded such situations as a challenge, as is evident in this young woman’s comments:

Well, there’s no partner, we’re not together anymore. We’re only talking for the baby’s sake. That’s good as my parents don’t like him! They are waiting for the chance to say something to him; my cousin says the same and I will be giving it to him too! Mum is coming in to the birth. If he comes in, God knows what will happen! If he’s not at the hospital when I go into labour, that’s it, he’s not coming in (Fieldnotes 20 July 2012).

Pregnant adolescents with partners said they felt less anxious about meeting the midwives when their partner came with them to appointments. Their partners were often young too, and also experienced coming to clinic as challenging if they were reliant on others for transport, worked long distances away, or were in apprenticeships where they were unable to leave work. They may not have informed their employer that this was an issue due to embarrassment or, as was revealed by one young woman, the mother “refused” to let her son miss work to attend the antenatal appointment. Influences on pregnant adolescents’ future planning were apparent from their relationships with their boyfriends or partners. Comments were, however, limited to wanting their presence as reassurance, though sometimes this appeared to be linked to social appearances in addition to the supportive nature: “It sucks him not coming to clinic with me, he hasn’t got his licence and takes a taxi or the bus and he can’t get time off work to come with me” (Key informant 6: Gina 6 January 2013).

The pregnant adolescents were seen in the waiting room both with and without partners accompanying them. Most rarely attended alone and I wondered if a pregnant adolescent who had no-one to accompany her may be less likely to attend antenatal clinic. Indeed, on a number of occasions I did not see a response when the midwife called out a name, and moved to the next appointment when there was no reply. One adolescent gave her view on attending clinic alone: “I was nervous going to clinic

because I don't normally go anywhere by myself, I usually have someone with me... so... [did not go]. I don't like going out by myself" (Key informant 5: Fiona 12 December 2012).

Another pregnant adolescent described the challenge of isolation because of moving from a rural area to the city for antenatal care at a time when she most needed her family around her: "[I have] come down from Karratha [a significant geographical distance that has separated her from her family] to have this baby, then I will return. "Why," asks another pregnant woman. She replied, "Because it is my first baby and I have to cos I am young" (Fieldnotes 20 July 2012). Another describes how her pregnancy affected her now lost apprenticeship: "I was having twins but I lost one [died]. I have had problems with high blood pressure, UTIs [urinary tract infections] and now I just can't work" (Fieldnotes 27 July 2012).

Some of the social challenges that affected the lives of key informants had serious complicating elements of drug or alcohol use, family separation or estrangement, low educational attainment, mental health issues and poor housing standards. For example, "My dad kicked me out of home when I found out I was pregnant" (Fieldnotes 13 July 2012). Key informants interviewed in the privacy of their homes raised these elements. They were not to be viewed as challenges but as part of their everyday background when telling their pregnancy stories: "Well, I didn't finish high school cos I got kicked out and stuff... I was just skipping school because I was getting bullied and they [school and parents] said I had missed too much and I might as well leave!" (Key informant 6: Gina 6 December 2012).

Other pregnant adolescents felt too scared to tell their mothers, delaying disclosure while they considered their options and anticipating a negative reaction:

The first thing she said to me was, "You can't keep it, you know, you are too young". I knew nothing about babies but I said, "Oh why can't I keep it?" and she said, like, "Don't be ridiculous!", thinking it was a joke. "What are you going to do with a baby!" (Key informant 8: Jessica 5 March 2013).

Those adolescents, who, on discovering or suspecting their pregnancy, told their boyfriends or friends still did not attend for any medical review until their mothers were aware of the pregnancy. The mothers, in many cases, instigated the adolescent's connection with medical services:

I felt relief as soon as I told [someone]. I felt relief cos she went and organised talking to my aunty and things... I felt a bit scared about my mum's reaction... but relieved when everything was told and out in the open as I wasn't hiding it anymore! (Key informant 4: Emma 6 December 2012).

Most adolescents agreed that they felt relief after telling their mother: "I don't know what I would have done if I hadn't told mum" (Fieldnotes 22 February 2013). The relationship with their mother was reported as the most influential on adolescents' attendance at antenatal clinic. Correspondingly, this relationship also significantly influenced their non-attendance.

### **Late Attendance for Antenatal Care**

Some pregnant adolescents arrived late for antenatal appointments, though these were few in number and were often attributable to other people. Challenges voiced by the adolescents were unemployment, limiting disposable income, and increased dependence on sometimes-unreliable family members transporting them to appointments. The adolescents also described other practical impediments; for example, poor public transport timetables and routes. However, more than one said they were pleased this hospital was serviced well by public transport and, as a result, they had no issues with attending appointments. For some pregnant adolescents, attending and having to wait for long periods at the antenatal clinic was problematic, in particular when it involved time away from work and not just for themselves:

A young woman comes out of her appointment and returns to her mother and toddler; she tells the mother that she has to return to the antenatal clinic on Tuesday. The mother angrily responded, "Are they serious! Well, you will have to ask your dad to bring you. I will be busy then". They leave the waiting room (Fieldnotes 7 December 2012).

Some pregnant adolescents were very thorough in their attendance plans, indicating an increasing realisation and maturity:

I researched this hospital, came had a look around. I chose it because it was pretty new and the nurses were nice. I went on a tour. They let you have water birth here but it's first come, first served. I went to look at the hospital I was born at but it was so old! (Fieldnotes 13 July 2012).

Several pregnant adolescents (aged 15-16 years old) attended the antenatal clinic for the first occasion less than four weeks from their deliveries. Conversations with some of them were limited as their pregnancy needs outweighed their ability to meet with a researcher; two of these adolescents were willing to be interviewed but they delivered their babies prior to our meeting. They had not attended for any antenatal care and described “not realising” they were pregnant or “hiding” their pregnancy from those around them.

### **Growing Up**

Milestones of physical and cognitive changes mark the time of adolescence. Social and cultural interactions are also constructed during this time and these influence the confidence and behaviours of adolescents. Pregnancy and accepting a mothering role has physical and psychological challenges, negotiated alongside adolescence. Complex influences affected changes and adaptations to the behaviours of adolescents. They recognised their behavioural changes as becoming responsible, taking care of themselves and planning for their future. One pregnant adolescent described the changes she experienced:

I would use to go out and see friends and stay out all hours and stuff like that, erm, and just not really care, erm, I've matured quite a lot and now, like, my friends would still be my good priorities but now I wouldn't put them first. I wouldn't cancel things to be with them. I wouldn't go out and spend all night out. I take a lot better care of myself in those kind of ways. So, yes, it [pregnancy] has matured me quite a lot... like, if someone came up to me and asked for advice, I wouldn't have cared... now I do... erm. Before I wouldn't be able to stay in the house by myself, it would get completely trashed and stuff. Now [laughs], you know, I kinda look after it and stuff. Even my mum has been amazed at how much I have changed. I think it has been a really good thing I got pregnant cos I was going down a really bad track so it has changed me, um, a lot” (Key informant 2: Claire 2 October 2012).

A stage of acceptance was observed when the adolescents actively participated in their pregnancy and thought of the baby as needing their care, regardless of the stage of gestation. This was indicated by adolescents who described their lives changing

because of their pregnancy, and was signalled in their language: “growing up”, “maturing” or “becoming more responsible”. It was also marked by their acceptance of tests regardless of discomfort:

I just have to get so many blood tests now because of the anaemia and the Hep C... I feel so sick after the blood tests... but it has to be done for her so... I really don't like needles in my arms! (Key informant 6: Gina 6 January 2013).

Anticipating the milestone events in their pregnancy and the realisation of “it's a real baby” as those events occurred, contributed to the process of pregnancy acceptance: “Seeing the ultrasound, yeah, but! Seeing my body change! Seeing my stomach [uses hands to show stomach swelling]... When I was 20 weeks, I was in a size 8 bridesmaid dress... then, the following week, it [my stomach] just popped out...” Experiencing little prior familiarity with pregnancy made this adjustment more challenging as this pregnant adolescent described:

I was scared, yeah. I'd never done anything like that before [antenatal clinic], never talked to anyone about the stuff that they talked to me about, and it was all new to me, like it [the baby] didn't really seem real. It was just like I'd gone to have a talk with someone about telling you all these different things but now, because it's so close, it really feels very real [laughs], very scary! The midwife said it wouldn't feel real until I was actually holding the baby, but it's starting to feel real... I really feel like I am going to have a baby now! (Key informant 7: Hayley 22 February 2013).

Milestone events included positive pregnancy tests, seeing the baby on ultrasound scans, first feelings of movements and the development of the obviously pregnant belly. Events included common pregnancy tests. The first shop-bought pregnancy test was a milestone which “shocked” adolescents: “I didn't believe it!”, “It only had a faint line!”, “[I had to repeat it:] The first time I did it, it was negative!” Ultrasound scans and feeling movements of baby were important to adolescents who previously denied their pregnancy. One disclosed her understanding of feeling her baby move: “[Initial realisation:] Not at first, no, it was just like gas at first! [laughs] but then I could see it, I could see my stomach moving and I knew that it was something in my stomach” (Key informant 6: Gina 6 January 2013).

Adolescents often indicated a growing realisation of life changes because of pregnancy separate from simply gestating or putting on weight: “I don’t want to get fat for no reason at all”. This realisation commenced at different points, and occurred at different speeds in individuals. The emotional “excited”, “shocked”, “scared” feelings experienced at first confirmation of pregnancy indicated the beginning of “growing up” and acceptance of the pregnancy. This then affected the subsequent speediness with which they identified and acted upon their need for support and medical intervention. Emotional immaturity and lack of personal confidence, interruptions in knowledge and limitations in support, seemed to slow this journey and adversely affected acceptance. One adolescent, whose baby’s birth was due in a few days, stated: “I feel different from when I wasn’t looking forward to anything before, I didn’t really want him [the baby]) before...” (Key informant 4: Emma 6 December 2012).

One day, while waiting at the clinic, I met an adolescent who approached the reception desk. This encounter triggered the category of growing up and provided an insight into differing aspects of pregnancy acceptance evident in individual adolescents:

A very young woman came in to the reception and spoke to the receptionist; she had been sent from another hospital to have some tests. She had no pregnancy notes or referral with her [as she had lost them] and appeared unsure of what she had to have done. As the receptionists questioned her [the second receptionist inserted herself into the conversation], she became very embarrassed and tried to talk more quietly, but the receptionists raised their voices, making her embarrassment worse.

She stood out because of her appearance. [Description:] Very tall; overweight; peroxide blonde, frizzy hair; her bearing not confident or articulate, in a way that indicated she had age-appropriate education. Dressed in low-slung, dirty track pants [underwear showing], pregnant belly showing [36+ weeks] and zip-up track top [very soiled] open to mid-chest. Flat, dirty white canvas shoes, decorated with thick black text words and names, ‘fuck ya’, ‘miss ya’, and explicit cartoon images of body depictions [penis and ejaculation]. The midwife came to her assistance and took her to a consulting room for privacy, as the women in the waiting room were all watching and listening.

When the young woman left the consultation room, she made to leave the hospital. I offered to buy her a hot chocolate if she would chat with me for a few minutes; we sat outside so she could have a cigarette. The young woman was 17 years old and lived in a rented property with her partner who was 45 years old. He did not come to the hospital with her, as she came by bus and there was only enough money for one person [and she disclosed it was not his baby anyway]. They were waiting for her fortnightly welfare payment so they could get things for the baby. So far, they had been given a bag of clothes and she had plans to look for a second-hand cot from one of the community sales websites.

Her baby is due the following week [making her 39/40] and she told me her usual hospital had told her to come for an ultrasound because [she thought] the baby was small. She keeps losing her handheld medical notes in the house somewhere as the numerous people staying there move them, but she thought that the nurses in the hospital will know what to do, so it didn't matter. She was rather upset and let down when the midwife here, after making phone calls to the tertiary hospital, could not find a reason for the young woman to have an ultrasound and sent her away without giving her a scan.

[Memo: My impression from this young woman was that having this baby was just something that 'happened'.] She discovered the pregnancy early on and, when she told the baby's father she was pregnant, he hit her, called her a whore and threw her out of their accommodation [she still had the scabs and bruising]. He threatened to kill her if she told anyone he was the father. She met her current partner whom she lives with three weeks ago; it was then she initiated antenatal care. I asked her if her family were aware of the pregnancy: "Yeah, but they don't want to know. I talk to my Nan but I don't really want to live with her, you know".

I asked her how prepared she felt she was for this baby coming. She shrugged and said, "I dunno, I suppose we will get stuff when it comes. Oh, it's a girl, they told me." She smiled as she said this but she did not sound excited and she poked her abdomen hard at the same time. She

was of the opinion that anything that the baby required would be provided by DCP (Department of Children's Services). The inference she gave was that they should provide it because she "had to do stuff for them anyway!"

Memo: I chatted to her for a while as she drank her hot chocolate and I got the very strong impression that she was glad someone was paying her some attention and talking to her as if she was special! I felt that she did not think that her pregnancy was special to anyone, even herself. The baby was viewed as another source of income [and expenditure]. My observations of this young woman's poor preparation and limited antenatal attendances appeared adversely affected because of her low acceptance of the value of her pregnancy (Fieldnotes 17 August 2012).

This adolescent appeared to be trying to accept her pregnancy and act grown up but was hindered by social challenges, including poor role models, lack of tangible support and educational limitations. She made the effort to travel to an unfamiliar hospital because she knew she "had to come to make sure the baby is well".

The pregnant adolescents with whom I shared waiting time at the antenatal clinic displayed behaviours and offered significant comments about their state of mind, engaging with the pregnancy, support in pregnancy and searching for information. The key informants clarified these themes.

### **Key Informants**

Phase Two involved concurrent in-depth interviews with key informants identified during Phase One of the research. Clinic midwives identified adolescents who were suitable for interview in this phase. To recap, the midwives then assessed the pregnant adolescents during confidential appointments for their interest. Midwives then introduced me to adolescents who were familiar with the antenatal clinic, and were willing to share their pregnancy story with a researcher. A few declined for unknown reasons. When introduced to those interested, I sat with them in the corridor outside the waiting room to introduce myself further and give them the opportunity to ask further questions.

I interviewed seven pregnant adolescents and one aged 20 years, expecting her second child; each recorded interview took between 50 minutes and two hours



(increased when the adolescents were happy to talk about their experiences). All the adolescents had attended the antenatal clinic for appointments and were in their last trimester of pregnancy at the time of interview. Two went into labour and delivered their babies before they could be interviewed. Some were unwell on the interview day. At the end of each interview, I gave each of them a box of chocolates as thanks for their involvement. The age range of the adolescents was between 15 years and 20 years. Six were Caucasian, one was Aboriginal and/or Torres Strait Islander and one was Samoan. Not all of the adolescents had completed their high school education. Pseudonyms were used to maintain confidentiality.

### **Eight Stories from Key Informants**

#### **Amber**

Amber was the first key informant I interviewed. She was 20 years old and was introduced to me by the midwife as, in her second pregnancy, she identified strongly with being pregnant during adolescence. Our conversation took place in a quiet garden at one of the hospital cafes. Amber was a calm, quietly spoken young woman who had been in Australia for a year. She and her partner originally came from New Zealand for work reasons and they lived in a crowded, three-bedroom rental house. Also living in the house, Amber revealed, were two teenage brothers and a girlfriend of Amber's who also had a young baby. Amber's first child was one year old (born when she was 19 years old) and, at the time of the interview, her pregnancy was term (40 weeks' gestation). During this planned pregnancy, she had three antenatal clinic appointments, the first at 36 weeks' gestation, and one GP appointment early in the pregnancy. Amber lived within the hospital catchment area; it nonetheless required her to catch two buses and one train, each way, to come to the appointments. Amber was a quiet and articulate young woman who gave thoughtful and humorous responses to the interview. She was happy to talk about her experiences and share them with me:

Researcher: So how does this pregnancy compare with your last one?

Erm, it's different. The feelings in my stomach are different [rubs her belly and smiles], erm, I think I'm a lot more capable this time round, like last time, I was a bit, erm, 'iffy' to do things like scared, nervous... yeah, yeah, things [are different] this time round, cos I've already got a son. I'm sort of running my house as well, taking care of my youngest

siblings too, so I... pretty much act like I'm not pregnant! (laughs). I still do the grocery shopping, like lug all the shopping everywhere and people, like, ask, "How far pregnant are you?" I laugh, saying, "Oh, I'm due next week" (laughs).

It's good, erm... easier, I think second time round. I was scared [last time]; I was scared for the actual birth, yeah, that that scared the heck out of me! (laughs). This time around, I'm still scared because now I *know* [emphasis] what it's like (laughs), and now I don't want to go through it again! But, I dunno, the first birth... erm, was fairly easy compared to some other stories that I had heard. Like, as soon as I went into labour, I had a natural birth, no drugs, no anything, so I'm hoping that this time round will be the same... erm, I was a week early the first time. This time, I'm looking like either I'm going to be on time or late (laughs).

Amber's fear of the pain of labour was something that she specifically emphasised in our conversation. Even as she was laughing, she was still shaking her head at the thought of the experience. As the conversation moved forward, she reflected how her attitude to planning and preparation were pivotal to her ability to cope with the pregnancy, which positively changed her perspective on her life:

Erm... I was very ill prepared the first time. We had just moved into the country so we had about 2-3 months for my partner to find a job, for me to find us a house and for us to not only get settled and put our house together but to have all our baby things ready! But, erm, luckily, with the help of family here, we managed to pull everything together. This time round, I'm a lot more prepared. I've got everything I need, everything I need for the baby. So, first time, we had, like, secondhand things, we had to accept gifts [donations] and stuff like that. This time, I was actually able to go out and buy everything, choose what I wanted for this baby! Yeah, I'm a lot more confident this time round (laughs). I didn't plan the first time round, so now that I'm already a mum, yeah [pause], that's obviously changed my path in life! We were both studying performing arts the first time I found out I was pregnant, so we (pause), my mother was moving to Australia and I decided we need to

move too. There was no way my partner was going to be able to support us [there] [pause] yeah! (laughs). That's it, pretty much, but, in the long run, it's, erm, sorta put our life on track. We have had to mature a lot faster and my partner was only, I think, 19 or 20 (years old) when I fell pregnant the first time. It was harder for him [pause], erm, yeah [pause], I think he found it a lot harder, and he finds this pregnancy very hard as well (laughs).

Amber described the influential relationships she has experienced in this pregnancy. She reflected on how the relationships affected her feelings of being valued, and subsequently how her self-reliance became influenced by this. Her partner was her prime support and she talked about him not "handling her well" as she was emotional and "witchy" due to being pregnant. Amber described what having family support meant to her during pregnancy. She noted how the lack of a close supportive relationship with her family and her mother affected her during this pregnancy. I asked her to tell me about the support she had other than her partner:

Not much... Yeah... like, not having wide support, you know. I've got a little bit of family but they're all busy living their lives, doing their own thing. They come around when they can, to see how I am... (but) not always having someone... [long pause and Amber looked pensive]. I've got my cousins here [in Australia] who have got two older kids... just sort of asking them, "Oh, when you were pregnant, did you do this and that?"... Like, every time questions would pop into my head then, and I would just ask them, like, their experience and sort of OK, learn from that, cos they are in their 30s... They'd just give me advice as well... Yeah, so, they have been the most support...

Mum, yeah, erm, yes, she (mum) wasn't there straight after the birth... I think she came when he was about one month old so that was quite shocking (laughs nervously).

Researcher: Was that hard for you?

Yeah, I was expecting her to get me through, be there, be my main support figure and things then just changed, so I had to adapt and sort of become more independent and just get through it. Back in Auckland (New Zealand), my Samoan family and my partner's family are very

supportive, so, had we been over there, we would probably see them every single day! They'd, you know, be around every single day, spending time with our kids, you know, but, over here, it's like we sort of have to rely on ourselves.

Amber's lack of support influenced her information needs. She said she used her family for information by asking and connecting with women in her family to share their experiences. She also used traditional approaches, for example, the pamphlets she received at the antenatal clinic and library books, to solve her breastfeeding problems.

Amber also described using modern sources of information. Her aunty had told her about an electronic application for her phone [app] which she downloaded. The app was something that Amber said she really liked as it "sends me information from pregnancy up until five years old" and she found relevant information she felt she could utilise: "Oh, yeah, it's good and you can watch videos on it. I watched a couple of births, erm, and then I decided to go ahead with a water birth, which I think I am going to do second time around as well".

Having this information seemed to help Amber with her planning for the birth of her baby, both emotionally and physically:

I know this is going to sound, like, really stupid for a mother to say (pause) but I don't like the, erm, I don't want, erm, I don't like the idea my son will be put on my stomach full of gunk and blood so (pause) that's sort of yuk [screws her face up in distaste].

Researcher: You want him to have a bath first?

(Nodding) I know it's silly, yeah (laughs), I want a clean baby. Like, people say, "don't be silly", but I like the idea of having a nice clean baby straight on to me!

Amber appeared to have such a strong emotional response to the anticipated birth of her baby, I wondered why she had not included the midwife at the antenatal clinic as a source of information or birth support, or discussed her birth plans with the midwife. Her first attendances at antenatal clinic in her first pregnancy, she reflected on as "scary". Even with her partner's support, she described feelings of not knowing what was going on or what to expect: "you don't really know anything!"

Amber spoke about how her life had changed by becoming pregnant and being a mother. She referred several times to how she and her partner had to "grow up quick"

and “just get on with it”. She described the changes she had to deal with becoming a first-time young mother:

Erm, it has changed me... I like the fact I am a mum. I think it's matured me and settled me down. I am more... very grounded now... Before I was out partying and drinking a lot, not focused really... Now, I'm more focused and, before, I could do courses that I wanted to do for fun like... but now, I'm just doing what I want to do. You know I just can't afford to, like (laughs), dither [shakes her hand and laughs] [explains she means she has to make decisions]... erm, so now I've sort of got, like, a plan... We actually have time to sit there and see what you want to do in life... Set a plan, for me and my partner! (laughs)... This is your life! (laughs). This is what you need to do on this date [going to have a baby]... I'm very organised now. I think being a stay-at-home mum is very boring... I find it very boring, which is why I've got my son in daycare twice a week now... I just think he's getting bored, too. It's changed me in the sense that I've grown up in a short amount of time.

Amber spoke about how difficult she found losing friends:

All my friends are still on the party scene or still studying and partying or working. Well, everyone's busy and I just feel that I am just plotting [plodding] and that [pause], in saying that, I still don't have time for anyone! So, yeah, it's just harder to maintain friendships, so you sorta find yourself becoming a little hermit (laughs). Is that what you call it? Like, I don't know anything outside of my house anymore and cleaning... I think I'm a maid, a chef slash maid (laughing) and I have no friends... like, you don't get out much, so... your whole life is in your house, pretty much.

Researcher: If someone had told you that when you were pregnant, would you have listened?

Nooo! You just don't know that's gonna happen! (laughs). You think everything's going to be fun. I'm going to have a baby, cool! I'm going to have a baby I can put him in my handbag!

At the time of our interview, Amber felt “well prepared” during this pregnancy for birth and parenthood. She related that her self-confidence was from prior experience, though she did still feel apprehensive about the upcoming labour and birth. She mentioned that she would have liked more accessible information in the form of local (to her) pregnancy well-being and exercise classes where “young mums like me” can meet and network.

## **Claire**

Claire was my second key informant. I met her for interview at the small tidy unit she rented from her mother. She lived alone but had plans for the baby’s father to move in when the baby was born. In that way, she anticipated that he will “help out”. Claire presented herself as a calm, organised young woman and was 17 years old, but was 16 when she found out she was five weeks’ pregnant. She and her boyfriend were living in Broome at that time where she was studying her initial childcare certificate. The pregnancy prompted the move back to Perth to be closer to her mother and to help with continuing her studies. I asked her to begin telling me her pregnancy story so far:

Erm... when I first found out. it was shock! Like, it was happy. Oh I don’t know. it was kinda weird, I just felt that that my body wasn’t quite right. I, like, took a few home tests for the first few times. So I continued and took another one, it came up negative, so I put it in the bin! Half an hour later, I had a feeling that I should check it again and it came up positive (laughs). When I went to the doctor’s [later] that day and got tested, they said it was positive.

Claire accepted the pregnancy and talked about how difficult it was to tell her parents she was pregnant, though she reflected that it was more difficult telling her father than her mother, being “daddy’s little princess”. She waited until she was 12-13 weeks’ gestation before telling him. Claire indicated that she had many antenatal concerns and, when she was worried, she would go and see her GP even though she attended regular antenatal clinic appointments. The main source of reassurance for her was her mother. I found, listening to Claire, what made her trust her mother and bring insights that were reassuring:

It’s always good to have someone in the family who has had bad experiences cos then you can always turn to them if something’s not

right. Like, you have really bad pains that aren't normal, and you can just ask them about it and they can say that they had that too... erm, I would probably say mainly my mum but I would ask my sister a bit but mainly my mum, yeah!

Claire talked about her feelings and the behaviours that changed during her pregnancy; she identified what were the important changes to her life. During the interview, Claire made several confident references to her prior experiences with babies and young children from the many family members who had had babies in recent years. She also mentioned her own childcare experience, which she identified as teaching her helpful skills she applied to this pregnancy. Claire identified many positive changes that being pregnant at 16 years of age brought to her:

I take a lot better care of myself in those kind of ways, so, yes, it has matured me quite a lot. Like, if someone came up to me and asked for advice, I wouldn't have cared, now I do. Erm, before I wouldn't be able to stay in the house by myself, it would get completely trashed and stuff! Now (laughs), you know, I kinda look after it and stuff!

