What Do Teenage Mothers Want From The Well Child / Tamariki Ora Service?

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Nursing

at the Eastern Institute of Technology Taradale, New Zealand.

Nicky Skerman

2010
Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.
Abstract

New Zealand has one of the highest rates of teenage pregnancy in the world. The UNICEF Innocenti Report Card (2001) places New Zealand third in the table of teenage births in rich nations with 29.8 per 1000 births by women aged 15-19 years. The literature suggests that teenage mothers often struggle to cope with the demands of caring for a baby while making the transition from adolescence to adulthood. They require additional support from families, partners and services to achieve good health outcomes for themselves and their children but for many, becoming a mother is a positive event.

The Well Child /Tamariki Ora (WC/TO) service is provided at no cost to all children in New Zealand aged from birth to five years. This study aimed to discover what teenage mothers wanted from the WC/TO service and to explore whether the service was being effective in meeting the needs of teenage mothers in Hawke’s Bay, New Zealand. The investigation is a qualitative descriptive analysis based on data from two focus group interviews with a total of 12 participants who were teenage mothers aged between 16 and 19 years attending a secondary school teenage parent unit.

Giorgi’s (1970) method of analysis was used as a guide for the data analysis, from which four main themes were generated. These formed the discussion about the teenage mothers’ experiences of contact with the WC/TO service, the information they received, attitudes toward teenage mothers, and the need for respect and caring. A comparison of these findings with other research revealed many similarities regarding the needs of and attitudes towards teenage mothers.

Recommendations for making the WC/TO service one that teenage mothers want, and to ultimately improve health outcomes for their children, include: a smooth transition from the Lead Maternity Carer to a WC/TO service of their choice; good communication and relationship building; consistent and correct information including practical demonstrations; and nurses who are respectful and caring. It is suggested that a WC/TO nurse specialist involved with teenage mothers could be a positive step in this direction.
Acknowledgements

First and foremost I would like to thank my husband Chris and my four wonderful children, Rebecca, Sam, Willy and Jack, who have shared their wife and mother with a computer for the last eighteen months. They have supported me while at the same time been mystified at what their mother was doing, with many questions but little complaint.

I would like to acknowledge my Principal supervisor, Dr Shona Thompson, and my Associate supervisor, Kathy Manhire, for their patience above all, but also their fantastic support and encouragement. I have never felt that anything asked of them was too trivial.

Thank you to the wonderful research participants from the teen parent unit, your willingness to participate in this research looking at better outcomes for teen mothers and their children was inspiring. Your questions and reflections justified some of the reasons for carrying out this research. To the staff and management at the teen parent school, thank you, your support in allowing me access to your students was appreciated as was your interest in the research.

To Tracey and the team at Hawke’s Bay Plunket, thank you for listening and supporting me.

Finally I would like to acknowledge my father-in-law, Jim Skerman, who passed away during the writing of this thesis. He was a strong supporter of his daughter-in-law and always said I could do it.
A Decision that changed my life

Too young to be a Mum

Too immature

Just a kid myself

Just fourteen years old

BUT

He changed my life

As soon as I saw him

I fell in love with him

He made me grow up

My baby made me a Mum.

Tell me a story 2009

The Hawke’s Bay School for Teenage Parents
# Table of Contents

Abstract  
Acknowledgments  
‘A decision that changed my life’  
Table of Contents  

**Chapter One: INTRODUCTION**  
Introduction  
Background  
The Well Child/Tamariki Ora service  
The Statistics  
The Hawke’s Bay Region  
The significance of the study  
Adolescent Developmental Stages  
Aim of the research  
The Researcher’s Interest  
Thesis outline  

**Chapter Two: LITERATURE REVIEW**  
Introduction  
The Experience of Teenage Pregnancy and Motherhood  
Services and Support for Teenage Mothers  
New Zealand: The Transition from Maternity Services to WC/TO Services  
Summary  

**Chapter Three: METHODOLOGY**  
Introduction  
Research design  
Focus groups  
Data collection  
Participant recruitment  
Data collection process  
Ethics  
Delimitations and Limitations  
Data analysis  
Trustworthiness of the Research  
Summary
**Chapter Four: FINDINGS**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of Analysis</td>
<td>34</td>
</tr>
<tr>
<td>Step One: Gaining a Sense of the Whole</td>
<td>35</td>
</tr>
<tr>
<td>Step Two: Identifying Units of Meaning</td>
<td>35</td>
</tr>
<tr>
<td>Step Three: Essential Themes are Generated and Described</td>
<td>35</td>
</tr>
<tr>
<td>Theme one: Teenage Mothers’ Experiences of Contact with the WC/TO Service</td>
<td>36</td>
</tr>
<tr>
<td>Transition from the Lead Maternity Carer to the WC/TO Provider</td>
<td>36</td>
</tr>
<tr>
<td>The Choice of Provider</td>
<td>38</td>
</tr>
<tr>
<td>Identification and Communication</td>
<td>39</td>
</tr>
<tr>
<td>Where the First Visit Took Place</td>
<td>40</td>
</tr>
<tr>
<td>The Amount of Time Available</td>
<td>41</td>
</tr>
<tr>
<td>Summary</td>
<td>42</td>
</tr>
<tr>
<td>Theme Two: The Information Received</td>
<td>42</td>
</tr>
<tr>
<td>Summary</td>
<td>45</td>
</tr>
<tr>
<td>Theme Three: Attitudes towards Teenage Mothers</td>
<td>45</td>
</tr>
<tr>
<td>Summary</td>
<td>47</td>
</tr>
<tr>
<td>Theme Four: Respect and Caring</td>
<td>48</td>
</tr>
<tr>
<td>Summary</td>
<td>51</td>
</tr>
<tr>
<td>Summary</td>
<td>51</td>
</tr>
</tbody>
</table>

**Chapter Five: DISCUSSION**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme One: Teenage Mother’s Experiences of Contact with the WC/TO Service</td>
<td>53</td>
</tr>
<tr>
<td>Theme Two: The Information Received</td>
<td>55</td>
</tr>
<tr>
<td>Theme Three: Attitudes towards Teenage Mothers</td>
<td>57</td>
</tr>
<tr>
<td>Theme Four: Respect and Caring</td>
<td>58</td>
</tr>
<tr>
<td>Summary</td>
<td>60</td>
</tr>
</tbody>
</table>

**Chapter Six: CONCLUSIONS AND RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>61</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusions</td>
<td>62</td>
</tr>
<tr>
<td>Recommendations for the Well Child/Tamariki Ora Service</td>
<td>64</td>
</tr>
<tr>
<td>Summary</td>
<td>67</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>67</td>
</tr>
</tbody>
</table>
REFERENCES

Appendix A:  RNZPS (Inc) Ethics Committee Approval  72
Appendix B:  Eastern Institute of Technology Research Approval  74
Appendix C:  Participant Information Sheet  76
Appendix D:  Letter from Kuia  78

List of Figures
Fig. 1: Age group of mothers delivering in hospital 2008/09  3
Fig. 2: Hawke’s Bay teenagers who have given birth (13-17 years)  4
Fig. 3: Hawke’s Bay teenagers who have given birth (13-19 years)  4
Chapter 1

INTRODUCTION

Introduction

New Zealand has the third highest teenage birth rate in the Organisation for Economic Cooperation and Development (OECD) after the United States of America and the United Kingdom (UNICEF, 2001). In 2009, 4642 births in New Zealand were to mothers aged between 15-19 years (Statistics New Zealand, 2009). Over the past twenty years, the pregnancy rate of 50 per 1000 teenage pregnancies (15-19 years) has remained about the same in New Zealand, but during this time the teenage abortion rate has nearly doubled, and the number of teenagers giving birth has declined. “Although a proportion of teenage pregnancies are intended and wanted, many do occur to young women who find it difficult to adequately care or support a child without significant assistance from social service agencies and family” (Ministry of Health, 2004, p. 94).

Some recent international qualitative studies sought to identify young people’s perspectives on teenage pregnancy, raising fundamental questions about the extent to which young women regard pregnancy and parenting in negative terms. These studies were carried out from the young woman’s perspective rather than the researchers’ and found that, for some young women, teenage pregnancy could be normative rather than deviant and could provide some young women with a sense of purpose (Kirkman & Moloney, 2005).

Access to appropriate child health services including Well Child and family health care, is one of the thirteen population health strategies outlined in the New Zealand Primary Health Care Strategy (2001). These services are partly delivered through an initiative called the Well Child/Tamariki Ora programme, of which the Royal New Zealand Plunket Society (Inc) (RNZPS (Inc) is the main provider. The Well Child / Tamariki Ora National Schedule outlines a package of care to be delivered to all New Zealand children. A key focus of the package is ensuring that all entitled families, receive the service, and families with high needs receive additional services, in order to reduce inequalities and improve child health (Ministry of Health, 1996). Young mothers may be in the group that has high needs therefore requiring additional service.
Background

The Well Child/Tamariki Ora Service:

The Well Child / Tamariki Ora (WC/TO) service is unique to New Zealand although other similar services exist in other countries. This primary health care service is delivered by Registered nurses who provide well child and well family care in the community, based on the WC/TO schedule. The WC/TO schedule includes three strands: health education and promotion, health protection and clinical assessment, and family or whanau care and support (RNZPS (Inc), 2003). The WC/TO Service is offered free to all New Zealand children from birth to five years of age. The WC/TO schedule states that surveillance and support services for at risk families or whanau, and for children or adolescents at risk of abuse or neglect, should be to the level specified in the schedule (Ministry of Health, 1996). In practice there are different needs and there should be accompanying services to meet these needs, for example; the needs of teenage mothers may be different from other mothers.

The Statistics

According to Statistics New Zealand, (Stats, N.Z. 2009) 4,642 teenagers aged 15 to 19 years gave birth in 2009. Of those 4,642 births, 2,361 were to those who identified as Maori, 1428 were to those who identified as non-Maori and 852 were to those who identified as Pacific. In 2008, 39 teenagers under the age of 15 gave birth. Maori teenagers are nearly three times more likely than European teenagers to become pregnant. Pacific Island teenagers are 2.4 times more likely to become pregnant (Statistics New Zealand, 2008).

The Ministry of Social Development Report (2008) stated that “New Zealand has a relatively high rate of child bearing at a young age compared with most other developed countries” (p. 14). In New Zealand between 1997 and 2002, the teenage fertility rate fell from 33.2 to 25.8 per 1,000 but rose by almost as much between 2002 and 2007. Over the same time period, Maori teenage fertility fell from 84.0 per 1,000 in 1997 to 61.8 per 1,000 in 2002, rising to 78.7 per 1,000 by 2007. For non-Maori females under 20 years, the pattern was similar but with a less pronounced fall in the rate between 1997 and 2003 (from 19.9 to 15.7 per 1,000), followed by a rise to 18.9 per 1000 in 2007. The birth rate for Pacific females aged 15 to 19 years dropped from 47.4 per 1,000 in 2000-2002 to 42.5 per 1,000 in 2005-2007. (Ministry of Social Development, 2008).
The Hawke’s Bay Region

This research was conducted in the Hawke’s Bay region within New Zealand. According to Statistics New Zealand in the 2006 national census, the population in Hawke’s Bay was 147,000, ranking ninth in population size out of the 16 regions in New Zealand. Of New Zealand’s Maori population, 5.9% (33,000) live in the Hawke’s Bay region, tracking eighth in size out of the 16 regions. Couples with children make up 38.6% of all families in Hawke’s Bay, where 21% are one parent families compared to the national figure of 18.1% (Statistics New Zealand, 2006).

The Hawke’s Bay District Health Board (HBDHB) Status Review (2010b) states that the conception rate (rates of births and medical abortions combined) in Hawke’s Bay has increased for the 13 to 17 year age group from 17.3 per 1000 in 2001-02 to 22.2 per 1000 in 2008-09. The teenage birth rate, 13 to 17 years, in Hawke’s Bay in 2008/09 was for Maori 25.3 per 1000 population, compared with 5.0 per 1000 for non-Maori (HBDHB, Status Review, 2010b).

The total number of births in Hawke’s Bay to mothers aged less than 20 years was two hundred and forty seven. One hundred and fifty seven identified as Maori, and twelve as Pacific, seventy eight as other (HBDHB, 2010c).

Figure 1 shows the age group of mothers having children in hospital in Hawke’s Bay in 2008/09 and indicates that the number of births in the 15 to 19 years age group was well above the national figures (HBDHB, 2010c).

![Age group of mothers delivering in hospital, 2008/09](image)

Fig 1: Age of mothers delivering in hospital, 2008/2009
Figure 2 shows the comparisons of 13 to 17-year-olds Maori and non-Maori in Hawke’s Bay and the comparisons with the rest of New Zealand. Hawke’s Bay Maori births to teenage mothers were still above the New Zealand Maori rates for teenage mothers giving birth (HBDHB, 2010c).

![Figure 2: Ethnicity of Hawke’s Bay teenagers (13 to 17 years) who gave birth.](image)

Figure 3 is the same statistics including the 18 and 19-year-olds which shows Maori teenagers in Hawke’s Bay have higher birth rates than Maori in the rest of New Zealand (HBDHB, 2010c).

![Figure 3: Ethnicity of Hawke’s Bay teenagers (13 to 19 years) who gave birth.](image)
The Hawke’s Bay District Health Board, (2010 a), Youth Health Workplan Draft 2010-2013 describes the demographics of youth, defining them as being between the ages of 12 and 24 years. The percentage of Hawke’s Bay youth who identify as Maori/ non-Pacific is 60.3%. This is followed by 35% who identify as only Maori which is higher than the Maori proportion in the overall population of 24% and then 4.4% who identify as Pacific. Thirty four percent of Hawke’s Bay youth live in areas of lower deprivation with scores, of nine or ten, compared with 26% nationally. Hawke’s Bay teenage (13 to 17 years) live birth rates are increasing and are consistently higher than national rates. Maori birth rates were five times those of non-Maori in 2008/09 (HBDHB, 2010 a) Youth Health Workplan Draft 2010-2013. The Hawke’s Bay Youth Health Workplan Draft, 2010-2013 has no objective or actions specifically for teenage parents. (HBDHB, 2010a)

The significance of the study

Since the Ministry of Health released the 2002 report Youth Health: A Guide to Action there has been continuing focus on youth making decisions about their primary health care (Ministry of Health, 2002b). As part of the groundwork for this report the Ministry of Health commissioned evidence based review of youth specific health services and their effectiveness. It found that youth-targeted primary care increases access and utilisation of health care significantly for young people (Ministry of Health, 2002b). Ministry of Health, (2002b) stated that in one of the studies included in the review, young people used youth-specific health services up to 10 times more than traditional services, such as general practitioners’ (GPs). There were better health outcomes for young people who used the youth-targeted primary health services “although it was acknowledged that it is difficult to attribute a change in health to a single intervention such as youth focused primary health care” (Ministry of Health, 2002b, p. 7). When youth were asked what they preferred in health services, there was resounding support for services that were targeted at youth, whether that be in a separate physical setting (e.g. in a school-based clinic) or within a traditional provider setting, such as an adolescent clinic run by a family doctor (Ministry of Health, 2002b).

