Meeting the Needs Of Teenage Parents: Reflections from Expectant 14-16 Year Olds Living in Hull

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Abstract

Teenage pregnancy is a key public health concern of the current government who in turn has implemented multi-agency strategies at local levels to increase the uptake of contraception, improve sex and relationship education and support young teenage parents. This paper reports some of the experiences of contraceptive use, education and decision making regarding continuing with pregnancy in a population of young expectant women aged 14-16 (n=23) who opted for the route of motherhood. The paper highlights that decisions to continue with pregnancy appeared to be largely made within the family without professional help. Data indicating that pregnancy appears to hamper continuation with education and perspectives on the relationship that the young expectant parents have with their partners are also included. The paper reflects on current intervention strategies and the important contribution that the views of young parents can make.

Introduction

In Britain, teenage pregnancy in recent years has become a subject of interest to government agencies, health professionals, psychologists and researchers. In 1997, the year prior to data collection in the present study, approximately 90,000 teenagers in England became pregnant, of whom 56,000 culminated in maternity bookings and 3,700 of these babies were born to under 16 year olds, (Office of National Statistics, 1998). In terms of age, approximately half of the pregnancies in the under 16 age group are terminated, compared with 30 per cent of pregnancies in the age group 16-18 (NHS Centre for Reviews and Dissemination, CRD, 1997). Those continuing with their pregnancies are more likely to live in poorer areas, such as inner cities (Smith, 1993; Ibbotson, 1993; Social Exclusion Unit, 1999).

The British government has highlighted the rising rates of teenage parenthood, specifically for those aged 16 and under, as a problem from the perspectives of teenage sexual health, health of the child born to the young parents and as a social exclusion issue. Teenage mothers are less likely than older women to finish their education and find employment. Consequently they are more likely to bring their children up in a socio-economically disadvantaged environment (Social Exclusion Unit, 1999). They are also more likely than older women to be single parents, relying on the welfare state. There is some evidence to suggest that the children of teenage parents are disadvantaged in that they are more likely than children of older parents to have low birth weights, and in childhood are more likely to have accidents, hospital admissions and subsequently become teenage parents themselves (NHS CRD, 1997).

In Great Britain and the United States, Harris et al, (1999) point out that teenage parenthood is generally perceived as a problem phenomenon in society and consequently the body of research stems from the view point that teenage pregnancy is unwanted. This value is not always shared by the young parents themselves and often is only owned by adults (Harris et al, 1999). When reviewing the 'teenage pregnancy' literature concerning attitudes to pregnancy, there appears to be a general view that if the pregnancy is unplanned then it is also unwanted, although the origins of this belief are not entirely clear. The current government (Department of Health, 2002) has outlined clear targets for the continuing reduction in teenage pregnancy rates over the next decade.

The local authority of Kingston upon Hull is included in the highest 10 per cent of under 18 conception rates in England, and has been listed 26th on an index of the most deprived local authority districts in England (Social Exclusion Unit, 1999). The high rate of teenage parenthood in Hull is not a recent finding. Ibbotson (1993) in an analysis of teenage conception trends reported that the number of births to mothers under 17 years of age in Hull doubled between 1982-1989, although births to teenagers aged 17-19 showed no upward trend. Despite the social and economic difficulties experienced by many in Hull, Ibbotson (1993) found that the local population often viewed teenage parenting as a normal pattern of behaviour, and the acceptability of early parenthood continues

to be reflected in Hull (Macleod and Weaver, 2003). While government targets are intended in the main for teenagers aged 16 and under, many studies to date do not differentiate between older (over 16) and younger expectant women. The results highlighted in this paper however focus on expectant teenagers aged 16 and under (n=23) and are intended to report on subjective experiences of contraception use, decisions to opt for the route of motherhood, relationships with partners and education. This is an area of importance to both health professionals and policy makers alike. The results reported here are part of a wider longitudinal study examining adjustment and attitude during the antenatal period (Macleod and Weaver 2002, Macleod and Weaver, 2003) in an expectant teenage population aged 14-18.