Even my mum has been amazed at how much I have changed! I think it has been a really good thing I got pregnant cos I was going down a really bad track, so it has changed me, um, a lot!

I reckon that I will still mature and age with the baby (pause) cos it's like (pause), now I'm nervous cos it's a little human being that, like, relies on you and you need to help it live and it's like really nervewracking! Me and my partner are both the same cos it's really nervewracking for each other, but we will learn and pick up things along the way, so, yeah!

Claire and her partner had only been together for 10 months, though knew each other from school. As she talked about parenting, she also talked about the future for her partner and having time off from work when she has the baby, to help her "have time for herself". As she talked about sources of information and parent education, Claire referred to herself as being a main source of education for her partner; and she anticipated "tell[ing] him what he needs to do as it crops up". She talked about her first thoughts of antenatal clinic and compared her sources of pregnancy information:

I was nervous cos I didn't know what to expect. I didn't know what sort of questions they [midwives] were going to ask. Erm, it kinda went, like, really easy and cruisy, just like the GP; it was "How you doing? Is baby moving?", erm, "if you are eating right". They will weigh you, kinda like the GP, but they focus more on the baby than you, erm [pause], but, yeah, it was pretty good. The bounty bag gives you, like, a whole bunch of, like, magazines and brochures on, like, depression and anxiety, like about everything that you can experience in pregnancy... they give you... classes you can go to like breathing classes and breastfeeding classes... erm. like yoga classes.

Claire also described her experience of appointments with the midwife at the clinic. She felt more comfortable when she saw the same midwife as then she did not have to keep going over the same information. She felt frustrated that her appointments were so short; "Yeah, yeah, but, like, it's just so quick and all they do is just read your book and then check baby and then you are out and it's, like, aw, OK... [it's over!]"

When describing what she found useful in her appointments, Claire described her pleasure at how the midwife talked about her baby:

They tell you the changes of baby in this week and, erm (long pause). Yep, that's it. This week, now its organs will be growing and its lungs will be growing, like they won't be fully developed... Erm, yeah, she tells me... most of the time, when she is checking the heartbeat, she... erm, they have charts and stuff like that but it's better when they tell you stuff like that. I find that really helpful and interesting stuff like that... cos it's cool when to know when they open their eyes and stuff like that. And then, when they tell me, erm, when to start looking for kicks and what they would feel like, cos they have said that the first time you don't actually realise it is and you don't actually realise it's a real baby until you are further along...

In describing her other sources of information, Claire was very detailed about the apps on her phone and how relevant she found them to her pregnancy:

They tell you how many weeks you are and how many weeks you have left and what size the baby should be, and what it should weigh and then it tells you how, like, what development the baby should be having and



what's happening with you. Like, this week, you know you might be getting blurry eyes because of, you know, all the extra fluid being (pause while thinking) and, erm, if I have any other concerns, I'll like call up Health Direct [free Medicare Telephone Service] or just have a look on Google just to see if anyone else is (pause) like... BabyCentre... to see if there's anything on there. But apps on the phone, yeah! Most of them are really good, yeah! quite helpful. I've also got nutritious lists of foods, you know, like contraction timers and kick counters and signs of labour, you know, quite helpful.

Claire was able to source information and referred to future planning so it appeared she had been thinking about what she may need in the future. She also identified important strategies for her coming birth and the role the midwife at the antenatal clinic took in her preparation for this:

Erm (silent pause while thinking), I wouldn't say they [midwives] have had much influence on it. I'd say, more, more like my mum has helped me more for planning of the birth, much more than the midwives have. Erm, the midwives kind of just give you, like in the book [orange file], there is a birthing plan, that you can choose what pain relief and how you want to have it. Like, if you want a water birth and what pain relief you can have, music and stuff like that, it pretty much covers, like, what the midwives ask. They helped me a little bit when I asked about pain relief and different ones. Cos I didn't want to have a big, like (pause), an epidural or things like that, I just wanted the gas or maybe the pethidine. So they helped a bit when I was asking about the different types of things and how people have reacted to the different types, so, yeah, it was good.

I got the impression from Claire that she was a capable young woman who was keen to learn and search out information for this pregnancy. She described wide sources of information; however, while she was aware of parent education classes, she shrugged [non-committedly] as she told me she had not managed to attend any.

## **Dawn**

I met Dawn at her home a few days after I was introduced to her at the antenatal clinic; she was the third key informant. At 18 years old, she was a well-presented young woman who lived in privately rented accommodation with her partner of 18 months. On my arrival, both she and her partner were present and eating sandwiches for lunch. They were both interested in the research and very happy to talk about ‘their’ pregnancy. At the time of interview, Dawn was at 40 weeks’ gestation and impatient for the baby to arrive. After a short period chatting to them both about general life events, mainly housing and jobs, Dawn’s partner left us alone for the interview.

Dawn initially began talking about her “shock” on discovering her pregnancy. She was previously told her chances of conception were limited due to having polycystic ovaries. Consequently, when the pregnancy was confirmed, she said: “We just didn’t know what to do!” She described heading off for scans and blood tests prior to the GP sending her to the antenatal clinic for her first appointment. Though excited, she talked about how unpleasant the early weeks of being pregnant were for her:

I think I’m too young to have a baby! (laughs). I honestly do! I think I am well prepared and I have a lot of support so it doesn’t really matter but... (long pause) it wasn’t as cruisy as I thought it was going to be! I didn’t really have a rocky early pregnancy, I was just quite sick [nausea and vomiting] through the whole thing. Yeah! Being unwell and feeling really tired!

I used to eat meat all the time at the time. I didn’t really have any problems with my iron or anything like that but [in early stages of pregnancy] I couldn’t eat meat at all! It’s only just been maybe in the last two weeks that I have been able to start eating meat again.

Dawn was in the late stages of an apprenticeship when she discovered her pregnancy and her partner was in the probation period of a new job. Both of them were working long hours for minimum wages. Dawn felt unwell in the pregnancy, necessitating her having to put her apprenticeship on hold which made things stressful for them.

Difficulties had arisen because of attending antenatal appointments around work commitments and the frustrating experiences of waiting at the appointments:

We would have an appointment for 11.30 and we wouldn't get in till 12.15, pretty much that was every time. It was kinda, like, you do this and take this and go do a urine sample, or do something, and it was very long. The wait, we had to wait ages and ages and ages!

Then you walk in and they [midwives] weigh you, do your urine thing. Then you go in there [examination room] and they don't really ask [anything], they might ask you how you are feeling... then they fill the book out, then tell you to go lay on the bench and they feel for the baby.

Dawn appeared to feel quite strongly that she was judged for being young. She felt that, as a person, she was not important to the midwives looking after her which, on reflection, gave her a "bad" experience of antenatal clinic:

When we went to the clinic, the midwife gave us the pamphlet on contraception and said, "Read this! as I don't want to see you back here!" That's what makes us feel kinda judged and very unwanted. Like, you shouldn't be here but we will tolerate you til [until] you go. I, like, even said that to her. I said to the midwife, to the midwife (repeated), I said that I didn't feel very welcome. She said, you know, I guess that's something she would work on. I said, yeah, you're grumpy, but you should!

Despite her antenatal experiences so far, I was keen to find out where she had built her personal confidence, as she presented herself confidently to me at interview. I asked her to tell me about her sources of information and support:

Erm, we got referred to go to the antenatal classes; we went to the first two but then after that [partner] and I didn't want to go to anymore but. We weren't very pregnant at that time, about 25 or 28 weeks pregnant, all the others [women in the class] were sort of like almost ready to, erm, go! [close to term].

Dawn said she and her partner found the antenatal classes frustrating because they did not like the prescriptive delivery of information, which limited their individual choices. She spoke about her preferred sources and the information she already had:

My partner's mother-in-law, I mean my partner's mum, sorry (laughs)... I don't really know but [who else], I guess I will do whatever I need to do when I get there [thinking]. Erm, I'm not really sure, I had my partner's mum sorta telling me what I can or can't do or that sort of thing. Erm, yeah, I know all my choices and I know what pain medicines there are and all that. Yeah! My partner's mum, she's actually been really, really good throughout the whole thing (pregnancy).

Focused on being healthy, Dawn made a change in lifestyle choices during her pregnancy. This could be seen clearly in her description about how her behaviours have changed as a direct result of the pregnancy: eating healthily, stopping smoking, drinking alcohol and reducing her emotional stress during her pregnancy. Her words demonstrated her positive change in attitude and a shift towards health for the baby. This was shown by her attitude towards smoking. A smoker for four years prior to the pregnancy, Dawn lived with her grandmother for a while in the first trimester. She described her as a heavy (50 a day) smoker who would smoke inside the house:

There's all cigarette smoke inside so I'd just stay in my bedroom or, at night, I'd just be in my bedroom and during the day I would go out, I would never be home... ever. If I wanted to go and watch something on the TV or watch a movie it was like, oh my God! I can't breathe! And then, cos she's old, she's quite oldfashioned-like and, "aw, smoking harms babies, but secondhand smoke won't do anything" [meaning there's no harm to baby being around smokers]. Hmm, yeah, right! [sarcastic]. So it was quite hard and quite stressful, as she didn't really understand any of it [pregnancy risks].

Dawn was impatient to stop the interview and move into the other room to join her partner and cousin with a new baby who had arrived at the house during the interview. Dawn told me about how, when one of her friends came to visit her recently, the friend was describing her lifestyle, saying she "was partying all the time, drinking and going out". Dawn responded to this with feelings of not wanting to be involved and described feeling 'removed' from the friend and her lifestyle. She appreciated that she had something much better for her life and a baby to look forward to. It seemed that she

was proud of herself for having achieved this state; to her, it was a pivotal moment of acceptance, and finally being an “adult”.

### **Emma**

Emma was the fourth key informant, 15 years old and lived with her parents. She had experienced some problems within the mainstream schooling system and, as a result, was recently home-schooled. She had yet to complete Year 9 of high school education. Emma’s baby was due three days after the interview. She had kept the pregnancy concealed from her family and friends, finally revealing the pregnancy two weeks previously. Until that time, she had maintained her schooling, her part-time job and her relationships with those around her. The only person she admitted the pregnancy to was the father of the baby [details undisclosed to those around her]. She was unaware of how advanced her pregnancy was when she finally disclosed it. She had hoped, “it would just go away”.

I met Emma at her home one morning. Her mother was present for the interview despite hints that Emma and I would be better talking alone. There was also quite an active small dog present. It took some prompting throughout the interview to maintain a conversation with Emma. I was unsure if this was natural reticence, embarrassment at the topic or guardedness because of her mother’s presence. Emma talked freely about her non-disclosure of the pregnancy; however, when talking about her feelings during that time and her reasons for this, she was less relaxed. Emma explained what it was that made her believe she was pregnant:

When I started adding things together like, being sick in the morning, not getting my period regularly. Erm, yeah, just all the typical pregnancy signs and I just thought... (pause) I didn’t do much about it. I thought less about it [she meant that she stopped thinking about it].

Emma talked about the physical sensations of being pregnant, saying she “thought” she felt baby moving inside her but did not recognise it until later: “Not at first, it was just like gas at first (laughs) but then I could see it, I could see my stomach moving and I knew that it was something in my stomach” (laughs nervously).

Emma said she had been in “total denial” about her pregnancy. Her feelings also extended to her own health and well-being during this time. Emma related her

experience of searching for information that may have helped her when she was the only one who knew of the pregnancy:

No, I didn't, not really [pause] it wasn't much... I didn't really want to look it up, there wasn't much I wanted to know about... [she shrugged, meaning she did not want to know anything and was ignoring it]. No, I just left it, hoping that it would go away [the baby] (laughs a little.)

Emma explained how she finally came to disclose her pregnancy and what it was that influenced her to do so:

Well, it was my cousin actually who got it out of me. I actually denied it when she asked me at first, but she ended up asking me what was wrong and I finally just told her. But I probably wouldn't have told anyone if she hadn't of got it out of me but.

It was Emma's fear of parental reaction that made her disclose her pregnancy to another younger adult whom she trusted. During the interview, Emma's mother joined in, talking animatedly about the sequence of events that then took place following Emma's disclosure. Emma nodded along with this and agreed at certain points, but Emma herself spoke little. I asked her what she was feeling while all the events described by her mother were going on but I was aware her explanation was likely modified because of her mother's presence:

Erm, still a bit anxious and stuff.

Researcher: Did you understand what was going on?

Yeah, but I didn't really say too much at that time cos everyone was still quite jaw dropped (laughs nervously), so... I kept quiet. But I think so. I understood everything that was happening.

[Now talking about her feelings when she experienced her first ultrasound scan, she nods firmly:]... I thought it [gestation] was a lot less... cos my stomach has only just started to pop out and it was little before, so I thought that I would have at least a couple, maybe two months but... ended up only having two weeks but, yeah (laughs).

It became quite difficult to get Emma to talk about her feelings and she became 'short' and grumpy, to the point her mother apologised for Emma's demeanour, blaming it on lack of sleep. I diverted the conversation away from her emotions and

asked her to share her experiences of antenatal clinic with me. She was very enthusiastic about being given the Bounty Bag:

The baby bag thing... lots of information about what to do when the baby's here, what to do before the baby's here. And I read up all about it, it's made me feel a lot more comfortable about it because I can expect some things.

Researcher: What did you learn?

Just how to detect some things, like with labour... and what to do with the baby and how to help it with what it needs and stuff, like that how to put it to sleep... how to prevent SIDS [Sudden Infant Death Syndrome] and stuff.

Emma spoke about feeling awkwardness while waiting at the antenatal clinic. Nonetheless, she felt, during her two antenatal visits, that the midwives were "all nice, and they made you feel a bit comfortable, they didn't judge me... that was what I wanted". Anticipated judgement from unknown people she met was a strong fear to Emma. After the interview, as I reflected on her conversation, I felt that there was an element of shame which, while not explicitly voiced, was something that had influenced Emma and her actions through her pregnancy. This was shown by her downcast eyes and body language and reluctance to talk about her feelings during her pregnancy. This also included how she thought her peers would react to her:

Researcher: You said you felt awkward because you were the youngest person there... even though that was the young mums' clinic day. Tell me more about how you felt that first time?

Everyone was older than me, about 20 [years old] but I don't look that age [meaning she looks younger because she wears dental braces] (she giggles). Nervous a little bit, because I didn't know what to expect... anxious... well, they didn't look at me and judge me in any way, but I felt that people [in the waiting room] would start to look at me differently and I was afraid to stand up [when my name was called].

Emma had not revealed her pregnancy to her closest friends. She said that her friends, who saw her every day at school, were shocked and disbelieving of the pregnancy. They both needed confirmation from Emma's mother before they accepted her word. Emma's sense-making of her pregnancy was not addressed until very late and

she was unable to elaborate on this. She did, however, reflect on her pregnancy, saying it was definitely not as she had seen portrayed on television where there was always a happy outcome and pregnancy was a comfortable experience. Emma also reflected on how she had changed over the past couple of weeks knowing she was going to be a mother very soon:

Well, I've matured a little so I know I've got to take care of someone, not just myself, no one's going to help me... well, they're [family] going to help me, but I've got to learn to do it myself and I can't really explain it. I've learned I've got to grow up fast (laughs).

Researcher: If you had a friend who was pregnant and she came to you for advice, what would you tell her?

Erm, to tell her parents because you need to. I have actually had someone ask me about this stuff, she's my sister's friend. I told her that she should tell her parents and if she is unsure she should take a test and stuff cos, tell your parents and get antenatal care... everything I didn't do! Yeah, it turned out that she wasn't pregnant.

Emma stated that since she disclosed her pregnancy, her biggest source of information in preparing for labour and birth was her mother and her female relatives who had children. Her mother prompted her to contact the midwife when she felt concerned over recent back pain. Emma did so and, as a result, was more reassured at her mother's reassurance than the midwife's positive response. Emma did not consciously include the midwives at the antenatal clinic in her pregnancy plans despite saying they were pleasant.

## **Fiona**

As the fifth key informant, Fiona's interview took place at the rented, state-provided house that she had lived in with her mother all her life. The interview was quite erratic as Fiona was not an easy conversationalist and obtaining detailed explanation required more prompting than I had experienced with previous interviewees. Fiona was also easily distracted and appeared quite nervous about the interview. I therefore used diverting, casual questions about family photographs and memorabilia on display to promote a more relaxed conversation. Fiona was 18 years old at the time of interview; she had completed full-time education in a special education



program and was in a relationship with the baby's Samoan father who came in from work part way through the interview. At the time of interview, Fiona was 39 weeks' gestation, had attended all her antenatal appointments and also attended antenatal education classes.

Initially, Fiona only disclosed her pregnancy to her best friend though she was only seven weeks pregnant when she attended her first ultrasound. Both her mother and her boyfriend were unhappy about the pregnancy when she did disclose it to them, so much so that Fiona's boyfriend had a "real problem with the idea of fatherhood" and 'broke up' with her:

He stayed with me once I told him, for a little while... once I told him but then he went [said], "No I can't do it. I will still support you and everything like this but [pause]". I thought, ah, whatever... well... but then after a week he got back with me.

Since her pregnancy, Fiona stated her life had not changed at all. She did not go out and socialise with friends very much and she described herself as a "home body". Never having worked in a job since she left full-time education, she did not believe the baby would make a difference to her lifestyle. When Fiona described ways that she had changed, she spoke about what she knew of to be healthy in her pregnancy:

I haven't really done anything healthy in my pregnancy (laughs). I've eaten a lot of junk food which I shouldn't... it isn't healthy! Cool drink [carbonated drinks], chips... I never used to drink water at all but since I have been pregnant that's all I have had.

Fiona was very knowledgeable about her pregnancy. This reflected information she received from her mother and her mother-in-law:

Erm [I will ask] if I, like, think something is wrong with the baby or if something doesn't feel right. I'll just ask her... if it's fine? "Is this supposed to be happening?" and stuff like that. She, like, she's says its fine sometimes, but if she doesn't think it's fine she'll just ring up the hospital [for me]. Sometimes I ask his mum about it cos she's had about seven or eight kids... so she'll know a lot (laughs).

I asked her if the midwife had been helpful. "She does, like... if you want to know something, you just ask and she'll tell you but [sic]".

Fiona usually attended the antenatal clinic with her mother or occasionally her partner. She recalled what she felt in the early days of attending the antenatal clinic and why she felt she was seeing the midwife. She was very nervous going to appointments on her own; she would normally only attend when someone was able to be with her. She told me what it was that was important to her about going to the antenatal clinic:

[By going to clinic] you know the baby is still alive, you hear his heartbeat and stuff. You know if you're... like, you're not allowed to go only 10 days over and stuff. Erm, so I know that I'm [OK], if anything does go wrong they can do something about it. They always do a pee test, erm, they measure your belly, they feel him where he is, to see what position he is in and they listen to his heartbeat.

I rang the hospital once cos he wasn't moving much, and they said if he doesn't move 10 times in 24 hours or something, then to ring them. They told me to come up and I had the things around my belly and, erm, yeah, he started moving then! (laughs). He wasn't moving much, then he [waving her hands to show large movements].

Fiona regarded her mother as her main trusted source of information but, even though she had not asked, she would trust relatives who had recently had babies to give her information. She also trusted midwives. Fiona did tell her Facebook friends that she was pregnant. Although she was aware of options, she had not accessed any information from Facebook or from any web-based source: "When I had it on... cos I put it on Facebook that I was pregnant, my friends were all like... If you need anything, just ask... anything you need to know!"

Fiona's major source of knowledge that she used to prepare for labour and birth was her antenatal classes. When I first asked her what she knew about antenatal education, she said "nothing". However, as the conversation relaxed, I asked what she had learned about pregnancy that she did not know before. She gave me a very clear description of this:

I did a mother's... no, not a mother's group, there's a thing you do up at the hospital, it goes for, like, four weeks. You go for, like, one day a week for, like, four sessions. They taught you, like, what position to be in for labour, like if you got really bad back pain, he [baby] could be, like... his back's on yours... or is it the other way around? Yeah, like

his back on yours. They showed us... she, like, had a video of her pregnancy and her birth... Yeah, I think it was one of the midwives. Yeah, she had a home birth... a water birth; she just showed the part where he was being born. Yeah, she (pause), there was one about breastfeeding and, erm... what else... pain reliefs [sic]... erm, there was a couple of other things too. She showed us how to wrap the baby up, like, tight... erm, she showed us some tools... like the little one they use to break the bag... [amniotic sac].

Yeah, there was something else, I can't remember what it was (pause), she showed us the epidural, she showed us the cord [epidural tubing], she didn't show us the needle! Erm, she told us about the group Strep B [sic], I think it was. They showed you... they showed you at these classes some massages and stuff like that... [trailed off].

This was a strong example of the knowledge that this young woman had gained from attending antenatal classes. As a result, she presented as self-confident and well-prepared, easily able to ask questions about her health: "Yeah, I wasn't at first [well-prepared] but now I am..."

With this in mind, Emma shared the way she felt her outlook had changed since becoming pregnant. She described becoming more mature and the changing relationship with friends whom she kept at a distance. Her increased maturity was illustrated in her opinion of another young mother:

She doesn't look after him that well. Like, when she comes over here, he'd, like, get really dirty. *I'd* put him in the shower and shower him... not her! I don't like the look of dirty babies. As soon as my baby gets dirty, it will be straight in the bath or the shower to get clean! She doesn't pay much attention to him which is sad.

Fiona continued telling me details of how well-prepared she was for this baby. This was indicative of practical assistance Fiona gained from her family and that she understood her own responsibility.

Despite the initial shock and challenges that Fiona faced, she accepted her pregnancy and need to find information to help her prepare for the changes she realised this would bring. She relied on her close family and partner as her main financial and social support but fully engaged with midwives for antenatal care. She did not miss any

antenatal appointments and completed four weeks of antenatal classes. She was the only one of the key informants to do so.

### **Gina**

My meeting with Gina took place on a very hot day. She was the sixth key informant interviewed. The crowded patio contained two plastic chairs and a small table, several large rabbit hutches and assorted paraphernalia. Family members kept popping out for a smoke, enthusiastic to give their point of view on Gina's pregnancy to the 'researcher'. There were also two very friendly Border collie dogs which, on several occasions, tried to climb into the lap of anyone outside. Because of the heat and the number of animals, there were many flies around, which was not comfortable for me.

Gina was a lively young woman aged 17 years who lived at home with her mother, stepfather and younger siblings. She was reliant on her family for housing and transport as she lived quite a distance from the hospital. She attended the hospital because her mother told her it was a "good" hospital to go to. She did not complete high school "cos I got kicked out and stuff". Gina told me that she experienced some bullying which contributed to this. She and her boyfriend (21 years old) had been together for seven months; he continued to live at home with his parents. Gina described his mother as "coming around to the pregnancy". Gina was very open and chatty, though gave the impression of some immaturity. She was happy to tell me her pregnancy story:

I went to a shop one time and I had this instinct to look at baby clothes and I thought it was weird (laughs), so I went to my boyfriend and told him I was looking at baby stuff and he said I was weird! Then my tummy got really bloated and I started feeling sick and I got lots of cravings like peanut butter and banana on toast and I hate peanut butter! Then I went and bought a test and I took it. Then I knew that I was pregnant and that was about six weeks. I went to the doctor when I was eight weeks. I was happy and scared... but I was scared to tell my mum, I knew she would be angry.

Researcher: And was she?

Yes! (laughs). I said... Mum, I'm, like, pregnant. She said, "You're not!" I showed her the test and she went "Oh my God!" and got all

angry; she didn't talk to me for a couple of days. But she didn't tell me to get an abortion because she's against it. But my boyfriend's mum told me to... but now she's all for it.

Gina told of the steps she had taken since discovering the pregnancy:

Well, I've been doing lots of research and stuff, asking my mum and nan and stuff and they've been helping me with all the baby stuff and telling me how to look after her. Like how to sterilise bottles, how to bathe her, what to do when she cries... like what kind of cry it is... yeah, they have helped me a lot.

Gina appeared very secure about the knowledge that she had gained from her family:

Yeah but [I am] just scared of labour though... if they have to stitch me up and stuff, that's really scary... a c-section [caesarean] sounds really scary! They [Mum and Nan] had normal births... they each have five kids.

The implication was that her family was very experienced with pregnancy and giving birth. As a result, she was very confident with the information given in the many stories they shared. Gina was also very enthusiastic about her use of social media during her pregnancy:

I do have this thing on Facebook that tells me what happens to her and me, it shows me what stage she is up to, how big she has grown and stuff... and how many weeks I am... it's called Baby Gaga. Yeah, it shows a little picture of what she's like inside... it's a cartoon picture but it's 3D.

Researcher: So has it taught you something that you didn't know?

Yeah! Like they do poos and wees inside you... and that they drink the amniotic fluid. I never knew their eyes were closed all the time.

Gina also discovered during her pregnancy that she carried the Hepatitis C virus. This had implications for both her health and baby's. Gina related her concerns on discovering the infection:

Oh, yeah, and I used Google! She laughs... I Googled... cos I want bigger boobs, I wanted my milk to come through so I can get bigger boobs; then I looked up how to dry the milk up after!