One of the four goals stated in Youth Health: A Guide to Action, (Ministry of Health, 2002b) was to have young people influence health policy and programme development. The Ministry of Health states, “young people want to be actively involved in decisions that affect them and in decisions about their own health care. Programmes and services work better when young people participate in their design and delivery” (p. 1). The document also proposed, “a shift in the way that the health sector has traditionally seen
young people: from being a problem to being solved to being active participants in creating a healthier world" (Ministry of Health, 2002, p. 4).

Many health services have taken the action plan and implemented the recommendations, providing “Youth One Stop Shops” around the country, some of which are run by youth health nurse practitioners or nurse specialists. They provide a range of primary health, mental health, and family planning services in youth-friendly, central settings at little or no cost to clients aged 10 to 25 years.

All District Health Boards are now required to have a Youth Health plan although, as with all health services, funding continues to be tenuous. The Hawke’s Bay Youth Workplan draft, 2010-2013 (HBDHB, 2010a) has been mentioned previously. In Hawke’s Bay there is a “Youth One Stop Shop” in Hastings that provides a range of accessible, youth friendly, social and other services in a holistic manner. All significant funding comes directly from the Hawke’s Bay District Health Board. The Ministry of Health (2009b) published an evaluation of Youth One Stop Shops in New Zealand and, among the findings, it was noted that there were gaps with other providers in the area of maternity and teen pregnancy support. Another resource for youth in Hawke’s Bay is a youth directory, listing all the agencies and websites youth are likely to need, with a summary of the services offered in both Hastings and Napier District Councils, including websites specifically for youth to access with invitations to join either youth council.

Adolescent Developmental Stages

The World Health Organisation defines adolescence as the period between the ages of 10 and 19 years (Watson, 2001). Bird and Drewery (2000) say that the divisions between adolescence, youth and young adults are becoming difficult to define as the stages become more blurred. The Ministry of Youth Development (2007) in their Youth Development Strategy state “there are no set boundaries between ‘children’ and ‘young people’ and ‘adulthood’ - they depend on the person’s culture, their individual personality and their choices and their social and financial circumstances” (p. 11). There are many terms that describe this time such as adolescent, youth, teenager, young adult, rangatahi, taioha, taitamariki, taiohi and tupulagatalavou (Youth Development Strategy, 2007). For the purpose of this research a teenager is 16 to 19 years of age.

Many different theories have been postulated about teenage developmental stages. Erickson (1980) describes his theory of eight stages of man, which he based on psychoanalytic theory, and suggested that humans move through different stages
during their lives, where they must complete specified roles or tasks in order to achieve the most from their lives. In adolescence, which occurs around the age of 12 to 18 years, a child moves into what Erickson terms the fifth stage. Erickson called this stage Identity versus Role Confusion. In this stage, Erickson suggests that teenagers can now start to think about other people’s thoughts and feelings and also wonder what others may think of them. This, Erickson says, is the time when the maturing adult develops a sense of self. Erickson states that those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and a feeling of independence and control. Those who remain unsure about their beliefs and desires will be insecure and confused about themselves and the future (Erickson, 1980).

Another theory of development in adolescence is the humanistic theory. Central to this theory are the concepts of choice and holism, in which psychologists refer to the uniqueness of being human, and consider that every person is more than a collection of the physical, cognitive and social parts (Bird & Drewery, 2000). Maslow, one of the humanistic theorists, proposed that needs could be arranged in a hierarchy with the lower order needs having to be met or satisfied before the higher ones could be met. Bird and Drewery (2000) state,

> Humanistic theory suggests that given the right conditions, the individual has the inbuilt capacity to learn and develop well. Thus humanistic psychology fosters an uncritical belief in the goodness of individuals and a well meaning focus on support for relationships as a basis for personal growth (p.195).

Elkind (1967, 1976) refers to a teenager’s egocentrism as the heightened self – consciousness of adolescents that is reflected in their belief that others are as interested in them as they are in themselves. One of the interesting facts about ego identity and the struggle to become independent is that the process is often too difficult for the teenager to do alone (McCallum, 1990; Dekovic & Meeus, 1997 as cited in Martis, 2004). Teenagers may therefore choose to go through this process in the same way as others in their peer group, and they change together. From personal observation the individual can become the collective ‘I’ which means that they eat the same food, drive the same cars, and drink the same drinks. According to Kuykendall (1989), becoming pregnant at this stage can alter the collective ‘I’ feeling and isolate the teenage mother from other teenagers and therefore affect the developmental process of her becoming an adult. Bird and Drewery (2000) note that,
Although adolescence is a western term, not all individuals born and raised in western societies identify as ‘adolescents’. The term adolescents must therefore be used with caution as it fails to accurately define, interpret or describe the experiences and norms of all young people within the ‘teen’ age group (p. 163).

This may be the case in different cultural groups.

**Aim of the research**

The aim of this research is to identify what some teenage mothers, aged 16 to 19 years, want from the Well Child/Tamariki Ora service.

The objective of the research is to provide recommendations to the WC/TO service so that teenage mothers and their babies will receive a youth friendly service. This service would ultimately assist teenage mothers and their children in ways they want towards improved health outcomes for their children.

The research question is:

**What do teenage mothers want from the Well Child/Tamariki Ora service?**

This question was developed because the organisation that I worked for as a WC/TO nurse had never conducted any research on the teenage mothers and their needs. I felt the one size fits all service was not improving health outcomes or connecting with the teenage mothers who I regularly visited at the teen parent unit. From the literature reviewed and personal experience it was important to ask the teenage mothers what they wanted and hence the development of the question.

**The Researcher’s interest**

My interest is in supporting teenage mothers with their children. This interest has developed over time from a professional perspective. As a Plunket nurse working with teenage mothers I started to question whether or not the WC/TO service was providing this group of mothers with the services that they wanted. As a Plunket nurse I found that my professional knowledge was being stretched, constraints on my time were a problem and my skills in the area of teenage development were lacking. With the statistics for teenage pregnancy so high in New Zealand and the literature surrounding outcomes for the children of teenage mothers not positive. I wanted to see if the services provided through the WC/TO programme were meeting the needs of teenage mothers and their
children. I wanted to conduct this research using teenage mothers as the research participants so the questions were being answered by the teenage mothers themselves.

**Thesis outline**

Chapter one: *Introduction*

The chapter is an introduction and background to the research issue. My interest and the significance of the topic are presented. The research question and objective are identified.

Chapter two: *Literature Review*

This chapter provides a comprehensive review of international and national literature related to the research topic. The literature has been drawn from the relevant published documents, journals, texts and databases. The literature included in this review further informs the background and relevance of this study.

Chapter three: *Methodology*

The research methodology is described in terms of the method and designs used. Participant selection and recruitment are presented along with both data collection and data analysis procedures. Ethical considerations including gaining approval from the Eastern Institute of Technology Research Approvals Committee and the Royal New Zealand Plunket Society (Inc) Ethics Committee are included as Appendix A and B.

Chapter four: *Findings*

This chapter presents the research findings from the analysis of the data transcribed from the focus group discussions. The research findings are related to the research question and objective.

Chapter five: *Discussion*

The research findings are discussed in detail in relation to each of the identified themes. Previous research and identified literature are discussed in support of and in contrast to the research question.

Chapter six: *Conclusions and Recommendations*

Conclusions and recommendations from the findings along with recommendations for future research are presented in this final chapter.
Chapter 2

LITERATURE REVIEW

Introduction

A literature review is a “comprehensive, in depth, systematic and critical review of scholarly publications, unpublished scholarly print materials, internet materials audiovisual materials and personal communications” (Schneider, Whitehead, & Elliott, 2007, p. 58). Schneider et al. (2007) state that a review of the literature is an essential part of the research process. It is used as a source of knowledge and to identify gaps in relation to a topic or issue. It contributes to the development of the research question as well as the design and methods used. It also allows the outcome of the analysis to be related back to previous studies.

This chapter reviews the literature related to teenage mothers in New Zealand and other countries. It includes the available literature about what teenage mothers want from health service including the WC/TO service in New Zealand. The review also considers research that has been carried out using teenage mothers as participants.

Searches were conducted on the Proquest, Pubmed, Goggle Scholar, Cumulative Index for Nursing and Allied Health Literature (CINAL) and the electronic library catalogues at the Eastern Institute of Technology, Hawke’s Bay. To provide some parameters for the search the key words used included pregnant teenager, adolescent, youth, teenage, mothers/motherhood, support, New Zealand, Well Child / Tamariki Ora service.

In preparation for undertaking this research and writing the thesis the literature covering a wide range of subject areas was reviewed. This included the topic of teenage pregnancy and areas of support for teenage mothers including literature from a political/legislative point of view. The majority of the literature regarding teenage pregnancy and motherhood was not based on the teenage mothers perspectives, instead, decisions on what was best for teenage mothers were made by others, and the ‘problem’ of teenage pregnancy was much discussed.

The literature reported in this chapter focuses more specifically on the experiences of teenage pregnancy and motherhood, and support for teenage mothers both overseas and in New Zealand, with a particular focus on the WC/TO service in New Zealand.
The experience of Teenage Pregnancy and Motherhood.

Teenage mothers often struggle to cope with the demands of caring for a baby as well as many other complex issues while they are making the transition from adolescence to adulthood. They require additional support from family, partner and services to achieve positive health outcomes (Wahn, Nissen, & Ahlberg, 2005).

Wahn et al. (2005) carried out a study in Sweden to describe the perspectives, experiences and reasons for becoming and being a teenage mother. Twenty pregnant and parenting teenagers aged 15 to 19 years were interviewed. In Sweden the rate of teenage pregnancy is low with a teenage birth rate of approximately 1700, 2% a year. From 1975 there was a sharp decline in teenage births possibly as a result of a long term government programme on sexuality and human relations. Sweden also has a long tradition of compulsory education on human relations and sex with a system of special youth clinics with school outreach clinics offering contraceptive advice, counselling and information. In addition to this abortion is free on request until the 18th week of gestation. Wahn et al. (2005) stated that “regardless of age, a girl’s transition to motherhood can be described as a significant rite of passage into adulthood. The age when a girl becomes pregnant is crucial, however, and becoming a teenage mother interrupts the course of her life” (p. 592). They describe teenagers as confronting parental responsibilities at the same time as they are dealing with their own developmental tasks of identity. The teenage mothers in Wahn et al.’s study described a lack of opportunity in their lives, a pattern of early childbirth in their families and ambivalence in contraceptive use as reasons for becoming a teenage mother. They described being pregnant and being a teenage mother as a positive transition into adulthood but also as a psychological and physiological hardship. The teenage mothers described the importance of supportive relationships as a prerequisite for successful parenting and the right type of support at the right time. In conclusion, Wahn et al. (2005) found “it was important for different professionals to collaborate in meeting both health and support needs of teenage mothers” (p. 602).

Hailes and Wellard (2000) carried out research in Australia with South Australian metropolitan mothers. The research used a qualitative method using focus groups. Five focus group interviews were held with a total of 24 women participating in the study. The research looked into the support for breastfeeding in the first postpartum month from the perceptions of breastfeeding mothers. Hailes and Wellard (2000) explored the perceptions of mothers about what breastfeeding support was available. Findings showed that breastfeeding mothers felt that the midwives were unable to provide the breastfeeding support and relationship that they needed and this was due to limitations of
time and inconsistent rosters. Hailes and Wellard (2000) also found that confusion had arisen for the mothers because of conflicting advice given by the midwives. Hailes and Wellard suggested that the issues raised by the participants provided an opportunity for midwives to look at their practice and consider reshaping their practice to meet the perceived needs of breastfeeding mothers in the early postpartum period.

Woodward, Horwood and Fergusson (2001) carried out research in New Zealand collecting data as part of the Christchurch Child Health and Development Study. This was a longitudinal study of a cohort of children born in the Christchurch urban region during mid 1977. This cohort was studied at birth, four months, one year, at annual intervals to sixteen years, at 18 years and again at 21 years. One of the aims of their study was to describe the lifetime prevalence of teenage pregnancy and parenthood, in addition to the psychosocial backgrounds and current circumstances of young parents. The sample size was 533 young women studied from birth to 21 years old. The findings showed that by the age of 21 years, 26% of the sample had been pregnant and 14% had become parents. Most pregnancies occurred between the ages of 17 to 21 years. The young women who became pregnant were characterised by higher rates of educational under-achievement, sexual risk taking, conduct problems, and family adversity. They were most likely to identify themselves as Maori. Among those who became pregnant, there was a tendency for the young women who had a history of family adversity to proceed with their pregnancy and become young mothers. Woodward, Horwood & Fergusson (2001) stated there was growing evidence suggesting that young women who become pregnant in their teenage years were characterised by multiple social and psychological disadvantages which may impair their ability to cope with the challenges of early motherhood. These women and their children are especially vulnerable to continued social and economic disadvantage, parenting difficulties and poor child health and development (Woodward, Horwood & Fergusson 2001).

Owens (1992) was commissioned by the New Zealand Family Planning Association to review the intervention programmes for the prevention of teenage pregnancy in New Zealand. He found that teenagers do not utilise reasoning skills when making decisions, but rather use irrational thought habits focusing on concrete and immediate short term goals. Owens states that the teenage stage of development is often characterised by the transition from a lifestyle in which parents’ involvement in major decisions is gone, and the teenager is now expected to think for themselves and take control of their own lives. Owens (1992) suggested that previously these teenagers had not had to think about long term outcomes or had many opportunities to gain experience (Owens, 1992). Owens
(1992) stated this may be a factor as to why some teenagers find it difficult to plan ahead for motherhood or the long term care of their child.

Collins (2004) presented her research titled, ‘If I didn’t have my baby, I don’t know where I’d be: Teenagers as mothers’ to the Social Policy Research and Evaluation Conference in New Zealand. Her research investigated how teenagers view and experience pregnancy. It was a qualitative study involving 18 teenage mothers who were individually interviewed in-depth, focus groups with 35 young women who were not parenting, and in-depth interviews with 7 women who were service providers. The presentation focused on the teenage mothers who at the time of the interviews were aged between 17 to 25 years. At the age of their first birth they ranged in age from 15 to 19 years old. Eleven identified as Pakeha, four as Maori, two as Maori/Pakeha and one as Pacifica. Collins (2004) concluded there was growing acknowledgment that young people can make valuable contributions if opportunities are given for them to express their views. Collins (2004) “identified sources of risk and protective factors, and identified many instances where people and institutions missed opportunities for connecting with young mothers in ways that could have enhanced their well-being” (p. 18). Collins also stated that young mothers are very aware of the stigma of teenage pregnancy and suggested that our policies, programmes and practices can continue to punish teenage mothers in New Zealand or support them to become more resilient by encouraging development of their resources, assets and strengths. Collins said that if teenage mothers were not already aware of the stereotypes of being a teenage mother the public left them in no doubt by the responses they were greeted with when in public. Collins found that contrary to popular belief some of the teenage mothers in her study saw their lives in positive terms, some felt that teenage pregnancy had put their lives back on track and the alternative of involvement with alcohol, drugs and crime were now not an option. Collins (2004) stated “stigma does not prevent young women becoming mothers. Rather it diminishes those who are” (p. 18).

In their human growth and development text, ‘Human Development in Aotearoa: A Journey through Life’, Bird and Drewery (2000) connect students with the history and current developmental issues in New Zealand. There are Maori and Pacific perspectives on development which Bird and Drewery struggled to find in other human development text. Bird and Drewery (2000) iterate that the field of human development stood to be enriched by openness to Maori and Pacific perspectives. For example they cite the valuing of ‘elders’ for their wisdom and life experiences which has only recently become a strong theme in western culture where in Maori and Pacific cultures have always seen increasing age as a marker of status. Similarly the perspectives of Maori and Pacific
teenage mothers could enrich western culture’s understanding of this aspect of human development.