Methodology

Design and Measures

Standardised questionnaires and semi-structured interviews were employed in a longitudinal design. Demographic information such as educational status, housing and postal address was gathered at 20 weeks (Table 1) and responses to a comprehensive maternity care survey devised by the author were elicited at 37 weeks gestation. It was felt that the participants towards the end of the third trimester would have experienced some antenatal care provision by health professionals which could be explored. Items included in the 37 week maternity care survey, which are the focus of the subjective experiences reported in this paper, were a series of open and closed questions such as 'Were you hoping to be pregnant?', 'Thinking back to the beginning of your pregnancy, did you have a choice about continuing or not continuing with your pregnancy?' 'Who helped you make that choice?' To explore contraception use, participants were asked what type of contraception, if any, they used prior to becoming pregnant. The comments reported in this paper regarding relationships with partners were volunteered freely by the participants during the course of the interviews. The resulting qualitative data, all of which was collected during the interviews at 37 weeks gestation were thematically organised and are reported here under the headings of contraception use, decision making, relationships and education.

Psychological measures were included in the study and were used at both 20 and 37 weeks. These were a short social support measure (Sarasen et al, 1987), and an instrument intended to measure adjustment to pregnancy during the antenatal period (Reading et al, 1984), the results of which have been reported elsewhere (Macleod and Weaver, 2003).

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Participants

Following Local Research Ethics committee (LREC) approval and a pilot study, 23 first-time expectant mothers aged 14-16 years at the projected time of delivery were recruited from the two maternity hospitals in the area, over the 4 month period of recruitment (October 1998 – March 1999). The teenagers were recruited on the basis of having a first singleton ongoing, low-risk pregnancy. Recruitment and consent for the study were obtained at the time when participants attended the main hospitals for a 20 week anomaly scan. Provision was made for participants to be interviewed alone by the researcher and 20 week data was collected at this time during a 20 minute face-to-face interview. Subsequent arrangements for the 37 weeks interview to take place either at a third trimester hospital clinic or at the teenager's home were negotiated. The 37 week face-to-face interview lasted approximately an hour. At 37 weeks, 21 of the 23 participants were interviewed. The two missing participants delivered prematurely at 30 weeks and 33 week's gestation respectively and the remainder was happy to continue to participate in the study, representing a 91 per cent response rate.

Results

Table 1 illustrates that the majority of the expectant teenagers lived with their families and in inner city areas. Just under half of the sample were attending the teenage mum school unit. Approximately a quarter of the sample was attending secondary school and the same number was unemployed. One participant was attending college.

Demographic information

Postal Address	**Number of teenagers aged 14-16 (N=23)**
Inner City	17 (74%)
Surrounding Villages	6 (26%)
Housing	
Family Home	17 (74%)
Living with boyfriend	4 (17%)
Living with extended family members	2 (9%)
Employment Status	
Specialist teenage mum school	10 (44%)
Secondary school	6 (26 %)
College	1 (4%)
Unemployed	6 (26%)

Contraception

The majority of the 17 (74%) young women were not hoping to be pregnant although it is noteworthy that the remainder stated that they were. However only 6 (29%) reported using any contraception. One teenager said she sometimes did but 14 (61%) said they did not use any form of contraception. The qualitative data indicated that many of the teenagers had considered contraception, but in the main had not used it effectively. The following quotation from one girl indicated that she had considered contraception, but not in time to prevent a pregnancy:

> *'I planned to go for the pill, then I found out I was pregnant'* (14 year old)

Another teenager indicated that she had got the contraceptive pill, but had not started using it:

> *'I went to get the pill, but didn't start it'* (16 year old)

One girl indicated that she wanted to discuss contraception with her mother but found it too difficult:

> *'I tried to go to my mum [for contraception] but couldn't quite'* (14 year old)

Another teenager indicated that although she had used the pill, she had thought she would like to have a baby, but found the realization of pregnancy difficult.