Researcher: So you want bigger boobs but don't want to breastfeed?

I'm not allowed to. Well, I went to the hospital one time and got my blood tests. My boyfriend was with me that time and I found out I've got Hepatitis C... and so I can't breastfeed. They are going to give me some injections or something... I don't know how I got it! I was going to pump but I don't know if I'm going to.

Researcher: Have you talked to the midwives about it?

Yeah, they're the ones who said I can't do it... but I can get injections.

Gina's impression of the midwives was that they were "helpful but weird!" Her explanation of weird referred to the swabs she had to self-take for group B Streptococcus [swabs taken from her perineum]. She felt quite embarrassed about these but was pleased she was trusted to do them herself rather than the midwife and she understood the midwife's explanation. I enquired about her knowledge of antenatal classes. Gina's mother had told her that she did not need to go to any classes, but Gina did watch a program on television as part of her "research":

Well, I watched this TV show that showed a woman giving birth and you get to see it [meaning the birth itself]... but that's enough education for me to know! [meaning she did not want to know any more] (laughs loudly). Erm... my friend has two babies but she's young like me, she's 15, and she told me some tips... like hot towels and using the exercise ball, erm, and... so I put that into [my] considerations. Yeah, she is my best friend, she has been telling me stuff like, I am going to bleed for about six weeks after and stuff... which is an awful thing to happen! Yeah, but, my boyfriend's not too happy about that part! [laughing, meaning no sex for six weeks].

Gina told me a little more about what challenges pregnancy had brought to her. Adolescents I had interviewed voiced their frustrations when given different or conflicting information from midwives. Gina, however, experienced this at home between her mother and her boyfriend's mother:

My mum and his mum hate each other!

Researcher: Will that make things awkward for you?

Yeah, when I go to his house, his mum is always bagging [criticising] my mum and, when I come home, my mum is always bagging her... it's

wonderful! (she giggles). Well, they hate each other because his mum says that my mum is all wrong about everything she says to me... [example provided was foods to avoid and listeria].

Researcher: Is it hard for you being in the middle of two mums who are both trying to tell you things?

Yeah... I just listen to my mum cos she's got more experience, but it's interesting though.

Gina illustrated here her certainty in her mother's information and continued support over any other external source. Her boyfriend's parents had a less crowded house and invited Gina to live with them in a show of their support. Gina was reluctant to accept this support but felt that, by rejecting it, she would compromise both her relationship with her mother and that with her boyfriend. Gina's mother came outside for a cigarette and joined in the conversation. Gina did not appear to be restricting her responses while her mother was present but I was mindful of the fact she may have done so unconsciously. While her mother was present, Gina spoke about her intense cravings for deep fried snickers bars. She described eating 24 in one sitting, knowing it was unhealthy but felt that during pregnancy it was okay, as she was going to become fat regardless (at interview, Gina's weight gain was close to 18kg: recommended weight gain in pregnancy is 10-12kg).

After her mum returned inside the house, Gina reflected on her first experience of antenatal clinic and the waiting room. She was 10 weeks' pregnant on that occasion and reliant on her family to get her there:

I felt nervous cos there were all other girls around me, staring at me and stuff, then I thought... erm, I realised I wasn't alone and there were loads of other girls who were pregnant too. And they had boyfriends with them too... It sucks that I couldn't have my boyfriend with me cos he's got work and he can't get off. He came once when I found out I had Hep C and then he's not allowed off work anymore to come with me. I miss him not coming to clinic with me. He hasn't got his licence [driving] and takes a taxi or the bus and he can't get time off work to come with me.

Gina spoke about how her mother had told her it was "OK" to miss appointments as they were only going to "feel her belly". Worrying about her baby was still not enough for Gina to override the directive her mother gave her about "being OK".

However, Gina did say if she had really worried, she would have telephoned the hospital. Gina described the experience of having to have “needles” in her arm each antenatal visit as “making her feel sick [with anxiety]”. Given the reference about needles, I asked Gina if she would share how she was preparing for her labour and birth:

Well, it’s really gonna hurt and that, erm, my waters have to broke [sic] first... there will be some contractions and the midwife will tell me what to do and then there’s the pain relief.

Researcher: What are you thinking of for that?

Well, I wanna do it natural but if I can’t, then I wanna have the gas but I don’t want the epidural (laughs), it’s a big needle!

She [mother] said she thinks mine [labour] will be a quick one; hers only lasted two hours... my friend said it could be longer, hers lasted 17 hours... so... I just don’t really want to have a caesarean - it scares me... the operation!

The conversation led into Gina explaining the worst and best of her pregnancy experiences:

I’m sick of not being able to dye my hair and stuff. I wanted to bleach my hair and dye it red but! they told me I wasn’t allowed to do it while I was pregnant. No more piercings, can’t have my nails done, and the morning sickness and feeling ill and sick all the time!

Yeah, that’s why I can’t wait to have her out so that I can go out and get my hair done, and get my nails done. Yeah [explaining why not], I can’t cos of the fumes. I was told [by my education worker] that the fumes wouldn’t be good for baby... and [I don’t like] being fat!

Researcher: Do you like being pregnant in general?

Yeah, I like... they know... I like feeling the movement. Ah, it was like bubbles of fart, I thought it was! She’s kicked a glass off my tummy before and it broke!

Gina felt that the best thing about being pregnant was that she was getting someone to love who was just hers. She spoke about her experiences of pregnancy and the influential advice she has passed on to another young woman in her position:

I would say to get a pregnancy test, she can get an abortion if she wants to, but she can keep it if she wants. Not to listen to anyone, they will



come around eventually. That's what I would say cos my friend wants a baby now (laughs).

Researcher: What have you told her?

Erm, she said she wants to have a baby, but with the right guy and I'm like, just wait for him to come along, don't just sleep with somebody randomly, if you pick someone up and then he leaves you, then you're stuck so, erm... she's like I will wait till we're official then, not pick anyone randomly.

Gina accepted that she was going to be a mother from very early on and her family lifestyle had always incorporated children, which contributed to her feelings of confidence. She was confident in her advice to do what she considered the "right thing" when she gave pregnancy advice to her friend.

Gina found antenatal clinic and midwives pleasant and necessary but amusing. She trusted her mother's information unquestioningly, even when it kept her away from antenatal clinic. Though she described her boyfriend as supportive, she was in a new relationship and she gave the impression she had no fear of being a single parent under her mother's care, knowing she would be able to rely on her family. She displayed signs of attention seeking and immaturity with her thoughts on self-image and unhealthy eating, which have affected her already compromised health. The fact that her family supported these signs perhaps gives an indication into the social challenges that this young woman faced in her pregnancy. At the conclusion of the interview, I thanked Gina for sharing her story. She told me, "Yeah, it was really nice talking to someone about it".

## **Hayley**

The seventh key informant was Hayley. Her interview took place at her family home; she was a little nervous and it took a while for her to relax. I let Hayley tell her story in her own words at her own pace. She was an Aboriginal young woman who did not identify with the culture. Her midwife was also a family friend which gave Hayley a familiarity interacting with her. Hayley was 36 weeks pregnant at the time of interview:

My name's Hayley and I'm only 17 [years of age] and before I got pregnant I was out a lot, with all my friends going to parties, a bit different... I wasn't home at all, I would stay out all the time... I was a

bit different, yeah! I wasn't very good in school... I went, but I wasn't a very good student. Erm, I get along differently with people now.

Researcher: Different in a good way or a bad way?

Erm, a little bit better. It got a bit intense after I got pregnant and everything turned upside down for a little bit... [reluctant to talk].

Hayley spoke about her partner and their relationship, giving some background to their 10-month relationship. He was now allowed to stay over at weekends:

"It's their [my parents'] house so their rules... He was a little bit scared to come here and meet my family but he had to (laughs). Yeah, he had to, that was when things changed, he started coming here and I started going there, so, yeah."

Hayley did not intend to become pregnant:

Nah [certain tone of voice], I found out about, maybe, erm... about two weeks before I told my mum, and someone mentioned to me that I was putting on weight. So I got a test and I waited till my mum was away on her honeymoon to tell her, in October, it was. I was staying at my dad's house for the week cos I got too scared to tell her; it wasn't planned or anything, I had no idea but, by the time I found out, I was 21 weeks so there was nothing I could do about it.

Researcher: Would you have done anything about it?

I probably would have (thinking pause) if I had the chance to, yeah, I would have done something about it if I could have.

Researcher: Meaning a termination?

Yeah, yeah, I would have (pause) but after a few weeks (pause), there was the choice of giving it up for adoption but I didn't want to do that do if I was going to have the baby anyway... after two or three weeks, I told mum.

Hayley was having sex regularly but, because her menses were not in a regular pattern, it did not occur to her that she could get pregnant and consequently she did not use contraception. She described her feelings when she discovered the pregnancy:

I cried straight away. I was shocked... I was really scared... I just didn't know what I was going to do, who to tell or anything, what I was going to do, yeah! I didn't know how to tell mum. Yeah, it was really scary

finding out! It was the first time I have ever seen anything like that so when I first saw it, it just didn't seem real, yeah... I called my boyfriend straight away and told him... he didn't believe me. He didn't for a very long time, yeah, until finally he did after the first ultrasound. Mum took me to the very first one, she came in with me; that was when we found out I was 21 weeks. We found out the baby was healthy, though, that was good, a relief. Now [looking back], it was brilliant. I've never seen anything like it before, it [the baby] seemed so real!

Hayley appeared to have a gap between the theory of contraception and the actual practice but it was beyond the scope of this research to explore this further. However, this gap in knowledge did contribute to the delay in acceptance that she was pregnant. The relationship she described with her mother was a close one though her fear of disappointing her and facing her potential anger contributed to the further delay before there was any medical assessment of her pregnancy. Hayley reflected on those early days of discovery:

I told my boyfriend first cos my mum was away and I was staying at my stepmum's house. So then I told her [stepmother] by text, then I told my dad and he told me how mum would react, then eventually I called her [mother]. It was Melbourne Cup day... and I said I needed to talk to her and it sort of came out. It wasn't so much me telling her, as her asking what was wrong and guessing I was pregnant... and I said, yeah, I am... she was a bit upset, not, like, angry at me but because I didn't tell her earlier... and didn't think of her.

Then, when she got back, she organised all the appointments with the GP and she [GP] just felt my stomach and said, "Yeah, you're pregnant"... then we went to the scan place and mum organised all the appointments with the midwife.

Researcher: Would you have known to do those things?

Nah, wouldn't have a clue... I don't know what I would have done if I hadn't told mum! Yeah, it's been hard and stressful. Erm... I think it was more harder in the start, more harder cos I had to tell my family. I didn't know what they would think of me and he had to tell his dad and I didn't know what he would think [of me] either... I was worried what

other people would think of me. Like how stupid it is... I am too young... like, I am a, erm [embarrassed, looking for words]...

Researcher: Like a slut, you mean?

Yeah! Like they would think of me like that when they found out. Yeah, but it was more harder when people first found out than it is now.

Hayley described her current knowledge of pregnancy and what information she felt she has needed to gather so far in her pregnancy:

Er, pretty much everything! I knew nothing about pregnancy but I am used to little babies as I have little brothers. My mum, yeah, she has told me about my breathing and what I need to do and everything and mum's friend who's a midwife, she tells me stuff too and some of mum's friends tell me things that will make it easier, yeah.

Just about what to expect, yeah (pause), what am I going to do like [in labour] (pause). When, before anyone told me, I thought the worst, that I wasn't [physically going to] be able to do it [be pregnant and give birth], because I'm too young, I thought it was too hard and too complicated for me. I thought I would never be able to do it! Yeah, before anyone told me, there were too many things at once to learn about and what I needed to know and learn about, it was too much, yeah! But now, because everyone has told me, I feel way more confident, like I can actually do it just easier, just easier for me now they have told me and I can ask them.

I am probably going to have an epidural. The midwife talked about morphine and stuff but my friend, she had just the gas and she said it didn't do much good, so to get the epidural... so I think I will (laughs).

Hayley's descriptions illustrated the growth of her acceptance of the pregnancy, which advanced with her self-confidence and maturity. Her self-confidence was aided by her mother's support and from her search for knowledge; Hayley clearly said she would have been "lost" without that support. While Hayley was talking about her knowledge, I asked if she knew about antenatal classes and if she had attended any:

Erm... I'm not too sure, my midwife said instead of doing that, she could go through stuff, instead of being in a roomful of people, yeah... she said it could be like just me and my boyfriend in a room and we

could go through it all and, yeah.

Researcher: Do you think that's better than being in a class?

Yeah! I feel much better asking questions and learning about stuff like that, sometimes she comes here [home], we go through stuff, and that's much better. I can ask her anything... and she checks I am doing OK, tells me what I am going to need to take to the hospital. Yeah, it would be much easier... yeah... and give me all the paperwork and helps me do it, yeah. My boyfriend mainly [comes with me] but sometimes mum will take me, yeah. Nah, he has no experience at all, so it's very scary for him, too! (laughs), Yeah, he tells me all the time he is excited (laughs). Yeah, there's a lot more [to learn] than I thought! (laughs).

Hayley talked about healthy and unhealthy actions she considered in her pregnancy. She ate well and exercised; her mother had told her to avoid eating ham, chicken and soft serve "Maccas" [soft serve ice-cream from fast food restaurants]. Since she informed her mother about the pregnancy, she also gave up smoking cigarettes and drinking alcohol. She defended her history of use during her early stages of pregnancy, saying, "Yeah, cos I didn't know... or I wouldn't have! [carried on]".

I asked Hayley while she was learning about her pregnancy if she ever used the internet or phone applications as other adolescents had told me about them:

Nah, only for baby names... Oh, but I did use one app that told us about how big the baby gets and... fruits and vegetables... I can't remember what it's called [thinking pause]: it told me how big baby was compared to fruit... like, this week, it's the size of a pumpkin! (laughs). I looked at it when I was about 28 weeks or something.

She talked briefly about talking to friends she has who also have babies and this led to an explanation about challenges she had experienced because of being pregnant:

Yeah, [talking] before to one of them but not anymore. I talked to the eldest girl who's just had hers, she told me what it was like. She had hers normal like... It's not very good (pause), well, I've got a few friends who have just had a little baby, two of them, but friends, like, from school, they don't talk as much, I don't hear from them as much anymore... (pause)

Hayley described her feelings about school. This was important to her as the

major source of her social networks as it was where her most familiar peers congregated:

When I found out I was pregnant, I just didn't go back, but I was in Year 11, should be Year 12 but I repeated 11. I just didn't feel very comfortable, being pregnant and just everyone thinking about me and stuff... and the teachers... I [would] feel very embarrassed about being pregnant if I went back.

The conversation continued as Hayley talked on the topic of, "what do you think will be the hardest thing about having a new baby?":

Erm, just knowing all the things I need to do, knowing what's right to do cos I am so young (thinking pause); err, having to tell mum I want to do things.

Researcher: Do you mean like parenting things?

Yeah, I haven't done well so far... saying when I want to go [out] somewhere even though I am pregnant.

Hayley meant that she had a responsible attitude because she was pregnant and felt her mother should treat her in a more adult fashion:

Yeah, I feel stronger, I feel more mature and responsible... I look after myself a lot more; before, I would always be, "mum, do this for me; mum, do that for me"... now I just do things for myself... Not so much cooking and cleaning (laughs) but taking responsibility for what I want... and Centrelink and stuff. It's scary being responsible for another life!

I asked her to tell me what advice she would give to someone young who thought she might be pregnant. She said, "To take each step as it comes, don't stress yourself out over anything, it just makes it harder if you stress! Tell your parents, yeah, or someone like [named midwife]".

Having a good relationship with her midwife, who had a flexible and kind approach, made a positive impact on Hayley's ability to successfully adapt to her pregnancy. Hayley reflected on the important milestones that she had experienced during the pregnancy: Seeing the ultrasound, yeah, but seeing my body change!

## **Jessica**

The eighth key informant, Jessica, had cancelled our appointment once before as she said she felt she had an interesting story but she felt embarrassed about it, too. Jessica was a talkative and articulate 17-year-old young woman. She and her boyfriend (19 years old) lived in a small house they had recently rented from her parents. Jessica knew I wanted to talk to her about her pregnancy and she had arranged to be alone so we could talk and she could tell me about the circumstances in her pregnancy that led to deliberate self-harm.

She began her story by describing her first feelings on discovering the pregnancy:

I felt a bit sick but it was the first day of a strict proper diet; I had been quite small and had put some weight on. I had done a pregnancy test the week before and it came up negative so I thought I must be sick. I was working and, half way through my shift, I took another test which probably wasn't a good idea as it came up positive and the rest of the shift was a blur!

Jessica described feelings of confusion and not knowing what she needed to do for her future. She tried to work all this out in her head without initially telling anyone about the pregnancy. She told her mother about the pregnancy early. Her mother had a history that Jessica identified with and felt that her mother would understand her confusion. Her words implied that the close, open relationship with her mother was her main influence in her pregnancy decisions. She also used her mother as a gateway in other relationships that were important to her; for example, her father and sister:

Like, I told mum first cos she had a kid when she was my age and she gave her up for adoption and that was really hard for her, so I only found out a few years ago and that was really hard for her because she told me that she never told her parents or anything... I told my mum first cos I knew she would understand cos she had been through it. The first thing she said to me was, "you can't keep it you know, you are too young". It was kind of like a wall that came up between us... but then it [pregnancy] got past the stage where I could do anything about it.

Jessica described how difficult it would be without her mother as her main source of emotional and social support during her pregnancy:

I don't know, I wouldn't have coped at all! Mum, especially now! Mum has gone out and bought car seats and pretty much paying for everything, [all the baby] stuff you know but my partner lives here too... we live here, mum and dad own this house and pretty much she pays for all our food; well, we help out a bit but we couldn't do it without them. We don't pay anywhere near enough what we should but... but, yeah, it's good. I'm glad, otherwise I wouldn't even know what we would do. She's going to be at the birth with me, too; otherwise I would have been even more worried about the birth than I already am but! Yeah, I am glad she did [come around]. I am lucky.

From our conversation, I interpreted that Jessica may have changed her decision about maintaining the pregnancy. She certainly acknowledged the struggle it would be without her mother's ongoing help and support.

Jessica had experienced some emotional challenges with her partner that boiled up, exacerbated by the pregnancy. The result of this was that she self-harmed, cutting herself. She stated that she was prepared to talk about this, as the emotional stress from the time had been resolved:

We [Jessica and her boyfriend] had been through a bad patch and it was all such a mess! We came back [to live] here and everything was such a mess and I think I was quite depressed at that time, cos I didn't really have anyone there [for me]. I was young and it was hard, you know. I didn't have many friends as they were all out partying and things were hard with mum and dad not being supportive, [and] then I got really depressed and, on my lowest day... I found out that he had cheated on me when he was at his mate's. I just couldn't believe it. I just tried self-harming myself. I just wanted everything to just go away, it was too much, the depression, I was getting bigger, I didn't feel pretty anymore, we had no money and, erm... He saw me trying to [cut my wrists]... and he just panicked and he called the ambulance that day and stuff. And, I think it was just a wake-up call to him to see me in the hospital



and... he didn't know what he was doing either cos he's quite young too and I think he got scared about having a family.

Jessica identified several difficult challenges that she experienced in her pregnancy, stemming from a lack of support and building in the early months of her pregnancy. This peaked with her not having a positive self-image, partner estrangement, lack of support from her girlfriends and, at the time, poor family support, all contributed to a significant loss in her emotional stability and her subsequent self-harm:

For a while there it was all such a big mess about half way through, huh... but then, support, yeah, support makes it all better! Yeah, definitely, everyone coming around helped, yeah, helped out... it has given me, yeah, given me the boost to get to the end (laughs) pretty much!

After a while, she began to talk about her sources of knowledge on pregnancy and her plans for preparing herself for motherhood. Jessica revealed her shift in attitude and the realisation that she has matured:

I don't really have that mothering instinct, but hopefully it will come after I give birth. I never wanted to have kids at all, I never wanted to have the responsibility, if you like. I never wanted to think of someone else before me cos I was selfish but, yeah, it's different now. Now that she is inside me and everything, I can't wait for her to get out. I pretty much would jump in front of a bullet for her now, so you understand much more when it's actually happening!

Jessica regularly used web-based sources and intended to "check out" some of the applications for phones. She is also part of a mothers' group on Facebook. She told me she enjoyed antenatal clinic because of her "chats" with midwives. She felt there was not much difference between a GP or midwife appointment. She did not consider that the midwives helped her prepare for labour and birth:

No, not really, they both kinda go over more of the technical things.

They don't really don't do anything different. The midwife, she gave me the swab thing for the group B Strep which I had to do. She explained all that but she doesn't really go over the whole giving birth thing.

Jessica reacted positively when I asked what benefit she felt she gained from coming to the antenatal clinic.

Yeah, it helps, it gives you that boost and makes the time go quicker. You know, next week when I go in, I will be 34 weeks; then the next time, it will be 36 weeks; see, ah, it's gone quicker already which is good!

Jessica was home alone with lots of time on her hands and regarded antenatal clinic as part of passing the time and counting down days to the birth. Jessica felt somewhat differently about antenatal classes, rather than the check-up she associated with the antenatal clinic. She really viewed the antenatal classes as a main source of education for herself and her boyfriend. She was very comfortable attending the classes and did not feel out of place as a younger mother to be:

They do a lot of stuff and do a lot of talking but they make it fun too, like, she wrote on the board 'endorphins' and 'adrenalin' and she split us in half and kinda had a little quiz thing going on, which was a fun way of learning stuff, yeah! She'd ask questions like 'other than meat, where would you get iron from' and all that stuff and it was good because it's for healthy babies!

Jessica's thoughts on what guidance she would give to a young woman who asked for pregnancy advice were philosophical and emphasised emotional support:

[I would tell her] that she is not alone, which is the big thing for me. There are all sorts of people out there to help and support you; and... whatever will be will be, and this baby must have been meant to be here and everything will work out in its own time.

## **Chapter Summary**

This chapter is the synthesis of findings collated over a nine-month period as participant observer in an antenatal clinic. During nine months of observation and speaking with waiting pregnant adolescents, I witnessed that the waiting room was often a site of confusion, perceptions of being judged by staff, and feelings of anxiety for pregnant adolescents. These characteristics influenced the ways in which individual pregnant adolescents reacted to the clinic environment.

Four important themes influencing attendance at antenatal clinic were identified from this study of pregnant adolescents. These were: connecting with midwives; the

importance of the maternal mother, supportive relationships; and engaging with the pregnancy.

Key informants highlighted the complex challenges facing pregnant adolescents who often lived in difficult circumstances. The reliance placed on family and friends for support and education over that of midwives was important. They also confirmed their preference for the use of web-based resources of information. Pregnant adolescents whose interviews revealed that they had not organised themselves to be a parent also exposed that opportunities to use midwives as a resource were not considered.

The following chapter will examine the findings revealed in this chapter and discuss the relevance of these findings within the context of midwifery care. Recommendations and limitations of the research are addressed, as are implications for future investigation.

## **Chapter Six**

### **Findings**

#### **Introduction**

This research explored the external influences and motivating reasons for pregnant adolescents' attendance at an antenatal clinic in Perth, Western Australia, and proffers understandings of the ways in which their behaviours and interactions revealed how these young women made sense of their pregnancies. Pregnant adolescents in this research responded to complex influences and viewed their pregnancy journey from a perspective that did not always align with that of the midwives. This knowledge has the potential to inform midwifery care practices for pregnant adolescents during the antenatal period.

This chapter discusses the key findings of the research. Four themes were revealed: connecting with midwives; the importance of the maternal mother; supportive relationships and engaging with pregnancy. These findings are then discussed in the context of current midwifery practice. The research's strengths and weaknesses are presented and the chapter concludes by making recommendations for future practice.

#### **Findings**

##### **Theme One: connecting with midwives**

Pregnant adolescents' initial appointments for antenatal care were pivotal to their continued attendance. The initial meeting with the midwife, and how this first interaction unfolded, largely influenced the young woman's assessment of the experience as a positive one, and formed the basis of her ongoing relationship with midwives.

Previous research pertaining to adult pregnant women indicates the importance of communication to patient satisfaction with midwives (Baker et al., 2005; Lori, Yi, & Martyn, 2011; Wheatley, Kelley, Peacock, & Delgado, 2008). These women wanted midwives to listen and treat them respectfully as individuals. Similarly, in this research, pregnant adolescents commented that they only enjoyed coming to the antenatal clinic when they experienced individualised care from midwives who spent time actively

listening to them. McCourt (2006) argued that a less hierarchical approach of communication with adult pregnant women provided them with more control and information. This research confirms that pregnant adolescents also valued a communication approach that flattened the power imbalance between midwives and adolescents. Pregnant adolescents appeared to respond more favourably to midwifery care when it was individualised and less task orientated.