Hanna (2001) undertook research in Australia to explore how teenage mothers negotiated motherhood and how they constructed their own identities and relationships through teenage parenting. Over a twelve month period five to six interviews were held with each young mother aged 16 to 19 years of age in her own home. Hanna (2001) found that the teenage participants’ education was often incomplete and job skills minimal and they described lives of disruption and unhappiness in childhood and turmoil during adolescence. Hanna (2001) described these teenage participants as having a need to find love and connection in their lives and that the pregnancies may have been an attempt to bring love into their lives. The pregnancies may have brought out the commitment of the male partner, and may also have been a way of ensuring that they, the teenage mother, had a child that would love them unconditionally. Hanna (2001) also found that the teenage participants had definite ideas about what they wanted from the community based nurses who were part of the community child health services. They did not like to be prejudged as being a young mother. They did not like being treated differently from older mothers but at the same time they expected the nurses to recognize that they had additional needs that may have been different from those of older mothers. Among the conclusions Hanna (2001) found that “nurses can do much to provide primary and secondary health promotion to assist these single mothers and ideally this should be in the first five years of a child’s life when good parenting patterns provide a degree of protection against delinquency and crime” (p. 462). Hanna stated that nurses could adopt a number of strategies that would make their services more appealing to teenage mothers and enhance the developmental tasks of adolescence, self worth, a sense of belonging, acquisition of skills and development of appropriate relationships.

These strategies included

- Using woman focused rather than child focused approach so that the nurse would see the mother and the child within the supportive community rather than just focusing on the child.

- Encouraging teenage mothers to feel respected and valued within networks of other mothers, but specifically other teenage mothers, which would encourage teenage mothers to learn more about parenting.
• The nurses using a communication framework that valued the individual’s right to autonomy. Parenting skills would still be the focus but with more attention being directed to communication skills and relationship building.

• Ensuring that the teenage mother was aware of all the community resources available to them.

• Using a model that encourages teenagers to develop assertiveness skills and skills of self confidence.

• For the nurse to work in a flexible and accessible way, so being able to spend extended time with the teenage mother if needed and taking the service to the home (Hanna, 2001).

Hanna (2001) also stated that “more research is needed to examine how nursing services can be more appealing and engaging to teenage mothers” (2001, p. 462).

In New Zealand the Ministry of Health (MOH) published ‘Youth Health: A Guide to Action’ (YHGA), (2002b). This document defined youth as being between the ages of 12 and 24 years. The mortality and morbidity data from this report shows that young New Zealanders have higher rates of suicide, teenage pregnancy and abortion than their counterparts in other countries in the OECD. The YHGA (2002b) also states that both the age group and international comparisons suggest that as a community we are not paying enough attention to the health of our young people. Maori continue to suffer more ill health and have higher teenage pregnancy rates than non Maori which they stated is of considerable concern. Outcomes for children of teenage mother have often been reported as negative. In New Zealand the children who identify as Maori are more disadvantages that non Maori with higher rates of abuse, poorer educational achievement, and worse health status (Dickson, Sporle, Rimene & Paul, 2000). The YHGA (2002b) states that “health services that work for Maori are likely to be based on the five principles identified previously by Mason Durie (1995) as being associated with successful outcomes” (p. 8). These five principles are firstly choice, making sure that there is a mainstream option as well as kaupapa Maori options available for Maori, secondly relevance, providing services that are relevant and address actual need and are culturally meaningful. Thirdly, Durie said that there needs to be integration between health services, they need to be linked with other sectors so they are providing a holistic approach to health. Quality was Durie’s next principle. Health services for Maori needed to be of a high quality, evidence based and linked with good outcomes. Finally Durie said that the health services that work for Maori needed to be cost effective “considering
“economics of scale and value for money” (YHGA, 2002b, p. 8). YHGA (2002b) is described in the Ministry of Health; Child and Youth Toolkit (2004, p. 13) as proposing a shift in the way the health sector has traditionally seen young people: from being a problem to be solved, to being active participants in creating a healthy world. The action plan proposes ways to make New Zealand’s health services more youth knowledgeable and youth focused and emphasises the need for the health sector to be more responsive to young people.

In an exploratory study in the United Kingdom, Dykes, Moran, Burt and Edward (2003) focused on the experience and support needs of adolescent mothers aged 13 to 19 years who had commenced breastfeeding. The research was done using focus groups and in-depth semi-structured interviews and took place in the North West of England. It identified three types of support for adolescent mothers who were breastfeeding. These included the benefits of specific educational strategies tailored to meet the ongoing needs of adolescent mothers who were breastfeeding; the value of appropriate professional support with the practical aspects of breastfeeding, and the importance of support from peers and significant others, such as other breastfeeding peers, male partners and mothers. These studies provided useful information on the range of specific support strategies for breastfeeding adolescent mothers. Dykes et al. (2003) found that “there is clearly a need for further research in this area that generates qualitative data from the perspectives of adolescent mothers” (p. 392).

Research carried out in New Zealand surveyed the health and wellbeing of secondary school students attending the teen parent units. This survey by Johnson and Denny (2007) was delivered under the umbrella of the Adolescent Health Research Group at the University of Auckland, as part of the wider ‘Youth 07’ Project. The teen parent unit’s survey used the pilot Youth 07 Student Health and Wellbeing Questionnaire with additional questions developed specifically for students attending teen parent units in New Zealand. The survey was carried out using hand held computers, allowing the questionnaire to be presented in audiovisual form. The questions were displayed on the screen and also read out over the headphones. Nineteen of the 21 teen parent units throughout the country agreed to be involved, a total of 220 students. The response rate was 49%. The age distribution of the participants was 13 to 19 years with the majority, 79%, being 17 years or over. The students were able to report themselves as of one or more ethnicities. Just over half of the participants, 62%, identified as Maori; New Zealand European comprised 26.3%, Asian 0.5% and Pacific 7.4%. At the time of the survey 13% of the participants were pregnant, 70% had one child, and 98% of those who had a child or children were the main caregiver.
When asked about their emotional health and well-being, 30% reported deliberate self-harm, 35% reported serious thoughts of suicide within the previous twelve months, and 12% had made an attempt at suicide. Less than a quarter of the students reported being happy or satisfied with their lives. Twenty-six percent reported depressive symptoms of a significant level, this compares with significant depressive symptoms in the wider secondary school female population of 18% (Adolescent Health Research Group, 2003 as cited in Johnson & Denny, 2007). This showed that “the level of depressive symptoms that were reported by the teen parent unit students was about 50% higher than their peers without children in the mainstream schools” (Johnson & Denny 2007, p. 13).

Recommendations from Johnson and Denny (2007, p. 18) included, "Health services for teenage mothers (including antenatal and child health) should be easily accessible, youth friendly, family focused, developmentally appropriate and low cost.” Johnson and Denny (p. 18) also stated “that ideally health services should provide health services within teen parent units.” A further recommendation was that the health services that supporting teenage mothers should be comprehensive and able to address complex issues including sexual health, mental health, substance abuse and family issues in a coordinated and integrated way.

Johnson and Denny (2007) reiterated the recurring theme that New Zealand has one of the highest teenage pregnancy rates among the OECD countries. This causes concern as teenage parents and their children are known to be at risk of psychological, medical, developmental and social problems. They cite the American Academy of Paediatrics stating that the other risks known for teenage mothers include alcohol and drug abuse, exposure to domestic violence, sexual abuse, mental health problems and repeat teenage pregnancy (1989, as cited in Johnson & Denny, 2007). Children of teenage parents have also been shown to be at increased risk of behavioural problems, developmental disabilities and infant mortality (Brooks-Gunn & Furstenberg 1986, as cited in Johnson & Denny, 2007).

Noted in the Johnson and Denny (2007) survey is the fact that there is no mention of the WC/TO service under any heading. Questions were asked of the teenage mother about who she can ask for help when stressed out with her child, who she asks for advice about her child’s health and what were her expectations of the people supporting her. The majority of the students reported that they talk to their family and friends for advice on their baby’s health or when they were stressed out with their children. They also reported that staff at the teen parent unit were supportive in these situations.
Wells and Thompson (2004) explored strategies for supporting teenage mothers. They believed that there are many challenges that the teenage mother might confront. Wells and Thompson discuss their attempt to delineate a process through which home visitors (professionals visiting the home) can reflect on the services and support that their programme provided to teenage mothers. They explored how the current professional literature can be applied to enhance the support to teenage mothers, and finally discussed specific strategies for supporting teenage mothers. In the conclusion Wells and Thompson (2004) state that, “teenage mothers may not realize the impact they have on their baby’s development” (p. 26). They say that there is a challenge in learning how to encourage teenage mothers to expand their current parenting skills, and that the skill of working with teenage mothers may take time and practice.

Dickson, Sporle, Rimene and Paul (2000) examined trends in birth and total pregnancy rates among teenage women in New Zealand. They looked at the ethnic differences and international comparisons. Dickson, et al. (2000) collected New Zealand data on births and abortions by age and derived teenage birth rates and the estimated teenage pregnancy rates. The results among other things showed the history in New Zealand of teenage pregnancy rates. Dickson et al. found was that “in 1997 the teenage birth rate for Maori was nearly five times that of European/Pakeha teenagers, and the Pacific teenage birth rate over three times” (p. 241). Dickson et al. concluded that the analysis showed that by collating and routinely collecting data it was possible to monitor national teenage pregnancy rates. They suggested the “importance of understanding the impact on Maori women who became pregnant as teenagers and on their children” (p. 241).

Services and Support for Teenage Mothers

Davis, Day and Bidmead’s (2002) book titled, *Working in Partnership with Parents: The Parent Advisor Model*, is about supporting parents, and was written for anyone who works with children and their families. Davis et al. describe a model of communication, the parent advisor model that was initially developed for the health workers that worked with families of children with severe disabilities. This communication model has now become the basis for work with families of children with or at risk of a wide range of problems. The model arose as parents they had worked with felt that they were not being listened to by professionals. The parents felt that they were not cared for as individuals and that professionals were not treating them with respect or treating them as people that had competence of their own. There was dissatisfaction with the communication skills of the professionals and that the focus was on the management of children’s problems with little account of the parents’ adaptation to the problem situation resulting in parents
feeling undervalued, misunderstood, ill informed, and in conflict with the advice they are given. Davis et al.’s communication model is about the full engagement of the parent so that the relationship between the professional and the parent is potentially supportive in itself. Davis et al. (2004) state that involving parents “as partners in the process, has the advantage of enabling them to use their skills and expertise fully and hence maximising the chances of them finding solutions of their own” (p. x).

In 2008 the New Zealand Ministry of Health (MOH) commissioned a Developmental Evaluation of Well Child / Tamariki Ora services provided for high needs clients by the Royal New Zealand Plunket Society (Inc). The evaluation focused on the systems and processes that Plunket uses to achieve good outcomes for high needs families, as well as the impacts on high needs families. As this was an evaluation the focus was on identifying areas where improvements could be made to systems, services and processes to improve outcomes for high needs families. Ministry of Health (2008a) state as one of the conclusions of this report,

Plunket use a standard approach in its delivery of the Well Child service, albeit providing an element of flexibility to cater to the different needs and circumstances of the client. By not tailoring services to certain groups, including Maori, Pacific and other ethnic groups, opportunities to build on the strengths of these groups diminishes. This one size fits all approach can mean that the needs of certain groups are not met (p. 107).

The Royal New Zealand Plunket Society Inc. (Plunket), as the largest WC/TO provider in New Zealand, is in a constant process of addressing the issues of different groups of clients by looking at what the WC/TO service could provide differently to engage these groups better. One of Plunket’s guiding principles, stated in their Annual Report 2009, is that they are committed to the principles of partnership, protection and participation inherent in The Treaty. Also in the Plunket Annual Report 2009, is stated “One size does not fit all and Plunket works hard to ensure those in the community have access to Plunket services in ways that work for them” (p. 16). Plunket has the aim to grow teen parenting courses and to eventually develop a steering group drawn from course participants to be champions for other teen parents in the community (Plunket Annual Report, 2009).

A report commissioned by the Ministry of Health named, ‘A focus on the Health of Maori and Pacific Children: Key Findings of the 2006/07 New Zealand Health Survey’ (Ministry of Health [MOH], 2009a) stated that, “Although access to and use of primary health care was similar among Maori and non Maori children, Maori children were more
likely to experience unmet need for general practitioner (G.P) services than non Maori” (p. 123).

The same report stated “that among Maori and non Maori children only half of children less than five years of age had seen a Well Child nurse in the past year. This Primary Health care service is important for the health of Maori children. Well Child nurses are able to support Maori families with the key long term outcomes of concern” (p. 123).

Findings showed that Pacific children also experience health disparities in health indicators compared with non Pacific children when accessing primary health care and seeing a well child nurse (MOH, 2009a). The Ministry of Health, (2009a) found that in childhood it is important that these disparities are addressed. If they are not the evidence suggests that good or poor health in adult years can be traced back to childhood (p. 127).

Rawiri (2007) carried out research to investigate the role of social support in helping adolescent Maori mothers cope with pregnancy, birth and motherhood, with a particular emphasis on its role in enabling them to continue at school. Rawiri looked at New Zealand research and found that young Maori mothers are more likely that their non Maori peers to have a history of family adversity, conduct problems and practice unsafe sex therefore increasing the risk of becoming pregnant (Woodwood, Horwood & Fergusson 2001). Maori women were also more likely that non Maori women to fail to use contraception when they had sexual intercourse for the first time ( Kirkman & Maolonet, 2005, as cited in Rawiri, 2007). Maori adolescent women who become pregnant appear less likely to seek or have access to a termination than their European peers (Dickson et al., 2000).

In her critique of the dominant views of teenage pregnancy Rawiri discusses the fact that most literature about teenage pregnancy is focused on the negative risk factors and outcome. Rawiri stated that research indicates that teenage motherhood can actually improve the life outcomes for some adolescents. Rawiri reported on research from overseas which involved eight pregnant adolescents who attended an alternative school, examined all aspects of their lives during their pregnancy and found that the majority of the participants reported that they saw their pregnancy as beneficial rather than detrimental (Spear, 2001, as cited in Rawiri, 2007). Rawiri continues that being a young mother can be a way for some adolescents to achieve adult status and maturity in an otherwise futile situation, thus young motherhood has been linked with positive values such as responsibility and maturity that is not often associated with teenagers (Dacey & Kenny, 1997; Pheonix, 1991, as cited in Rawiri 2007).
The aims of Rawiri’s research were to understand and make sense of young Maori women’s experiences and to identify gaps within an individual’s social network. Rawiri (2007) conducted nine in-depth interviews with young Maori women under the age of 20 who had become pregnant and decided to continue with their pregnancy. Interview questions included questions about caring for their child. Rawiri (2007) stated that “Support during the transition from pregnancy to motherhood is essential for a mother. It is natural to want support but at the same time it can be daunting to ask for help. Most of the mothers had good support from family and friends” (p. 129). Two of the research participants had no experience with children so they had to learn the basics of child care. Rawiri (2007) found that this was learned from their mothers and social support services such as Family Start, an early intervention and prevention programme, welfare and education which is home based and services families facing challenges in areas of health. In conclusion Rawiri (2007) stated that social support was highly valued among the research participants. The strongest support came from female members within the social networks which included sisters, mothers, friends and midwives. One of the objectives of the research was to find out what kind of social support work best in helping adolescent Maori mothers raise their children. At no point in the research was the WC/TO service mentioned by the respondents, and it did not seem to feature as a support in these adolescent Maori mothers’ lives.