> 'It [the pill] gave me migraines, I was going through a phase of I wouldn't mind having a baby, I was hoping to be pregnant, but when I found out it was different' (15 year old)

Shock at finding out about the pregnancy was indicated by another participant:

> *'I didn't know what to think when I found out – it was a shock'* (16 year old)

One participant also reported the perceived reaction of her mother after breaking the news of her pregnancy:

> *'My mum hates the sight of me now'* (16 year old)

Decision making

When asked, 19 (90%) of the pregnant participants felt they had a choice whether or not to continue with their pregnancies. Only one girl said that she did not perceive that she had a choice and one other stated that she was trying to become pregnant. The majority relied predominately on their mothers or occasionally partners to help them make their decisions, but notably only one girl mentioned that she had had a consultation with a health professional in the decision making process, this being at a family planning clinic. Ninety-five per cent of the teenagers had booked for maternity care with their midwife by 16 weeks, and all of the group by 20 weeks gestation.

The following quotation reflected the view of several of the participants who indicated that their mothers were supportive in some of the choices that were made. This participant perceived that her mother helped her in deciding where to have the baby:

> *'I had a choice – mum helped me, she said I could ask which hospital I could have the baby at'* (16 year old)

The following girl perceived that her mother helped her to decide whether or not to continue with the pregnancy:

> *'Yes I made the choice myself with a bit of help from mum – she gave me the choices and I decided myself'* (16 year old)

Relationships

The reality of the pregnancy for some was the end of their relationship with the baby's father, which was indicated by some of the comments that the girls made. The following quotation is illustrative:

> *'The baby's dad doesn't want to know'*
> (16 year old)

This lack of paternal interest is also echoed in the following quotation:

> *'My boyfriend told me to get rid or he was going, so I told him to go'* (15 year old)

The following quotation indicates that, although the relationship with the baby's father had ended, the expectant girl perceived that he was still interested in the baby:

> *'I'm not in a relationship with the baby's dad anymore, but we're still friends, he'll come for the birth, he's interested in the baby'*
> (16 year old)

Education

The advent of impending motherhood appeared to be an impediment for some participants in carrying on with education, even in the specialist school girl mums unit where travel expenses and childcare facilities were offered. The importance of continuing with education was not apparent from the perspectives of the teenagers, and during the interviews there was no evidence of encouragement from anyone else in the family to continue with schooling. The following excerpt illustrates a lack of interest in education:

> *'I'm painting my bedroom so not going to school'* (15 year old living in family home)

The following girl indicated that she did not like her teacher, therefore decided not to go to school:

> *'I hate her [the teacher] and she hates me so I'm not going'* (16 year old living in family home)

Another girl, who did not appear to be in long term housing indicated that travel to school was too expensive:

> *'I left school to move in with my partner, then couldn't afford to get there, we were in a hostel for 4 months, then a flat for 5 weeks and now this house for 6 months'* (15 year old)

Discussion

The qualitative data reported provides a brief but valuable insight into some of the perceptions of a small number of young vulnerable expectant mothers regarding contraceptive use, decision making about continuing with pregnancy, relationships with partners and education.

There is a need for schools to have a policy for Sex and Relationship Education (SRE), although the Department for Education and Employment (2000) which initiated the programme have stated that implementation of SRE is non-statutory. For many schools SRE is incorporated into the curriculum too late when students are 14 and 15 years of age (Kiddy, 2002), and the results from the present study indicate that, for those young people living in the Hull area, earlier implementation might be advantageous. The age of first teenage sexual encounters appears to be increasingly younger over the last decade but is not necessarily related to the provision of SRE in schools (Wellings et al, 1995). Indeed two salient points from the large survey conducted by Wellings and colleagues is that boys who receive their sex education from schools rather than friends are more likely to be virgins at sixteen years of age. Secondly, there appears to be a gap in the literature exploring teenage sexual behaviour in relation to sex education. The results relating to the use of contraception in the present study seem to indicate that young people's knowledge of contraceptive use is questionable, a result that concurs with other studies (Mackereth and Forder, 1996). The majority of participants in the present

study did not use any contraception, but those who were using it seemed to be worryingly apathetic about using it properly as a barrier to pregnancy.