In this research, pregnant adolescents' concerns with midwifery care centred on the judgement assigned by midwives to being very young and pregnant and being labelled as "stupid" or someone who "sleeps around". Hence, midwives need to be consistently aware of providing care that is non-judgemental. If this attitudinal position is not maintained, midwives risk alienating already stressed pregnant adolescents and subsequently having them distance themselves from antenatal care. James, et al. (2012), in their exploration of African teenagers' perceptions of the antenatal clinic environment, exposed the reluctance on the part of teenagers to attend an antenatal clinic when they felt they were treated as inferior or insensitively regarded by midwives. This highlights the potential lack of connection between midwives and pregnant adolescents that impacts on the health of the mother and baby and inhibits the ongoing effective practice of care provision.

James, et al. (2012) found that the anxiety experienced by pregnant adolescents when attending antenatal clinic may be lessened by regular attendance at the clinic. However, in this research, anxiety did not always improve with subsequent appointments. This may be attributed to poor relationships with midwives, exacerbated by an apparent underlying attitude of some midwives that alienated some adolescents. Active steps to retain engagement with adolescents is necessary in therapeutic relationships which, if not maintained, may lead to an increase in the health risks from a poorly monitored pregnancy (Stickley & Basset, 2008). Kingston, Heaman, Fell, and Chalmers (2012) argued that it is important for midwives to identify the behaviours of pregnant adolescents who are less comfortable at antenatal clinic as those adolescents may be at increased risk of not continuing to attend for regular antenatal care, having not developed a trusting relationship with midwives.

When midwives provided information to pregnant adolescents, the manner in which the information was delivered influenced the way in which the pregnant adolescent responded. If the pregnant adolescent was made to feel that her pregnancy

was important and that she was valued by the midwife, receptiveness to the information was more likely to be considered. Notably, if midwives were able to cue into the ways in which pregnant adolescents viewed the milestones of their pregnancy, that is, from a wider personal perspective than a predominantly medicalised perspective, communication and the basis for subsequent attendances were established and meaningful dialogue, emphasising moments of importance to the pregnant adolescent, were acknowledged. This included initial acknowledgement of the pregnancy even when “it didn’t feel real”, seeing the baby for the first time on the ultrasound scan, applying a developing personality to the fetus, such as “opening eyes to light”, “hiccoughs”, “wees and poos” inside the mother, and responding to parental voices. Midwives who were able to connect with pregnant adolescents in this way were viewed favourably because they were able to help with adaptation to physical and emotional changes that occurred in pregnancy and the information they provided had more relevance to adolescents.

This research captured the behaviours and voices of some pregnant adolescents who presented late into the second or third trimester of pregnancy. This delay limited the opportunity for midwives to develop a relationship with them. Interestingly, the work of Thynne et al. (2014) contends that the incidence of delay and/or concealment of a pregnancy is not a phenomenon of adolescence. However, a number of the adolescents in this research had delayed disclosure and presented late for antenatal care. Those who presented late to the antenatal clinic did not seek early professional advice and relied on family, friends and/or social media to inform their pregnancy.

## **Theme Two: the importance of the maternal mother**

Pregnant adolescents were strongly influenced by their mothers in making the decision to attend for antenatal care and the way in which they made choices related to their pregnancy. Pregnant adolescents deemed the information provided by their mothers to be more significant than the information provided by midwives. Mothers reinforced pregnancy knowledge, promoted health behaviours and provided reassurances as a way to influence adolescents’ behaviours in pregnancy. Mothers were able to express pregnancy progression in a way that was understood by their daughters, on an ongoing basis and from within a context that was familiar to the pregnant adolescent.

The ways in which maternal mothers influenced the adolescents' responses to pregnancy was evident in the pregnant adolescents' adoption of a series of physical events in their search for knowledge. These differed from the gestational stages of a pregnancy used as a screen by midwives and were events used by pregnant adolescents as springboards to increase their pregnancy knowledge. That is, the simpler goals they applied as milestones during their pregnancies were more understandable and tangible to the pregnant adolescents and made it easier to comprehend the changes to their bodies and apply gleaned information to their pregnancy. For example, pregnant adolescents described the positive pregnancy test as the key to initiating talking to parents. They may have missed menstruation, but pregnancy was only a factor as a positive pregnancy test result. Ultrasound scans were valued as a means of validating the pregnancy rather than a process of establishing dates or finding anomalies. In addition, a growing awareness of pregnancy that culminated with the milestone of fetal movements was a point of psychological attachment and maternal feelings. Those adolescents who delayed pregnancy disclosure beyond this point attributed increased anxiety without reassurances from those around them. This contributed to their subsequent disclosure.

Pregnant adolescents identified abdominal growth as a milestone that indicated healthy growth and imminent motherhood: "all of a sudden my belly just popped out!" The adolescents appeared to have a surge of attachment when they could no longer fit into their normal clothes and had to *embrace* the pregnant belly. This point seemed to be where those few adolescents who chose to conceal the pregnancy voiced most anxiety. They also hid their worry from physical discomfort associated with advancing pregnancy, not knowing if it was normal or not: "I attended school as much as I could, even though sometimes I was too sick".

Sharing anecdotal stories from maternal mothers and other family members provided adolescents with information, knowledge and reassurance during pregnancy (Kildea, Stapleton, Murphy, Low, & Gibbons, 2012). Irwin (2009) and Plutzer and Keirse (2012) attest that social values held by mothers, family and friends provide pregnancy and parenting guidance to younger family members as paramount. Mothers, sisters and significant female experiences provided the context to pregnancy and birth for pregnant adolescents and this cultural knowledge is a tacit acquisition supported over time through repeated stories (Boyd, Richerson, & Henrich, 2011; Grassley &

Eschiti, 2008). Cronin (2003) and Whitfield et al. (2013) reported that maternal mothers and friends were significant to the pregnant adolescents' capacity to make sense of their pregnancy and sexual health. Although Cronin found that, despite the information provided by mothers, primiparous (first time pregnant) adolescents reported being unprepared for birth and parenting when interviewed postpartum.

This research extends this finding by adding the dimension that maternal mothers had an unspoken expectation that their advice would be followed because the adolescent was still being parented. Some pregnant adolescents in this research found challenging their mother's advice difficult and this often meant following advice contrary to the midwife. The implication of this finding for first-time pregnant adolescents raises the issue of how midwives address potentially entrenched poor health habits and anecdotal beliefs related to pregnancy. Ngum Chi Watts et al. (2014) found that poor sources of information were loaded with myth, and Yee and Simon (2010) interviewed a minority group of women about their influences about making contraceptive decisions, finding that family and friends were major sources of inaccurate information. Despite the research addressing contraceptive decision-making and the accuracy of information provided to adolescents by extension, this has implications for the pregnant adolescents in this research. Moreover, pregnant adolescents supplemented the knowledge provided by their mothers with information from the internet.

The pregnant adolescents in this research used web-based technology and almost all displayed a preference for receiving information in this way. Many pregnant adolescents were seen accessing technology while waiting for antenatal clinic appointments. Importantly, one of the participants checked the accuracy of information provided by the midwife. Pregnant adolescents, in this research, already seemed to be exposed to a vast amount of interesting, entertaining, and regular, non-specific information from internet sources. This information when delivered daily served to raise awareness and knowledge of their pregnancy and made them more confident to attend antenatal clinic and tolerate the short amount of time allocated with the midwife in which to validate questions. Pregnant adolescents are likely to be adept and comfortable in the culture of internet use and the use of technology in the antenatal clinic would be valuable in assisting midwives in reaching this group (Valaitis & Sword, 2005). Khan et al. (2011), in a study of the use of current technology in diabetes clinic waiting rooms,



found that, with its use, patient satisfaction increased in addition to clinic retention, both of which can be applied to antenatal clinics. This may be adapted for use in midwifery by offering adolescents a medium for online education related to the pregnancy using popular mediums such as social networks (Park & Calamaro, 2013) or, as Holland, Christensen, Shone, Kearney, and Kitzman (2014) suggest, phone texting, and making use of portable smart phone technology (Adams, Daly, & Williford, 2013), whereby contact with midwives may nurture a degree of comfort and reassurance from a distance.

However, whilst web-based technologies provided another easily accessed source of information, the accuracy and relevance of information remained questionable. The pregnant adolescents “did not know what they did not know” and their reliance on their mothers as their primary source of information may have compounded their dismissal of advice from midwives which, in turn, was sometimes different to that from internet sources and their maternal mothers. McInnes and Haglund (2011) suggested that the use of technology may induce anxiety in pregnant adolescents because they often may be unaware of their knowledge shortfalls and struggle to interpret the information provided, particularly if contradictory information must be deciphered. Hence, midwives play a significant role in guiding the individual application of information. Whilst this research found that pregnant adolescents thought there was too little time given to them at antenatal appointments to be able to ask about or question information, this cultural insight into information seeking behaviours needs to be harnessed by midwives as a means of supporting this age group (Whitfield et al., 2013; Wilmore et al., 2015).

Midwives also need to accommodate the fact that maternal mothers greatly influence the adolescents’ decisions to attend for antenatal care and the way in which their preparation for birth and pregnancy is understood. Pregnant adolescents often regarded their mothers as more knowledgeable than midwives and the short length of appointments and the immediacy of the mother enhanced this view. Osuchowski-Sanchez (2011), Vaisanen and Murphy (2014) and Herrman (2008) found that early pregnancy is often repeated within family groups and generations. This research found evidence of entrenched attitudes towards pregnancy and parenting within groups that attended the antenatal clinic. Freitas and Domingues (2013) found a similar group of pregnant adolescents experienced difficulty breaking free of their socioeconomic cycle

and argued that support and modelling by professionals may assist with this. Freitas and Domingues also reported on the effect of unchanging behaviours and role models for adolescents in lower socioeconomic groups that were reflected by some of the adolescents in this research. Given this situation, midwives need to be inclusive of maternal mothers and negotiate a plan with the pregnant adolescent that includes the input of the maternal mother and in a language that is understood by all involved, particularly in relation to describing milestones, diplomatically clarifying family stories and providing reliable and, more challengingly, age-appropriate web-site information.

Midwives may not only need to be more alert to the content and delivery of web-based information (McInnes & Haglund, 2011) but may actively have to embrace more contemporary means to reach pregnant adolescents, as Beck et al. (2014) and Ghaddar, Valerio, Garcia, and Hansen (2012) found. Furthermore, as Tolman and Ebrary (2005) points out, adolescence is a time of emotional change and egocentricity which shapes the behaviour of adolescents. Midwives need to be cognisant of the personal impact of these changes in addition to pregnancy (Schwinn, Schinke, Fang, & Kandasamy, 2014; Walker, Im, & Vaughan, 2012). As Yin et al. (2012) implies, much can still be absorbed into midwifery practice to identify adolescent parents and their supporting families who may benefit from education while in contact with midwives. One of the significant indicators of regular attendance at antenatal clinic was that of supportive relationships.

### **Theme Three: supportive relationships**

Support from family and partners influenced pregnant adolescents' behaviours in ways that initiated links with antenatal services and provided ongoing assistance and preparation for motherhood. This kind of maternal support is described by Gottlieb (2000) as social support, that is, a "process of interaction in relationships which improves coping, esteem, belonging and competence through actual or perceived exchanges of physical or psychosocial resources" (p28). Maternal mothers were not only seen as primary information providers but also offered much in the way of physical support and practical assistance. Emmanuel, Creedy, St John, and Brown (2011) stress that development of the maternal role in the pregnant adolescent is facilitated by having strong supportive role models. Most pregnant adolescents in this research had wide support networks in place, including family, partners and friends. However, in some

cases where there was a suggestion of long-term social problems, minimal family support was indicated by fewer antenatal visits. This also raised concern in relation to the pregnant adolescent's adaptation to the mothering role because of poor support mechanisms and the potential for erroneous role models (Cook & Cameron, 2015; Murphy et al., 2015). This augments the health risk to adolescent mothers and the likelihood of perpetuating an adolescent pregnancy cycle (Mollborn & Jacobs, 2012; Moriarty Daley, Sadler, & Dawn Reynolds, 2013)

Griswold et al. (2013) and Kane, Philip Morgan, Harris, and Guilkey (2013) found that the younger the pregnant adolescent, the more likely there will be an increased need for physical supports such as finances and housing, coupled with the potential challenges on continuing education. Younger, pregnant adolescents did not consider or have the choice of living and caring for their baby away from the support of their parental home and appeared to expect the support of parents. Some of the older adolescents in this research had completed high school, lived outside the parental home but remained partially reliant on the family for financial support and practical assistance. Others faced with severe life challenges experienced estrangement, abandonment, family violence and severe financial hardship, amongst other scenarios, during their pregnancy. This reduced the options that these pregnant adolescents had to access services and antenatal care (Smid et al., 2014; Whalen & Loper, 2014). In this research, as in previous studies (Herrman, 2006; Meadows-Oliver, Sadler, Swartz, & Ryan-Krause, 2007; Popkin, Leventhal, & Weismann, 2010), participants presented adverse social experiences in matter-of-fact ways, giving the impression that their situation was 'their normal' and that any hardships experienced were acceptable and a part of life.

The pregnant adolescents in this research also identified that their need for supportive persons included friends and the father of the baby. Sympathetic friends were used as sounding boards and *leaning on* for emotional support. Positive peer support is significant in building self-esteem within this age group of adolescent females (Currie, 2012; Widman, Choukas-Bradley, Helms, Golin, & Prinstein, 2014). All but one participant disclosed their pregnancy initially to close friends, broaching the subject of 'being pregnant' with them before doing so with their parents. This seemed to provide emotional safety and some security, and allowed the pregnant adolescent to remain within the context of her age group (Ragan, Osgood, & Feinberg, 2014). This

research is congruent with the work of Rose et al. (2012) and Viner et al. (2012) who found that, when encountering problems, it is usual adolescent female behaviour to seek the support and confidence of peers prior to approaching parents. This is important as the incidence of bullying and harassment experienced in the age group is high (Bauman, Toomey, & Walker, 2013; Skoog & Bayram Özdemir, 2015). Kretschmer et al. (2015) further highlighted the differing nature and quality of the adolescent friendship relationships. This too may have complex cultural implications for those pregnant adolescents who enable early pregnancy ideals within their peer group in the process of shared support. Sharing pregnancy experiences with friends who wanted or who had babies was important to them. This supports the work of (Sherman & Greenfield, 2013) who argued that pregnant friends were most supportive. In this research, the sharing of experiences with others provided a support network of close friends from which pregnant adolescents began to negotiate their pregnancy journey and the lifestyle changes it brought.

In their earlier work, Wiemann, Rickert, Berenson, and Volk (2005) concluded that the loss of friendships and poor support structures have a significant long-term influence on the self-esteem and subsequent mental health of pregnant adolescents. Stanton-Salazar and Spina (2005) also described friends and peer group relationships as important to adolescents' coping and stress management. This can be assumed to have relevance to pregnancy during adolescence as peers may support each other in decisions and choices related to pregnancy. Stanton-Salazar and Spina also warned of the dangers of reliance on friends in this age group. Alison Bryant, Sanders-Jackson, and Smallwood (2006) extend this idea, warning that some friendships that are founded through social media sites may not be sustainable. The recent work of Frison and Eggermont (2015) and Ellison, Vitak, Gray, and Lampe (2014) also emphasises that support may not be guaranteed in online friendships if there is no depth and consistency to the friendship.

Shah, Gee, and Theall (2014) assert that partner involvement results in better pregnancy outcomes though my research was unable to comment on the outcomes of the pregnancies seen. However, this research illuminated that these young women felt that the babies' fathers involvement seemed to lend a degree of respectability to the pregnancy, as previously found (Alio, Lewis, Scarborough, Harris, & Fiscella, 2013; Boath, Henshaw, & Bradley, 2013). It is unclear whether this stemmed from their fear

of being stigmatised for being a teenage mother *and* a single parent, as Wood and Barter (2014) suggest.

What seemed more valuable to pregnant adolescents in this research was the reduction in vulnerability that they experienced when attending antenatal clinic alone. This adds to work of Whitworth and Cockerill (2010), Alio, Mbah, Grunsten, and Salihu (2011) and Landers, Mitchell, and Coates (2014) who recommended the provision of antenatal care that incorporates the father of the baby or partner because accepted shared responsibility for the baby gave emotional support and assisted in planning for the pregnancy, birth, and parenting, and, subsequently improved neonatal outcomes. The presence of a partner whilst waiting for an antenatal appointment was also reassuring to the pregnant adolescents who felt able to share their experiences. This is important, as pregnant adolescents who are comfortable at antenatal clinic are more likely to attend regularly and maintain appointments.

Supportive relationships with family, friends and father of the baby provided a cumulative support framework for the pregnant adolescent. If the young woman had all supports in place, they appeared to benefit emotionally and physically and acceptance and positive engagement with the pregnancy seemed to occur.

#### **Theme Four: engagement with pregnancy**

Engaging with the pregnancy is a process that many pregnant women experience as a form of protective bonding with their unborn baby (Alhusen, 2008). Becoming a mother is a journey that has been described as the development of awareness that facilitates the mothering role (Mercer, 2004; Rubin, 1967). More recently, Swan-Foster (2012) described this developing bond as a higher psychological process in preparation for important parental attachment. The depth of preparation the pregnant adolescents had in this research varied according to their age and support, while the degree to which they engaged with their pregnancy appeared to be influenced by their prior knowledge and experiences.

The level of engagement with their pregnancy may be further restricted by the late disclosure and social hardships encountered by the pregnant adolescent. Those pregnant adolescents who had limited or poor prior knowledge of pregnancy and poor supportive relationships appeared less engaged with their pregnancy and showed limited understanding and meaningful appreciation of the gestational indicators of pregnancy

and the need for antenatal care. Rowe, Wynter, Steele, Fisher, and Quinlivan (2013) found that those pregnant women who were disengaged with their pregnancies were less likely to present for first trimester screening. Early work by Fine (1988) said adolescent females signalled their personal limitations in knowledge and experiences by their use of language and demeanour. This has relevance to pregnancy as it suggests that pregnant adolescents may present as uninterested and avoid reading information provided by midwives. However, La Greca and Ranta (2015a) argued that disengagement may also stem from a social anxiety which manifests in some adolescents. A significant event such as a pregnancy during adolescence may trigger or exacerbate such disengagement.

The ambivalence shown by pregnant adolescents towards their pregnancies sometimes took the form of belligerent behaviour whilst they were in the antenatal clinic. Ambivalence as a form of inappropriate coping may indicate an underlying anxiety or a denial of reality (George, Luz, De Tyche, Thilly, & Spitz, 2013). Exploring depression in non-pregnant adolescents, Francis, Malbon, Braun-Courville, Lourdes, and Santelli (2014) found that anxiety was associated with an attitude of ambivalence. It is reasonable to assume that this finding also applies to pregnant adolescents. One indicator of ambivalence appeared to be in the way that pregnant adolescents discussed the support and information they received during their pregnancy, as their body language and the conviction in their voices seemed to dismiss their need for support. For example, when asked to describe their feelings about their pregnancy or their plans for birth, the pregnant adolescents' replies comprised a shrug or ambivalent comments like "it'll be right". The lack of engagement in their pregnancy saw a lack of planning and preparation for birth and motherhood, with these adolescents passively accepting advice from midwives and expecting that the midwife would "just tell me what to do when it happens". This may be a reflection of adolescents being slow to adopt a confident mothering affect. However, it was apparent from this research that there were levels of engagement at different gestational stages that indicated the degree of risk and, hence, antenatal concern for attendees at the clinic. Engagement with their pregnancy seemed also connected to some participants' perceptions of themselves as pregnant with their confidence suffering, suggesting that these pregnant adolescents experienced greater difficulty engaging with their pregnancy as a result.

The apparent lack of confidence about and anxiety over perceptions of how they looked, amplified the emotional sensitivity of the adolescents to judgements made by others as other researchers have found (de Jong, Sportel, de Hullu, & Nauta, 2012; Ferudun, 2011). This, in turn, limited their sense of control and power and was an obstacle to their developing cohesive relationships with midwives during pregnancy, as Hunter, Magill-Cuerden, and McCourt (2015) found in their study of teenage mothers in the UK. Some adolescents in this study were happy to be pregnant and their positive self-image was reflected in their communication and use of language, which, showed that they were proud and wanted to show off their pregnancy to all around them. In contrast, those with a reduced self-image were quieter and appeared more sensitive to perceived criticisms.

Altered self-image amongst pregnant adolescents warrants further investigation, particularly for those whose pregnancies were unexpected, or discovered too late to access the full range of choices on pregnancy continuance, or in those that concealed the pregnancy. There is a paucity of recent research that addresses self-image in pregnant adolescents and the potential adjustment of adolescents to their role as new mothers based on changes to self-image (Brown, Rance, & Warren, 2015; Ferudun, 2011; Figueiredo, Tendais, & Dias, 2014).

This research saw pregnant adolescents affected in ways that reduced their personal confidence and ability to communicate about their pregnancy with others, particularly with midwives at the antenatal clinic and during pregnancy. For some participants, this led to emotional isolation and poor coping strategies to the point of self-harm. This finding supported the work of Hawton, Saunders, and O'Connor (2012) and Laye-Gindhu and Schonert-Reichl (2005) who also identified emotional isolation and inappropriate coping strategies leading to self-harm in adolescents. In many cases, the pregnant adolescents in this research may have benefited from a therapeutic relationship with midwives that addressed their emotional and coping needs. This is important as failing to address this potential risk for pregnant adolescents may precede mental health problems at a later stage, with harmful outcomes. Sipsma et al. (2011) support this view, asserting that reduced self-esteem contributed to pregnancy risks in adolescents and affected mental health through pregnancy. Early intervention by midwives with women, at any age, who appear to be at psychological risk, is necessary

to mediate positive health and pregnancy affirmations (Cohen et al., 2011; Sockol, Epperson, & Barber, 2014).

The growth of self-esteem is a fundamental aspect in the developmental process from adolescence to adulthood (Rawana & Morgan, 2014; Suls, 2014). It is known that adolescent women are more affected by self-esteem issues and related anxiety than adult women (Figueiredo et al., 2014; La Greca & Ranta, 2015b). Therefore, changes in self-esteem during adolescence place women in this already vulnerable group at greater risk for poor health outcomes (Cohen et al., 2011). The findings from this research suggest that *knocks* to the self-esteem of pregnant adolescents may, therefore, hinder the growth and development of their mothering role.

This research also found that there were factors that influenced pregnant adolescents' self-esteem. These factors included lifestyle, background and the general social wellbeing of adolescents who were affected by bullying and romantic relationships. This was in addition to often limited support availability and less than optimal emotional preparedness for mothering. Such poor quality relationships surrounding pregnant adolescents have been found to potentially contribute to a fivefold decrease in self-esteem and compound depressive symptoms during the postnatal period (Kim et al., 2014).

Overall, the process by which pregnant adolescents may successfully engage with their pregnancy may be affected by the quality of the surroundings and the relationships they encounter prior to and during pregnancy. Any delay in, or absence of, signs of positive engagement with the pregnancy may signify that that pregnant adolescent may be at increased risk of health-related problems. Midwives have the unique opportunity to identify and act upon problems as they arise and in order to provide pregnant adolescents with positive and encouraging perspectives of pregnancy and motherhood.

### **Summary of Findings**

Midwives providing antenatal care had a pivotal role in forming positive connections with pregnant adolescents at their initial attendance. If a therapeutic relationship was enabled by a welcoming and non-judgemental stance from the midwife, the pregnant adolescents appeared more likely to attend regularly at the antenatal clinic and felt reassured of being respected and valued. In addition to



midwives having a positive manner towards the adolescents' pregnancies, the support structures surrounding individual adolescents were significant. The maternal mother was influential to the ways in which pregnant adolescents attended at the antenatal clinic, valued information, emulated the mothering role, and engaged with their pregnancies. The pregnant adolescents sought out their mothers as trusted providers of information and guidance in preference to the midwives.

The pregnant adolescents in this research regarded their personal pregnancy milestones from a perspective of positivity, as opposed to the diagnostic stance adopted by midwives. Midwives may connect with pregnant adolescents by using these milestones, enabling communication on a level that appeals to adolescents.

Using this approach to communication may also serve to include those people who accompany pregnant adolescents. When possible, the attendance of the father of the baby at antenatal clinic had significance to pregnant adolescents as it sanctioned the pregnancy to some degree, thereby increasing their comfort when attending appointments. Feelings of well-being associated with antenatal clinic encouraged pregnant adolescents to engage more fully with midwives.

Developing a therapeutic relationship with pregnant adolescents based on communication would enable midwives to assess varying levels of engagement throughout pregnancy. The pregnant adolescents' levels of engagement may be an indicator of their self-esteem and anxiety with their pregnancy and, consequently, their health risk. By developing positive relationships with pregnant adolescents, midwives may be better positioned and hence, more able, to identify those at higher risk.

Midwifery care may mitigate risks to pregnant women. However, there has been limited evidence available to midwives to help them provide culturally appropriate care to pregnant adolescents. The findings from this research have highlighted the behaviours and understanding exhibited by a group of pregnant adolescents whilst attending for antenatal care. The research also revealed reasons why these pregnant adolescents attended the clinic, how they understood their pregnancies, and the way in which this understanding prepared them to birth and assume their mothering role.

### **Implications of the findings for Midwifery**

Midwives hold a pivotal role in influencing pregnant adolescents to engage positively with their pregnancies and mothering. Midwives, if willing and open in their approach to pregnant adolescents, are also placed to offer antenatal support to young fathers, who are often not considered in antenatal care. The first meeting with midwives is significant in fostering a therapeutic relationship between the adolescent and the midwife in terms of making the experience a positive one and forming the basis for ongoing trust in subsequent meetings.