Mantell, Craig, Stewart, Ekeroma and Mitchell (2004) reviewed ethnicity and birth outcomes in New Zealand from 1980 to 2001. This article was specifically looking at pregnancy outcomes for Maori women. The paper focused on three areas of the Maori reproductive experience; the age of childbearing and the effect that young motherhood can have on the birth outcomes, the prevalence of small babies (both small for gestational age and preterm) and finally the influence of economic deprivation on obstetric parameters. The area of most interest for the research reported here was the age of childbearing for Maori women and the fact that Mantell et al. (2004) state that “teenage pregnancy is not a risk factor for adverse outcomes for Maori women once economic status has been taken into account” (p. 538). This, Mantall et al. stated, was significantly different for European and Pacific women and suggested that a potential explanation is that “the Maori environment can be more accepting of teenage pregnancy, a hypothesis supported by the fact that once pregnant Maori teens are less likely to have an abortion” (p. 538). Mantell et al. also says that teenage pregnancy, although not having a significant impact on the reproductive outcomes, the social impact may be more significant. Mantell et al. suggest that this has significant educational implications for two generations of Maori, both for the mother who must leave school during her
secondary education and for the subsequent educational aspirations and opportunities available to her children. Thus the development of ‘second chance’ educational policies may have a greater impact for Maori than for other ethnic groups (p. 539)

New Zealand: The transition from Maternity services to Well Child / Tamariki Ora Services

The contractual arrangements and obligations of the WC/TO service providers as they relate to the transition of care from the Lead Maternity Carer (LMC) to the Well Child Service are outlined in The Well Child Framework (MOH, 2002a). It states that every family in New Zealand should be given a choice as to their preferred provider of WC/TO services. Dwyer (2009) states there are formal obligations under the Section 88 Maternity Notice that require the LMC to refer mothers to the WC/TO services. Lead Maternity Carers must provide a written referral to WC/TO services before the baby is four weeks old so the WC/TO nurse should be visiting and undertaking the initial assessment of the family in their own home before the baby is six weeks of age.

In 2009 the New Zealand Families Commission research fund commissioned a report (Dwyer, 2009) which provided a snapshot of both antenatal education and the transitions of maternity care in this country. Data were collected from many sources using many methods including focus groups, key informant interviews, a questionnaire and extracting data from the Plunket data base. There were 30 research questions, each one relating to one of the 11 project objectives. Two of Dwyer’s project objectives were relevant to this research. One was to, “Determine the extent to which the transition between the LMC and the Well Child services is co-ordinated by service providers or left to the mother and whanau” (Dwyer, 2009, p. 10). Dwyer found that, if the formal obligations of the LMCs and the Well Child providers were adhered to, the transition between these two services would not be left to the mother and her whanau. In practice in most regions, transition between the services is not left to the mother. It was clear that in some regions there were problems with the transition process which resulted in a substantial proportion of women having to initiate contact with the WC/TO service themselves or they fell through the gaps. Some of the factors contributing towards parents having to take responsibility for the transition were midwives forgetting to send paperwork to the Well Child providers, Well Child providers failing to follow up on all referrals and parents choosing not to access Well Child services.
The second project objective was to “Identify gaps between the support that the maternity and Well Child services aim to provide and what happens in practice” (Dwyer, 2009, p. 10). Five types of gaps were noted. The first was information gaps: Maternity and Well Child services aim to provide families with the information to help them know what services are available and what services they provide, so they can make informed decisions about their care. Dwyer (2009) found that there were many families who were unaware of the services available. Also, that woman reported that “providers failed to give them information on specific topics that might have aided informed decision making. Such topics included unexpected events, bottle feeding and parenting” (p. 86).

The second gap was that services should aim to identify and respond appropriately to families who are at risk of adverse outcomes and have higher needs. In practice many of these families are missed. Dwyer (2009) stated, “Part of the problem is a lack of screening or monitoring and the other part is a lack of responsiveness” (p. 86).

The third gap is engagement. It is widely seen that the families living in the most deprived areas with the greatest need are the most difficult to engage. To address the engagement gap Dwyer (2009) stated, “providers need to understand engagement as an ongoing process, find innovative ways of reaching out to people, consider how the services are packaged and make services more attractive and suitable for different client groups” (p. 87). Focus group participants agreed that they benefited and felt more comfortable from the social support provided by homogenous groups of women. Dwyer reiterated that, “It is no surprise, then, that single, teenage mothers generally do not attend antenatal classes with married, educated older women” (p. 87). The differences between the different population groups will need to be catered for.

The fourth gap was in the service itself. Services aim to achieve good coverage of their target population and achieve an equable level of service across all the different regions of New Zealand. Dwyer (2009) stated that “This project highlighted gaps in both service coverage and equity of servicing across regions” (p. 87). The final gap found under this project objective was clinical or performance gaps. The providers aim to provide services that are of a high quality and meet the consumers’ needs. Dwyer (2009) states that “Unfortunately, consumers’ needs are all too often not met and the quality of the services is questionable” (p. 87). Recommendations from the research included addressing the known barriers that prevent women and their families accessing the Well Child service such as perceptions and beliefs, stigma, language and cultural competence. Another recommendation was to provide the public with information about entitlements and the services provided by the maternity and Well Child provider, and why they are important.
The handover process between the LMC and the Well Child provider needed strengthening. Further recommendations are to consider standardising the handover process, strengthening relationships between the LMCs and the WC/TO providers and monitoring or auditing the handover process.

Summary

Previous research shows that there can be negative consequences for teenage mothers and their children, although in some cases there may also be positive outcomes depending on culture and situation of the mother. Teenage mothers need additional and culturally safe support during their pregnancy and parenting which is shown through the literature to be universal and not always provided well. Some studies completed in New Zealand did not specifically inquire or discuss the WC/TO service however some research has found that there are gaps in clinical service delivery of the WC/TO support for this group. There was a need for more qualitative data about teenage motherhood to be generated from the teenage mothers themselves. On the basis of these findings, this research aims to investigate WC/TO service delivery to teenage mothers from their perspective in an attempt to fill this gap in the literature.
Chapter 3

METHODOLOGY

Introduction

The purpose of this research is to obtain information of a qualitative nature through open ended questions and discussion about what teenage mothers want from the Well Child /Tamariki Ora service. This chapter presents the research objectives and question followed by the reasons for the choice of the qualitative method of research. This is followed by the research design. The use of focus groups is discussed, along with their limitations and appropriateness for teenagers. The recruitment and data collection process is described, followed by the ethical considerations in the planning and conduct of the research. Next the limitations and delimitations of the research are presented and then finally the data analysis which is discussed alongside trustworthiness of the research.

Research Objectives:

• To gather data that may be used to both inform the design and delivery of a Well Child / Tamariki Ora service, that is specific to teenage mothers, and to increase the access to the service by teenage mothers.

• To contribute to the improved health outcomes for children aged from birth to five years of teenage mothers.

Research Question

What do teenage mothers want from the Well Child/ Tamariki Ora service?

Research Design

This investigation is a qualitative, descriptive thematic analysis. Qualitative research is designed to help us understand naturally occurring social phenomena through exploring the attitudes, meanings, beliefs, values, and experiences of the research participants. It has potential through inquiry with the chosen research participants to raise awareness of the need for change. This is where qualitative research has the greatest potential to be useful (Schneider, et al. 2007).
Qualitative research is designed to provide an impression; to tell what kinds of “something” there are to tell, what it is like to be, do or think something. Qualitative researchers exercise great discipline in order to find out what is going on here, from the perspective of those in the situation being researched (Bouma, 2000, p. 171).

Qualitative research method was considered to be the most logical method to get the information from the participants involved in the research. The qualitative method would give the data that was needed as the participants needed to tell the researcher what was going on and their experiences needed to be explored. The participant age group are renowned for being difficult to engage and share their experiences. Bassett and Beagan (2008) state “Encouraging a teenager to have a conversation in a semi structured research interview is fraught with difficulties” (p. 119). The focus group method was chosen instead of individual interviews for this reason. The participant group in the past have been perceived as not having the cognitive skills necessary to contribute to decisions about their lives, meaning that those who care for this group are making decisions for them, contributing to making the participant group passive subjects of research (Pole, Mizen, & Bolton, 1999; Neal, 1995; Gecas & Seff, 1990; as cited in Bassett & Beagan, 2008).

Disadvantages of using a qualitative research design may be the timeframes required to undertake the study and the difficulties in getting the information needed from the participant group.

Focus Groups

The qualitative data for this research were collected using focus groups as the method. Focus groups are widely used in both market research and social research. They basically involve group discussion focused around the particular issues to be researched. Focus groups provide a very powerful technique for gaining an insight into the beliefs, opinions and values of a particular segment of the population. Their strength lies in the freedom that the group situation gives its participants to discuss the issues of concern (Davidson & Tolich, 2003). As stated by Krueger (1994, p. 14) “focus groups are created to accomplish a specific purpose through a defined process”.

The limitations of focus groups have been acknowledged. Most researchers who use focus groups acknowledge that group influences can distort individual opinion (Berg, 2001). Researchers running focus groups usually require high levels of interviewing skills. They may need to act as ‘gatekeeper’ to avoid ‘group think outcomes’ to prevent
any individuals from monopolising conversations as well as teasing the information from the quieter members of the group (Schneider et al., 2007).

Bassett and Beagan also found that some of the problems encountered when interviewing teenagers in semi-structured interviews were firstly “recruitment of the teenagers, locating a quiet space for the interviews, the silencing effect of the tape recorder, and asking about abstract concepts” (2008 p. 119). These factors all seemed to be constraints on the teenagers’ conversational abilities which contribute to the reasons why the choice was made with this research to hold focus groups. The nature/developmental stage of the participant emphasize that being in a group rather than being alone is important. Pope and Mays (2006) found when talking about focus groups that “Most researchers recommend aiming for homogeneity within each group to capitalise on peoples shared experiences” (p. 24). The groups can be naturally occurring such as the students at the teen unit. “An additional advantage is that friends and colleagues can relate each others comments to actual incidents in their shared daily lives” (Pope & Mays, 2006, p. 24).

Data collection

Data was collected in September 2009 via two focus groups with a total of 12 participants; there were five teenage mothers in group one and seven in group two. Seventeen per cent (2) had two children while 83% (10) had one child. Across both focus groups, 66% (8) of mothers identified as Maori and 34% (4) identified as European/Pakeha.

Participant Recruitment

The participants in the research were teenage mothers who attended the unit for teenage mothers within a Secondary School in Hawke’s Bay. They were all aged between 16 and 19 years and had had a baby born since November 2008. All had attended at least one WC/TO check by the WC/TO nurse. To recruit the teenagers a poster was placed on the notice board at the unit for teenage parents asking for participants to be involved in a focus group, with the criteria for participation clearly visible. The participant information sheets were available under the poster which provided the following information: (Appendix C)

- An invitation to join the focus group.
- An explanation of participant selection.
- The involvement that will be required including the venue for the focus group.
• Ethical considerations.

• That a tape recorder will be used to record the discussion.

• Information on how the results will be shared.

• The researcher and supervisor information. This included the email address and cell phone number of the researcher so any questions could be answered.

Students who wanted to participate in the focus groups placed their name on the participant information sheet, and placed this in a sealed envelope and left it in the box provided.

The Data Collection Process

The focus group meetings were held in a classroom at the school for teenage parents. They were audio taped. Group one lasted 43 minutes while group two was 32 minutes. Refreshments were provided as the focus groups were held over the participants’ lunch break. A research assistant was present to help with the smooth running of the group, she also took notes. There were questions used to help direct and structure the discussion.

The questions explored,

• What are the good things the Well Child / Tamariki Ora service gives you and your baby now in terms of caring for your child and in terms of being a teenage mother?

• What does the Well Child / Tamariki Ora service not deliver that would be useful in providing better health outcomes for your child?

• What do you see as being a better/different way of providing the Well Child / Tamariki Ora service so that you as a teenage parent would find it more useful?

There was also a short data collection form for the participants to fill in at the start of the focus group asking ethnicity, number of children the mother has, and number of visits there have been to the Well Child / Tamariki Ora nurse.

Ethics

This research was approved by the Royal New Zealand Plunket Society (Inc) and the Eastern Institute of Technology Research Approvals Committee. (Appendix A & B).
Participation in this research was voluntary. Withdrawal was possible at any time up to the transcribing of the data. Informed consent, including consent to use the audiotape, was obtained prior to the commencement of the focus group, with the opportunity to ask questions. There was also a form for all participants, researcher, research assistants and transcribers to sign to ensure confidentiality of all the data obtained within the focus group. All transcript, notes, audiotapes and memory stick were kept secure, with access available only to the researcher. Electronic data was only able to be accessed with a password known only to the researcher. All the above information will be stored for five years after completion of the thesis and then destroyed. All data has been de-identifiable and reported anonymously.

The research was not intended to cause harm or distress to participants it is acknowledged that reflecting on what has happened in life can be emotive. In the event of this occurring the participants had access to a school counsellor.

Indigenous people are a particular cultural group that pose additional ethical concerns as they may have experienced the harmful effects of colonisation (Schneider et al., 2007). Steps taken to protect participants’ cultural integrity included getting approval for the research from the Maori Health Unit at the Hawke’s Bay District Health Board. The research was discussed with the Kuia for the Royal New Zealand Plunket Society (Inc) in Hawke’s Bay and a summary of the findings will be reported to the participant. (Appendix C)

**Delimitations and Limitations**

All research methods have limitations which also apply to focus groups. These have been discussed earlier. For example, most researchers who used focus groups acknowledge that group influences can distort individual opinion (Berg, 2001). Researchers may need to act as ‘gatekeeper’ to avoid ‘group think’ outcomes, to prevent any individuals from monopolising conversations as well as teasing the information from the quieter members of the group (Schneider et. al, 2007). While it is acknowledged that teenagers often have a group think as a developmental process the researcher was aware of this and every effort was made to avoid these limitations. The researcher felt confident that the teenagers in both focus groups all participated fully. No one person dominated the discussion. The first focus group was more forthcoming than the second focus group, this may be because the second group were all friends, and may have been concerned that what they were saying was going to be judged by their friends. A further limitation of this research is that the information collected did not include the experiences of teenage mothers younger than 16 years-old. Also, teenagers all attended the Hawke’s Bay teen
parent unit, which is only one teen parent unit in one New Zealand city therefore it may not be feasible to generalize beyond this city.

The delimitations of this research are the criteria for participation. The participants were aged between 16 and 19 years-old, attend a Hawke’s Bay teen parent unit, have a baby born since November 2008, and have had at least one visit with the WC/TO nurse.