Health professionals, particularly midwives, are faced with legal and ethical dilemmas when consulting with pregnant teenagers under 16 with a continuing pregnancy. While the data suggests that a decision to continue with the pregnancy has been made, it is important to recognize that that the teenager under 16 is 'Gillick competent' (Gillick v Norfolk and Wisbech Area Health Authority, 1986) to make her own decision to continue with her pregnancy. It is not clear in the present study if and how this had been assessed. The young women in the present study appeared to have made up their minds about continuing with their pregnancies, without the help of a health professional. It was, in addition, difficult to tease out if the decision was driven by the mothers or by the girls themselves, given that some teenagers indicated that their mothers were influential in the decision making process. The data from the present study appears to indicate that decisions for this vulnerable group of young women are largely made within the family before the benefits of professional help are known and are sought. It could be suggested that the commendable provision of counselling services to facilitate decision making that was suggested by the Department of Health (2002) might be difficult to achieve at the opportune time.

Those participants who made comments about their relationships with their boyfriends highlighted that their relationships had ended, an observation consistent with previous research (NHS CRD, 1997; Social Exclusion Unit, 1999). However, during the assessment of social support at 37 weeks (Macleod and Weaver, 2003) over 76 per cent of the whole 14-18 year old sample cited their boyfriends as providers of social support. Qualitative comments from the younger group about relationships appeared to have been more forthcoming from those participants whose relationships had ended. It is therefore difficult to draw any conclusions about the results regarding relationships with boyfriends without further exploration.

The Department of Health (2002) has identified clear strategies and targets to engage young pregnant women and mothers to continue in education, largely through the provision of extra funds for childcare and the provision of a flexible curriculum. The qualitative data in this study however highlight that even with encouragement, finance and support in a specialist school, the underlying difficulty of convincing the young person and her family that education is important remains substantial. However the league tables of the inner Hull schools in the year following the period of data collection demonstrated that pregnancy occurred in a culture of underachievement in Hull schools. Only two of the state secondary schools in inner Hull reported having candidates achieving A levels (Guardian 16th November 2000), and proportionately the numbers obtaining GCSEs was low compared with other parts of the country. It has been suggested that if the level of education is low, teenage girls are more at risk of becoming pregnant (Fergusson and Woodward, 2000), and perhaps the route of motherhood appears a more preferable life option for this population (Macleod and Weaver, in 2003).

While the disadvantages of early parenthood seem clear, the future for teenagers who are accidentally pregnant or contemplating parenthood hold much promise in terms of government funded support, as arguably the most comprehensive strategy to date to support young teenage parents is in place. The multidisciplinary partnerships, which have evolved since the inception of the Teenage Pregnancy Unit, are providing SRE and support during pregnancy for young teenage parents aiming to meet the needs of local populations. However, a recent systematic review concluded that primary prevention strategies do not delay the initiation of intercourse or improve the uptake of contraception (DiCenso et al, 2002), although the authors point out that lower socio-economic groups may have been over-represented. The reviewers noted that few intervention strategies incorporated the views and values of teenagers themselves. Agencies working with teenagers may have more success in meeting their targets if negotiation, communication and social resistance skills were incorporated into intervention programmes, which hopefully might contribute to engendering a healthy teenage sexual culture.

It would seem that one of the most difficult tasks is to make these very young teenagers aged 16 and under, who in the main seem oblivious to their vulnerability, aware of all the options and benefits which public health partnerships can provide. Emphasis should be placed on the importance of the continuing collection of qualitative data from young pregnant teenagers such as those interviewed for the present study who were keen and willing to share their views. Although the observations highlighted in the present study are limited to a small number of teenagers in Hull, the importance of their views should not be underestimated when evaluating the impact of service provision.

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