Pregnant adolescents appeared to respond more favourably to midwifery care when it was individualised, less task orientated and where the communication approach used by the midwife was non-judgemental or not one of condescension. Hence, midwives require knowledge of communication strategies that address the potential power imbalance between them and pregnant adolescents. If midwives fail to maintain a non-judgemental attitude, they risk alienating already stressed pregnant adolescents and reducing their attendance for antenatal care. Midwives also need to be able to identify those pregnant adolescents who are uncomfortable at antenatal clinic as these adolescents may be at increased risk of not continuing to attend for regular antenatal care, possibly because they have not formed a trusting relationship with midwives.

The midwife's demeanor influenced the way in which the pregnant adolescent responded to the information delivered. If the pregnant adolescent was made to feel that her pregnancy was important and that the midwife valued her, her receptiveness to the antenatal information was enhanced. When midwives cued into the ways in which pregnant adolescents viewed the milestones of their pregnancy and acknowledged moments of importance to the adolescent beyond risk assessment, then meaningful dialogue between the midwife and pregnant adolescent was possible. Midwives need to be able to connect with pregnant adolescents in this way to help them adapt to the physical and emotional changes of pregnancy, providing them with individualised information.

Midwifery care also needs to embrace the importance of the maternal mother of the pregnant adolescents in the practical and informational support provided to their pregnant daughters. Examples of this included, but were not limited to, transport, financial assistance and maintaining the principal residence for the adolescent and her baby following birth. A supportive mother plays a significant role in the successful

antenatal connection with midwives. The inclusion of the maternal mother in the antenatal care of the pregnant adolescent represents a holistic view of the adolescent's pregnancy experience. Maternal mothers were deemed by their daughters as more significant providers of information than were midwives. Mothers were able to express pregnancy progression in a way that was understood by their daughters, on an ongoing basis, and in a context that was familiar to pregnant adolescents.

Maternal mothers identified simpler milestones to pregnancy that were more understandable and tangible to pregnant adolescents and made it easier for them to comprehend the changes to their bodies and apply the information provided by their mothers to their pregnancy. Sharing anecdotal stories from maternal mothers and other family members provided adolescents with information, knowledge and reassurance during pregnancy. Moreover, midwives need to acknowledge that maternal mothers and friends were significant to the pregnant adolescents' capacity to make sense of their pregnancy and sexual health. Midwives should work in unison with maternal mothers, and refine traditional gestational milestones, so that understandable physical and tangible changes to the pregnant adolescent body are used as springboards to augment their pregnancy knowledge.

Pregnant adolescents supplemented the knowledge provided by their mothers with information from the internet and almost all displayed a preference for receiving information in this way. Midwives have an opportunity to combine the application of professional knowledge with technology to develop localised educational strategies to connect with adolescents during their pregnancy and while waiting at the antenatal clinic. This has the potential to enhance engagement with those adolescents who are poor attendees, those with low literacy levels, and those who may prefer a visual method to receiving health and pregnancy information (Guttman, 2009). Malata and Chirwa (2011), and also Park and Calamaro (2013), identified the positive role that the internet may play in the wider health-seeking behaviours of adolescents, advising that asking some health questions online is less confronting than face-to-face contact. Interestingly, the midwife also needs to be prepared for the challenges presented by pregnant adolescents who refer to the internet and their mothers as primary sources of pregnancy information.

The reliance on maternal mothers as the primary source of information may compound the way in which pregnant adolescents respond to information from

midwives who often moderate the advice provided by the internet and maternal mothers. Thus, midwives play a significant role in guiding the individual application of information, whatever the source. Whilst web-based technologies transmitted information, the accuracy and relevance of such information remains questionable. This, coupled with the knowledge shortfalls of maternal mothers, means that midwives must struggle to interpret the information that bombards pregnant adolescents, particularly if contradictory information must be deciphered. Pregnant adolescents reported that little time was given to them at antenatal appointments to ask about or question information. Midwives must harness pregnant adolescents' information-seeking behaviours in order to support members of this age group (Miller, Wickliffe, Jahnke, Linebarger, & Dowd, 2014; Roxas, 2008). Contemporary communication technologies now require midwives to be knowledgeable of web-based approaches to sharing knowledge of the antenatal experience. This will allow midwives to have input into the level, appropriateness and authenticity of transmitted information related to pregnancy. Knowledge of web-based communication opens another space for midwives to have dialogue with pregnant adolescents. This is pertinent in relation to the use of the physical space in an antenatal clinic. Having Wi-Fi and other communicative technologies in the antenatal clinic creates an opportunity for midwives to enter into the world of the pregnant adolescent, to share with their contextual lives and to create sustainable dialogue over the gestational period. Midwives need to be more alert to the content of web-based information (McInnes & Haglund, 2011) and actively embrace more contemporary means to reach pregnant adolescents.

Midwives should also use the support of family and the partners of pregnant adolescents to initiate links with antenatal services and provide ongoing assistance with preparation for motherhood. As having strong social relationships around adolescent mothers is known to be beneficial, midwives should be alert to cultural and social risks from family estrangement and the loss of friends during pregnancy (Anwar & Stanistreet, 2014; Byrd-Craven & Massey, 2013). Gazmararian et al. (2014) also highlighted that, not only do some young parents experience poor family involvement but they also struggled with communicating with midwives. In some cases, where there was minimal family support, fewer antenatal visits were attended. This was an added concern as less family support may be associated with increased health risk to

adolescent mothers, and perpetuate the adolescent pregnancy cycle where behaviours such as poor antenatal attendance are normalised.

Aubrey, Behm-Morawitz, and Kim (2014) found that the cycle of pregnancy associated with maternal mothers, themselves also young mothers, might have normalised the view of pregnancy in this age group. This impeded the options of these pregnant adolescents to access services and antenatal care (Smid et al., 2014; Whalen & Loper, 2014). In these circumstances, adverse social experiences were presented in matter-of-fact ways, giving the impression that their situation was 'their normal' and that any hardships experienced were acceptable and a part of life (Popkin et al., 2010). Sutherland et al. (2012) support the need for midwives to identify adolescents at increased risk during pregnancy and to focus care and education commensurate to their needs. Thus, midwifery practice must embrace that pregnant adolescents require both emotional and practical supports during pregnancy. Poor assessment of support structures of pregnant adolescents and poor monitoring of referrals reflect a deficit in midwifery practice in risk assessment. Moreover, midwives need to understand that an adolescent's perception of support may not always be reliable or tangible. Furthermore, midwives need to be aware of any change in their support structures that may have repercussions on the adolescent's successful connection to the antenatal clinic and, inversely, upset the adolescent's ease of attendance.

Midwifery models of care, whilst including the maternal mother, should also be inclusive of the pregnant adolescents' significant friends and the father of the baby to maintain and enhance the emotional safety of this already at-risk group. Midwifery practices should acknowledge that the sharing of experiences with others, at this developmental stage, provides a support network from which pregnant adolescents may negotiate their pregnancy journeys and reconcile with the lifestyle changes of becoming imminent mothers (Sherman & Greenfield, 2013). Moreover, sound peer group relationships also assist adolescents' coping and stress management as peers support each other's decisions and choices related to pregnancy. Midwives need to harness existing peer networks to guide decisions in adolescent pregnancy.

The father of the baby lent valuable support to pregnant adolescents in the antenatal clinic. The delivery of antenatal care that incorporates the father of the baby implies shared responsibility for the baby and an enhanced emotional support to the pregnant adolescent whilst planning for the pregnancy and birth. This finding is

significant as pregnant adolescents who are comfortable at antenatal clinic are more likely to attend regularly, maintain appointments (Alio et al., 2011; Landers, Mitchell, & Coates, 2014; Whitworth & Cockerill, 2010) and engage with their pregnancy in a way that positively influences the outcomes of pregnancy (Shah, Gee, & Theall, 2014).

Developing a bond, or engaging in their pregnancy, is a psychological process in preparation for parental attachment. The level of preparation the pregnant adolescents had in this research varied according to their age and support, while the degree was influenced by their prior knowledge and experiences. Also, late disclosure had a bearing on the pregnant adolescents' engagement to their pregnancy. Those pregnant adolescents who were disengaged with their pregnancies were less likely to present at the antenatal clinic for first trimester screening.

Midwives may assess adolescents' acceptance of pregnancy and adaptation towards a mothering role by positive connections with others around them, including antenatal clinic, and from their preparations for the changes birth and motherhood bring. A disruption or lack in these positive indications of engagement would also imply increased risk of health concerns to which midwives should be alerted. Midwifery continues to miss opportunities to identify and connect with some high-risk adolescents to encourage early pregnancy disclosure and reinforce any positive life changes. However, in keeping with the work of La Greca and Ranta (2015a), disengagement may also be a reflection of social anxiety which manifests in some adolescents and may be triggered by an event such as a pregnancy during adolescence. Furthermore, ambivalence as a form of coping may have indicated an underlying anxiety or a denial of what is happening to them. This research revealed that pregnant adolescents were affected in ways that reduced their personal confidence and ability to communicate about their pregnancy with others; in particular, the midwives at the antenatal clinic. Notably, there was a gap in the support provided to pregnant adolescents by midwives. Other researchers have similarly found that, sometimes, midwives are the instigators of poor communication and support which may worsen the emotional isolation of pregnant adolescents and prevent the identification of early pregnancy risk factors in this age group (Brand, Morrison, & Down, 2014; Feldman, 2012; Malabarey et al., 2012; Vieira et al., 2012).

The approach of midwives and the pregnant adolescents' lack of confidence and self-esteem may have heightened their emotional isolation and diminished their coping

abilities. It is known that, when pregnant adolescents fail to develop and maintain a therapeutic relationship with midwives, they are unable to receive appropriate emotional support which may contribute to their reduced self-esteem and mental health-associated problems throughout pregnancy (De Genna & Cornelius, 2014; Hawton et al., 2012; Tzoumakis, Lussier, & Corrado, 2014; World Health Organisation, 2011). This was illustrated in this research by a pregnant adolescent whose self-harm was most likely related to lowered self-esteem, lowered body image, withdrawal of support and partner infidelity. Furthermore, some pregnant adolescents in this research were in denial for a time, or chose to conceal their pregnancy, indicating a poor connection to their pregnancy. Not disclosing their pregnancy restricted their health knowledge and prevented early access to antenatal care. In some cases, their ability to make a considered decision on continuing with the pregnancy was affected, as they were unaware of the physical time frames for pregnancy termination. Being unable to confide in a reliable adult, they felt overwhelmed by the pregnancy and it was “too much” [emotionally] to deal with. In these circumstances, increased stress and anxiety from being unaware of their gestation, and the thought of giving birth alone and unaided, prompted the pregnant adolescents to disclose their pregnancy. Midwives should pay particular attention to pregnant adolescents who present late for care or who concealed their pregnancy, as premature deliveries amongst concealed pregnancies and the levels of high anxiety experienced by concealing a pregnancy warrants psychological support when the pregnancy is disclosed and care to address neonatal impact (Ali & Paddick, 2009; Friedman, Heneghan, & Rosenthal, 2009).

Early intervention by midwives with women, at any age, who appear to be at psychological risk is necessary to mediate positive health and pregnancy affirmations (Darwin, McGowan, & Edozien, 2015; Sukhato et al., 2015). Midwives have a similar noteworthy role in the assessment of pregnant adolescents’ self-esteem, mental health and maternal role development during the pregnancy upon attendance at an antenatal clinic. As Vescovi, Pereira, and Levandowski (2014) suggest, pregnancy during adolescence should be regarded as enabling an opportunity for positive supportive relationships by professionals, rather than increasing stigmatisation and social exclusion. Midwives are in a position to liaise with other health professionals to effectively monitor changes throughout the adolescent's pregnancy and implement protective strategies early.

The pregnant adolescents were apprehensive attending antenatal clinic and, combined with perceptions of judgement and stigma, many avoided connecting with midwives in a way that established a supportive rapport. Maternal mothers were seen as more available to pregnant adolescents and thus the preferred source of antenatal influence and education over that of midwives.

This research revealed that not all pregnant adolescents appreciated the benefits they could obtain from support during their pregnancy, including midwifery support. It was also apparent that support incorporated a variety of social standards that some adolescents seemed to have very little experience of and, hence, had low expectations. This suggested that some pregnant adolescents were at higher risk psychosocially during their pregnancy as they merely accepted, rather than planned, their pregnancies and were subsequently unenthusiastic and unattached from supportive networks. As such, they were less likely to attend appointments when there was little positive family support to encourage them. A lack of attachment with a developing pregnancy needs identification by midwives as this may be indicative of lowered self-esteem and increased anxiety in these pregnant adolescents.



## **Recommendations**

Recommendations related to midwifery practice within the culture of the antenatal clinic are outlined below.

### Recommendation One

Antenatal appointments focused on pregnant adolescents should be clustered together at regular times in a dedicated area, to facilitate a space where they experience cultural safety within the bounds of their development group.

### Recommendation Two

Time “countdown” to the next antenatal appointment should be displayed for all attendees to allay frustration.

### Recommendation Three

Personable midwifery triage is recommended to facilitate waiting time and to establish continuum of care from point of entry to the antenatal clinical clinic.

### Recommendation Four

Re-design antenatal waiting space to incorporate visual educational themes relevant to pregnancy. This area should also be an access to assistance from a midwife with forms and paperwork, as described in Recommendation Three.

### Recommendation Five

Review of current pregnancy information is required to ensure clear *easy to read* information targeted to pregnant adolescents and the baby's father.

### Recommendation Six

Review midwives' workload model to allow for an increase in appointment time. This would increase availability for interaction between those pregnant adolescents who require extra midwifery time.

### Recommendation Seven

Consider the application of free Wi-Fi to engage attendees at the antenatal clinic with ease of access to antenatal education and to facilitate points of personal interest while waiting for appointments.

## **Research**

### Recommendation One

Further research is required to identify the degree of knowledge held by younger adolescents of pregnancy symptoms and the associated risks from not identifying and acting on pregnancy early.

### Recommendation Two

An exploration into ways in which internet applications support pregnant adolescents is required.

### Recommendation Three

Longitudinal research is required to explore the implications of antenatal care of pregnant adolescents in Australia post-partum.

### Recommendation Four

Research requires expansion into the role of the maternal mothers and their potential role in breaking the cycle of adolescent pregnancy.

### Recommendation Five

Explore midwifery models of care to include the mothers of pregnant adolescents, and their potential influence on enabling the independence of their daughters as adults and mothers.

### Recommendation Six

Self-esteem, anxiety and engagement with pregnancy require further research in this adolescent group to identify relationships between the same and subsequently identify pregnant adolescents at risk.

## **Limitations of the Research**

Limitations to the research were identified as follows:

- 1 This research would have gained a more representative sample if there was wider representation of varying ethnic groups from within those pregnant adolescents attending the antenatal clinic.
- 2 This research occurred at one location due to the limited number of cluster appointments at other antenatal clinics that catered for adolescents.
- 3 Undertaking data collection in an open antenatal area, shared on many occasions with other women attending for antenatal appointments, may have affected the responses of those adolescents who felt they were being overheard or observed.

## **Conclusion**

This research sought to increase the body of midwifery knowledge related to how adolescents make sense of their pregnancy whilst waiting in an antenatal clinic. Qualitative research embedded in the interpretive process was used to give voice to pregnant adolescents. In particular, ethnographic methods encompassing researcher immersion in an antenatal clinic over a nine-month period during clinic hours allowed contact with pregnant adolescents. Data collection occurred in two stages: participant observation with the researcher alongside pregnant adolescents who attended and waited at an antenatal clinic, and interviews with eight key informants to supplement and validate data. Spradley's (1980) developmental research sequence (DRS) was applied to data collection and analysis. The data analysis discovered the ways in which pregnant adolescents negotiated their pregnancy experience. Four themes were revealed: connecting with midwives, the importance of the maternal mother, supportive relationships, and engaging with pregnancy.

Early and regular attendance at antenatal clinic is essential to identify and reduce risks that impact on the health of the adolescent mother and her baby. The initial connection and subsequent relationship forged by the midwife with the pregnant adolescent had a significant bearing on pregnant adolescents' understanding of the importance of regular antenatal care.

The importance of maternal mothers to the success of the pregnant adolescents' engagement with their pregnancy and timely attendance at the antenatal clinic was also pivotal to the successful provision of midwifery care. Nonetheless, it was found that some maternal mothers also influenced pregnant adolescents in ways that were confusing, unreliable and not in concert with safe pregnancy care.

Using ethnographic methods, this research provided an in-depth examination of adolescents' voices and behaviours captured in the waiting room while attending an antenatal clinic during their pregnancy. Using an approach that caught the interpretations that these adolescents placed on pregnancy and their experiences at antenatal clinic brings insights to midwives. The insights gained will increase understanding and assist midwives to provide an antenatal service for adolescent pregnant women that more effectively meets their complex needs. Midwives, maternal mothers and their wider support network influenced the complex needs of individual

pregnant adolescents. Reliable and consistent supportive relationships promoted early and regular antenatal clinic attendance by pregnant adolescents. The adolescents' personal history, and their social environment prior to pregnancy, also had a bearing on how they interpreted their own needs during pregnancy and sought out informative and guiding relationships. An enhanced understanding of the world of pregnant adolescents provides midwives with the opportunity to identify those adolescents who may experience higher risk factors during pregnancy.

## References

- Adams, S. K., Daly, J. F., & Williford, D. N. (2013). Adolescent sleep and cellular phone use: recent trends and implications for research. *Health Services Insights*, 6, 99.
- Alhusen, J. L. (2008). A literature update on maternal-fetal attachment. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37(3), 315-328. doi: 10.1111/j.1552-6909.2008.00241.x
- Ali, E. A., & Paddick, S. (2009). An exploration of the undetected or concealed pregnancy. *British Journal of Midwifery*, 17(10), 647-651.
- Alio, A. P., Lewis, C. A., Scarborough, K., Harris, K., & Fiscella, K. (2013). A community perspective on the role of fathers during pregnancy: a qualitative study. *Pregnancy and Childbirth*, 13, 60. doi: 10.1186/1471-2393-13-60
- Alio, A. P., Mbah, A. K., Grunsten, R. A., & Salihu, H. M. (2011). Teenage pregnancy and the influence of paternal involvement on fetal outcomes. *Journal of Pediatric and Adolescent Gynecology*, 24(6), 404-409. doi: 10.1016/j.jpbg.2011.07.002
- Alison Bryant, J., Sanders-Jackson, A., & Smallwood, A. M. K. (2006). IMing, text messaging, and adolescent social networks. *Journal of Computer-Mediated Communication*, 11(2), 577-592. doi: 10.1111/j.1083-6101.2006.00028.x
- Allan, H. T. (2006). Using participant observation to immerse oneself in the field. *Journal of Research in Nursing*, 11(5), 397-407.
- Anwar, E., & Stanistreet, D. (2014). 'It has not ruined my life; it has made my life better': a qualitative investigation of the experiences and future aspirations of

- young mothers from the North West of England. *Journal of Public Health*  
doi:10.1093/pubmed/fdu045
- Arber, A. (2007). "Pain talk" in hospice and palliative care team meetings: an ethnography. *International Journal of Nursing Studies*, 44(6), 916-926.
- Arthur, A., Unwin, S., & Mitchell, T. (2007). Teenage mothers' experiences of maternity services: a qualitative study. *British Journal of Midwifery*, 15(11), 672-677.
- Atkinson, P., Coffey, A., Delamont, S., Lofland, J., & Lofland, L. (Eds.). (2010). *Handbook of Ethnography* (1st ed.). Los Angeles: Sage.
- Aubrey, J. S., Behm-Morawitz, E., & Kim, K. (2014). Understanding the effects of MTV's 16 and pregnant on adolescent girls' beliefs, attitudes, and behavioral intentions toward teen pregnancy. *Journal of Health Communication*, 19(10), 1145-1160. doi: 10.1080/10810730.2013.872721
- Australian Bureau of Statistics. (2012). *Births, Australia 2011*. Canberra Australia.
- Baker, S., Choi, P., Henshaw, C., & Tree, J. (2005). 'I Felt as though I'd been in Jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology*, 15(3), 315.
- Bandyopadhyay, M., Small, R., Watson, L. F., & Brown, S. (2010). Life with a new baby: how do immigrant and Australian-born women's experiences compare? *Australian and New Zealand Journal of Public Health*, 34(4), 412-421. doi: 10.1111/j.1753-6405.2010.00575.x
- Bar-Kalifa, E., & Rafaeli, E. (2014). Above and below baselines: The nonmonotonic effects of dyadic emotional support in daily life. *Journal of Social and Personal Relationships*, 32(2), 161-179. doi: 10.1177/0265407514525888

- Bar-Zeev, S., Barclay, L., Kruske, S., & Kildea, S. (2014). Factors affecting the quality of antenatal care provided to remote dwelling Aboriginal women in northern Australia. *Midwifery*, 30(3), 289-296. doi: 10.1016/j.midw.2013.04.009
- Barton, T. D. (2008). Understanding practitioner ethnography. *Nurse Researcher*, 15(2), 7-18. doi: 10.7748/nr2008.01.15.2.7.c6322
- Bauman, S., Toomey, R. B., & Walker, J. L. (2013). Associations among bullying, cyberbullying, and suicide in high school students. *Journal of Adolescence*, 36(2), 341-350. doi: 10.1016/j.adolescence.2012.12.001
- Baumbusch, J. L. (2011). Conducting critical ethnography in long-term residential care: experiences of a novice researcher in the field. *Journal of Advanced Nursing*, 67(1), 184-192.
- Beck, F., Richard, J.-B., Nguyen-Thanh, V., Montagni, I., Parizot, I., & Renahy, E. (2014). Use of the internet as a health information resource among French young adults: results from a nationally representative survey. *Journal of Medical Internet Research*, 16(5), e128. doi: 10.2196/jmir.2934
- Bell, S., & Lee, C. (2008). Transitions in emerging adulthood and stress among young Australian women. *International Journal of Behavioural Medicine*, 15(4), 280-288. doi: 10.1080/10705500802365482
- Bender, S. S. (2008). Three cases of adolescent childbearing decision-making: the importance of ambivalence. *Adolescence*, 43(172), 861-879.
- Benoit, C., Wrede, S., Bourgeault, I., Sandall, J., Vries, R. D., & Teijlingen, E. R. v. (2005). Understanding the social organisation of maternity care systems: midwifery as a touchstone. *Sociology of Health & Illness*, 27(6), 722-737.
- Black, D. (1979). Antecedent factors in teenage pregnancy. *Fertility and Contraception*, 3(4), 59-64.

- Black, K., & Lobo, M. (2008). A conceptual review of family resilience factors. *Journal of Family Nursing*, 14(1), 33-55.
- Boath, E. H., Henshaw, C., & Bradley, E. (2013). Meeting the challenges of teenage mothers with postpartum depression: overcoming stigma through support. *Journal of Reproductive and Infant Psychology*, 31(4), 352-369. doi: 10.1080/02646838.2013.800635
- Boden, J. M., Fergusson, D. M., & Horwood, J. L. (2008). Early motherhood and subsequent life outcomes *Journal of Child Psychology and Psychiatry*, 49(2), 151-160.
- Boonstra, H. (2002). Teen pregnancy: Trends and lessons learned *The Guttmacher Report on Public Policy* (Vol. 5, pp. 7-10).
- Boyd, R., Richerson, P. J., & Henrich, J. (2011). The cultural niche: Why social learning is essential for human adaptation. *Proceedings of the National Academy of Sciences*, 108(Supplement 2), 10918-10925. doi: 10.1073/pnas.1100290108
- Boyle, J. S. (1994). Style of Ethnography In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 159-185). CA: Thousand Oaks: Sage Publications
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research* 42(4), 1758-1772.
- Brand, G., Morrison, P., & Down, B. (2014). How do health professionals support pregnant and young mothers in the community? A selective review of the research literature. *Women and Birth*, 27(3), 174-178. doi: 10.1016/j.wombi.2014.05.004



- Breheny, M., & Stephens, C. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science & Medicine*, 64(1), 112-124.
- Breheny, M., & Stephens, C. (2010). Youth or disadvantage? The construction of teenage mothers in medical journals. *Culture, Health & Sexuality*, 12(3), 307-322.
- Brown, A., Rance, J., & Warren, L. (2015). Body image concerns during pregnancy are associated with a shorter breast feeding duration. *Midwifery*, 31(1), 80-89. doi: 10.1016/j.midw.2014.06.003
- Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender Society*, 21(4), 528-552.
- Bunting, L., & McAuley, C. (2004). Research Review: Teenage pregnancy and motherhood: The contribution of support. *Child & Family Social Work*, 9(2), 207-215.
- Burns, E., Fenwick, J., Schmied, V., & Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery* 28(1), 52-60.
- Byrd-Craven, J., & Massey, A. R. (2013). Lean on me: Effects of social support on low socioeconomic-status pregnant women. *Nursing & Health Sciences*, 15(3), 374-378. doi: 10.1111/nhs.12043
- Byrne, J., Hauck, Y., & Fisher, C. (2011). Mindfulness Based Childbirth Education. *Women and Birth*, 24, S3-S3.
- Carnevale, F. A., Macdonald, M. E., Bluebond-Langner, M., & McKeever, P. (2008). Using participant observation in pediatric health care settings: Ethical challenges and solutions. *Journal of Child Health Care : For professionals working with*

*children in the hospital and community*, 12(1), 18-32. doi:

10.1177/1367493507085616

Cashin, A., Newman, C., Eason, M., Thorpe, A., & O'Discoll, C. (2010). An ethnographic study of forensic nursing culture in an Australian prison hospital.