**Data Analysis**

The audiotapes of both focus group meetings were transcribed verbatim and the transcription was used for the analysis. The data underwent a qualitative analysis using Giorgi’s (1970) method of analysis as a guide to ensure there was a process to follow with a clear end. Crotty (1996) states that Giorgi’s method of analysis lets the experience unfold as it exists for the participant and looks for the description of the phenomenon under study. The steps include reading the entire transcripts to get a sense of the whole, then identifying and clarifying the units of meaning by relating them to each other and the whole. Extracted units that are relevant to the research topic are used to generate themes and combine these into descriptions of the research topic, which are then integrated into a description. This is then communicated to the other researchers for confirmation and criticism (Giorgi, 1970; Schneider et al., 2007). A more detailed description of this process is presented in Chapter 4.

Two other researchers, the candidates’ supervisors, independently reviewed one of the focus group transcriptions to cross check for thematic coding and to help provide trustworthiness.

**Trustworthiness of the Research**

According to Schneider et al., (2007) there is not one agreed upon way among qualitative researchers about how to ensure or evaluate, the ‘correctness/rightness’ of the results of a qualitative study. This is often called ‘trustworthiness’, which is the equivalent term for ‘rigour ‘in quantitative research. The criteria for judging trustworthiness include credibility, which is the truth of the findings as judged by the participants, auditability of the researcher’s trail for getting information from the raw data through the steps to the interpretation of the findings, and fittingness is the faithfulness of the reported data to the everyday reality of the participants. These allow others in the discipline to evaluate the importance of research for their own practice, research and theory development. Conformability refers to the extent to which the findings reflect the implementation of credibility, auditability and fittingness standards.
This research attempts to have trustworthiness by having confidence in the truth of what discussion of the participants reported of their experiences and presented it faithfully. It can be argued that the credibility of the research was assisted by the background of the researcher who has long term experience working in the area on which the research focused and with the age group of the participants. Fittingness has been addressed with the participant selection. Auditability will be addressed by decisions that are made by the researcher and that the processes followed were transparent and consistent (Roberts & Taylor, 2002). The use of the data analysis guide and the feedback from the research supervisors assisted to achieve conformability (Schneider et al, 2007). The trustworthiness of this research has been assisted by the comparison of its findings to other research about teenage mothers.

**Summary**

In this chapter I have discussed the research design for this study. A qualitative research method was chosen using focus groups. This was partly because of the nature of the participants who as a group are renowned as difficult to converse with in a semi structured interview, but also because needed was rich data was possible from a group discussion for the emergence of themes that both describe and explore the area to be discussed. Also discussed in this chapter are the processes of selecting and recruiting participants and the data collection method. Finally the cultural and ethical considerations in this study have been discussed.
Chapter 4

FINDINGS

Introduction

As discussed in the previous chapter the data collected in this study has been analysed using Giorgi’s four step method of qualitative thematic analysis (Schneider et al., 2007). Crotty (1996) states that Giorgi’s method of analysis lets the experience unfold as it exists for the participant and looks for the description of the phenomenon or experience under study. Giorgi (1970) states when describing his emerging philosophy that “Certain units of meaning can be clearer even if the total gestalt lends itself to multiple interpretations. Moreover the numbers of interpretations that are possible are limited and not finite so that a range of meanings is possible” (p. 215).

This chapter will present findings from the analysis process using the first three steps of Giorgi’s four step method. Schneider et al., (2007) describe the four steps in Giorgi’s method of analysis. Step one is described as gaining a sense of the whole. This was achieved by reading the transcripts and repeatedly listening to the tapes of the two focus group interviews, until there was a sense of the participants’ experiences. Step two requires distinguishing the text into units of meaning. The participants’ experiences were read many times until all the units of meaning were found. This was achieved by identifying repeated descriptions or experiences as well as those that were different. Step three involves generating essential aspects and themes. The units of meaning were put into groups and from there the main aspects were generated and presented as themes. The fourth step of Giorgi’s method of analysis is to “synthesize the essential aspects of understandings and reflections into a consistent statement” (Schneider at al., 2007, p. 111) which will be presented in Chapter five.

At this time it is important to reiterate the research question:

What do teenage mothers want from the Well Child/Tamariki Ora service?

As a background to the analysis the research participants will again be described. They were women between the ages of 16 and 19 years who were teenage mothers. They attended a secondary school which has within it a teenage parent unit where pregnant teenagers and teenage mothers can continue their education while having their
child/children cared for in the early childhood centre attached to the unit. Of the 12 participants who were involved in the research all had given birth to their child. Seventeen per cent (2) had two children while 83 % (10) had one child. Across both focus groups, 66% (8) of mothers identified as Maori and 34% (4) identified as European/Pakeha

The literature suggests that teenage mothers often struggle to cope with the demands of caring for a baby while they are making the transition from adolescence to adulthood. They require additional support from their families, partners and services to achieve positive health outcomes (Wahn et al., 2005). Long term follow up of the children of teenage parents shows a higher risk of poor educational outcomes, incarceration, depression and the continuation of an intergenerational cycle of teenage parenting (American Academy of Paediatrics, as cited in Johnson & Denny 2007). It is also suggested that being a young mother may have positive values such as responsibility and maturity, which for some adolescent women can be the only way to achieve adult status in an otherwise futile situation (Dacey & Kenny, as cited in Rawiri, 2007)

**Process of Analysis**

**Step One of Giorgi’s Method of Analysis: Gaining a Sense of the Whole.**

Finlay and Ballenger (2006) describe gaining a sense of the whole as immersing yourself in what the participant has said or written to tune into the existential dimensions of their situation. This process involved listening to the taped focus group interviews noting tone of voice, predominant voices and checking with the notes taken by the research assistant during the interview to get a feeling of the overall scene that was created when the focus group discussions were taking place. The next step was reading the transcript many times to get an overall sense of the tone of what the two different focus groups were saying. Clearly identified from both focus group interviews was that the participants needed and welcomed support from the WC/TO service. The participants were interested in the issues that were discussed. They cared about how they were doing as mothers and perceived that they were a different group with different needs compared to older mothers. However they also wanted to be treated the same as older mothers depending on the issues being discussed. These findings alone provided affirmation for the research undertaken. The following quotation from one of participants describes the importance to the teenage mother of the WC/TO nurse and service. The nurse talked about the issues that the mother had as well as caring for her and her baby.
My Well Child nurse came and sat down, she was like my social worker in a way, she would talk about stuff that was happening, she would even worry, well not worry about my stress levels and stuff, but she kind of asked about it. She wasn’t there just for my baby she gave me the impression that all was good. She was there for me and my baby (FG .1, p. 20).

Step Two of Giorgi’s Method of Analysis: Identifying Units of Meaning.

After listening to the original tapes and then reading the transcribed word documents, units of meaning started to emerge. Units of meaning according to Roberts and Taylor (2002) refer to specific words or combination of words identified within the text. Roberts and Taylor (2002) describe units of meaning as being explicit in their descriptive meaning and their contribution to the research aims. The units of meaning are easily identified and often emerge from the first readings of data. During this process of data analysis the individual units of meaning were underlined and an interpretive description was put in the margin beside it. Next the analysis compared the similarities and differences and the relationships that emerged from the units of meaning. A collection of similar or related units of meaning is what makes up a sub-theme or theme. Roberts and Taylor (2002, p. 432) state that “sub themes are related to main themes and are like subsections, or further elaborations on a theme”. Some of the emerging sub-themes were combined into themes as similarities became apparent within the data. The elements of each of the merged sub-themes were not lost but instead provided a depth to describe each new main theme. In this analysis, the units of meaning are presented in the way they contribute to each theme. For example, one of the themes to emerge from the research concerned the teenage mothers’ experience of contact with the WC/TO service. The units of meaning identified as contributing to this theme include the teenage mothers’ comments about not knowing the service from which their WC/TO nurse came, the amount of time the nurse spent with them, how the nurse initially contacted them and where the visit took place. These and the corresponding units of meaning contributing to the other themes are presented in this chapter and illustrated with quotations from the focus group interviews.

Step Three of Giorgi’s Method of Analysis: Essential Themes are Generated and Described.

From analysis of the data derived from the focus group interviews and through drawing together units of meaning, four essential themes emerged that linked with the aims of the research. These themes described the major issues teenage mothers raised in relation to the services provided to them through the WC/TO service. These themes are:
Theme One: Teenage mothers' experiences of contact with the WC/TO service

Theme Two: The information received

Theme Three: Attitudes toward teenage mothers

Theme Four: Respect and caring

Each theme will now be described and illustrated with description and participants' quotations.

Theme One: Teenage Mothers’ Experiences of Contact with the Well Child / Tamariki Ora Service.

The focus group participants were very forthcoming in describing the contact that they had from the WC/TO service. There were many issues discussed. Firstly, the form and style of contact by the WC/TO nurses was commented upon repeatedly. These included transition from the Lead Maternity Carer to the WC/TO provider and the participants’ choice of WC/TO provider. The next issue was the lack of identification of the WC/TO provider and communication about what the WC/TO service would deliver and when the WC/TO nurse would visit, where the visit would be and the amount of time that would be available for the visit. It was clear in the focus group interviews that when the term ‘Plunket’ nurse or service were spoken it was used as a generic term and was not necessarily referring to the Plunket service. It appeared to be the term used to describe all WC/TO services delivered to the participants.

Transition from the Lead Maternity Carer to the WC/TO Provider.

The contractual arrangements and obligations of the WC/TO service providers as they relate to the transition of care from the Lead Maternity Carer (LMC) to the Well Child Service are outlined in The Well Child Framework (Ministry of Health 2002a). It states that every family in New Zealand should be given a choice as to their preferred provider of WC/TO services. Dwyer (2009) states there are formal obligations under the Section 88 Maternity Notice that require the LMC to refer mothers to the WC/TO services. Lead Maternity Carers must provide a written referral to WC/TO services before the baby is four weeks old so the WC/TO nurse should be visiting and undertaking the initial assessment of the family in their own home before the baby is six weeks of age. Dwyer (2009) notes that the transition between the LMC and the WC/TO service has recently been the subject of attention. Also, “although the reliability of the transition has improved in recent years that there are still problems on both the LMC and the Well
Child provider sides that contribute to families and whanau falling through the gaps” (p. 91) and therefore not receiving contact.

There was evidence of this problem among the participants in the focus groups. The continuity of care of a midwifery service being followed by a WC/TO service is important. In the early stages of mother and baby’s lives together there are many times when support and advice may be needed with such problems as feeding and crying issues and postnatal depression. Early identification, intervention and support by health professionals and whanau have been proven to be the key for better outcomes for both mother and baby. “The earlier intervention is commenced, the more likely it is to be effective and less expensive” (Goldfield and Oberklaid, 2007). In the Child Health Strategy, Ministry of Health (1998) when discussing early intervention from health professionals stated it was important that when providing education that it “must take place in a supportive environment in a culturally effective way” (MOH, 1998). Intensive home visiting was identified as being an effective strategy, as it improved health outcomes for children from disadvantaged groups.

Unfortunately the transition from the LMC to the WC/TO service did not always achieve the desired continuity for the participants of this research. Two of the participants spoke of the transition not happening at all:

They booked an appointment and it is even in my well child book but na nothing. (FG.1, p. 7)

I chose a [health provider], they haven't come to see me yet. (FG.2, p. 14)

A third participant explained how she had to effect the transition herself:

At 8 weeks when you switch from your midwife to a Plunket Nurse well I hadn’t met my Well child lady. We ended going to the [health provider] to see her, had nothing against her I know they are overworked and everything but they could have just rung. Then when I went in she was like, “oh we were about to ring you, I have been busy”. (FG.1, p. 5)

Transition was not problematic in every case,

My midwife just told me that someone will turn up and see me and I was like “k” and they just turned up. (FG.2, p. 15)

However this experience highlighted another issue, which concerns the mothers’ choice of WC/TO provider.
Choice of Provider

In New Zealand every mother of a new baby is given a choice as to which WC/TO provider she would like to visit her and her baby. In Hawke’s Bay there are five providers of the WC/TO service: The Royal New Zealand Plunket Society Inc. (RNZPS) who hold a national contract with the Ministry of Health and see 91% of babies in Hawke’s Bay (Plunket Client Information System, 2010). The four Maori Health providers who hold contracts with the Hawke’s Bay District Health Board (HBDHB) deliver WC/TO Services to see the other 9% of babies in Hawke’s Bay. The four Maori health providers in Hawke’s Bay are Choices, Te Taiwhenua O Heretaunga in Hastings, Te Kupenga Hauora Ahuriri in Napier, and Kahungunu Executive Kit e Wairoa Charitable Trust in Wairoa.

The conversation about the choices available to the mother and baby, which describes what each WC/TO service offers, should take place between the LMC and the mother during the pregnancy and also again before the LMC sends the referral to the WC/TO provider which is before the baby is four weeks old. Many of the participants did not recall having a conversation with the LMC about which WC/TO service was available to them and what that service would provide. Neither were they given a choice of provider. Two said for example:

Na I didn’t get to choose, it was given to me. (FG.2, p. 14)

I just got these people who turned up with my midwife they were like” I am your Plunket nurse. (FG.1, p. 15)

In another case, one mother chose a WC/TO provider and had another one chosen for her.

I asked my midwife for someone else and she gave me a [health provider]. (FG.2, p. 14)

In summary the participants’ experiences of choosing their WC/TO provider varied. Some participants were offered no choice or, after choosing a provider, had another provider visit. It seems there are problems with this group of mothers regarding the concept of choice in the WC/TO service, which may reflect on the referral system in operation or on other communication issues.
Identification of the Provider and Communication

There were obvious issues around the identification of the health provider visiting the teenage mother and her baby. Some of the participants were still unaware after three or four visits from their WC/TO nurse, exactly which provider the WC/TO nurse represented and what services would be delivered to the mother and her baby by that provider. During the focus group discussions there were several examples of problematic communication issues that the participants had with their WC/TO service. One of the issues was the lack of information about how to contact the WC/TO service. This participant said:

They never come or contact me or, like, get hold of me.....I don’t even know who to ring. (FG.2, p. 3)

This quotation shows that there are instances where communications between mothers and WC/TO nurses are particularly poor, meaning that the outcome for an ongoing relationship may also be poor. The following statement is an example of how poor communication can lead to a teenage mother not engaging with the WC/TO service at all.

Oh they were like, we are moving buildings so... we will get back to you ... and then they were like, can you come tomorrow, and I said no I am moving house so I will be flat out, and they were like “oh” and they never rung me back, and the lady that I went and seen was real rude and wrote a rude comment in my baby’s book and so I don’t like them. So am not going back there. (FG.2 p. 2)

Another issue concerned the number of visits the WC/TO service delivered and ongoing communication about when the visits might occur. For example the following participant said,

I have only seen her once. They came over to my house but they never contacted me to let me know that they were coming over so I wasn’t home the two times that they came over. (FG.2, p. 2)

There was confusion among some of the participants about the expectations of what the service might offer them. The following quotation describes the participant who wanted the WC/TO nurse to visit made the initial contact with the WC/TO service herself. Her expectation of the WC/TO nurse was that they would have rung her and this did not occur:
When baby was 8 weeks and I hadn’t met my Well Child lady so we ended up going to the [Health Provider] to see her. I know they are overworked and everything but they could of just rung, and when I went in she was like “oh we were about to ring you, I have been busy”, and I didn’t have a problem with it but it would’ve been nice to have someone who rang and even said we are overworked. (FG.1, p. 5)

Two participants however were very satisfied with the service that the WC/TO service provided:

I have got a nice Plunket lady. She comes around every time she says she will. (FG.2, p. 3)

We were going through a rough patch with him because he was just crying and crying nonstop, she said that if you have any problems just contact me straight away and I can come around and sort it out and get you referred to the hospital if it is not getting better. (FG.1, p. 2)

From the participants’ discussion about their expectations of the WC/TO service it was clear that they wanted someone to contact them initially, to visit them when the visits were booked and to let them know if they were not able to come. It was clear that communication between teenage mothers and the WC/TO nurses needed to be better if a good relationship was going to even begin, let alone last.