*Journal of Psychiatric and Mental Health Nursing*, 17(1), 39-45. doi:

10.1111/j.1365-2850.2009.01476

Chantrapanichkul, P., & Chawanpaiboon, S. (2013). Adverse pregnancy outcomes in cases involving extremely young maternal age. *International Journal of Gynaecology and Obstetrics*, 120(2), 160-164.

Chen, X.-K., Wen, S. W., Fleming, N., Demissie, K., Rhoads, G. G., & Walker, M.

(2007). Teenage pregnancy and adverse birth outcomes: A large population based retrospective cohort study. *International Journal of Epidemiology*, 36(2), 368-373.

Choudhury, S. (2010). Culturing the adolescent brain: what can neuroscience learn from anthropology? *Social Cognitive and Affective Neuroscience*, 5(2-3), 159-167.

doi: 10.1093/scan/nsp030

Choudhury, S., Charman, T., & Blakemore, S.-J. (2008). Development of the teenage brain. *Mind, Brain, and Education*, 2(3), 142-147.

Clark, L. F., Cordero, F., Desai, M., Drake, P., & Lim, I. (2015). Adult Identity

Mentoring 4 Teen Moms (AIM4TM): Adapting an evidence-based pregnancy prevention program (Project AIM) to reduce rapid repeat pregnancies and

improve outcomes for adolescent mothers. *Journal of Adolescent Health*, 56(2), S26. doi: 10.1016/j.jadohealth.2014.10.052

- Cohen, D., Lisle, C., Williams, W. R., Brunsdon, C. F., & Batstone, T. (2011).  
Exploratory study to evaluate the provision of additional midwifery support to  
teenage mothers. *Public Health*, 125(9), 632-638. doi:  
10.1016/j.puhe.2011.06.008
- Coleman, L., & Cater, S. (2006). 'Planned' teenage pregnancy: Perspectives of young  
women from disadvantaged backgrounds in England. *Journal of Youth Studies*,  
9(5), 593-614.
- Commendador, K. (2007). The relationship between female adolescent self-esteem,  
decision making, and contraceptive behavior. *Journal of the American Academy  
of Nurse Practitioners*, 19(11), 614-623. doi: 10.1111/j.1745-7599.2007.00267.x
- Connie, L. (2009). Mothering and Childbirth Education. *International Journal of  
Childbirth Education*, 24(2), 4.
- Cook, S. M. C., & Cameron, S. T. (2015). Social issues of teenage pregnancy.  
*Obstetrics, Gynaecology and Reproductive Medicine*.  
10.1016/j.ogrm.2015.06.001 doi:10.1016/j.ogrm.2015.06.001
- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: techniques and  
procedures for developing grounded theory* (3rd ed.). Thousand Oaks, Calif:  
Sage Publications, Inc.
- Coren, E., Barlow, J., & Stewart-Brown, S. (2003). The effectiveness of individual and  
group-based parenting programmes in improving outcomes for teenage mothers  
and their children: a systematic review. *Journal of Adolescence*, 26(1), 79-103.
- Correa-Velez, I., & Ryan, J. (2012). Developing a best practice model of refugee  
maternity care. *Women and Birth*, 25(1), 13-22. doi:  
10.1016/j.wombi.2011.01.002

- Couch, J. (2011). 'My life just went zig zag': Refugee young people and homelessness. *Youth Studies Australia*, 30(2), 22.
- Crawford, D. M., Trotter, E. C., Hartshorn, K. J., & Whitbeck, L. B. (2011). Pregnancy and mental health of young homeless women. *American Journal of Orthopsychiatry*, 81(2), 173-183. doi: 10.1111/j.1939-0025.2011.01086.x
- Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches*. Thousand Oaks: SAGE Publications.
- Crittenden, C. P., Boris, N. W., Rice, J. C., Taylor, C. A., & Olds, D. L. (2009). The role of mental health factors, behavioral factors, and past experiences in the prediction of rapid repeat pregnancy in adolescence. *Journal of Adolescent Health*, 44(1), 25-32.
- Cronin, C. (2003). First time mothers – identifying their needs, perceptions and experiences. *Journal of Clinical Nursing*, 12(2), 260-267. doi: 10.1046/j.1365-2702.2003.00684.x
- Currie, C. (2012). Social determinants of health and well-being among young people. In C. Zanotti, A. Morgan, D. Currie, M. de Looze, C. Roberts, O. Samdal, O. R. F. Smith & V. Barnekow (Eds.), *Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey*. Copenhagen: WHO Regional Office for Europe.
- Darwin, Z., McGowan, L., & Edozien, L. C. (2015). Antenatal mental health referrals: review of local clinical practice and pregnant women's experiences in England. *Midwifery*, 31(3), e17-22. doi: 10.1016/j.midw.2014.11.004

- De Genna, N. M., & Cornelius, M. D. (2014). Maternal drinking and risky sexual behavior in offspring. *Health Education & Behavior*, 42(2) 185-193 doi: 10.1177/1090198114547812
- De Genna, N. M., Cornelius, M. D., & Donovan, J. E. (2009). Risk factors for young adult substance use among women who were teenage mothers. *Addictive Behaviours*, 34(5), 463-470. doi: 10.1016/j.addbeh.2008.12.014
- de Jong, P. J., Sportel, B. E., de Hullu, E., & Nauta, M. H. (2012). Co-occurrence of social anxiety and depression symptoms in adolescence: differential links with implicit and explicit self-esteem? *Psychological Medicine*, 42(03), 475-484. doi: doi:10.1017/S0033291711001358
- DeCherney, A. (2007). Adolescent pregnancy: Psychological issues. *McGraw-Hill's Access Medicine*, 10e ed.
- Denzin, N. K. (2001). *Interpretive Interactionism* (2nd ed.). Thousand Oaks, Calif: Sage Publications.
- DeWalt, K. M., & DeWalt, B. R. (2011). *Participant observation; a guide for fieldworkers* (2nd ed.). Pittsburgh: Altamira.
- Doğan-Ateş, A., & Carrión-Basham, C. Y. (2007). Teenage pregnancy among Latinas: Examining risk and protective factors. *Hispanic Journal of Behavioral Sciences*, 29(4), 554-569.
- Downe, S., Finlayson, K., Walsh, D., & Lavender, T. (2009). 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *International Journal of Obstetrics & Gynaecology*, 116(4), 518-529.

- Duggan, R., & Adejumo, O. (2012). Adolescent clients' perceptions of maternity care in KwaZulu-Natal, South Africa. *Women and Birth*, 25(4), e62-e67. doi: 10.1016/j.wombi.2011.10.004
- East, P. L., Reyes, B. T., & Horn, E. J. (2007). Association between adolescent pregnancy and a family history of teenage births. *Perspectives on Sexual and Reproductive Health*, 39(2), 108-115. doi: 10.1363/3910807
- Ellison, N. B., Vitak, J., Gray, R., & Lampe, C. (2014). Cultivating social resources on social network sites: Facebook relationship maintenance behaviors and their role in social capital processes. *Journal of Computer-Mediated Communication*, 19(4), 855-870. doi: 10.1111/jcc4.12078
- Ely, M. (1991). Doing qualitative research: circles within circles. In Margot Ely, Margaret Anzul, Teri Freidman, Diane Garner & Ann McCormack-Steinmetz (Eds.), (pp. 256). London ; New York: Routledge
- Emmanuel, E. N., Creedy, D. K., St John, W., & Brown, C. (2011). Maternal role development: the impact of maternal distress and social support following childbirth. *Midwifery*, 27(2), 265-272. doi: 10.1016/j.midw.2009.07.003
- Engebretson, J. (2011). Clinically applied medical ethnography: Relevance to cultural competence in patient care. *The Nursing Clinics of North America*, 46(2), 145-154, .
- Faridi, R., Zahra, A., Khan, K., & Idrees, M. (2011). Oncogenic potential of Human Papillomavirus (HPV) and its relation with cervical cancer. *Virology Journal*, 8(1), 1-8.
- Feldman, J. (2012). Best practice for adolescent prenatal care: Application of an attachment theory perspective to enhance prenatal care and diminish birth risks. *Child & Adolescent Social Work Journal*, 29(2), 151.

- Ferudun, D. (2011). Self-esteem and body image of Turkish adolescent girls. *Social Behavior and Personality*, 39(4), 553-561.
- Fetterman, D. M. (2010). *Ethnography: Step by step* (3rd ed.). Melno Park, CA: Sage.
- Figueiredo, B., Tendais, I., & Dias, C. C. (2014). Maternal adjustment and maternal attitudes in adolescent and adult pregnant women. *Journal of Pediatric and Adolescent Gynecology*, 27(4), 194-201. doi: 10.1016/j.jpag.2013.09.014
- Fine, M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review*, 58(1), 28-54.
- Finkler, K., Hunter, C., & Iedema, R. (2008). What Is going on?: Ethnography in hospital spaces. *Journal of Contemporary Ethnography*, 37(2), 246-250.
- Flynn, L., Budd, M., & Modelski, J. (2008). Enhancing resource utilization among pregnant adolescents. *Public Health Nursing*, 25(2), 140-148. doi: 10.1111/j.1525-1446.2008.00690.x
- Forsey, M. G. (2010). Ethnography as participant listening. *Ethnography*, 11(4), 558-572.
- France, E. F., Wyke, S., Ziebland, S., Entwistle, V. A., & Hunt, K. (2011). How personal experiences feature in women's accounts of use of information for decisions about antenatal diagnostic testing for foetal abnormality. *Social Science & Medicine*, 72(5), 755-762. doi: 10.1016/j.soscimed.2010.11.031
- Francis, J., Malbon, K., Braun-Courville, D., Lourdes, L. O., & Santelli, J. (2014). Ambivalence about pregnancy and its association with symptoms of depression in adolescent females initiating contraception. *Journal of Adolescent Health*, 56(1), 44-51. doi: 10.1016/j.jadohealth.2014.07.002

- Freeman, M. (2005). Rethinking Gillick. *The International Journal of Children's Rights*, 13(1-2), 201-201.
- Freitas, P., & Domingues, M. (2013). *Social determinants of adolescent pregnancy in Brazil*. Paper presented at the European Journal of Epidemiology. Conference: EuroEpi 2013 and NordicEpi 2013: Non-Communicable Disease Epidemic: Epidemiology in Action, Aarhus Denmark.
- Friedman, S. H., Heneghan, A., & Rosenthal, M. (2009). Disposition and health outcomes among infants born to mothers with no prenatal care. *Child Abuse & Neglect*, 33(2), 116-122.
- Frison, E., & Eggermont, S. (2015). Exploring the relationships between different types of Facebook use, perceived online social support, and adolescents' depressed mood. *Social Science Computer Review*.  
<http://ssc.sagepub.com/content/early/2015/01/21/0894439314567449.abstract>  
doi:10.1177/0894439314567449
- Gazmararian, J., Dalmida, S., Merino, Y., Blake, S., Thompson, W., & Gaydos, L. (2014). What new mothers need to know: Perspectives from women and providers in Georgia. *Maternal and Child Health Journal*, 18(4), 839-851. doi: 10.1007/s10995-013-1308-8
- Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.
- Genest, L., Decroix, H., Rotten, D., & Simmat-Durand, L. (2014). Early motherhood: sociodemographic profiles of 220 teenage mothers in Seine-Saint-Denis. *Journal de Gynecologie, Obstetrique et Biologie de la Reproduction*, 43(5), 351-360.
- George, A., Luz, R. F., De Tyche, C., Thilly, N., & Spitz, E. (2013). Anxiety symptoms and coping strategies in the perinatal period. *Pregnancy and Childbirth*(13), 233. doi: 10.1186/1471-2393-13-233



- Ghaddar, S. F., Valerio, M. A., Garcia, C. M., & Hansen, L. (2012). Adolescent Health Literacy: The Importance of Credible Sources for Online Health Information. *Journal of School Health*, 82(1), 28-36.
- Gogna, M., Binstock, G., Fernández, S., Ibarlucía, I., & Zamberlin, N. (2008). Adolescent pregnancy in Argentina: Evidence-based recommendations for public policies. *Reproductive Health Matters*, 16(31), 192-201. doi: 10.1016/S0968-8080(08)31358-5
- Gomez-Scott, J., & Cooney, T. M. (2014). Young women's education and behavioural risk trajectories: clarifying their association with unintended-pregnancy resolution. *Culture, Health and Sexuality*, 16(6), 648-665. doi: 10.1080/13691058.2014.898794
- Gortzak-Uzan, L., Hallak, M., Press, F., Katz, M., & Shoham-Vardi, I. (2001). Teenage pregnancy: Risk factors for adverse perinatal outcome. *Journal of Maternal-Fetal and Neonatal Medicine*, 10(6), 393-397.
- Gottlieb, B. (Ed.). (2000). *Selecting and Planning Support Interventions*. London: Oxford University Press.
- Grassley, J., & Eschiti, V. (2008). Grandmother breastfeeding support: what do mothers need and want? *Birth*, 35(4), 329-335. doi: 10.1111/j.1523-536X.2008.00260.x
- Gray, N. J., Klein, J. D., Noyce, P. R., Sesselberg, T. S., & Cantrill, J. A. (2005). Health information-seeking behaviour in adolescence: The place of the internet. *Social Science & Medicine*, 60(7), 1467-1478. doi: 10.1016/j.socscimed.2004.08.010
- Griswold, C. H., Nasso, J. T., Swider, S., Ellison, B. R., Griswold, D. L., & Brooks, M. (2013). The prenatal care at school program. *The Journal of school nursing : the official publication of the National Association of School Nurses*, 29(3), 196-203.

- Gross, K., Alba, S., Glass, T. R., Schellenberg, J. A., & Obrist, B. (2012). Timing of antenatal care for adolescent and adult pregnant women in south-eastern Tanzania. *Pregnancy and Childbirth*, 12, 16. doi: 10.1186/1471-2393-12-16
- Guba, E. G. (2013). The Alternative Paradigm. In J. W. Creswell (Ed.), *In Qualitative Enquiry and Research Design Choosing Among Five Approaches*: Thousand Oaks: SAGE Publications.
- Guttman, C. (2009). Technology enhances patient education (Vol. 34, pp. 60). North Olmsted: Advanstar Communications, Inc.
- Hadley, A. (2014). Reducing Teenage Pregnancy: Lessons Learned From the UK Government's Teenage Pregnancy Strategy for England. *Journal of Adolescent Health*, 54(2), S35.
- Hahn, R. A. (1995). *Sickness and healing: An anthropological perspective*. New Haven, CT: Yale University Press.
- Hall, K. S., Kusunoki, Y., Gatny, H., & Barber, J. (2014). The risk of unintended pregnancy among young women with mental health symptoms. *Journal of Adolescent Health*, 54(2), S21-S22.
- Hall, M. H. (2001). Rationalisation of antenatal care. *The Lancet*, 357(9268), 1546-1546.
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: principles in practice*. Milton Park, Abingdon, Oxon: Routledge.
- Hanna, B. (2001). Negotiating motherhood: The struggles of teenage mothers. *Journal of Advanced Nursing*, 34(4), 456-464.
- Hanson, C. (2004). *A cultural history of pregnancy: Pregnancy, medicine and culture 1750-2000*. Basingstoke, UK: Palgrave.

- Harlow, E. (2009). Eliciting narratives of teenage pregnancy in the UK: Reflexively exploring some of the methodological challenges. *Qualitative Social Work*, 8(211).
- Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: A critical ethnography. *International Journal of Nursing Studies*, 47(6), 723-731.
- Hawton, K., Saunders, K. E. A., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373-2382. doi: 10.1016/S0140-6736(12)60322-5
- Heidegger, M. (1927). Being and time (John Macquarrie & E. Robinson, Trans.). Oxford: Blackwell.
- in *Martin Heidegger*, Clarke, T., (2011)
- Hemmings, A. (2009). Ethnographic research with adolescent students: Situated fieldwork ethics and ethical principles governing human research. *Journal of Empirical Research on Human Research Ethics: An International Journal*, 4(4), 27-38.
- Herrman, J. (2006). The voices of teen mothers: The experience of repeat pregnancy. *The American Journal of Maternal Child Nursing*, 31(4), 243-249.
- Herrman, J. (2008). Adolescent perceptions of teen births. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(1), 42-50.
- Herrman, J., & Waterhouse, J. K. (2011). What do adolescents think about teen parenting? *Western Journal of Nursing Research*, 33(4), 577-592.
- Holder, A. R. (2008). Research with adolescents: Parental involvement required? *Journal of Adolescent Health*, 42(1), 1-2.

- Holland, M. L., Christensen, J. J., Shone, L. P., Kearney, M. H., & Kitzman, H. J. (2014). Women's reasons for attrition from a nurse home visiting program. *Journal of Obstetric Gynecological and Neonatal Nursing*, 43(1), 61-70. doi: 10.1111/1552-6909.12263
- Hollowell, J., Oakley, L., Kurinczuk, J. J., Brocklehurst, P., & Gray, R. (2011). The effectiveness of antenatal care programmes to reduce infant mortality and preterm birth in socially disadvantaged and vulnerable women in high-income countries: a systematic review. *Pregnancy and Childbirth*, 11(1), 13-13. doi: 10.1186/1471-2393-11-13
- Holub, C. K., Kershaw, T. S., Ethier, K. A., Lewis, J. B., Milan, S., & Ickovics, J. R. (2007). Prenatal and parenting stress on adolescent maternal adjustment: identifying a high-risk subgroup. *Maternal and Child Health Journal*, 11(2), 153-159. doi: 10.1007/s10995-006-0159-y
- Huang, C. Y., Costeines, J., Kaufman, J. S., & Ayala, C. (2014). Parenting Stress, Social Support, and Depression for Ethnic Minority Adolescent Mothers: Impact on Child Development. *Journal of Child and Family Studies*, 23(2), 255-262.
- Hughes Lee, S., & Grubbs, L. M. (1995). Pregnant teenagers' reasons for seeking or delaying prenatal care. *Clinical Nursing Research*, 4(1), 38-49.
- Hui Choi, W. H., Lee, G. L., Chan, C. H., Cheung, R. Y., Lee, I. L., & Chan, C. L. (2012). The relationships of social support, uncertainty, self-efficacy, and commitment to prenatal psychosocial adaptation. *Journal of Advanced Nursing*, 68(12), 2633-2645. doi: 10.1111/j.1365-2648.2012.05962.x
- Hunter, C. (2007). On the outskirts of education: The liminal space of rural teen pregnancy. *Ethnography and Education*, 2(1), 75-92.

- Hunter, L., Magill-Cuerden, J., & McCourt, C. (2015). Disempowered, passive and isolated: how teenage mothers' postnatal inpatient experiences in the UK impact on the initiation and continuation of breastfeeding. *Maternal & Child Nutrition*, 11(1), 47-58. doi: 10.1111/mcn.12150
- Imamura, M., Tucker, J., Hannaford, P., da Silva, M. O., Astin, M., Wyness, L., Bloemenkamp, K. W. M., Jahn, A., Karro, H., Olsen, J., & Temmerman, M. (2007). Factors associated with teenage pregnancy in the European Union countries: A systematic review. *The European Journal of Public Health*, 17(6), 630-636.
- Irwin, S. (2009). Locating where the action is: Quantitative and qualitative lenses on families, schooling and structures of social inequality. *Sociology*, 43(6), 1123-1140. doi: 10.1177/0038038509345701
- James, S., Rall, N., & Strümpher, J. (2012). Perceptions of pregnant teenagers with regard to the antenatal care clinic environment. *Curationis*, 35(1), 1-8.
- Jewell, D., Tacchi, J., & Donovan, J. (2000). Teenage pregnancy: whose problem is it? *Family Practice*, 17(6), 522-528.
- Kaiser, M. (2004). The Adolescent Prenatal Questionnaire: assessing psychosocial factors that influence transition to motherhood. *Health Care for Women International*, 25(1), 5-19. doi: 10.1080/07399330490253184
- Kaiser, M. M., & Hays, B. J. (2005). Health-risk behaviors in a sample of first-time pregnant adolescents. *Public Health Nursing*, 22(6), 483-493.
- Kane, J. B., Philip Morgan, S., Harris, K. M., & Guilkey, D. K. (2013). The educational consequences of teen childbearing. *Demography*, 50(6), 2129-2150. doi: 10.1007/s13524-013-0238-9

- Katz, A. (2011). Adolescent pregnancy: the good, the bad and the promise. *Nursing for Womens Health, 15*(2), 149-152.
- Kaye, D. (2008). Negotiating the transition from adolescence to motherhood: Coping with prenatal and parenting stress in teenage mothers in Mulago hospital, Uganda. *BioMedCentral: public health, 8*(1), 1-6.
- Kearney, M. S., & Levine, P. B. (2012). Why is the teen birth rate in the United States so high and why does it matter? *Journal of Economic Perspectives, 26*(2), 141-166.
- Kearney, M. S., & Levine, P. B. (2014). Media Influences on Social Outcomes: The Impact of MTV's 16 and Pregnant on Teen Childbearing. *The National Bureau of Economic Research*(Working Paper No. 19795).
- Kelly, D., Pearce, S., & Mulhall, A. (2004). 'Being in the same boat': Ethnographic insights into an adolescent cancer unit. *International Journal of Nursing Studies, 41*(8), 847-857.
- Khan, M. A., Shah, S., Grudzien, A., Onyejekwe, N., Banskota, P., Karim, S., Jin, J., Kim, Y., & Gerber, B. S. (2011). A diabetes education multimedia program in the waiting room setting. *Diabetes Therapy, 2*(3), 178-188.
- Kildea, S., Stapleton, H., Murphy, R., Low, N. B., & Gibbons, K. (2012). The Murri clinic: a comparative retrospective study of an antenatal clinic developed for Aboriginal and Torres Strait Islander women. *Pregnancy and Childbirth, 12*, 159. doi: 10.1186/1471-2393-12-159
- Kim, T., Connolly, J., & Tamim, H. (2014). The effect of social support around pregnancy on postpartum depression among Canadian teen mothers and adult mothers in the maternity experiences survey. *Pregnancy and Childbirth, 14*(1), 162. doi: 10.1186/1471-2393-14-162

- Kingston, D., Heaman, M., Fell, D., & Chalmers, B. (2012). Comparison of adolescent, young adult, and adult women's maternity experiences and practices. *Pediatrics*, 129(5), e1228-e1237. doi: 10.1542/peds.2011-1447
- Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42(4), 344-351.
- Krediet, A. C., Kalkman, C. J., Bonten, M. J., Gigengack, A. C. M., & Barach, P. (2011). Hand-hygiene practices in the operating theatre: An observational study. *British Journal of Anaesthesia*, 107(4), 553-558.
- Kretschmer, T., Sentse, M., Meeus, W., Verhulst, F. C., Veenstra, R., & Oldehinkel, A. J. (2015). Configurations of adolescents' peer experiences: Associations with parent-child relationship quality and parental problem behavior. *Journal of Research on Adolescence*. doi:10.1111/jora.12206
- Kulkarni, J. V., Kulkarni, V. G., & Sreekantha Avinash, S. S. (2014). The study of obstetric outcome in teenage primigravidae. *International Journal of Pharmacology and Biomedical Sciences*, 5 (1), 267-280.
- La Greca, A. M., & Ranta, K. (2015). Developmental transitions in adolescence and their implications for social anxiety. In K. Ranta, A. M. La Greca, L.-J. Garcia-Lopez & M. Marttunen (Eds.), *Social Anxiety and Phobia in Adolescents* (pp. 95-117): Springer International Publishing
- Landers, M., Mitchell, O., & Coates, E. (2014). Teenage fatherhood as a potential turning point in the lives of delinquent youth. *Journal of Child and Family Studies*, 1-12. doi: 10.1007/s10826-014-9971-y

- Laye-Gindhu, A., & Schonert-Reichl, K. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “Whats” and “Whys” of self-harm. *Journal of Youth and Adolescence*, 34(5), 447-457. doi: 10.1007/s10964-005-7262-z
- Lee, Y. (2009). Early motherhood and harsh parenting: the role of human, social, and cultural capital. *Child Abuse and Neglect*, 33(9), 625-637. doi: 10.1016/j.chiabu.2009.02.007
- Lehana, T. V., & van Rhyen, L. (2003). A phenomenological investigation of experiences of pregnancy by unmarried adolescents in Maseru. *Health SA Gesondheid*, 8(1), 26-38.
- Leppalahti, S., Gissler, M., Mentula, M., & Heikinheimo, O. (2013). Is teenage pregnancy an obstetric risk in a welfare society? A population-based study in Finland, from 2006 to 2011. *BMJ Open*, 3(8), e003225. doi: 10.1136/bmjopen-2013-003225
- Lesser, J., Anderson, N. L., & Koniak-Griffin, D. (1998). "Sometimes you don't feel ready to be an adult or a mom:" The experience of adolescent pregnancy. *Journal of Child and Adolescent Psychiatric Nursing*, 11(1), 7.
- Liamputtong Rice, P., & Ezzy, D. (2002). *Qualitative research methods: A health focus* (2nd ed.). Melbourne: Oxford University Press.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, Calif: Sage Publications.
- Lloyd, S. L. T. (2000). *Adolescent perceptions of parent-adolescent communication and adolescent pregnancy*. (Ph.D.), University of San Diego. Retrieved from <https://login.kelibresources.health.wa.gov.au/login?url=http://search.ebscohost.c>



om/login.aspx?direct=true&db=rzh&AN=2002066650&site=ehost-live

Available from EBSCOhost rzh database.

- Lori, J., Yi, C., & Martyn, K. (2011). Provider characteristics desired by African American women in prenatal care. *Journal of Transcultural Nursing*, 22(1), 71-76.
- Lothian, J. A. (2008). Childbirth education at the crossroads. *The Journal of Perinatal Education*, 17(2), 45-45.
- MacLeod, A., & Weaver, S. (2002). Are expectant teenage mothers adequately informed? *British Journal of Midwifery*, 10(3), 144-147.
- Malabarey, O., Balayla, J., Klam, S., Shrim, A., & Abenhaim, H. (2012). Pregnancies in young adolescent mothers: A population-based study on 37 million births. *Journal of Pediatric and Adolescent Gynecology*, 25(2), 98.
- Malata, A., & Chirwa, E. (2011). Childbirth information needs for first time Malawian mothers who attended antenatal clinics. *Malawi Medical Journal*, 23(2), 43-47.
- Malinowski, B. (1978). *Argonauts of the Western Pacific: An account of native enterprise and adventure in the Archipelagoes of Melanesian New Guinea*. Preface by Sir James Frazer (2005 ed.). London: Taylor and Francis
- Maputle, M. S. (2006). Becoming a mother: teenage mothers' experiences of first pregnancy. *Curationis*, 29(2), 87-95.
- Marshall, J. E., Fraser, D. M., & Baker, P. N. (2010). Reflexivity: the experience of undertaking an ethnographic study to explore issues of consent to intrapartum procedures. *Evidence-Based Midwifery (Royal College of Midwives)*, 8(1), 21.
- Martin, E. (1992). *The woman in the body: A cultural analysis of reproduction*. Boston MA: Beacon Press

- Maxwell, S., Brameld, K., Bower, C., Dickinson, J. E., Goldblatt, J., Hadlow, N., Hewitt, B., Murch, A., Murphy, A., Stock, R., & O'Leary, P. (2011). Socio-demographic disparities in the uptake of prenatal screening and diagnosis in Western Australia. *The Australian & New Zealand Journal of Obstetrics & Gynaecology*, 51(1), 9-16. doi: 10.1111/j.1479-828X.2010.01250.x
- McCourt, C. (2006). Supporting choice and control? Communication and interaction between midwives and women at the antenatal booking visit. *Social Science & Medicine*, 62(6), 1307-1318. doi: 10.1016/j.socscimed.2005.07.031
- McCracken, K. A., & Loveless, M. (2014). Teen pregnancy: An update. *Current Opinion in Obstetrics and Gynecology*, 26(5), 355-359.
- McInnes, N., & Haglund, B. J. A. (2011). Readability of online health information: implications for health literacy. *Informatics for Health and Social Care*, 36(4), 173-189. doi: 10.3109/17538157.2010.542529
- Mead, M. ([1928] 1963). Coming of age in Samoa. In Atkinson P, A. Coffey, S. Delamont, J. Lofland & L. Lofland, . (Eds.), *Handbook of ethnography* (pp. 507). Thousand Oaks CA: Sage 2010
- Meadows-Oliver, M. (2006). Homeless adolescent mothers: A metasynthesis of their life experiences. *Journal of Pediatric Nursing*, 21(5), 340-349. doi: 10.1016/j.pedn.2006.02.004
- Meadows-Oliver, M., Sadler, L. S., Swartz, M. K., & Ryan-Krause, P. (2007). Sources of stress and support and maternal resources of homeless teenage mothers. *Journal of Child and Adolescent Psychiatric Nurses*, 20(2), 116-125. doi: 10.1111/j.1744-6171.2007.00093.x
- Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 36(3), 226-232.

- Michels, T. M. (2000). "Patients like us": pregnant and parenting teens view the health care system. *Public Health, 115*(6), 557-575.
- Middleton, S. (2011). I Wouldn't Change Having the Children—Not at All.' Young women's narratives of maternal timing: What the UK's Teenage Pregnancy Strategy hasn't heard. *Sexuality Research and Social Policy, 8*(3), 227-238.
- Milan, S., Kershaw, T. S., Lewis, J., Westdahl, C., Rising, S. S., Patrikios, M., & Ickovics, J. R. (2007). Caregiving history and prenatal depressive symptoms in low income adolescent and young adolescent women: Moderating and mediating effects. *Psychology of Women Quarterly, 31*(3), 241-251.
- Miller, M. K., Wickliffe, J., Jahnke, S., Linebarger, J. S., & Dowd, D. (2014). Accessing general and sexual healthcare: Experiences of urban youth. *Vulnerable Children and Youth Studies, 9*(3), 279-290. doi: 10.1080/17450128.2014.925170
- Mollart, L. (1995). Pregnant teenagers antenatal education research. *Australian College of Midwives Incorporated journal, 8*(4), 26-28.
- Mollborn, S., & Jacobs, J. (2012). "We'll figure a way": Teenage mothers' experiences in shifting social and economic contexts. *Qualitative Sociology, 35*(1), 23-46.
- Montgomery, K. S. (2004). Planned adolescent pregnancy: Themes related to the pregnancy. *Journal of Perinatal Education, 13*(4), 27-27. doi: 10.1624/105812404x6207
- Moriarty Daley, A., Sadler, L. S., & Dawn Reynolds, H. (2013). Tailoring clinical services to address the unique needs of adolescents from the pregnancy test to parenthood. *Current Problems in Pediatric and Adolescent Health Care, 43*(4), 71-95. doi: 10.1016/j.cppeds.2013.01.001
- Morse, J. M. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5.

- Morse, J. M., & Field, P. (1996). *Nursing Research: The application of qualitative approaches*. (2nd ed.). London: Chapman & Hall.
- Mulvey, E. P., & Iselin, A.-M. R. (2008). Improving professional judgments of risk and amenability in juvenile justice. *The Future of Children*, 18(2), 35-57. doi: 10.1353/foc.0.0012
- Murphy, A., Steele, H., Bate, J., Nikitiades, A., Allman, B., Bonuck, K., Meissner, P., & Steele, M. (2015). Group Attachment-Based Intervention: Trauma-Informed Care for families with adverse childhood experiences. *Family & Community Health*, 38(3), 268-279. doi: 10.1097/FCH.0000000000000074
- Murphy, E., & Dingwall, R. (2010). The ethics of ethnography. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland & L. Lofland (Eds.), *Handbook of Ethnography* (pp. 507). Los Angeles: Sage
- Myers, J., Heazell, A., Jones, R., & Baker, P. (2007). Obstetric management of teenage pregnancy. *Fetal and Maternal Medicine Review*, 17(04), 317-325.
- National Health and Medical Research Council. (2007). *National statement on ethical conduct in human research*. Canberra: NHMRC.
- Ngum Chi Watts, M. C., Liamputtong, P., & Carolan, M. (2014). Contraception knowledge and attitudes: truths and myths among African Australian teenage mothers in Greater Melbourne, Australia. *Journal of Clinical Nursing*, 23(15-16), 2131-2141. doi: 10.1111/jocn.12335
- Nirmal, D., Thijs, I., Bethel, J., & Bhal, P. S. (2006). The incidence and outcome of concealed pregnancies among hospital deliveries: an 11-year population-based study in South Glamorgan. *Journal of Obstetrics and Gynaecology* 26(2), 118-118.

- Nove, A., Matthews, Z., Neal, S., & Camacho, A. V. (2014). Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries. *The Lancet Global Health*, 2(3), e155-164. doi: 10.1016/S2214-109X(13)70179-7
- O'Sullivan Oliviera, J., & Burke, P. (2009). Lost in the shuffle: Culture of homeless adolescents. *Pediatric Nursing*, 35(3), 154-161.
- Olausson, P. O., Haglund, B., Weitoft, G. R., & Cnattingius, S. (2001). Teenage childbearing and long-term socioeconomic consequences: a case study in Sweden. *Family Planning Perspectives*, 33(2), 70-74.
- Oliffe, J. (2005). Why not ethnography? *Urologic Nursing*, 25(5), 395.
- Osbourne, G., Howat, R., & Jordan, M. (2005). The obstetric outcome of teenage pregnancy. *International Journal of Obstetrics & Gynaecology*, 88(3), 215-221.
- Osuchowski-Sanchez, M. K. (2011). *Teen pregnancy and parenting: Attitudes and behaviors of teenaged long-term Hispanics in northern New Mexico*. (Dissertation/Thesis). Retrieved from <http://hdl.handle.net/1928/12840>
- Paranjothy, S., Broughton, H., Adappa, R., & Fone, D. (2009). Teenage pregnancy: who suffers? *Archives of Disease in Childhood*, 94(3), 239.
- Park, B. K., & Calamaro, C. (2013). A systematic review of social networking sites: Innovative platforms for health research targeting adolescents and young adults. *Journal of Nursing Scholarship*, 45(3), 256-264. doi: 10.1111/jnu.12032
- Patton, G. C., Ross, D. A., Santelli, J. S., Sawyer, S. M., Viner, R. M., & Kleinert, S. (2014). Next steps for adolescent health: a Lancet Commission. *The Lancet*, 383(9915), 385-386.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, Calif: Sage Publications.

- Peterson, W., Sword, W., Charles, C., & DiCenso, A. (2007). Adolescents' Perceptions of Inpatient Postpartum Nursing Care. *Qualitative Health Research*, 17(2), 201-212.
- Pilgrim, N. A., & Blum, R. W. (2012). Protective and risk factors associated with adolescent sexual and reproductive health in the English-speaking Caribbean: a literature review. *Journal of Adolescent Health*, 50(1), 5-23. doi: 10.1016/j.jadohealth.2011.03.004
- Plutzer, K., & Keirse, M. J. (2012). Effect of motherhood on women's preferences for sources of health information: a prospective cohort study. *Journal of Community Health*, 37(4), 799-803. doi: 10.1007/s10900-011-9513-0
- Poffald, L., Hirmas, M., Aguilera, X., Vega, J., Gonzalez, M. J., & Sanhueza, G. (2013). Barriers and facilitators to antenatal care in adolescents: results of a qualitative study in Chile. *Salud Publica Mex*, 55(6), 572-579.
- Popkin, S. J., Leventhal, T., & Weismann, G. (2010). Girls in the 'Hood: How safety affects the life chances of low-income girls. *Urban Affairs Review*, 45(6), 715-744. doi: 10.1177/1078087410361572
- Prout, A. (1985). Teenage girls' knowledge of antenatal care, and its implications for school-based preventive strategies. *Health Education Journal*, 44(4), 193-197.
- QSR. (2012). NVivo (Version 10): QSR International Pty Ltd.
- Quinlivan, J. A. (2000). *Teenage Pregnancy in WA*. A Report for the Government of Western Australia. Perth.
- Quinlivan, J. A. (2004). Teenagers who plan parenthood. *Sexual Health*, 1(4), 201-208.
- Quinlivan, J. A., & Evans, S. F. (2004). Teenage antenatal clinics may reduce the rate of preterm birth: a prospective study. *International Journal of Obstetrics & Gynaecology*, 111(6), 571-578. doi: 10.1111/j.1471-0528.2004.00146.x

- Quinlivan, J. A., Petersen, R. W., & Gurrin, L. C. (1999). Adolescent pregnancy: Psychopathology missed. *Australian and New Zealand Journal of Psychiatry* 33(6), 864-868.
- Ragan, D. T., Osgood, D. W., & Feinberg, M. E. (2014). Friends as a bridge to parental influence: Implications for adolescent alcohol use. *Social Forces*, 92(3), 1061-1085. doi: 10.1093/sf/sot117
- Redshaw, M., Hennegan, J., & Miller, Y. (2014). Young women's recent experience of labour and birth care in Queensland. *Midwifery*, 30(7), 810-816. doi: 10.1016/j.midw.2013.06.018
- Redwood, T., Pyer, M., & Armstrong-Hallam, S. (2012). Exploring attitudes and behaviour towards teenage pregnancy. *Community Practitioner*, 85(3), 20.
- Renesme, L., Garlantezec, R., Anouilh, F., Bertschy, F., Carpentier, M., & Sizun, J. (2013). Accidental out-of-hospital deliveries: a case-control study. *Acta Paediatrica*, 102(4), e174-177. doi: 10.1111/apa.12156
- Rentschler, D. D. (2003). Pregnant adolescents' perspectives of pregnancy. *The American Journal of Maternal and Child Nursing*, 28(6), 377-383. doi: 10.1097/00005721-200311000-00009
- Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Duell-Piening, P., & Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *Health Services Research*, 12, 117. doi: 10.1186/1472-6963-12-117
- Riva Crugnola, C., Ierardi, E., Gazzotti, S., & Albizzati, A. (2014). Motherhood in adolescent mothers: maternal attachment, mother-infant styles of interaction and

- emotion regulation at three months. *Infant Behaviour and Development*, 37(1), 44-56. doi: 10.1016/j.infbeh.2013.12.011
- Rose, A. J., Schwartz-Mette, R. A., Smith, R. L., Asher, S. R., Swenson, L. P., Carlson, W., & Waller, E. M. (2012). How girls and boys expect disclosure about problems will make them feel: Implications for friendships. *Child Development*, 83(3), 844-863. doi: 10.1111/j.1467-8624.2012.01734.x
- Rowe, H. J., Wynter, K. H., Steele, A., Fisher, J. R. W., & Quinlivan, J. A. (2013). The growth of maternal-fetal emotional attachment in pregnant adolescents: A prospective cohort study. *Journal of Pediatric and Adolescent Gynecology*, 26(6), 327-333. doi: 10.1016/j.jpag.2013.06.009
- Roxas, K. (2008). Keepin' it real and relevant: Providing a culturally responsive education to pregnant and parenting teens. *Multicultural Education*, 15(3), 2-9.
- Rubin, R. (1967). Attainment of the maternal role : Part 1. Processes. *Nursing Research*, 16(3), 237-245.
- Rudge, T. (1996). (Re)writing ethnography: The unsettling questions for nursing research raised by post-structural approaches to "the field". *Nursing Enquiry*, 3, 146-152.
- Ruff, B., Mzimba, M., Hendrie, S., & Broomberg, J. (2011). Reflections on health-care reforms in South Africa. *Journal of Public Health Policy*, 32(S1), S184-S192.
- Ruiz, R. L., Shah, M. K., Lewis, M. L., & Theall, K. P. (2014). Perceived access to health services and provider information and adverse birth outcomes: findings from LaPRAMS, 2007-2008. *Southern Medical Journal*, 107(3), 137-143. doi: 10.1097/smj.0000000000000065
- Rumbold, A. R., Bailie, R. S., Si, D., Dowden, M. C., Kennedy, C. M., Cox, R. J., O'Donoghue, L., Liddle, H. E., Kwedza, R. K., Thompson, S. C., Burke, H. P.,



- Brown, A. D. H., Weeramanthri, T., & Connors, C. M. (2011). Delivery of maternal health care in Indigenous primary care services: baseline data for an ongoing quality improvement initiative. *Pregnancy and Childbirth, 11*(1), 16-16.
- Saal, E. (2011). The effect of teenage language in health communication: A study among English and Sepedi teenagers. *Language Matters, 42*(1), 83-103.
- Sadler, L., Swartz, M., Ryan-Krause, P., Seitz, V., Meadows-Oliver, M., Grey, M., & Clemmens, D. (2007). Promising outcomes in teen mothers enrolled in a school-based parent support program and child care center. *Journal of School Health, 77*(3), 121-130.
- Saewyc, E. M. (2003). Influential life contexts and environments for out-of-home pregnant adolescents. *Journal of Holistic Nursing, 21*(4), 343-367. doi: 10.1177/0898010103258607
- Salekin, R. T., & Grimes, R. D. (2008). Clinical forensic evaluations for juvenile transfer to adult criminal court. In Jackson R (Ed.), *Learning forensic assessment* (pp. 330). New York: Routledge Taylor & Francis Group
- Sandelowski, M. J. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18*, 179-183.
- Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing, 11*(5), 383-393.
- Scheppers, E., Van Dongen, E., Dekker, J., & Geertzen, J. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice, 23*(3), 325.
- Schwinn, T. M., Schinke, S., Fang, L., & Kandasamy, S. (2014). A web-based, health promotion program for adolescent girls and their mothers who reside in public

- housing. *Addictive Behaviors*, 39(4), 757-760. doi:  
10.1016/j.addbeh.2013.11.029
- Seamark, C. J., & Lings, P. (2004). Positive experiences of teenage motherhood: A qualitative study. *British Journal of General Practice*, 54(508), 813-818.
- Shah, M. K., Gee, R. E., & Theall, K. P. (2014). Partner support and impact on birth outcomes among teen pregnancies in the United States. *Journal of Pediatric and Adolescent Gynecology*, 27(1), 14-19. doi: 10.1016/j.jpag.2013.08.002
- Shaw, M., Lawlor, D. A., & Najman, J. M. (2006). Teenage children of teenage mothers: Psychological, behavioural and health outcomes from an Australian prospective longitudinal study. *Social Science & Medicine*, 62(10), 2526-2539.
- Sheeran, N., Jones, L., & Rowe, J. (2013). The relationship between maternal age, communication and supportive relationships in the neonatal nursery for mothers of preterm infants. *Journal of Neonatal Nursing*, 19(6), 327-336. doi:  
10.1016/j.jnn.2013.01.006
- Shenton, A. K. (2004). Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information*, 22(2), 63-75.
- Sherman, L. E., & Greenfield, P. M. (2013). Forging friendship, soliciting support: A mixed-method examination of message boards for pregnant teens and teen mothers. *Computers in Human Behavior*, 29(1), 75-85. doi:  
10.1016/j.chb.2012.07.018
- Simmons, B. J. (2006). *Understanding teen pregnancy through the younger sisters voice*. (Doctor of Philosophy), Georgia state University, Georgia. Retrieved from (1212793681)
- Singh, K., Fong, Y. F., & Loh, S. Y. (2002). Profile of women presenting for abortions in Singapore at the National University Hospital. *Contraception*, 66(1), 41-46.

Sipsma, H. L., Ickovics, J. R., Lewis, J. B., Ethier, K. A., & Kershaw, T. (2011).

Adolescent pregnancy desire and pregnancy incidence. *Women's Health Issues*, 21(2), 110-116.

Skinner, S. R., Smith, J., Fenwick, J., Hendriks, J., Fyfe, S., & Kendall, G. (2009).

Pregnancy and protection: Perceptions, attitudes and experiences of Australian female adolescents. *Women and Birth*, 22(2), 50-56. doi: 10.1016/j.wombi.2008.12.001

Skoog, T., & Bayram Özdemir, S. (2015). Explaining why early-maturing girls are more exposed to sexual harassment in early adolescence. *The Journal of Early Adolescence*.

<http://jea.sagepub.com/content/early/2015/01/16/0272431614568198>. Abstract doi:10.1177/0272431614568198

Smid, M., Martins, S., Whitaker, A. K., & Gilliam, M. (2014). Correlates of pregnancy before age 15 compared with pregnancy between the ages of 15 and 19 in the United States. *Obstetrics and Gynecology*, 123(3), 578-583. doi: 10.1097/aog.0000000000000136

Smith, G. C., & Pell, J. (2001). Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: population based retrospective cohort study. *British Medical Journal*, 323(7311), 476.

Smith, J., Skinner, R., & Fenwick, J. (2011). Perceptions of teen motherhood in Australian adolescent females: Life-line or life derailment. *Women and Birth*, 25(4), 181-186. doi: 10.1016/j.wombi.2011.10.007

Smith, P., Beck, J., & Davies, D. (2011). Contraceptive use among high-risk adolescents. *Journal of Sex Education Therapists*, 13, 52-57.

- SmithBattle, L. (2000). The vulnerabilities of teenage mothers: challenging prevailing assumptions. *Advances in Nursing Science*, 23(1), 29.
- Sockol, L. E., Epperson, C. N., & Barber, J. P. (2014). The relationship between maternal attitudes and symptoms of depression and anxiety among pregnant and postpartum first-time mothers. *Archives of Women's Mental Health*, 17(3), 199-212. doi: 10.1007/s00737-014-0424-9
- Sommer, K. S., Whitman, T. L., Borkowski, J. G., Gondoli, D. M., Burke, J., Maxwell, S. E., & Weed, K. (2000). Prenatal maternal predictors of cognitive and emotional delays in children of adolescent mothers. *Adolescence*, 35(137), 87.
- Spicker, P. (2011). Ethical covert research. *Sociology*, 45(1), 118-133.
- Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt Rinehart and Winston.
- Spradley, J. P. (1980). *Participant observation*. FortWorth [Tex.]: Holt, Rinehart and Winston.
- Stanton, C., Blanc, A., Croft, T., & Choi, Y. (2006). Skilled care at birth in the developing world: progress to date and strategies for expanding coverage. *Journal of Biosocial Science*, 39(1), 109-120.
- Sterling, C. M., & Walco, G. A. (2003). Protection of children's rights to self-determination in research. *Ethics & Behavior*, 13(3), 237 - 247.
- Stevens-Simon, C., Sheeder, J., Beach, R., & Harter, S. (2005). Adolescent pregnancy: do expectations affect intentions? *Journal of Adolescent Health*, 37(3), 243.e215-243.e222. doi: 10.1016/j.jadohealth.2005.01.007
- Stevens, C. A. (2006). Being healthy: Voices of adolescent women who are parenting. *Journal for Specialists in Pediatric Nursing*, 11(1), 28-40.

- Stickley, T., & Basset, T. (2008). *Learning about mental health practice*. Hoboken, NJ: Wiley.
- Sukhato, K., Wongrathanandha, C., Thakkestian, A., Dellow, A., Horsuwansak, P., & Anothaisintawee, T. (2015). Efficacy of additional psychosocial intervention in reducing low birth weight and preterm birth in teenage pregnancy: A systematic review and meta-analysis. *Journal of Adolescence*(44), 106-116
- Sutherland, G., Yelland, J., & Brown, S. (2012). Social inequalities in the organization of pregnancy care in a universally funded public health care system. *Maternal and Child Health Journal*, 16(2), 288-296.
- Swan-Foster, N. (2012). Pregnancy as a feminine initiation. *Journal of Prenatal & Perinatal Psychology & Health*, 26(4), 207.
- Symon, A. G., & Wrieden, W. L. (2003). A qualitative study of pregnant teenagers' perceptions of the acceptability of a nutritional education intervention. *Midwifery*, 19(2), 140-147. doi: 10.1016/S0266-6138(03)00004-4
- Tamkins, T. (2004). Recent childbirth or acquisition of new partner boosts sexually transmitted disease risk in female teenagers. *Perspectives on Sexual and Reproductive Health*, 36(3), 132-133.
- Thornton, H. (2010). Providing specialist sexual health advice within adolescent diabetes services. *Journal of Diabetes Nursing*, 14(1), 21.
- Thynne, C., Gaffney, G., O'Neill, M., Tonge, M., & Sherlock, C. (2014). Concealed pregnancy: Prevalence, perinatal measures and socio-demographics *The Irish Medical Journal*, 107(1).
- Toffoli, L., & Rudge, T. (2006). Organizational predicaments: Ethical conditions for nursing research. *Journal of Advanced Nursing*, 56(6), 600-606.