Where the First Visit Took Place

Another issue associated with communication between the participants and the WC/TO service concerned where the participant would prefer to be seen by the nurse. Depending on the WC/TO provider, mothers usually have a choice either to go to a clinic or to be visited in their homes. The participants in the focus groups suggested circumstances which would influence that choice. For example:

More visiting just because, yeah, you’re younger and you can’t really drive around and go and visit the Plunket. It would be nicer if they take you as a priority and look at you as having no transport kind of thing and you need to visit them. (FG.1, p. 18)
One obvious problem was mobility and the forms of transport available to the participants. They pointed out that most of them did not have access to cars and if they did they were reliant on someone else to drive them where they wanted to go.

*If Plunket could come on a regular basis, just because the majority of us don’t have cars and can’t just go and visit Plunket even if some of our Mums do drive us around (FG.1, p. 18)*

The amount of money the participants had is likely to be minimal this may have been another reason for not having access to cars or other forms of transport. In New Zealand the single teenage mother aged 15 years or under is not eligible for any allowance. If the single mother is 16 to 17 years of age and their parents can not support them, or it is unreasonable to expect this support, they can be eligible for state assistance from 27 weeks into their pregnancy. This is on the sickness benefit for hardship allowance which is $161.76 a week plus accommodation and medical costs if needed. Once the baby is born the emergency maintenance allowance applies, which is $129.41 a week if living at home and $278.04 if not living at home. This continues until the mother is 18 years of age when she goes on to a Domestic Purposes Benefit which is currently $278.04 a week. Work and Income New Zealand, (WINZ) (personal communication, Case Manager, WINZ, April 26, 2010).

**The Amount of Time Available**

Other suggestions the participants made concerned the amount of time the WC/TO nurses were able to devote to them, in contrast to the amount of time they felt they needed. One said:

*Sometimes they don’t have enough time for you. If I want to ask questions they kind of brush you off … they just give you the short answer when you really want more in depth. (FG.1, p. 4)*

One participant described the problem as, “Just booking too close” (FG.1, p. 4), that is, booking appointments too close together and therefore not being able to spend sufficient time with each mother.

Many participants agreed that they would like more time with a WC/TO nurse.

*Especially if you have got something that you really want to sit down and talk about in depth. (FG.1, p. 7)*
Summary

In summary there was a wide variation in the participant experience’s of contact with the WC/TO service. The participants described a service that is not well understood by the user. The transition from the LMC to the WC/TO service was varied, in some cases the transition was initiated by the participant. The participants describe having no choice in who their WC/TO provider would be or having the choice made for them. They were not allowed an informed choice and were unclear who their WC/TO provider was and which service she worked for. It was also unclear what services the mother could expect to receive. This was apparent from the way the participants talked about various aspects of the service, they were not able to articulate what the WC/TO service provided. There were times when communication between the WC/TO service /nurse and the participant was an issue. It was obvious to the researcher that most of the participants viewed all WC/TO nurses as ‘Plunket’ nurses regardless from which WC/TO service they came. The final issue was the amount of time that the WC/TO nurse had available for the visit was not always long enough, some participants wanted more in depth answers from their WC/TO nurse.

Theme Two: The Information Received

The information that a teenage mother receives when making decisions about her child may be critical to the child’s health outcomes. We know from New Zealand research by Woodwood, Horwood & Fergusson (2001, p. 3) that “children born to teenage mothers have been shown to have higher rates of health problems, physical injury, behavioural difficulties, cognitive problems, and educational under-achievement than children born to older mothers.”

From the focus groups interviews it became apparent that the participants received information about parenting from many different sources and the participants were concerned that they may not always have the best information on which to make an informed decision about what was best for their child. The participants concerns focused on the presentation of the information and who had discussed the information with them. Their overwhelming desire was to do the best for their babies and in order to do this the information that they received needed to be the “correct” information.

The following quotations are examples of when information had been positively received and understood by the participant.
The last visit that I had with the Plunket nurse I thought was good, coz she measured my baby, weighed her and then got the chart out and showed me her growth from the last check up and told me what, like produced those lines.....actually explaining what everything is in the charts and then showing her growth from the last check was good. (FG.1, p. 2)

My baby had reflux and she sat down with me and had a really good conversation about medication, formulas and stuff and gave me a lot of information. It was really helpful because mum and I were going through a really bad patch. (FG.1, p. 2)

The participants found it difficult to make decisions about the information that they received as at times there was so much conflicting information. Sources of information were described as coming from a large range of people and places. Perhaps because they are young they are bombarded more than older mothers with information from well meaning family, friends and health professionals. One participant said:

I got information from my Aunty. She came in when I was pregnant with my son ...she came in and said do this do that and I was sitting there going wow. (FG.1, p. 13)

And another,

Yea I got heaps of messages from heaps of people. (FG.1, p. 13)

Some were in families in which their mothers were having children at the same time as them, so they did things together,

My mum’s got seven kids so she just helped me. (FG.2, p. 12)

Health professionals also gave conflicting advice:

One of the Plunket said to me “oh your baby is four months put her on solids”. Well my baby is happy on the breast.....My son tries to give her biscuits and stuff and she is, like you know, she is old enough now and then I got told from another one “just when she is ready”. I should know, I have had the second one. (FG.1, p. 12)

Another participant stated, when she was deciding what information she was going to use and what she was not going to use,
You just listen and do what you feel is right, you just go with the flow. (FG.2, p. 7)

The way the participants wanted the information given to them was often in a more practical format than just being told how to do something or by being given pamphlets. Several participants explained how they wanted to be shown how to care for their babies, as the following quotations explain:

More of showing you how to do it (FG.1, p. 11)

It would be nice if when they do come that they show you like little ideas on how to do things. (FG.1, p. 11)

They could give you ideas on where to take your baby and, you know, show you how to wrap your baby up properly and like different ways to settle your child. There should be classes or something. (FG.1, p. 16)

This participant in the following quotation was evaluating what she had been told by the WC/TO nurse and was making her own choice about the information she had been given. It is as though she has already formed a personal ideology about mothering which has helped her make a choice and guided her behaviour about how to use the information that the WC/TO Nurse has shared with her.

She gives me advice, but na I don’t listen to her cause she tells me that my baby is not supposed to be eating this food and this food....but my baby likes it. (FG.2, p. 13)

Many mothers, as some of the participants indicated, decide to go with their ‘gut feeling’. However intuition is developed from previous knowing and experiences (Belenky, Clinchy, 1997, Goldberger & Tarule, 1986). It could be suggested that a teenage mother might not have the same skills or previous knowledge to be able to do this well, although some may have had previous parenting experience, whether with a previous child or with extended family or younger siblings.

The next two quotations show that some of the participants used what they referred to as intuition, and were going to do what they thought was best regardless of the information provided by the WC/TO nurse.

I just did mother’s intuition you know. I just did what I think was right. (FG.1, p. 13)
Summary

In summary, the participants firstly described times when the WC/TO service provided the information in a way that meant it was positively received. Secondly, the amount of conflicting information is a concern for the participants as they do not know who they should listen to. For any new mother, the amount of information available can be overwhelming. According to Rajan (1993) the provision of easily accessible information and appropriate support is vital to ensure that the new mother is confident, has understanding and peace of mind. Thirdly, the participants wanted to be shown ways of caring for their baby and the more practical format better suited their learning style.

The participants, because of their developmental stage, may interpret information differently. The collective “I” that can characterise this developmental stage has gone even though in some of these quotations it seems to be evident. The information that the participants received is confusing. Every new mother has to contend with conflicting information from many different sources but perhaps, for the teenage mothers, their level of maturity and lack of experience effects how information is received and interpreted.

Theme Three: Attitudes Towards Teenage Mothers

The third major theme to arise from the focus group discussion concerned how these teenagers felt about being a teenage mother and the attitudes they had to deal with because they had children. Most if not all of these comments focused around their age and the perception that they were too young for motherhood. For example, although one participant indicated that she was not treated as a “bad parent” by the WC/TO service, she herself felt she was. She may have internalised societal perceptions of young mothers. She said:

I just consider myself to be a bad parent because I am only 18. (FG.1, p. 8)

It was apparent from the data that the participants felt that as teenage mothers they were being judged because of their age, for example:
I used to walk up there when I wasn’t pregnant they was alright and then I got pregnant and then people used to give me dirty looks..... (FG.2, p. 20)

They look at you funny when you are walking and pushing your pram (FG.2, p. 20)

You will see old people looking ...Yea it’s the old ones that are the worstest.
(FG.2, p.20)

The participants discussed how they perceived they were treated by the nurses and others in society and how that made them feel. Rudeness by strangers was also commented on frequently. They also described how they felt different to older mothers and were part of a “teenagers’ culture”. This was described by the participants as the way they spoke and the things teenagers talk about, their likes and dislikes and how they want to be treated. One said:

I don’t want to be treated like a young kid who had a baby cause some of them get judgemental. (FG.1, p. 14)

The discussion about how the teenage mothers perceived other peoples’ attitudes towards them highlighted the contradictory position they held- young in age but with the responsibilities of motherhood that are associated with maturity. These contradictions were also reflected in the way the participants spoke of how they wanted to be treated as mothers. On the one hand, they wanted to be treated as a special group, differently from mothers in older age groups because they saw many of the issues they faced as being different, while on the other hand they wanted to be treated the same as mothers and given the same respect. As one participant said:

OK I am younger but I understand things the same way as anyone else does.
(FG.1, p. 8)
The following quotations come from the discussion about support groups with older mothers where it was decided within the focus group that they would prefer to have a support group of mothers all the same age. They described their reasons:

Then you don’t get judged. It’s like old people tend to judge you and stuff. (FG.1, p. 17)

There is more stuff to talk about ... With a whole bunch of thirty year olds it would be like, so is this fourth kid. (FG.1, p. 17)

Yeah it’s a bit weird going with heaps of old people. It’s better around our age. (FG.1, p. 17)

If Plunket could just run, like a special teenage programme where they do checks (FG.1, p. 22)

Then there was an opposing discussion where the mothers wanted to be the same as all other mothers. When asked how they wanted to be treated the unanimous answer was:

Like everybody else. (FG.1, p. 14)

I don’t really see the big difference between myself and another person older or anything. (FG.1, p. 13)

Summary

These quotations firstly illustrate how the participants felt about themselves as teenage mothers and the fact that they felt they may not be good mothers because they were young. The next issue was that the participants felt they were being judged by society and the WC/TO nurse because of their age, whether this was the way they were looked at when pushing a pram down the street or when they felt the WC/TO nurse was being judgemental and not giving them the respect they wanted during the visit. How the
participants felt that they should be treated was interesting. While acknowledging they were young to be mothers and wanted to be treated as a special group, they also wanted to be treated the same as older mothers.

**Theme four: Respect and Caring**

The overwhelming desire from the participants was that the attitude of the WC/TO nurse was one of support from “someone who cares”.

The next quotation illustrates the importance to the participant of the support from the WC/TO nurse and service because the nurse talked about the issues that the mother had as well as caring for her and her baby. The nurse was able to attend to her needs as well as the provision of Well Child care.

> My Well Child nurse came and sat down, she was like my social worker in a way, she would talk about stuff that was happening, she would even worry, well not worry about my stress levels and stuff, but she kind of asked about it. She wasn’t there just for my baby she gave me the impression that all was good. She was there for me and my baby. (FG.1, p. 20)

The following quote from one of the participants indicated both the need and the level of appreciation that occurs when respect and caring as part of good support is provided by the WC/TO nurse.

> The well child nurse put my baby in a routine, she wrapped him up and she put him in bed. It was just amazing, she was like came and took out her time and helped me. She sat there and stayed there until Jordan was asleep. She was just awesome.

> (FG.1, p. 11)

This next quote illustrates how the participant felt that she was being respected because her WC/TO nurse was being polite to her.

> Yea they were real polite and just really nice and weren’t rude. (FG.1, p. 9)
This participant said that she needed for herself the service/care that the WC/TO nurse was providing for her child.

_I reckon Plunket should be for a mother and baby well being, not just the baby_ (FG.1, p. 20)

Another participant expressed the same need.

_I want someone to sit down and say how are you feeling, and do you need some help._ (FG.1, p. 21)

Respect for the mother and her environment was also important. The following participant said that she felt respected as the WC/TO Nurse took her time and respected her culture.

_They were quite good because they had respect for the house, like they stop and take off their shoes and they don’t just bowl in eh._ (FG.1, p. 9)

When asked to tell the researcher about what was a good visit from a WC/TO nurse, the entire focus group said in unison,

_When they are interested in you._ (FG.1, p. 1)

The second part of the theme about respect and caring is the participants caring about their child and the respect they are seeking through being a mother.

The participants talked about being a teenage mother and some of the feelings they had about having a baby. Reflected in the following three quotes is an overwhelming need for the teenagers to not want to be alone and having a baby fulfilled this need.

_I will never be alone._ (FG.1, p. 24)

_What won’t leave me, a baby_ (FG.1, p. 24)

_I will never be without someone_ (FG.1, p. 24)
The age and the developmental stage of these mothers appears to have implications for their relationships with their baby, their parents, the father of the baby, the WC/TO nurse and the people that support them in the community and school. This was well illustrated in the data.

The following quotation is from one of the participants justifying her view of herself as a good mother when she felt her WC/TO nurse had been rude to her:

*I don’t know why she was rude, I was clean, my baby was clean and looked after...*  
*(FG.2, p. 12)*

This was the participants understanding of what she thought the WC/TO Nurse expected of her. Her own understanding of being a good mother is defined as having a clean baby. Another of the participants defined this expectation cleanliness when describing other teenage mothers that did not meet the standard.

*I see lots of them and some of them look like scum and that’s the ones that everybody remembers, the scummy paru ones with dirty as kids, not being rude or anything but they are the ones that everyone remembers.*  
*(FG.2, p. 23)*

As cited in Bird and Drewry (2000, p.159), “Erickson suggested that the teenage years were typified as psychosocial conflict, between the establishment of a personal identity versus the uncertainties of role confusion.” Muuss (1996) describes the adolescents search for a personal identity as including the formation of a personal ideology or philosophy of life which gives the adolescent a frame of reference for evaluating events which helps in making choices and in guiding their behaviour. Young women who become pregnant and continue through to motherhood may develop their sense of identity through this role. This is a part of their development which they may not have gained through having an occupation or continuing their education as other adolescents would do. (Medora & Von Der Hellen, 1997; Theriot, Pecoraro & Ross Reynolds, 1991 as cited in Rawiri, 2007).

When the participants of the focus group were discussing what it was like to be a teenage mother it was clear that they had developed their identity through this role. One participant stated that when explaining her peer group that:

*Everyone is pregnant.*  
*(FG.2, p. 24)*
Another described herself, meaning she now identifies more strongly as a mother with responsibilities.

*I am not like a young kid who has had a baby...*  (FG.1, p. 14)

Summary

New Zealand based research carried out by Boden, Fergusson and Horwood (2008) indicates that teenage mothers are typically from disadvantaged backgrounds especially in areas of education and economic status, and also in areas of family functioning and adolescent adjustment. Woodwood, Horwood and Fergusson (2001) carried out research to understand why some young women get pregnant and enter parenthood at an early age. Findings included poor school achievement, Maori ethnicity, early adolescent conduct problems and family adversity. To have respect and caring is a recognised human need. According to Maslow’s Hierarchy of Needs his level three, after the physiological and security needs are met, are social needs, the need for belonging, love and affection (Bird & Drewery, 2000). The participants in this research because of their age and stage of development, predominantly fit Woodwood, Horwood & Fergusson (2001) characteristics, they are likely to have more unfulfilled needs, some of which the WC/TO service can help to meet. According to Hammerton, (1992, as cited in Rawiri, 2007) the presence of support has been found to improve lives of adolescent mothers and reduce the chances of negative outcomes, but insufficient support can be disempowering and cause negative feelings in adolescent mothers which can worsen their situation. This may also be because of the negative role teenage mother have as perceived by society. It may help to explain the overwhelming desire throughout the focus group discussion to have support, respect and caring from the WC/TO nurses.

Summary

This chapter has described the first three steps of the data analysis process followed in order to generate themes. The focus group discussion provided the quotes to illustrate the four themes described in step three.

Theme one concerns the teenage mothers’ experiences with the WC/TO service. Discussed within this theme was the transition from the LMC to the WC/TO service, the choice of WC/TO provider, the identification and service provision as understood by the participant. A further issue was how often the participant had been seen by the WC/TO nurse and finally the issue of access for the participant. Theme two concerned the information received by the participants. There was discussion about where the
information came from and how the teenage mothers would like to receive information. It highlighted how teenage mothers receive conflicting information and the effect that had on their parenting and the decisions they made. Finally the developmental stage of the participant was discussed and how that may have had an impact on the way they received information. Theme three, attitudes towards teenage mothers, considers firstly how teenage mothers felt about being a teenage mother themselves, then how they felt society viewed them. It also discusses the contradictory position they held about how they wanted to be treated as mothers by the WC/TO service. The fourth theme was respect and caring. Within this theme was the discussion of the underlying need for the participants to feel respect and caring as part of good support from anyone who is in their lives especially the WC/TO nurse, and how their need for respect and caring was reflected in their feelings toward motherhood and their babies.

The fourth and final step of Giorgi’s analysis is to “synthesize the essential aspects of understandings and reflections into a consistent statement” (Schneider et al., 2007, p. 111). To achieve this fourth step a discussion of the four themes will be presented in the next chapter.
Chapter 5

DISCUSSION

Introduction

In the previous chapter four themes were identified. Each theme was described and illustrated using selected quotes from the focus group interviews carried out with teenage mothers. The following discussion completes the fourth and final stage in Giorgi’s data analysis to “synthesize the essential aspects of understandings and reflections into a consistent statement” (Schneider et al., 2007, p. 111).

In this chapter the research themes are discussed as an interpretation of each identified theme. The discussion will be related to the existing literature, the research questions and the objectives of the investigation.

**Theme one: The Contact the Teenage Mother had with the Well Child / Tamariki Ora service.**

There was wide variation in the participants’ experience of contact with the WC/TO service. These findings are supported by a report commissioned by the New Zealand Families’ Commission Dwyer (2009) which provided a snapshot of both antenatal education and the maternity care transitions to Well Child care in this country. Dwyer found that some regions had problems with the transition process between the LMC and the WC/TO service which resulted in a substantial proportion of women having to initiate contact with the WC/TO service themselves and that some women fell through the gaps. The research participants in this study talked about the transition from the LMC to the WC/TO service as not happening at all in some cases. Some of the participants did not have any one contact them from the WC/TO services. One turned up on the doorstep of a provider to try to initiate the transition herself. Some talked of not being given a choice of provider and one had someone turn up at their home whom she did not recall having a conversation about with her midwife. In another case the WC/TO provider arrived with the midwife on one of her visits, introducing herself and stating that she was the mothers WC/TO nurse. In some of the more positive experiences, however, the participants had a WC/TO provider ring and turn up when they said they would before the baby was six weeks old and good relationships grew from there. Collins (2004) made the same conclusions from her research. She stated that in many instances opportunities
for enhancing the well being of teenage mothers were missed as the connection was not made by people or services.

Woodward, Horwood & Fergusson (2001) report growing evidence suggesting that young women who become pregnant in their teenage year are characterised by multiple social, psychological and economic disadvantages. Dwyer (2009) identifies another gap in practice in the services provided by the WC/TO, suggesting that families at risk of adverse outcomes and having higher needs should be identified and responded to appropriately but that in practice many of these families are missed. According to Dwyer (2009), part of the problem is lack of screening or monitoring and the other part is a lack of responsiveness. Dwyer also said that families living in the most deprived areas with the greatest need are the most difficult to engage. The literature reviewed provides evidence that teenage mothers can be part of this group of families most difficult to engage.

For most of the participants in this study this was their first experience as a parent with a new baby. The initiation of contact with the WC/TO nurse was the first step in a relationship that could continue until the child is five years old. When the mother had difficulty with the transition process, such as the WC/TO service not contacting her or the choice of the WC/TO provider being made for her, she may have felt that the WC/TO service did not value her, resulting in the development of a poor relationship. Davis, Day and Bidmead (2002) describe relationship building between the parent and the helper as a vital task, “without an effective relationship, communication will fail and the helping process will become ineffective. Support is impossible, for example, if the helper is disliked or distrusted” (Davis et al., p. 35). Dwyer (2009) described engagement as an ongoing process and that services should find innovative ways of reaching out to people by firstly looking at how the services are packaged and making them more attractive to the different groups. Wahn et al. (2005) also said that the teenage mothers in their study described the importance of supportive relationships as a prerequisite for successful parenting, providing the right type of support at the right time.

The participants in this study described the WC/TO service as one that was not well understood by the users. Dwyer (2009) discusses the information gap between what services are available and what services are provided and how this gap needs to be bridged so that parents can make informed decisions about their care. It was clear from the researcher’s knowledge of the services in Hawke’s Bay that the participants mostly did not know which service their WC/TO nurse was from, as the nurses about whom they
spoke were most commonly referred to as a Plunket Nurses even when they were from a WC/TO provider other than Plunket.

Where the visit from the WC/TO nurse took place and the amount of time available for the visit were both issues to the participants. Lack of available transport was a common reason for the participants to want to be seen at home. The need to have more time with the WC/TO nurse was also common, feeling “brushed off” and wanting more in depth answers was discussed. Hanna (2001), in one of her research recommendations, suggested how community based nurses could be more appealing to teenage mothers, by the nurse working in a more flexible and accessible way. This included being able to spend extended time with the teenage mother if needed, and taking the service to the mother’s home. Youth Health: A Guide to Action stated that youth targeted health care should be a priority for youth and that the input from youth into their own health care was a recommendation (MOH, 2002b).

**Theme Two: The Information Received**

It was apparent from the research that the participants received information about parenting from many different sources and that much of it was conflicting. The participants were concerned that the information they were given by the WC/TO was not always the best on which to make an informed decision regarding their child. Research carried out by Hailes and Wellard (2000) found that their participants “reported that midwives gave conflicting advice with help for breastfeeding. As a consequence mothers were confused and did not know who or what to believe” (p. 8). Hailes and Wellard commented about how conflicting advice that was given did not encourage a good relationship with the midwife.

The participants of this research, when deciding what they were going to do with the information provided by the WC/TO nurse, stated that they listen and then “go with the flow” or use their intuition. Belenky et al. (1997) state that intuition is developed from previous knowing or experiences. On the basis of their age and minimal prior experience of mothering it could be suggested that a teenage mother may not be well placed to make the best decision based on intuition.

The way the information was delivered or discussed may have been a deciding factor for the participants about how they would use it. This has implications for WC/TO nurses when visiting teenage mothers. Wells and Thompson (2004) from England in their article
describe specific strategies for supporting teenage mothers based on reflections by home visitors. The home visitors were professionals in child development working for a community agency which provided home visits to teenage mothers whose children were considered to be at high risk of developmental problems, and also to assist with parenting classes for these mothers. One of the home visitors described the teenage mothers she visited as a “difficult group” with whom to work saying they do not listen to anything you tell them and they think they know it all. Another said that she felt that the “teenage mothers do not think what the home visitor has to say or do has any application to them, and like many adolescents, they usually think they know what is best” (Wells & Thompson, 2004, p. 21). When the home visitor reviewed how she felt, she described to the researcher that it was her inability to connect with the teenage mothers and her lack of the appropriate skills and strategies that meant she was not successful in meeting the needs of teenage mothers. Wells and Thompson (2004) described strategies to ensure that teenage mothers found value and benefit from the support offered. One of strategies involved using a videotape. It was found that although teenage mothers may not be interested in listening to information, when they are able to see the information played out on a videotape became much more meaningful. A different way of learning that may have suited this age group.

The participants of the research presented here discussed having the information given to them in a more practical format. Several explained that they did not want to be given pamphlets and be told how to do things, but that they wanted to be shown, for example, ways of caring for their child. This more practical approach may better suit their learning style. A suggestion that was made by one of the participants was that there could be groups for teenage mothers with newborn babies to help with the practicalities of parenting in the first few months. Teenage mothers are chronologically adolescents but with the birth of their child they are suddenly in a world of adult responsibility. Knowles (1990, as cited in Wells & Thompson, 2004) suggests that in adult learning the individuals are all viewed as learners rather than there being a teacher and learners. The teacher’s role is not just to impart knowledge to the learner but to work collaboratively with the learner in a way to ensure that the learner’s desired goals are met. Knowles (as cited in Wells and Thompson, 2004) suggests that programmes should avoid having a teacher/ learner approach but rather an approach in which the parent/ support professional encourages the mother to identify her immediate ‘need to know’ issues so that the “home visits thus become centred on the parents’ needs and their perception of reality. In this way the young mothers feel supported and capable of providing care and nutrition to their infants” (p. 23).
The Ministry of Health (2002 b) ‘Youth Health: a Guide to Action’ suggested making New Zealand’s health services more youth focused and emphasised the need for the health sector to be more responsive to young people. At present in Hawke’s Bay there is not much available within the community that specifically meets the need for the development of practical parenting skills for teenage mothers, in the early months of caring for their babies. The Hawke’s Bay District Health Board (2010a) Youth Health Work Plan 2010-2013 Draft states in the demographics that, in Hawke’s Bay, live birth rates are increasing for teenagers aged 13 to 17 years and are consistently higher that the national rates, with Maori rates five times those of non Maori in 2008/09 (HBDHB, 2010a). However there is no reference in the Youth Health work plan 2010-13 draft to specifically supporting teenage mothers. Maybe the provision of education about the practical skills of parenting, through providing peer support for teenage mothers or using new technologies such as texting, Face book or You Tube for this education and connection, could help to address this gap.

Theme three: Attitudes Towards Teenage Mothers

The attitude that teenage mothers were too young for motherhood was an impression the participants in this study perceived from several different areas. Firstly there was the teenage mother herself who just considered herself a bad parent because of her age. Hanna (2001) says that when looking at the strategies to make services more appealing to teenage mothers one recommendation would be to enhance the developmental tasks of adolescence, such as feelings of self worth, a sense of belonging, acquisition of skills and development of appropriate relationships. Hanna (2001) found that teenage mothers experienced “negative public attitudes directed towards them wherever they went, and this included their visits to the community child health centres” (p. 456). The same finding was evident in this research; the participants discussed how they perceived they were treated by WC/TO nurses and others in society. They felt that they were being looked at and judged negatively because of being young and having a baby. Rudeness by strangers was commented on frequently. Attitudes towards the participants highlighted the contradictory position that they held; they were young in age but with the responsibilities of motherhood that are associated with maturity. This contradiction made it difficult when the participants were trying to work out how they wanted to be treated as a mother. Collins (2004) had the same finding in her research; that teenage mothers felt that they were judged negatively in society because they were young. Some of the teenage mothers in Collins’ (2004) research stated that they saw their lives in positive terms and that becoming pregnant as a teenager had turned their life around for the better. Hanna (2001) states,
The young women had definite ideas of what they wanted from nurses, and that was not to be prejudged as being a young mother. They did not like being treated differently from the older clientele, but equally they did expect nurses to recognise that they had additional needs that may have been different from those of older mothers (p. 460).

The same sentiments were evident in the findings of this research. The participants stated that they wanted to be treated like everyone else, but they also wanted to be treated differently as they saw the issues that they faced as being different from older mothers.

**Theme four: Respect and Caring**

The need for respect and caring was evident throughout the research. The participants wanted support from someone who cares. Davis et al. (2002) state that there are six qualities needed by helpers to develop a partnership with parents; these include respect, genuineness and empathy as well as the need for technical knowledge. Dykes et al. (2003) say when discussing support for teenage parents that “support was crucial to the adolescents in enhancing their feelings of self-worth, ability, and being valued as a mother” (p. 396) and that it was important to note that the teenager wanted to be treated as an adult. In the research presented here the participants described their need for respect and caring. They wanted the WC/TO nurse to be interested in them, to take her time and to respect their culture.

The second part of this theme is the participants’ care for their child and the respect they are seeking through being a mother. Wahn et al. (2005) state that “teenage pregnancy is not always unplanned” (p. 596). Some of the teenage girls in Wahn et al.’s research had chosen to become pregnant and when interviewed described their reasons for continuing their pregnancy to term. These included early childbirth being a pattern or history in their family, a desire for a child or something that would be “permanently one’s own,” and the lack of alternative opportunities in life. Some of the teenagers in Wahn et al.’s research saw “pregnancy as an escape from a violent or unhappy home where they had not felt loved” (2005, p. 596). Woodwood, Fergusson and Horwood (2001) found that childhood exposure to dysfunctional family relationships and coercive childrearing practices “may encourage an early pregnancy and a premature transition to parenthood” (p. 1172). Several of the participants in this research also described having a baby in similar terms, because ‘it would not leave them’ and ‘they would never be alone.’ It was clear that they had developed their identity through this role, identifying as a mother now with responsibilities and a long-term caring bond with another human being. It needs to be recognised therefore, that teenage mothers do not necessarily regard their pregnancy or
status as a teenage mother as negative, in line with the negative attitudes they experience, but may in fact be positive and empowering. Rawiri (2007) discusses how, although teenage pregnancy is viewed most commonly as a social problem, for some teenagers who become mothers it can be a way out of an already helpless situation. Their child may become a source of affection and love that may have been attributes that were missing in their lives and provide opportunities for personal growth and development. Pregnancy in the lives of teenage mothers growing up in difficult circumstances may be seen as their last hope for a better life.

Attitudes towards teenage pregnancy and motherhood at a young age vary considerably between cultures. For example, in traditional Maori society women were considered important as they were the bearers of all humans. Dickson et al. (2000) state that women’s primary role within the traditional Maori society was to raise their child to maturity, with all the support of her whanau, hapu and iwi. Colonisation led to a breakdown of communal living so Maori mothers could no longer rely on the same support. Dickson et al. discussed a hui they attended in 1996 where only one of the 200 pakeke or Kaumatua attending identified contraception and teenage pregnancy as a health issue for rangatahi while, in contrast, over half of the rangatahi women interviewed considered these as important issues. This may suggest that there are differing opinions between age groups concerning motherhood in Maori society.