- Tolman, D. L., & Ebrary. (2005). *Dilemmas of Desire: Teenage Girls Talk about Sexuality*. Cambridge: Harvard University Press.
- Tzoumakis, S., Lussier, P., & Corrado, R. R. (2014). Profiles of maternal parenting practices: Exploring the link with maternal delinquency, offending, mental health, and children's physical aggression. *International Journal of Offender Therapy and Comparative Criminology*.  
<http://ijo.sagepub.com/content/early/2014/04/28/0306624X14531386.abstract>  
doi:10.1177/0306624x14531386
- Ukil, D., & Esen, U. I. (2002). Early teenage pregnancy outcome: a comparison between a standard and a dedicated teenage antenatal clinic. *Journal of Obstetrics & Gynaecology*, 22(3), 270-272.
- Vaisanen, H., & Murphy, M. (2014). Social inequalities in teenage fertility outcomes: childbearing and abortion trends of three birth cohorts in Finland. *Perspectives on Sexual and Reproductive Health*, 46(2), 109-116. doi: 10.1363/46e1314
- Valaitis, R. K., & Sword, W. A. (2005). Online discussions with pregnant and parenting adolescents: perspectives and possibilities. *Health Promotion Practice*, 6(4), 464-471.
- Van Maanen, J. (2006). Ethnography then and now. *Qualitative Research in Organizations and Management*, 1(1), 13-21.
- Vandenberg, H. E. R., & Hall, W. A. (2011). Critical ethnography: extending attention to bias and reinforcement of dominant power relations. *Nurse Researcher*, 18(3), 25(26).
- VanderWeele, T. J., Lauderdale, D. S., & Lantos, J. D. (2013). Medically induced preterm birth and the associations between prenatal care and infant mortality. *Annals of Epidemiology*, 23(7), 435-440. doi: 10.1016/j.annepidem.2013.04.010

- Vescovi, G., Pereira, M., & Levandowski, D. C. (2014). Protective factors in the experience of pregnancy and motherhood among Brazilian adolescents living with HIV: A Case-Series Report. *Journal of the Association of Nurses in AIDS Care*, 25(6), 541-554. doi: 10.1016/j.jana.2014.02.005
- Vieira, C. L., Coeli, C. M., Pinheiro, R. S., Brandão, E. R., Camargo Jr, K. R., & Aguiar, F. P. (2012). Modifying effect of prenatal care on the association between young maternal age and adverse birth outcomes. *Journal of Pediatric and Adolescent Gynecology*, 25(3), 185-189. doi: 10.1016/j.jpag.2011.12.070
- Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet*, 379(9826), 1641-1652.
- Wahn, E. H., & Nissen, E. (2008). Sociodemographic background, lifestyle and psychosocial conditions of Swedish teenage mothers and their perception of health and social support during pregnancy and childbirth. *Scandinavian Journal of Public Health*, 36(4), 415-423.
- Walcott, H. (1990). *Writing up qualitative research*. Newbury Park: Sage Publications.
- Walker, L. O., Im, E. O., & Vaughan, M. W. (2012). New mothers' interest in web-based health promotion: association with healthcare barriers, risk status, and user characteristics. *Telemedicine Journal and E-Health*, 18(10), 785-790. doi: 10.1089/tmj.2012.0008
- Watts, J. H. (2010). Ethical and practical challenges of participant observation in sensitive health research. *International Journal of Social Research Methodology*, 14(4), 301-312.

- Whalen, M. L., & Loper, A. B. (2014). Teenage pregnancy in adolescents with an incarcerated household member. *Western Journal of Nursing Research* 36(3), 346.
- Wheatley, R. R., Kelley, M. A., Peacock, N., & Delgado, J. (2008). Women's narratives on quality in prenatal care: a multicultural perspective. *Qualitative Health Research*, 18(11), 1586-1598.
- Wheeler, R. (2006). Gillick or Fraser? A plea for consistency over competence in children. *British Medical Journal*, 332(7545), 807-807.
- Whitfield, C., Jomeen, J., Hayter, M., & Gardiner, E. (2013). Sexual health information seeking: a survey of adolescent practices. *Journal of Clinical Nursing*, 22(23-24), 3259-3269.
- Whitworth, M., & Cockerill, R. (2010). Antenatal management of teenage pregnancy. *Obstetrics, Gynaecology & Reproductive Medicine*, 20(11), 323-328. doi: 10.1016/j.ogrm.2010.08.003
- Widman, L., Choukas-Bradley, S., Helms, S. W., Golin, C. E., & Prinstein, M. J. (2014). Sexual communication between early adolescents and their dating partners, parents, and best friends. *Journal of Sex Research*, 51(7), 731-741. doi: 10.1080/00224499.2013.843148
- Wiemann, C. M., Rickert, V. I., Berenson, A. B., & Volk, R. J. (2005). Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health*, 36(4), 352.e351-352.e357. doi: 10.1016/j.jadohealth.2004.06.006
- Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies*, 47(6), 761-769.



- Wilmore, M., Rodger, D., Humphreys, S., Clifton, V. L., Dalton, J., Flabouris, M., & Skuse, A. (2015). How midwives tailor health information used in antenatal care. *Midwifery*, 31(1), 74-79. doi: 10.1016/j.midw.2014.06.004
- Wilson-Mitchell, K., Bennett, J., & Stennett, R. (2014). Psychological health and life experiences of pregnant adolescent mothers in Jamaica. *International Journal of Environmental Research and Public Health*, 11(5), 4729-4744. doi: 10.3390/ijerph110504729
- Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse*, 33(1), 69-79.
- Witt, W. P., Cheng, E. R., Wisk, L. E., Litzelman, K., Chatterjee, D., Mandell, K., & Wakeel, F. (2014). Preterm birth in the United States: the impact of stressful life events prior to conception and maternal age. *American Journal of Public Health*, 104 Suppl 1, S73.
- Wolcott, H. F. (1994). *Transforming qualitative data: description, analysis, and interpretation*. Thousand Oaks, CA: Sage Publications.
- Woodgate, R. L., & Leach, J. (2010). Youth's perspectives on the determinants of health. *Qualitative Health Research*, 20(9), 1173-1182.
- World Health Organisation. (2011). World Health Organization (WHO) statement on antenatal care. Accessed 16/12/2014.  
[http://whqlibdoc.who.int/hq/2011/WHO\\_RHR\\_11.12\\_eng.pdf](http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.12_eng.pdf)
- Yee, L., & Simon, M. (2010). The role of the social network in contraceptive decision-making among young, African American and Latina women. *Journal of Adolescent Health*, 47(4), 374-380. doi: 10.1016/j.jadohealth.2010.03.014
- Yin, H. S., Dreyer, B. P., Vivar, K. L., MacFarland, S., van Schaick, L., & Mendelsohn, A. L. (2012). Perceived barriers to care and attitudes towards shared decision-

making among low socioeconomic status parents: Role of health literacy.

*Academic Pediatrics*, 12(2), 117-124. doi: 10.1016/j.acap.2012.01.001

Young, E. (2008). Maternal expectations: Do they match experience? *Community Practitioner*, 81(10), 27(24).

Zasloff, E., Schytt, E., & Waldenstrom, U. (2007). First time mothers' pregnancy and birth experiences varying by age. *Acta Obstetrica Gynecologica Scandinavica*, 86(11), 1328-1336.

## Appendix A



Government of **Western Australia**  
Department of **Health**  
South Metropolitan Area Health Service



### **Notice to Patients Attending this Clinic.**

A research study: Antenatal Clinic: Using Ethnographic Methods to Listen to the Voices of Pregnant Adolescents, is being carried out at this clinic.

Why are we doing this study?

This research is trying to find out the reasons young pregnant women have for attending the Antenatal Clinic, the challenges they may experience, plus the views and understanding they have about the clinic and the antenatal care they are given by the midwives. We are interested to know how this service meets your needs and we would like you to tell us why you attend this service and what influences your attendance. We are also interested in your views about what would make this service better for you.

Who is carrying out the study?

This project is being undertaken by a midwife as part of the requirements of her PhD studies at Edith Cowan University, Perth. It is carried out with the permission of South Metropolitan Area Health Service Human Research Ethics Committee, Edith Cowan University and the Aboriginal Health Council WA.

What are we doing?

The researcher-midwife will be attending the clinic waiting areas on

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to observe the activities that take place that involve the patients. She will also talk briefly with patients attending the clinic about their experiences and their understanding. Some patients may be asked to share more detailed stories away from the clinic at another time. If you are interested in offering information, please make the researcher-midwife or any other member of staff aware.

No private or confidential medical information will be requested.

What will the study tell us?

This information will form a report that will include the stories and experiences of young pregnant women who come to the antenatal clinic, and may help decisions made about this service. We will not identify who you are in any stories. The researcher-

midwife conducting the study will be available to answer any questions or concerns you may have about the study and your involvement in it.

Researcher-midwife: Deborah Ireson Ph. 0414 194 764

Antenatal Clinic Supervisor today: \_\_\_\_\_

If you should have any complaints or concerns about the way in which the study is being conducted, you may contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

## **Appendix B**

### **Interview Guide Stage Two**

a) explicit purpose b) ethnographic explanations c) ethnographic questions (Spradley, 1979)

#### **a) Demographic Information**

Informant number\_\_\_\_\_

Date of interview

Suburb and who lives with

Age

Place in siblings

Schooling

Cultural group

How do you travel to appointments?

Who comes with you?

How many have you attended so far?

Have you missed any?

#### **b) Experiences of pregnancy, antenatal care and clinic**

Q Can you tell me what it was like when you found out you were pregnant?

Your feelings

How many weeks pregnant were you?

Who you told

What you did

Describe the effect it had on your life at that time

Q What was your impression the first time you came to clinic?

How did you feel?

What happens there?

What is useful to you?

What is not so good for you?

Can you tell me about the orange folder you carry at clinic?

**Main strike** ‘Does coming to clinic make a difference to you?’

Q What do you know about antenatal education (parenting classes)?

How does the midwife help you at clinic?

Classes - are they necessary - have you experienced any?

**Beliefs about antenatal health**

Q What does it mean to you now being pregnant?

Plans

Future

Feelings now – what, if anything, has changed?

What do you feel is too young to have a baby (if you were not pregnant)?

**Knowledge and practice – healthy and unhealthy actions**

Q Tell me about your supports

What do you need?

Where is it from?

When do you need it?

When do you get it?

What happens if there is no support?

Q Have you changed knowing you are going to be a parent?

What ways?

Q Who provides you with information about pregnancy, birth and preparing to be a mum?

Do you sit down to talk about it deliberately?

Who do you trust the most to tell you about pregnancy?

**c) Plans for parenting**

Q Tell me about your future plans.

Q What have you had to do to prepare for labour and birth?

Q What have you prepared so far for the baby?

**What knowledge is important to share?**

Q What are the most important pieces of advice that you would give a young woman who just found out she was pregnant?

Q So far in your pregnancy, what has been the biggest impact on you?

Q What have you learned that you did not know before?

Q is there anything else about your pregnancy story that you would like to tell me about?

**\*Q If you were in the researcher's shoes able to interview young women - is there anything important I should be asking that I haven't already?**

\*How do you spend your time now you are pregnant that is different from before? Will this change after the baby comes?

\*Ask about finance and budgeting, how prepared they are.

\*What is the best thing about being pregnant? What is the worst thing about being pregnant?

\*How does the partner feel about it?

\*The questions participants suggested.

## Appendix C

### Cover letter to Department Managers



Government of **Western Australia**  
Department of **Health**  
South Metropolitan Area Health Service



Deborah Ireson  
School of Nursing and Midwifery  
Edith Cowan University  
270 Joondalup Drive  
JOONDALUP WA 6027

To Department Managers: Antenatal clinic

I am writing to ask for your help in conducting a study to investigate the activities of young pregnant women at antenatal clinics and to identify factors that may influence their experience and clinic attendance.

As part of my PhD studies at Edith Cowan University, I propose to conduct an ethnographic research study of young, English-speaking pregnant women, 12 to 17 years, attending antenatal clinic. I am a researcher-midwife but throughout this study I will not be performing in a clinical (midwifery) role.

With your permission, I would like to address the clinical staff of the antenatal clinic to inform them of the aims and objectives of the proposed study and answer any questions that they may have. Their assistance will be invaluable in providing basic information to patients from 36 weeks' gestation about the study and directing queries to me (researcher-midwife). They will also be able to identify minors who attend the clinic, including those who may be unsuitable to participate in the study.

Stage 1 of the proposed data collection will involve me (researcher-midwife) making anonymous observations and informally interviewing young pregnant women in the waiting areas of the antenatal clinic. Appropriate signage will be displayed



informing clinic attendees of the study in progress and where to locate me for further information. All observations and informal interviewing in Stage 1 will take place in the public space of the antenatal clinic. No confidential clinical interactions between staff and patients will be observed or recorded. Should any risk or distress to participants be observed, the clinic coordinator will be informed.

For Stage 2, young pregnant women, suitable for participating in the study and reaching 28 weeks' gestation, will be provided with written information on the study. They may be recruited to a follow on interview in the community.

It is anticipated that the project will take place between May 2012 and December 2013.

If you have any queries or need additional information, please do not hesitate to contact me (Ph. 0414 194 764) or my Principal Supervisor, Dr Joyce Hendricks (Ph. 6304 3511).

This study has been approved by:

South Metropolitan Area Health Service Human Research Ethics Committee, Edith Cowan University Human Research Ethics Committee, WA Aboriginal Health and Ethics Committee and with the involvement of the Aboriginal Maternity Statewide Services Unit.

Should you have any concerns and want to speak to an independent person, please contact:

Research Ethics Officer  
Edith Cowan University  
270 Joondalup Drive  
JOONDALUP WA 6027  
Phone: 6304 2170 Fax: 6304 2661  
Email: [research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au)  
Or

If you should have any complaints or concerns about the way in which the study is being conducted, you may contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

Kind regards

Deborah Ireson  
Research Midwife  
Ph.0414194764

## Appendix D



Government of **Western Australia**  
Department of **Health**  
South Metropolitan Area Health Service



### Consent for taped interview

#### FORM OF CONSENT

(Agree to tape interview)

**PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND SUBJECTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE OR ACCESS TO SERVICES.**

I ..... have read

Given Names

Surname

the information explaining the research project

#### **Antenatal Clinic: Using Ethnographic Methods to Listen to the Voices of Pregnant Adolescents**

I have read and understood the information given to me. Any questions I have asked have been answered and I am happy with the response. I agree to participate in the study.

I understand I may withdraw from the study at any stage and withdrawal will not interfere with my routine care.

I understand that if I tell the interviewer anything that shows that I am at risk of harm, the interviewer must pass that information to the Antenatal clinic coordinator or my general practitioner.

I agree that the interview will be taped for the purpose of accurately recording the information from the interview.

I agree that research data gathered from the results of this study may be published, provided that names are not used.

Dated ..... day of ..... 20 .....

Participant's Signature .....

I, ..... have explained the above to the

(Investigator's full name)

signatory who stated that he/she understood the same.

Signature .....

## **Appendix E**

### **WAAHIECS consent**

### **WESTERN AUSTRALIAN ABORIGINAL HEALTH ETHICS**

### **COMMITTEE**

#### **(WAAHEC)**

Aboriginal Health Council of WA

Dilhorn House

2 Bulwer Street

PERTH WA 6000

Email – [ethics@ahcwa.org](mailto:ethics@ahcwa.org)

The WAAHEC wishes you every success in your research.

Kind Regards

Dr Dan McAullay

For

Mr Chris Bin Kali

Chair, WAAHEC

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*, *NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. The process that HREC uses to review multi-centre research proposals has been certified by the NHMRC.

## **Appendix F**

### **South Metropolitan Health Service Ethics consent**



**Government of Western Australia**  
**Department of Health**  
South Metropolitan Area Health Service

Government of Western Australia  
Department of Health  
South Metropolitan Area Health Service  
Human Research Ethics Committee  
ab121118

29 May 2012

Ms Deborah Ireson  
Clinical Midwife  
Coordinator Adolescent Support Service  
King Edward Memorial Hospital,  
Bagot Rd  
SUBIACO WA 6008

Dear Deborah

Re: / Antenatal Clinic: Using Ethnographic Methods to Listen to the Voices of Pregnant Adolescents

Further to my correspondence dated 22 May 2012, I am writing to confirm that on 22 May 2012 the Chief Executive's delegate, under delegated authority from the Minister for Health incorporated as the Board of the Hospitals formerly comprised in the Metropolitan Health Service Board, endorsed the South Metropolitan Area Health Service (SMAHS) Human Research Ethics Committee's (HREC) recommendation to approve the above study.

Since writing previously, I have received your email, addressing concerns raised by the HREC at the previous meeting and enclosing an amended Patient Information Sheet and Protocol. I have perused your response including the revised documents and I am satisfied that you have addressed the concerns raised by the HREC and that the protocol now conforms to the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (National Statement). As the conditions of approval have now been addressed, you may commence the study. Please note that HREC approval is for a three year period from the date of final approval and the research should be commenced and completed within that period. If the study period is longer than three years, you are required to seek an extension to the approval before the end of this period. In the event that the study does not commence within 12 months from the date of final approval the study must be resubmitted to the HREC for approval. The HREC is bound by NHMRC Guidelines to monitor the progress of all approved projects until completion, to ensure they continue to conform to approved ethical standards. In accordance with the National Statement Chapter 5.5.3, researchers also

have a significant responsibility in monitoring their research activity and must submit the following to the HREC, in relation to this study:

Annual reports on the progress (including compliance with any conditions of approval and maintenance and security of records). Final report on completion (including a copy of the results and any publications). Reports of adverse/serious adverse events, according to the Committee's SAE Reporting Guidelines and advise the Committee if the event has resulted in an amendment to the protocol and/or to the informed consent document.

Page 2

\*Protocol amendments, or changes to informed consent documents. Any significant deviation from, or violation of, the study protocol. If the study is withdrawn, terminated or suspended before the expected date of completion (providing reasons for this). \*When submitting a protocol amendment to the Committee, you should provide, in a covering letter, a statement outlining to the Committee the significance of the change/s, whether they are procedural and/or whether they are likely to have an impact on the safety of participants. You should also give an indication as to whether you believe research subjects should be informed of the change/s and/or if the informed consent document needs to be revised. Would you please also highlight any changes made to this document when submitting it to the Committee.

An annual report on this study is due in May 2012

Please quote the following reference number on any future correspondence with the Committee regarding this protocol 1211 18

Yours sincerely

JDR DAVID BLYTHE  
CHAIRMAN  
SOUTH METROPOLITAN AREA HEALTH SERVICE  
HUMAN RESEARCH ETHICS COMMITTEE  
Human Research Ethics Committee  
c/- Fremantle Hospital and Health Service  
Alma Street Fremantle Western Australia 6160  
Postal Address: PO Box 480 Fremantle Western Australia 6959  
Telephone (08) 9431 2929 Fax (08) 9431 3930  
172a.doc wa.gov.au

## Appendix G



### Edith Cowan University Ethics Committee

19th March 2012  
Ms Deborah IRESON  
32 Turnbury Park Drive  
JANDAKOT WA 6154  
Principal Supervisor:  
Associate Supervisor:  
Senior Student Progress Officer  
Research Assessments - SSC  
Principal Supervisor:  
Associate Supervisor:  
HDR

JOONDALUP CAMPUS  
270 Joondalup Drive, Joondalup  
Western Australia 6027  
Phone 134328  
Facsimile (61 8) 9300 1257  
ABN 54361 485361 cricos ipc  
002798

Dear Ms Ireson,  
I am pleased to write on behalf of the Research Students and Scholarships Committee who have approved your PhD research proposal: Antenatal Clinic: Using Ethnographic Methods to Listen to the Voices of Pregnant Adolescents.  
I also wish to confirm that your proposal complies with the provisions contained in the University's policy for the conduct of ethical research, your application for ethics has been approved. Your ethics approval number is 5801 and the period of approval is: 14th March 2012 - 31st December 2013.  
Approval is given for your supervisory team to consist of:

The examination requirements on completion are laid down in Part VI of The University (Admissions, Enrolment and Academic progress) Rules for Courses Requiring the Submission of Theses available at: [http://www.ecu.edu.au/GPPS/leealesis/uni\\_rules.html](http://www.ecu.edu.au/GPPS/leealesis/uni_rules.html)  
Additional information and documentation relating to the examination process can be found at the Graduate Research School website: <http://research.ecu.edu.au/grsl>

Please note: the Research Students and Scholarship Committee has resolved to restrict doctoral theses to a maximum of 100,000 words with a provision that under special circumstances a candidate may seek approval from the Faculty Research and Higher Degrees Committee for an extension to the word length. (RSSC 99/24).

I would like to take this opportunity to offer you our best wishes for your research and the development of your thesis.

Yours sincerely

Amy Roberts

cc  
Dr Joyce Hendricks- ECU  
Dr Judith Pugh - ECU  
A./ Professor Christopher Churchouse - ECU  
Dr Joyce Hendricks - ECU  
Dr Judith Pugh - ECU  
A/ Professor Christopher Churchouse – ECU

FCBS Student Information Office





## Appendix H



Government of **Western Australia**  
Department of **Health**  
South Metropolitan Area Health Service



### **The CAYM study: Antenatal Clinic and Young Mothers**

#### **Information Sheet for Participants**

##### **Why are we doing this study?**

This research is observing women and their activities at antenatal clinic, trying to understand the particular experiences of young women, like you, who attend. Some of the observations have been carried out anonymously so that normal patterns of behaviour were not altered. We are interested in talking to young women to learn how this service meets their needs, why they attend this service and what influences their attendance. We are also interested in their views about what would make this service better for them.

##### **Who is carrying out the study?**

This project is being undertaken by a researcher as part of the requirements of her PhD study at Edith Cowan University, Perth.

##### **What will the study tell us?**

This study will collect the stories and experiences of young women who come to the antenatal clinic, to help midwives understand the needs of young women better. This will help decision making about this service. We will not identify who you are in any stories.

##### **What will you be asked to do if you take part in this study?**

You will be asked to meet with the researcher, to share your story about the antenatal clinic, your experiences and to tell us what you think would make the service better. The interview will last about an hour and if you agree it will be audio-recorded. You do not have to agree to have the interview recorded; instead the interview can be recorded by written notes taken at the time. The researcher may contact you following the interview to check her understanding.

##### **Is there likely to be a benefit to other people in the future?**

The study will benefit young women like you in the future because the information can be used to improve antenatal health services for young women, including Aboriginal young women.

**Where is your information kept?**

All study information will be kept in a secure locked office and a locked filing cabinet only accessible by the researcher. The computer and electronic storage used will be password protected. All the information gathered will be used for this study only and destroyed after a period of five years. Paper notes will be shredded and electronic storage will be physically broken up.

**What about my privacy?**

Your privacy is assured, and no personal information will be released to any person or organisation in a way that you could be recognised. Names and contact details will be kept separate from the notes that are taken; pseudonyms (false names) will be used in place of real names in the notes taken. You may withdraw any information about you or your involvement at the clinic that may have been collected by the researcher at the antenatal clinic. If you tell the interviewer anything that shows you are at risk or harm, the interviewer must pass on that information to the Antenatal clinic coordinator or your general practitioner (GP). In addition, if you tell the interviewer anything of an illegal nature the interviewer must pass that information on to the relevant authorities.

**What happens if I volunteer?**

Your care at the clinic will not change whether you volunteer to take part in the study or not.

**Who has approved the study?**

The study has been approved by the South Metropolitan Area Health Service Human Research Ethics Committee, Edith Cowan University Human Research Ethics Committee, the Western Australian Aboriginal Health Information and Ethics Committee (WAAHEC) and with the support of the Aboriginal Maternity Services Support Unit (AMSSU).

**Who to contact for more information about this study:**

If you would like any more information about this study, please do not hesitate to contact one of the research team. They are very happy to answer your questions.

<b>Name</b>	<b>Title</b>	<b>Contact Number</b>
Deborah Ireson	Research Midwife	0414 194 764
Dr Joyce Hendricks	Research Supervisor	(618) 6304 3511

**Who to contact if you have any concerns about the study?**

For all queries, please contact:

**HUMAN RESEARCH ETHICS COMMITTEE**

Research Ethics Officer

Edith Cowan University

270 Joondalup Drive

JOONDALUP WA 6027

Phone: 6304 2170

Fax: 6304 2661

Email: [research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au)

Or

If you should have any complaints or concerns about the way in which the study is being conducted, you may contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

**What to do next if you would like to take part in this research:**

If you would like the researcher to contact you to talk over this research study further, please sign the slip below.

Alternatively, if you would like to take part in this research study, please read and sign the consent form provided and give it to the researcher.

**THANK YOU FOR YOUR TIME**

I (print name)

.....

Give permission for the researcher of this study to contact me by phone to provide further information about the study. This is not consent to participate.

Signature

.....

Phone number

.....

## Appendix I

### Tabled Results of database searches

Database search engine	Searches	Headings	Results	Met criteria
CINAHL	s1	Adolescent pregnancy MH	4841	13
	s2	"Pregnancy in Adolescence"	9954	
	s3	prenatal care	150	
	s4	prenatal clinic	1048	
	s5	adolescent mothers experiences and/or perceptions	504	
	s6	s1+s2	372	
	s7	s3+s4	2	
	s8	s5+s6+s7	12	
Embase	s1	Adolescent pregnancy	3456	8
	s2	prenatal care	14949	
	s3	s1+s2	33832	
	s4	prenatal clinic	207	
	s5	adolescent mothers experiences and/or perceptions	650	
	s6	s3+s5	188	
	s7	s4+s6	44	
	s8	s4+s6	1	
Pubmed	s1	Adolescent pregnancy	71949	2
	s2	prenatal care and/or prenatal clinic	136421	
	s3	s1+s2	5155	
	s4	s3+ perceptions and/or experiences	305	
	s5	adolescent mothers	219	
	s6	s4+s5	66	
Science Direct	s1	Adolescent pregnancy	7246	
	s2	prenatal care	2090	
	s3	prenatal clinic	637	
	s4	adolescent mothers	418	
	s5	s1+s2	16004	
	s6	s3+s4	4383	

	s7	s5+s6	219	
	s8	s7+ experiences and/or perceptions	463	3
Proquest	s1	Adolescent and/or teenage and/or pregnancy AND prenatal or antenatal care AND experiences and/or perceptions	160	1
Popline	s1	Adolescent pregnancy prenatal (care and/or clinic) experiences and/or perceptions	163 9 0	3
Informit	s1	Adolescent pregnancy and/or (adolescent and/or/ teenage) AND (antenatal care and/or clinic) AND experiences and/or perceptions	10	0
Note: adolescent used synonymously with teenage or teen or young mothers; prenatal used synonymously with antenatal.				