The statistics that describe ethnicity within the age at birth data indicate high rates of teenage births are to mothers who identify as Maori. Although not a finding of this research (maybe because the researcher and assistant were Pakeha) it is acknowledged that culture is important when providing a service such as the WC/TO. The WC/TO service should reflect an understanding of the Maori culture in it service provision regardless of being a Maori WC/TO provider or not.

The stage of development that the teenager may be experiencing is described as a time when the human is developing a sense of self (Erickson, 1980). This developmental stage is named by Erickson as Identity versus Role confusion (Bird & Drewery, 2000) and it is during this stage that teenagers are generally just starting to think about others thoughts and feelings but at the same time wondering what others think of them. Muuss (1996) says young women who become pregnant in this stage may develop their sense of identity through being a mother. This is also reiterated by Medora and Von Der Hellen (1997, as cited in Rawiri, 2007) who say that women who enter motherhood as an adolescent may acquire a sense of identity through this role, and this is a pathway for their development that they may otherwise not gain as other adolescents do, such as
through education or having a paid occupation. The development of identity through the role of teenage motherhood may also achieve the fulfilment of one of Maslow’s hierarchy of needs. Respect and caring may be found through this role.

**Summary**

The discussion presented here has completed the fourth and final stage of Giorgi’s data analysis method. It has provided the process to achieve “synthesizing the essential aspects of understandings and reflections into a consistent statement” (Schneider, 2007, p. 111). These findings have implications for WC/TO nursing and how teenage mothers would like a service that may look different from what is delivered at present. The findings answer the research question: What do teenage mothers want from the WC/TO service? These implications will be discussed in the following chapter.
Chapter 6

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This study sought to identify what teenage mothers wanted from the WC/TO service. The significance of the study was introduced in Chapter one. A need to ask youth what they want from primary health services in order to improve health outcomes was identified as being of international, national and regional importance (Hanna 2001; HBDHB 2010a; MOH, 2002b). This research project has been significant because it focused on what teenage mothers wanted from the WC/TO service. The WC/TO service is unique to New Zealand, delivering three strands of primary health care, education and promotion, health protection and clinical assessment and family or whanau support. The WC/TO service is supported by the Well Child Tamariki Ora schedule (Ministry of Health, 1996) which is at present in the process of being reviewed.

The literature reviewed in this study identified gaps in research both internationally and nationally investigating the teenage mother’s perspective (Hanna, 2001; MOH, 2002b). It also identified no specific New Zealand research focusing on teenage mothers and the WC/TO service from the teenage mother’s perspective. The literature review provided the rationale for this research issue, the question and the design used.

Hanna’s (2001) research indicating that teenagers require a different approach for improving health outcomes for their children and themselves and that health providers need to develop an understanding of these teenagers. This research strengthens that approach by asking the teenagers themselves what they wanted from the WC/TO service which seemed to be one way to provide a service that meets their needs.

The use of a qualitative research method using focus groups enabled rich data to be gained from a group of participants that are renowned as difficult to get information from (Bassett & Beagan, 2008). The qualitative descriptive approach used in this study allowed an inductive analysis of data guided by Giorgi’s method from which four themes were identified. The conclusions and recommendations in this chapter have emerged from the findings and discussion.
Conclusions

The participants represented teenage mothers aged between 16 to 19 years of age. They willingly shared their experiences of the WC/TO service within the two focus groups that were held. From their accounts four themes were generated. The first theme described contact that the teenage mother had with the WC/TO service. There was wide variation of contact among the participants. The conclusions from theme one were, firstly, the transition from the LMC to the WC/TO service did not occur consistently. Some of the participants were transferred and visited by the WC/TO service within the allotted time, while others had to make contact with a WC/TO service themselves if they were to receive a WC/TO service. Secondly, participants had differing experiences in the choice of their WC/TO provider. Some were visited by the WC/TO provider they chose, while others were offered no choice. One of the participants chose a WC/TO provider but had another one visit. This lack of consistency in the handover from the LMC to the WC/TO service was also the case found by Dwyer (2009). The repercussions of not providing continuity of care between the services meant that some of the participants did not continue with the WC/TO service. The issue of relationship building between the WC/TO nurse and the participants did not arise specifically but, Davis et al. (2000) discussed there is a need to build relationships of trust and respect so that the WC/TO nurse can provide the three stands of the Well Child/ Tamariki Ora schedule (1996).

Lack of information about what the WC/TO service could deliver and from which WC/TO provider the nurse came were identified as indicators of poor communication in the next part of this theme. Some of the participants were still unaware after three visits which provider the WC/TO nurse came from and what the WC/TO service provided. These issues contributed to the conclusion that communication was problematic, possibly affecting the relationship the participants had with the WC/TO service and consequently the service that was received by the teenage mother may have resulted in poorer health outcomes for the child. Further issues were identified around time and place of visits by the WC/TO nurse. The participants identified mobility as a problem as many did not have access to cars and had very little money for travel therefore preferred to be seen in their home. Additionally, they spoke of wanting longer visits with the WC/TO nurse. This highlighted the need for WC/TO services to be delivered with specific consideration of the social circumstances of those age group and reiterates the Youth Health: A Guide to Action (2002b) where it was proposed that New Zealand’s health services needed to
be more youth focused and emphasised the need for the health sector to be more responsive to young people.

The second theme of the analysis was about the information the participants received that informed them when making decisions about their children’s welfare. It was apparent from the participants that information about parenting came from many different sources. They spoke of finding it difficult to make decisions about information they received as some was conflicting, including that which came from health professionals including WC/TO nurses. This meant that they would often make parenting decisions based on what they thought was best for their child from their own usually limited experience or intuition. Some of the participants discussed how the more practical way of being shown parenting skills suited their learning style and how they wanted more of this available to them. These findings have implications for the ways WC/TO services need to be streamlined, packaged and presented to teenage mothers. Johnson and Denny (2007) discussed the need for health services for teenage mothers to be family focused and developmentally appropriate. This was also affirmed by the research participants regarding the information they were given and how they made decisions about their children’s care. Rawiri’s (2007) thesis concluded that informational support was needed and this was a large part of the reason why the participants of this research went back to education such as that provided by the teen parent unit.

Theme three described the participant’s beliefs about themselves and their perceived attitudes of others towards teenage mothers. The participants discussed how they felt judged when they were out with their babies and perceived negatively judgemental looks from the public. They also articulated the dichotomy of being a teenage mothers and wanting to be treated as a special group, with many different issues from older mothers, while still wanting to be treated the same way as older mothers and given the same respect.

The final theme was one of respect and caring. There were two sides to this issue. One concerned the respect and caring that a mother receives through assistance and positive support the WC/TO service. The participants identified a need for support from someone who cared and had respect for them. The WC/TO nurse needed to care for the mother and meet her needs as well as, or ahead of providing Well Child care. This was also one of Hanna’s (2001) findings in research about using a women- focused rather than child focused approach to care, so the nurse would see the mother and child within a support supportive community rather than just focusing on the child. This mother/ WC/TO nurse relationship was crucial if the partnership was to survive and consequently provide
positive health outcomes for the child. The second part of this theme explored the respect the participants are seeking through being a mother and having a child to care for. The participants described how they felt as mothers and how having a child met their own personal needs such as a need to prevent loneliness. This information contributes to understanding the positive aspects of teenage motherhood and the motivations for pregnant teenagers’ choices.

**Recommendations for the WC/TO service**

All mothers of children born in New Zealand have a choice about their WC/TO provider. There are many different needs and cultures within the whanau and communities of New Zealand which the WC/TO service tries to meet. The WC/TO service attempts to address different needs within the scope of the contract the WC/TO providers work. This research aimed to explore what teenage mothers want from the WC/TO service. A review of literature highlighted the many often negative outcomes identified for teenage mothers and their children and the importance of providing support that met this special groups needs was evident.

The transition from the LMC to the WC/TO service for teenage mothers needs to be improved so that every teenage mother has a WC/TO provider visit them in their home by the time their child is six weeks of age. The possible ramifications of not improving this process are that the connection with the WC/TO service for the children of teenage mothers may never be made, meaning the best health outcomes for mother and child may be jeopardised. The WC/TO providers need to see teenage mothers as a priority and ensure that this transition takes place.

Part of the LMC’s role is to ensure that the choices of WC/TO provider that will be available to her and her child are discussed with the teenage mother. The choice of WC/TO provider can be made in the antenatal period but must be finalised by the time the LMC needs to refer the mother to the WC/TO service, before the child is four weeks of age. There needs to be a system of checking this process, which needs to involve better communication between the LMC and the WC/TO provider to prioritise teenage mothers. This should be a priority of both the LMCs and the WC/TO service.

Once the referral from the LMC is received it is the role of the WC/TO service to contact the mother and visit the mother and child before the child is six weeks of age. This should be a priority with teenage mothers and their children as the need for early intervention is an opportunity not to be missed with this high needs group. When this contact is made the WC/TO nurses role is to make sure the mother understands which
provider the WC/TO nurse is from, and to outline the service that will be delivered to her and her child. Every opportunity should be taken to make sure the message is delivered in ways that the mother understands and she is given the opportunity to ask questions. This is an important beginning to the ongoing relationship between the mother and WC/TO nurse and it involves building mutual trust and respect.

The first visit from the WC/TO nurse should include discussion between the mother and the WC/TO nurse as to where future visits will take place. This should be agreeable to both parties. If the contract between the WC/TO nurse and the teenage mother is not made at this time it can lead to confusion, resulting in missed appointments.

The length of the visit from the WC/TO nurse is another area to be discussed at the first visit from the WC/TO nurse. Teenage mothers may need more time and explanation because of their developmental stage, learning style, lack of experience and/or need for extra support. This information needs to be taken into account when Ministry of Health contracts for WC/TO services are being written.

There is a need for all WC/TO providers to be giving the same parenting information. This is especially important for teenage mothers as they may be bombarded with parenting information from all areas of society, including family and friends, based on the preconceived idea that because they are young they do not know how to parent. The WC/TO nurse must provide consistent and correct information for teenage mothers to be able to make informed decisions about their parenting. The information a teenage mother receives when making decisions about her child maybe critical to the child’s health outcomes. The information shared must be consistent and also appropriate to mothers and whānau learning needs and styles. It is also important to include significant others in explanations as these are the people who support the mother and they need to be reinforcing what has been discussed between the WC/TO nurse and the mother.

Teenage mothers may benefit from practical parenting sessions in the weeks after the child is born. The participants of this research specifically asked for this, commenting that being shown how to do basic things such as wrap a baby suited their style of learning. There would also be the added benefits of being part of a group of ‘like mothers who may build bonds for support of each other leading into the future. The development of parenting support groups with a practical aspect specifically for teenage mothers would be a recommendation. Rawiri (2007) concluded that support for Maori teenage mothers in her research was strongest from female members within social networks, including mother, sisters and friends. The inclusion of these support people may be another consideration when starting parenting sessions for teenage mothers.
Society has ideas and attitudes about teenage mothers, as teenage mothers have ideas about themselves. The feeling that these teenage mothers had of being judged did not only come from their communities but also from WC/TO nurses. We may not be able to change the views of others about teenage motherhood but as WC/TO providers, should be aware of the prejudices that their WC/TO nurses may have, and not assign judgemental nurses to care for teenage mothers. Additionally education for staff with stereotypical beliefs would be beneficial to clients and the provider itself. It is paramount for the WC/TO nurse to understand that teenage mothers are a special group with differing needs from older mothers when providing a WC/TO service, while it is also important to recognise that teenage mothers want and are entitled to the same kind of respect as a mothers who are older women.

Referral to other support services to help teenage mothers who are really struggling with their identity and role may be a helpful option. One way to ensure that teenage mothers and their children are getting a WC/TO service that encompasses teenage mothers’ needs is to employ a WC/TO specialist nurse or nurse practitioner who has a special interest and flexibility to work in a frame work that meets the needs of teenage mothers and their children. This WC/TO nurse specialist would be able to spend more time and be more accessible to the mother when needed working in a way in which better respect, caring and trust would result and would encourage a plan of care together. This WC/TO specialist nurse would develop strong links within the community agencies that also support teenage mothers and their children. Commencement of the relationship between the WC/TO nurse specialist and the teenage mother could happen in the antenatal period thus preventing any of the complications of the handover from the LMC as discussed previously. Having a WC/TO nurse specialist involved with the teenage mother at the time of antenatal care was also a recommendation made by Lidington (2009), a Plunket nurse who worked with teenage mothers in Rotorua and reported in the paper she presented at the Royal New Zealand Plunket Society conference in 2009 entitled “Delivering Well Child services to teenage mothers- can we do it differently?” Johnson and Denny (2007) stated in their recommendations that services supporting teenage mothers should be able to address complex issues such as sexual health, mental health, substance abuse and family issues in a co-ordinated and integrated way.

Respect and caring are human needs. The importance of these was overwhelming, and interwoven throughout the transcripts. This has implications when providing the WC/TO service, starting from the first contact made with the mother. As the findings showed, if contact with the WC/TO service was not made, the service not understood, the time or place for the WC/TO visit not suitable or the WC/TO nurse was seen to have a negative
attitude towards teenage parents, the chances of a good working relationship being formed between the WC/TO nurse and the teenage mother was greatly reduced and the health outcomes for the child are jeopardised. Training for staff in the Family Partnership model (Davis et al., 2002) would help develop more effective and responsive relationships with teenage mothers.

The teenage mothers in this research wanted respect through being a mother. The discussions about how this group of teenage mothers felt about their children highlighted their unfulfilled need to have someone to care for that they hoped will “never leave them”. The implications for the WC/TO providers is the need to be aware that this mother / child relationship is important and how the teenage mother views her child may be very different from other mothers.

Summary

The research found that the participants wanted a service that met their needs as teenagers and mothers. Throughout all their time with WC/TO providers they wanted to feel respected and cared for. They needed society not to judge them and also to feel good about themselves in their role as mothers. When discussing the WC/TO service they had received they needed to make the transition from the LMC to the WC/TO service as easy as possible and within the first six weeks after their child was born. This would provide them with the early support that they wanted. They needed to be able to choose the WC/TO service themselves and it was important that the WC/TO service turned up when they said they would. It was important for them to know the service they would receive from the WC/TO provider, as well as always feeling part of a valued and caring relationship. They wanted parenting information to be consistent between professionals so they could make correctly informed decisions about parenting.

Recommendations for future research

Considering the high number of births to teenage mothers in New Zealand and the majority of research showing poor outcomes for both the mothers and their children, it would be helpful for more in-depth research about what teenage mothers want from the WC/TO service for themselves and their children to be undertaken with a larger and wider ranging population.

Research needs to be completed by the different WC/TO providers to explore how they each provide services for teenage mothers and their children would be valuable. It would
provide impetus for the WC/TO providers to look at how their service could be changed or focused to better care for this group.
References


Hawke’s Bay District Health Board. (2010 a). *Youth health workplan 2010-2013 Draft*. Hawke’s Bay: Author


Ministry of Health. (2009 a). *A focus on the health of Maori and Pacific: Key findings of the 2006/07 New Zealand health survey*. Wellington: Author


Appendix A

RNZPS (Inc) Ethics Committee Approval
Appendix B

Eastern Institute of Technology Research Approval
Appendix C

Participant Information Sheet
Appendix D

Letter from Kuia